Simpson Thacher

Insurance Law Alert

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"Extremely thorough, detailed, always well prepared when getting ready for trial, they knew every aspect of the record."

–*Chambers 2016*, quoting a client

Washington Supreme Court Rules That Insurance Fair Conduct Act Does Not Create Independent Cause Of Action

The Washington Supreme Court ruled that the Insurance Fair Conduct Act does not create an independent cause of action for regulatory violations. *Perez-Crisantos v. State Farm Fire & Cas. Co.*, 2017 WL 448991 (Wash. Feb. 2, 2017). (Click here for full article)

Maryland Court Of Appeals Rules That Insurer Failed To Establish Prejudice Resulting From Three-Year Notice Delay

Maryland's highest court ruled that an insurer was not entitled to disclaim coverage under a claims-made-and-reported policy, notwithstanding a nearly three-year delay in notice. *National Union Fire Ins. Co. of Pittsburgh, PA v. Fund for Animals*, 2017 WL 383453 (Md. Jan. 27, 2017). (Click here for full article)

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The New Jersey Supreme Court ruled that an anti-assignment clause does not preclude a post-loss transfer of insurance benefits. *Givaudan Fragrances Corp. v. Aetna Cas. & Sur. Co.*, 2017 WL 429476 (N.J. Feb. 1, 2017). (Click here for full article)

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The Tenth Circuit ruled that "other insurance" clauses in two policies cancel each other out and that losses should be apportioned on a pro rata basis. *Philadelphia Indem. Ins. Co. v. Lexington Ins. Co.*, 845 F.3d 1330 (10th Cir. 2017). (Click here for full article)

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The Oregon Supreme Court ruled that the term "recovery," as used in a state statute that imposes attorneys' fees against insurers under certain circumstances, does not require an actual monetary judgment against the insurer. *Long v. Farmers Ins. Co. of Oregon*, 2017 WL 445087 (Or. Feb. 2, 2017). (Click here for full article)

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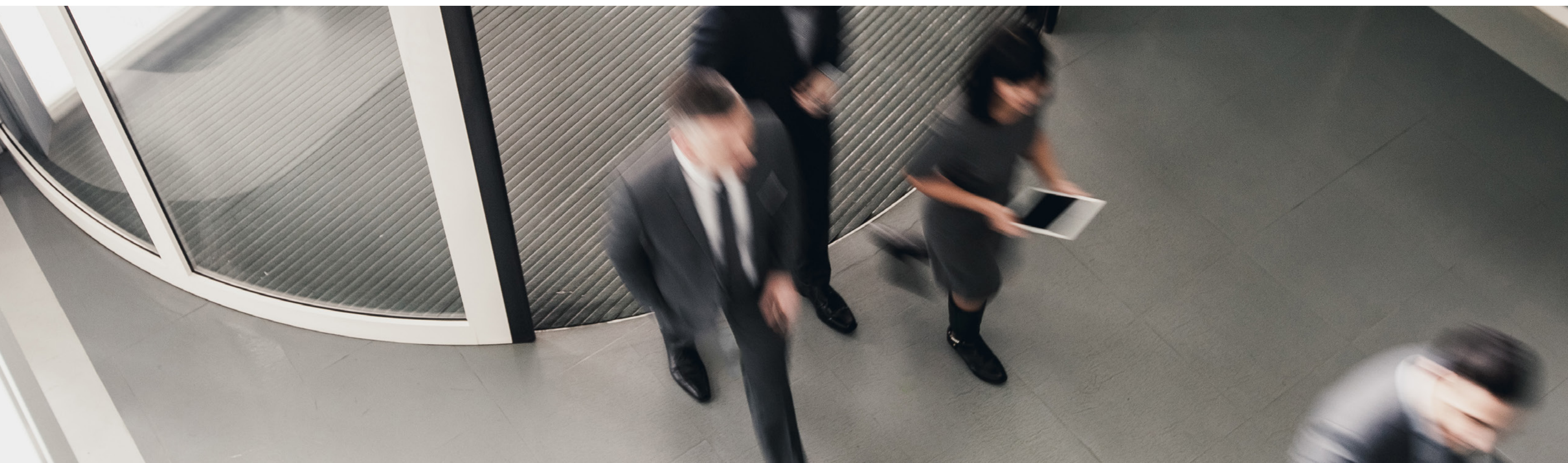

Duty To Defend Alert:

Rejecting Constructive Knowledge Claim, Ninth Circuit Says No Duty To Defend Without Tender

The Ninth Circuit ruled that absent formal tender, insurers had no duty to defend a policyholder in an underlying environmental contamination suit. In so ruling, the court rejected the policyholder's argument that a duty to defend was triggered by the insurers' constructive knowledge of the suit. *M.B.L., Inc. v. Federal Ins. Co.*, 2017 WL 128095 (9th Cir. Jan. 13, 2017).

MBL, a defunct dry cleaning company, was insured under policies issued by Federal, Great American and Utica. MBL argued that its failure to tender the suit to its insurers was not fatal to its coverage claim because the insurers had constructive knowledge of the suit. In particular, MBL contended that its previous tender of a potential administrative proceeding was sufficient to establish tender of the lawsuit. The court disagreed.

Each policy imposed a duty to defend any "suit" against MBL. Under California law, an administrative proceeding pursuant to environmental statutory law is not the equivalent of a "suit" for insurance coverage purposes. The court therefore reasoned that MBL's tender of the agency proceeding did not trigger a duty to defend the lawsuit. The court distinguished cases finding constructive tender, explaining that in those cases, the policyholder tendered a suit, but failed to "conform precisely to the required formalities," whereas here, there was no tender at all. The court also ruled that the insurers' receipt of notice from another insurer (seeking contribution) did not establish constructive tender. Finally, the court noted that MBL received a full defense from two other insurers and that California statutory law (Cal. Civ. Code § 2860(c)) forecloses MBL from seeking additional defense costs from Appellees.

Reservation Of Rights Alert:

South Carolina Supreme Court Addresses Effectiveness Of Reservation Of Rights And Coverage For Punitive Damages

The South Carolina Supreme Court ruled that an insurer's reservation of rights was ineffective and that the policy provides coverage for punitive damages. *Harleysville Grp. Ins. v. Heritage Comtys., Inc.*, No. 2013-001281 (S.C. Jan. 11, 2017).

Harleysville provided a defense to Heritage under a reservation of rights in underlying construction defect litigation. After verdicts were entered against Heritage in those suits, Harleysville filed a declaratory judgment action, alleging that it had no duty to indemnify Heritage. Alternatively, Harleysville sought apportionment of the underlying judgments. A Special Referee ruled that coverage was triggered because the juries' general verdicts included some covered damages. The Referee further held that it would be improper and speculative to allocate the general verdicts between covered and non-covered damages. Therefore, he ordered full payment of the damages, but limited Harleysville's obligation to its pro rata time on the risk. Lastly, the referee ruled that punitive damages are covered by the policies. The South Carolina Supreme Court affirmed.

The court ruled that Harleysville failed to properly reserve the right to contest coverage by sending generic denials of coverage, coupled with "a verbatim recitation of all or most of the policy provisions." The court

held that a valid reservation must explain the insurer's position as to the policy provisions invoked therein. Here, the reservation letters failed to advise Heritage of the need for allocation between covered and non-covered losses, Harleysville's intent to dispute "occurrence" and policy period issues, or a potential conflict of interest, among other things. The court also rejected Harleysville's reliance on oral reservations, explaining that even assuming that oral reservations are permitted in South Carolina, the statements at issue fell short of the specificity required. However, the court ruled that the reservation of rights was sufficient with respect to one issue – punitive damages – for which a detailed basis for denial was provided.

Nevertheless, the court ruled that the policy covers punitive damages because it does not expressly limit coverage to actual or compensatory damages. The court explained that punitive damages may be awarded in South Carolina for gross negligence and that the record did not establish a finding of an intent to cause harm.

Finally, the court ruled that punitive damages are not subject to pro rata time-on-the-risk allocation, notwithstanding the availability of pro rata allocation for actual damages. The court reasoned that time-on-the-risk allocation "was developed as a means of apportioning actual, compensatory damages where the injury progressed over time." Therefore, the "logic and policy considerations underlying the time-on-the-risk method may not as easily lend themselves to the application of this concept to punitive damages." Notably, the court declined to establish a bright-line rule in this context and expressly limited its holding to the facts presented.

Bad Faith Alert:

Washington Supreme Court Rules That Insurance Fair Conduct Act Does Not Create Independent Cause Of Action

Resolving a conflict among lower courts, the Washington Supreme Court ruled that the Insurance Fair Conduct Act ("IFCA") does not create an independent cause of action for regulatory violations. *Perez-Crisantos v. State Farm Fire & Cas. Co.*, 2017 WL 448991 (Wash. Feb. 2, 2017).

Perez-Crisantos sought coverage from State Farm for injuries sustained in a car accident. State Farm agreed to pay the limits of his personal injury coverage, as well as $400 for lost wages, but denied his claim for underinsured motorist coverage. Perez-Crisantos sued State Farm alleging violations of the IFCA and Consumer Protection Act. The action was stayed pending arbitration of the claims. After an arbitration panel awarded Perez-Crisantos another $24,000, he amended his complaint against State Farm to clarify that the basis for his IFCA claim was State Farm's alleged violation of a Washington Administrative Code provision that prohibits insurers from forcing first-party policyholders to litigate to recover "amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in such actions." WAC 284-30-330(7). A Washington trial court dismissed the claims. The Washington Supreme Court granted direct review and affirmed.

The IFCA provides a cause of action against insurers who unreasonably deny coverage and permits courts to award attorneys' fees or treble damages under certain circumstances.

RCW 48.30.015. Addressing a matter of first impression, the Washington Supreme Court ruled that the IFCA does not create a new and independent private right of action for violations of state regulations in the absence of an unreasonable denial of coverage. Although the court deemed the statutory language ambiguous, it concluded that legislative history did not evidence an intent to create a private cause of action for regulatory violations.

Late Notice Alert:

Maryland Court Of Appeals Rules That Insurer Failed To Establish Prejudice Resulting From Three-Year Notice Delay

Our February 2016 Alert discussed a Maryland appellate court decision holding that an insurer was not entitled to disclaim coverage under a claims-made-and-reported policy, notwithstanding a nearly three-year delay in notice. *Fund for Animals, Inc. v. National Union Fire Ins. Co. of Pittsburgh, PA*, 2016 WL 385222 (Md. Ct. Spec. App. Feb. 1, 2016). Last month, the Maryland Court of Appeals affirmed. *National Union Fire Ins. Co. of Pittsburgh, PA v. Fund for Animals*, 2017 WL 383453 (Md. Jan. 27, 2017).

In 2000, the Fund for Animals sued Feld Entertainment, Inc., a circus operator, alleging violations of the Endangered Species Act (the "ESA Case"). In 2007, Feld filed a separate action against the Fund, alleging RICO violations in connection with the Fund's prosecution of the ESA Case. Feld asserted that the Fund bribed individuals to testify falsely and committed other criminal acts for the purposes of establishing standing in the ESA Case. The RICO suit was stayed pending resolution of the ESA Case and was ultimately settled.

Nearly three years after the RICO action was brought, the Fund sought coverage from National Union under a 2007 claims-made-and-reported policy. By that time, a court had ruled against the Fund in the ESA Case and had made numerous factual findings detrimental to the Fund. National Union denied coverage based on late notice. The coverage dispute went to trial, and at the close of evidence, the court granted National Union's motion for judgment, finding that it had met its prejudice burden. (Maryland statutory law requires an insurer to establish actual prejudice by a preponderance of the evidence in order to deny coverage based on late notice under a claims-made policy. *See* Ins. Sec. 19-110). The appellate court reversed, finding that National Union failed to establish a causal link between the delay and any prejudice. The Court of Appeals affirmed.

The Court of Appeals stated that "the mere passage of time is not enough to establish actual prejudice." Rather, National Union is required to establish that "actual harm … resulted from the delay in receiving notice of the RICO claim." The court held that National Union failed to meet this burden. The court explained that National Union did not prove that, had it been given timely notice of the RICO case earlier, it would have taken some action that would have affected the outcome in that case (*e.g.*, that it would have settled for a sum less than the actual settlement). The court emphasized that National Union did not insure any defendant in the ESA Case and thus had no contractual right to control any aspect of that litigation. In this respect, the case is distinguishable from cases in which an insurer is not provided notice until after a judgment has been issued against the policyholder in an underlying suit in which the insurer could have controlled the defense. Under such circumstances, an insurer would presumably be prejudiced by the delay due to its inability to investigate claims and control the defense.

Assignment Alert:

New Jersey Supreme Court Rules That Anti-Assignment Clause Does Not Bar Post-Loss Assignments

Joining a growing majority of jurisdictions, the New Jersey Supreme Court ruled that an anti-assignment clause does not preclude a post-loss transfer of insurance benefits. *Givaudan Fragrances Corp. v. Aetna Cas. & Sur. Co.*, 2017 WL 429476 (N.J. Feb. 1, 2017).

Givaudan Fragrances ("GF") sought coverage under various liability policies for environmental contamination claims. Insurers denied coverage on the basis that GF was not a named insured, and that any purported assignment of policy benefits to GF was invalid because consent was not given. In ensuing litigation, a New Jersey trial court ruled in the insurers' favor. An appellate court reversed, reasoning that the transfer was valid because the covered loss had already occurred and the insurers' risk was therefore unchanged. *See* September 2015 Alert. The New Jersey Supreme Court affirmed.

The New Jersey Supreme Court stated: "We hold that, once an insured loss has occurred, an anti-assignment clause in an occurrence policy may not provide a basis for an insurer's declination of coverage based on the insured's assignment of the right to invoke policy coverage for that loss." The court further held that it is not necessary for the claims to be reduced to a judgment, reasoning that "the relevant event giving rise to coverage is the loss event, not the entry of a judgment fixing the amount of damage for that loss."

Rescission Alert:

Insurer Did Not Waive Right To Rescind Based On Misrepresentations, Says Third Circuit

The Third Circuit ruled that an insurer did not waive its right to rescind a policy based on the policyholder's material misrepresentations in the application. *H.J. Heinz Co. v. Starr Surplus Lines Ins. Co.*, 2017 WL 108006 (3d Cir. Jan. 11, 2017).

Starr issued a product contamination policy to Heinz. The policy application posed two questions pertaining to complaints or recalls of Heinz products. Heinz responded "no" to one of the questions, and left the other blank, but attached a loss history spreadsheet. After the policy incepted, Heinz notified Starr of a contamination claim. During its investigation of the claim, Starr discovered that Heinz had incurred a loss in excess of $10 million in connection with baby food contamination and reserved its right to limit or deny coverage. Heinz sued, alleging breach of contract and bad faith. Starr counterclaimed for rescission. A jury found that Heinz made material misrepresentations in its application, but that Starr waived its right to assert rescission. A Pennsylvania federal district court agreed with the jury on the misrepresentation issue, but disagreed with the waiver finding. The district court declared the policy void. The Third Circuit affirmed, rejecting three arguments asserted by Heinz on appeal.

First, the court rejected the notion that by invoking the policy's choice-of-law clause, Starr had essentially ratified the policy. Heinz argued that Starr was not entitled to assert that the policy should be rescinded as if it never existed while seeking to enforce its choice-of-law provision. The court explained that the choice-of-law provision itself refutes that argument because it explicitly states that the "validity … of this Policy will be governed" by New York law, indicating that the choice-of-law provision can be invoked to determine the validity of the policy in the first place. Second, the Third Circuit rejected Heinz's contention that the district court improperly applied a preponderance of the evidence burden of proof on Starr's rescission claim. According to Heinz, New York law requires the elements of rescission to be established by clear and convincing evidence.

Without deciding the issue, the Third Circuit ruled that the factual evidence satisfied both standards. Finally, the court rejected the assertion that Starr waived its right to assert rescission based on its knowledge of Heinz's misrepresentations. Heinz argued that email communications suggested that Starr knew of Heinz's prior losses. The Third Circuit affirmed the district court's finding that "[t]hese items, without more, would not trigger a reasonably prudent insurer to follow-up further." The court also rejected the contention that Starr failed to assert rescission promptly after learning of the misrepresentations, reasoning that a five-month period of investigation preceding the rescission claim was reasonable.

Allocation Alerts:

Rhode Island Supreme Court Rejects Application Of Stacking Statute In Underinsured Motorist Case

The Rhode Island Supreme Court ruled that a statute that allows stacking of underinsured motorist benefits for policies issued by "the same insurance company" does not apply where policies are issued by insurance companies owned by the same parent company. *Progressive Cas. Ins. Co. v. Dias*, 2017 WL 66148 (R.I. Jan. 6, 2017).

Dias was involved in an accident while riding a motorcycle. He settled his personal injury claim against the tortfeasor's automobile insurer. Because that settlement did not fully compensate his injuries, Dias subsequently filed and settled an uninsured-motorist claim against Progressive Northern, which covered the motorcycle. Seeking additional coverage, Dias also filed suit against Progressive Casualty, which insured the automobiles owned by Dias and his wife. Progressive Casualty denied coverage based on an "owned-but-not-insured" clause. Dias did not contest the applicability of the provision, but argued that it was preempted by R.I. Gen. Laws. §27-7-2.1(i). Section 27-7-2.1(i) states that when an insured has multiple uninsured/underinsured policies "with the same insurance company, the insured shall be permitted to collect up to the aggregate amount of coverage for all the vehicles insured, regardless of any language in the policy to the contrary." Dias contended that this provision entitles him to stack the limits of the Progressive Northern and Progressive Casualty policies. The court disagreed.

The court ruled that Progressive Northern and Progressive Casualty are not "the same insurance company," although both companies are wholly-owned subsidiaries of the same parent (The Progressive Corporation). Dias argued that stacking should nonetheless be permitted based on the reasonable expectations doctrine. He argued that a policyholder would reasonably believe that the two insurers are the same company based on the following facts: they use the same claims manual, they advertise under the same Progressive brand, they employ some of the same individuals, and they list the same telephone number and website on their policies. Rejecting this argument, the court explained that the reasonable expectations doctrine applies only to interpreting insurance policies, not to statutory language. In any event, the court concluded that the phrase "the same insurance company" is clear and unambiguous.

Finding "Other Insurance" Clauses Mutually Repugnant, Tenth Circuit Applies Pro Rata Allocation

The Tenth Circuit ruled that "other insurance" clauses in two policies cancel each other out and that losses should be apportioned on a pro rata basis. *Philadelphia Indem. Ins. Co. v. Lexington Ins. Co.*, 845 F.3d 1330 (10th Cir. 2017).

A school building that suffered fire damage was insured by both Philadelphia Indemnity and Lexington. Philadelphia issued a policy to

a charter school that was leasing the building, and Lexington issued a policy to the school district, the lessor. The insurers disputed their respective responsibilities to indemnify the loss. An Oklahoma federal district court ruled that the identical "other insurance" provisions in the policies were "mutually defeating" and that the loss should be apportioned on a pro rata basis according to policy limits. The Tenth Circuit affirmed.

The Tenth Circuit ruled that under Oklahoma law, "their respective excess-coverage clauses cancel each other out and that their identical pro rata clauses require the two insurers [to] share the loss." Lexington argued that the clause-cancellation rule does not apply because each insurer covered a different named insured. The court disagreed, explaining that both policies protect the same building against the same risk of fire damage. The court also rejected Lexington's argument that the lease agreement between the charter school and the district (which required the school to procure property insurance) makes Philadelphia the primary insurer. The court reasoned that it is the insurance policies, not the lease, that control loss apportionment. Finally, the court dismissed Lexington's assertion that Philadelphia is the primary insurer because its policy is "more specific to the risk." Lexington noted that Philadelphia's policy covered only the damaged building, whereas Lexington's "blanket" policy covered more than 100 sites owned by the district. Noting a lack of Oklahoma authority for this argument, the court deemed this fact irrelevant to the allocation analysis governed by the "other insurance" clauses.

Arbitration Alert:

Second Circuit Declines To Vacate Arbitration Awards Based On Umpire's Evident Partiality

Affirming a New York federal district court decision, the Second Circuit ruled that an umpire-arbitrator did not demonstrate "evident partiality" requiring vacatur of the awards. *National Indem. Co. v. IRB Brasil Reseguros S.A.*, 2017 WL 421944 (2d Cir. Jan. 31, 2017).

In this reinsurance arbitration, IRB petitioned to vacate certain arbitration awards issued against it on the basis of arbitrator partiality. IRB argued that the umpire was not impartial because (1) he refused to withdraw after IRB objected to his service as a party-arbitrator in another matter on behalf of Equitas, an entity that IRB claims is effectively identical to National Indemnity; and (2) he accepted an appointment as Equitas' party-arbitrator in a second arbitration while the present arbitrations were pending. The district court disagreed and granted National Indemnity's petition to confirm the awards. The Second Circuit affirmed.

Under the Convention on the Recognition and Enforcement of Foreign Arbitral Awards, a court must confirm an award unless it finds a ground for refusal specified in the Federal Arbitration Act. The FAA permits vacatur of an award "where there was evident partiality or corruption in the arbitrators." The court reasoned that the umpire's work as a party arbitrator on behalf of Equitas does not amount to "evident partiality." Even assuming that Equitas and National Indemnity are corporate affiliates, the court held that this relationship standing alone is insufficient to establish partiality. The court also noted that the umpire was not alleged to have any personal or business relationship with National Union or Equitas. Finally, the court emphasized that the umpire had ultimately voted against Equitas in the other arbitration and has also accepted arbitrator appointments "against" National Indemnity-reinsured parties, like Equitas.

Statutory Alert:

Oregon Supreme Court Rules That "Recovery" In Attorneys' Fees Statute Does Not Require Adverse Judgment Against Insurer

The Oregon Supreme Court ruled that the term "recovery," as used in a state statute that imposes attorneys' fees against insurers under certain circumstances, does not require an actual monetary judgment against the insurer. Rather, an insurer's voluntary payments satisfy the "recovery" requirement of the statute. *Long v. Farmers Ins. Co. of Oregon*, 2017 WL 445087 (Or. Feb. 2, 2017).

Farmers made several payments to a homeowner for damage caused by a water leak. The homeowner sued, alleging that her losses exceeded Farmers' payments and that Farmers failed to submit to an appraisal process. The court ordered an appraisal, after which Farmers made two additional payments. Following a trial, the homeowner petitioned for attorneys' fees under ORS 742.016, which provides that

> if settlement is not made within six months from the date proof of loss is filed with an insurer and an action is brought … and the plaintiff's recovery exceeds the amount of any tender made by the defendant in such action, a reasonable amount to be fixed by the court as attorney fees shall be taxed as part of the costs of the action.

The parties disputed the meaning of "recovery" in the statute. The homeowner argued that the term refers to "any kind of restoration of a loss, including a voluntary payment," whereas Farmers argued that it is limited to money judgments in a civil action. The court deemed the provision ambiguous and concluded that legislative history and overall statutory language indicated an intent to encompass voluntary payments as part of "recovery." In particular, the court noted that "recovery" has not been limited to monetary judgments in other statutory contexts and that the compensatory purposes of the statute would be furthered by an interpretation that includes voluntary payments as "recovery." In so ruling, the court explained: "the insured received a sum from the insurer that exceeded any amount timely tendered, a result that indicates that, at least in some practical sense, the insured prevailed in the action." However, the court emphasized that a declaration of coverage is insufficient to trigger ORS 742.061; a policyholder must also obtain a monetary recovery after filing an action, although that recovery need not be a formal judgment.

STB News Alerts:

Simpson Thacher received the National Insurance Practice of the Year Award at Euromoney's *Benchmark Litigation* 2017 Awards Dinner for the fifth consecutive year. In addition, Mary Beth Forshaw was shortlisted for the Insurance Lawyer of the Year Award.

Deborah Stein and Karen Cestari co-authored "Conflicts of Interest, Independent Counsel, and Control of the Insured's Defense." The article, featured in the *Winter 2016 Edition of New Appleman on Insurance: Current Critical Issues in Insurance Law*, discusses the complex issues that may give rise to an insured's right to independent counsel in underlying litigation.

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Simpson Thacher has been an international leader in the practice of insurance and reinsurance law for more than a quarter of a century. Our insurance litigation team practices worldwide.

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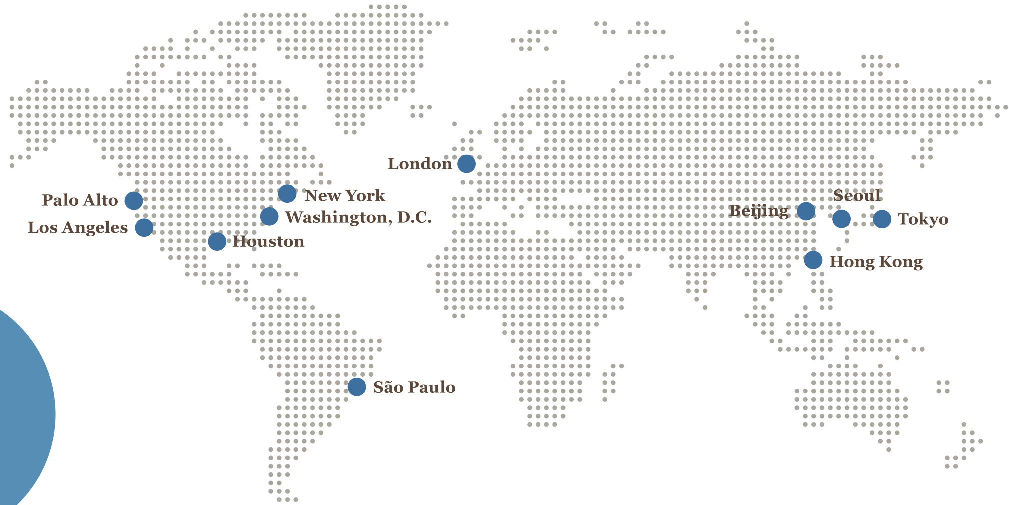

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