Simpson Thacher

Insurance Law Alert

November 2017

In This Issue

Massachusetts Appellate Court Rules That Insurer Is Not Responsible For Defense Costs When Insured Unreasonably Rejects Insurer's Defense

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Pennsylvania Appellate Panel Rules That Facultative Certificates Provide Coverage For Defense Expenses In Excess Of Liability Cap

Ruling on a matter of first impression, a Pennsylvania Superior Court ruled that facultative reinsurance certificates provide coverage for defense expenses in excess of the liability cap set forth in the reinsurance agreement. *Century Indem. Co. v. OneBeacon Ins. Co.*, 2017 WL 4639578 (Pa. Super. Ct. Oct. 17, 2017). (Click here for full article)

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Concluding That Privacy Pledge Is Not Part Of Policy, Illinois Court Dismisses Data Breach Suit Against Insurer

An Illinois district court dismissed a putative class action suit against an insurer alleging improper handling of policyholders' personal information, finding that a privacy pledge submitted to insured parties with the insurance policy was not part of the contract. *Dolmage v. Combined Ins. Co. of Am.*, 2017 WL 5178792 (N.D. Ill. Nov. 8, 2017). (Click here for full article)

Montana Supreme Court Rules That Fee Shifting Applies To Favorable Rulings As To Amount Of Coverage

The Montana Supreme Court ruled that a first-party insured is entitled to attorney's fees if he is compelled to sue for benefits and recovers more than the insurer's final settlement offer. *Mlekush v. Farmers Ins. Exch.*, 2017 WL 4785359 (Mont. Oct. 24, 2017). (Click here for full article)

Florida Supreme Court Rejects Heightened Standard For Use Of Contingency Fee Multiplier

The Florida Supreme Court ruled that use of a contingency fee multiplier in awarding attorney's fees is not limited to "rare and exceptional" circumstances, but rather may be applicable based on various case-specific factors. *Joyce v. Federated Nat'l Ins. Co.*, 2017 WL 4684352 (Fla. Oct. 19, 2017). (Click here for full article)

Defense Alert:

Massachusetts Appellate Court Rules That Insurer Is Not Responsible For Defense Costs When Insured Unreasonably Rejects Insurer's Defense

A Massachusetts appellate court ruled that when an insurer offers to defend without a reservation of rights and the insured refuses to cede control of the defense to the insurer's selected counsel, the insured is not entitled to reimbursement of defense costs incurred during the period in which control over the defense was in dispute. *OneBeacon Am. Ins. Co. v. Celanese Corp.*, 92 Mass. App. Ct. 382 (2017).

OneBeacon agreed to defend Celanese without a reservation of rights and sought to assume control of Celanese's defense. Celanese refused to cede control of the defense or replace its existing counsel with OneBeacon's selected counsel, alleging that a conflict of interest existed. OneBeacon filed suit, seeking a declaration that it had the right to control Celanese's defense, which the court granted. Thereafter, a dispute arose as to whether OneBeacon was responsible for the defense costs incurred during the time frame in which the parties disputed control over the defense. A Massachusetts trial court ruled that OneBeacon was liable for the reasonable fees incurred by Celanese during that period. The appellate court reversed.

The appellate court ruled that when OneBeacon offered to defend Celanese without a reservation of rights, it obtained the right to control the defense, including the right to select counsel. The court further held that although a conflict of interest may justify an insured's refusal to cede control of the defense, none existed here. In particular, the court rejected Celanese's assertion that a conflict existed by virtue of a prior "unfair practices" ruling against OneBeacon, explaining that that ruling related to a discrete issue about the cost sharing agreement and did not concern the manner in which OneBeacon would defend Celanese. The court also noted that a conflict does not exist simply because the insured and insurer have differing views as to the insured's liability or defense strategy.

Opioid Epidemic Alert:

California Appellate Court Rules That Insurer Need Not Defend Pharmaceutical Companies In Opioid Cases

A California appellate court ruled that an insurer is not obligated to defend or indemnify pharmaceutical manufacturers and distributers in suits alleging deceptive marketing practices and other state, federal and common law claims in connection with the sale and distribution of opioids. *Travelers Prop. Cas. Co. of Am. v. Actavis, Inc.*, 2017 WL 5119167 (Cal. App. Ct. Nov. 6, 2017).

The coverage dispute arose out of suits filed in California and Chicago against the Defendants alleging a "highly deceptive marketing campaign" designed to increase sales of opioids by promoting the drugs for purposes for which they are not suited or intended. Travelers refused to defend the suits on the basis that the alleged injuries were not caused by an accident under the liability policies. Following a jury trial, a California court ruled that Travelers had no duty to defend because there was no "accident" as required by the policies' "occurrence" provision. The appellate court affirmed.

The appellate court held that there was no potential for coverage because all claims asserted against the Defendants arose out of deliberate or intentional conduct. The court further held that there was no "additional, unexpected, independent, and unforeseen happening" that resulted from the intentional conduct. The court reasoned that all of the alleged injuries (*e.g.*, a "public health epidemic," a resurgence in heroin use, and increased long term health care costs) were neither unexpected nor unforeseen consequences of a marketing campaign designed to promote opioid use. The court emphasized that under California "occurrence" law, it is irrelevant whether Defendants intended to cause injury or whether they mistakenly believed that their deliberate conduct would not cause injury. In addition, the court rejected Defendants' assertion that a public nuisance claim in the California action triggered Travelers' defense obligation because nuisance claims may be based on negligent conduct. The court

explained that notwithstanding the label of the cause of action, the facts alleged suggest liability based only on intentional conduct.

Alternatively, the court held that even if the complaints created a potential for coverage based on unintentional conduct, the claims fall within the Product Exclusions, which bar coverage for injury that arises out of "warranties or representations . . . with respect to the . . . safety or use of such goods or products." In so ruling, the court rejected the notion that Products Exclusions are limited to defective products. As the court noted, the Eleventh Circuit similarly applied a Products Exclusion to bar coverage for opioid-related claims. *See Travelers Prop. Cas. Co. of Am. v. Anda, Inc.*, 658 F. App'x 955 (11th Cir. 2016).

Notably, two courts have reached a contrary conclusion with respect to other opioid claims. *See Liberty Mut. Fire Ins. Co. v. JM Smith Corp.*, 602 F. App'x 115 (4th Cir. 2015); *Cincinnati Ins. Co. v. Richie Enters., LLC*, 2014 WL 838768 (W.D. Ky. 2014). The court distinguished these cases based on different underlying allegations and applicable state law. In particular, the court explained that the complaints in *JM Smith* and *Richie* contained allegations of negligence, and that, in any event, South Carolina and Kentucky law define "accident" to include intentional conduct that results in unintended injuries, whereas "[u]nder California law, in contrast, a deliberate act is not an accident, even if the injury is unintentional, unless the injury was produced by an additional, unexpected, independent, and unforeseen happening."

Reinsurance Alert:

Pennsylvania Appellate Panel Rules That Facultative Certificates Provide Coverage For Defense Expenses In Excess Of Liability Cap

Ruling on a matter of first impression, a Pennsylvania Superior Court ruled that facultative reinsurance certificates provide coverage for defense expenses in excess of the liability cap set forth in the reinsurance agreement. *Century Indem. Co. v. OneBeacon Ins. Co.*, 2017 WL 4639578 (Pa. Super. Ct. Oct. 17, 2017).

Century and Pacific Employers issued excess policies to companies named in asbestos-related lawsuits. The policies included coverage for defense costs. The Century and Pacific Employers policies were reinsured under certificates issued by OneBeacon's predecessor. The current litigation arose when OneBeacon refused to pay the insurers under the facultative certificates. While the litigation was pending, OneBeacon paid the limits listed in the "Reinsurance Accepted" provision, but refused to pay any amount above that for defense costs. In ensuing litigation, a Pennsylvania trial court denied OneBeacon's summary judgment motion as to liability limits, finding that the certificates were ambiguous as to whether the "Reinsurance Accepted" amount applied only to losses or to both losses and defense expenses. Following a non-jury trial, the trial court entered judgment against OneBeacon. The appellate court affirmed.

The "Reinsurance Accepted' provision states that "the liability of the Reinsurer . . . shall follow that of the Company and except as otherwise specifically provided herein, shall be subject in all respects to all the terms and conditions of the Company's policy." OneBeacon argued that under *Bellefonte Reinsurance Co. v. Aetna Cas. & Sur. Co.*, 903 F.2d 910 (2d Cir. 1990) and its progeny, this language provides a cap for both indemnity and defense costs. The appellate court disagreed, emphasizing a variation in the policy language at issue in *Bellefonte*. There, the clause stated that the reinsurance is "subject to the terms, conditions and amount of liability set forth herein," whereas here, the "subject to" clause refers only to the general conditions, not the reinsurance limit.

In addition, the court noted that its ruling was supported by the follow form provision because Century's and Pacific Employers' underlying policies provided coverage for expenses in addition to limits. The court stated: "absent language providing the entire certificate is 'subject to' the 'Reinsurance Accepted' amount, a reasonable interpretation of the language is that where the underlying policy covers expenses in addition to liability limits, the reinsurance certificate provides the same coverage."

As the court noted, two other courts have distinguished *Bellefonte* based on variations in policy language and deemed facultative certificates ambiguous as to whether expenses were excluded from the reinsurance limits of liability. *See Utica Mut. Ins. Co. v. Munich Reinsurance Am. Inc.*, 594 F. App'x 700 (2d Cir. 2014) (discussed in our December 2014 Alert); *Utica Mut. Ins. Co. v. R & Q Reinsurance Co.*, 2015 WL 4254074 (N.D.N.Y. 2015) (discussed in our June 2015 Alert). Further, as discussed in our December 2016 Alert, the New York Court of Appeals has accepted a certified question to address whether the dollar amount provided in a "Reinsurance Accepted" section of a reinsurance certificate applies to both losses and expenses. *Global Reinsurance Corp. of Am. v. Century Indem. Co.*, 843 F.3d 120 (2d Cir. 2016).

Coverage Alert:

Tenth Circuit Rules That SEC Investigation Is Not A Covered "Claim" Under Claims-Made Policy

The Tenth Circuit ruled that an investigation and issuance of subpoenas by the Securities and Exchange Commission ("SEC") are not covered "claims" under a claims-made policy. *MusclePharm Corp. v. Liberty Ins. Underwriters, Inc.*, 2017 WL 4675701 (10th Cir. Oct. 17, 2017).

MusclePharm sought coverage under a Liberty policy for defense costs incurred in connection with an SEC investigation. The investigation began in May 2013 when the SEC sent a letter indicating that an inquiry was being conducted. In July 2013, the SEC issued an order stating that it had "information that tends to show" that MusclePharm "possibly violated" federal securities laws. Thereafter, the SEC issued subpoenas directing testimony and the production of documents. In February 2015, the SEC issued Wells Notices to MusclePharm executives, stating that a preliminary determination had been made to recommend an enforcement action against the individuals.

Liberty Mutual denied coverage for all costs incurred prior to the Wells Notices, arguing that prior events did not constitute a "claim" alleging a "wrongful act" under the policy. A Colorado district court agreed and ruled in the insurer's favor. *See* September 2016 Alert. Last month, the Tenth Circuit affirmed.

The policy covers losses incurred as a result of a "Claim first made during the Policy Period . . . for a Wrongful Act." Claim is defined as "a written demand for monetary or non-monetary relief" or a "formal administrative or regulatory proceeding." The Tenth Circuit ruled that the July 2013 order and related subpoenas were not a written demand for non-monetary relief, reasoning that "the SEC was not seeking relief, but was only gathering information." The court also ruled that the July 2013 order was not a formal administrative proceeding notwithstanding a caption on the document stating that it "is a proceeding of the United States of America Before the Securities and Exchange Commission." Finally, the court held that there was no "claim" prior to the Wells Notices because there had been no allegations of wrongdoing.

Late Notice Alert:

California Court Refuses To Extend Notice-Prejudice Rule To Claims-Made-And-Reported Policy When Notice Is Late But Within Policy Period

A California federal district court ruled that an insurer need not establish prejudice when an insured violates a time-specific notice provision in a claims-made-and-reported policy, even if the notice was provided within the policy period. *Centurion Med. Liab. Protective Risk Retention Grp., Inc. v. Gonzalez*, No. CV 17-01581 (C.D. Cal. Nov. 1, 2017).

The professional liability policy provides coverage for claims "first made against the insured and reported to the [insurer] in writing during the policy period." The policy requires the insured to provide written notice of a claim "not more than 20 days after receiving such claim." Based on these provisions, the insurer denied coverage for claims that were served on the insured in November 2016, but not tendered to the insurer until January 2017. The court upheld the denial.

The court noted that under California law, the notice-prejudice rule applies to both occurrence-based policies and claims-made policies that do not require the claims to be reported within the policy period or within a specified period of time. However, the court declined to extend the notice-prejudice rule to the scenario presented here – when a claim was not reported within the policy's specified time frame, but was reported within the policy period. Emphasizing the restrictive nature of claims-made-and-reported policies, the court stated that "[c]ase law has yet to make a distinction between a claim reported within the policy period but outside of an additionally imposed time limit, and a claim reported outside of the policy period."

Pollution Exclusion Alert:

Missouri Supreme Court Rules That Pollution Exclusion Unambiguously Bars Coverage For Lead Emissions

Ruling on a matter of first impression, the Missouri Supreme Court ruled that a pollution exclusion bars coverage for claims alleging injury caused by toxic emissions of lead, arsenic and other harmful substances. *Doe Run Res. Corp. v. Am. Guarantee & Liab. Ins.*, 2017 WL 5078078 (Mo. Oct. 31, 2017). Reversing a lower court decision, the Missouri Supreme Court held that the exclusion was unambiguous, notwithstanding its failure to define "contaminant" or "irritant" or to list specific contaminants. Significantly, the court distinguished *Hocker Oil Co. v. Barker-Phillips-Jackson, Inc.*, 997 S.W.2d 510 (Mo. App. 1999), which deemed a pollution exclusion ambiguous as to gasoline-related damage based on its failure to identify gasoline as a pollutant. The court explained that the finding of ambiguity in *Hocker* was based on the fact that the insured party was a gasoline company that considered gasoline to be a product rather than a pollutant. Here, however, the bodily injury claims arose out of toxic substances released into the atmosphere rather than out of exposure to Doe Run's commercial lead products. Although some of the toxins were lead particulates, the court emphasized the distinction between commercially valuable lead products and the harmful particulate lead toxins in the atmosphere. The court stated: "That its toxic or hazardous materials are valuable products if Doe Run properly contains them does not make them any less 'pollutants' when they are abandoned and released into the environment."

Data Breach Alerts:

New Jersey Court Finds No Coverage For Fraudulent Wire Transfers Based On "Ownership of Property" Provision

A New Jersey district court ruled that a crime policy does not cover losses arising out of a fraudulent wire transfer because the insured never had ownership of the funds. *Posco Daewoo Am. Corp. v. Allnex USA, Inc.*, 2017 WL 4922014 (D.N.J. Oct. 31, 2017).

The dispute arose out of a wire transfer that originated with a series of fraudulent emails. Allnex owed Posco money for a shipment of chemicals. An imposter posing as a Posco employee sent emails to Allnex requesting that payment be sent to certain bank accounts. Without confirming the authenticity of the imposter's email or bank accounts, Allnex wired numerous payments to the imposter. After the fraud was discovered, some but not all of the money was recovered and sent to Posco. When Allnex refused to pay the remainder of the amount due, Posco sought coverage from Travelers pursuant to a crime policy, which the insurer denied. In ensuing litigation, the court granted Travelers' motion to dismiss the complaint.

The parties disputed whether the losses arose out of "computer fraud" and whether there was a "direct loss" given the intervening acts of Allnex prior to transferring the funds. However, the court declined to address either of these issues, instead ruling that there was no coverage based on the "Ownership of Property" provision, which requires Posco to "own or lease" the property at issue. The court concluded that Posco did not plead sufficient facts to establish that it possessed or had legal title to the money that Allnex had transferred to the fraudulent accounts. The court explained that although Allnex had intended Posco to receive the money, intention does not establish ownership. The court stated that Posco "owned a receivable, or a right to payment, as well as a potential cause of action for payment if it was not made," but it did not legally own the money that had been wrongfully sent to the imposter's account, and thus could not seek coverage for its loss.

Concluding That Privacy Pledge Is Not Part Of Policy, Illinois Court Dismisses Data Breach Suit Against Insurer

Our March 2016 Alert reported on an Illinois district court decision denying an insurer's motion to dismiss a putative class action suit alleging improper handling of policyholders' personal information. *Dolmage v. Combined Ins. Co. of Am.*, 2016 WL 754731 (N.D. Ill. Feb. 23, 2016). This month, the court granted the insurer's summary judgment motion, finding that a privacy pledge submitted to insured parties with the insurance policy was not part of the contract. *Dolmage v. Combined Ins. Co. of Am.*, 2017 WL 5178792 (N.D. Ill. Nov. 8, 2017).

The insurer issued disability, health, life and accident policies to the plaintiff and putative class members. When the policies were issued, the insurer sent each enrollee a document entitled "Our Privacy Pledge to You," along with other materials relating to the policies. The Privacy Pledge describes the insurer's handling of policyholders' personal information and states, among other things, that it maintains safeguards that comply with federal regulations to protect personal data.

The insurer retained Enrolltek, a vendor that performs enrollment and other administrative functions, and provided it with enrollees' personal information. According to the complaint, the personal information was readily accessible online to the general public for several months before the security lapse was discovered. Thereafter, a fraudulent tax return was filed in the plaintiff's name by an unknown identity thief. Plaintiff filed a putative class action against the insurer, alleging, among other things, a breach of contract claim based on the insurer's alleged breach of the Privacy Pledge.

Plaintiff alleged that the Privacy Pledge was part of the insurance contract based on the following facts: (1) the policy expressly states that "Policy means this policy with any attached application(s), and any riders and endorsements"; (2) the table of contents for the policy states that "A copy of the application and any riders and endorsements follow page 17"; (3) following page 17 were various documents, including the Privacy Pledge; and (4) some policy materials contained an express disclaimer stating that "THIS IS NOT A PROPOSAL AND IS NOT PART OF THE INSURANCE CONTRACT," but the Privacy Pledge contains no such disclaimer. The court disagreed and granted the insurer's summary judgment motion.

Applying Iowa law, the court concluded that the Privacy Pledge was not part of the parties' agreement. In particular, the court held that the Privacy Pledge did not constitute a "rider or endorsement" to the insurance policy, but rather was "simply a loose document, like the blank forms and brochures, that was included in the fulfillment materials sent to Plaintiff." In so ruling, the court noted that the insurer had not filed the Privacy Pledge with state insurance regulators, which is the usual and customary practice with respect to riders and endorsements. Additionally, the court explained that the Privacy Pledge does not bear any of the traditional hallmarks of a rider or endorsement, such as a "label" at the top of the page or a signature by an insurance company representative.

Attorney's Fee Alerts:

Montana Supreme Court Rules That Fee Shifting Applies To Favorable Rulings As To Amount Of Coverage

The Montana Supreme Court ruled that a first-party insured is entitled to attorney's fees if he is compelled to sue for benefits and recovers more than the insurer's final settlement offer. *Mlekush v. Farmers Ins. Exch.*, 2017 WL 4785359 (Mont. Oct. 24, 2017). Mlekush sought benefits under a Farmers policy after sustaining injuries in an automobile accident. After receiving some claim information, Farmers stated that it had not yet made a determination about

coverage. Thereafter, Mlekush sued, seeing "all sums due and owing" under the policy. The parties exchanged numerous settlement offers and engaged in mediation, but were unable to reach an agreement. Farmers' final offer was $77,500. Following a trial, a jury returned a verdict in favor of Mlekush for $450,000. Mlekush sought attorney's fees under Montana's insurance exception to the "American Rule" prohibiting fee shifting.

A trial court denied the motion, finding that Mlekush was not "forced to assume the burden of legal action" to obtain the benefit of an insurance contract. The trial court reasoned that Farmers had not denied coverage and that Mlekush had initiated litigation prematurely. The Montana Supreme Court reversed, explaining that "the determination of whether an insured is entitled to attorney fees under the insurance exception . . . necessitates factual findings that take into consideration both parties' actions during the entire process leading up to the ultimate resolution of the claim." On remand, the trial court again denied Mlekush's attorney's fee motion, reasoning that the insurance fee-shifting exception does not apply to disputes over the value of an insurance claim, but rather is limited to situations in which an insurer denies coverage altogether. The Montana Supreme Court again reversed.

The Court ruled that the insurance exception extends to cases where the value of the first-party claim is in dispute, even if coverage is not disputed. The court stated:

> when a first-party insured is compelled to pursue litigation and a jury returns a verdict in excess of the insurer's last offer to settle an underinsured motorist claim, the insurer must pay the first-party's attorney fees in an amount subsequently determined by

the district court to be reasonable. To be clear, if a first-party insured goes to trial and obtains a verdict in excess of the insurer's last offer, this constitutes prima facie proof that the insured was forced to assume the burden of legal action to obtain the full benefits of the policy, thus obviating the need for an inquiry as to whether or not the insurance exception applies. However, in cases in which the policy limits are tendered prior to a verdict being returned, the district court may consider the entirety of the litigation to determine "whether, and to what extent, [the] insured was forced to assume the burden of legal action in order to recover the full benefits of the insurance contract."

Florida Supreme Court Rejects Heightened Standard For Use Of Contingency Fee Multiplier

The Florida Supreme Court ruled that use of a contingency fee multiplier in awarding attorney's fees is not limited to "rare and exceptional" circumstances, but rather may be applicable based on various case-specific factors. *Joyce v. Federated Nat'l Ins. Co.*, 2017 WL 4684352 (Fla. Oct. 19, 2017).

In a dispute between homeowners and a property insurer, the parties agreed that the homeowners were entitled to recover reasonable attorney's fees pursuant to Florida statutory law. Following a fee hearing, a Florida trial court awarded the homeowners $76,300 based on a two-step process. First, the court calculated the "lodestar" amount, based on reasonable rates and billable hours. Second, the court applied a contingency fee multiplier of 2.0 to the lodestar amount, based on the following factors: the need of a multiplier to obtain competent counsel in the relevant market; counsel's inability to mitigate the risk of non-payment in any way; the amount of money involved in the dispute; the complexity of the case; the results obtained; and the type of fee arrangement between plaintiff and counsel.

An intermediate appellate court affirmed the lodestar calculation, but reversed the trial court's use of a contingency fee multiplier. The appellate court reasoned that the lodestar approach includes a strong presumption that the lodestar amount is a "reasonable fee" and that a multiplier may be used only in "rare and exceptional" cases. The Florida Supreme Court reversed.

The Florida Supreme Court ruled that there was no basis in Florida law for the "rare and exceptional" standard. Rather, trial courts may utilize a multiplier based on specific factual findings, including whether the relevant market requires a multiplier to obtain competent counsel, whether the attorney could mitigate the risk of non-payment, and the fee arrangement between plaintiff and attorney. The court expressly declined to adopt the reasoning set forth in two United States Supreme Court cases that rejected contingency multipliers under federal fee shifting statutes.

Notably, the court emphasized that courts are not required to use a multiplier, and when they do, evidence must be presented to justify its use. Additionally, the court explained that use of multiplier must be consistent with the purpose of the fee authorizing statute at issue, citing a case in which the Florida Supreme Court rejected a multiplier as inconsistent with an offer of judgment statute.

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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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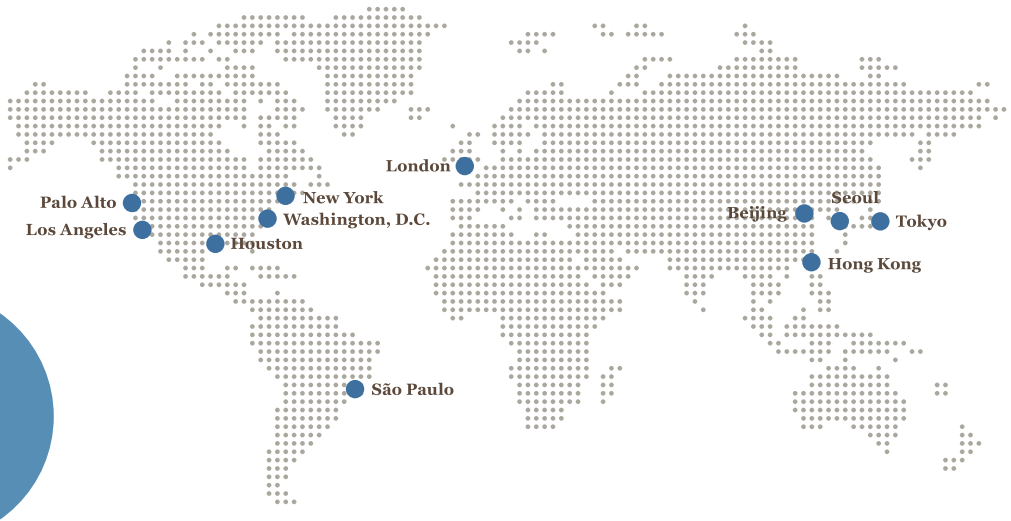

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