Simpson Thacher

Insurance Law Alert

May 2019

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Reversing Trial Court, Illinois Appellate Court Rules That Asbestos-Related Claims Do Not Arise From A Single Occurrence Under Liability Policies

An Illinois appellate court ruled that bodily injury claims arising out of asbestos exposure arose out of multiple occurrences based on location and nature of exposure, rather than a single occurrence based on the manufacture of an allegedly defective product. *Continental Casualty Co. v. Hennessy Indus., Inc.*, 2019 WL 1803101 (Ill. Ct. App. Apr. 23, 2019). (Click here for full article)

Cyber Coverage Claims Dismissed In Part By New Jersey Court

A New Jersey federal district court granted part of an insurer's motion to dismiss claims arising out of a denial of coverage for cyber fraud losses under a crime protection policy. *Children's Place, Inc. v. Great American Ins. Co.*, 2019 WL 1857118 (D.N.J. Apr. 25, 2019). (Click here for full article)

New York Court Deems Insured v. Insured Exclusion Ambiguous As To Creditor Trust

A New York court ruled that an insured v. insured exclusion in an excess D&O policy was ambiguous as to whether it applied to claims brought by a creditor trust and therefore did not bar coverage. *Westchester Fire Ins. Co. v. Schorsch*, 2019 WL 1901372 (N.Y. Sup. Ct. N.Y. Cnty. Apr. 29, 2019). (Click here for full article)

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"[Simpson Thacher] is one of the preeminent and most sophisticated coverage litigation firms."

– *Chambers USA* 2019 (quoting a client)

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The Second Circuit affirmed a New York district court decision dismissing coverage claims based on late notice, finding that the insurers did not waive their right to disclaim coverage on that basis. *New York State Electric & Gas Corp. v. Century Indem. Co.*, 2019 WL 1817781 (2d Cir. Apr. 25, 2019). (Click here for full article)

Iowa Supreme Court Rules That Bad Faith Claims Are Not Viable Against Third-Party Claims Administrator

The Iowa Supreme Court held that a common law cause of action for bad faith failure to pay workers' compensation benefits is not actionable against a third-party claims administrator. *De Dios v. Indem. Ins. Co. of N. Am.*, 2019 WL 2063289 (Iowa May 10, 2019). (Click here for full article)

Policyholder Entitled To Appoint Independent Counsel At Insurer's Expense, Says Illinois Appellate Court

An Illinois appellate court ruled that an insured was entitled to retain independent counsel rather than use insurer-appointed counsel based on a conflict of interest arising out of a punitive damages claim. *Xtreme Protection Servs., LLC v. Steadfast Ins. Co.*, 2019 WL 1976482 (Ill. Ct. App. May 3, 2019). (Click here for full article)

Florida Appellate Court Rules That Insurer's Post-Suit Payment Of Appraisal Award Constitutes Confession Of Improper Coverage Denial

A Florida appellate court ruled that an insurer's post-suit payment of an appraisal award constitutes a confession that it incorrectly denied benefits and that such conduct raised an issue of fact as to the insurer's bad faith. *Bryant v. GeoVera Specialty Ins. Co.*, 2019 WL 2017972 (Fla. Ct. App. May 8, 2019). (Click here for full article)

Fifth Circuit Enforces Arbitration Clause Notwithstanding State Law Banning Arbitration Of Insurance Disputes

The Fifth Circuit ruled that an arbitration clause was enforceable notwithstanding a state statute banning arbitration of insurance disputes and a "conformity to statute" clause in the insurance policy. *McDonnel Grp., LLC v. Great Lakes Ins. SE,* 2019 WL 2082905 (5th Cir. May 13, 2019). (Click here for full article)

STB News Alerts

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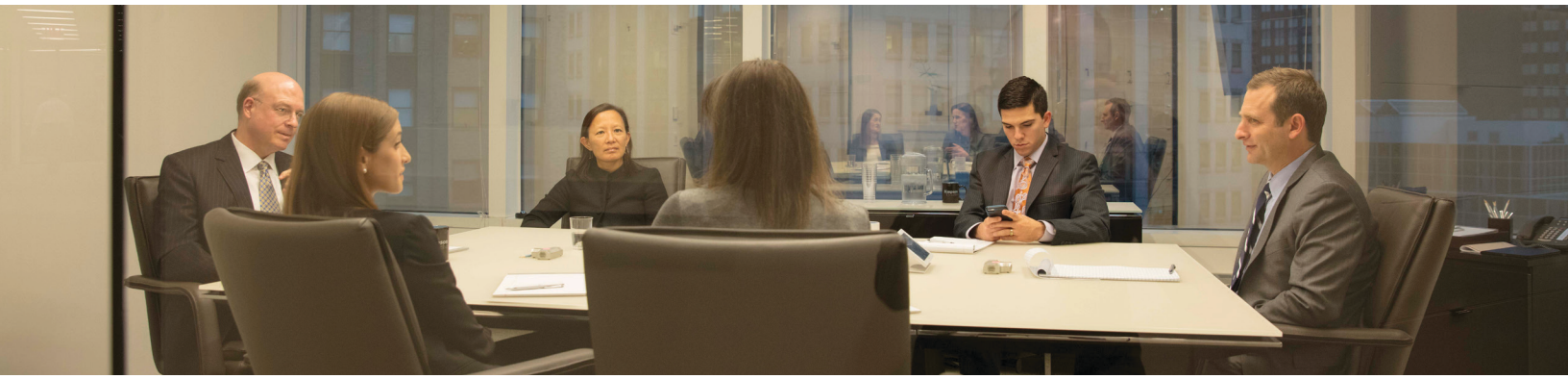


Number Of Occurrences Alerts:

Sixth Circuit Rules That Three Harassment And Assault Claims Arise Out Of A Single Occurrence

Reversing an Ohio district court decision, the Sixth Circuit ruled that sexual assault and harassment claims by three women against a co-worker arose out of the single occurrence of negligent hiring and supervision. *Scott Fetzer Co. v. Zurich American Ins. Co.*, 2019 WL 1925550 (6th Cir. Apr. 30, 2019).

Three women sued Fetzer, a vacuum manufacturer, and a Fetzer employee, alleging that he harassed and assaulted them and that Fetzer negligently hired and supervised him. After the parties settled the suit, Fetzer sought reimbursement from Zurich under general liability policies. The policies provided $2 million of coverage per occurrence, with a $1 million per-occurrence deductible. Of the three settlements, only one exceeded the per-occurrence deductible. Zurich paid the amount in excess of the deductible but refused to pay anything for the other two settlements. In ensuing litigation, the parties disputed whether the underlying claims arose out of a single occurrence or multiple occurrences. An Ohio district court found that the claims alleged multiple occurrences.

The Sixth Circuit reversed, finding that "occurrence" was subject to more than one reasonable interpretation in this context. The court explained that while "occurrence" could refer to the separate acts of assault against each woman, it could also refer to Fetzer's overall negligent supervision. Construing this ambiguity in Fetzer's favor, the court held that the operative occurrence was the company's negligent supervision. In doing so, the court noted that Ohio's cause-oriented approach to number-of-occurrence disputes support this result. The court explained that although three women incurred separate injuries as a result of the alleged harassment, their injuries arose from one proximate cause.

Reversing Trial Court, Illinois Appellate Court Rules That Asbestos-Related Claims Do Not Arise From A Single Occurrence Under Liability Policies

An Illinois appellate court ruled that bodily injury claims arising out of asbestos exposure arose out of multiple occurrences based on location and nature of exposure, rather than a single occurrence based on the manufacture of an allegedly defective product. *Continental Casualty Co. v. Hennessy Indus., Inc.*, 2019 WL 1803101 (Ill. Ct. App. Apr. 23, 2019).

Ammco, a brake equipment manufacturer, was sued in numerous personal injury asbestos suits. Ammco's insurers sought a declaration as to several coverage issues, including the number of occurrences for purposes of determining the limits of liability under the policies. An Illinois trial court ruled in the insurers' favor, finding that the continuous manufacture of allegedly defective products constituted a single occurrence. The appellate court reversed.

The appellate court ruled that the underlying asbestos claims should be grouped by location such that each location constitutes a separate occurrence. The court relied on "premises language" in the policies' definition of "occurrence," which states that "all such exposure to substantially the same general conditions existing at or emanating from each premises location shall be deemed one occurrence."

The court declined to apply a "cause test" for determining the number of occurrences, explaining that the cause-based analysis is appropriate only when the terms of the policy do not otherwise clarify the number-of-occurrences issue. Such an analysis was not appropriate, the court reasoned,

because "the premises language clearly requires the bundling of claims that arise from substantially the same conditions at the same location."

Cyber Coverage Alert:

Cyber Coverage Claims Dismissed In Part By New Jersey Court

A New Jersey federal district court granted part of an insurer's motion to dismiss claims arising out of a denial of coverage for cyber fraud losses under a crime protection policy. *Children's Place, Inc. v. Great American Ins. Co.*, 2019 WL 1857118 (D.N.J. Apr. 25, 2019).

The Children's Place, Inc. ("TCP") discovered two payments totaling nearly $1 million made to an unauthorized third-party hacker. According to the complaint, the hacker allegedly falsified email domain names to appear identical to those of individuals employed by a vendor of TCP. Additionally, the hacker allegedly intercepted emails between TCP and the vendor and altered payment instructions in order to direct payments to the hacker's account. TCP sought coverage under three provisions of a crime protection policy: (1) Computer Fraud; (2) Forgery or Alteration; and (3) Fraudulently Induced Transfers. The insurer denied coverage and, in ensuing litigation, moved to dismiss TCP's breach of contract and declaratory judgment claims.

The court refused to dismiss the claims for coverage under the Computer Fraud provision, finding that the complaint alleged facts sufficient to state a claim for relief. The policy defines Computer Fraud as "the use of any computer . . . to gain direct access to [TCP's] computer system." The court held that a viable claim for Computer Fraud coverage existed because the complaint alleged that the hacker accessed the vendor's email system and intercepted emails between TCP and the vendor. The insurer argued that a valid claim was not alleged because the complaint alleged access to the vendor's emails, not TCP's computer system. Rejecting this argument, the court reasoned that by improperly accessing the vendor's email system, the hackers effectively gained access to TCP's computers as well, noting that "an email system that does not send the messages to the intended recipient is no longer under the control of the sender." The court also rejected the insurer's causation argument (*i.e.,* that the loss of funds was caused by the actions of TCP employees in effectuating the transfer rather than the hacker's computer fraud). The court explained that at the dismissal stage, it was obligated to accept as true TCP's allegation that loss was a "direct result" of the hacker's access to the computer system.

However, the court granted the insurer's motion to dismiss claims seeking coverage under the Forgery or Alteration and the Fraudulently Induced Transfers provisions. The policy defines Forgery or Alteration as "loss resulting directly from forgery or alteration of checks, drafts, promissory notes, or similar written promises, orders, or directions to pay a sum certain in money." The court noted that the complaint failed to allege that any forged materials referenced "a sum certain in money."

In dismissing the claims seeking coverage under the Fraudulently Induced Transfers provision, the court explained that TCP had failed to allege that it verified the authenticity and accuracy of the payment instructions, a condition precedent to coverage. The court granted leave to amend these claims within thirty days.

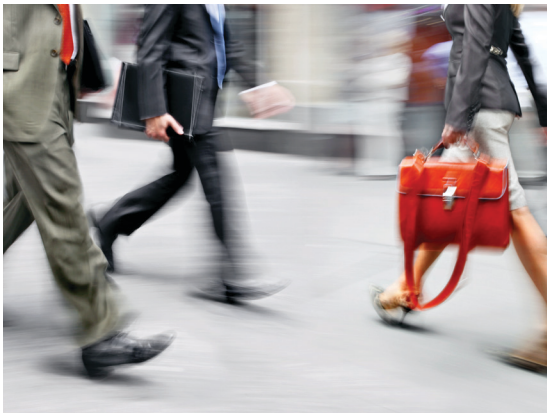
Approximately a dozen courts have addressed coverage for cyber-related losses presented under similar Computer Fraud provisions. Many of those cases arose out of a wire transfer initiated by a fraudulent email sent by third-party hackers impersonating a bank, vendor or other entity with whom the policyholder regularly communicates. Outcomes have turned largely on courts' interpretation of the terms "use" (as in "use of a computer") and "directly" (as in whether there is causation between the fraudulent activity and the policyholder's loss) as applied to the facts at issue. In some cases, the determinative issue was whether there was "unauthorized entry" into the policyholder's computer system, a requirement that has been deemed unfulfilled where the policyholder's employees effectuated a transfer (even if at the instruction of a hacker/impersonator).

D&O Alerts:

New York Court Deems Insured v. Insured Exclusion Ambiguous As To Creditor Trust

A New York court ruled that an insured v. insured exclusion in an excess D&O policy was ambiguous as to whether it applied to claims brought by a creditor trust and therefore did not bar coverage. *Westchester Fire Ins. Co. v. Schorsch*, 2019 WL 1901372 (N.Y. Sup. Ct. N.Y. Cnty. Apr. 29, 2019).

Westchester Fire Insurance Company, a seventh-level excess insurer of RCAP Holdings, LLC, sought dismissal of coverage claims based on an insured v. insured exclusion. The exclusion bars coverage for claims brought by one insured against another under the policy. However, an exception to the exclusion applies to claims brought by a bankruptcy trustee or examiner, receiver, conservator, liquidator "or other comparable authority." The parties disputed whether a creditor trust, established pursuant to a restructuring agreement in connection with RCAP's bankruptcy proceedings, falls within the scope of "other comparable authority."



Westchester argued that the exclusion barred claims brought by a creditor trust established to gather and distribute creditor assets under the supervision of a three-member board, because such a trust is not "substantively independent and disinterested in the same way that a bankruptcy trustee or similar entity is and, consequently, is not a comparable authority." In contrast, RCAP contended that "comparable authority" is ambiguous and that in any event, the creditor trust is the substantive equivalent of a creditor committee because it was established to obtain funds for RCAP's creditors. The court agreed with RCAP, finding the exclusion to be ambiguous. Construing this ambiguity in favor of coverage, the court held that it did not bar coverage under Westchester's policies.

Ninth Circuit Reverses Dismissal Of Breach Of Contract Claims Against D&O Insurer

The Ninth Circuit ruled that a district court erred in dismissing breach of contract claims against a D&O insurer, finding that issues of fact exist as to whether a demand letter against the insured company constituted a "claim" first made outside the policy period. *Kelly v. Starr Indem. & Liab. Co.*, 2019 WL 1895825 (9th Cir. Apr. 29, 2019).

Scott Kelly and John DeWald ("Plaintiffs") operated a real estate investment firm. Kenneth Brehnan loaned Plaintiffs money in exchange for promissory notes. In 2010, Brehnan sent a demand letter, seeking payment of amounts due and warning that he "would like to try not to proceed with legal remedy . . . as being recommended by my legal team."

In May 2011, Plaintiffs applied for and obtained a claims-made D&O policy issued by Starr. In November 2011, Brehnan issued a second demand letter warning of his intention to assert claims against Plaintiffs. In August 2012, Brehnan filed suit. Starr disclaimed coverage. After Plaintiffs settled with Brehnan, they sued Starr, alleging breach of contract and negligence. A California district court granted Starr's summary judgment motion, finding that the insurer had no duty to defend or indemnify because the initial Brehnan demand letter was a claim first made prior to inception of the policy.

The Ninth Circuit reversed, finding issues of fact as to whether the demand letter was a "claim." The court explained that the demand letter was not necessarily a "claim . . . against such Insured Person for any Wrongful Act" because it was not clear that the demand letter alleged any wrongful acts. The court stated: "Brehnan demanded money owed pursuant to contracts with Plaintiffs' companies, which at most establishes a question of fact whether the claim would be covered by the Policy."

The Ninth Circuit also declined to uphold the dismissal of Plaintiffs' claim on the basis of material misrepresentations in the policy application. It reasoned that Plaintiffs' failure to disclose the initial demand letter in the application did not constitute a material misrepresentation because issues of fact exist as to whether the demand was a "circumstance[] that might lead to potential claims."

Late Notice Alert:

Second Circuit Affirms Insurers' Win On Late Notice And Waiver

The Second Circuit affirmed a New York district court decision dismissing coverage claims based on late notice, finding that the insurers did not waive their right to disclaim coverage on that basis. *New York State Electric & Gas Corp. v. Century Indem. Co.*, 2019 WL 1817781 (2d Cir. Apr. 25, 2019).

New York State Electric & Gas Corporation ("NYSEG") sued Century and OneBeacon, seeking indemnity for expenses relating to the investigation and remediation of contamination at numerous gas plant sites. The insurers denied coverage based on late notice. NYSEG argued that the insurers had waived their right to do so. A New York district court granted the insurers' summary judgment motion, and the Second Circuit affirmed.

As to waiver, the Second Circuit ruled that NYSEG failed to demonstrate a clear manifestation of intent to waive the late notice defense, as required by New York law. NYSEG based its waiver argument on the fact that a disclaimer letter that included late notice as a basis for denying coverage was never sent to NYSEG. Deeming this insufficient to establish waiver, the court noted that the letter was not sent because NYSEG had not, at that time, asked Century to take action and no coverage determination had been made. In any event, Century ultimately issued a general reservation of rights that listed "late notice" as a potential issue.

The court also rejected NYSEG's assertion that OneBeacon waived its late notice defense because although it specifically mentioned late notice in a disclaimer for a different policy, it issued a general disclaimer reserving "all of its rights" under the policy at issue. The court explained that since neither party was able to locate the relevant policy at the time of disclaimer, OneBeacon "did not have knowledge of the facts upon which the existence of its right to disclaim coverage under the relevant policy depended."

After finding no waiver, the court addressed the merits of the late notice defense. The parties disputed whether NYSEG's obligation to provide notice of an occurrence "as soon as practicable" was first triggered at the time of the operative occurrence or when NYSEG reasonably should have known that liability from the occurrence was likely to implicate coverage. The court declined to resolve that issue, finding that under either standard, NYSEG failed to provide timely notice.

Bad Faith Alert:

Iowa Supreme Court Rules That Bad Faith Claims Are Not Viable Against Third-Party Claims Administrator

Answering a certified question, the Iowa Supreme Court held that a common law cause of action for bad faith failure to pay workers' compensation benefits is not actionable against a third-party claims administrator. *De Dios v. Indem. Ins. Co. of N. Am.*, 2019 WL 2063289 (Iowa May 10, 2019).

A worker who was injured during the course of employment sued his workers' compensation insurer and its third-party claims administrator, alleging bad faith failure to pay benefits. The Iowa Supreme Court ruled that the claim was not actionable against the third-party administrator. The court explained that the primary

justification for recognizing bad faith claims against workers' compensation carriers is "the existence of certain 'affirmative obligations' placed upon them by our statutory and regulatory scheme." However, those same duties do not apply to third-party administrators under Iowa law, and administrators are therefore not the equivalent of insurers for purposes of bad faith liability.

As the court noted, courts in the majority of jurisdictions that have addressed this issue have concluded that bad faith is not actionable against third-party administrators in the workers' compensation context. Colorado courts, as an exception to this general trend, have allowed such bad faith claims to proceed based on a specific statutory and regulatory scheme governing workers' compensation. Courts in other jurisdictions, including Arizona, Oklahoma and Washington, have allowed claimants to pursue claims against third parties where those entities (1) engaged in tasks that created a quasi insurer-insured relationship; (2) were subject to the same statutory duties as insurers; or (3) bore some of the financial risk of loss for the workers' compensation claims.

Independent Counsel Alert:

Policyholder Entitled To Appoint Independent Counsel At Insurer's Expense, Says Illinois Appellate Court

An Illinois appellate court ruled that an insured was entitled to retain independent counsel rather than use insurer-appointed counsel based on a conflict of interest arising out of a punitive damages claim. *Xtreme Protection Servs., LLC v. Steadfast Ins. Co.*, 2019 WL 1976482 (Ill. Ct. App. May 3, 2019).

A lawsuit brought against Xtreme Protection Services alleged eavesdropping, trespass, intrusion upon seclusion and intentional infliction of emotional distress. Xtreme tendered the complaint to Steadfast, but requested permission to select its own defense counsel. Xtreme argued that a conflict of interest existed because the underlying complaint alleged intentional conduct, which was excluded from coverage under the policy. Steadfast appointed counsel and reserved its right to deny coverage. Xtreme continued to use its own counsel to defend the suit and sought a declaration that it was authorized to retain independent counsel based on a conflict of interest arising from Steadfast's reservation of rights. In response, Steadfast waived its right to deny coverage based on any policy exclusions but reserved its right to deny coverage for punitive damages. Steadfast argued that as a result of this waiver, there was no longer any conflict of interest, and Xtreme was obligated to utilize insurer-appointed counsel.

An Illinois trial court disagreed and granted Xtreme's motion for judgment on the pleadings. The trial court held that Xtreme was entitled to counsel of its choice based on Steadfast's ongoing reservation as to punitive damages. The appellate court affirmed, stating that Steadfast "has little interest in defending against [the underlying] claims for punitive damages."

Importantly, the court noted that an underlying claim for punitive damages does not automatically give rise to a conflict of interest justifying the use of independent counsel. Rather, a conflict of interest exists when punitive damages form a substantial portion of the potential liability and where the insurer's disclaimer for punitive damages leaves the policyholder with the greater interest and risk in the litigation. The court deemed this standard met because the underlying complaint sought no less than $120,000 in compensatory damages and no less than $2.1 million in punitive damages.

Property Coverage Alert:

Florida Appellate Court Rules That Insurer's Post-Suit Payment Of Appraisal Award Constitutes Confession Of Improper Coverage Denial

A Florida appellate court ruled that an insurer's post-suit payment of an appraisal award constitutes a confession that it incorrectly denied benefits and that such conduct raised an issue of fact as to the insurer's bad faith. *Bryant v. GeoVera Specialty Ins. Co.*, 2019 WL 2017972 (Fla. Ct. App. May 8, 2019).

The coverage dispute arose out of a water leak in the policyholders' residence. An adjuster estimated the loss at approximately $21,000. The insurer requested a sworn proof of loss, which the policyholder did not provide within the 60-day period required by the policy. However, before the 60 days expired, the insurer issued a coverage notice, indicating that it would pay for limited coverage of $6,000. Thereafter, the policyholders filed suit, alleging breach of contract and bad faith. They submitted a proof of loss on the same day they filed an amended complaint. Litigation was stayed so that the parties could comply with the policy's appraisal provision. The appraisal award itemized damages in excess of $30,000. One month after the appraisal award was issued, the insurer paid the balance due under the appraisal award.

Following this payment, a Florida trial court granted the insurer's summary judgment motion, holding that the policyholders had not timely submitted a proof of loss and had never disputed the insurer's adjustment of the loss prior to filing suit. The appellate court reversed.

The appellate court ruled that the insurer's payment of the appraisal award constituted a confession that it breached the policy by erroneously invoking certain policy provisions to limit coverage. The court noted that not all post-suit payments by an insurer fall within the "confession of judgment" doctrine, but explained that where, as here, an incorrect partial denial of benefits is followed by the insurer's abandonment of its prior coverage position and payment of an appraisal award, the doctrine applies.

The appellate court also ruled that the insurer waived the proof of loss requirement by issuing the initial payment of $6,000 and denying coverage above that amount without citing the failure to provide proof of loss as a basis for denying or limiting coverage.

Finally, the court ruled that in light of the aforementioned findings, issues of disputed fact exist as to whether the insurer acted in good faith when it incorrectly limited coverage in the first place.

Arbitration Alert:

Fifth Circuit Enforces Arbitration Clause Notwithstanding State Law Banning Arbitration Of Insurance Disputes

The Fifth Circuit ruled that an arbitration clause was enforceable notwithstanding a state statute banning arbitration of insurance disputes and a "conformity to statute" clause in the insurance policy. *McDonnel Grp., LLC v. Great Lakes Ins. SE*, 2019 WL 2082905 (5th Cir. May 13, 2019).

The dispute centered on whether a builder's risk policy provided coverage for water damage to a construction project. When McDonnel brought suit, the insurers moved to dismiss pursuant to the policy's arbitration provision. McDonnel argued that the arbitration provision was invalid in light of a "conformity to statute provision," which stated that "[i]n the event any terms of this Policy are in conflict with the statutes of the jurisdiction where the Insured Property is located, such terms are amended to conform to such statutes." McDonnel noted that Louisiana statutory law expressly prohibits arbitration agreements in insurance policies covering property located within the state. *See* La. Rev. Stat. Ann. § 22:868(A)(2).

A Louisiana federal district court dismissed the suit in favor of arbitration, ruling that federal law preempted Louisiana statutory law. The Fifth Circuit affirmed. The Fifth Circuit ruled that the McCarran-Ferguson Act, which allows state statutes governing the business of insurance to reverse preempt

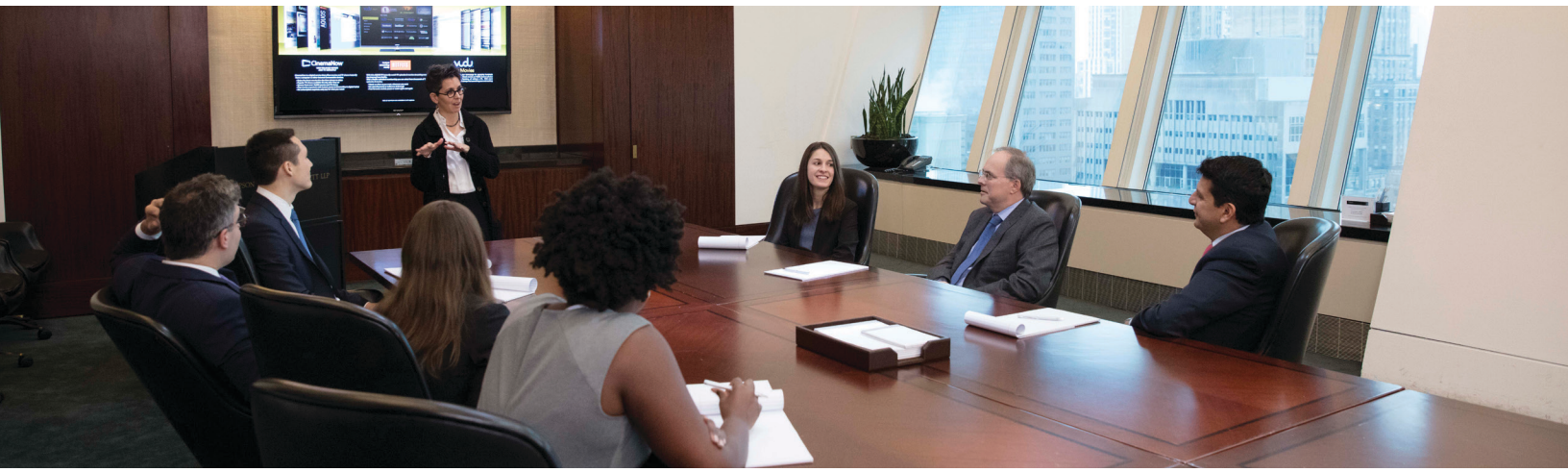
federal law, did not apply. Under Fifth Circuit precedent, McCarran-Ferguson reverse preemption is limited to federal legislation and does not encompass an international treaty such as the Convention on the Recognition and Enforcement of Foreign Arbitral Awards. *See Safety Nat'l Cas. Corp. v. Certain Underwriters at Lloyd's London*, 587 F.3d 714 (5th Cir. 2009). Having rejected application of the Louisiana statute barring arbitration, the court concluded that there was no conflict between state law and the policy so as to invoke the conformity provision.

The two other federal circuit courts that have addressed whether reverse preemption pursuant to the McCarran-Ferguson Act extends to the Convention have reached conflicting conclusions. *Compare Stephens v. American Int'l Ins. Co.*, 66 F.3d 41 (2d Cir. 1995) (holding that state law that precludes insurance dispute arbitration reverse preempts the Convention) *with ESAB Grp. Inc. v. Zurich Ins. plc*, 2012 WL 2697020 (4th Cir. July 9, 2012) (rejecting reverse preemption and reasoning that the McCarran-Ferguson Act applies only to federal statutes, not international treaties such as the Convention) (discussed in July/ August 2012 Alert).

STB News Alerts

Simpson Thacher has been ranked among the leading law firms in the United States in *Chambers USA 2019*. The Firm and its lawyers were recognized in 54 practice categories, including a #1 ranking for "Insurance: Dispute Resolution" in the *Chambers*' Nationwide and New York categories.

Bryce Friedman spoke at the New York State Bar Association's Insurance Coverage Update 2019 program on May 10 in New York City. Bryce spoke on a panel entitled "Fundamentals of Policy Interpretation," which discussed black letter law, policy ambiguities, intent of parties and extrinsic evidence.



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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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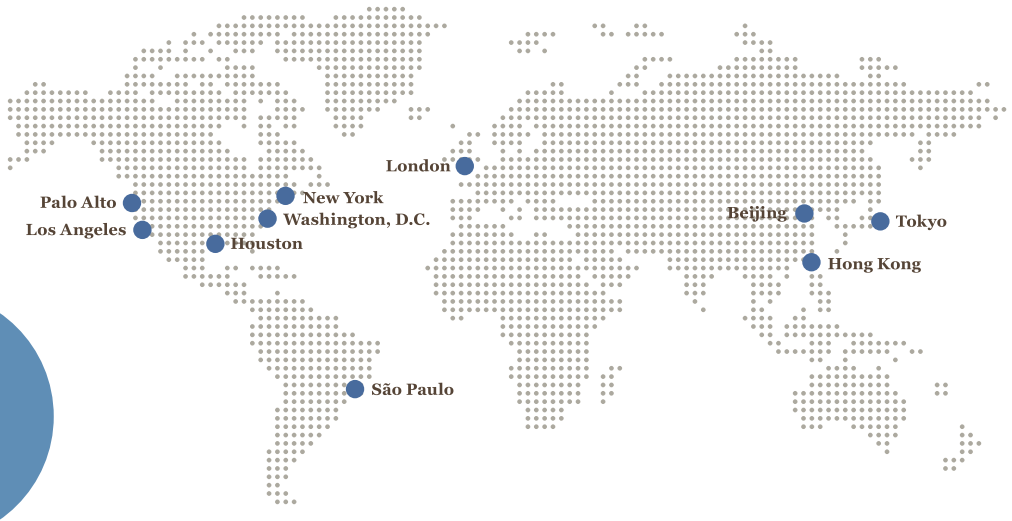

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