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Nevada Supreme Court: Insurer that Expressly Reserves Rights May Obtain Reimbursement for Defense Costs

On a certified question from the Ninth Circuit, the Nevada Supreme Court instructed that an insurer who is determined not to have owed a duty to defend is entitled to be reimbursed by the policyholder for the costs it paid for the policyholder's defense, as long as the insurer reserved the right to seek reimbursement in writing.

The Case

The policyholder sold medical devices. It was sued by a former business partner. One of the 31 counts asserted in the complaint was for interference with prospective economic advantage.

The policyholder submitted a claim to Nautilus, its insurer. There was some question as to whether the claim fell within the offenses enumerated within the definition of "personal and advertising injury."

Nautilus defended under a reservation of rights. Nautilus in writing reserved the right to disclaim coverage, withdraw from the defense, and obtain reimbursement of defense fees if a court determined that no potential for coverage existed for the claims. Nautilus began defending and then sought a declaration in federal court that it had no duty to defend.

Nautilus prevailed in its declaratory judgment action. It then moved for further relief under the Declaratory Judgment Act seeking reimbursement of the expenses it had already

incurred defending the underlying suit. The district court denied its request, finding that Nautilus had not demonstrated that Nevada law provided for reimbursement of defense costs.

On appeal, the Ninth Circuit affirmed that Nautilus had no duty to defend. But it reserved judgment on whether Nautilus could seek further relief. The Ninth Circuit explained that an insurer's entitlement to reimbursement of defense costs was unresolved under Nevada law. It certified the question to the Nevada Supreme Court.

The Nevada Supreme Court's Decision

Nautilus sought reimbursement of defense costs under a theory of unjust enrichment and quasi-contract. The policyholder argued that unjust enrichment is unavailable when there is a written contract covering the same subject matter. It contended that the court should not look beyond the insurance policy. The court disagreed, finding that the existence of the insurance contract did not foreclose an unjust enrichment claim.

The court then determined that the first two elements of an unjust enrichment claim had been satisfied – the insurer conferred a benefit by providing a defense and the policyholder appreciated that benefit by accepting the defense. The issue was whether equity requires the policyholder to pay.

An insurer that refuses to defend a claim and then loses the coverage dispute may be subject to significant liability. The court felt that this creates a disincentive for the insurer to deny a defense outright when there is any possibility—even a relatively remote one—that the claim may turn out to be covered.

Citing the Restatement (Third) of Restitution and Unjust Enrichment, the recognized the general principle that a party that performs a disputed obligation under protest, and does not in fact have a duty to perform, is entitled to reimbursement. In the insurance context, time is

precious – the parties must decide quickly what to do and litigate later who must pay. Because the insurer has a lot at risk if it is found to have wrongfully refused to defend, the court determined that it was equitable to require the policyholder to pay where the insurer never had a duty to defend.

Thus, in answering the certified question, the Nevada Supreme Court held that when a court finally determines that the insurer had no contractual duty to defend, the insurer may ordinarily recover in restitution if it has clearly reserved its right to do so in writing.

The court said that its holding was in line with the majority. But it noted that some courts have ruled against reimbursement, so the court devoted some time to explaining why it rejected the minority viewpoint.

Some courts adhering to the minority viewpoint have stated that reimbursement should only be allowed if the insurance contract expressly permits. In their view, permitting reimbursement was tantamount to amending the contract.

The Nevada Supreme Court disagreed. It explained that because the insurer's obligations under the policy were never triggered in the first place, no contract governed the policyholder's defense. In these circumstances, there is no reason an insurer cannot reserve a right it has, not pursuant to the contract, but pursuant to the law of restitution. Furthermore, because Nautilus did not have any contractual duty to defend, it could properly condition its provision of a defense on a reservation of rights. Stated differently, Nautilus agreed to defend against certain kinds of allegations, and not others. Allowing reimbursement does not modify the policy, but rather gives effect to the parties' agreement.

The court also found that permitting restitution would not amount to a retroactive erosion of the broad duty to defend under Nevada law. Some courts that deny reimbursement do so on

the basis that a court cannot hold that there never was a duty to defend, only that there is no longer a duty to defend. Because an insurer in those states necessarily has a duty to defend any time it does defend, the court recognized that it may be true that permitting reimbursement would narrow that duty. But it distinguished that rationale because the duty to defend in Nevada has never been that expansive. Under Nevada law, when a court concludes that a claim was never even potentially covered, then the court should hold that the duty to defend never arose.

The court concluded by stating that the parties bargained for Nautilus to defend against certain kinds of allegations. The federal courts determined that the underlying claims were not of that kind. Therefore, in permitting reimbursement of defense costs, the court is not eroding the duty to defend by acknowledging its existing limits.

The case is *Nautilus Ins. Co. v. Access Med. LLC,* No. 79130 (Nev. March 11, 2021).

Indiana Supreme Court: Ransomware Payment Resulted Directly from Use of Computer

Reversing an award of summary judgment in favor of an insurer, the Indiana Supreme Court found that a policyholder's payment of ransom to recover its hacked computer files was a loss that resulted directly from the use of a computer and that the act of paying the ransom did not break the causal chain. The policyholder was not necessarily covered for the loss, however. It still must prove under its commercial crime policy that the attack fraudulently caused a transfer of money.

The Case

An oil company, G&G, was the victim of a ransomware attack. G&G believed that the hackers gained access to its network through a targeted spear-phishing email and link. It paid the

hackers $35,000 worth of Bitcoin to regain access to its computer systems. It then sought coverage under its commercial crime policy.

The policy's "Computer Fraud" provision covered loss "resulting directly from the use of any computer to fraudulently cause a transfer of money." The insurer denied coverage on the basis that the Bitcoin was voluntarily transferred by G&G to the hacker.

G&G sued. Both parties moved for summary judgment. The trial and appellate courts upheld the insurer's denial.

The issue before the Indiana Supreme Court was whether the ransomware attack "fraudulently caused a transfer of money" and whether the loss "resulted directly from the use of a computer."

The Decision

The Indiana Supreme Court first determined that the phrase "fraudulently cause a transfer" is unambiguous and can reasonably be understood to mean "to obtain by trick." But it held that the phrase was construed too narrowly by the courts below.

It noted that not every ransomware attack is fraudulent. If insufficient safeguards were in place and a hacker entered a company's servers unhindered, that would not be by trick. But it found that summary judgment was not appropriate for either party.

The court was skeptical that G&G had sufficient evidence supporting its claim of spear-phishing. Though little was known about the hack's initiating event, there was at least a reasonable inference that access to G&G's computer systems was obtained by trick. This unresolved factual issue was enough to defeat summary judgment for the insurer.

It next considered whether the loss resulted "directly from the use of a computer." G&G argued that a computer was part and parcel of the entire scheme. The insurer argued that G&G's voluntary transfer of Bitcoin was an intervening cause.

The court focused on the word "directly." It concluded that G&G must demonstrate that its loss resulted either "immediately or proximately without significant deviation from the use of a computer." The court viewed G&G's Bitcoin payments as "voluntary" only in the sense that G&G consciously made them. The court thought they were more appropriately viewed as having been made under duress. Without access to its computer files, G&G would likely have incurred further business losses. Under these circumstances, the payment was not so remote that it broke the causal chain. Thus, the court found that the losses resulted directly from the use of a computer.

But the court found that neither party was entitled to summary judgment and remanded the case for further proceedings.

The case is *G&G Oil Co. of Indiana v. Continental Western Ins. Co.*, No. 20S-PL-617 (Ind. Mar. 18, 2021).

New Hampshire Supreme Court: Workers' Comp Insurer Must Pay Injured Employee's Medical Marijuana Costs

Reversing the Compensation Appeals Board ruling, the New Hampshire Supreme Court found that a workers' compensation insurer could not rely on federal preemption doctrines to withhold payments for an injured employee's medical marijuana costs.

The Case

An employee qualified for New Hampshire's therapeutic cannabis program after sustaining a work-related injury to his back. The employer's workers' compensation insurer declined to

reimburse the employee for his medical marijuana costs on the ground that they were neither reasonable nor medically necessary. The employee pursued an administrative hearing before the state's Department of Labor. The Board found the costs were reasonable and necessary, but ultimately ruled that the insurer would be aiding and abetting a federal crime under the Controlled Substances Act (CSA) if it paid for the employee's medical marijuana prescription.

The New Hampshire Supreme Court had previously ruled that the insurer's reimbursement of medical marijuana costs would not violate state law. The issue now was whether federal preemption principles apply.

The Decision

The New Hampshire Supreme Court considered two preemption standards: impossibility preemption and obstacle preemption.

The court first considered impossibility preemption. Would it be impossible for the insurer to comply with a Board order to reimburse medical marijuana costs without violating the CSA? The court found that there was no direct conflict between the CSA and a Board order requiring reimbursement because the CSA does not criminalize the act of insurance reimbursement for an employee's purchase of medical marijuana.

The court agreed with the employee that aiding and abetting liability requires knowledge at a point when the person has an opportunity to quit performing the crime. State law gave the insurer no discretion to choose whether to comply once a finding is made that the treatment is reasonable and the injury work-related. Simply put, the court found that an insurer that reimburses a claimant for purchases of medical marijuana is not guilty of aiding and abetting because the insurer lacked the requisite *mens rea*. Nor could the insurer be liable for conspiracy

because compliance with a mandatory order does not constitute voluntary participation. Thus, impossibility preemption presented no bar to reimbursement.

The court next considered obstacle preemption. Would reimbursement thwart the purposes and objectives of the CSA?

The court found that a high threshold must be met before a state law will be preempted. The court observed that CSA's main objectives were to conquer drug abuse and to prevent drugs from being diverted from legitimate to illicit channels. The New Hampshire Supreme Court failed to see how an insurer's reimbursement of medical marijuana costs would stand "as an impermissible obstacle to the accomplishment and execution of the full purposes and objectives" of the CSA. The court reasoned that the CSA does not regulate insurance in any manner.

Furthermore, the federal government is still free to prosecute the employee for marijuana possession, whether the employee was reimbursed by the insurer or not. Thus, the court concluded that the high threshold for obstacle preemption was not met.

The court reversed the Board's decision.

The case is *Appeal of Andrew Panaggio N.H. Comp. Appeals Bd.*, No. 2019-0685 (N.H. Mar. 2, 2021).

Seventh Circuit Finds No Duty to Defend TCPA or Fair Debt Collection Practices Claim

The Seventh Circuit ruled that a policy exclusion for Telephone Consumer Protection Act (TCPA) claims applied to common law claims for invasion of privacy and that an insurer had no duty to defend any claims arising therefrom.

The Case

Zurich American Insurance sold a policy to a debt-collection company. A disgruntled consumer sued the debt collector, alleging violations of the Fair Debt Collection Practices Act (FDCPA), TCPA, and common-law invasion of privacy claims. The consumer discharged a mortgage loan in bankruptcy. But the debt collector aggressively pursued the consumer for the debt. The consumer alleged that she suffered emotional and physical distress as a result of the debt collector's tactics, and economic injury because the debt collector wrongly reported the alleged default to credit agencies.

The debt collector tendered the dispute to Zurich, but Zurich asserted that policy exclusions relieved it of any duty to defend. The policies contained exclusions for coverage "directly or indirectly arising out of" violations of the TCPA or any other statute that imposes liability for the unlawful use of a telephone or other communication device.

Zurich sought a declaratory judgment in federal court in Illinois. The district court concluded that all of the factual allegations in the underlying complaint fell within the scope of the policy exclusions. It declared that Zurich had no duty to defend.

The debt collector appealed to the extent the district court's ruling applied to the common law claims in the underlying action. It argued that the underlying complaint included the possibility that (1) some calls were made to the claimant's *home* phone using a *live* operator, and (2) some calls were not made with the intent to annoy, abuse, or harass.

The Decision

The Seventh Circuit affirmed. Applying Illinois law, the court found that the "arising out of" language in the exclusion covered underlying conduct that forms the basis of the violation of an

enumerated law, even if liability for that underlying conduct might exist under a legal theory not expressly mentioned in the policy exclusion.

The court also found that the underlying complaint, read as a whole, contained no factual allegations that would substantiate the existence of calls that the debt collector placed to her home phone. The court also found that the underlying complaint's references to negligence, as opposed to intentional calls, were "legal labels" that Illinois courts refuse to credit without factual elaboration. The court concluded that the district court did not err in inferring an intent to harass from the debt collector's persistence in the face of the consumer's requests that they stop calling her.

For these reasons, the court concluded that Zurich had no duty to defend the underlying claim.

The case is *Zurich Am. Ins. Co. v. Ocwen Fin. Corp.*, No. 19-3052 (7th Cir. Oct. 26. 2020).

California Appellate Court Rejects a Bad Faith Special Verdict for Claimant

A California court ruled that a special verdict in favor of a claimant on a bad faith claim was defective because it did not address the reasonableness of the insurer's conduct, and since the claimant was responsible for the defective verdict sheet, judgment for the insurer was warranted.

The Case

The victim of a single-car traffic accident offered to settle his claim against the vehicle's owner in exchange for payment of the owner's policy limits. The insurer failed to accept the offer, which then lapsed. After the victim obtained a judgment against the owner in excess of policy limits, the owner assigned her claims against the insurer to the victim, who then sued the insurer

in California state court for bad faith. At trial, evidence was presented by both sides concerning the reasonableness of the insurer's conduct both in adjusting the victim's claim and in failing to accept his offer. The special verdict form, however, asked nothing about the reasonableness of the insurer's conduct, and the jury made no finding that the insurer acted unreasonably. The jury nevertheless found for the plaintiff, and judgment was entered against the insurer based solely on the special verdict. The insurer appealed.

The Decision

The appellate court reversed. The court found that a bad faith claim requires a finding that the insurer acted unreasonably. Because the jury made no such finding (not having been asked for one), the court concluded the judgment must be vacated and a contrary judgment entered for the insurer. The court observed that if a fact necessary to support a cause of action is not included in a special verdict, judgment on that cause of action cannot stand.

The court further concluded that judgment for the insurer was the appropriate remedy for the defective verdict. The court found that the claimant was responsible for the error by failing to propose an appropriate verdict and opposing attempts to clarify the verdict.

The case is *Pinto v. Farmers Ins. Exchange*, B295742 (Cal. Ct. App. Mar. 8, 2021).

Ohio Federal Court Finds that Notice of Environmental Claim after EPA Settlement Was Too Late

A federal court in Ohio found that coverage was barred based on a policyholder's failure to timely provide notice of an environmental cleanup claim until after it settled the claim with EPA.

The Case

Canton Drop Forge, Inc. (CDF) is a company that utilizes its property for forging manufacturing operations. CDF historically operated an engineered wastewater recycling and disposal system, which included retention basins known as ponds.

CDF was aware since 1993 of an issue with one or more of the ponds and considered closing or remediating them. During the late 1990s, it performed various remedial work on the ponds. EPA inspected the site in 2012. In 2013, EPA issued a notice of violation (NOV) to CDF. From January 2013 through the summer of 2014, CDF negotiated with EPA and the Ohio EPA to resolve the NOV and its potential liability. CDF was assisted by environmental consultants and attorneys in those negotiations. CDF ultimately committed to pay certain remedial costs under written agreements with EPA.

CDF, however, did not provide notice of claim to its insurer until November 2016. The insurer denied coverage and CDF filed a declaratory judgment action in the Northern District of Ohio for a ruling on the insurer's indemnity obligation.

The Decision

The court ruled in favor of the insurer. Applying Ohio law, the court concluded that CDF failed to provide reasonable notice of its pond closure claim, prejudicing the insurer.

The policy required notice to be provided "as soon as practicable" or "immediately." There was nearly a 4-year gap between the time EPA issued the NOV and when notice was first given to the insurer. The court found that this was an unreasonable delay. The court noted that even if CDF acted immediately in 2012 to avoid the NOV or challenged the NOV before reaching a settlement with the regulators, those actions did not demonstrate that CDF's decision to wait until November 2016 to first notify its insurer was reasonable.

The late notice also prejudiced the insurer. The court emphasized that CDF settled the pond closure claim without the insurer's consent. By failing to provide notice until after it settled the NOV, the court found that "CDF left [the insurer] with no opportunity to be involved in defending or negotiating a resolution to the environmental claim." Accordingly, the court granted summary judgment to the insurer.

The case is *Canton Drop Forge, Inc. v. Travelers Cas. & Sur. Co*., 18-cv-01253 (N.D. Ohio Mar. 11, 2021).

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