SPRING 2023 INSURANCE COVERAGE UPDATE

Provided by the Ohio Association of Civil Trial Attorneys (OACTA) Insurance Coverage Committee

Message from the OACTA Insurance Coverage 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 the calendar year 2022. Many thanks to the following members of our outstanding OACTA Insurance Coverage Committee who volunteered to summarize these cases and make this edition possible: Kelli J. Amador of Dinsmore & Shohl LLP; Kurt D. Anderson of Collins, Roche, Utley & Garner, LLC; Patrick Cannell of Weston Hurd LLP; 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; Eric K. Grinnell of Carr Law Office, LLC; Arthur O. Kostendt of Bonezzi, Switzer, Polito & Hupp Co., LPA; Lynne Longtin of The Cincinnati Insurance Company; Robert Mitchell of Freund Freeze & Arnold LPA; 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. Lawyers Get Schooled on Sanctions, Part I

Wesco Ins. Co. v. Roderick Linton Belfance, LLP, 39 F.4th 326 (6th Cir. July 1, 2022)

HOLDING – An award of attorney fees against unsuccessful plaintiff lawyers under the IDEA based on improper conduct constituted "sanctions;" therefore the award did not fall within the definition of covered "damages" under the lawyers' professional liability policy.

After lawyers brought unsuccessful claims against schools under the Individuals with Disabilities Education Act ("IDEA"), the frustrated school defendants sought and were awarded attorney fees against the lawyers. The IDEA's fee shifting provision allowed the court to award attorney fees against the lawyers if the complaint was "frivolous" or "presented for any improper purpose". The schools presented evidence that the attorneys filed sloppy, factually inaccurate pleadings, made legally irrelevant allegations and unnecessarily prolonged the proceedings.

The lawyers turned to their professional liability carrier, Wesco Insurance Company ("Wesco") for coverage of these fees. Wesco's policy provided coverage to the attorneys for any awarded "damages." The Policy defined "damages" to exclude "civil or criminal fines, sanctions, penalties or forfeitures, whether pursuant to federal, state or local law, statute, regulation or court rule and

injuries that are a consequence of any of the foregoing." Wesco denied the claim, based on the policy's exclusion for "sanctions."

Since the policy did not define "sanctions," the court employed the definition that an average policyholder in the legal malpractice context would attribute to the term. Relying on Black's Law Dictionary 1608 (11th ed.2019), the court concluded that the average lawyer would describe a legal sanction as a "penalty or coercive measure that results from failure to comply with a law, rule, or order." The court determined that the fees awarded under the IDEA were based on abusive litigation tactics, and therefore concluded that such fees would fall within the definition of "sanction." Acknowledging that its decision was supported by a "large body of judicial decisions" and reflected what the "legal community routinely describes …as a 'sanction,'" the court found no coverage for the attorney fees under Wesco's policy.

Ohio Federal District Court Cases

2. Court Allows Appraiser to Consider Causation Issues for Covered Damages

Westview Village v. State Farm Fire & Cas. Co., 2022 WL 3584263 (N.D. Ohio August 22, 2022)

HOLDING – A federal court construed the language "amount of loss" in an insurance appraisal clause to allow the appraiser to consider causation for the purposes of establishing covered versus non-covered claims.

This is the second of two "property appraisal" cases decided this year and unfortunately in both cases the courts (both federal courts) allowed the cases to go to appraisal to address coverage issues.

Westview owned condominiums that sustained storm damage. When Westview submitted a claim under its policy, State Farm paid a portion of the claim, but asserted that the remaining damages were due to normal wear and tear, which was not covered. Westview then invoked State Farm's appraisal clause, which permits either party to have a panel of appraisers resolve disagreements over the "amount of loss," a term not defined in State Farm's policy. Westview also filed a declaratory judgment action and requested the court to compel the appraisal. State Farm opposed the appraisal, asserting that the court, not the appraiser, must determine coverage issues, which included whether the claims for storm damage constituted wear and tear.

At issue was whether the policy language allowing appraisers to consider the "amount of loss" permitted them to determine causation of loss. While the Ohio Supreme Court had not addressed the issue, Ohio appeals courts had reached conflicting decisions. The federal court predicted that the Ohio Supreme Court would allow an appraiser to consider causation, based on the earlier Ohio Supreme Court decision allowing appraisers to determine the extent of the loss (*Saba v. Homeland Ins. Co. of America*, 159 Ohio St. 237, 240, 112 N.E.2d 1 (1953)) as well as other jurisdictions' recognition that determining the extent of loss necessarily requires an appraiser to separate covered from non-covered damages. Even without this prior authority, however, the court noted that the

phrase "amount of loss" encompassed causation determinations. According to the court, even "if Ohio courts were silent on whether appraisers could consider a loss's extent, the phrase 'amount of loss' requires the causation determinations. Dictionaries define 'loss' in the insurance context 'by reference to the insurer's 'liability' under the contract. And to determine what damage an insurer might be liable for under the policy, appraisers must decide what caused the damage.'" Id. at *3. The court classified the extent of damage that a covered event caused as a factual question, not a legal one. Therefore, the court determined that appraisal was the proper mechanism to resolve the parties' disagreement.

3. Remitted Damages Award or New Trial Appropriate when Jury Applies the Wrong Policy Limit and Confuses ACV with RCV

Blues to You, Inc. v. Auto-Owners Insurance Co., 2022 WL 9753916 (N.D. Ohio Oct. 17, 2022)

HOLDING – Court orders the plaintiff insured to accept either a new trial or remitted damages award when jury applies the wrong policy limits and confuses ACV with RCV.

The plaintiff's bar was damaged in a fire in 2019; it sought coverage for its losses from its carrier Auto-Owners. While the claim was still open, in 2020, a fire in an apartment above the bar occurred, causing water damage to the bar, constituting another claim for coverage. The plaintiff proceeded to trial on both claims. The jury awarded plaintiff a verdict including compensatory and consequential damages which significantly exceeded the policy's limits, punitive damages and the right to recover attorney's fees. Auto-Owners moved for a new trial and/or remittitur, advancing various arguments that the verdict was against the weight of the evidence.

In response, the court rejected most arguments but accepted two. Of note are the following rulings:

- A bad faith claim does not need to be proven by expert testimony;
- The expert testimony of a public adjuster who does not have experience in claims handling from the insurer's perspective is not inadmissible; rather, the "one-sided" nature relates to the weight and credibility of the testimony;
- When the jury applied the higher CGL limits on a BPP claim, a remitted damage award or new trial on the damages was necessary; and
- When the jury accepted evidence of RCV on a claim for ACV, a remitted damage award or new trial on the damages was necessary.

4. Default Judgment is Proper against Non-Answering Defendants in Declaratory Judgment Action Where Companion Cases Are Decided on the Merits.

Great West Cas. Co. v. Maric Transp., Inc. 2022 WL 4290684 (N.D. Ohio., E. Div. Sept. 16. 2022)

HOLDING: Plaintiff Insurer filed Motion for Default Judgment against two non-answering defendants, having succeeded in prevailing on a dispositive motion declaring no coverage existed under the issued policy for two non-defaulting defendants. Court granted motion, holding that (1) a default judgment is proper even when the issue to be determined involves a question of coverage under an insurance policy, and (2) even though courts frequently prefer to delay a default judgment against defaulting defendants until the claims against non-defaulting defendants are resolved in order to avoid inconsistent judgments, in this case the claims against non-defaulting defendants were already resolved on the merits.

Plaintiff Great West filed a declaratory judgment action against Defendants Maric, Maric Transp., Quinones, McKenzie, and Ladejo, requesting a finding of coverage under a Great West policy for injuries suffered in an accident. Quinones and McKenzie appeared and filed answers to the complaint; Marie and Ladejo did not file answers. The Court granted Great West's Motion for Summary Judgment against Quinones and McKenzie, declaring that there was no coverage under the policy for their injuries. The Court then entered a default judgment against the remaining non-answering defendants, finding that it was not necessary to delay entering this default as the Court's prior ruling against Quinones and McKenzie resolved the entire case on its merits.

5. **No "Total Loss" or Additional ALE Coverage for Fire-Damaged Residence Where Dwelling is not a Total Loss and ALE was Already Paid**

Carpenter v. Liberty Ins. Corp., 2022 WL 1406654 (S.D. Ohio, W. Div. May 4, 2022)

HOLDING: Plaintiffs were not entitled payment of "total loss" value of his residence, when the residence was repaired and thus did not lose its identity and specific character as a building. The plaintiffs were also not entitled to Additional Living Expense benefits, when the prescribed limit of 12 months expenses had already been reimbursed by the insurer.

Plaintiffs' residence was damaged by a fire, and they sought coverage under a residential fire insurance policy's Dwelling Coverage. A dispute arose as to whether the amount payable by the defendant insurer under the policy was the "total loss" value or the cost of repair or replacement of the residence. The Court cited to Ohio Rev. Code sec. 3929.25, which provides a definition of "total loss," and stated that a building is only a statutory "total loss" if an "absolute extinction" of the building occurs, which is nothing more than "a mass of ruins, parts of which may remain standing, but of no value in repairing or rebuilding the structure." A "total loss" also occurs where damages exist to such an extent that an insured is unable to secure a building permit to repair the same. As plaintiffs' home was ultimately repaired, they were not entitled to total loss proceeds.

Plaintiffs also claimed Additional Living Expenses ("ALE") coverage over and above the stated 12-month maximum payable under the policy. As this maximum sum had already been remitted by the insurer, the Court held plaintiffs were entitled to no further proceeds.

6. "Claims in Progress" Exclusion Absolved an Insurer from the Obligation to Defend or Indemnify

James River Casualty Company v. Unicontrol, Inc., 2022 WL 2916867 (N.D. Ohio, E. Div. July 25, 2022)

HOLDING: Insured was sued for environmental damages occurring from 1918 to 1971, and sought coverage for indemnity and defense costs under five successive annual term CGL policies first incepting in 2015. Each policy had a "Claims in Progress" exclusion. In a declaratory judgment action brought by the Insurer, the Court held the language of the exclusion was unambiguous, and that the claim of "property damage" insured against took place sometime between 1918 and 1971, and the policies' coverage did not extend into the policy period

An underlying lawsuit was brought by municipalities against Unicontrol and several of its predecessors, for causing environmental damage through its manufacturing activities between 1918 and 1971. Unicontrol tendered the suit to its Insurer, James River Cas. Co., which had issued five successive annual term CGL policies to Unicontrol, the first of which incepted in 2015. Each policy contained a Claim in Progress exclusion which provided as follows:

> *This Coverage Part does not apply to…'property damage'…which begins or takes place before the inception date of coverage, whether such…'property damage'….is known to an 'insured', even though the nature and extent of such damage or injury may change and even though the damage may be continuous, progressive, cumulative, changing or evolving, and even though the 'occurrence' causing such…'property damage'… may be or may involve a continuous or repeated exposure to substantially the same harm.*

After sending a denial of coverage letter to Unicontrol, James River filed a declaratory judgment action, seeking a ruling that it had no contractual duty to defend or indemnify Unicontrol in the underlying lawsuit. James River filed a Motion for Summary Judgment, and the Court held that under the federal Declaratory Judgment Act (28 U.S.C. sec 2201) it was appropriate to resolve this dispute in the instant action.

The Court granted James River summary judgment, finding that "[g]iving the terms their plain and ordinary meaning… the Policies do not cover the Underlying Lawsuit because the 'property damage' 'beg[an] or [took] place' sometime between 1918 and 1971, which is undisputedly 'before the inception date of coverage.' The Court further found that under the plain and ordinary meaning of the Claim in Progress exclusion, "coverage does not extend to damages that continue into the coverage period."

Unicontrol argued that a court must interpret the exclusion's terms strictly against the insurer, under both Indiana and Ohio precedent. The court pointed out that Ohio and Indiana only enforce exclusions if the insurance company articulates the exclusions in its policy, and that James River's exclusion "explicitly stated it was not on the hook for any liability that occurred or began to occur before the policy's inception." Unicontrol also argued that, since the exclusion was ambiguous, James River must, at a minimum, indemnify and defend it on a *pro rata* basis for any damage that occurred during the policy period. The Court found that the exclusion did not include any language indicating that the parties contemplated *pro rata* coverage for ongoing or continuous harm. Finally, Unicontrol argued that, at most, the exclusion only absolves James River of the duty to indemnify, not defend. The Court stated that, while the duty to defend is broader than the duty to indemnify, Ohio and Indiana do not prohibit an insurance company from limiting its duty to defend if the limitation is made clear. Here, the exclusion explicitly covered James River's duty to defend because it modified the insurer's obligation in the Insuring Agreement provision, and one of the duties mentioned in that Insuring Agreement was the duty to defend

7. Court Reaffirms that Stacking of Underinsured Motorist Policy Limits not allowed over Liability Limits of Tortfeasor's Policy

Hemmelgarn v. Banner, 2022 WL 899770 (S.D. Ohio, W. Div. March 28, 2022)

HOLDING: Insured's $500,000 limit underinsured motorist policy did not afford any coverage above the limits of a tortfeasor's $1 mil auto liability policy.

The Hemmelgarns filed suit against KLLM Transport Services for personal injuries sustained in a vehicular accident, and included in the suit co-defendant SafeCo, for coverage under their underinsured motorists policy issued by that insurer. The limits under KLLM 's auto liability policy were $1 mil., and the limits of SafeCo's underinsured motorist policy were $500,000. SafeCo filed a Motion for Summary Judgment, arguing that Ohio Rev. Code sec. 3937.18 precluded the Hemmelgarns from recovering funds from their underinsured motorist policy because KLLM was insured for a greater amount than the limits of the underinsured motorist policy.
ORC 3927.18 provides: "Underinsured motorist coverage in this state is not and shall not be excess coverage to other applicable liability coverages, and shall only provide the insured an amount of protection not greater than that which would be available under the insured's uninsured motorist coverage if the person or persons liable to the insured were uninsured at the time of the accident." The Court held that the Hemmelgarns' underinsured policy is "not an umbrella policy" to make up for damages in excess of the KLLM policy. The SafeCo underinsured coverage would need to be greater than the KLLM coverage in order for the Hemmelgarns to draw from it, and the Court therefore granted SafeCo summary judgment.

8. Attorney Conflict Rules Applied: What Constitutes "Same Matter" and "Substantial Responsibility"?

Seaman Corporation v. Zurich American Insurance Company, 2022 WL 17251819 (N.D. Ohio, E. Div. Nov. 28, 2022)

This case discusses the proper context under which an attorney and law firm might be disqualified under the Rules of Professional Conduct.

Seaman filed a motion to disqualify Zurich's counsel, which the court granted, finding that the attorney's new firm was also disqualified and that the conflict could not be avoided through an ethical screen. Although the attorney on whose basis the disqualification was awarded did not participate in the new litigation and she was screened off from that litigation, the court still found that her new firm was entirely disqualified from engaging in litigation against her prior client, Seaman, because she had "substantial responsibility" for representing Seaman in an insurance coverage matter when she was a partner at her prior firm, even though she was only third chair in that prior litigation.

The court based its decision on the fact that she was involved in "some communications to the insurance carrier ... in the role of defense counsel," that she prepared an initial draft of a demand to Zurich seeking settlement authority and asserting Seaman's position that Zurich had failed to fulfill obligations owed to its insured in connection with the prior litigation, and that she participated in and was privy to discussions leading up to and following the draft demand letter that she authored. Citing Rules 1.9 and 1.10, the court noted that, "A violation of the Rules of Professional Conduct may, but does not always, require disqualification," but that, "with a view of preventing the appearance of impropriety" a court must "resolve all doubts in favor of disqualification." The issue boiled down to whether the attorney represented the client in the "same matter" under Rule 1.10 and held that this does not necessarily mean the same "lawsuit"; and whether the attorney had "substantial responsibility" in that matter.

The court found that she had represented the client in the "same matter" because she had provided legal representation to Seaman on the insurance coverage dispute with Zurich during the pendency of that action, including direct involvement in drafting a demand letter to Zurich in May of 2021. In addition, she had "substantial responsibility" in the matter because she had "partner-level responsibilities" in the prior case and because her "intimate access to confidential information about Seaman's coverage strategies," and her direct participation in insurance coverage issues discussed in May 2021 demonstrate she had "substantial responsibility" in the matter. Thus, these facts "demonstrate[] that [she] had 'substantial responsibility' in the insurance coverage issues as counsel for Seaman even though she was not sole or lead counsel."

Finally, the court held that her new firm could not avoid the conflict by screening her off under Rule 1.10(d) because that Rule, "does not apply if disqualification occurs under Rule 1.10(c)." Because the court concluded that disqualification was required under Rule 1.10(c), the court further determined that "the imputed conflict cannot be avoided under Rule 1.10(d)," and the firm was also conflicted out of representing Zurich in the subsequent case.

9. "Safelite Repair, Safelite Replace" – for $1 Million per inch of Windshield

ACE American Insurance Company v. Zurich American Insurance Company, 2022 WL 16534826 (S.D. Ohio, E. Div. Oct. 28, 2022)

This is an equitable contribution action in which the plaintiff, ACE, asked the Court to compel Defendants Discover and Zurich to reimburse ACE for the cost of defending their joint insured, Safelite Group, Inc., from a tort action filed against it by Richard Campfield and Ultra Bond, Inc., regarding a claim for "personal and advertising injury" damages involving certain products designed to repair windshield cracks greater than six inches. Plaintiff alleged that Safelite violated Section 43(a) of the Lanham Act, 15 U.S.C. § 1125(a)(1)(B), by "falsely stat[ing] that windshield cracks longer than six inches cannot be repaired and require that the windshield be replaced or, conversely, that only windshield cracks up to six inches (or the size of a dollar bill) can be safely repaired."

Safelite tendered the underlying civil action to ACE initially but waited nearly four years to tender the defense to Discover and Zurich, who also issued liability insurance policies to Safelite. The parties agreed that they would jointly cover Safelite's defense costs going forward, but Discover and Zurich declined to reimburse ACE for the costs incurred for the years in which ACE solely defended Safelite. ACE then sued Discover and Zurich for equitable contribution to compel them to reimburse a share of the pre-tender defense costs. After nearly six years of litigation in the tort action, the district court entered summary judgment in Safelite's favor on Campfield's claims. Total defense costs incurred by ACE were $4,971,636.70. Discover and Zurich agreed not to contest whether these defense expenses were reasonable and necessary and the suit proceeded on the merits of the contribution claim. They further agreed to reimburse ACE in equal shares (one-third each) for all reasonable post-tender defense costs, but they declined to reimburse ACE for any of the pre-tender defense costs because they had not been properly noticed of the loss during that time period. As for the policies themselves, ACE issued seven CGL policies to Safelite for annual policy periods from December 31, 2012, through December 31, 2019, while Discover issued two CGL policies from December 31, 2010, through December 31, 2012, and Zurich issued nine CGL policies from December 31, 2001, through December 31, 2010.

ACE first argued that the court should apply an "all-sums" approach to the recovery, but the court refused under the authority of *Lubrizol Advanced Materials, Inc. v. Nat'l Union Fire Ins. Co.*, 161 Ohio St.3d 1, 160 N.E.3d 701 (Ohio 2020) because the alleged harms were discrete and knowable. In addition, ACE was precluded from seeking equitable contribution from Discover

and Zurich for the pre-tender litigation expenses because equitable contribution requires the existence of a shared obligation, and Discover and Zurich simply did not share the same obligation with ACE. Further, under current relevant Ohio law,
insurers are usually not liable for pre-tender defense costs when the insured fails to provide timely notice. The uncontroverted record in this case showed that Safelite waited nearly four years after Campfield filed suit before notifying Discover and Zurich. This nearly four-year delay, coupled with the evidence indicating that Safelite knew how to provide notice because it did so with ACE shortly after Campfield filed suit, led the Court to conclude that Safelite's notice to Discover and Zurich was unreasonably late, and therefore breached the relevant policies' prompt-notice provisions. In addition, it was not necessary for
Discover and Zurich to show prejudice under *Dover Lake Park (*2003-Ohio-3312) because the *Campfield* litigation did not involve an uncompensated tort victim, because Safelite's late notice (which arrived after the district court had already ruled on Safelite's motion to dismiss) precluded Discover and Zurich from assuming control of the investigation and defense against Campfield's claims, and because relieving Discover and Zurich from liability for pre-tender defense costs would not amount to a windfall at the insured's expense since Safelite had been whole throughout the Campfield litigation because ACE covered Safelite's pre-tender expenses and ACE, Discover, and Zurich agreed to jointly share the post-tender expenses.

The court therefore granted Discover's and Zurich's Motions for Summary Judgment and denied ACE's Motion for Summary Judgment.

10. Appraisals: The "New Normal"?

Stonebridge at Golf Village Squares Condominium Association v. Phoenix Insurance Company, 2022 WL 7178548 (S.D. Ohio, E. Div. Sept. 22, 2022)

This is a case that attempts to answer the question, "Whether Stonebridge, a condominium association, is entitled to an 'impartial' appraisal of damages that its insurer preemptively refuses to cover." This is another one of the cases involving property appraisal and this court, like the *Westview* Court, found that it was.

Stonebridge is a condo association in a multi-building condominium complex in Powell, Ohio, and it was insured by Phoenix under a "Businessowners Property" Policy. The Policy contained a $10,000 deductible and an appraisal provision which provided either party the option to "make a written demand for an appraisal" if they ever disagreed on "the amount of loss."

For anyone familiar with the appraisal process, each party first selects a "competent and impartial" appraiser and the two appraisers huddle together and select an umpire (which sometimes can take months). If they cannot agree, either may request that selection be made by a judge of a court having jurisdiction. Once the umpire is selected, the appraisers then inspect the property and state separately the value of the property, the amount of net Income and operating expense, or the amount of loss. If they fail to agree, they submit their differences to the umpire

and a decision agreed to by any two will be binding. This appraisal was no different except that the Phoenix policy "retaine[d] [Phoenix's] right" to deny any claim Stonebridge made, even after an appraisal occurred.

Stonebridge notified Phoenix of the Loss in November of 2019, even though it claimed the storm occurred on September 1, 2019. In late November, both parties simultaneously dispatched their own roofing contractors to inspect the Stonebridge property. Eventually, Phoenix's contractor determined that "no hail damage to the roof shingles" occurred, but Stonebridge's contractor disagreed. Phoenix then hired an engineer -- HAAG Engineering ("HAAG")—to re-inspect the Stonebridge property, and HAAG confirmed that Stonebridge's roof shingles had not incurred any hail damage. HAAG did, however, find "48 wind-damaged shingles on 16 of the 45 buildings." Later, in January 2020, "additional shingles" were reportedly blown off of Stonebridge's roofs (the "January Storm").

Based on HAAG's assessment, Phoenix estimated Stonebridge's total wind-related loss to be $4,157.04, but because that amount fell below the Policy's $10,000 deductible, Phoenix denied payment for the Loss. This prompted Stonebridge to retain an engineer of its own -- Forensic Building Science, Inc. ("FBS") -- who submitted a forty-four-page report which: (1) Concluded that Stonebridge had, indeed, incurred "wind, hail and rain" damage from the September Storm; and (2) Recommended "full replacement" of Stonebridge's "roof assembly" at a total cost of $3,775,029.98.

When Phoenix continued to refuse payment, on February 1, 2021, Stonebridge formally demanded an appraisal under the Policy. Two weeks later, Phoenix partially rejected the appraisal demand as it pertained to "hail damage" and "any damages not identified" by HAAG on the basis that, "[a]ppraisers only determine the amount of loss and do not resolve questions of coverage." In addition, because the policy had a time limitation provision, Phoenix also determined that any hail damage Stonebridge incurred fell "outside of the policy period" and therefore was beyond the scope of the appraisal clause, as were any damages not identified in the HAAG report.

So in sum, Phoenix agreed to submit to an appraisal solely of the shingle damage that HAAG identified and when notified of this, Stonebridge filed suit to compel the appraisal on its own terms.

In Stonebridge's suit, it sought a judicial declaration that the appraisal panel be ordered to "resolve the entire disputed amount of Loss," instead of just the "Loss" Phoenix wanted the appraisal panel to assess (emphasis added). We note that Stonebridge also relied on *Westview Village v. State Farm Fire & Cas. Co.* – the other "appraisal case" which is summarized in these Case Summaries – and the court did, in fact, heavily rely on *Westview* for its analysis.

The court began its analysis of the appraisal question by first noting that in Ohio, parties may enforce appraisal provisions just as they can any other bargained-for contractual right. In

addition, appraisals are generally binding as to the amount of loss. But in reality, separating coverage issues from loss issues is not a simple task. That is why, out of precaution, parties engaged in appraisal sometimes agree to an appraisal format that prohibits appraisers from answering causation questions when setting the amount of loss. But where, as in this case, an appraisal provision is otherwise silent as to how an appraiser should measure the "extent" of the "loss," courts in a variety of Ohio jurisdictions have interpreted the process to require (or simply permit) a causation analysis.

Therefore Stonebridge phrased the issue not as what constitutes a "covered event" under the Policy, but rather "the extent of damage that a covered event"—i.e., the September Storm—actually "caused." Thus, according to Stonebridge, nothing prohibits an appraiser from answering that inquiry. Phoenix, on the other hand, disagreed, and argued that it was not required by the insurance policy to enter into an appraisal against its will since the policy clearly states that either party "may" invoke appraisal, not "shall." In Phoenix's view, this "permissive" language excuses it from complying with Stonebridge's demand, as both parties here did not only disagree on the "amount of loss," but also whether Stonebridge incurred any "roof 'damage' at all."

The court sided with Stonebridge. The court first noted that the Ohio Supreme Court had addressed almost similar appraisal language in another insurance policy and stated that this language means that either party, on its own demand, could trigger the policy's full appraisal process. In addition, what Stonebridge wanted was for someone to determine, "the extent of damage that a covered event"—i.e., the September Storm—actually "caused." And no language in the policy prohibits an appraiser from answering that question.

The Ohio Supreme Court construed this "simple and unambiguous" provision to mean that either party, on its own demand, could trigger the policy's full appraisal process. *Saba v. Homeland Ins. Co. of Am*erica, 159 Ohio St. 237, 238, 112 N.E.2d 1 (1953) Here, the Policy's appraisal provision contained virtually identical language so Phoenix was required to participate in the appraisal. As for the distinction between coverage questions and damages questions, the court stated that, "[c]overage issues are contract-interpretation issues," i.e., they are "legal questions" which require courts to determine a given policy's "categories of coverage." In the case before the court, there was simply no dispute regarding the types of "coverage" the Policy provided -- windstorm and hail damage were both unambiguously covered. Nor was there any dispute that it was a storm that damaged Stonebridge's roof because Phoenix's own estimate admitted that Stonebridge suffered $4,157.04 in wind damage. But the disagreement between the parties was over what specific damage that the storm caused. This, according to the court, was a "factual inquiry, not a legal one." And it was a question that, in the court's view, was best left for an appraisal team who could go out and visibly inspect the property, rather than a second-hand review by a court.

Thus, this case and *Westview* represent a new majority of cases across the country that appear to be broadening the scope of first-party appraisals and allowing causation (i.e. "coverage")

evidence into the appraisal process. The problem with that, it would seem, is that it encourages insureds to get greedy and want more than what their insurance policy usually covers (i.e. to be put back into an economic condition they would have been in had the loss never occurred rather than "winning the lottery" and getting a brand new roof to replace 20+-year-old shingles). The benefit, however, is that the appraisal process is usually more efficient and less expensive than a jury trial and the benefit all boils down to the quality of the appraisers.

As for Stonebridge, the court granted its Motion to Compel Appraisal and ordered that a "full appraisal" take place.

11. When You Have to Give Over Your Claims File, Part I

Sutter v. American Family Insurance Company, 2022 WL 1611796 (S.D. Ohio, W. Div. May 20, 2022).

This case is actually a two-parter and is a good example of how a motion to compel attorney-client protected information will likely be dealt with in an Ohio federal court.

Plaintiff filed an underinsured motorist case with a bad faith claim against American Family. Plaintiff's counsel wanted American Family's claims file. American Family opposed and advised Plaintiff that it would not advance settlement and would instead take a reduction for medical expenses paid under the medpay coverage from the underinsured motorist coverage.

The case went kind of sideways after that (according to the court's narrative) when Plaintiff provided copies of her medical records to American Family but "[D]espite timely confirming receipt of Raymonda's email," American Family sent an email to Plaintiff stating it had not yet received the supporting documents outlined in the policy limits demand claim. Then American Family demanded reimbursement from the tortfeasor's insurance company for the $5,000.00 in medpay expenses it paid on behalf of Plaintiff.

American Family then denied plaintiffs' UIM claim, determining that Plaintiff "was made whole with the $25,000.00 policy limits settlement" by the tortfeasor's insurance company. This prompted Plaintiff to file suit in Warren County state court and allege that American Family had committed bad faith by failing to reasonably investigate the facts and circumstances of the collision and the severity of Plaintiff's injuries. The case was subsequently removed to federal court.

Plaintiffs then filed a motion to compel American Family's "Claims Handling Policies and Procedures for UIM Claims and Employee Compensation & Incentive Information" Manual. American Family filed a motion for a protective order and also refused to provide a request for its employee compensation program and information regarding "employee incentives" (i.e. information related to bonuses, etc., shared in by American Family employees).

The court determined initially that American Family's claims handling policies and procedures were relevant to Plaintiff's request and discoverable under Fed. R. Civ. P. 26(b)(1). The court, however, limited the request because it found it to be "overly broad and unduly burdensome," since it was not limited by time, geography, or type of insurance claim. Therefore, the court limited plaintiff's requests to "American Family's handling of uninsured/underinsured motorist claims in the State of Ohio for 2018, 2019, and 2020." In addition, to the extent that any documentation contained "confidential and propriety information related to American Family's internal processes for adjusting claims," this information would be produced subject to the agreed protective order previously entered in the matter. The Court also found American Family's employee compensation plans and incentive information were relevant and discoverable under Fed. R. Civ. P. 26(b)(1) because they showed the "motivation underlying employees' actions in handling bad faith claims" and whether insurance company employees are "rewarded financially for denying a certain number of claims or achieving a particular outcome with regard to claims handling."

Part II: Claims File is Not Work Product "In Anticipation of Litigation" if the Document is Prepared as Part of an Ordinary Business Purpose or the Subjective Anticipation of Litigation is Not Objectively Reasonable

Sutter v. American Family Insurance Company, 2022 WL 1605458 (S.D. Ohio, W. Div. May 20, 2022).

In a companion decision by the same district court on the same date, the court considered American Family's similar Motion for Protective Order related to certain claims file documents protected by the attorney-client privilege.

The court there cited Ohio Supreme Court precedent, and held that the insured WAS entitled to the insurer's claims file, noting the law in the *Boone v. Vanliner* exception to the attorney-client privilege where an insured alleges bad faith: "[W]e hold that in an action alleging bad faith denial of insurance coverage, the insured is entitled to discover claims file materials containing attorney-client communications related to the issue of coverage that were created prior to the denial of coverage. At that stage of the claims handling, the claims file materials will not contain work product, i.e., things prepared in anticipation of litigation, because at that point it has not yet been determined whether coverage exists." The court also cited the Sixth Circuit case of *In re Professionals Direct Ins. Co.*, 578 F.3d 432 (6th Cir. 2009) which upheld the trial court's decision to order production of all claims file documents that were created prior to the date of denial of coverage under the *Boone* exception to the attorney-client privilege. The Sixth Circuit rejected *Professionals Direct*'s argument that the court was required to examine each of the disputed documents individually to determine whether they contained evidence of bad faith and were "unworthy of protection" under *Boone*. The Sixth Circuit noted that, in applying the *Boone* exception to a discovery dispute involving a bad faith denial of insurance coverage claim, "[t]he

critical issue is whether the documents 'may cast light' on whether the insurer acted in bad faith."

After an in camera review, the district court determined that the correspondence at issue did NOT "cast light" on whether the denial of plaintiffs' UIM claim was made in bad faith and rather, as American Family's privilege log indicated, the subject matter of the correspondence concerned the status of recovery amounts paid under the Medpay provisions of the policy, and therefore, since none of the information would shed any light on the bad faith claim, the court refused production of the documents.

The analysis is what is important for us: The court noted that whether a document has been prepared "in anticipation of litigation" and is protected work product depends on: "(1) whether that document was prepared 'because of' a party's subjective anticipation of litigation, as contrasted with ordinary business purpose; and (2) Whether that subjective anticipation was objectively reasonable." If a document is prepared in anticipation of litigation, the fact that it also serves an ordinary business purpose "does not deprive it of protection, but the burden is on the party claiming protection to show that anticipated litigation was the 'driving force behind the preparation of each requested document.'"

In addition, whether a party reasonably anticipated litigation at a particular point in time does not answer the question of whether a disputed document was prepared "because of" litigation. If the document was created as part of the ordinary business of a party and the ordinary business purpose was the "driving force" or impetus for creation of the document, then it is not protected by the work product doctrine. In determining whether a document has been prepared in anticipation of litigation, the Court examines the documents themselves and the context in which they were prepared. A party may satisfy its burden of showing anticipation of litigation in any of the traditional ways in which proof is produced in pretrial proceedings such as affidavits made on personal knowledge, depositions, or answers to interrogatories, and that showing can be opposed or controverted in the same manner.

After reviewing the subject documents in camera, the court determined that the claim log notes were protected as work product because the "content, context and timing of the creation of the notes" were created in response to plaintiff's October 22, 2020, filing of the complaint in state court. Therefore, since at the time these documents were created, suit had already been filed by plaintiffs and thus any subjective anticipation of litigation would be objectively reasonable. In addition, the substance of the notes themselves indicated that the "driving force" behind their creation was plaintiff's lawsuit, and they were created in response to such lawsuit. The court therefore refused to order the production of these documents.

Further, as to claim log notes generated by a Ms. Cain (an American Family claims adjuster) on June 9, 10 and 11, 2020, outlining opinions and analysis of Plaintiff's UIM claim, and discussing value, the court determined (also after considering the "context and timing of the creation" of these notes), that American Family's June 11, 2020, coverage decision on her UIM claim was

preceded by a May 5, 2020, demand letter from plaintiffs' counsel seeking policy limits on the UIM claim and forcefully threatening that, "Your deadline to accept our demand is Friday, June 12, 2020. If our demand is not met, we will not give you the opportunity to settle the case again in exchange for a release. We will immediately file suit with a bad faith claim and push the case for an immediate trial date and obtain a verdict in excess of policy limits."

The court therefore determined that, after its *in camera* review of those claim log notes, that the "driving force" behind the creation of the claim log notes was plaintiff's attorney's threat of litigation in the demand letter and the primary focus of the creation of the notes was anticipation of litigation. The claim notes were therefore deemed protected work product. The court further noted that, the "substance of the claims notes reflect that the impetus behind the creation of the notes was plaintiff's demand letter, and the timing of the decision to deny UIM benefits was made in accordance with the specific deadline set by plaintiffs' demand letter. The Court's review shows these claim log notes were prepared 'because of' American Family's subjective anticipation of litigation, which the Court determines was objectively reasonable in light of the specific threat of the 'immediate[ ]' filing of a lawsuit in plaintiffs' demand letter." The court further observed that the fact that the notes also served an ordinary business purpose (i.e. making a decision on a claim for UIM coverage), did not eliminate the work product protection for these claim log notes.

The court then denied plaintiff's motion to compel defendant's claims file.

12. You Can Live in Florida and Reside in Ohio Too

Esurance Prop. & Cas. Ins. Co. v. Kyle, 2022 WL 9993733 (N.D. Ohio, E. Div. Oct. 17, 2022)

This case arose out of a wintertime water loss at an insured's Ohio premises upon which the mortgagee had foreclosed. The insured had been in Florida for some time and taken employment there. The insurer filed suit in federal court to seek a declaration that the water loss was not covered for three reasons: (1) The insured lacked an insurable interest given the foreclosure; (2) The insured did not reside at the premises; and (3) The insured did not take reasonable care to prevent the water loss by winterizing the property. The insurer moved for summary judgment on all three bases, but the court found genuine disputes of material fact as to all three reasons for the denial.

For brief background, the insured-defendant stopped making payments on the mortgage in 2017 and the mortgagee obtained a decree of foreclosure in February 2019. Important to the decision, the property did not sell until October 2020. During the period of the foreclosure process (in August 2018), the insured went to Florida to visit her sister. She entered into a residential lease for one year, claiming a short-term lease would have cost more, and even obtained employment there. She believed she could have returned to her job in Ohio at any time. During this period, she kept her Ohio voter registration, driver's license, and vehicle registration. Mail continued to go to her Ohio address.

While away, the insured had her siblings and friends check on the property and, a few weeks before the water loss, the insured herself stayed at the property. Unsurprisingly, the property was not winterized and a water loss happened at some point between the end of February 2019 and the middle of March 2019. Esurance denied the claim, filed suit, and moved for summary judgment.

As to the first basis (insurable interest), the court stated that Ohio law provides an absolute right to redeem foreclosed property before the confirmation of sale, as well as an equitable right of redemption, and given the sale did not occur until October 2020, the early 2019 water loss was before the right to redeem extinguished the insured's interest in the property. Therefore, the insured retained an insurable interest in the property and additionally, the insurable-interest argument failed to address any purported lack of interest in the insured's damaged personal property.

As to the second basis (residency), the court found a reasonable jury could find in favor of the insured because Ohio state courts have repeatedly found that people can have more than one residence—but only one domicile. Applying Ohio law, the court found a reasonable jury could find the insured still resided at the Ohio residence because she had kept registration to vote, drive, and own a car in Ohio, and she kept her mailing address in Ohio.

Finally, as to the third basis (reasonable care), there was a genuine dispute that a jury needed to resolve because although she failed to winterize, the court found that having people check on the property and the thermostat, as well as staying at the property within the month before the loss, could have been reasonable care to prevent what could otherwise be an excluded plumbing-related water loss.

13. Little Wiggle-Room for Commercial Insured on Proof of Loss and Cooperation Conditions

Hackman v. Selective Ins. Co. of Am., 2022 WL 3018098 (S.D. Ohio, E. Div. July 29, 2022)

Although on a motion for summary judgment again, this case went in favor of the insurer. A corporation insured two properties with Selective Insurance: A building on East Broad Street in Columbus; and a commercial warehouse. After presenting two claims (arguably well beyond timely), the insurer denied both. The first, relating to the East Broad building, was for failure to provide a sworn proof of loss. The second, relating to the warehouse, was for failure to cooperate. Following the denials, the insured filed suit for breach of contract and bad faith. The insurer counterclaimed for breach of contract and also sought declaratory judgments. The insurer moved for summary judgment on all claims, which the court granted.

The policy at issue in this case required a sworn proof of loss from the insured when requested. The first claim arose out of a water loss reported on March 11, 2019 (even though the loss allegedly occurred on January 24, 2019). The insurer invoked the proof-of-loss requirement on March 29, 2019. After the insured failed to timely provide a response, Selective sent out a letter

advising that the claim would be closed on June 6, 2019. Citing Ohio decisions, the federal court found this to be an enforceable basis to disclaim coverage.

The second claim was for a purported theft at the insured's warehouse on January 30, 2019, which the insured did not report until August 24, 2020. The insured did not file a police report until August 26, 2020, either. The insurer requested a proof of loss on September 18, 2020, as well as documentation to support both the theft and the value of the items stolen. The insured provided some scant documentation, but the court seemed primarily to hone in on the lack of evidence provided as to the value of the items stolen. The insured did not have tax returns, inventory documents, invoices, or ledgers for accounts payable or receivable to demonstrate the value. In addition, the alleged value claimed changed at least three times, always increasing upon each submission. The court found this to be a failure to cooperate under the policy and granted summary judgment on all contract-related claims.

Given the grant of summary judgment on contractual issues, the court also dismissed the bad-faith claim for want of underlying coverage.

14. Beware the Ponzi Scheme Settlement Before Seeking Reimbursement

Huntington Natl. Bank v. AIG Specialty Ins. Co., 2022 WL 17741060 (S.D. Ohio, E. Div. Dec. 16, 2022), *appeal pending*, 6th Cir. No. 23-3039 (filed Jan. 17, 2023)

Huntington Bank provided a line of credit to Cyberco Holdings in 2002, which was ultimately repaid to Huntington in October 2004. Although unknown to the bank at the time of the initial lending agreement, Cyberco and its chairman were committing vast fraud. Huntington became suspicious of Cyberco in 2003 and began to investigate. Yet, business between the two carried on as usual despite the bank's concerns. The fraudsters ultimately ended up in bankruptcy with many creditors who had significant losses.

The bankruptcy court appointed trustees—who then initiated adversary proceedings against the bank for, essentially, disgorgement of the funds repaid to it. Ultimately, this went up to the Sixth Circuit and back down to the bankruptcy court. The courts found a lack of good-faith acceptance by the bank for funds repaid after a certain date. Huntington ultimately settled with the trustees for $32 million.

While there had been demands for coverage at various stages, Huntington's primary and excess carriers denied coverage based on several endorsements in the policies. The bank filed suit against the insurers seeking reimbursement of $15 million (the policy limits after a $10 million retention). The claims were for breach of contract and bad faith. The parties filed cross-motions for summary judgment. The trial court found for the insurers and dismissed the case.

Instead of sorting through any definitional-coverage issues, the court went straight to exclusions. First, an uninsurable-loss exclusion stated it would not pay for a loss (which included settlements) that was uninsurable under the jurisdiction where the policy was to be construed. In other words, if the settlement was uninsurable under Ohio law, then there was no coverage. The court noted there was no Ohio case law directly on point but Ohio was "unlikely" to permit

coverage for wrongfully obtained money under these facts because disgorged funds are not likely insurable under Ohio law. Because the settlement arose out of an adversary proceeding seeking disgorgement, the settlement funds were not insurable.

In addition, the policy excluded coverage for lending acts relating to claims made, "for the principal and/or interest of any unrepaid, unrecoverable or outstanding credit." Among other things, Huntington argued this exclusion did not apply because the fraudsters repaid the line of credit. But the court disagreed because the bankruptcy court had found that some of the payments were accepted without good faith and, as a result, the bank was really seeking coverage for repayment of the loan it was forced to return and so the exclusion applied.

Finally, as it relates to the bad-faith claim, the court granted summary judgment in favor of the insurers because the claim arose from the same allegations underlying the breach-of-contract claim.

II. STATE COURTS

Ohio Supreme Court

15. Can You Download "Physical Damage"? Software Cannot Sustain Physical Loss Under Business Owners Policy

EMOI Services, LLC v. Owners Ins. Co., 2022-Ohio-4649 (Ohio Dec. 27, 2022)

HOLDING: 1) When policy language is clear, the writing itself determines the parties' intent, 2) Electronic-equipment policy required direct physical loss or damage to media, 3) Computer software cannot experience direct physical loss or physical damage because it does not have physical existence, and 4) Where the insurance policy covers "physical damage" there must be direct physical loss or physical damage to trigger coverage.

In 2019, Emoi Servs. LLC ("Emoi"), a computer software company that caters to medical offices' need for appointment setting, record keeping, and billing, experienced a ransomware attack. A "hacker" gained access to its computer system and encrypted files necessary for using software and databases. Whenever a file was opened following the attack, a "ransom note" would pop up, notifying the user that the files were encrypted but could be restored using a decryption key that would be provided through paying a ransom of 3 bitcoin, "approximately $35,000 at the time."

After consideration, Emoi decided to pay the ransom. The decryption key worked to an extent: while a majority of systems returned to normal, an automated phone system on a separate server remained encrypted. Ultimately, there was no hardware or equipment damaged as a result of the attack. Emoi submitted a claim to its business owners insurance policy, issued by Owners Ins. Co. ("Owners"). Owners denied the claim, determining that the policy did not cover the type of damages experienced by Emoi (the ransom, investigation, and subsequent system upgrade). In its letter, Owners cited to provisions potentially applicable to the loss, under the "Data Compromise" endorsement, and the "Electronic Equipment" endorsement. The "Data Compromise"

endorsement specifically excluded coverage for "any threat, extortion, or blackmail" including "ransom payments." Owners also explained that the Electronic Equipment endorsement did not apply because the endorsement required, "direct physical loss" as a result of the hacker's attack.

Emoi filed a lawsuit against Owners, alleging breach of the insurance policy contract through the denial, and bad faith. The trial court granted summary judgment to Owners. On appeal by Emoi, the Second District reversed in a two-to-one decision.

Though Owners cited to three propositions of law for review, the Supreme Court of Ohio found merit with the first proposition, and reversed the judgment on those grounds. The Supreme Court agreed with Owners that a business owners property policy that requires "direct physical loss" does not cover losses from ransomware attacks. The electronic equipment endorsement was "clear and unambiguous" and since "software is an intangible item that cannot experience direct physical loss or direct physical damage, the endorsement does not apply in this case." Though Emoi argued that computer software is "media" under the policy, the Supreme Court of Ohio found that "the most natural reading of the phrase 'direct physical loss or damage'" meant direct physical loss of or direct physical damage to its media. The Court opined that, "Computer software cannot experience 'direct physical loss or physical damage' because it does not have a physical existence." While computers have physical components, software, as the information stored upon computers, "is entirely intangible." Because the policy did not cover the loss Emoi suffered, Owners did not breach its contract with Emoi and the judgment of the Second District was reversed.

16. COVID Shutdowns Do Not Cause Direct Physical Loss, Resulting in No Lost Revenue Under Policy

Neuro-Communication Services v. Cincinnati Ins. Co., 2022-Ohio-4379 (Ohio Dec. 12, 2022)

HOLDING: 1) Businesses cannot obtain coverage for business interruption caused by COVID-19 in the absence of direct physical loss to their business premises.

This case is consistent with national trends regarding alleged losses caused by COVID-19 shutdowns.

Plaintiff Neuro-Communications Services, Inc. ("Neuro") filed suit in the U.S. District Court for the Northern District of Ohio alleging that its insurer, Cincinnati Insurance Company and related entities ("Cincinnati"), wrongly denied its claim under a commercial general liability policy for lost revenue sustained by its audiology practice due to COVID-19 shutdowns. Cincinnati denied the claim on the basis there was no direct physical loss to Neuro's premises caused by a covered cause of loss.

Judge Benita Y. Pearson certified three questions to the Supreme Court of Ohio to help resolve the dispute; whether: (1) the presence of COVID-19 in the community, (2) particles of the virus on the surfaces of the insured premises, or (3) the presence of a person infected with COVID-19 on the premises can constitute "direct physical loss or damage to property," which is required to

trigger business interruption coverage under many property and casualty policies. Finding that none of these claims constituted "physical loss or damage to property," the Supreme Court likely laid to rest the major issue of COVID-19 business interruption claims.

Neuro argued that its loss due to shutdowns qualified as a direct physical loss, citing the definition of "deprivation" under loss, and it had been deprived of use of its property. The Court disagreed, noting that the definition of loss is clear and requires loss or damage to be physical in nature. This reading was supported by other portions of the policy addressing the "period of restoration" including time for repair, replacement, or rebuilding. To gain use of its property again, Neuro merely needed the government to lift its restriction to operate its business following the loss. And though Neuro relied on several cases for the proposition that physical alteration or damage was not required for a finding of direct physical loss, the Court was able to distinguish them. Those cases involved situations where the property was completely uninhabitable due to pollution or natural disasters. While COVID-19 is dangerous, "[t]he harm here is different."

The other scenarios posed by Neuro were similarly unconvincing. The mere presence of COVID-19 in the community did not constitute loss as it did not alter the premises. And although COVID-19 particles on the surfaces of the premises had a physical effect, they did not alter any physical characteristic of the property as they were temporary in nature. In sum, shutdowns due to COVID-19 do not qualify as covered losses because they contain no elements that would constitute physical loss or damage to the property.

17. Not Every Bodily Injury Triggers the Duty to Defend

Acuity v. Masters Pharm, Inc., 2022-Ohio-3092 (Ohio Sept. 7, 2022)

HOLDING: 1) An insurer's duty to defend is determined by allegations in the complaint and the four corners of the policy and results where the claim potentially or arguably falls within coverage; 2) Allegations of bodily injury alone do not automatically bring an action within insurance coverage for damages due to bodily injury; and 3) Coverage for "damages because of bodily injury" cover only specific individual injury, not aggregate harms alleged by governmental entities.

The Supreme Court of Ohio joined other jurisdictions in ruling that the duty to defend was not triggered by lawsuits brought by governmental entities in the wake of the opioid crisis.

Masters Pharmaceutical, Inc. ("Masters") was sued by various governmental entities in West Virginia, Michigan, and Nevada, for "economic losses caused by the opioid epidemic." The Supreme Court of Ohio determined that Masters' insurer, Acuity, did not owe Masters a duty to defend because the governments did not seek "damages because of bodily injury," but instead, "damages for their own economic loss."

Acuity claimed that the suits did not fall within coverage because the policy covered damages for bodily injury to a specific identifiable person, and not an insured's liability for corporate conduct that allegedly caused governmental entities to sustain economic loss. Secondly, Acuity claimed that Masters knew that the bodily injury had occurred, and so the loss-in-progress exclusion barred

coverage. The Supreme Court of Ohio determined that Acuity was correct on the first proposition, and declined to address the second.

The Court acknowledged the growing diverging body of case law that recognizes such lawsuits as covered under "damages for bodily injury." However, it noted that the governments' theories of recovery in the underlying suits was not for specific opioid-related injuries incurred by their citizens, but rather, Masters' role in the opioid epidemic which caused economic damages based on the public-health crisis. "Stated differently, the governments seek damages for their own aggregate economic injuries caused by the opioid epidemic and *not* for any particular opioid-related bodily injury sustained by a citizen as a direct result of Master's alleged failures."

Masters argued that Acuity had a duty to defend because the governments alleged that they suffered economic loss because of the opioid epidemic, which in turn was caused by opioid related injuries sustained by citizens. The Court rejected this interpretation of "damages because of bodily injury" as "so expansive[] as to include any suit in which the damages sought merely relate to bodily injury, regardless of whether the claims are in fact tied to any particular bodily injury sustained by a person." The Court further found that the repeated use of the phrase, "*the* bodily injury" throughout the policy indicated a particular bodily injury had occurred to an individual. Additionally, while the Court declined to address the loss-in-progress provision, it did use the provision to bolster its finding that the policy was intended to cover a specific injury instead of the aggregate harms alleged by the governments.

Ohio District Appellate Courts

18. No UM/UIM Coverage for Injuries Sustained by Insured Passenger in Her Own Insured Vehicle due to the Negligence of the Driver who is a Family Member

Kaiser v. Goff, 2022-Ohio-4725, (1st Dist. Dec. 29, 2022)

HOLDING: Summary judgment was proper because the policy provided no UM/UIM coverage under R.C. 3937.18, due to an intrafamily exclusion

This case reaffirms the validity of intrafamily exclusions in policies of insurance providing UM/UIM coverage.

Donna Kaiser ("Donna") sustained serious injuries as a passenger in her own car, a Toyota Solara, driven by her daughter, Donna Williams ("Williams"). The accident occurred when Donna's car and a car driven by Troy Goff, an employee of Pizza Hut, collided. Donna had a policy of insurance with Safeco for herself and her vehicle. The cause of the accident was disputed, and the Kaisers sued Goff, Pizza Hut, and Williams for the accident. The Kaisers also sued Safeco for UM/UIM coverage as to the daughter's negligence in causing the accident, alleging that Goff and Donna's daughter were "uninsured motorists" and/or "underinsured motorists" in the Safeco policy.

Safeco moved for summary judgment, attaching an authenticated copy of the policy which contained a provision stating that, "any vehicle or equipment… [] Owned by or furnished or available for the regular use of you, a family member, or any other driver listed in the Declarations" did not constitute an uninsured motor vehicle. The trial court granted summary judgment for Safeco on these grounds.

On appeal, the Kaisers argued that the policy was unenforceable, because it was void as against public policy. They also argued that the policy was a contract of adhesion, unconscionable as written, and must be reformed based on mistaken understanding of coverage that the policy provided. Ultimately, none of these arguments swayed the court.

First, the court found that the policy did not violate public policy because of the clear intent of the Ohio legislature under R.C. 3937.18(I) to *allow* intrafamily exclusions, such as the one in Safeco's policy, in UM/UIM coverage. While the Kaisers cited to *Kyle v. Buckeye Union Ins. Co.*, 103 Ohio St.3d 170, 2004-Ohio-4885, 814 N.E.2d 1195 to support their position, the court found this reliance misplaced, as the Supreme Court of Ohio had affirmed the exclusion of UM/UIM coverage in their holding in that case.

Additionally, the Kaisers misapplied the law with respect to adhesion contracts, The court noted that because insurance contracts are not per se unenforceable as contracts of adhesion, the Kaisers would have had to argue that the contract was ambiguous, which they failed to do on summary judgment. The Kaisers further failed to provide evidence to support their assertions that the contract was unconscionable, because it would be "unreasonable and unexpected" to enforce the intrafamily exclusion. The court disregarded this argument because under Ohio law, insureds have a duty to examine the coverage provided and are charged with knowledge of the contents of their own insurance contracts. Finally, the Kaisers final argument was dismissed because they failed to present any evidence regarding the intent of the parties that would justify reforming the contract based on mistaken understanding of the coverage provided.

19. Assignment of Insurance Claim Collides with Anti-Assignment Clause and Public Policy

Blue Ash Auto Body v. Grange Property & Cas. Ins. Co., 2022-Ohio-4599 (1st Dist. Dec. 21, 2022)

HOLDING: Assignments of property damage claims held unenforceable due to violation of policy anti-assignment clauses and public policy interests.

Body shop collected assignments of interest from owners of 14 vehicles insured by Grange, where Grange allegedly "underpaid" the insureds for collision repairs. The body shop then sued Grange to collect on the alleged underpayments, asserting claims for both breach of contract and unjust enrichment. The trial court granted summary judgment to Grange. The First District affirmed, noting that the purported assignments violated all three conditions established in *Pilkington N. Am., Inc. v. Travelers Cas. & Sur. Co.*, 112 Ohio St.3d 482, 2006-Ohio-6551, and specifically: 1) The assignments violated "clear contractual language prohibiting assignment", precluding

assignment of policy rights without Grange's written consent; 2) The assignments would materially change Grange's obligations and leave Grange "at the mercy of whatever Blue Ash determined was necessary to repair the vehicles"; and 3) Would violate public policy regarding assignment of prospective insurance claims as set forth in *W. Broad Chiropractic v. Am. Family Ins.*, 122 Ohio St.3d 497, 2009-Ohio-3506 (ruling that "[a] person may not assign the right to the future proceeds of a settlement if the right to the proceeds does not exist at the time of the assignment"). The Court of Appeals also affirmed summary judgment on the claim for unjust enrichment, finding that because the insurer and the repair shop were not in direct privity, "the connection between the body shop and the insurer "is too indirect to constitute a 'benefit conferred' for purposes of a common law claim of unjust enrichment." ¶ 22, citing *Three-C Body Shops, Inc. v. Nationwide Mut. Fire Ins. Co.*, 10th Dist. Franklin No. 16-AP-748, 2017-Ohio-1462.

20. "Who's on First?": Comparing "Other Insurance" Clauses To Determine Primary Coverage For Costs of Defense

Great Am. Ins v. Philadelphia Indemnity Ins. Co. 2022-Ohio-1160, (1st Dist. April 6, 2022)

HOLDING: "Other Insurance" clause declaring policy to be excess enforced with regard to costs of defense, because it specifically referenced defense costs and other policy had no "Other Insurance" provisions.

From 2015 to 2018, Great American Ins. Co. incurred more than $360,000 in defense costs to litigate and settle three lawsuits brought by 16 residential tenants against Great American's insured, Satellite Affordable Housing Association ("SAHA"). The suits asserted claims for bodily injury and civil rights violations, due to "unlivable" conditions of the SAHA premises. Great American, whose policy provided CGL coverage for bodily injury claims, sought equitable contribution from Philadelphia Indemnity Insurance Co., whose policy provided SAHA with coverage for civil rights violations.

The trial court awarded Great American $153,855.32 as Philadelphia's proportionate share of the defense costs. On appeal, the 1st District reversed, finding that both the "Defense Costs" and "Other Insurance" provisions in Philadelphia's policy made its policy excess over any other policy that had a duty to defend. The Court of Appeals applied the rule that disputes about primary and excess coverage are to be resolved by comparing the policies, particularly their respective "other insurance" clauses. In this case, the Court noted that although each policy covered distinct claims (i.e., the Great American policy covered bodily injury claims but not civil rights claims, and the Philadelphia policy covered civil rights claims but not bodily injury claims), the issue in dispute was not indemnity coverage but the duty to defend. Great American did not dispute its duty to defend, had undertaken the defense, and its policy provided that its coverage was primary and it had no "other insurance" clause. In contrast, the Philadelphia policy expressly provided that its coverage was excess when there was "other insurance" that had a duty to defend. Its policy further provided that coverage of "Defense Costs" did not include defense costs for which other insurance was available. Thus, because Great American's policy provided defense costs and considered itself primary without regard to any "other insurance," Philadelphia's coverage for defense costs was contractually excess to Great American. Because Great American did not exhaust its coverage

limits, Philadelphia's coverage was never triggered. And because the respective obligations of the parties were established by contract, the equitable doctrine of contribution did not apply.

21. Lessee Held To Be "Real Estate Manager" And Thus An Insured Entitled To Coverage Under Landlord's Policy from Indemnity Claim Asserted by Landlord

Fairless v. Acuity, 2022-Ohio-10 (1st Dist. Jan. 5, 2022)

HOLDING: In construing policy issued to apartment building owner as named insured, lessee who operated apartment complex held to be within policy definition of "insured" which included "real estate manager" and thus entitled to defense from owner/lessor's claim for indemnification for costs to litigate and settle slip-and-fall claim asserted against owner/lessor.

Coverage litigation resulted from a slip-and-fall claim where the injured plaintiff sued Brookmeadow, Ltd., the titled owner of an apartment complex known as "Bayberry Crossing". Brookmeadow then filed a Third-Party Complaint against Joseph Fairless and Bayberry Crossing, LLC, asserting that Brookmeadow was simply an owner-out-of-possession and that Fairless and Bayberry had assumed all obligations and liabilities for maintenance and operation of the apartment complex under a Lease with Option to Purchase.

Fairless and Bayberry, in turn, tendered the defense of Brookmeadow's Third-Party Complaint to Brookmeadow's insurer, Acuity. Acuity denied coverage, asserting that its policy was only issued to Brookmeadow and did not insure Fairless or Bayberry and did not provide coverage for Brookmeadow's Third-Party Complaint against them.

Brookmeadow then settled the underlying personal injury claim and dismissed its Third-Party Complaint. It then billed Fairless and Bayberry for its settlement and attorney fees. When Acuity again declined to accept coverage for this claim, Fairless and Bayberry filed suit against Acuity, seeking declaratory judgment regarding Acuity's coverage and also asserting a claim of bad faith. They argued that coverage existed because it was Fairless who had purchased the Acuity policy in order to comply with the insurance requirements of the Lease, that Fairless had made all premium payments, that the Policy expressly included "Bayberry, Inc." as an additional insured (and identified as "Co-Owner" of the property), and that in any event Fairless and Bayberry qualified as Brookmeadow's "real estate manager" within the policy's definition of insured.

The trial court granted interlocutory summary judgment on the coverage DJ, holding that Fairless and Bayberry were insureds and that Acuity had a duty to defend them against Brookmeadow's Third-Party Complaint. The trial court denied Fairless and Bayberry's motion for summary judgment as to fees incurred in pursuing the coverage action, stating these were not damages for which the Acuity policy would provide coverage and rather were bad faith damages that needed to await that portion of the suit. The trial court certified an immediate appeal of the coverage order, while the bad faith claim remain stayed.

On appeal the First District affirmed, finding that Fairless and Bayberry constituted Brookmeadow's "real estate manager" within the definition of insured and thus triggering the policy's duty to defend them from Brookmeadow's claim. The Court of Appeals agreed that Acuity was obligated to reimburse Brookmeadow's costs incurred in defending the underlying personal injury claim, and affirmed the denial of summary judgment for their attorney fees incurred in pursuing the declaratory judgment action, finding such fees could only be awarded as part of the bad faith claim that remained pending.

EDITOR'S NOTE: Analytically, the opinion leaves many questions unanswered. First, it is unclear why Brookmeadow did not tender the defense of the personal injury suit directly to Acuity, since Brookmeadow was the named insured. Was Brookmeadow aware of the policy? Even if Fairless purchased the policy, one would expect Acuity to provide a copy to Brookmeadow, as the named insured, or that with a Lease of this magnitude that Brookmeadow would have obtained a Certificate of Insurance. Additionally, the decision contains no discussion of exclusions that might seem to apply in this circumstance, including exclusions for "intra-insured" claims and the exclusion for liability assumed by contract. Indeed, the dispute seems to be less about the scope of coverage than the identification of the intended insured, in which case it seems more appropriate for an analysis under reformation principles, since the parties seemingly intended that Bayberry be an additional insured but simply used the wrong corporate name (i.e., "Bayberry, Inc." as "co-owner" instead of "Bayberry Crossing, LLC"). Perhaps these answers can be found in the trial court filings, but they escape this reader's understanding in studying the 1st District's opinion.

22. HO Policy's 1-year Limit for Filing Suit Upheld as Unambiguous and Reasonable

White v. Grange Ins., 2022-Ohio-497 (2nd Dist. Feb. 18, 2022)

HOLDING: Policy condition requiring suit to be filed within 1 year of loss was enforceable; claim against insurance company did not qualify as a CSPA claim subject to a 2-year statute of limitation.

Pro se action by insured seeking recovery under homeowners policy for damage to roof during a windstorm. After bench trial, trial court entered judgment for Grange holding that suit was untimely filed. On appeal, the Second District affirmed, holding it was not error to dismiss the Plaintiff's suit as untimely, because the 1-year time limit in the policy was unambiguous and not unreasonable as a matter of law, nor did the insurer engage in any conduct that induced plaintiff's delay or otherwise impliedly waived the limitation period.

The Court of Appeals further held that Plaintiff's insurance claim did not fall within the Consumer Sales Practices Act (and thus the CSPA 2-year statute of limitations did not apply to rescue the untimeliness), because insurance companies are "persons" defined in R.C. 5725.01 and thus expressly excluded from the CSPA under R.C. 1345.01(A).

EDITOR'S NOTE: The appellate decision is predominantly a procedural study in final appealable orders and the effect of untimely objections to magistrate's recommendations and on final judgment. It is also a reminder that the failure to file timely objections to a magistrate's

decision waives all such objections, so that appellate review is limited to plain error. (Although the opinion makes clear that this distinction would not affect the rulings in this particular case).

23. Give The Insured A Chance: Appellate Court Reverses Trial Court That Failed To Follow Civil Rules By Converting Motion To Dismiss Into Motion For Summary Judgment Without Giving Insured Opportunity To Properly Respond

Timberlake Apartments, L.L.C. v. Underwriters of Lloyds London, 2022-Ohio-29 (2nd Dist. Jan. 7, 2022)

Plaintiff/Insured sought to invoke the policy's appraisal condition and appoint a neutral umpire to resolve an insurance claim for property damage allegedly caused by wind and hail in April 2020. The Insurer disputed the nature and scope of the damages, including taking the position that some of the damage occurred prior to the policy's inception. The Insurer denied the claim because its estimated repairs of nearly $5,000 were below the policy's $25,000 deductible. The Insured's estimate and appraisal reflected damages around $275,000.

The Insured filed suit after the Insurer failed to pay for full roof replacements or to appoint an appraiser under the policy's appraisal condition. The Insurer moved to dismiss for failure to state a claim, arguing that: (1) The petition failed to allege sufficient facts to trigger appraisal; (2) Unresolved coverage issues made the appraisal process premature; and (3) The Insured breached the policy by failing to cooperate with the investigation.

The Insurer included the policy as well as numerous pages of correspondence, estimates, and other materials as exhibits. The Insured filed an opposition, which included an argument that the court could not consider certain exhibits attached to the Insurer's motion without giving the Insured notice and converting the motion to dismiss into a motion for summary judgment.

The trial court converted the motion to dismiss to a motion for summary judgment, and entered judgment in favor of the Insurer because it found that issues as to coverage rendered appointing an umpire for appraisal of the property to be premature.

On appeal, the Second District agreed with the Insured's argument that the trial court improperly converted the motion into a motion for summary judgment without allowing the Insured a reasonable opportunity to respond. The appellate court found that the Insurer attached correspondence and estimates in support of its motion to establish a lack of cooperation by Plaintiff/Insurer and to establish the presence of unresolved coverage issues.

The trial court improperly considered these materials without providing the Insured an opportunity to present its own evidence addressing its cooperation and the coverage disputes. The appellate court reasoned that the Insured "had no obligation to seek leave to file a sur-reply to present its own evidence" because it "reasonably could have anticipated that the trial court would comply with the civil rules and give [the Insured] notice before entering summary judgment for [the Insurer]."

Thus, the Second District reversed the summary judgment decision and remanded for further proceedings.

24. Two Is The Same As One: No UIM Coverage Available When Combined Single Limit Reduced By Two Separate Payments From Tortfeasor's Insurer To Individual Insureds

Kent v. Motorists Mut Ins. Co., 2022-Ohio-1136 (3rd Dist. April 4, 2022)

Tortfeasor caused a motor vehicle accident with Plaintiff/Insured and her Husband. Tortfeasor's insurer paid $25,000 to the Insured and $25,000 to Husband under Tortfeasor's automobile liability policy. The Insured then sought additional UIM coverage through the Insurer, which provided a combined single limit of $50,000 per accident in UIM coverage under policy issued to Husband. The UIM coverage available under the Insurer's policy stated that the limits "shall be reduced" by all sums paid by Tortfeasor's insurer.

The Insured alleged that the Insurer owed an additional $25,000 under the UIM endorsement. She filed for summary judgment, arguing that she only received $25,000 from Tortfeasor's insurer and that the Insurer owed an additional $25,000 because the UIM endorsement had a $50,000 limit of liability.

The Insurer also filed for summary judgment, asserting that the single combined limit of UIM coverage for both insureds would be $50,000. Because they each received $25,000 from Tortfeasor's insurer, the total amount paid on behalf of Tortfeasor equaled $50,000. Since the UIM coverage required a set-off of the payments made by Tortfeasor's insurer, the Insurer argued that no funds were available under the UIM endorsement – the $50,000 liability limits fully off-set the $50,000 UIM limits.

The trial court denied the Insured's motion and granted the Insurer's motion. On appeal, the Third District affirmed the trial court's decision. The two separate $25,000 payments to the Insured and Husband from Tortfeasor's insurer totaled $50,000 on behalf of tortfeasor. Because the UIM coverage available under the policy had single limits of $50,000, which were required to be reduced by the $50,000 sums paid by Tortfeasor's insurer, the Third District held that the trial court properly found that the Insurer had no liability under the UIM endorsement.

Thus, the Insured and Husband received an amount from Tortfeasor's insurer that was equal to the amount available under the Insurer's UIM coverage, and the trial court properly granted the Insurer summary judgment.

25. Complex But Unambiguous: Appellate Court Finds "Convoluted" Policy Is Not Ambiguous And May Exclude Coverage For Non-Scheduled Autos An Insured Uses To Move, Tow, Haul, Or Carry Other Autos, Including Trailers

Pierson v. White Pine Ins. Co., 2022-Ohio-2702 (4th Dist. July 28, 2022)

Plaintiffs/Appellees, Richard Pierson and Hillsboro Scrap & Metal, Inc. (collectively, "Appellees"), sought coverage for claims arising out of a fatal automobile accident when Pierson, while in the course and scope of employment with HSM, caused an accident while operating a 1999 Freightliner semi-truck with an attached 2006 Transcraft trailer that carried a load of inoperable vehicles. Pierson's collision caused one fatality and injuries to the occupants.

Appellant, White Pine Insurance Company ("WPIC"), insured HSM under a commercial auto insurance policy. WPIC denied coverage due to an exclusion that precluded coverage for "bodily injury" arising out of the use of any "auto" not identified in the Declarations that the insured used to move, tow, haul or carry "autos". WPIC asserted that it owed no coverage per this exclusion since the policy's Declarations only identified a 1999 International Rollback, which was not the vehicle that Pierson drove at the time of the accident, and because Pierson used an unidentified "auto" to haul other "autos", i.e., the 2006 Transcraft trailer.

After coverage denial, Appellees filed a complaint for declaratory judgment, seeking a determination that WPIC's policy provided primary liability coverage and that WPIC owed a defense. WPIC filed counterclaims against Appellees and third-party claims against United Financial Casualty Company ("UFCC"), alleging that UFCC owed primary coverage for the loss, that WPIC's policy excluded coverage for the losses, and WPIC owed no duty to defend or indemnify. The parties filed motions for summary judgment.

The trial court denied WPIC's motion and entered judgment in favor of Appellees and UFCC, finding WPIC owed a duty to defend and indemnify Appellees for all claims and damages. The trial court reasoned that WPIC's policy "is very convoluted, confusing and written in a way that is not easily understood without rigorous reading and rereading of the policy" and the policy's schedule of autos created an ambiguity with respect to which autos were covered. The trial court also concluded that the exclusion did not apply.

On appeal, the Fourth District reversed because a plain reading of the entire policy showed that WPIC's policy did not provide coverage for the accident. With respect to the exclusion, the appellate court determined that the plain language showed that the exclusion precluded coverage if an insured used an auto, other than an auto listed in the Declarations, to tow, move, haul, or carry other autos. While the court agreed with "the trial court's view of the complexity and difficulty in deciphering insurance contract language," no ambiguity existed as to the exclusion.

Because Pierson used an auto other than the identified 1999 International Rollback to tow, move, haul or carry autos, the exclusion applied to preclude coverage under the WPIC policy. The Fourth District disagreed with Appellees' and UFCC's arguments that the semi-truck could not be considered to have been towing another "auto", i.e., the trailer, because a semi-truck and an attached trailer are functionally one vehicle for insurance purposes. The appellate court concluded, "an insurance policy may exclude coverage for autos that are used to move, tow, haul or carry other autos, including trailers." Thus, because Pierson used the 1999 Freightliner to tow, move, haul, or carry the 2006 Transcraft, WPIC owed no coverage for the accident.

26. You Get What You Pay For: Insured Not Covered For Medical Payments Coverage Or UM/UIM Coverage For Injuries Sustained In ATV Accident When Coverage Only Extended To Certain "Autos" In Declarations

Maher v. United Auto Ins. Co., 2022-Ohio-1015 (4th Dist. March 28, 2022)

Plaintiff/Insured sued the Insurer for injuries that the Insured sustained as a passenger in an ATV accident. The Insurer issued a commercial auto policy to the Insured, but only for a 2006 Nissan Titan. The Insured sought medical payments and UM/UIM coverage under his policy with the Insurer.

The policy's medical payments and UM/UIM coverage only applied to "Symbol 7" autos, or "Specifically Described 'Autos'", defined to include only those "autos" described in the policy's Declarations for which the Insured paid a premium. Since the policy did not specifically list the ATV as a covered auto on the policy, the Insurer denied coverage.

The Insured brought claims for breach of contract and bad faith, asserting that the Insurer breached its contract by refusing to negotiate in good faith and declining coverage under the policy's medical payments and UM/UIM provisions. The Insurer filed for summary judgment on the basis that the Insured elected to have coverage for medical payments and UM/UIM only for "covered autos" listed on the Declarations, which only included the 2006 Nissan Titan.

The trial court denied the Insured's motion for summary judgment and granted the Insurer's motion for summary judgment. On appeal, the Fourth District affirmed that decision.

As to the medical payments coverage, the appellate court construed the definition of an "insured" to be read under a reasonable interpretation with the rest of the policy. An "insured" under that coverage part included the Insured "while 'occupying' or, while a pedestrian, when struck by any 'auto'," but the word "any" modified the auto striking the Insured, not the vehicle he occupied at the time of the single-vehicle accident. The medical payments endorsement therefore did not deviate from the coverage provided in the business auto form, under which the Insured selected and paid for medical payments coverage for only the 2006 Nissan Titan.

As to the UM/UIM coverage, the appellate court similarly found that the coverage form only applied to the 2006 Nissan Titan, as selected by the Insured. That endorsement did not include any language that would permit coverage for any auto. The court determined that "the only reasonable interpretation of [the Insured's] policy is that the premium paid is for the 2006 Nissan Titan," and the business auto coverage form provided that UM/UIM coverage is limited to numerical symbol 7, a "covered 'auto,'" i.e., the 2006 Nissan Titan.

Thus, the appellate court affirmed the trial court's decision, which enforced the terms of the policy as written and the coverages as paid for by the Insured.

27. We Can't Figure It Out Either Without A Transcript

Ocheltree v. Pike Mut. Ins. Co., 2022-Ohio-3304 (5th Dist. Sept. 20, 2022)

Pike Mutual issued a homeowner insurance policy to its insureds, who then suffered a fire loss. Under the terms of the policy, the insureds could not recover replacement cost unless the coverage limit was at least 80% of the replacement cost. The ratio of the dwelling coverage limit to replacement value of the insured property, stated in the application, was 50%.

The Pike Mutual adjuster estimated the replacement cost for the damage, but depreciated the loss to its actual cash value in accordance with the policy.

The insureds' counsel and the insurer each obtained two independent estimates for repair, replacement cost, and actual cash value. This resulted in four entirely different estimates.

The insureds filed suit for a declaratory judgment, breach of contract, and bad faith. At the insurer's request, the trial court ordered the two sides to conduct an appraisal under the terms of the insurance contract. Each side was to select an appraiser. The court selected a third appraiser as the umpire. The written agreement of any two of the three was to be binding. Unfortunately, the umpire did not agree entirely with each of the other two appraisers.

The insurer moved for summary judgment. The trial court found that the policy was ambiguous and referred the matter to trial by a jury. At trial, the jury answered no to an interrogatory on whether Pike Mutual had breached its contract. The result was a defense verdict. After trial, the insureds moved for a declaratory judgment, JNOV, and a new trial, all of which were denied.

The court of appeals followed the presumption of regularity of the proceedings below, based on the failure of the insureds to file a transcript of the two-week trial. The trial court entry denying the post-trial motions stated that the trial testimony was adversarial, convoluted, and complicated. The court of appeals agreed with the trial court that based on the jury's answer to the interrogatory, nothing more remained for the trial court to determine.

Note to newer attorneys: Never fail to file a transcript of your jury trial if you want the court of appeals to rule effectively on your case.

28. Final Appealable Order Means "Final" Appealable Order

McKinley Dev. Leasing Co. v. Westfield, 2022-Ohio-2128 (5th Dist. June 22, 2022)

Westfield insured a property developer under a commercial business owner policy. The insured claimed a loss of business income because of government orders closing businesses during the COVID-19 pandemic. Westfield denied coverage because there was no direct physical loss of or damage to the insured's property.

The insured filed suit for breach of contract, for breach of the covenant of good faith and fair dealing, and for a declaratory judgment. The insurer moved to dismiss the complaint and for

summary judgment. The motion to dismiss was denied. The trial court also denied the insurer's motion for summary judgment, except as to punitive damages and bad faith. The insured moved for partial summary judgment on liability. The trial court granted this motion and certified the order for an immediate appeal. Damages were never determined.

The court of appeals dismissed the appeal, finding that the lack of a determination on damages prevented the declaratory judgment from becoming final.

29. An Auto Exclusion Excludes Auto Accidents

Grange Ins. Co. v. Riggs, 2022-Ohio-955 (5th Dist. Mar. 24, 2022)

Grange issued a personal automobile policy and a farmowner policy to a family whose sixteen-year-old driver killed two people and injured a third in an auto accident. The farmowner policy had an auto exclusion. Grange filed suit for a declaratory judgment to enforce the exclusion.

The parties stipulated that the sixteen-year-old was using a cellphone at the time of the accident with her mother's encouragement, consent, or permission. The parties further stipulated that the driver's communications with her mother distracted the driver at the time of the collision, that the mother was negligent in this regard, and that the mother's negligence was a proximate cause of the accident.

The claimants moved for summary judgment, arguing that the mother's negligent acts were separate and distinct from her daughter's operation of the motor vehicle. The claimants argued that the auto exclusion did not apply. Grange moved for summary judgment based on the auto exclusion in the farmowner policy.

The trial court granted summary judgment to the insurer. The court of appeals affirmed. The court of appeals noted that had the driver not been operating a motor vehicle at the time the mother called or texted her daughter, there would have been no claim of negligence. Further, the injuries could not have occurred unless the driver had been operating a motor vehicle at the time she was distracted. The vehicle was thus an essential element of the cause of the injuries. The auto exclusion applied and was enforced.

30. Don't ~~Drink~~ Toke and Drive

Grange Ins. Co. v. Farmers Ins. Co, 2022-Ohio-4303, (6th Dist. Dec. 2, 2022)

This Sixth District Court of Appeals case involved a declaratory judgment action filed by plaintiff/appellee Grange Insurance Company that centered around a chaotic March 26, 2021 motor vehicle accident. Defendant Jaylah Cleveland drove her grandmother's 2003 Ford Focus vehicle to work on the morning of October 27, 2018. The vehicle was insured by Grange. Cleveland worked at a Starbucks. Cleveland admitted to smoking weed that morning before driving into work, and her manager observed Cleveland acting strange and advised that she could

not work her shift and asked her to leave. Cleveland then got into the Ford Focus and proceeded to drive it through the front window of the Starbucks store. Cleveland then put the vehicle in reverse and exited the Starbucks. She ultimately pulled out into oncoming traffic and struck several other vehicles before Cleveland's vehicle became disabled. Cleveland injured several different individuals throughout this chaotic process.

Grange then filed a complaint for a declaratory judgment requesting a declaration by the court that it had no duty to defend, indemnify, or provide liability coverage to Cleveland, or the vehicle owner, against the potential claimants and their insurers. Grange specifically pointed to two separate exclusions in the relevant policy; the intentional act exclusion and the criminal act exclusion.

Grange subsequently filed a motion for summary judgment, which was granted by the Lucas County trial court. Defendant/appellant Farmers Insurance of Columbus subsequently appealed the trial court's decision granting the motion for summary judgment.

The Sixth District affirmed the trial court's decision to grant Grange's motion for summary judgment. The analysis was very straightforward.

First, in looking at the criminal act exclusion, the Sixth District noted that there was no dispute that Defendant Cleveland was under the influence of marijuana at the time of the accident and that she admitted at her deposition that she would not have caused all the injuries and property damage had she not been under the influence. Furthermore, she was charged with operating a motor vehicle while under the influence of drugs and alcohol, vehicular assault, and recklessly causing serious physical harm while operating a motor vehicle. The Sixth District then looked at the plain language of the criminal act exclusion in the Grange policy and held that Grange did not have any duty to defend or indemnify Cleveland and was entitled to summary judgment in its favor.

Additionally, the Grange policy also had a marijuana use exclusion. The court's analysis on this exclusion was rather brief and simply noted that this exclusion applied and that there were clear reasons for insurers to exclude coverage for drivers using marijuana.

31. One-year Policy Time Limit to Sue Tolled by Ongoing Negotiations Between Insured and Insurer; Bad Faith Claim Governed by Statute of Limitations for Torts, Not Policy Clause

Ransom v. Erie Ins. Co., 2022-Ohio-3528 (7th Dist. September 30, 2022)

The insured homeowner suffered damage to his roof and sued the non-paying insurer Erie Insurance for breach of contract and bad faith.

The parties agreed that the policy contained a requirement for the insured to sue within one year of injury. The insured argued that his bad faith claim was a tort not subject to the clause, and

further that ongoing negotiations over the claim's value were occurring at the time the policy clause ran, estopping the insurer from invoking it.

The insured did not plead waiver or estoppel in his complaint, and attached uncertified copies of e-mails to his opposition to dismissal, raising the insurer's objection.

The trial court dismissed the insured's entire lawsuit, but the appeals court reversed. The insured and insurer had engaged in a lengthy dispute over coverage, during which time the one-year policy requirement to bring a coverage lawsuit expired. The insurer declined coverage and canceled the insured's policy before ultimately covering the claim in part. Therefore, the court found that the insurer waived its policy time-limitation to sue provision based on its conduct "that holds out a reasonable hope" of coverage, following *Hounshell v. Am. States Ins. Co.*, 67 Ohio St.2d 427, 428, 424 N.E.2d 311 (1981). The insurer could have avoided this result by communicating its refusal to cover to the insured in definitive language, and giving reminder notice of the one-year lawsuit deadline.

The bad faith claim was also improperly dismissed, because policy provisions do not apply to bad faith claims, which are a tort separate from the contract. Therefore, the regular statute of limitations for torts applied.

(The appeals court further found that the trial court, which did not discuss the issue, should have stricken the uncertified e-mail copies attached to the insured's opposition brief to dismissal, both because they were unsworn (Civ.R. 56(E)) and because attachments aren't properly considered at the dismissal stage.)

Practical note: ALWAYS cite the policy time-limitation language from your first-party policies in ALL communications with the insured during settlement and claims-adjusting communications.

32. Drilling Machine Excluded from Definition of Uninsured Vehicle

Ameduri v. Machine Technology & Field Services, 2022-Ohio-3423 (7th Dist. September 19, 2022)

An insured self-propelled drilling machine operator sued his insurer for uninsured motorist coverage after sustaining an injury while attempting to drill holes in a gas station parking lot. The appeals court affirmed summary judgment for the insurer.

The policy definition of "uninsured motor vehicle" specifically excluded "any vehicle designed for use mainly off public roads [that is] not on public roads [at the time of injury]."

The trial court granted summary judgment for the insurer, finding that the insured sustained injury while operating the drill rig rather than while operating the truck it was mounted on. Therefore, the instrumentality causing injury was considered a vehicle designed for use mainly off public roads, which was off public roads at the time of the insured's injury.

The appellate court affirmed, noting additionally that the policy exclusion conforms to the requirements of R.C. 3937.18(A) ("…'motor vehicle,' for purposes of the uninsured motorist coverage…means a…vehicle designed for use and principally used on public roads.")

33. Insurer Need Not Show Prejudice When Insured Fails to Provide Timely Notice under Policy with a Defined Time Limit (a "Claims-Made-and-Reported Policy")

Bosley v. Associated Paper Stock, Inc., 2022-Ohio-2649 (7th Dist. June 30, 2022)

The insured sought coverage under an Employment Practices Liability endorsement in a "claims made and reported" policy for an age discrimination claim, which did not trigger automatically (like an "occurrence" policy), but instead required the insured to report any claims within 30 days of the end of the coverage period. The insured did not provide the insurer notice of the lawsuit against it within the time limit.

No facts were in dispute. The trial court granted the insured summary judgment on coverage, and found a genuine issue of fact existed as to bad faith claims. The appeals court reversed on every count.

The appeals court first criticized the trial court's failure to analyze the insurer's burden to demonstrate that it was prejudiced by the insured's untimely notice, because this claim is made under a "claims made and reported" policy rather than an "occurrence" policy.

The appeals court found to the contrary and that the *Ferrando* "notice-prejudice" rule doesn't apply to "claims made and reported" provisions because "a cut-off date is integral" to the value and pricing of such policies. In this case, the plaintiff's voluntary dismissal, re-filing, and complaint amendments did not "toll" the notice period; instead the commencement of the notice period was triggered permanently when the original complaint was filed – including claims regarding a co-party added in a subsequently filed amended complaint, because the original complaint contained allegations against that party (though unnamed in the original complaint).

The appeals court further found that the insured did not respond to the insurer's motion for summary judgment on bad faith claims, and therefore it was error for the trial court to determine that a genuine issue of material fact remained. The insured was not permitted to rest on the allegations of its pleadings when the insurer provided evidence that its denial of coverage was reasonable (precluding bad faith).

Finally, the appeals court ruled the plaintiff had no standing to sue the re-insurer because there was no contractual relationship between the re-insurer and the plaintiff.

34. Insured's Declaratory Judgment Action Seeking Disclaimer of Insurer's Subrogation Rights Properly Stayed When Defendant Insurer is Engaged in Arbitration with Other Insurer over that Subrogation Interest

Epps v. State Farm Auto, 2022-Ohio-4084 (8th Dist. November 17, 2022)

A car-crash-insured sought declaratory judgment that her insurer, State Farm, had no subrogation rights to settlement proceeds she negotiated with the tortfeasor's insurer, Allstate.

State Farm paid the insured $5,000 pursuant to a medical payments coverage provision. The insured notified State Farm of her plans to settle the car crash lawsuit with Allstate. State Farm notified the insured that she was not authorized to recover State Farm's $5,000 subrogated interest from Allstate due to the language of the State Farm insurance contract.

Despite State Farm's warning, the insured settled with Allstate. The settlement agreement held $5,000 in abeyance, pending the insured obtaining a release from State Farm of the subrogated interest. State Farm refused to release the subrogated interest and notified the insured that it was engaged in arbitration proceedings with Allstate to recover its $5,000 subrogated interest. The insured sued, alleging State Farm retained no subrogated interest where it "expressly declined the insured's assistance in collecting its subrogation interest and then failed to timely initiate a civil action against the tortfeasor."

State Farm moved to stay the insured's lawsuit pending the resolution of its arbitration with Allstate, and the trial court granted the stay. The insured filed this appeal, challenging the stay. The appeals court affirmed. Although the insured was not a party to the arbitration agreement that forced State Farm and Allstate into arbitration, the court noted Ohio's preference for arbitration and cited R.C. 2711.02(B), which requires a trial court to stay an action upon a party's motion brought on any issue referable to arbitration. This command of R.C. 2711.02(B) applies even when not all parties to the stayed action are parties to the arbitration agreement.

35. Payment to an Abatement Fund Constitutes "Damages"; Lead Paint Damages Do Constitute Damages "Because of Bodily Injury [and] Property Damage"

Sherwin-Williams Co. v. Certain Underwriters at Lloyd's London, et al., 2022-Ohio-3031 (8th Dist. Sept. 1, 2022)

HOLDING: Payment to a lead-based paint abatement fund constituted "damages" for which coverage existed under the insured's policies. Intentional act exclusion is not triggered unless the intentional act is intrinsically tied to the resulting harm. Bodily injury and property damage suffered by the public was sufficient to trigger coverage for damages awarded to governmental entities to mitigate those harms.

Sherwin-Williams Company ("SW") was found to have intentionally promoted lead-based paint despite having actual knowledge of its hazards and that its deterioration would cause injury. SW

and several other paint manufacturers were ordered to pay over $400 million into an Abatement Fund.

This appeal addressed assignments of error in SW's declaratory judgment action, in which it sought coverage for the millions of dollars it was ordered to pay into the Abatement Fund. The trial court determined payment to an abatement fund did not constitute "damages" under the policy and SW appealed. SW's insurers filed several cross-appeals arguing coverage was precluded by the intentional act exclusion and there was no bodily injury or property damage suffered by the governmental entities benefiting from the Abatement Fund.

The policies' language provided coverage for "all sums" SW becomes "legally obligated to pay as damages" or "for damages." Although the policies did not define "damages," the Eighth District overturned the decision of the trial court and determined the plain meaning of "damages" was broad enough to encompass a variety of remedies, including compensatory damages, injunctive relief, restitution, and other equitable relief. Because payment to the abatement fund serves the purpose of reimbursing the government's costs in responding to the lead-based paint hazard, it fit within the definition of "damages" and was covered by the policies.

The insurers cross-appealed arguing, *inter alia*, SW's act of promoting the use of lead-based paint at a time when SW had actual knowledge that its use in home interiors was poisonous to children triggered the intentional-act exclusion under the policies. However, the intentional-act exclusion required proof that the injury itself was expected or intended and intent is found only when "the insured's intentional act and the harm caused are intrinsically tied so that the act has necessarily resulted in the harm." *Cincinnati Ins. Co. v. Discount Drug Mart, Inc.*, 2021-Ohio-4604 (8th Dist.). Therefore, SW's actual knowledge of potential harm without an intent to cause harm to children, did not trigger the intentional-act exclusion.

Additionally, the insurers argued there was no coverage because the governmental entities benefitting from the Abatement Fund did not suffer any bodily injury or property damage themselves. However, SW's liability was imposed "because of" bodily injury or property damage, which was sufficient to trigger coverage under the policies.

36. Conflict of Laws Governing Torts Applies to Bad-Faith Claims

The Scott Fetzer Co., et al. v. American Home Assurance Co., Inc., 2022-Ohio-1062 (8th Dist. March 31, 2022).

The Scott Fetzer Company sought coverage under a general-liability policy with Travelers for cleanup of two hazardous waste sites, located in Michigan, identified by the EPA. When its claim was denied, Fetzer filed a declaratory judgment action, which included claims for breach of contract and bad faith.

A discovery dispute arose when Fetzer requested the production of certain documents Travelers argued were protected by attorney-client privilege. The Cuyahoga County Common Pleas Court concluded Ohio law applied to the discovery dispute, reviewed the disputed documents

accordingly, and ordered Travelers to produce certain documents. Travelers filed an interlocutory appeal.

The 8th District relied upon *Hoskins v. Aetna Life Ins. Co*., 6 Ohio St.3d 272, 276, 452 N.E.2d 1315 (1983) to affirm 1 Restatement of the Law 2d, Conflict of Laws, § 145, governing tort claims, as the appropriate analysis to determine choice of law for bad-faith claims because a bad-faith claim sounds in tort, rather than contract.

Section 145 required the court to evaluate: 1) Where the injury occurred; 2) Where conduct causing the injury occurred; 3) The domicile and place of business of the parties; and 4) The place where the relationship between the parties is centered.

Based on this analysis, the court found that: 1) The injury occurred in Ohio because Fetzer was the injured party and Fetzer was located in Ohio; 2) Despite the waste site being located in Michigan, communications regarding coverage occurred between Travelers in Connecticut and Fetzer in Ohio so the conduct occurred in Ohio; 3) Fetzer is a Delaware corporation headquartered in Ohio and Travelers is a Connecticut corporation headquartered in Connecticut but licensed to provide insurance in Ohio so this factor also favored Ohio; and 4) The relationship between the parties consisted primarily of communications that occurred with Travelers in Connecticut and Fetzer in Ohio.

Under this analysis, the 8th District affirmed Ohio as the appropriate choice of law.

Although Travelers also appealed the trial court's decision as to what documents were protected by attorney-client privilege, its failure to provide the documents to the appellate court for its review prevented the appellate court from evaluating that issue. Therefore, the trial court's determination was affirmed.

37. Will all Dogs go to Heaven?

Santiago v. Costanzo, 2022-Ohio-611 (8th Dist. March 3, 2022)

Holding: Policy excluding coverage for a second injury caused by a dog was triggered despite the fact that the first injury was not intentionally caused by the dog.

Defendant Costanzo was wrestling with his own dog in 2015 when the dog's teeth grazed his arm, causing him to seek medical treatment. Although Costanzo did not make any claim for damages under his homeowner's policy with Grange or report the incident to any authority, the hospital where he sought treatment did notify the Cuyahoga County Board of Health of the incident.

Three years later, while Costanzo was out of town, his dog-sitter's guest, Santiago, was attacked and severely injured by the dog. Santiago sued; however, Grange denied coverage due to a second-injury exclusion in its policy.

The policy excluded coverage for any "bodily injury … caused by … any dog with a prior history of causing bodily injury to a person …".

Both Costanzo and Santiago appealed the trial court's summary judgment in favor of Grange. The appellate court affirmed the trial court's decision relying upon basic tenets of contract interpretation.

First, Santiago argued the policy's exclusion of prior injury to a "person" was ambiguous because, here, that first injury occurred to Costanzo, who qualifies as an "insured person" under the policy. Her argument was that if the policy intended prior injury to an "insured person" to trigger the exclusion, it should have incorporated that defined term into the exclusion. The 8th District affirmed the trial court's conclusion that, under its plain meaning, the undefined term "person" was broad enough to include an "insured person." Therefore, injury to Costanzo triggered the exclusion despite the fact that he was also an "insured person."

Next, both Santiago and Costanzo argued it was Costanzo, not his dog, that caused the first injury. However, Costanzo admitted the dog's teeth are the thing that injured his arm. The 8th District held, "[T]here is no need to assess degrees of fault or graft concepts of legal liability onto the plain language of the policy." Therefore, the exclusion was triggered because the dog had a prior history of causing bodily injury to Costanzo.

Santiago and Costanzo also argued the exclusion should only apply to vicious dogs or those with a propensity toward violence. However, under the plain meaning of the policy language, the exclusion is not limited to vicious dogs.

38. Attorneys Get Schooled on Frivolous Conduct, Part II

Ohio Bar Liability Insurance Co. v. Wallace, et al., 2022-Ohio-131 (8th Dist. Jan. 20, 2022)

Holding: Coverage under professional liability policy was barred by exclusion for any award of attorney fees imposed under a statute designed to deter frivolous conduct by any party or attorney engaged in litigation. Fees sought for the cost of hearing officers and court reporters did not constitute "money damages" covered by the policy.

Daniel Bache, Jason Wallace, and their firm Wallace & Bache (collectively, "Wallace & Bache") represented students and their families in administrative law proceedings brought against school boards under the Individuals with Disabilities Education Act ("IDEA").

After prevailing in IDEA claims brought by Wallace & Bache, seven different school boards ("Boards") filed separate suits alleging claims against Wallace & Bache and seeking an award of attorney fees available to prevailing parties under IDEA. The Boards alleged the complaints filed by Wallace & Bache on behalf of their student-clients between December 2014 and November 2016 were "frivolous, unreasonable, or without foundation" and/or were pursued after the underlying cases had clearly become "frivolous, unreasonable, or without foundation" and/or that the cases were brought for an "improper purpose."

Wallace & Bache presented each claim to its professional liability insurance carrier, Ohio Bar Liability Insurance Co. ("OBLIC"). OBLIC denied coverage and, ultimately, sought a declaratory judgment that it did not owe defense or indemnity pursuant to several exclusions in its policy.

The OBLIC policy had a frivolous conduct exclusion barring coverage for "any claim for money damages for: … attorney's fees ***imposed*** against any Insured … under any one or more of the following: Rule 11 of the Federal Rules of Civil Procedure, Rule 11 under the Ohio Rules of Civil Procedure, Ohio Revised Code Section 2323.51 (the "frivolous conduct" statute) or under any other federal, state, or local statute or rules of procedure or common law ***designed*** to deter frivolous conduct by any party or attorney engaged in litigation." (emphasis added) The OBLIC policy also had exclusions for any "act, error or omission" that occurred prior to April 30, 2016, and specifically excluded the claims by the Akron School Board.

The trial court issued judgment on the pleadings in favor of OBLIC, which was affirmed by the 8th District.

Wallace & Bache first argued the frivolous conduct exclusion did not bar OBLIC's duty to defend because the attorney fees sought had not yet been "imposed." However, the duty to defend is triggered by the allegations in the complaint and, in this case, those allegations, which sought coverage for frivolous conduct, triggered the exclusion and precluded the duty to defend.

Next, Wallace & Bache argued the frivolous-conduct exclusion did not bar coverage because IDEA was not a statute ***designed*** to deter frivolous conduct and IDEA's administrative law proceedings did not constitute "litigation". However, the policy does not require the entire IDEA be designed to deter frivolous conduct. Federal courts have held the fee-shifting permitted under IDEA is a sanction. Because the applicable provision was designed for that purpose, the policy's exclusion is triggered. Furthermore, the policy's requirement that a statute be designed to prevent frivolous conduct in litigation does not preclude application of the exception to administrative law proceedings.

Finally, Wallace & Bache argue OBLIC failed to consider claims against them for litigation costs and expenses, which they argue do not trigger the frivolous-conduct exclusion. However, the policy provides coverage for "money damages" – not costs or expenses; therefore, there is no coverage for the litigation costs and expenses.

One justice wrote a dissent arguing application of the frivolous-conduct exclusion based on allegations alone was premature and ignored the policy's use of the past-tense verb "imposed". She also opined the phrase "statute … designed to deter frivolous conduct" was ambiguous and should, therefore, be construed against OBLIC. Finally, she disagreed with the majority's interpretation of the phrase "engaged in litigation" because the plain meaning of the word litigation means "decided in a court of law."

39. If the Order Doesn't Fit, You Must Revisit

State Auto v Rowe, 2022-Ohio-4443 (9th Dist. Dec. 12, 2022)

State Auto sought a declaratory judgment that it owed no liability coverage or duty to defend its insureds under a homeowner policy. The insureds owned a home but never lived there. Their adult daughter, who did live there, conducted a daycare business on the property. A young child, who was a daycare customer, drowned in the pool. This led to a criminal conviction for the adult daughter and a wrongful death lawsuit against the insureds.

The insureds filed their own lawsuit against State Auto and its agent alleging bad faith, fraud, negligence, and abuse of process. The insureds requested production of the claim file, which State Auto refused to provide. The trial court directed State Auto to produce the file for in camera inspection by the court. Following the inspection, the trial court issued an order finding no legal basis for discovery by the insureds but also directing State Auto to produce the file to the insureds' counsel for an "eyes only inspection."

State Auto appealed, as did the insureds.

The court of appeals noted that the trial court had not stated any basis for its determination that the documents were not discoverable. The court of appeals further held that the trial court had not provided any authority or explanation for why the insureds' counsel should be given access to documents that the trial court had already found the insureds had no legal right to discover.

The court of appeals dismissed the appeal and remanded the case so the trial court could create an entry that complied with the law and provided for meaningful appellate review.

40. Don't Blame the Insurance Agent if you Don't Know Your Policy

Nazareth Deli LLC v. John W. Dawson Ins. Inc., 2022-Ohio-3994 (10th Dist. Nov. 8, 2022)

This was a Tenth District Court of Appeals case involving whether or not an insurance agent and insurance agency made negligent representations and breached fiduciary duties in securing relevant auto insurance policies for the plaintiff/appellant.

Plaintiff/Appellant Hany Baransi ("Baransi") owned Nazareth Deli, LLC ("the Deli"). The Deli was located by the offices of defendant John W. Dawson Insurance, Inc. ("Dawson"). Defendant/Appellee Michael Palmer ("Palmer") was an employee of Dawson and would frequent the Deli as a patron. Palmer and Baransi developed a relationship over the years, which eventually led to Palmer handling Baransi and the Deli's relevant insurance policies.

Palmer initially procured an insurance policy for Baransi in the mid-2000s. In 2006, Palmer procured a commercial insurance auto policy for the Deli that was written by Grange. That policy only had one vehicle as a listed auto on the policy. Palmer also secured personal auto policies for Baransi in the mid-2000s. These policies were also written by Grange.

In June of 2016, Baransi removed the one vehicle that was listed on the commercial auto policy for the Deli. Thus, from June 2016 moving forward, there was no listed vehicle on the commercial auto policy held by the Deli. No premiums were paid for any UM coverage at that time. Baransi still had a personal auto policy that was procured by Palmer, which did list all of his own vehicles at the time.

In December of 2016, Baransi was involved in a serious motor vehicle accident with an uninsured motorist while working. Baransi then sought to collect UM benefits under the commercial auto policy but Grange denied the claim. At the time, the commercial auto policy liability limits were 1 million dollars (and previously had 1 million dollars in UM coverage when there were listed autos on the policy). The personal policy only had UM limits of $100,000.00/$300,000.00 at the time of the accident.

Baransi and the Deli subsequently filed suit against Palmer and Dawson Insurance alleging negligent misrepresentation and breach of fiduciary duty. Defendants/appellees filed a motion for summary judgment arguing that the claims were barred by the statute of limitations. Defendants/appellees further argued that Palmer had not breached a duty of care, that no fiduciary relationship existed, and that Palmer made no negligent misrepresentation of fact. The trial court granted the defendants/appellees' motion for summary judgment and plaintiffs/appellants subsequently appealed to the Tenth District.

The Tenth District first addressed the issue of whether or not the plaintiffs/appellants' claims were barred by the statute of limitations. At issue here was whether or not the cause of action accrued in 2012 or 2016. The Tenth District looked at a variety of case law and ultimately held that the general rule regarding claim accrual was applicable in this case, and thus, the negligence claim accrued "when the allegedly negligent act was committed." Accordingly, the court held that the negligence claim accrued in June of 2016 and was not barred by the four-year statute of limitation set forth in R.C. 2305.09(D). Thus, the Tenth District sustained this assignment of error.

The Tenth District then performed analysis on the breach of fiduciary duty claim. Essentially, the Tenth District held that there was no evidence that a fiduciary relationship was created between Palmer and Baransi despite years of being familiar with each other and having some personal relationship. Thus, the Tenth District held that the trial court did not err in granting the defendants/appellees' motion for summary judgment as to the claim for breach of fiduciary duty.

Lastly, the Tenth District held that the trial court did not err in granting the defendants/appellees' motion for summary judgment in regards to the negligent misrepresentation claim. The Tenth District noted that it was unambiguously demonstrated that once the lone vehicle was removed from the Deli's commercial auto policy in June of 2016, there was no longer any UM coverage for any vehicle. There was significant discussion as to both Baransi's and Palmers' versions of what was said between the two regarding applicable coverage, but regardless, the court still held that plaintiff/appellant could not establish any justifiable reliance on any of Palmer's alleged statements regarding the terms of the relevant policies.

41. A Claims-Made Policy is a Claims-Made Policy

Garrison Southfield Park LLC v. Aspen Specialty Ins. Co., 2022-Ohio-709 (10th Dist. March 10, 2022)

This Tenth District Court of Appeals case centered around whether or not coverage was owed by Aspen Specialty Insurance Company under a commercial general liability and environmental exposure policy for cleanup costs associated with improperly storing cathode ray tubes.

Closed Loop entered into a lease agreement for several properties in Columbus, Ohio that were owned by plaintiff/appellant Garrison Southfield Park, LLC ("Garrison"). Closed Loop stated in the lease that its business at the property included "warehousing, distribution, electronic recycling and manufacturing of cathode ray tubes (CRTs)." The lease required Closed Loop to maintain specified insurance policies, including a pollution and remediation legal liability policy. Closed Loop obtained several insurance policies in the form of a commercial general liability and environmental exposure policy from Aspen Specialty Insurance Company. Under the terms of the policy, Garrison was endorsed on the policy as an additional insured.

There were subsequently a number of environmental violations at the properties. These began on October 17, 2013, when the Ohio EPA sent Closed Loop a notice of violation of Ohio's Hazardous Waste Laws. There were a number of additional violations, and communications between the Ohio EPA and Closed Loop in 2014, 2015, and 2016. In April of 2016, the Ohio EPA sent a notice of violation and referred Closed Loop to the Attorney General of Ohio for initiation of enforcement actions against Closed Loop.

Garrison filed two separate complaints for eviction, injunction, and damages against Closed Loop alleging breaches of the occupancy agreement between Closed Loop and Garrison in 2015 and 2016. Garrison sought damages in the amount of nearly 4 million dollars under the lease in addition to additional amounts to be determined for the damage to the property and an amount to be determined at trial that would be in excess of millions of dollars incurred by Garrison to perform the environmental cleanup of the property. Garrison sent Aspen notice of their action against Closed Loop in May of 2016. Aspen sent Garrison acknowledgment of receipt of the letter and assigned a claim number.

Garrison then filed the subject complaint seeking damages and a declaratory judgment against Aspen and Closed Loop in February of 2017. Garrison indicated that it had been awarded in excess of 18 million dollars as a result of the two separate actions filed against Closed Loop. Garrison argued that Aspen was contractually obligated under the policy to provide coverage to Garrison for these cleanup costs. Aspen filed a motion for summary judgment, which was granted by the trial court. Most notably, the trial court found that the policy did not provide coverage for Garrison's claim for cleanup costs due to the fact that the claim for coverage was not made and reported during the policy period, as required by the claims-made policy. The trial court also found that Garrison's claim for cleanup costs under the policy was not due to a "pollution incident" as

defined in the policy, and therefore, was not subject to coverage. Garrison subsequently appealed the trial court's decision granting the motion for summary judgment.

While there is a significant amount of factual background here, the Tenth District Court of Appeals analysis was essentially limited to whether or not Garrison's claim for coverage was timely made. The Tenth District noted that the relevant policy was a "claims-made policy" that covered the period from April 12, 2015, to April 12, 2016. The court noted that Aspen was not notified of the claim by Garrison until the May 6, 2016, letter. The court additionally noted that Garrison had been on notice of the alleged pollution incidents and EPA issues/violations well within the policy period. Furthermore, the Tenth District noted that it was undisputed that Aspen was not aware of the issues prior to the May 6, 2016, letter. Thus, the Tenth District affirmed the trial court's decision on summary judgment that the claim was untimely made and that coverage was not owed for this reason.

The Tenth District simply addressed the three other assignments of error presented by Garrison by noting that they were unnecessary to address given that it was held that Garrison's claims could not succeed because Garrison failed to timely notify Aspen with the policy period of the claims-made policy.

42. When a Jury Has Lost Its Way

Ambrose v. USAA, 2022-Ohio-2629 (11th Dist. Aug. 1, 2022)

This Eleventh District Court of Appeals case centers around a motor vehicle accident that took place between plaintiff/appellant Caroline Ambrose ("Caroline") and defendant/appellee Morticia Williamson ("Williamson"). This was an automobile-pedestrian accident that took place in a Marc's parking lot in Kent, Ohio. Ms. Williamson backed her vehicle into Caroline's shopping cart, which subsequently threw Caroline to the ground. Caroline was in her early 90s at the time of the incident. She passed away while the case was pending for unrelated causes and was subsequently substituted by her daughter, Mary Ambrose ("Ambrose"). The Ambrose claim against defendant Williamson was one of simple negligence.

The case proceeded to a jury trial at the Portage County Court of Common Pleas. Defendant Williamson admitted to negligence before the start of the jury trial. The plaintiff presented two expert witnesses who opined that Caroline had suffered two fractures from the incident. The experts further addressed Caroline's medical treatment subsequent to the accident. The defense presented their own medical expert who also opined that Caroline did sustain two injuries as a result of the accident – a skin tear and a pubic bone fracture.

Despite the fact that there was no liability dispute, that the plaintiff presented multiple expert witnesses relating Caroline's injuries to the accident, and that the defense's own medical expert related two injuries to the accident, the jury returned a defense verdict. Specifically, the jury answered the first interrogatory as to whether or not the defendant's negligence proximately caused the injury to Caroline Ambrose as "no." Plaintiff subsequently filed a motion for judgment

notwithstanding the verdict (JNOV), or in the alternative, motion for a new trial. The plaintiff listed seven grounds to grant the motion for JNOV or new trial. The trial court denied the motion. Plaintiff subsequently appealed to the Eleventh District.

The Eleventh District addressed all eight of the plaintiff's assignments of error. Most significantly, the Eleventh District ruled that the trial court erred in denying the motion for judgment notwithstanding the verdict. The Eleventh District noted that both medical experts opined that Caroline suffered at least two injuries as a direct and proximate result of the incident. There was also additional testimony by Caroline's family members concerning the pain and suffering and physical limitations after the accident, along with medical evidence provided to support the medical expert's opinion. Thus, the Eleventh District held that there was "no objectively discernable reason why the jury may have rejected the expert medical testimony in the case," that the jury verdict was simply not supported by competent, credible evidence, and that the trial court should have granted the plaintiff's motion for JNOV or in the alternative, motion for a new trial.

The Eleventh District further addressed the plaintiff/appellant's other assignments of error, which were not as significant as the denial of the motion for JNOV and the new trial motion. Nevertheless, the Eleventh District did also rule that the trial court erred in failing to provide an "eggshell" jury instruction (the trial court refused to do so since there was not a standard Ohio Jury Instruction on the issue). The Eleventh District also held that the trial court erred in overruling the plaintiff's objections to defense counsel's cross-examination on the plaintiff's out-of-pocket medical bills, and defense counsel's questioning of plaintiff's character. Lastly of note is that the Eleventh District ruled that the trial court erred in ruling that security camera video footage of the accident was excluded because it could not be authenticated by the defendant despite the fact that defendant clearly testified that she recognized the vehicle in the video as her vehicle and that the video clearly and accurately depicted how the accident took place.

43. Case of Mistaken Identities? Court Holds that "Dueling Excess" Clauses Result in Pro-Rata Coverage Obligation

Acuity v. Progressive Specialty Ins. Co., 2022-Ohio-1816 (11th Dist. May 31st, 2022), appeal allowed, 167 Ohio St.3d 1525, 195 N.E.3d 157 (Table), 2022-Ohio-3322.

Progressive covered a car involved in a single-car accident. Acuity covered the car's owner personally, and, by permission of the insured, the person who was driving the car. The coverage limits were identical. Acuity sought to avoid covering the accident due to an "other insurance" clause stating its coverage was "excess over any other collectible auto liability insurance." Progressive sought to avoid covering accident, due to a policy clause defining "insured person" as "any person who is not insured for liability coverage by any other insurance policy." The driver of the car was listed as a permissive driver on the Acuity policy.

Acuity and Progressive filed cross-motions for summary judgment, each claiming the other was primarily responsible for covering the accident. At trial, the court found that the driver was not an "insured person" under Progressive's policy, and therefore Progressive had no duty to cover

the accident (and that Acuity's "other insurance" clause did not apply as a result). Progressive's summary judgment motion was granted at trial.

On appeal, summary judgment was reversed. The Eleventh District held that *State Farm Mut. Auto. Ins. Co. v. Home Indem. Ins. Co.* applied to this case. 23 Ohio St.2d 45, 261 N.E.2d 128 (1970). That case established the rule that an "escape clause," such as the language in Progressive's definition of "insured person," was ineffective to relieve an insurer from coverage when the relevant "other insurance policy" also declines coverage of a claimant with another insurance policy.

After finding Progressive's escape clause ineffective, the Eleventh District determined that the "excess clauses" present in both Progressive's and Acuity's policies *were* effective simultaneously. The Court applied *Buckeye Union Ins. Co. v. State Auto Mut. Ins. Co.*, 49 Ohio St.2d 213, 216-218, 361 N.E.2d 1052 (1977), which held "since there can be no primary insurance of the risk where there are conflicting excess clauses, [they] a fortiori cannot be a valid means of establishing only 'secondary' liability…. The two insurers become liable in proportion to the amount of insurance provided by their respective policies." The Court ordered the trial court to issue a declaratory judgment that the insurers must cover the accident pro-rata (in this case, because the limits were identical, 50-50).

Editor's note: This case is currently on appeal and will probably be reversed on the authority of *Wohl v. Swinney*, 118 Ohio St.3d 277, 888 N.E.2d 1062, 2008-Ohio-2334; *Chapman v. Am. Family Ins.*, (9th Dist.) 2016-Ohio-5906; *Ramsey v. State Farm Mut. Auto. Ins. Co.,* (2d Dist.) 2016-Ohio-5871; and *W. Am. Ins. Co. v. State Farm Mut. Auto. Ins. Co., (*1st Dist.) 2010-Ohio-6311.

44. One-Year Nationwide Policy Limitation Provision Upheld

Jochum v. Nationwide Gen. Ins. Co., 2022-Ohio-756 (11th Dist. Mar. 14th, 2022)

Homeowner contended that Nationwide improperly refused to cover the remediation of damaging salt deposits he discovered under his house post-purchase. Nationwide contended that salt is not a contaminant covered by the insured's policy. The Court did not address the substance of the appeal, holding that the trial court properly barred the action for failure to sue Nationwide within the time limit prescribed by the policy (one year).

At trial, it was undisputed that the insured (1) purchased the home in 2015; (2) became aware of the damaging salt in 2016; and (3) sued Nationwide in 2019.

Because the threshold matter of coverage was resolved in favor of Nationwide, the insured's additional claims relating to bad faith (and bifurcation thereof) could not be supported, even though an insurer can commit "bad faith" in ways other than claim denial, the insured's bad faith allegations here were premised only on an allegedly bad-faith *claim denial*. The claim denial, however, was proper under these facts.

45. Criminal Acts Excluded from Personal Liability Coverage

Allstate Vehicle & Prop. Ins. Co. v. Inabnitt, 2022-Ohio-2098 (12th Dist. June 21st, 2022).

Insured pushed a man down a flight of stairs in a fight causing serious injury. The insured was convicted of felonious assault. Allstate sought a declaratory judgment that it was not required to cover its insured's civil damages, or defend the victim's lawsuit, due to the intentional or criminal acts exclusions in the policy.

At summary judgment, the insured denied that he intended to cause injury by his criminal act, and he presented evidence that his criminal judge supported, who stated on the record that, "I do not believe that you intended to cause those serious injuries." In the civil case, and based on this evidence, the trial court found that there was a genuine issue of material fact as to the insured's intent to injure.

Because the insured's conviction for felonious assault under R.C. 2903.11(A)(1) required a "knowing" state of mind, the Court held that it conclusively established intent for purposes of applying Allstate's intentional-acts exclusion (citing *Farmers Ins. of Columbus, Inc. v. Martin*, 12th Dist. Clermont No. CA2004-03-022, 2005-Ohio-556, ¶ 15). Importantly, the "knowing" state of mind was sufficient because Allstate's exception involved "the *expected* results of one's [intentional] acts," not simply *intended* results. Allstate was not required to prove that the insured *intended severe injury* while *intending* to commit felonious assault, contrary to the trial court's determination. The actual-versus-expected *severity* of the victim's injuries was found to be irrelevant, due to policy language excluding coverage when "such bodily injury is of a different kind or degree than intended or reasonably expected."

At the same time, the victim-plaintiff's attempt to re-characterize the insured's criminal act as "negligence" in order to invoke the insurance policy was found to be ineffective because the claims stemmed, by all reasonable interpretations, from the commission of felonious assault.

Note that the court also determined that items from the criminal docket in support of Allstate's Motion for Summary Judgment were properly certified by the clerk of courts, and were therefore competent evidence at summary judgment.

46. UIM Pedestrian Fails to Support Injury with Sufficient Evidence

Withrow v. Geico Advantage Ins. Co., 2022-Ohio-1703 (12th Dist. May 23rd, 2022)

The insured sought UIM coverage for injuries suffered allegedly by a hit-and-run motor vehicle while in the parking lot of a retirement home. An eyewitness testified the insured actually fell on her face after appearing dazed and no motor vehicle was involved in the incident. No cameras recorded the incident.

Records from the insured's initial treatment classified the cause of injury as a fall. There was no indication of injuries to the insured's back. The insured testified she recalled the motor vehicle collision only after four or five months, during which time her memory "gradually" recovered. The insured's testimony about factual context was inconsistent.

The insured appealed her summary judgment loss, claiming that medical records and photographic evidence established a genuine issue of material fact. The Court disagreed, holding first that the Geico policy precluded the insured's own testimony from being used as the required "independent corroborative evidence" of a phantom UIM-covered hit-and-run injury, and then that none of the insured's evidence was sufficient.

Although the policy's evidentiary requirement may have been more restrictive than R.C. 3937.18(B)(3) allows, the Court did not analyze this issue because it held that the insured's evidence contained no suggestion that she was struck by a motor vehicle at all. Any photographs the insured apparently referred to on appeal were not properly filed in the trial court.

47. A Detour - or Two - Does Not Take a Truck Driver Out of the Business of a Motor Carrier

Great Am. Assur. Co. v. Acuity, 2022-Ohio-501 (12th Dist. Feb. 22, 2022), cause dismissed sub nom. *Great Am. Assur. Co. v. Acuity*, 166 Ohio St.3d 1533, 2022-Ohio-1927, 188 N.E.3d 207.

HOLDING: Trucking carrier's liability policy covered accident which occurred when driver, while driving the company truck home from his shift, took two short detours from his normal route. The court determined that, even with two short detours, the driver was operating the truck in the business of the carrier at the time of the accident, rendering his own non-trucking liability policy inapplicable.

A transportation company retained an independent contractor to transport contents to and from different warehouses. The company provided the contractor with a company truck, which was insured for business use under a policy with Acuity. The independent contractor maintained a separate policy with Great American that excluded coverage when the truck was "being used in the business of any lessee" or while "being used to transport cargo of any type."

After the contractor completed his shift, he dropped the chassis off at the company shipyard and drove the truck home. He took two short detours on the way – first stopping at a store where his wife worked to purchase an item and then stopping for gas. On his way from the gas station to his home, he was involved in an accident. The contractor was on the same route he normally took without detours; the detours only took him about a half mile from the highway he traveled to drive home.

On Great American's declaratory judgment action, the court affirmed the lower court's decision applying the business use exclusion under its policy. The court followed the general rule espoused in *Illinois Nat. Ins. Co. v. Ohio Sec. Ins. Co*., 452 Fed.Appx. 651, 655 (6th Cir. 2011), that minor personal detours do not take a driver out of the carrier's business. The court rejected Acuity's

attempts to distinguish *Illinois Nat'l* on the grounds that the policy language was different and the contractor made two detours instead of one, finding these to be a "distinction without a difference."