

Coverage Matters

Quarterly Investigation of the Underlying Trends & Developments in Insurance Coverage

February 2025

Coverage for BIPA-Related Lawsuits Continues to Be Litigated

By Jonathan Meer

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A Warning to Carriers on the Risks of Undefined Terms in Policies

By Erik Tomberg and Spencer Hoisington

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By Ashley Gilmore and Connor McKinney

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By Daniel E. Tranen

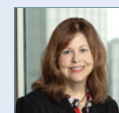
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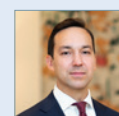
By Joshua N. Willis

Many insurance carriers have begun issuing various types of insurance policies for different aspects of cannabis operations, each involving different risks that may require distinct types of policy language, security measures, and underwriting practices. This article discusses some recurring coverage and underwriting issues in connection with these policies. ▶ [Read More](#)

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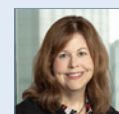
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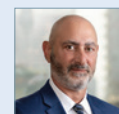
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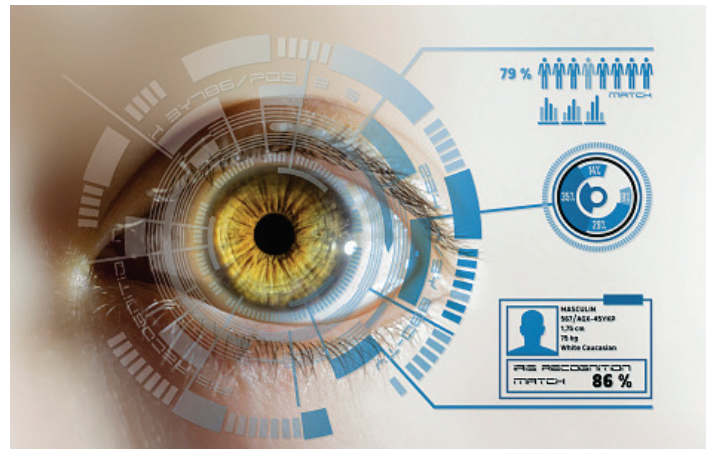
Coverage for BIPA-Related Lawsuits Continues to Be Litigated

By Jonathan Meer

The use of biometric information is becoming more frequent in our society. Whether it is logging on to your phone with your face or fingerprint, or shopping online with a virtual try-on tool, technology is enabling access to information that was not common a decade ago. With the sharing of a person's biometric information to facilitate this access, there is a growing concern as to what protections are available to safeguard that data. Currently, there are more privacy laws being enacted at the federal and state level. While there are many laws addressing biometric information, one of the most frequently cited is the Illinois Biometric Information Protection Act (BIPA). All the latest developments have led to more litigation and, in turn, more requests for coverage for the defense of these claims. Insurers are making decisions, consciously or not, as to whether they want or intend to afford coverage for these biometric privacy claims. This has prompted the filing of many coverage litigation suits. This is an evolving area of the law, as reflected in recent 2024 decisions.

There are several coverage disputes focused on not only whether the Commercial General Liability (CGL) policy's insuring agreement is triggered in the first instance but, more frequently, whether an exclusion is applicable precluding coverage for a lawsuit alleging a violation of biometric privacy. One recent decision on December 2, 2024, *Ohio Sec. Ins. Co. v. Wexford Home Corp.*, in the Appellate Court of Illinois, First District (1-23-2311), involved the court's interpretation of a policy's "Recording and Distribution of Material or Information In Violation of Law" exclusion. The *Ohio Security* case examined coverage for the underlying litigation, claiming that the insured violated BIPA through its biometric employee timekeeping policy by collecting and discussing its employees' biometric information without providing written notice, obtaining consent, or implementing any of the requisite guidelines regarding destroying, retaining, or disseminating the data to third parties. The court found that while the underlying complaint may involve "personal and advertising injury," the policy's recording and distribution exclusion was applicable. As part of the recording and distribution exclusion, the policy precludes coverage for

violations of "[a]ny federal, state or local statute, ordinance or regulation, other than the TCPA [Telephone Consumer Protection Act], CAN-SPAM Act or FCRA [Fair Credit Reporting Act] and their amendments and additions, that addresses, prohibits, or limits the printing, dissemination, disposal, collecting, recording, sending, transmitting, communicating or distribution of material or information."



The court in *Ohio Security* focused on what was distinguishable from *West Bend Mutual Insurance Co. v. Krishna Schaumburg Tan, Inc.*, 2021 IL 125978 (May 20, 2021), where the Illinois Supreme Court rejected the application of a similar, but not identical, exclusion to BIPA claims. The court found that the exclusion evaluated in *Krishna* included not only the TCPA and CAN-SPAM Act, "but also the FCRA and FACTA [Fair and Accurate Credit Transactions Act], which made it impossible to limit the exclusion to statutes regarding methods of communication." The court noted that the inclusion of laws such as FCRA and FACTA "protect a consumer's confidentiality in his or her financial freedom," which is different from the TCPA and CAN-SPAM, which protect "consumer's freedom from unwanted solicitation." In reasoning that BIPA "regulates the collection, dissemination, and disposal of one's biometric identifiers and information," and is closer to "protecting a consumer's confidentiality," the court reversed the lower court and held that the policy's recording and distribution exclusion precluded coverage.

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This decision follows another recent decision from the U.S. District Court for the Northern District of Illinois on August 5, 2024, *Westfield Insurance Co. v. UCAL Systems Inc. et al.*, case number 1:21-cv-03227, which held that the policy’s exclusion for recording and distribution of material or information of law “applies to violations of BIPA.” In granting summary judgment, the court focused on a similar “Recording and Distribution of Material or Information In Violation of Law Exclusion” which included catch-all language precluding “FCRA and their amendments and additions, that addresses, prohibits, or limits the printing, dissemination, disposal, collecting, recording, sending, transmitting, communicating or distribution of material or information.” The *Westfield* court not only distinguished *Krishna* based upon other Illinois state court decisions but also considered the Seventh Circuit decision in *Citizens Ins. Co. of Am. v. Wynndalco Enters., LLC*, 70 F.4th 987, 995 (7th Cir. 2023) (holding the underlying BIPA lawsuit fell within the coverage of the policy because a BIPA violation is a violation of privacy). In *Wynndalco*, the court evaluated a “Distribution of Material in Violation of Statutes Exclusion” which contained a “catchall provision that applied to personal and advertising injury arising out of ‘any other laws, statutes, ordinances, or regulations that address, prohibit or limit the printing, dissemination, disposal, collecting, recording, sending, transmitting, communicating or distribution of material information.’” In contrast, the court in *Westfield* found that an exclusion that includes “FCRA and their amendments” is materially distinguishable from the exclusion at issue in *Wynndalco*. Therefore, the court held “that the Recording and Distribution of Material or Information of Law Exclusion applies to violations of BIPA.”

Another recent decision in a matter before the U.S. District Court for the Northern District of Illinois involving coverage for a BIPA matter under a CGL policy examined a different exclusion for the violation of communication or information law. *Tri City Foods Inc. v. Commerce and Industry Insurance Co.*, 24 C 414 (N.D. ILL. Nov. 26, 2024). In the November 2024 decision, the court in *Tri City Foods* addressed whether the underlying lawsuit alleging a violation of BIPA related to the sharing of workers’ biometric information with a third-party vendor was considered a “publication” under the CGL policy’s insuring agreement for

personal or advertising injury. Regarding the violation of law exclusion, the court noted that the exclusion in this case was arguably broader than the exclusion in *Krishna*, but not as broad as the exclusion in *Westfield*. The court ruled that it “cannot say that the applicability of the Violation of Laws Exclusion to BIPA claims is ‘clear and free from doubt’ and that “at a minimum, there exists an ambiguity that must be resolved in the insured’s favor.”

AN EVOLVING AREA

These recent decisions in the past couple of months evaluating coverage for BIPA claims under CGL policies show that the issue continues to evolve, particularly in Illinois. *Ohio Security*, *Westfield*, and *Tri City Foods* all evaluate similar exclusions under a CGL policy, but the specific wording in each policy’s exclusion was determinative. This focus on the specific language found in an exclusion will continue to be scrutinized, as there are a number of other lawsuits currently pending involving coverage for biometric claims. They include disputes over employment-related practices exclusions, access or disclosure exclusions, expected or intended injury exclusions, right of privacy created by statute exclusions, and professional services exclusions. As such, the scope of coverage for BIPA claims will likely continue to be a heavily litigated area in 2025.

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A Warning to Carriers on the Risks of Undefined Terms in Policies

By Erik Tomberg and Spencer Hoisington

On December 13, 2024, the North Carolina Supreme Court issued a ruling in a business interruption coverage case that strayed from the national trend of courts finding in favor of insurance carriers following government-ordered business closures during the COVID-19 pandemic. Specifically, in *North State Deli, LLC, et al. v. The Cincinnati Ins. Co.*, the court concluded that loss of physical use of property – such as a restaurant – can constitute “direct physical loss” under property policies, paving the path to coverage for policyholders who are unable to access or otherwise use insured spaces. While the height of the pandemic may have passed, perhaps even more notable is the court’s striking emphasis on the “reasonable expectations of the policyholder” as the “lodestar” for insurance contract interpretation where terms are disputed, potentially tipping the scales in favor of policyholders – particularly where those terms are not expressly defined in the policy.

North State Deli v. The Cincinnati Ins. Co.

In *North State Deli, LLC, et al. v. The Cincinnati Ins. Co.*, No. 225PA21-2, 3 (N.C. Dec. 13, 2024), the plaintiffs were a collection of North Carolina restaurants that were forced to curtail or suspend business operations after then-Governor Roy Cooper and local municipalities issued orders imposing broad limitations on the use and operation of such establishments during the COVID-19 pandemic. The restaurants filed an action against their shared commercial property insurer, Cincinnati Insurance Company, seeking a declaratory judgment that gubernatorial, county, and municipal orders constitute covered perils that caused “direct physical loss” to their properties. The restaurants carried similar “all-risk” commercial property policies that protected the building and personal property, as well as business income, from any “direct physical loss” to property. Notably, the policies did not contain a virus or viral contamination exclusion.

After the trial court agreed with the restaurants, a unanimous panel at the North Carolina Court of Appeals reversed the order. However, on further appeal, the North Carolina Supreme Court ultimately reversed the Court of Appeals and agreed with the trial court, determining that the restaurants had successfully stated a claim for coverage due to “direct physical loss” to their insured spaces. The policies in question did not define “direct physical loss,” which proved fatal to Cincinnati’s position.



The North Carolina Supreme Court focused on the “contextual and common-sense expectation that insurance should protect from threats to property that make it unusable for the purpose for which it is insured.” Property “loss,” the court reasoned, “surely occurs when it is no longer usable for its insured purpose, *as a policyholder would reasonably expect.*” (emphasis added). Therefore, based on the “reasonable expectations” doctrine and the lack of clearly defined terms in the policy, the court concluded that “when the restaurants lost physical use of their properties as restaurants due to the pandemic orders, they experienced a direct physical loss.”

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Cato Corporation v. Zurich Am. Ins. Co.,

In the companion case of *Cato Corporation v. Zurich Am. Ins. Co.*, No. 353PA23 (N.C. Dec. 13, 2024), decided the same day, the North Carolina Supreme Court addressed a similar claim for coverage brought by a clothing retailer that alleged COVID-19 transformed and destroyed its property. In stark contrast to the policy in *North State Deli*, the *Cato* policy expressly excluded viral contamination as a covered cause of loss – which proved to be dispositive, as the court enforced the exclusion and affirmed the lower courts' rulings that dismissed the insured's declaratory judgment action. The *Cato* court implied it would have come to a different conclusion if the Zurich policy had not contained a detailed viral contamination exclusion, as "[the] parts of *Cato's* policy that grant coverage are functionally the same as the parts of *North State Deli's* policy that grant coverage." Thus, *Cato* is an example of how a well-defined exclusion carved out coverage for a claim that was otherwise subject to essentially the same policy language as *North State Deli*.

TAKEAWAYS

All that said, any executive orders and local regulations concerning COVID-19 are long expired, so what are the takeaways?

- In the short term, insurance carriers should check their pending claims in North Carolina to confirm whether they are impacted by the state's new interpretation of "direct physical loss," and confirm whether they have up-to-date provisions reflecting the changing landscape since the advent of the pandemic. Prudent carriers writing in North Carolina also should examine their current policies – particularly "all-risk" or "open-perils" policies – to check for language similar to that contained in the Cincinnati and Zurich policies, and take action to address future claims.
- Carriers that have sought to streamline their policies with fewer definitions should pay particularly close attention to the *North State Deli* court's admonishment that "[it] is the insurance company's responsibility to define essential policy terms...." (emphasis added). "Otherwise," the court observed, "insurance companies are licensed to pitch consumers on an expansive, 'all-risk' policy, while hiding behind a

narrower definition imposed by judicial fiat when it comes time to pay out. Such a setup contradicts our court's holdings that the lodestar for insurance contract interpretation is the reasonable expectation of the policyholder and that ambiguities should be resolved in the insured's favor."

- These sentiments should serve as a fair warning to carriers that if policy terms are left undefined, North Carolina courts are likely to lean toward an interpretation that the terms are ambiguous and therefore should favor the "reasonable expectations" of the policyholder, regardless of the carrier's rationale for employing the terms. Accordingly, carriers should consider reviewing their policy forms and reevaluating whether undefined terms they previously left to the dictionary to define should be clarified or expressly defined, even where they have been interpreted in a largely consistent manner across most jurisdictions.
- Arguably, the North Carolina Supreme Court's decision is at odds with its prior ruling in *Accardi v. Hartford Underwriters Insurance Co.*, 373 N.C. 292, 295, 838 S.E.2d 454, 457 (2020), where it held that "[ambiguity] is not established by the mere fact that the insured asserts an understanding of the policy that differs from that of the insurance company." One reading of *North State Deli* is that the court looked to the insured's expectations of coverage first as a means of establishing ambiguity, instead of the other way around. Either way, as *Cato* demonstrates, carriers are likely to be in a more favorable position when policy terms are clearly defined and articulated.

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Texas Supreme Court Provides Framework for Determining Whether an Excess Liability Policy Covers Defense Expenses

By Ashley Gilmore and Connor McKinney

On December 20, 2024, the Texas Supreme Court issued an interesting decision addressing whether an insured was entitled to coverage under its excess liability policy for legal expenses it incurred in defending an underlying suit. *Ohio Casualty Insurance Company v. Patterson-UTI Energy, Inc.*

BACKGROUND

The coverage dispute arose from a drilling rig incident that resulted in multiple lawsuits against the insured. The amounts paid for the defense and settlement of the lawsuits exhausted the limits of the insured's primary policy and lower-level excess policies. The insured then sought coverage under its higher-level excess policy. The excess insurer paid portions of the settlement amounts, but declined coverage for the defense amounts. Coverage litigation ensued.

The trial court granted summary judgment for the insured, finding coverage because the excess policy did not clearly and unambiguously exclude coverage for defense expenses. The intermediate court of appeals affirmed. In doing so, the intermediate appellate court reasoned that because the underlying policy covered defense expenses and the excess policy was a "follow form" policy that did not unambiguously exclude defense expenses, the excess policy necessarily provided coverage.

TEXAS SUPREME COURT ANALYSIS AND DECISION

The Texas Supreme Court began its analysis with what it characterized as a "cardinal principle" of insurance law dating back to 1886, which holds that the policy is the contract, and outside papers can be imported only if done "in so clear a manner as to leave no doubt of the intention of the parties." Pursuant to this authority, the supreme court instructed that the proper framework is to start with the text of the policy at issue, to refer to extrinsic documents only if the policy at issue clearly requires doing so, and then to refer to such extrinsic documents only to the extent of incorporation.

The supreme court emphasized that this same framework applies when addressing coverage under a follow-form excess policy and that the court of appeals improperly inverted this framework by starting with the underlying policy:

True ... it is expected that a contractual dispute about a follow-form excess policy will implicate the underlying policy. The extent of that implication, however, is not a binary choice but one that presents an array of options. The excess policy could adopt the underlying policy in its entirety; it could do so except for various express exclusions; or it could substantially change the scope of initial coverage by providing its own terms. Characterizing an excess policy as a "follow-form" policy, in other words, confirms only that the excess policy will *to some degree* incorporate the provisions of the underlying policy—the degree of incorporation is determined by the excess policy's text. At all times, the excess policy itself remains the contract that governs a dispute about its coverage. The court of appeals should have first "look[ed] to the excess policy to determine coverage" rather than "first examining the terms of the [underlying] policy." (alterations and emphasis in original).



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While the insured indicated that it agreed with this framework, it argued that because the underlying policy covered the defense expenses, the follow-form excess policy necessarily did as well. The underlying policy obligated the insurer to pay “ultimate net loss,” which was defined to include defense expenses. Relying on this definition, the insured asserted that a follow-form excess policy is bound by the underlying policy’s coverage choice unless it expressly repudiates that choice. The supreme court disagreed, reasoning that the insured’s argument “amounts to the approach we emphatically reject: starting with the underlying rather than the excess policy.”

Instead, starting with the excess policy, the supreme court explained that the excess policy’s insuring agreement did not use the term “ultimate net loss” from the underlying policy. Rather, the insuring agreement obligated the insurer to pay the amount of “loss” in excess of the “Underlying Limits of Insurance.” Thus, the excess policy covered the defense expenses only if those expenses constituted “loss,” which term was defined as sums actually paid in the settlement or satisfaction of a claim that the insured is legally obligated to pay as damages.

It was undisputed that the defense expenses were “actually paid” and that the insured was legally obligated to pay them via the engagement letter with its attorneys. However, the supreme court emphasized that “a party’s own attorney’s fees ‘are not, and have never been, damages.’” Recognizing that contracting parties may give “bespoke definitions to ordinary terms,” the supreme court explained that for the defense expenses to qualify as “loss,” the parties must have agreed by contract to give the term “damages” a specialized meaning. The court noted that the excess policy did not include any special definition of “damages” and that the context surrounding the use of the term “damages” suggested the usual definition, not one that included defense expenses. The supreme court reasoned that “because a party paying its own defense expenses would not do so ‘in the settlement or satisfaction of a claim’” (emphasis in original), this language must refer to sums that insured was obligated to pay to an adverse party such as the third-party claimant who was injured in the incident. The supreme court further explained that if the insured became obligated to pay the claimant’s attorney’s

fees, those fees could be covered. However, the excess policy did not cover the fees that the insured paid to its own attorneys.

The supreme court concluded that the insured could not sustain its burden to establish coverage for the defense expenses and, therefore, reversed the judgment of the court of appeals and rendered judgment for the insurer.

Takeaway: This ruling reinforces the principle that Texas courts are to look to the policy in question to determine coverage and that the scope of coverage under an excess policy is governed by the terms of the excess policy itself, even if it follows form to the underlying policy in some respects.

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New Missouri Supreme Court Case Outlines Mechanism for Insurers to Intervene and Seek a Stay of Underlying Tort Actions While Simultaneously Seeking a Declaration of Coverage Rights

By Daniel E. Tranen

Insurers operating in Missouri received an early Christmas present with the Missouri Supreme Court's December 2024 decision in *McCrackin v. Mullen*.¹ The court ruled in favor of Safeco Insurance Company's motion to intervene and stay an underlying tort action while the insurer sought a declaration of its rights under a homeowner's policy of insurance. This procedure was previously introduced in a Missouri appellate court decision in the 1980s but was challenged or otherwise ignored in subsequent Missouri decisions.² Until now, the Missouri Supreme Court has not weighed in on whether this was a viable action to be taken by an insurer.

In *McCrackin*, Mullen was sued in a wrongful death case filed by McCrackin on behalf of the decedent's estate for alleged criminal conduct in luring the decedent out of a pool hall and into the parking lot, ambushing him and participating in his killing. While Mullen was being criminally prosecuted, McCrackin sued him for damages. Safeco, Mullen's homeowner's insurer, denied coverage for the civil lawsuit based upon the intentional and criminal acts exclusion in the policy.

Thereafter, Safeco filed a declaratory judgment action seeking a declaration that it did not owe Mullen a defense or indemnity for his part in the alleged wrongful death of the decedent. Safeco then sought to intervene in the civil action for the sole purpose of staying it until its declaratory judgment action could be resolved. The motion to intervene was opposed and ultimately denied by the trial court. McCrackin eventually obtained a \$16.5 million civil judgment against Mullen.

Safeco appealed the trial court's decision denying its right to intervene. The Missouri Supreme Court held that Safeco was wrongfully denied this right because the insurance company had an interest in the outcome of the tort action involving its insured, even though Safeco had previously denied coverage for it. The Court pronounced, "Insurers with a good faith coverage question should file a declaratory action simultaneous with the underlying tort action and seek a stay of the tort action until the declaratory judgment action is resolved." The Missouri Supreme Court determined that because Safeco met the criteria for intervention as of right, for the purpose of seeking a stay, the trial court's decision to deny Safeco's motion to intervene constituted error.



¹ 2024 LEXIS (Mo. Banc. Dec. 23, 2024).

² See *State ex. Rel. Rimco, Inc. v. Dowd*, 858 S.W. 2d 357 (Mo. App 1993); *Lodigensky v. Am. States Preferred Ins. Co.*, 898 S.W.2d 661 (Mo. App 1995); and *Estate of Langhorn v. Laws*, 905 S.W.2d 908 (Mo. App 1995).

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IMPLICATIONS AND OPPORTUNITIES

This decision has broad implications for insurers in Missouri. Unlike many states, Missouri insurers often must make a very quick choice about whether to deny coverage altogether or control the defense without reserving their rights when coverage is tendered to them, oftentimes before the insurer may fully appreciate its coverage defenses or its insured's liability defenses. This is because, in Missouri, an insurer wishing to reserve its rights typically must do so without controlling the defense or using its choice of counsel since policyholders have the right to reject a "reservation of rights" defense.³ As a result, in many instances in Missouri, there is no middle ground for an insurer to both reserve its rights and control the defense, especially when dealing with sophisticated policyholders. Instead, insurers operating in Missouri routinely must give up their right to dispute coverage if they want to control the defense.

With this new decision, insurers in Missouri will have another option: disclaim if there is a basis to do so, and then file a simultaneous declaratory judgment action while seeking to stay the underlying action. If the insurer wins the coverage action, it can walk away from the underlying dispute before it even develops. If the insurer loses the coverage action, then it can control the defense (and likely the settlement) of the underlying dispute, once again, before it fully develops.

While seeking a declaratory judgment may increase the expense for insurers in some cases, by using this process, the insurer can now essentially determine its coverage rights, assuming it has a basis to dispute a duty to defend, without losing control of the defense of the underlying action should it turn out that the insurer is wrong regarding its coverage defenses. Taking the opportunity to stay the underlying case and litigate its coverage defenses may also present the insurer an opportunity to resolve the underlying case, with all parties understanding the risk that there may not be coverage (and therefore, may not be anything to gain in litigating the underlying dispute) should the insurer win. Thus, the upshot of this decision

may ultimately be an opportunity to increase settlements across the board in Missouri without litigation of the underlying dispute. This decision may also effectively save defense costs in some cases because insurers with strong coverage defenses will be able to stay the underlying case without incurring defense costs from independent counsel or risking the consequences of bad faith if the disclaimer is not well-taken.

For many years, Missouri has been considered a sort of "coverage wasteland." However, the tide may be turning for the better for insurers in the state following the *McCrackin* decision.

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³ See *Kinnaman-Carson v. Westport Ins. Group*, 283 S.W.3d 761 (Mo. 2009).

Useful Policy Language and Underwriting Practices for Cannabis Carriers

By Joshua N. Willis

Nearly all Americans live in a state where some form of cannabis is legal. Given that the cannabis industry is now valued in billions of dollars and has created hundreds of thousands of jobs across 39 of the 50 states, it requires the same range of insurance products that protect businesses in other sectors. As a result, many insurance carriers have begun issuing various types of insurance policies for different aspects of cannabis operations. For example, there are policies that insure cannabis dispensaries while still others insure manufacturing operations. Suffice it to say, each involves different risks that may require distinct types of policy language, security measures, and underwriting practices. This article discusses some recurring coverage and underwriting issues in connection with these policies.

SECURITY COMPLIANCE IN CANNABIS DISPENSARY POLICIES

A common question in connection with issuance of cannabis dispensary policies is whether the storage of on-site harvested cannabis or finished stock complies with the Locked Safe Warranty provision that most cannabis policies require. Policy language varies, but most require harvested plant material or stock to be stored in a secured cage, a safe, or a vault room.

The definitions and terms used within security safeguard warranties and exclusions in cannabis commercial property policies have evolved over the past few years to better align with insureds' business operations and should avoid ambiguity and unnecessary coverage disputes and litigation.

In this regard, examples of precise requirements for a compliant vault should include the following language:

- Located in an enclosed area constructed of steel and concrete with a single point of entry
- A minimum steel door thickness of one inch
- Continuously monitored by a central station alarm, motion sensors, and video surveillance
- A minimum of one-hour fire rating for all walls, floors, and ceilings
- Procedures that limit access to authorized personnel only.

Such detailed definitions are, needless to say, preferable over vague references to a "vault," "vault room," "safe," or "secured cage" in order to avoid any ambiguity argument at a later time. Thus, it is imperative that a carrier be as precise as possible when detailing the type of security required under dispensary policies.



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In addition, other common security safeguards required by the policy include specific requirements for what qualifies as a central station burglar alarm and the location of motion sensors and video surveillance equipment. Again, in this regard, it is imperative that language be as precise as possible to avoid coverage disputes later.

INSPECTIONS REQUIRED IN CANNABIS MANUFACTURING POLICIES TO AVOID FIRE RISK

As noted above, in addition to dispensary policies, there are many cannabis manufacturing policies that carry with them an entirely different risk than the foregoing, and therefore may require different underwriting requirements. Specifically, because such operations often use solvents and other substances that are highly flammable, it may be necessary to inspect such risks not only prior to the inception of the policy but also regularly throughout the policy term. Indeed, this will help ensure that an insured's operations comply with applicable law and are being conducted safely throughout the policy term. As a result, many carriers have incorporated rigorous inspection requirements, such as the foregoing, in connection with their cannabis manufacturing policies.

CONCLUSION

There are many opportunities for carriers to capitalize on the expanding cannabis market. In so doing, however, carriers should be precise in their policy language, as well as in their underwriting practices, in order to avoid later coverage disputes and minimize risk as much as possible.

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