Simpson Thacher

Insurance Law Alert

December 2016

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Second Circuit Asks New York Court Of Appeals If Reinsurance Limits Apply To Both Losses And Expenses

By certified question, the Second Circuit asked the New York Court of Appeals 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.*, 2016 WL 7156549 (2d Cir. Dec. 8, 2016). (Click here for full article)

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***–Chambers USA 2016,* quoting a client**

Florida Supreme Court Rules That Property Policy Covers Loss Caused In Part By Excluded Perils

The Florida Supreme Court ruled that a homeowner is entitled to coverage under a property policy where the losses are attributable to both covered and excluded perils. The court rejected application of the efficient proximate cause doctrine in favor of a concurrent cause analysis. *Sebo v. American Home Assurance Co., Inc.,* 2016 WL 7013859 (Fla. Dec. 1, 2016). (Click here for full article)

Eleventh Circuit Rules That Underlying Settlement Reached In Bad Faith Is Not Enforceable Against Insurer

The Eleventh Circuit ruled that an underlying settlement was negotiated in bad faith and that an insurer is not obligated to provide indemnity for settlement payments. *Sidman v. Travelers Casualty and Surety*, 841 F.3d 1197 (11th Cir. 2016). (Click here for full article)

Rejecting Latent Ambiguity Argument, Sixth Circuit Enforces Consent-To-Settle Clause

The Sixth Circuit ruled that a consent-to-settle provision in an excess policy is unambiguous and that the insurer is not obligated to indemnify settlements made without its consent. *Stryker Corp. v. National Union Fire Ins. Co. of Pittsburgh, PA*, 842 F.3d 422 (6th Cir. 2016). (Click here for full article)

Insurer Has No Duty To Settle For All Insureds

Addressing a matter of first impression, a New Jersey court ruled that an insurer may settle claims for one insured, without reaching a settlement for additional insureds, so long as the settlement was made in good faith. *Nat'l Surety Corp. v. First Specialty Ins. Corp.*, 2016 WL 7057503 (N.J. Superior Ct. Nov. 18, 2016). (Click here for full article)

West Virginia Supreme Court Holds That Intentional Acts Exclusion Bars Coverage For Innocent Co-Insureds, Notwithstanding Severability Clause

The West Virginia Supreme Court ruled that intentional acts exclusions in homeowners' policies bar coverage for negligence claims against co-insureds, notwithstanding severability clauses. *Am. Nat'l Prop. & Cas. Co. v. Clendenen*, 2016 WL 6833123 (W. Va. Nov. 17, 2016). (Click here for full article)

Consecutive Claims-Made Policies Create Continuous Coverage Period For Notice Purposes, Says Delaware Court

A Delaware court ruled that coverage is not barred under a claims-made policy even though the policyholder failed to provide notice of a claim within the policy period, because notice was provided during a subsequent renewal policy period. *Med. Depot, Inc. v. RSUI Indem. Co.*, 2016 WL 5539879 (Del. Superior Ct. Sept. 29, 2016). (Click here for full article)

STB News Alerts:

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Reinsurance Alert:

Second Circuit Asks New York Court Of Appeals If Reinsurance Limits Apply To Both Losses And Expenses

By certified question, the Second Circuit asked the New York Court of Appeals 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.*, 2016 WL 7156549 (2d Cir. Dec. 8, 2016).

The appeal arises out of a dispute between Century and Global Reinsurance regarding the extent of Global Reinsurance's obligation to pay Century pursuant to certain reinsurance certificates. A New York federal district court ruled that the certificates unambiguously capped Global Reinsurance's liability at $250,000 (the amount set forth in the Reinsurance Accepted provision) for both losses and expenses. In so ruling, the district court relied on *Bellefonte Reinsurance Co. v. Aetna Casualty & Surety Co.*, 903 F.2d 910 (2d Cir. 1990) and *Unigard Security Insurance Co. v. North River Insurance Co.*, 4 F.3d 1049 (2d Cir. 1993).

Century appealed, arguing that *Bellefonte* and *Unigard* were wrongly decided. Century argued that the certificates should be interpreted to cover both loss and expenses because the certificates follow form to underlying policies, and the underlying policies expressly provide for payment of expenses in addition to loss. Noting that Century's argument "is not without force," the Second Circuit rejected Global Reinsurance's contention that *Excess Insurance Co. v. Factory Mutual Co.*, 3 N.Y.3d 577 (2004) is controlling because it did not explicitly address whether a stated limit represents a coverage limit for losses and expenses combined. The court further distinguished *Factory Mutual* because the expenses in question related to the cedent's cost of litigating with the underlying insured, not the insured's defense costs.

On this basis, the Second Circuit certified the following question to the New York Court of Appeals:

> Does the decision of the New York Court of Appeals in *Excess Insurance Co. v. Factory Mutual Insurance Co.*, 3 N.Y.3d 577 (2004), impose either a rule of construction, or a strong presumption, that a per occurrence liability cap in a reinsurance contract limits the total reinsurance available under the contract to the amount of the cap regardless of whether the underlying policy is understood to cover expenses, such as, for instance, defense costs?

We will keep you posted on further developments in this potentially-significant matter.

First-Party Coverage Alert:

Florida Supreme Court Rules That Property Policy Covers Loss Caused In Part By Excluded Perils

The Florida Supreme Court ruled that a homeowner is entitled to coverage under a property policy where the losses are attributable to both covered and excluded perils. The court rejected application of the efficient proximate cause doctrine in favor of a concurrent cause analysis. *Sebo v. American Home Assurance Co., Inc.,* 2016 WL 7013859 (Fla. Dec. 1, 2016).

A homeowner sought coverage for water-related damage under an all risk policy issued by American Home, which denied coverage. In ensuing litigation, a jury found in the homeowner's favor. A Florida appellate court reversed, ruling that the trial court improperly applied the concurrent cause doctrine, under which coverage may exist when a loss is caused by both insured and excluded perils, even if a covered peril is not the primary cause. The appellate court held that the proper standard in a first-party property case involving multiple perils is efficient proximate causation, which requires a covered peril to be the efficient proximate cause of the loss. The Florida Supreme Court reversed.

The Florida Supreme Court held that the efficient proximate cause doctrine is inapplicable because "there is no reasonable way to distinguish the proximate cause of Sebo's property loss – the rain and construction defects acted in concert to create the destruction of Sebo's home. As such, it would not be feasible to apply the EPC doctrine because no efficient cause can be determined." In this respect, the decision may be limited to situations in which multiple causes simultaneously cause loss, and may not apply where a loss is caused by a sequence of covered and uncovered events. In addition, the court noted that insurers may contract out of concurrent causation through explicit policy language.

Settlement Alerts:

Eleventh Circuit Rules That Underlying Settlement Reached In Bad Faith Is Not Enforceable Against Insurer

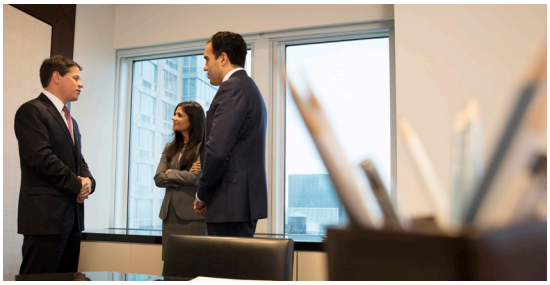
Affirming a Florida district court decision, the Eleventh Circuit ruled that an underlying settlement was negotiated in bad faith and that an insurer is not obligated to provide indemnity for settlement payments. *Sidman v. Travelers Casualty and Surety*, 841 F.3d 1197 (11th Cir. 2016).

Culbreath, a property owner association, sued Kirkwood, a homeowner, seeking to enforce restrictive covenants relating to property care and appearance. Kirkwood counterclaimed for slander. Travelers agreed to defend Culbreath with respect to the counterclaim. When Kirkwood prevailed and sought attorneys' fees, Travelers refused to defend the attorneys' fee claim. That refusal to defend was held to be wrongful by the Eleventh Circuit.

Culbreath and Kirkwood reached a settlement under which Culbreath paid $295,000 on the attorneys' fee claim (more than three times the actual amount of Kirkwood's fees), and assigned Kirkwood the proceeds from any action against Travelers, in exchange for Kirkwood's agreement not to execute judgment against Culbreath. Kirkwood and Culbreath also executed a promissory note that was not disclosed to the court or Travelers. The note provided that if Kirkwood was not successful in obtaining $50,000 or more against Travelers, then Culbreath would pay Kirkwood $50,000. (If Kirkwood recovered an amount less than $50,000, then Culbreath would pay the difference up to $50,000). In ensuing litigation, Travelers argued that the underlying settlement was the product of collusion. A Florida district court agreed, ruling that the settlement was neither reasonable nor negotiated in good faith and thus was unenforceable against Travelers. The Eleventh Circuit affirmed.

Under Florida law, an insurer that wrongfully refuses to defend is generally bound by a settlement, so long as it did not result from fraud or collusion. In determining whether there is fraud or collusion, Florida courts look to "evidence of an unreasonable settlement amount and of bad faith on the part of the negotiating parties." Finding both bad faith and unreasonableness here, the court noted that Culbreath "was willing to agree to any fee," so long as the judgment would be enforced only against Travelers. The court held that this fact, together with the undisclosed side arrangement that limited Culbreath's exposure to $50,000, established bad faith. Bad faith was also evidenced by Culbreath's similar settlement with another homeowner.

The court rejected the argument that the settlement could not be deemed collusive as a matter of law because Kirkwood and Culbreath did not share the settlement proceeds. The court explained that while shared settlement proceeds may establish collusion, it is not required. The court also rejected the argument that Travelers was bound by the settlement because it failed to object to it, stating that "the practical effect of such a rule would be that once an insurer is given prior notice of and fails to object to a settlement agreement … it will be deemed to have waived all objections despite underlying fraud or collusion of which it had no knowledge. There is no such rule in Florida law."



Rejecting Latent Ambiguity Argument, Sixth Circuit Enforces Consent-To-Settle Clause

The Sixth Circuit ruled that a consent-to-settle provision in an excess policy is unambiguous and that the insurer has no obligation to indemnify settlements made without its consent. *Stryker Corp. v. National Union Fire Ins. Co. of Pittsburgh, PA*, 842 F.3d 422 (6th Cir. 2016).

In this longstanding coverage litigation arising out of defective knee replacement parts, Stryker sought indemnification for settlements under excess liability policies issued by TIG. TIG disputed coverage, arguing that the direct product liability claims that were the subject of the settlement do not constitute "ultimate net loss" under TIG's policy. TIG's policy defines "ultimate net loss" as "the amount of the principal sum, award or verdict actually paid or payable in cash in the settlement or satisfaction of claims for which the insured is liable, either by adjudication or compromise with the written consent of [TIG]." Stryker argued that, as applied to the particular facts presented, the ultimate net loss provision is latently ambiguous. In particular, Stryker argued that it "was forced to present its direct settlements to TIG years after they were made" because the underlying primary insurer gave priority payment to claims against Pfizer (a partially-owned subsidiary of Stryker), before addressing any direct liability claims against Stryker. A Michigan district court agreed and granted Stryker's summary judgment motion. The Sixth Circuit reversed.

Applying Michigan law, the Sixth Circuit held that TIG's policy required written consent for any and all settlements. The court rejected Stryker's contention that "the unusual facts" of this case give rise to a latent ambiguity. The court ruled that TIG employees' testimony about the provision did not create a latent ambiguity. The court also rejected Stryker's assertion that TIG waived its right to enforce the consent provision, explaining "that contention rests on the false premise that [the primary insurer]'s denial of coverage should be imputed to TIG, simply because the excess-liability policy followed form."

Insurer Has No Duty To Settle For All Insureds

Addressing a matter of first impression, a New Jersey court ruled that an insurer may settle claims for one insured without reaching a settlement for additional insureds, so long as the settlement was made in good faith. *Nat'l Surety Corp. v. First Specialty Ins. Corp.*, 2016 WL 7057503 (N.J. Superior Ct. Nov. 18, 2016).

The coverage dispute arose out of a murder at a shopping mall. The deceased's family sued the mall and a security company, among others. First Specialty, which provided primary additional insured coverage to the mall and the security company, agreed to defend the suit. After attempts to reach a global settlement failed, First Specialty reached an agreement with the underlying plaintiff and the security company's excess insurer. Under the agreement, First Specialty would pay its $2 million policy limit to settle the claims against the security company. The settlement did not resolve the claims against the mall defendants. National Security, the mall's excess insurer, filed suit to prevent First Specialty from finalizing the settlement. National Security argued that First Specialty was obligated to allocate its policy limits equally among additional insureds in any settlement. National Security further argued that even if First Specialty could exhaust its policy limits by settling the claims on behalf of the security company, it was nonetheless required to continue defending the mall in the underlying action. The court rejected both arguments.

First Specialty's policy states that "We (FSIC) may, at our discretion, investigate any 'occurrence' and settle any claim or 'suit' that may result." The court ruled that this language unambiguously gives the insurer the discretion to exhaust its limits to settle on behalf of any insured defendant, so long as the settlement is made in good faith. The court further explained that First Specialty had engaged in extensive good faith negotiations, and that the mall defendants had a substantial amount of coverage and defense costs available under their own primary and excess policies. Finally, the court held that First Specialty no longer had a duty to defend once its policy limit was exhausted because the policy expressly stated

that defense obligations terminate upon exhaustion of limits by payment of judgment or settlement.

Policy Construction Alert:

West Virginia Supreme Court Holds That Intentional Acts Exclusion Bars Coverage For Innocent Co-Insureds, Notwithstanding Severability Clause

The West Virginia Supreme Court ruled that intentional acts exclusions in homeowners' policies bar coverage for negligence claims against co-insureds, notwithstanding severability clauses. *Am. Nat'l Prop. & Cas. Co. v. Clendenen*, 2016 WL 6833123 (W. Va. Nov. 17, 2016).

Two teenage girls were convicted of murdering a fellow student. The deceased's family sued the girls' parents for negligent supervision, among other things. Each family sought coverage under a homeowner's policy. The insurers argued that coverage was barred by an intentional acts exclusion. The homeowners claimed that the exclusions did not apply to them, as innocent co-insureds, because severability clauses require coverage to be applied separately to each insured. A West Virginia federal district certified the following two questions to the state supreme court:

> 1. Applying West Virginia public policy and rules of contract construction, do the unambiguous exclusions in American National's policy for bodily injury or property damage "which is expected or intended by any insured even if the actual injury of damage is different than expected or intended," and "arising out of any criminal act committed by or at the direction of any insured," and the unambiguous exclusion in Eire's policy for "bodily injury, property damage, or personal injury expected or intended by 'anyone we protect' … ," preclude liability coverage for insured who did not commit any intentional or criminal act?
>
> 2. If so, do the unambiguous severability clauses in the insurance policies, which state that the insurance applies separately to each insured, prevail over the exclusions and require the insurers to apply the exclusions separately to each insured, despite the intentional and criminal actions of co-insureds?

The West Virginia Supreme Court answered "yes" to first question and "no" to the second. It reasoned that the plain language of the exclusions bar coverage for intentional acts committed by "any insured" or "anyone … protect[ed]." Rejecting the policyholders' public policy arguments, the court noted that a majority of jurisdictions have applied similar exclusions to preclude coverage to an insured based on the intentional or criminal acts of a co-insured. The court also ruled that the severability clauses have no bearing on the exclusionary language and do not render the exclusions ambiguous, contrary to a ruling of the California Supreme Court. *See Minkler v. Safeco Ins. Co. of Am.*, 232 P.3d 612 (Cal. 2010) (discussed in our July/August 2010 Alert).

Notice Alert:

Consecutive Claims-Made Policies Create Continuous Coverage Period For Notice Purposes, Says Delaware Court

A Delaware court ruled that coverage is not barred under a claims-made policy even when the policyholder fails to provide notice of a claim within the policy period. The court reasoned that coverage is available pursuant to the "claims-made relationship" because notice was provided during a subsequent renewal policy period. *Med. Depot, Inc. v. RSUI Indem. Co.*, 2016 WL 5539879 (Del. Superior Ct. Sept. 29, 2016).

RSUI issued a claims-made policy to Medical Depot in effect from June 15, 2013 through June 15, 2014, and then renewed the policy for the June 15, 2014 – June 15, 2015 period. The policies required notice of any claim to be provided "as soon as practicable" or within 60 days after the policy's expiration. On June 18, 2013, Tony Mezzadri sent a demand letter to Medical Depot threatening

to sue. In March 2014, Mezzadri filed a complaint seeking monetary and injunctive relief. Although Mezzadri did not serve the complaint on Medical Depot, the company was aware of it, but did not notify RSUI of its existence or the demand letter. On September 2, 2014, during the policy renewal period, Mezzadri served an amended complaint on Medical Depot. Medical Depot notified RSUI within a week. RSUI denied coverage based on Medical Depot's failure to give notice of the demand letter or initial complaint. Ruling on the parties' cross-motions for summary judgment, the court held that: (1) the demand letter is not a claim; (2) the initial complaint is a claim; (3) Medical Depot failed to give notice of the initial complaint as soon as practicable or within the first policy period; and (4) the claim is nonetheless covered because it falls within RSUI's coverage as part of the "claims-made relationship."

The court ruled that the demand letter is not a claim because it did not seek monetary relief. However, the court concluded that the initial complaint constitutes a "claim" because it is a written demand for money. The court rejected Medical Depot's argument that a "claim" does not exist until a complaint is served. The court further held that Medical Depot failed to comply with the policy's condition precedent notice requirements because it did not notify RSUI of the initial complaint as soon as practicable or within 60 days of the policy's expiration.

Nonetheless, the court ruled that coverage was not precluded based on a "New York Regulation 121 Disclosure Supplement" that defines "Claims-Made Relationship" as "the period of time between the effective date of the first claims-made policy between Us and You and the cancellation and nonrenewal of the last consecutive claims-made policy between Us and You, where there has been no gap in coverage." The Disclosure Supplement further states that "coverage is provided for liability ONLY IF THE CLAIM FOR DAMAGES IS FIRST MADE AGAINST THE INSURED AND REPORTED TO US IN WRITING DURING THE POLICY PERIOD, ANY SUBSEQUENT RENEWAL AND ANY APPLICABLE DISCOVERY PERIOD." The court ruled that these provisions operate to provide a seamless two-year period of coverage, rejecting RSUI's argument that the policy's notice provisions override the Disclosure Statement. The court acknowledged that the Disclosure Statement explicitly states that "the provisions of the policy and the endorsements attached thereto are controlling," but concluded that no conflict exists between the policy provisions and Disclosure Statement. The court reasoned that the notice provisions would bar coverage if there had been no renewal policy, but that once a renewal was issued, the Disclosure Statement became operative.

Finally, the court ruled that prejudice is required to deny coverage based on late notice under a claims-made policy where, as here, notice is untimely but still within the coverage period. Under Delaware law, prejudice is not required in the claims-made context when notice is provided outside the policy period.

STB News Alerts:

Simpson Thacher's Insurance Practice was ranked as Tier 1 by Euromoney's Benchmark Litigation for the tenth consecutive year. Mary Beth Forshaw was named a "Top 10 Star" for Insurance. The lists were compiled based on six months of intensive peer, client, and case review.

Bryce Friedman spoke on the arbitration process at the 2016 ARIAS•U.S. Fall Conference on Thursday, November 17th. His panel, "Improving the Arbitration Process through Better Contract Wording," assessed the efficacy of the arbitration process in reinsurance disputes.

Simpson Thacher

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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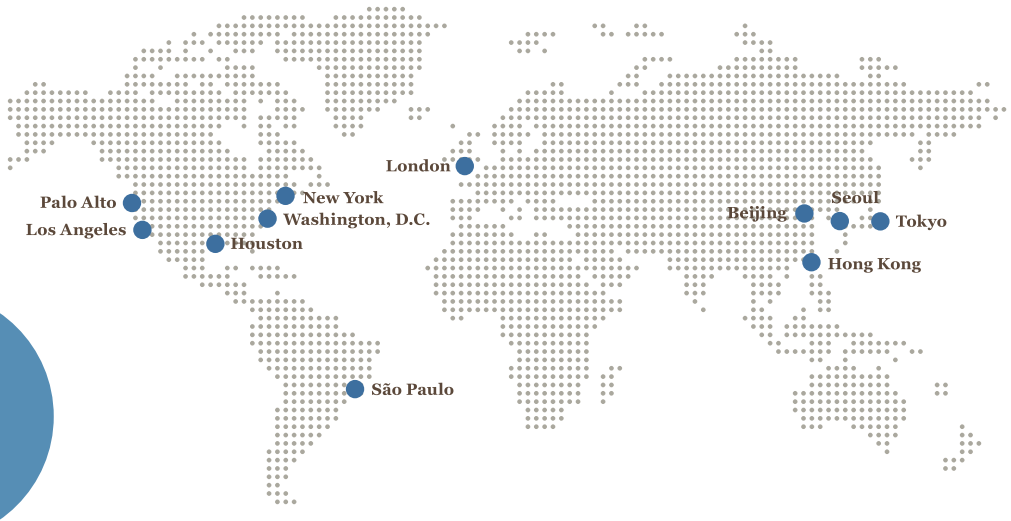

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