# SPRING 2022 INSURANCE COVERAGE UPDATE

***Message from the Committee Chair, Michael M. Neltner:***

*The following cases represent the more relevant insurance coverage cases decided by the Sixth Circuit, Ohio Federal District Courts, and Ohio Supreme and state appellate courts applying Ohio law in late 2020 through 2021. Many thanks to the following Members of our outstanding Insurance Coverage Committee who volunteered to summarize these cases and make this edition possible: Kurt D. Anderson of Collins, Roche, Utley & Garner, LLC; Dawn R. Bonnett of Grange Insurance; Adam E. Carr of Carr Law Office, LLC; David C. Comstock, Jr. of Bonezzi, Switzer, Polito & Hupp Co., LPA; Christine M. Duraney of The Cincinnati Insurance Company; Michael D. Farley of the Ohio Insurance Institute; Eric K. Grinnell of Carr Law Office, LLC; Stu Harris of Nationwide Ins. Co.; Greg Kendall of Porter Rennie Woodard Kendall, LLP; David Orlandini of Collins Roche Utley & Garner, LLC; Kent D. Riesen of Anspach Law; Gerald Southard of The Cincinnati Insurance Company; Brian D. Sullivan of Reminger Co., L.P.A.; and Trent Thacker of Curry Roby, LLC. These summaries are provided simply for the reading pleasure of the audience and the content herein is not necessarily a reflection of the views or opinions of OACTA or any of the other writers.*

## I. FEDERAL COURTS

### Sixth Circuit Cases

#### 1. Professed Ignorance is not a Warranty

*Certain Underwriters at Lloyd's v. KG Administrative Services, Inc.*
855 Fed.Appx. 260 (6th Cir., May 14, 2021)

**HOLDING: 1) Statement in policy application claiming ignorance of prior claims was a subjective statement of belief or opinion that constituted a mere "representation" rendering policy voidable, and was not a stipulation of objective fact necessary to constitute "warranty" as to make policy void *ab initio*; and 2) Question of fact prevented judgment on the pleadings as to whether one of three lawsuits filed prior to the claims-made policy inception was served during the policy period and triggered coverage.**

Lloyd's insurer sought to rescind its claims-made policy of professional liability insurance and/or a declaration that it owed no duty to defend insured against 3 different lawsuits filed against the insured prior to the insured's application for insurance with Lloyd's. In the application, the insurer's president signed a statement that "After inquiry I, nor any principal, partner, director, officer or professional employee have any knowledge or information of any act, error, omission, fact, circumstance or contentions of any incident which may give rise to a claim being made against us."

The district court had granted the insurer's motion for judgment on the pleadings, finding the application statement to be a false warranty, rendering the policy void ab initio. The 6th Circuit reversed on this point, finding the statement to be a subjective statement of opinion or belief, and not a stipulation of objective fact necessary to constitute a warranty under Ohio law.

The district court had not found it necessary to rule on the insurer's additional argument -- that the three lawsuits, filed prior to the insured's application, did not fall within the claims-made policy period. The 6th Circuit proceeded to consider these arguments and ruled that—for purposes of a motion for judgment on the pleadings—it was clear from the pleadings and judicial notice of the dockets that two of the three lawsuits were filed and served prior to the policy period, and thus fell outside coverage. But there was uncertainty—at least at the pleading stage—as to when the third lawsuit was served on the insured, and thus the insurer was not entitled to judgment as to coverage for this third lawsuit, and the case was remanded for further proceedings.

### 2. COVID-19 Shut-Down Orders did not Cause a "Direct Physical Loss"

*Santo's Italian Café LLC v. Acuity Insurance Company,* 15 F.4th 398 (6th Cir., Sep. 22, 2021)

**HOLDING: State of Ohio's order suspending all in-person dining operations at restaurants to slow the spread of the COVID-19 virus did not qualify as "direct physical loss of property" or "damage to property," within meaning of commercial property insurance policy, or policy's additional coverage for business income losses.**

An Italian restaurant in Medina, Ohio, sued its insurer for coverage for loss of business caused by the government shut-down that prohibited in-person dining (although the restaurant could remain open for carry-out and delivery services). Restaurant claimed coverage should be granted under either Property Damage or Business Income coverages. The 6th Circuit held that while the shut-down orders certainly caused a "loss of use," the policy's coverage for either "direct physical loss of property" or "damage to property" required a tangible damage to physical property.

> "Whether one sticks with the terms themselves (a "direct physical loss of" property) or a thesaurus-rich paraphrase of them (an "immediate" "tangible" "deprivation" of property), the conclusion is the same. The policy does not cover this loss. The restaurant has not been tangibly destroyed, whether in part or in full. And the owner has not been tangibly or concretely deprived of any of it. It still owns the restaurant and everything inside the space. And it can still put every square foot of the premises to use, even if not for in-person dining use."

### 3. "Actual Cash Value" Means "Actual" Cash Value and Not Taxes and Fees

*Wilkerson v. Am. Family Ins. Co.*, 997 F.3d 666 (May 13, 2021)

Plaintiff/insured filed an insurance claim after a car accident. The policy covered loss of or damage to an insured vehicle and its equipment, less any deductible. However, this amount was limited to the lesser of the "actual cash value" of the stolen or damaged property or the amount necessary to repair or replace the vehicle.

The insured filed a class action suit, arguing that the "actual cash value" also included the various sales taxes and fees parties typically incur when purchasing a replacement car. The district court dismissed the complaint.

On appeal, the Sixth Circuit phrased the issue as whether, "actual cash value of the stolen or damaged property" unambiguously excluded taxes and fees typically incurred when purchasing replacement property.

The court held that, while the plain meaning of the phrase would unambiguously exclude any fees associated with a new vehicle, the plain language did not automatically control in the insurance context, where the phrase "actual cash value" had its own meaning. The phrase was amenable to two separate meanings – the price parties would pay on the open market for a car and replacement cost minus normal depreciation, which is the default rule in states such as Florida. However, this does not mean the contract is necessarily ambiguous. Viewing the contract as a whole, the term "actual cash value" was not defined, but the insured's proposed meaning would effectively render the second half of the clause largely redundant, as both would then provide for the replacement value of the property. This was sufficient to overcome the presumption that ambiguous portions of a contract are to be construed against the drafter. An Ohio regulation recommending that insurers pay the sales tax on a replacement car if bought within thirty days of receiving a cash settlement was not relevant and did not affect the court's interpretation.

The court then held that, "actual cash value" is unambiguous as it appears in the insured's policy and refers to the market value of the lost or damaged vehicle and does not include taxes and fees incurred in purchasing a new vehicle. The insured's appeal was therefore denied, and the district court's dismissal of the insured's complaint was upheld.

### 4. No Known Loss Where the Insured Didn't Know What it was Not Knowing

*Allied World Surplus Lines Ins. Co. v. Richard Goettle, Inc.*, No. 20-3339/3394, 2020 U.S. App. LEXIS 35147 (6th Cir. Nov. 5, 2020)

This case reaffirms Ohio's disdain for known loss exclusions.

Defendant, Richard Goettle, Inc., was an engineering and construction firm that obtained professional services liability insurance from the plaintiff, Allied World, from June 28, 2016 to June 28, 2017. After a year of coverage, the insured elected to renew coverage for a year. The renewal application asked whether any person at the insured's business knew of any circumstances that could be the basis of a claim under the policy and noted that if any person did know of such a claim, the carrier had the right to withdraw coverage or modify the agreement. The insured answered "no," and its policy was renewed for another year. In August 2017, the insured informed its carrier of a potential claim arising out of a mining accident in November 2016. The insured had first been notified of this potential claim on June 1, 2017. Shortly after, two suits – one for damages arising out of the mining accident, and another for breach of contract with the same party – were filed against the insured. The carrier denied the insured's claim on the basis that the insured failed to inform it of the claim when the insured renewed its coverage. The carrier filed a declaratory judgment action against the insured, and the insured counterclaimed and sought damages for breach of contract and indemnification.

The district court granted summary judgment in favor of the insured and found that the carrier was required to provide coverage under the policy. While the policy did reserve the right to withdraw or modify any insurance quotations or agreements if the insured failed to update the carrier, the court held that it could not be enforced because there was no express penalty for a failure to update the carrier at the time of renewal after coverage was issued.

On appeal, the court characterized the issue as being whether the carrier properly denied coverage when the insured received notice of a potential claim weeks before it renewed its insurance policy. The court noted that insurance contracts are to be construed against the carrier who drafted the policy and that because a pollution provision in the policy clashed with a professional liability provision, the exclusion therefore could not bar coverage.

As for the requirement that the insured give notice of any potential or pending claims, the specific provision did not state that the carrier could deny coverage upon a failure to update. Rather, the provision only allowed the carrier to withdraw or modify an agreement if the insured failed to give it notice of putative claims. Because the carrier did not withdraw the agreement and accepted the insured's premium payments, it could not deny coverage. Furthermore, though the breach of contract and mining accident cases overlapped, the trial court properly reviewed the fees paid in both actions to ensure the carrier was only paying the fees it covered for the mining accident action.

**5. Insurer May Maintain its Right to Continue Claim Investigation Without Waiving Policy Limitations Provision if it Clearly Advises the Insured that it is Not Waiving the Provision.**

*Write Start Early Christian Edn. Ctr., LLC v. Natl. Fire & Marine Ins.*, 836 F.App'x 362, 363 (6th Cir. Nov. 12, 2020)

The policy here contained a two-year policy limitation clause barring suit more than two years after the damage occurs.

In 2016, the insured suffered damage during a break-in. The carrier largely denied the claim in July 2016 but did pay a small portion of damages. In March 2018, the insured asked the carrier to reopen the claim. The carrier agreed, but it noted it was reserving its right and defenses under the policy, including the policy limitations provision. The insured offered a new repair estimate, but in June 2018, the carrier declined to increase its initial payment. The carrier then requested documentation from the insured to support a request for reconsideration of coverage.
In October 2018, the carrier sent the insured a letter reminding the insured that the carrier's request for additional documentation had gone unanswered. That letter again reserved the carrier's rights and defenses under the policy.

In April 2019, the insured then sued the carrier for breach of contract in state court. The carrier removed to federal court, then filed a motion to dismiss the case for failure to state a claim under the limitations provision. The insured requested leave to file an amended complaint, which claimed that the carrier waived the limitations period through its correspondence with the insured through March and October 2018. The district court denied leave on the grounds of futility and dismissed the insured's complaint.

The issue on appeal, then, was whether the insured's complaint was barred by the policy's limitations period when the carrier and insured corresponded during the limitations period, but the claim was filed after the limitations period had elapsed. The Sixth Circuit stated that under current relevant Ohio law, limitations in an insurance policy may be waived by a carrier when it recognizes liability or holds out a reasonable hope of adjustment so that the insured delays filing suit. Here, the carrier repeatedly denied that it was liable and expressly reserved its rights under the policy's limitations period several times. Such conduct, in the court's opinion, did not evidence a recognition of liability or reasonable hope of adjustment. Therefore, the carrier was permitted to reopen its investigation into the insured's claim without accepting liability and the court held that the carrier did not waive its right to enforce the limitations period when it agreed to reinspect the insured's claim because it expressly reserved its rights to enforce the limitations period against the insured several times throughout the parties' correspondence. The carrier's agreement to reinvestigate the insured's claims did not constitute a waiver of its defenses to that claim.

### 6. One Does Not Simply Walk Into Alaska -- First One Must Crash an ATV and Then One Must Litigate Pennsylvania Contract Law in Federal Court in Ohio

*Commerce & Industry Ins. Co. v. Century Surety Co.,* 809 Fed.Appx. 311 (6th Cir. April 30, 2020)

Weston Solutions (Commerce's insured) contracted to provide decontamination services at a remote location in Alaska. Weston subcontracted for "transportation services" (which in remote Alaska means ATV rides) with Aniakchak Co. (Century's insured). After an ATV crash, the hapless passenger filed her first complaint (in Alaska) against the driver; against Aniakchak for negligence and vicarious liability as the driver's employer; and against Weston for negligence. Two years later, the passenger filed an amended complaint, adding allegations that the driver was also employed by Weston, and that Weston was vicariously liable also. The injury lawsuit resolved. The two insurers differed over payment of defense costs.

Commerce filed its coverage suit in Ohio, ostensibly because Ohio is Century's principal place of business.

The district court found that the dueling excess clauses meant both insurers had a duty to pay for defense costs for Weston, looking to both Pennsylvania and Alaska law. The district court held that Commerce alone was liable for all of the driver's defense costs. Commerce's other-insurance provision applied only to "you," which was Weston, not the driver. Century's language was broader, and thus Century was excess to Commerce for the driver's coverage, meaning Century had no duty to defend the driver. The court was not particularly interested in whether this result complied with the subcontractor agreement between Weston and Aniakchak, as neither was a party to this dispute between their two insurers.

The Sixth Circuit agreed with the district court in all respects, except for the timing of the joint duty to defend the driver. Commerce's duty to defend the driver could not have existed until the driver arguably became Commerce's insured. This might have occurred at the filing of the second complaint, or at a prior event. The Sixth Circuit found an issue of fact as to when Commerce first became aware of the allegation that the driver was Commerce's employee. The case was remanded to the district court to determine this date.

### 7. No More Cash For Your Crash

*Pieczonka v. Progressive Select Ins. Co.*, 840 Fed.Appx. 856 (6th Cir. Jan. 20, 2021)

This was a diversity case seeking class certification in an Ohio court but decided under Florida law. Progressive's insured was a Florida resident who crashed his 2013 Audi Q5 and submitted a claim to Progressive, which insured the vehicle. Progressive made a total loss settlement offer, which did not include title fees, registration fees, or license plate fees. The insured claimed that under Florida law, actual cash value included these fees associated with purchasing a replacement vehicle. The parties agreed that Florida law applied.

The district court granted a 12(b)(6) motion to dismiss the complaint, finding that Florida law required a plain reading of the policy language, and the policy language did not require Progressive to make this payment. Rather, "actual cash value" as defined in the policy required only an assessment of "market value, age and condition at the time of the loss." The Sixth Circuit affirmed.

### 8. "Suspension of Operations" for Purposes of a Business Interruption Loss Claim Requires a Complete Shutdown of Business Operations, as Opposed to Just a Reduction in Lost Business Income

*Hastings Mut. Ins. Co. v. Mengel Dairy Farms, LLC*, 2021 WL 3021919 (6th Cir., July 16, 2021)

Will and Jennifer Mengel managed commercial dairy farms in Pennsylvania and Ohio and cared for over 1000 cows. Disaster struck the dairy farms when the Mengels' cows tragically started to die en masse and the cows that didn't die began producing less milk. The Mengels spent months searching for a possible explanation. They tested the water for contaminants, consulted a nutritionist, and sought help from various experts without relief. Eventually, the Mengels asked an electrician to investigate. The electrician determined that stray electric current on the property was electrocuting the cows.

The Mengels had insured their cows against factors such as possible electrocution so they submitted an insurance claim for the deceased cows and reduced milk production. Their insurer, Hastings Mutual Insurance Company, paid for the loss of the cows, but refused to pay for the reduced milk production. As a result, the Mengels sued.

Under the insurance policy, Hastings was required to compensate the Mengels for the "loss of business income .. due to necessary suspension of [the Mengels] operations." The Mengels argued that the reduced milk production, and the resulting loss in sales, qualified as "suspension" of their dairy farm's operations. But the District Court agreed with Hastings and held that a "suspension" required a "complete cessation of business activity."

On appeal, the Sixth Circuit agreed with the District Court. It noted that the insurance policy did not define the term "necessary suspension of operations," so the court gave the phrase its "natural and commonly accepted meaning" and stated that, a 'suspension' is commonly understood to mean a temporary -- but complete -- stop in activity.

## Ohio Federal District Court Cases

### 9. A Private Cause of Action Does Not Exist Under the Telephone Consumer Protection Act

*Less v. Quest Diagnostics*, 515 F. Supp. 3d 715, 2 (N.D. Ohio, W.Div. Jan. 26, 2021); reconsideration denied, 2021 U.S. Dist. LEXIS 24156 (Feb. 9, 2021)

Due to the proliferation of Telephone Consumer Protection Act (TCPA) cases cursing coverage counsel throughout Ohio, we take every opportunity to apprise you of good news in this venue, so here is one such case.

Plaintiff Deborah Less brought an action for TCPA damages against Quest Diagnostics Incorporated and its subsidiary MedXM. The defendants filed a motion to dismiss and argued that plaintiff's claim under 42 U.S.C. 227(b)(1)(A)(iii) was barred because this provision was unconstitutional during the time of the alleged conduct at issue. The district court granted that motion to dismiss, relying on a Supreme Court decision which held that, "[A]n unconstitutional statutory amendment 'is a nullity' and 'void' when enacted, and for that reason has no effect on the original statute."

Quest also sought dismissal of the plaintiff's claims because "there were no telephone solicitation calls as defined by the statute," which defines "telephone solicitation" as, "The initiation of a telephone call or message for the purpose of encouraging the purchase or rental of, or investment in, property, goods, or services, which is transmitted to any person," but such term does not include a call or a message: "(A) to any person with that person's prior express invitation or permission, (B) to any person with whom the caller has an established business relationship, or (C) by a tax exempt non-profit organization." The court denied the motion to dismiss on that basis.

In reviewing an example of a specific prerecorded message at issue in the case, the court ultimately determined that there was insufficient information to determine whether or not the prerecorded message fell within the provisions of the statute, and as a result denied without prejudice the defendant's motion. The court indicated that depending on additional facts disclosed during focused discovery, the defendants could invite the court to revisit the issue.

Finally, the defendant challenged the constitutionality of 47 CFR 64.1200(A)(1)-(2) for the reasons set forth Lindenbaum v. Reagy, LLc, 497 F. Supp. 3d 290, 2020 U.S. Dist. LEXIX 201572, 2020 WL 6361915 (N.D. Ohio 2020). Further, defendants argued that there is no private right of action under both 47 CFR 64.1200(A)(1)-(2) and 47 CFR 64.1200(B)(3), and that (B)(3) only applies to solicitation calls. The court agreed that there is no private right of action under these sections of the statute (see Charvat v. NMP, LLC, 656 F.3d 440, 449-50 (6th Cir. 2011).) The court, therefore, dismissed those claims.

**10. Where an Insurance Policy Contains an Express Promise to Pay Applicable Sales Tax for Damaged Property if the Loss is Paid in Money, the Failure to do so Will Give Rise to a Viable Cause of Action for Breach of Contract Under Ohio Law**

*Romaniak v. Esurance Prop. & Cas. Ins. Co.*, 2021 WL 5171040 (N.D. OH, Sept. 14, 2021), 2021 U.S. Dist. LEXIS 173787

Marie Romaniak's vehicle was involved in a collision. She filed a claim for property damage with Esurance. Esurance, through a third-party vendor, determined that the vehicle was a total loss. The vendor calculated the base value of the vehicle to be $5,750 and the adjusted value of the vehicle to be $5,835.00. The vendor also calculated the sales tax on the adjusted vehicle value to be $466.80. Romaniak alleged that Esurance paid for her loss "in money" but only paid her $5,835 minus her deductible of $500, or $5,335 in total, for her loss. Romaniak alleged that Esurance failed to pay her any sales tax for her totaled vehicle, to which she was entitled under the following policy language:

> *"We" may pay for a "loss" in money or repair or replace the damaged or stolen property. If "we" pay for a "loss" in money, "our" payment will include the applicable sales tax for damaged or stolen property.*

The court, relying on dictionary definitions, defined the word "applicable" as "capable of or suitable for being applied; appropriate." The word "for" was defined as "used as a function word to indicate the object or recipient of a perception, desire or activity," or "used as a function word to indicate an actual or implied enumeration or selection." The phrase "damaged or stolen property" was derived from the Policy's definition of Loss. The policy defined "Loss" as "sudden, direct, and unintended physical damage; or theft." As a result, the court concluded that this provision plainly meant that if Esurance paid for Romaniak's loss in money, its payment must include the appropriate sales tax connected to the damaged property – i.e. Romaniak's totaled 2007 Pontiac G6 GT.

Esurance raised several arguments to the contrary, all of which the court rejected. Esurance argued that the meaning of the payment of loss provision only requires the payment of sales tax when it is "applicable" after the loss vehicle has been replaced. The court found this argument to conflict with the plain language of the policy. Second, the court also rejected Esurance's argument that the payment of loss provision prescribes payments "to be calculated based on circumstances at the time of loss and afterwards – not retroactive payments for taxes that may (or may not) have been incurred when the insured's vehicle was acquired years earlier.

### 11. Insured Employer Rewarded with CGL Coverage Because its Failure to Obtain Workers' Compensation Insurance Did Not Trigger Application of the Workers' Compensation and Similar Laws Exclusion in CGL Policy

*P.I. & I. Motor Express, Inc. v. RLI Insurance Co.*, 499 F.Supp.3d 486 (N.D. Ohio, E.Div. Nov. 9, 2020), appeal pending, 6th Cir., No. 21-3412

Ryan Marshall was an independent truck driver working for Russell Trucking and assigned to drive loads at a Dura-Bond pipe manufacturing facility pursuant to a subcontract agreement between Russell Trucking and Plaintiff P.I. & I Motor Express, Inc. A load of pipe fell onto Mr. Marshall's legs, which were subsequently amputated rendering him permanently disabled.

Plaintiff filed this case seeking coverage under its CGL policy and alleging an anticipatory breach of contract claim against its insurer because the insurer had denied coverage based on two policy exclusions, one of which was a "Workers' Compensation and Similar Laws" exclusion, which excluded coverage for, "any obligation of the insured under a workers' compensation, disability benefits, or unemployment compensation law or any similar law".

Plaintiff argued the exclusion did not apply because Plaintiff did not carry workers' compensation coverage. The insurer argued public policy supported its interpretation that no CGL coverage existed if the injury would have been covered under a workers' compensation policy. The insurer argued its position was supported by public policy and encouraged the employer to obtain appropriate workers' compensation coverage.

The court disagreed. The court examined another policy exclusion, not at issue in this case, and concluded that exclusion would have rendered this exclusion meaningless under the insurer's interpretation. Therefore, despite the fact that Plaintiff did not have a workers' compensation policy, the "Workers' Compensation and Similar Laws" exclusion was not triggered and Plaintiff was entitled to coverage under the CGL policy.

### 12. Additional Insured Owed a Defense Where Policy Language Provided Coverage for Liability "Caused in Whole or in Part" by Named Insured – Which Implies More Than Just Vicarious Liability

*FirstEnergy Generation, LLC v. Valley Forge Insurance Co.*, 487 F.Supp.3d 630 (N.D. Ohio, E.Div., Sept. 16, 2020)

A subcontractor and named insured (Enerfab)'s employees were injured when exposed to harmful gas at a power plant owned by additional insured, FirstEnergy. FirstEnergy filed this declaratory judgment action seeking defense and indemnification for claims brought against it by the injured employees in underlying litigation. Valley Forge Insurance had denied FirstEnergy's request for defense and indemnification citing numerous Ohio cases limiting an additional insured's coverage to claims for vicarious liability only.

The policy provided an additional insured with coverage for liability "caused in whole or in part" by the named insured. The court determined this language provides a greater scope of coverage than that provided under policies limiting coverage to liability "arising out of [named insured's] conduct" or "limited solely to the additional insured's vicarious liability that is a specific and direct result of [the named insured's] conduct."

The court concluded the broader "caused in whole or in part" language indicated an intent to protect FirstEnergy from all potential liability caused in whole or in part by Enerfab, not just vicarious liability arising out of Enerfab's actions.

### 13. Policy Not Ambiguous if Undefined Words Followed by a Blank Space Did Not Create Ambiguity When the Only Reasonable Interpretation for it Was a Zero

*Faraj v. Ohio Casualty Insurance Co.*, 2021 WL 2354977 (N.D. Ohio, E.Div., June 9, 2021)

Plaintiff sought coverage under a builder's risk – rehabilitation and renovation policy with Ohio Casualty Insurance Co. Plaintiff hired a contractor to perform the renovation; however, the contractor died and no work was performed at the property during the 18-month period from the date of the contractor's death on July 1, 2018, until a fire occurred on December 27, 2019.

The policy provided coverage for existing buildings, "while in the course of rehabilitation or renovation". Although the terms, "while", "rehabilitation", and "renovation" were not defined in the policy, the court looked to the ordinary meaning of those words to determine that the policy covered damages occurring "during the time of a series of acts intended to restore a property to a previous or better condition."

Plaintiff argued the 18-month period without work merely constituted a pause in the renovation work and he fully intended to resume renovations. However, the court held an intent to renovate did not defeat the policy language providing coverage only during active renovation or repair work.

Coverage was also denied under a vacant building limitation which stated that the policy would "only cover a vacant 'existing building' for ___ consecutive days from the inception date of this policy unless building permits have been obtained and rehabilitation or renovation work has begun on the 'existing building'."

Plaintiff argued the blank space created ambiguity and should be construed in his favor to provide coverage for some period of time between 1 day and 364 days remaining in the policy period. The court disagreed because Plaintiff's interpretation would require the court to insert additional language (i.e. some number of days greater than zero). The court concluded the blank

space was not ambiguous but, instead, indicated the only reasonable interpretation of the blank space was that zero days of coverage existed.

**14. District Court Certifies Question of State Law To Supreme Court of Ohio To Answer Whether the Alleged Presence of COVID on Surfaces, in the Premises, or Community-at-Large Constitutes "Direct Physical Loss or Damage to Property"**

*Neuro-Communications v. Cincinnati Insurance Company*, 2021 WL 274318 (N.D. Ohio January 19, 2021)

Following the onset of the COVID Pandemic in March 2020, insureds across the country commenced making claims for business interruption coverage due to government shutdowns and reductions in service. One such case was filed in the Norther District of Ohio by an audiologist practice group out of northeast Ohio. Early in the case Judge Benita Pearson was asked to certify a question of state law to the Supreme Court of Ohio. Judge Pearson granted the request and certified the following question:

> *"Does the general presence in the community, or on surfaces at a premises, of the novel coronavirus known as SARS-CoV-2, constitute direct physical loss or damage to property; or does the presence on a premises of a person infected with COVID-19 constitute direct physical loss or damage to property at that premises?"*

The Supreme Court of Ohio agreed to answer the certified question on April 14, 2021. Oral arguments were held on February 8, 2022. This will be amongst the first cases to reach a state supreme court.

**15. District Court Affirms Removal From Warren County Common Pleas Court Was Permitted On The Question Of Amount In Controversy Where Potential Punitive Damages are Sought**

*Raymonda Sutter, et al v. American Family Insurance*, 2021 WL 4593962 (S.D. Ohio, W. Div., Oct. 6, 2021)

Plaintiffs (husband and wife) were passengers in a vehicle covered by the driver's insurer. Plaintiffs had a policy with American Family (underinsured motorist $100,000). The automobile was involved in an accident. Plaintiffs' injuries exceeded the coverage provided under the driver's policy ($25,000). Plaintiffs settled with the driver's insurer for policy limits--$25,000 and received $5,000 in medical payments. American Family asserted that they had no underinsured motorist coverage as Raymonda "was made whole by the $25,000 policy limits settlement" by driver's insurer.

Plaintiffs filed suit in Warren County Common Pleas Court. American Family moved to remove the case to the Southern District of Ohio. Plaintiffs objected to removal on the grounds that American Family could not meet the amount in controversy ($75,000) required for removal.

The District Court upheld removal citing U.S. Sixth Circuit precedent that punitive damages must be considered in determining amount in controversy. "When determining the jurisdictional amount in controversy in diversity case, punitive damages must be considered unless it is apparent to a legal certainty that such cannot be recovered." Here, the plaintiffs alleged bad faith and sought punitive damages. (The underlying case continues in the Southern District of Ohio.)

### 16. My Travel Insurance Covers COVID Cancellations, Right?

*DePasquale v. Nationwide Mut. Ins. Co.*, S.D.Ohio No. 2:20-cv5370, 2021 U.S. Dist. LEXIS 86726 (May 6, 2021)

The issue in this case was whether or not travel insurance purchased by the plaintiffs in January of 2020 covered the cancellation of their trip to Mexico in April of 2020 as a result of COVID-19.

In January of 2020, the plaintiffs purchased travel insurance from Nationwide to protect a trip from Oregon to Mexico that was planned for early April 2020. The travel insurance policy included coverage for trip cancellation and interruption caused by the insured "being…quarantined…within ten days of departure." The travel insurance policy did not define "quarantine."

As everyone is all too familiar, COVID-19 reached the United States in the beginning of March 2020. In March of 2020, the United States State Department subsequently recommended that Americans avoid all discretionary travel and advised Americans not to travel outside of the United States. Additionally, the CDC issued their own recommendations and the Oregon governor declared a state of emergency.

The plaintiffs subsequently canceled their trip to Mexico on April 1, 2020 and filed a claim under the Nationwide travel insurance policy's quarantine coverage. The plaintiffs argued that their travel cancellation was caused by the COVID-19 civil authority orders and travel advisories, which functioned as a "quarantine" since they restricted non-essential travel. Defendant Nationwide denied coverage and argued that the civil authority orders and travel advisories were not considered to be a "quarantine".

The plaintiffs filed suit in October 2020, requesting declaratory judgment and damages based on Nationwide's alleged breach of contract for failure to pay their claim. Nationwide filed a motion to dismiss in response.

The court applied Ohio law and looked at various dictionary definitions of the word "quarantine". The court ultimately agreed with Nationwide that the cancellation coverage did not apply because the recommendations and advisories did not fit the definition of "quarantine". The court reasoned that the notion of an "imposed isolation" was a hallmark of what defined a "quarantine" and that none of the orders and travel advisories included an imposed isolation.

Thus, the court granted defendant Nationwide's motion to dismiss.

### 17. Reasons Not to Own a Drinking Establishment

*Atl. Cas. Ins. Co. v. Rutz,* 493 F.Supp.3d 616 (S.D. Ohio, October 7, 2020)

The issue in this case was whether or not Atlantic Casualty Insurance Company owed coverage to Kenneth Rutz (doing business as Zappz Sports Bar) under a commercial lines policy for bodily injuries sustained by patrons of Zappz Sports Bar.

Defendant Rutz had a commercial lines policy which provided coverage for bodily injury and property damage, but it included a punitive damages exclusion, an assault and/or battery exclusion, and an expected or intended injury exclusion.

On April 22, 2018, Bradley Polly, a Zappz patron, became intoxicated and subsequently became involved in a verbal and physical altercation at Zappz. At some point later in the evening, Mr. Polly left the bar, got into his car, drove that car into the bar, and caused serious bodily injuries to other patrons.

Mr. Polly subsequently pled guilty to charges of aggravated vehicular assault and vandalism. He did not appeal his judgment.

The injured patrons then filed a complaint against Zappz and the bartender serving Mr. Polly, amongst others. In that action, the injured patrons sought punitive damages amongst other damages for the bodily injuries that they sustained while at Zappz.

Zappz subsequently filed a separate complaint for declaratory judgment, demanding that Atlantic Casualty provide a defense. Atlantic Casualty filed a motion for summary judgment arguing that they did not owe coverage based on the assault and/or bodily exclusion in the policy. The injured patron parties responded and argued that the assault and/or bodily exclusion was ambiguous and did not necessarily prohibit coverage for any claims arising out of the incident.

The court applied Ohio law, looked at the terms of the policy, and granted Atlantic Casualty's motion for summary judgment. The court reasoned that while the term "assault" was not defined under the policy, the policy's language was still clear and that the term has a plain and ordinary meaning that encompassed both its common-law and statutory definitions. Additionally, the court held that the policy's exclusion of coverage for bodily injuries arising in whole or in part out of any actual or threatened assault unambiguously excluded coverage for bodily injuries that resulted from any legally cognizable form of assault.

### 18. Is a "Loss" a "Loss" When Your Employee Embezzles Two Million Dollars From You?

*M&C Holdings Del. Pship. et al. v. Great Am. Ins. Co.,* S.D.Ohio 1:20-cv-121, 2020 U.S. Dist. LEXIS 185426 (October 6, 2020)

This case dealt with whether or not Great American Insurance Company owed coverage for loss caused by the fraudulent acts of a former employee of M&C Holdings Delaware Partnership (and other business entities collectively referred to as "Millenium").

Millennium operated a chain of hotels throughout the United States. It paid commissions to third-party travel agencies in exchange for bookings at certain properties. A Millennium employee engaged in a fraudulent scheme to siphon off the commission payments from Millennium to fictitious travel agencies created by the employee. He diverted both payments legitimately owed to third-party travel agencies for services that those travel agencies had actually rendered, and he accepted payments for services that were not rendered at all. The total amount of fraudulent payments received by the employee was nearly two million dollars.

Millennium had a policy with Great American that, in relevant part, stated that it would pay for loss resulting "directly from dishonest acts committed by an employee…which cause[d] you to sustain a loss." "Loss" was not defined in the policy. Additionally, the policy contained a limitations period of "[t]wo years from the date Millennium discovers the loss."

Great American investigated the claim and concluded that it was not a covered loss. Great American did acknowledge that Millennium suffered a loss to the extent that it paid the fraudulent travel agencies approximately $379,000.00 for services not rendered by any agency. However, Great American took the position that the payments made to the fictitious travel agencies for services actually rendered by the real travel agencies were only covered losses if Millennium also paid commissions to those travel agencies for services they did actually render. Thus, Great American essentially argued that Millennium only suffered a loss if it made a "double payment" for the actual services rendered.

Millennium then filed suit in February of 2020 arguing breach of contract, bad faith for denial of coverage, and declaratory relief. Great American filed a motion to dismiss in response. The magistrate judge denied the motion to dismiss in a Report and Recommendation. Great American then filed two specific objections to the Report and Recommendation, arguing 1) that the court erroneously held that the employee's theft of funds from Millennium owed to legitimate third-party travel agency constituted a "loss"; and 2) that the court erroneously ruled that Millennium's allegations were sufficient to raise a plausible question that Great American waived the policy limitations clause.

The court overruled Great Americans' objections, adopted the magistrate judge's Report and Recommendation, and denied the motion to dismiss. In coming to their ruling, the court looked at Ohio case law and held that in determining whether or not an actual loss has occurred, the critical element was whether or not there has been a "disbursement of funds". The court held that Millennium alleged that it made disbursement of funds to its employee, and the employee's fraudulent agencies, for services that were not rendered. The court held that was sufficient to state a plausible claim that Millennium suffered a "loss" under the policy.

Additionally, the court held that Millennium pled sufficient facts to raise a plausible question whether or not Great American waived enforcement of the policy's limitations clause. In coming to this conclusion, the court looked at a number of facts, including that Great American "took an unnecessarily excessive amount of time to investigate the claim," that Great American acknowledged the Millennium employee did divert and/or embezzle payments of nearly two million dollars from Millennium, that a letter in December of 2019 did not mention any contractual

limitations, and that a January of 2020 letter did reference a limitation but it did not do so as a basis for denying liability or coverage.

### 19. No Bad Faith Bifurcation Allowed

*Sutter v. American Family Ins. Co.*, 2021 WL 630825 (S.D. Ohio, W. Div., Feb. 18, 2021)

Plaintiffs, husband ("Larry") and wife ("Raymonda"), were involved in a car accident in Ohio when a vehicle driven by Hicks ("Hicks") crossed into plaintiffs' lane of travel causing a head-on collision. Raymonda suffered temporary and permanent injuries caused by the accident. Raymonda was insured by defendant insurer American Family which included underinsured motorist's coverage ("UIM") with limits of $100,000.00 per person. Hicks' insurance policy included a limit of $25,000.00 for bodily injury/liability coverage. Raymonda's injuries, however, exceeded the coverage provided under Hicks' liability insurance policy. Because of delays in the resolution of the claim, purportedly by American Family, Raymonda filed a lawsuit for breach of contract and bad faith.

Ultimately, the court reserved its evaluation of the UIM coverage issue because the Magistrate determined that a "bifurcation and a stay of discovery on the bad faith cause of action is not warranted at this stage of the proceedings" since American Family's assertion of prejudice lacked the specificity and particularity necessary to sustain its burden of proof and because, "[t]o bifurcate the issues would neither expedite this litigation nor promote judicial economy."

### 20. Roller Rink Patrons get More Fun Than They Bargained For

*Winter Enters., LLC v. West Bend Mut. Ins. Co.*, 2021 WL 4193213 (S.D. Ohio, W. Div., Sept. 15, 2021)

In this commercial property case, the property owner, Winter Enterprise, LLC ("Winter" or "insured"), operated a roller rink and entertainment venue known as the "Fun Factory." Winter obtained a commercial property insurance policy for the Fun Factory from West Bend Mutual Insurance ("West Bend" or "insurer"). Following a heavy rainstorm, the Fun Factory sustained severe water damage. Upon inspection, the Fun Factory Owner ("Scott") noted that the skate floor was underwater. To locate the source of the water, Scott explored the rest of the building and "followed the water entering under the double door at the southeast rear corner that leads into the rear storage area." Ultimately, Scott discovered that both "the roof in the 'back room' and a wall near the alleyway had completely collapsed … [and] a large tree [was] laying inside the building near the collapsed wall."

The policy contained a surface water exclusion with anti-concurrent cause language. The insured and the insurer both engaged commercial property adjusters who agreed that "a clogged drain on the roof caused water to pool, and that the weight of the pooled water caused the roof to collapse," but they disagreed as to the reason for the collapse of the wall near the alleyway. The

insured's adjuster indicated that "wind drove a tree into a C block wall causing it to collapse and allowing water to enter the building," while the insurer's adjuster contended that the "excessive amount of rain in a short period of time caused a rush of water, including from a nearby sports field located uphill from the south wall of the building, which collected against and, eventually collapsed, the masonry wall."

The court determined that the surface water exclusion barred coverage for damage caused by the surface water and found the insurer's expert cogently opined that the south wall collapse "was caused by fast moving surface water…" and therefore summary judgment was granted in favor of the insurer.

### 21. "Occupying" a Vehicle for UIM Purposes Depends on Proximity to the Insured Vehicle

*Bonasera v. New River Elec. Corp.*, 518 F. Supp. 3d 1136 (S.D. Ohio, E. Div., Feb. 10, 2021)

This is an "occupying" a vehicle case in which a road flagger for Wright Brothers, Inc ("Wright"), Alaina Steele, was struck and killed by a vehicle while retrieving road signs in the course and scope of her job.

As the two women were completing work for the day, an out-of-control Jeep suddenly came barreling down on them and both women took off running. Samantha ran to the driver's side and Alaina ran on the passenger side of their insured work vehicle, which was parked near a ditch off the side of the road. Samantha then witnessed the Jeep roll over toward the ditch, hit Alaina in the ditch, roll up on the embankment and then settle down on top of Alaina's leg, subsequently causing her death.

In Alaina's estate's suit against Wright's insurer, Penn National Insurance ("Penn National"), seeking underinsured motorist coverage ("UIM"), Penn National denied coverage to Alaina because she was not 'occupying' the vehicle. The court determined the coverage issue to be whether Alaina's "sufficient relationship" with the insured vehicle was such that she was in a reasonable geographic area (proximity) to the vehicle itself. The court concluded that she was, and was therefore entitled to UIM coverage. The court also determined that there was sufficient evidence for the bad faith claim to move forward, but that the punitive damages portion of the lawsuit would be bifurcated.

## 22. Your Neighbor is Not Your Resident

Am. Nat'l Prop. & Cas. Co. v. Williamson, Case No. 2:20-cv-00539-ALM-EPD, 2021 U.S. Dist. LEXIS 123018 *; 2021 WL 2712168 (S.D. Ohio July 1, 2021)

Gary Lee Allen held a farm policy and an umbrella policy with ANPAC. He owned a large tract of land straddling a highway that included his own home as well as a separate house across the road. The two houses had separate addresses and separate utilities. Allen paid for trash removal fees and taxes on the second house. Allen's daughter and her husband Michael Williamson moved into the second house and handled maintenance and upkeep of the home and utilities other than trash, although they did not pay rent to Allen. Allen did not possess keys to the second house, did not store any property there, and had never stayed overnight at the house. Allen and Williamson never slept under the same roof, never shared the cost of utilities or storage space, and neither had free access to the others' separate residence without permission.

In 2018, Williamson was staying at a hotel where he allegedly extinguished a lit cigarette in a mulch bed, which led to a fire at the hotel that caused extensive damage. The hotel filed suit against Williamson in the Franklin County Court of Common Pleas seeking $2.5 million under a negligence theory. After the hotel informed ANPAC about the lawsuit, ANPAC responded that Williamson had not tendered the lawsuit to ANPAC for coverage and that in any event, Williamson did not constitute an insured under either of the policies because he was not a "resident relative" of its named insured, Allen.

The court ruled in favor of ANPAC and explained that for Williams to be an insured under the Farm Policy, he would need to be a family member of Allen who resided in the same "dwelling" as Allen. Thus, according to the ordinary principles of contract interpretation, "dwelling" means a single structure rather than a large tract of connected properties with several buildings. The separate houses were two separate one-family dwellings and could not constitute a single "residence" within the meaning of the Farm Policy, so it was impossible for Williamson to have resided in the same residence as Allen under the facts. Accordingly, Williamson was not insured under the terms of the Farm Policy. In other words, under the facts of the case, Allen and Williamson were more akin to neighbors rather than a family living under one roof or as a social unit.

## II. STATE COURTS

### Ohio Supreme Court

#### 23. Umbrella Policy Does Provide Coverage for Integrated Product Where Insured Was Unaware Third Party's Combined Product Was Defective

*Motorists Mut. Ins. Co. v. Ironics, Inc.,* 2022-Ohio-841 (Ohio March 23, 2022)

This is an important case that deals with coverage for an integrated product when the insured does not know that the product it is receiving from a third party is defective before it integrates its own product (or processes the third party's product) to form a "multicomponent" product that it will sell to a customer. The lower appellate decision was the focus of our 2020 *Update* summaries and the facts were set forth there in more detail (and, of course, are also set forth in the Supreme Court's Decision) so we will not dwell on them here at length.

The Court held that under the Motorists Umbrella policy at issue here (the CGL was not before the Court), Motorists DID owe coverage to Ironics where its insured delivered a defective integrated product (tube scale) to its customer because the tube scale the insured received from its supplier was defective and there was no way to know this and because there was both "property damage" and an "accident," since the ultimate product that was sold to the customer could not be used for its intended purpose.

This case is important because insureds and insurers have struggled for years to separate contract damages from tort damages since the latter are covered under general liability policies but the former are not. In essence, as we all know, a contract usually only involves two (or relatively few) parties while a tort is one's breach of contract with the world. Distinguishing contract damages from tort damages, however, is not always easy – especially where insurance is involved.

For example (and the Court does an excellent job of giving many examples in the Opinion – the following example is my own in order to illustrate the analysis more simply), suppose a person hires a painter to paint a room in her house and both parties agree on the color, but then after the room is painted (as agreed), the homeowner does not like the color so she sues the painter and the painter contacts his insurer to cover the damages and defend him in the lawsuit. Should this be covered? The answer, of course, is obvious because this is simply a breach of contract between two parties and allowing insurance coverage under these facts would not be feasible.

On the other hand, where a contractor builds a deck on the back of a customer's house and the deck collapses, injuring the occupants, everyone would agree that insurance should cover the injuries to the occupants.

The more difficult question is what is being dealt with in *Ironics* and the Court does an excellent job of realizing the equities involved by focusing on the inability of Ironics to be able to "control" the defect in this case, or even know that the supplier's product is defective in the first place. One hopes, however, that had Ironics itself manufactutred the defective product that was introduced into the mix and had controlled the process (i.e. the defect in the tube scale was actually placed there by the insured, Ironics, and not its supplier), or if there simply had been no "physical damage" to the resulting product after the insured performed its work on it (as in the case of the telephone pole resin in the First District case of *Home Ins. Co. of Illinois v. OM Group, Inc.*, 2003-Ohio-3666, cited in the case), that the Court's Decision would have been different and coverage would have been denied. But these were not the facts of the case, and so the result makes sense.

The Court's studied analysis is worth a read, as are the Concurring and Dissenting Opinions.

### 24. Failure to Advise Insurer of Household Resident Voids Auto Policy Coverage for Resident

*Nationwide Mut. Fire Ins. Co. v. Pusser*, 2020-Ohio-2778 (Ohio May 6, 2020)

The policyholder applied for an automobile insurance policy with Nationwide and indicated on the application that she was the only member of her household, and no other individuals were listed as members of the policyholder's household. However, at the time of the application, the policyholder's sister lived in the household. The policy stated that it incorporated the application and provided that if any warranties made by the policyholder were incorrect, the policy "may be held void ab initio." The policy further stated that information provided in the application about other operators in the household was a warranty, which "if incorrect, could void the policy from the beginning.

On August 13, 2012, the policyholder's sister was driving a car covered under the policy when she struck and killed a pedestrian. Nationwide filed a complaint for declaratory judgment, claiming that it had issued the policy in reliance on the information in the policyholder's application. The trial court granted Nationwide's motion for summary judgment, finding that the policy was void ab initio due to the insured's breach of warranties contained in the policy. The Ohio Seventh District Court of Appeals reversed, determining that the policy's terms did not "clearly and unambiguously" indicate that the policyholder's misstatements as to a warranty could render the policy void ab initio. The court of appeals also determined that because Nationwide had failed to declare the policy void and return the policyholder's premium before filing suit, it failed to attempt to void the policy according to its terms.

On appeal, the Supreme Court found that Nationwide plainly incorporated the application into the policy and that answers provided to the questions in the application were warranties. The use of the word "could" sufficiently warned applicants about the consequences of providing incorrect information, as it plainly informed the applicant that a breach of warranty could lead to a void

policy. The Court further held that Nationwide was not required to itself declare the policy void and return the premium before seeking a declaratory judgment, as such a requirement would have served no purpose and would have been uneconomical, in addition to leaving the policyholder without insurance during the pendency of the declaratory judgment action. The Court reversed the court of appeals' ruling and reinstated the trial court's grant of summary judgment to Nationwide.

### 25. Water is Water Even if it is Sewer Water

*AKC, Inc. v. United Specialty Ins. Co.*, 2021-Ohio-3540 (Ohio Oct. 6, 2021)

In 2014, sewage from a local sewer system backed up into the Bank Nightclub in Akron. The bar submitted a claim to its insurer, who denied the claim, citing an exclusion in the policy for damage caused by water that backs up or overflows from a sewer. The policy language stated the insurer "will not pay for loss or damage caused directly or indirectly by * * * [w]ater that backs up or overflows from a sewer, drain or sump."

The bar assigned its claim to the company it hired to clean up the site, and that company instituted a breach of contract action. The company asserted that the exclusion was inapplicable based on a distinction between pure forms of "water," such as rainwater, as opposed to sewage. Because the policy excluded damage from "water" backups but not "sewage" backups, the company argued the exclusion did not apply.

The trial court granted summary judgment in favor of the insurer, and the Ninth District Court of Appeals reversed.

The Supreme Court held for the insurer, declining to adopt a hyper-literal reading of the term "water." It explained that the average person purchasing insurance would understand that sewage contains water and water backing up from a sewer would contain sewage. Because exclusions in insurance contracts are read narrowly to apply only to that which is clearly intended to be excluded, and because a court cannot create ambiguity in a contract where there is none, the court of appeals erred by asking whether the parties could have included different or more specific language in their agreement. Accordingly, the Court held that the water backup exclusion includes damage caused by sewage. The Court reversed the court of appeals' judgment and reinstated the trial court's award of summary judgment in favor of the insurer.

## 26. "All sums" Only Applies Where Damages Occur Over Time and in Multiple Insurers' Policy Periods.

*Lubrizol Advanced Materials, Inc. v. National Union Fire Ins. Co.*, 161 Ohio St.3d 1, 160 N.E.3d 701, 2020-Ohio-1579 (Ohio April 23, 2020).

Lubrizol manufactured and sold allegedly defective resin to IPEX, Inc., between 2001 and 2008. IPEX used the resin to make pipes that were sold to consumers in the United States and Canada. These pipes failed, resulting in numerous claims against IPEX for selling defective pipes. IPEX settled the claims, but sued Lubrizol alleging negligence, breach of contract, and breach of warranty on the basis that Lubrizol knew or should have known that the resin it sold to IPEX was defective. IPEX sought indemnification from Lubrizol and then settled their claims.

Lubrizol then sued its insurer, National Union, which had an umbrella policy effective February 28, 2001, to February 28, 2002. Although Lubrizol had other policies in force in addition to the National Union policy which provided coverage for the loss, Lubrizol argued that under Ohio's "all sums" approach, it should be able to recover under the policy of its choice and it chose National Union to pay all defense costs incurred in defending the IPEX lawsuit, leaving National Union to then seek contribution against Lubrizol's other insurers.

Based on the language of its policy ("We will pay on behalf of the Insured those sums in excess of the Retained Limit that the Insured becomes legally obligated to pay by reason of liability imposed by law or assumed by the Insured under an Insured Contract because of Bodily Injury, Property Damage, Personal Injury or Advertising Injury that takes place during the Policy Period and is caused by an Occurrence happening anywhere in the world"), National Union filed a counterclaim seeking a declaration that Lubrizol was not entitled to allocate all defense costs and indemnity to a single policy period when multiple policies and corresponding policy periods were triggered.

The parties certified the following question to the Ohio Supreme Court: "Whether an insured is permitted to seek full and complete indemnity, under a single policy providing coverage for 'those sums' the insured becomes legally obligated to pay because of property damage that takes place during the policy period, when the property damage occurred over multiple policy periods."

The Supreme Court accepted the question and, citing its past holding in *Goodyear*, noted that the contract language in *Lubrizol* provided coverage for "those sums," and not "all sums," as in past cases. The Court noted that the insurer drafted the policy and refused to engage in a "hypertechnical grammar analysis" to determine whether the phrase "those sums" is always more limited than "all sums" and would always lead to a different allocation. Rather, the Court stated that the phrase should be interpreted as written and the meaning of the phrase would depend on the context of each policy and each case.

The Court also made an important distinction between the *Lubrizol* facts and the *Goodyear* facts. In *Goodyear*, the issue of allocation arose in the context of long-term environmental cleanup claims where it is difficult to determine which insurer must bear the loss. *Lubrizol*, on the other

hand, did not involve long-term or progressive injury or property damage and the Court pointed out that National Union had alleged that the harm there was "discrete, not ongoing and continuous."

Based on these facts, then, the policy language that controls the coverage is not "those sums" but rather injury or damage "that takes place during the Policy Period." Therefore, in answering the certified question, the only conclusion they could draw was that there is no reason to allocate liability across multiple insurers and policy periods if the injury or damage for which liability coverage is sought occurred at a discernible time. In that circumstance, under those facts, and based on that policy language, the insurer who provided coverage for that time period should be liable to the extent of its coverage.

## Ohio District Appellate Courts

### 27. Vertical and Horizontal Exhaustion Revisited

*William Powell Company v. OneBeacon Insurance Company*, 2020-Ohio-5325 (1st Dist. Nov. 18, 2020)

This case involved coverage for asbestos claims and held that vertical exhaustion applied to excess liability insurance policies issued by OneBeacon and Federal between 1969 and 1977.

"Horizontal exhaustion" refers to the idea that all triggered primary policies must be exhausted before any excess policy will be triggered. "Vertical exhaustion," on the other hand, means that (depending on the policy language) an excess policy is considered excess only to the primary policy directly below it.

Plaintiff ("Powell") manufactured industrial valves. Some valves manufactured before 1987 included one or more components of asbestos. As a result, Powell began receiving bodily-injury claims from plaintiffs all over the country related to asbestos exposure involving its products. Powell sought defense and indemnification under its various insurance policies.

Powell had primary and excess CGL policies. The court noted that coverage typically begins at a certain level otherwise known as the "attachment point" of the excess policy. Federal (later OneBeacon) issued ten different One Beacon primary liability policies and three excess policies covering various periods from 1969 to 1976, as well as a Federal policy consisting of one excess policy covering from 1976.

Beacon sought a declaratory judgment that its excess policies had not been triggered because Powell had other "collectible and underlying insurance," relying on a clause in its insurance policies. Powell sought a declaratory judgment that in the event the underlying policies were triggered, OneBeacon was required to pay all of the defense costs and settlement costs under its excess policies under Ohio law.

The parties disagreed on how to allocate losses where an occurrence spanned over multiple policy periods. Powell argued that pursuant to *Goodyear Tire & Rubber Co. v. Aetna Cas. & Sur.*

*Co*., 95 Ohio St.3d 512, 2002-Ohio-2842, 769 N.E.2d 835, it was permitted to allocate all sums expended in relation to an individual claimant to any single triggered insurance policy up to the that policy's limit (the "all sums" approach). The trial court agreed and allowed Powell to allocate claims pursuant to *Goodyear*.

With respect to excess insurance, the parties disagreed as to whether the excess policies were triggered to provide coverage. This disagreement stemmed from a clause in OneBeacon's policies and Federal's policy which limited their liability to net losses in excess of an insured's underlying insurance, including, for instance "the applicable limits of any other underlying insurance collectible by the insured." OneBeacon and Federal argued that their excess policies were not triggered because the policy language stated that excess policies do not attach to cover any claims until all underlying and collectible insurance held by the insured is exhausted (i.e., when the policy limits of the underlying insurance are expended). OneBeacon and Federal argued that, in addition to unexhausted primary liability insurance policies issued by OneBeacon, Powell had an underlying and collectible primary liability insurance policy issued by National Union which covered bodily injury claims from 1977 to 1979, that was not yet exhausted.

The First District ruled that excess policies support vertical exhaustion because of their policy language. The court found no ambiguity in the policies and determined that because the OneBeacon policies agreed to "[indemnify] the insured for all sums which the insured shall become legally obligated to pay . . . in excess of the insured's retained limits . . . ," while the Federal policy agreed to "pay on behalf of the insured all sums, as more fully defined by the term ultimate net loss, for which the insured shall become obligated to pay . . . ," that the policies were relatively the same as far as their coverages were concerned. Likewise, the "retained limits" sections of the policies were also similar.

The court noted that in *Goodyear*, the Ohio Supreme Court specifically refused to require proration among insurance policies when an occurrence spanned multiple policy periods, as proration would require an insured to take on the burdensome task of proving the value of damages in a specific year. Consequently, the *Goodyear* court held that an insured "is entitled to secure coverage from a single policy of its choice that covers 'all sums' incurred as damages 'during the policy period,' subject to that policy's limit of coverage." Like the "all sums" method of allocation, the aggregation of concurrent policies, such as a primary policy coupled with an excess policy, provides a degree of certainty and predictability. Thus, the insurers here "are only liable for an occurrence during the coverage period, and only when their respective attachment points are reached" and so vertical exhaustion does not require OneBeacon or Federal to pay more than it contracted to pay for any given policy year. Finally, vertical exhaustion also preserves the distinction between primary and excess insurers while precluding excess insurers from avoiding coverage in long-term, continuous-exposure cases such as this one.

### 28. Intentionally Tearing Down a Building is Not an Accident

*Al Neyer, LLC v. Westfield Insurance Company*, 2020-Ohio-5417 (1st District, November 25, 2020)

This case involves coverage issues related to the interior demolition of a restaurant in Oakdale, Pennsylvania, but applies Ohio law to the interpretation of the insurance policy.

Building owner, the King Trust ("King"), alleged that its tenant, KRG Kings, LLC, ("KRG") breached its lease because KRG failed to maintain a restaurant in the building. King filed an ejectment against KRG in Pennsylvania federal court. King meanwhile began to explore other options for the space, including leasing the property as a new medical center to Weirton Medical Center ("Weirton").

Weirton therefore entered into a lease with King and contacted Neyer, a Cincinnati-based construction company, to do the renovations. A project manager for Neyer then took it upon himself to proceed with the demolition before King and Weirton had even finalized the deal and, as it turned out, King's right to lease the building to Weirton was being disputed by KRG, who contended that it still had legal possession of the property.

When KRG learned of the demolition, it added a claim to its counterclaims against King in the Pennsylvania action, claiming that King "aided and abetted" the tortious conduct and negligence. KRG also asserted third-party claims against Weirton and Neyer for trespass, conversion, tortious interference with contractual relations, and negligence.

Neyer sought coverage under its CGL policies with Westfield and Berkley Assurance Company ("Berkley"). Westfield agreed to defend Neyer under a reservation of rights. When the litigation settled, however, Westfield refused to indemnify Neyer for the amount Neyer paid for the settlement.

Neyer sued Westfield and Berkley in Hamilton County Common Pleas Court for declaratory judgment and the trial court granted Neyer's and Berkley's motions for summary judgment but denied Westfield's, stating that, "although the demolition was volitional, the resulting damage to the property of KRG was not intended or anticipated by anyone at Neyer." The trial court reasoned that although senior management at Neyer knew of a lease dispute involving the property, it did not know of the project manager's plans to begin with the demolition and, while the project manager knew of his own plans for the demolition, he did not know of the lease dispute. Therefore, the trial court held that the demolition of the property "was an accident and the result of an 'occurrence' under the Westfield policy." The trial court rejected Westfield's argument that, because Neyer intended to demolish the property, the property damage was not accidental. The trial court also rejected Westfield's argument that policy exclusions applied to deny coverage. The trial court found that Berkley's coverage was in excess of Westfield's liability limits, and therefore Berkley had no duty to defend or indemnify Neyer.

In the appeal, the First District held that the trial court erred in declaring that Neyer was entitled to coverage for the King Lawsuit because there was no "accident" or "occurrence" under these facts, citing *Custom Agri* and *Ohio Northern*.

The court further explained that here, "the interior demolition of the restaurant was Neyer's desired result and Neyer controlled the process leading to the damages. That is, Neyer was anticipating a contract with Weirton for this specific demolition. Thus, we cannot say these claims are a fortuitous accident." Further, "Proceeding with a demolition without a formal contract in place was not accidental, it was entirely within the project manager's control. Neyer could have anticipated that premature performance—i.e., performance without a contract in place—could cause damages to a known third party. Such a result was not within 'the statistical abstract' of 'truly accidental property damage,'" per *Custom Agri*.

**29. An Assault is an Assault and a Battery is a Battery – Except in Certain Ohio Appellate Courts.**

*Krewina v. United Specialty Insurance Co.*, 2021-Ohio-4425 (1st Dist. Dec. 17, 2021)

This is an odd case and was featured in Randy Maniloff's Coverage blog for being an outlier in the otherwise fairly well-settled world of "Assault or Battery" exclusions enforcement.

The question here is whether a person determined to have a mental-health condition that renders him "incapable of governing his conduct in accordance with reason" can commit an "assault" or "battery" under current relevant Ohio law for coverage purposes. The trial court ruled for the insurer and granted summary judgment. The First District reversed based on a really old Ohio Supreme Court case.

The case involves a situation where the tortfeasor and the Plaintiff, Colin Doherty and Austin Krewina, lived at the insured Brown County Care Center ("BCCC"), a group care facility that provided room and board for adults transitioning from jails and restrictive health facilities to independent living. In September 2014, Doherty attacked Krewina with a razor blade. According to the Opinion, the details surrounding the attack were "unclear," but Krewina sustained multiple lacerations to his face and neck.

USIC issued a CGL policy which covered BCCC as a "group home." The policy had an Assault or Battery Exclusion which excluded coverage for bodily injury claims arising out of "an actual, threatened, or alleged assault or battery." As in most of these policies, "assault" and "battery" were not defined in the policy.

The quirk in this case was that the State of Ohio had indicted Doherty for multiple counts of attempted murder, attempted aggravated murder, and felonious assault in a published opinion from the Brown County Court of Common Pleas. This court, however, found Doherty not guilty by reason of insanity and held that Doherty "did not know, as a result of a severe mental disease or defect, the wrongfulness of [his] acts" because he lived with "auditory hallucinations that have involved command hallucinations that indicate homicidal threats and aggression toward others."

Further, Doherty experienced "delusional beliefs and paranoia, which commonly involve[d] themes that other individuals are attempting to harm him."

In 2016, Krewina sued BCCC and Doherty in civil court for the injuries and the parties entered into a Settlement Agreement and Consent Judgment after United Specialty denied coverage. The trial court therefore entered judgment against BCCC in the amount of $952,924.36. Notably for the appeal on the coverage matters, the parties stipulated in the trial court that when "Doherty inflicted serious bodily injury on Krewina, [he] suffered from a derangement of his intellect which deprived him of his capacity to govern his conduct in accordance with reason."

Krewina then sought payment from United Specialty under an assignment and the First District opinion makes much of the fact that a Joint Stipulation of Facts entered into by Krewina and BCCC in the underlying tort case included a stipulation that stated that, "when Doherty inflicted serious bodily injury on Krewina, [he] suffered from a derangement of his intellect which deprived him of his capacity to govern his conduct in accordance with reason."

The trial court ruled in favor of USIC and dismissed Krewina's complaint, determining that the Exclusion precluded coverage for Krewina's claims and USIC had no duty to indemnify or satisfy the judgment amount stipulated by Krewina and BCCC because, "Krewina was injured by an assault and battery inflicted upon him by another resident of BCCC" and that, "the fact that Doherty was found to lack the requisite mental state for a criminal conviction does not change that his conduct fits that plain and unambiguous language."

The Court of Appeals disagreed. The Court of Appeals recognized that Ohio tort law defines battery as, "acting with intent to cause a harmful or offensive contact and a harmful contact results," while civil assault has been defined to consist of a "willful threat or attempt to harm or touch another offensively," which includes the "essential element * * * that the actor knew with substantial certainty that his act would bring about harmful or offensive contact."

Based on these "legal" definitions, the Court reversed the trial court and stated that, "At their core, tort claims for assault and battery require a perpetrator to act with intent. And criminal assault requires that the defendant act knowingly or recklessly. Consequently, for the Exclusion to apply, Doherty must have acted with 1.) intent to harm Krewina; 2.) knowledge that his actions would cause a result or would likely be of a certain nature; or 3.) heedless indifference to the consequences and disregarding a substantial and unjustifiable risk."

The court then cited a 25-year old Supreme Court decision that considered an Intentional Acts Exclusion under circumstances where the insured was "mentally incapable of committing an intentional act" (*Nationwide Ins. Co. v. Estate of Kollstedt*, 71 Ohio St.3d 624, 627, 646 N.E.2d 816 (Ohio 1995)), and held that, under the circumstances of that case and applying the Intentional Acts Exclusion (which, unlike an Assault or Battery Exclusion, requires an element of *mens rea*) an individual's acts are not "'intentional' if the insured was suffering from a derangement of his intellect which deprived him of the capacity to govern his conduct in accordance with reason" and therefore, since the insured could not form the requisite intent, the Intentional Acts Exclusion did not apply.

But, unfortunately, the exclusion here was not an Intentional Acts Exclusion, but rather an Assault or Battery Exclusion, and the First District made the same mistake as the Third District in *Hawk v. The Cincinnati Specialty Underwriters Insurance Co*., 2014-Ohio-2335, by conflating the Intentional Acts Exclusion (which requires *mens rea*, or mental intent) with the Assault or Battery Exclusion (which does not) and focused on the intent of the perpetrator/defendant rather than on the proximate cause of the injury and on the language of the exclusion itself. The First District could have cited a more recent Supreme Court decision that did distinguish between an Intentional Acts Exclusion and an Assault or Battery/Abuse Exclusion, but it did not. See *World Harvest Church v. Grange Mut. Cas. Co.,* 2016-Ohio-2913. The Third District kind of realized its mistake after two more bar fights in the same bar and they held (without specifically overruling *Hawk*) that the Exclusion (in the same insurance policy issued to the same bar) DID apply, after all, and that there is a very good reason why insurers do not want to insure assaults in bars and mental facilities and insureds would not want to pay the premiums required if they did.

At bottom, the mistake here was ignoring the well-settled rule in Ohio that, "When there are undefined terms in a policy, we look to the **plain and ordinary** meaning of the language used in the policy. Dictionary definitions can aid in determining a term's plain and ordinary meaning; however, there is no requirement that a dictionary definition be used, or that a particular dictionary's definition be used." See, e.g., *Stiriz v. Motorists Mut. Ins. Co.*, 2002 WL 479826 (6th Dist. 2002) at *6. Following this rule, the exclusion could have been taken at face value and applied as intended: to exclude coverage for bodily injury claims arising out of an "unconsented-to-touching" (my tort law professor's definition of "battery," and what everyone has come to accept as a "medical battery" where no intent is required to cause injury to another person – I looked this one up in Google) of the plaintiff by the defendant. That would have solved the whole problem.

The case is currently being appealed to the Ohio Supreme Court.

### 30. Does the Government's Loss of Money Due to its Citizens' Abuse of Opioids Constitute Damages "Because of Bodily Injury"?

*Acuity v. Masters Pharmaceuticals, Inc.*, 2020-Ohio-3440 (June 24, 2020)

This case concerns an insurance company's duty to defend and indemnify an insured pharmaceutical distributor in lawsuits brought by city, county, and state governments for economic damages in response to the opioid epidemic.

Masters Pharmaceutical, Inc. ("Masters") is a defendant in the National Prescription Opiate Litigation which involves a number of lawsuits brought by cities and counties in the states of West Virginia, Michigan, and Nevada. In these lawsuits, the governments claim that Masters failed to monitor, investigate, refuse, and report suspicious orders of opiates. The governments' purported damages are economic—citing increased costs in law enforcement, judicial expenditures, substance abuse treatment, and emergency and medical services.

Masters was insured by Acuity. Acuity accepted a duty under the policies to defend and indemnify any suit seeking damages "because of bodily injury."

Acuity sought a declaratory judgment in the Hamilton County Court of Common Pleas. Acuity argued that the coverage for "bodily injuries" under the policies does not extend to the economic damages being sought by the governments in response to the opioid epidemic and that Acuity is not obligated to defend the claims brought against Masters.

The trial court found that Acuity had no duty to defend or indemnify Masters because the governments seek economic damages, not damages for "bodily injury," and the governments cannot seek damages for their citizens' bodily injury from opioid addiction because they would not have standing to do so. In addition, the loss-in-progress provision prevents coverage because well before 2010, Masters was under scrutiny for filing "suspicious orders" and was aware of opioid addiction issues. Because the trial court found that there was no coverage under the policies, the court also found that Acuity did not owe Masters a duty to defend.

The First District reversed the trial court's judgment on both the duty to defend and the duty to indemnify.

The First District held that Acuity owed a duty to defend because there may be a causal connection between Masters' distribution of opioids, the bodily injury suffered by addicted or overdosed individuals, and the damages suffered by governmental entities, namely medical expenses or treatment costs. Second, the Court of Appeals found that the trial court incorrectly analyzed the loss-in-progress provision. It held that Masters' mere knowledge of risk of opioid addiction is not enough to bar coverage. Finally, the plaintiffs are properly considered "organizations" under the policies' definition of "damages." Therefore, the governments can claim economic damages that occur because of bodily injury and Acuity must defend such claims. The Court of Appeals did not address the duty to indemnify and indicated that it would be premature to decide whether Acuity must indemnify Masters.

Acuity has appealed to the Ohio Supreme Court on the duty to defend, but not on the indemnity holding.

### 31. No Final Appealable Order if No Magic Language

*Berardo v. Felderman-Swearingen*, 2020-Ohio-3098 (May 27, 2020)

It is often good to remind attorneys that in order for an order to be a *final* *appealable* order, it has to be both.

Bernardo addresses the failure of a trial court to make express reference to the language of Civ.R. 54(B) in its so-called final appealable order. This case arises from an automobile accident caused by the negligence of Defendant Felderman-Swearingen. Progressive was defending a

medical payments claim by Plaintiffs and pursuing a subrogation claim against Defendant Felderman-Swearingen. Humana intervened in the lawsuit seeking subrogation against Defendant Felderman-Swearingen and Progressive for the medical expenses it paid on behalf of the Bernardos.

The case went to trial and the jury returned a verdict in favor of Luigi Bernardo and Tina Bernardo on their bodily injury claims against Defendant Felderman-Swearingen only. The med pay claim against Progressive and the subrogation claims of Progressive and Humana remained pending.

The Bernardos were not satisfied with the verdict and filed a post-trial motion for judgment notwithstanding the verdict, additur, or, in the alternative, a new trial on damages. The trial court denied this motion and stated in its entry, "Pursuant to Civil Rule 54, this is a final appealable order." At the time of the trial court's judgment, the Berardos' medical-payments subrogation claim against Progressive and both insurers' claims against Defendant Felderman-Swearingen, and Humana's claim against Progressive remained pending.

The Berardos appealed the decision of the trial court denying their motion. The First District dismissed the Bernardos' appeal because, even though the trial court's entry cited Civ.R. 54 B's "final appealable order" language in part, the order did not include the magic, "there is no just reason for delay" language. Therefore, "[m]erely describing an order as final and appealable, without express reference to the language of Civ.R. 54(B), is not sufficient to satisfy the rule's certification requirement."

### 32. Auto Policy Does Not Cover Shooting of Insured.

*Par v. Geico General Ins. Co.*, 2020-Ohio-5247 (November 10, 2020)

In this case, the First District (applying Kentucky law because the policy was issued to Kentucky insureds in Kentucky but the accident happened in Ohio), Lian Cung Nung and his wife Plaintiff Sigan Hlei Par were driving in Cincinnati when an unknown assailant shot and killed Lian Cung Nung. Par filed a claim with Geico to recover for her husband's injuries under both the uninsured motorist coverage and the Kentucky PIP provisions of the policy. Geico denied the claim because the injuries were not caused by the "use of an auto."

The Geico UM policy provided that, "[Geico] will pay damages for bodily injury caused by accident which the insured is legally entitled to recover from the owner of an uninsured auto * * * arising out of the ownership, maintenance or use of that auto." And, the PIP provision used similar language: "[Geico] will pay, in accordance with Kentucky law, personal injury protection benefits for * * * bodily injury * * * caused by an accident arising out of the operation, maintenance or use of a motor vehicle as a vehicle."

The First District determined that the accident did not arise out of the use of a vehicle and affirmed the decision granting summary judgment to Geico, citing the Kentucky Supreme Court case of *State Farm Mut. Auto. Ins. Co. v. Rains*, 715 S.W.2d 232 (Ky. 1986), in which the victim was killed while driving after the victim's brother shot him through the rear window. The Kentucky Supreme Court stated that any connection between the use of motor vehicles and the injury was merely "incidental."

### 33. No Breach of Contract or Bad Faith Where Insured Failed to Meet a Condition Precedent for Coverage.

*Perrin v. The Cincinnati Ins. Co.*, 2020-Ohio-1405 (2d Dist. April 10, 2020)

Julieta Perrin was involved in a motor vehicle accident in Dayton, Ohio. The Cincinnati Insurance Company (CIC) insured both Perrin and the tortfeasor. Perrin's counsel pursued a claim against the tortfeasor and a first party claim under Perrin's policy with CIC for medical payment expenses (the Medpay Claim). In response to the Medpay Claim, CIC requested documentation and/or authorization to obtain documentation related to Perrin's relevant medical records and bills. Neither Perrin nor her counsel complied with CIC's request.

Perrin filed suit against the tortfeasor and CIC. With regard to CIC, the complaint alleged breach of contract, bad faith, breach of fiduciary duty, and violation of R.C. Chapter 3904 and Ohio Adm. Code Chapter 3901. CIC moved for judgment on the pleadings, resulting in two of the four causes of action against CIC being dismissed. CIC subsequently filed a motion for summary judgment regarding Perrin's remaining causes of action.

The Second District affirmed the trial court decision to deny Perrin's discovery motions and limit the scope of discovery. The Court of Appeals further held that the trial court did not err by determining that Perrin failed to meet a condition precedent for coverage by failing to comply with CIC's request for medical records and bills and, as such, the trial court properly found that CIC did not breach its contractual obligation without reasonable justification.

### 34. Summary Judgment Granted After Insured Failed to Cooperate in the Investigation of a Fire Loss.

*Koscielak v. United Ohio Ins. Co.*, 2020-Ohio-3224 (3d Dist. June 8, 2020)

United Ohio Insurance Company (United) insured a pole building and personal property. In January 2015, a fire occurred at the premises, destroying the pole building. Koscielak filed a claim with United in the amounts of $14,800 for the pole building, $103,600 for personal property, and $28,600 for loss of use coverage. In the ensuing months after the fire, United investigated Koscielak's claim and the cause of the fire. United also requested Koscielak submit an itemized list of personal property lost in the fire.

Believing the claim to involve arson, United requested Koscielak's husband to submit to an examination under oath (EUO). Koscielak's husband testified that Koscielak admitted to him that she had started the fire to collect the insurance proceeds. United subsequently demanded Koscielak submit to an EUO, but after multiple requests, United denied the claim based on its investigation of the loss and Koscielak's failure to provide an EUO and her failure to submit the requested itemized list of personal property items. When she failed to respond to United's motion for summary judgment, the trial court granted United's motion, dismissing the complaint. The Third District affirmed, holding that the evidence established that Koscielak repeatedly failed to comply with United's demands for her to submit to an EUO and cooperate in the investigation of the loss.

### 35. Insured Cannot Recover Underinsured Benefits Wherein He Failed to Satisfy Precondition of Coverage.

*Pursley v. Estate of Messman*, 2020-Ohio-2985 (3d Dist. May 18, 2020)

Billy Pursley filed suit against Russel Williams and various defendants stemming from a multi-vehicle accident that occurred in Paulding County, Ohio. Williams filed a counterclaim against Pursley and requested joinder of Progressive Insurance as a defendant related to underinsured motorist benefits (UIM).

The trial court determined that Williams violated OCR 4511.21(A) by failing to maintain an assured clear distance. Because Pursley and other defendants were not liable for the accident, the trial court also granted Progressive's motion for summary judgment on Williams' request for UIM coverage. The Progressive policy contained the following provision:

If you pay the premium for this coverage, we will pay for damages that an insured is legally entitled to recover from the owner or operator of an underinsured auto because of bodily injury:

1. sustained by an insured;
2. caused by an accident; and
3. arising out of the ownership, maintenance, or use of the underinsured auto.

The Court of Appeals held that Williams had not demonstrated that he was legally entitled to damages and, accordingly, Williams was not entitled to UIM coverage as he failed to establish that any of the parties in the action were legally liable for his claimed damages.

### 36. How to Divide Fire Insurance Payment During a Tricky Real Estate Transaction

*Stamper v. Polley*, 2020-Ohio-3709 (4th Dist. July 15, 2020)

This case involves the purchase of real estate by the Polleys from the Stampers in the Village of Seaman, Ohio. The Polleys also owned additional property that was located in Winchester, on

which they secured a $115,000 home equity loan in order to purchase the real estate in Seaman. Around that same time the Polleys also insured the Seaman property for $45,000.

In 2016, the Polleys and Stampers entered into a contract whereby the Stampers agreed to purchase the Seaman property from the Polleys for $25,000 with interest and monthly payment. Within the contract was a provision that required the Stampers to have fire and extended insurance coverage. Once the contractual obligation was fulfilled, the Polleys were to convey the property to the Stampers by a general warranty deed. In 2017, a fire destroyed the Seaman property and the Polleys received $44,626 from their insurance company. The Polleys used $31,563 to pay off the home equity loan on the Winchester residence and offered the Stampers $3,000 if they cleared the destroyed structure. While the Stampers accepted the $3,000, they viewed it as a down payment until the parties could agree on how to split the insurance proceeds. When the parties could not come to an agreement on how to divide the proceeds, the Stampers filed a complaint asking the district court to order specific performance for the Polleys to pay the Stampers their share of the proceeds. At trial, the court found that the Stampers were entitled to $19,766 of the insurance proceeds and ordered the Polleys to give the Stampers the warranty deed.

### 37. The Aggregate Limit and Not the Occurrence Limit Applied to a Singular Event Under the Products Completed Operations Hazard Coverage

*Grange Ins. Co. v. Swearengen*, 2021 Ohio 3596 (7th Dist. Oct. 6, 2021)

In November 2016, James and Carolyn Swearingen called Mutton's Heating and Cooling for service on their heating system. On February 5, 2017, Mr. and Mrs. Swearingen were found unresponsive in their home. The couple died from carbon monoxide poisoning. The Estates filed suit against Mutton's claiming Mutton's failure to advise the Swearengens that the boiler was "ancient" led to the deaths of the Swearengens. Mutton's was insured by Grange under a CGL policy.

Grange argued that $1,000,000 was the policy limit per claim under the products completed operations hazard (PCOH) and offered that amount to the Estates in exchange for a release. The Estates disagreed that the PCOH limit was $1,000,000 and argued the policy limits for the PCOH coverage was $2,000,000 per claim. The parties agreed to a settlement that released Mutton's from liability, required Grange to pay the undisputed policy limit of $1,000,000, and allowed the policy limit issue to be decided by the court. Per the terms of the agreement, if the PCOH limit was determined to be $2,000,000, Grange would pay $800,000 additional in damages. If the PCOH limit was determined to be $1,000,000, Grange would pay nothing further.

The trial court ruled that the PCOH limit was $2,000,000. When the Estates requested post judgment interest, the trial court awarded it. Grange appealed.

The appellate court upheld the trial court's ruling that the PCOH limit was $2,000,000. The per occurrence limit that is applicable to a liability claim is not, in the courts' opinion, applicable to a Products Completed Operations Hazard claim. The court, looking at the Declarations Page of the policy, determined that the occurrence limit did not apply to a PCOH claim. The appellate court reversed the interest award, explaining that the settlement agreement provided the full agreement on damages which did not include payment of interest.

### 38. Whether Insured's Five Month Delay in Reporting the Fire Was Reasonable Is an Issue of Fact

*LTF 55 Props. v. Charter Oak Fire Ins. Co.*, 2020 Ohio 4294 (8th Dist. Sept. 3, 2020)

Plaintiff LTF 55 Properties ("LTF") owned a building in Cleveland that was damaged by fire. One of the tenants, NEO Contractors ("NEO"), was claimed to have caused the fire. Charter Oak issued a commercial property policy insuring the building. LTF was an Additional Insured under the Charter Oak policy. NEO was insured by Grange.

LTF was advised of the fire on the day of the fire. LTF hired a public adjuster who "repeatedly" told LTF to file an insurance claim with Charter Oak but, "for business reasons," this was never done. Prior to notifying Charter Oak of the fire, LTF agreed to release NEO from liability in exchange for the Grange liability limits of $100,000, and evidence of the fire had been removed.

Five months later, in March of 2017, LTF advised Charter Oak of the claim and provided a Proof of Loss for more than $350,000 in damages to the building and personal property. Charter Oak disclaimed coverage for the fire, explaining that LTF had breached the notice provision of the commercial property policy. LTF filed suit alleging breach of contract and bad faith. The trial court granted summary judgment to Charter Oak, dismissing all claims.

The Eighth Appellate District reversed the trial court's decision. The court determined a five month delay did not violate the notice provision as a matter of law. The court also determined that the delayed notice did not prejudice Charter Oak's investigation into the fire because: 1) The release of the tenant was allowed under the subrogation provision of the policy; and 2) While the evidence was cleared from the building, Charter Oak did not attempt to locate the evidence to inspect it or seek documentation from Grange's investigation of the fire. As a result, it was premature to determine whether Charter Oak's investigation of the claim was prejudiced.

Regarding the Bad Faith claim, the appellate court held there was a question of fact of whether the denial of the claim "lacked reasonable justification." The court explained that Charter Oak did not attempt to secure the photographs and other information available to fully assess the loss prior to the disclaimer of coverage.

### 39. Regular Use Exclusion Bars Underinsured Motorist Coverage

*Casey v. Erie Ins. Co.*, 2020 Ohio 4067 (8th Dist. August 13, 2020)

Joseph Casey was a passenger in a vehicle owned by Heights Driving School, Inc., when it collided with a vehicle operated by K.M., a minor. Casey was a driving instructor and was instructing a student driver, M.M., at the time of the loss. K.M. had a red light but drove through the intersection causing the accident. Casey was injured in the accident and died twenty months later. At the time of the loss, K.M. was driving two minor children to their mother's place of employment as requested by the mother. K.M. was babysitting the two minors whose parents' names were Derrek and Joy Supple. Erie Insurance issued a commercial auto policy to Heights, and State Farm issued a personal auto policy to Casey.

The Estate sued K.M. and the Supples alleging negligence claims. The Estate sued Erie Insurance and State Farm seeking Underinsured Motorist coverage. Erie agreed that there was UIM coverage for Casey's injuries. State Farm disclaimed UIM coverage under the policy, explaining the regular use exclusion applied. The Estate and Erie argued that the application of the regular use exclusion should be decided by a jury, not as a matter of law.

The appellate court affirmed the trial court's ruling dismissing the Supples. K.M. was properly classified as an independent contractor and, therefore, the Supples were not liable for K.M.'s negligence. The appellate court also determined that the Supples were not joint tortfeasors with K.M., dismissing the action against them because the Supples did not participate in or encourage K.M.'s tortious actions.

Regarding the Underinsured Motorist claim against State Farm, the appellate court held that the regular use exclusion applied to bar coverage. Casey was a driving instructor with Heights and drove a Heights' vehicle to instruct the students. It was immaterial that Casey was a passenger in the vehicle instead of the driver. He used the vehicle five to six days a week for instruction and the vehicle was kept at Casey's home. While Casey typically used the same vehicle, the court explained that it did not have to be the same Heights vehicle used. Casey's use of the vehicle amounted to regular use, and the policy did not provide coverage.

### 40. An Insured Is Not Entitled to Sales Tax and Fees for Totaled Vehicle When Retaining the Salvaged Vehicle if Properly Limited in the Policy.

*Williams-Diggins v. Permanent Gen. Assur. Corp.*, 2020-Ohio-3973 (8th Dist. Aug. 6, 2020)

Seems like suing insurers for sales tax was the *soup du jour* on the menu of plaintiffs' firms this year.

This case involved a class-action against Permanent General Assurance Corporation for failing to pay out sales tax, title fees, and registration fees as part of the actual cash value ("ACV") in a

total-loss settlement for a vehicle damaged in an auto accident. The applicable policy limited the property-damage payout to the lesser of ACV, amount necessary to repair, or amount necessary to replace. The policy generally defined actual cash value to be fair market value ("FMV").

The insurer totaled out the plaintiff/insured's vehicle at actual cash value and he accepted that payment without objection. However, the problem is the representative who filed this lawsuit retained the salvage title to the vehicle. The insured later sought sales tax and title and registration fees (which is implied he never incurred) from the insurer.

At the trial court, the insurer filed a Civ.R. 12(B)(6) motion to dismiss, which the trial court granted. The lower court found that the actual cash value (i.e., FMV without tax and fees) was the measure of damages under the policy. It further found the policy did not contain any promise from the insurer to pay sales tax and fees following the acceptance of an ACV payment.

On appeal, the court affirmed the dismissal by finding that the policy was limited to FMV at the time of the accident. Although the Eighth District recognizes ACV as either FMV at the time of the loss *or* replacement cost less depreciation, the parties are free to contract for the more-stringent FMV only. Here, the insurance policy was limited to FMV. The court quickly dispatched of the insured's several other arguments, including the make-whole doctrine (only applicable in tort).

### 41. Expect Insurers to Pay for All Costs, However Derivative, for Damaged Utility Poles in the Eighth District

*Illumination Co. v. Boseman*, 2020-Ohio-3663 (8th Dist. July 9, 2020)

The ongoing saga as to what costs an insurer or tortfeasor owes for the replacement of a damaged utility pole continues to divide Ohio courts. Unsurprisingly, this case dealt with a utility pole owned by Cleveland Electric Illuminating Co. ("CEI") and damaged by the defendant during a 2015 auto accident. CEI claimed direct replacement costs (such as crewmembers' time, materials, vehicle usage) at $1,595.72. It claimed indirect costs of $447.20, which essentially consisted of overhead, pension-related benefits, and other post-retirement benefits—calculated by using a percentage multiplier for the direct costs.

The parties consented to a bench trial and, after submitting many stipulations, only two primary issues remained: how to calculate indirect costs and which party is responsible for those; and whether any depreciation to the utility pole would offset any direct and indirect costs. The pertinent stipulations were: the defendant admitted liability; a utility pole has an average lifespan of eighty years; the pole had been in service for twenty-two years at the time of the accident; and the amount of the direct and indirect costs.

At the bench trial, a witness for CEI testified that, among other things, there is no certain age when a utility pole must be replaced. He indicated a pole must generally be tested since they do not show signs of aging easily. Another witness for CEI testified the pole was inspected in 2007

and 2014 without signs of decay. This second witness also provided testimony on the issue of how indirect costs are calculated based upon guidance from FERC and the PUCO.

The defendant called a forensic accountant. He calculated damages solely for the direct costs less depreciation and opined the indirect costs could not be calculated with reasonable certainty as caused by the accident. In essence, he reduced the damages to $1,156.90, which represented the direct costs less twenty-two years of depreciation (out of eighty useful years).

The trial court granted judgment in favor of CEI for all of its requested damages. The Eighth District then affirmed both issues on appeal. As it relates to depreciation, the court declined to adopt a bright-line rule. Instead, and utilizing a manifest-weight review, it found that the defendant failed to sufficiently establish the "life expectancy" of the pole at issue because the parties only stipulated that poles generally have a life expectancy of eighty years. The appellate court did note there is a split in authority on depreciation of utility poles, but explained away those cases by stating the defendants were able to establish life expectancy with reasonable certainty.

Finally, the Eighth District affirmed the imposition of indirect costs. The court noted damages include both direct and indirect costs so long as indirect costs are proven with reasonable certainty and with sound accounting principles. As to the second issue, utilizing FERC and PUCO guidelines constituted sound accounting principles (and was conceded by the defendant). As to the first issue, after first acknowledging another district split, the appellate court noted the Eighth District has found the multiplier method of calculating indirect costs sufficient to satisfy the reasonable-degree-of-certainty standard.

### 42. Mailbox Rule Allows Insurer to Avoid Dog-Bite Judgment

*Villaos v. Nationwide Mut. Fire Ins. Co.*, 2020-Ohio-5123 (12th Dist. Nov. 2, 2020)

In 2015, the plaintiff was soliciting in a neighborhood when he was attacked by the insureds' dog. The problem was the dog had previously injured the insureds' son. The insureds had been insured by Nationwide through a homeowner's policy for many years. Nationwide added a dog-liability exclusion to the policy in 2003, which excluded coverage for injuries caused by a dog with a prior history of causing bodily harm. Based upon that exclusion, Nationwide denied defense and indemnity to the dog owners.

The homeowners confessed a judgment of $175,000 in favor of the plaintiff and assigned their claims against Nationwide to the plaintiff. The plaintiff then initiated suit against Nationwide for breach of contract, claiming two issues: lack of notice of the renewal terms; and the policy should be reformed to cover the loss. At the trial level, the homeowners provided testimony they did not receive notice of the exclusion or otherwise know about it. Nationwide provided proof of its notice history to the homeowners, including the 2003 notice and for additional changes made to the form in 2011 and 2013. The trial court granted summary judgment to Nationwide.

The Twelfth District affirmed. As to the notice issue, the court applied the mailbox rule. Nationwide met its burden to prove it sent the notices—and the homeowners and plaintiff failed to rebut the presumption of the mailbox rule. As to the reformation issue, the court held that, because there was proper notice, the equitable remedy of reformation for a unilateral mistake was not available. The court gave full force and effect to the dog-liability exclusion.