Simpson Thacher

Insurance Law Alert

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"Many other firms do insurance work, but we go straight to Simpson Thacher for the 'bet-the-company' fact-intensive stuff."

–Benchmark 2016, quoting a client

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The New Hampshire Supreme Court ruled that an excess insurer has no duty to defend until the primary insurer's coverage is exhausted. *Old Republic Ins. Co. v. Stratford Ins. Co.*, 2016 WL 302212 (N.H. Jan. 26, 2016). (Click here for full article)

Failure-to-Warn Suit Alleges Bodily Injury Triggering Insurer's Duty to Defend, Says California Court

A California federal district court ruled that an insurer was obligated to defend a class action suit alleging that a mattress company failed to warn consumers of harmful product defects because the complaint alleged "bodily injury." *Hartford Fire Ins. Co. v. Tempur-Sealy Int'l, Inc.*, 2016 WL 232431 (N.D. Cal. Jan. 20, 2016). (Click here for full article)

Courts Reach Contradictory Conclusions Whether Prejudice Is Required for Late Notice Defense Under Claims-Made Policy

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A Florida appellate court upheld a homeowner's post-loss assignment of policy benefits to a water removal company despite her failure to obtain insurer consent. *Bioscience W., Inc. v. Gulfstream Prop. & Cas. Ins. Co.*, 2016 WL 455723 (Fla. Dist. Ct. App. Feb. 5, 2016). (Click here for full article)

Hawaii Supreme Court Clarifies Scope of Work-Product Protection and Insurer Bad Faith

The Supreme Court of Hawaii ruled that issues of fact precluded summary judgment on an insurer bad faith claim, and that application of the work-product doctrine to documents prepared by a dual capacity in-house attorney/claims adjuster turns on whether the documents were prepared "because of" litigation. *Anastasi v. Fidelity National Title Ins. Co.*, 2016 WL 462380 (Haw. Feb. 4, 2016). (Click here for full article)

Minnesota Supreme Court Rules That Depreciated Labor Costs May Be Considered in Calculating Actual Cash Value

The Minnesota Supreme Court ruled that where a policy does not define "actual cash value," the trier of fact may determine whether the depreciation of labor costs should be considered. *Wilcox v. State Farm Fire & Cas. Co.*, 2016 WL 516707 (Minn. Feb. 10, 2016). (Click here for full article)

STB News Alerts

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Defense Alert:

D.C. Court of Appeals Rules That Professional Services Exclusion Does Not Negate Duty to Defend

The District of Columbia Court of Appeals vacated a superior court decision holding that insurers had no duty to defend underlying suits on the basis of a professional services exclusion. *Carlyle Inv. Mgmt., LLC v. Ace Am. Ins. Co.*, 2016 WL 555742 (D.C. Feb. 11, 2016).

Following the "mortgage and liquidity crises" in 2008, several lawsuits were filed against the Carlyle Capital Corporation, its parent company and other affiliates. The suits alleged, among other things, that the Carlyle defendants enticed investors into unsafe investments by issuing false and misleading statements. The Carlyle defendants turned to their private equity management and professional liability insurers for the advancement and reimbursement of defense costs, which the insurers denied on the basis of a professional services exclusion. The Carlyle defendants brought suit alleging breach of contract and seeking a declaration as to the insurers' defense obligations. A District of Columbia trial court granted the insurers' motion to dismiss, ruling that the professional services exclusion was unambiguous and excluded coverage for all losses alleged in the underlying suits. The appellate court vacated the ruling and remanded the matter for discovery.

The appellate court ruled that the term "professional services" was ambiguous. Noting that the definition of "professional services" contained eight sub-parts and included various important terms that were undefined (such as "investment management services," "fund" and "organization"), the court held that the exclusion was "not easy to interpret." In addition, the appellate court expressed doubt as to the trial court's application of the "eight corners rule" in dismissing the duty to defend suit as a matter of law. For example, the court questioned whether all of the claims alleged in a 121-page, nineteen-count complaint filed by liquidators of the Carlyle Capital Corporation (including claims alleging breach of fiduciary and other duties, breach of fiduciary duty as a de facto or shadow director, wrongful trading and unjust enrichment) fell within the scope of the exclusion as a matter of law. Similarly, the appellate court noted the trial court's failure to specify how the exclusion encompassed underlying claims relating to corporate governance or arising out of conduct or statements unrelated to the solicitation for the purchase or sale of interests.

Excess Alert:

New Hampshire Supreme Court Rules That Excess Insurer's Duty to Defend is Triggered Only Upon Exhaustion of Primary Coverage

Answering a question certified by the First Circuit, the New Hampshire Supreme Court ruled that an excess insurer has no duty to defend until the primary insurer's coverage is exhausted. *Old Republic Ins. Co. v. Stratford Ins. Co.*, 2016 WL 302212 (N.H. Jan. 26, 2016). Noting that the allocation of defense costs between a primary and an excess insurer was previously unsettled under New Hampshire law, the New Hampshire Supreme Court joined the majority of jurisdictions in holding that an excess insurer has no obligation to participate in the defense of a policyholder until primary policy limits have been exhausted. The court explained that "[u]ntil the excess insurer has indemnity exposure, there is no reason it should have a role in making strategic decisions regarding the defense of an insured, nor should it be required to pay a share of the defense costs." The court expressly distinguished cases in which two insurers, both with excess "other insurance" provisions, have been required to shared defense costs equally. In those cases, competing excess "other insurance" provisions were deemed mutually repugnant and thus unenforceable, rendering both policies co-primary.

Bodily Injury Alert:

Failure-to-Warn Suit Alleges Bodily Injury Triggering Insurer's Duty to Defend, Says California Court

A California federal district court ruled that an insurer was obligated to defend a class action suit alleging that a mattress company failed to warn consumers of harmful product defects because the complaint alleged "bodily injury." *Hartford Fire Ins. Co. v. Tempur-Sealy Int'l, Inc.*, 2016 WL 232431 (N.D. Cal. Jan. 20, 2016).

A class action complaint alleged that Tempur-Sealy failed to inform consumers that its products emitted a chemical odor that contained a known carcinogen and caused serious allergic reactions. Although the complaint contained numerous allegations relating to personal injuries, it explicitly stated that plaintiffs were not seeking damages for physical injuries. Rather, the underlying plaintiffs sought injunctive relief and compensatory, actual and statutory damages pursuant to various consumer protection statutes, as well as "such other and further relief as this Court may deem just and proper." Hartford initially defended the suit, but later sought a declaration that the underlying claims were not covered by the policies. Both parties moved for summary judgment. The court ruled in favor of Tempur-Sealy, finding that the complaint at least potentially alleged damages for "bodily injury."

Although the complaint did not assert any specific claims for bodily injury, the court reasoned that the statutory consumer protection claims incorporated and derived from factual allegations of bodily injuries. Therefore, the court concluded that the complaint demonstrated potential liability under the policy. The court rejected the argument that there was no duty to defend because the complaint expressly declined to seek damages for physical injuries, explaining that the plaintiffs' "purported disavowal of bodily injury claims is not dispositive." Finally, the court ruled that the complaint alleged an "occurrence" notwithstanding allegations of intentional fraud and deceit. The court held that the series of events leading up to the alleged misrepresentations —*i.e.*, the manufacture and sale of defective mattresses—sufficiently alleged an unexpected "occurrence."

The court relied on *Plantronics, Inc. v. American Home Assurance Co.*, 2014 WL 2452577 (N.D. Cal. May 30, 2014), which required an insurer to defend a complaint that alleged facts supporting a potential claim for bodily injury but that explicitly disclaimed damages for physical injury. However, as reported in our July/August 2011 Alert, a California appellate court ruled that a failure-to-warn lawsuit alleging that nail products contained harmful toxins did not trigger an insurer's duty to defend, because the complaint did not allege bodily injury. *Ulta Salon, Cosmetics & Fragrance, Inc. v. Travelers Prop. Cas. Co. of Am.*, 127 Cal. Rptr.3d 444 (Cal. Ct. App. 2011). Although the underlying complaint in *Ulta* differed in some significant respects from the complaint in *Tempur-Sealy,* the *Ulta* court explicitly rejected the notion that a potential for coverage could be established by speculating about ways in which the complaint might be amended in the future.

Late Notice Alerts:

Courts Reach Contradictory Conclusions Whether Prejudice Is Required for Late Notice Defense Under Claims-Made Policy

New Jersey Supreme Court Says Prejudice is Not Required

The New Jersey Supreme Court ruled that an insurer need not establish prejudice in order to deny coverage under a claims-made policy based on late notice. *Templo Fuente De Vida Corp. v. Nat. Union Fire Ins. Co. of Pa.*, 2016 WL 529602 (N.J. Feb. 11, 2016).

National Union insured First Independent Financial Group under a claims-made policy. The policy required as a "condition precedent" to coverage "written notice to the Insurer of any Claim made against an Insured as soon as practicable." First Independent sought coverage under the policy for claims arising out of a failed purchase agreement. National Union denied coverage based on late notice because First Independent did not provide notice until six months after receiving the first-amended complaint. In ensuing coverage litigation, a New Jersey trial court granted National Union's summary judgment motion. Although the trial court found insufficient evidence that the claims had been made outside the policy period, it found that coverage was nonetheless barred because notice was not provided "as soon as practicable." An appellate court affirmed, explaining that the policy required the insured to provide notice both within the policy period *and* as soon as practicable. The New Jersey Supreme Court affirmed.

The New Jersey Supreme Court ruled that First Independent's unexplained six-month delay in providing notice violated the policy's notice provision as a matter of law. The court further ruled that National Union was not required to establish prejudice from First Independent's failure to provide notice "as soon as practicable." In so holding, the court expressly referenced the unambiguous condition precedent policy language and emphasized the equal bargaining power of First Independent and National Union as two sophisticated business entities. The court explained that equitable concerns presented in late notice cases involving policyholders who are "unsophisticated consumers" were not at issue given First Independent's business acumen. For this reason, it is likely that policyholders will argue that *Templo Fuente*'s no-prejudice rule should be limited to cases involving sophisticated corporate insureds.

Maryland Appellate Court Requires "Actual Prejudice"

Maryland statutory law requires an insurer to establish actual prejudice in order to deny coverage based on late notice under a claims-made policy. *See Sherwood Brands, Inc. v. Great Am. Ins. Co.*, 13 A.3d 1268 (Md. 2011) (under Ins. § 19-110, an insurer may disclaim coverage based on untimely notice only if it "establishes by a preponderance of the evidence that the lack of cooperation or notice has resulted in actual prejudice"). Applying section 19-110, a Maryland appellate court recently held that an insurer was not entitled to disclaim coverage as a matter of law under a claims-made-and-reported policy, notwithstanding a nearly three-year delay in notice. *Fund for Animals, Inc. v. Nat. Union Fire Ins. Co. of Pittsburgh, Pa.*, 2016 WL 385222 (Md. Ct. Spec. App. Feb. 1, 2016).

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 and alleged RICO violations in connection with the Fund's prosecution of the ESA Case. Feld asserted that the Fund bribed individual plaintiffs 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 countersuit was brought, the Fund sought coverage for the RICO suit from National Union under a 2007 claims-made-and-reported policy. By that time, a court had already ruled against the Fund in the ESA Case and 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 under section 19-110. The appellate court reversed.

The appellate court acknowledged the untimeliness of the Fund's notice of the RICO suit and that the adverse ruling in the ESA Case prejudiced National Union. However, the court held that National Union failed to establish a causal link between the delay and the prejudice. In particular, the court explained that National Union did not prove that, "had it been given timely notice of the RICO Case, in 2007 or early 2008, instead of untimely notice in 2010, it would have taken some action in that period of delay that would have averted that judgment." In so ruling, the court emphasized that National Union did not insure any defendant in the ESA Case and 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, the court noted that the insurer would be prejudiced by the delay due to its inability to investigate claims and to control the defense.

Disclaimer Alert:

New York Statute Requires Insurer to Issue Separate Disclaimer to Additional Insured, Says New York Court

A New York trial court ruled that New York Insurance Law section 3420(d) requires an insurer to provide separate and timely disclaimers to each "additional insured" and that failure to do so results in a waiver of policy exclusions. *Vargas v. City of New York*, 2016 WL 184531 (N.Y. Sup. Ct. N.Y. Cnty. Jan. 15, 2016).

Liberty issued insurance to a sub-contractor involved in a construction project. The policy provided additional insured coverage to several parties involved in the project, including other contractors and certain New York City agencies. When a personal injury lawsuit was served against the contractors and the City agencies, one of the additional insured contractors tendered defense and indemnity to Liberty. Liberty promptly disclaimed coverage on the basis of a policy exclusion. However, the City defendants did not receive a copy of the disclaimer letter. The City defendants filed a third-party complaint against Liberty, arguing that as to the City's claim for coverage, Liberty violated its timely disclaimer obligation under section 3420(d). The court agreed.

Liberty argued that it timely disclaimed coverage to the City defendants via its disclaimer letter to the other additional insured party. Alternatively, Liberty argued that it was not obligated to disclaim as to the City defendants until they had tendered a claim, which Liberty argued occurred upon the City's filing of a third-party complaint. The court rejected both arguments. First, the court ruled that an insurer's obligations under section 3420(d) apply to additional insureds and that Liberty's disclaimer to a different additional insured was not effective as to the City defendants. Second, the court held that even if the City defendants' third-party complaint was the event that triggered Liberty's disclaimer obligation, its disclaimer was still untimely as a matter of law. The court explained that Liberty's answer, which effectively disclaimed coverage, was served 45 days after receipt of the complaint. Under New York law, delays of more than 30 days have been declared untimely as a matter of law.

Settlement Alert:

California Appellate Court Rules That Policyholder's Failure to Obtain Excess Insurer's Consent Prior to Settlement Constitutes Prejudice

Applying Missouri law, a California appellate court ruled that a policyholder was obligated to obtain the consent of an excess insurer prior to settling an environmental pollution suit. *Doe Run Res. Corp. v. Fidelity & Cas. Co. of N.Y.*, 2016 WL 379839 (Cal. Ct. App. Feb. 1, 2016).

Environmental litigation against Doe Run began in 2001. Doe Run notified its excess insurer, Fidelity, of the suit, but Fidelity did not participate in the defense. In 2011, Doe Run informed Fidelity of anticipated mediation but did not specify that a potential settlement might implicate Fidelity's excess coverage. At mediation, Doe Run agreed to settle for $55 million. Approximately one month later, in response to a status inquiry, Doe Run informed Fidelity of the settlement. Shortly thereafter, Doe Run filed suit seeking coverage from Fidelity. A California trial court granted Fidelity's summary judgment motion and the appellate court affirmed.

The Fidelity policy provided indemnification for "ultimate net loss," defined as "the sum actually paid or payable in cash in settlement or satisfaction of losses for which the Insured is liable either by adjudication or compromise with the written consent of the company." The appellate court ruled that Doe Run violated this provision by failing to obtain Fidelity's consent prior to settlement. The court further ruled that under Missouri law, a violation of a consent clause, without more, is sufficient to preclude coverage. The court explained that a showing of prejudice is not required, because the "very fact of depriving the insurer of the 'opportunity to protect its interests'" prior to settlement constitutes prejudice itself. The court stated, "[t]here [is] no need for the insurer to prove that, despite the loss of that opportunity, it might have done better if it had been notified."

Allocation Alert:

Insured Responsible for Pro Rata Shares of Insolvent Insurers, Says New Jersey Appellate Court

A New Jersey appellate court ruled that a policyholder was responsible for sums allocated to insolvent insurers and that such costs should not be reallocated to solvent primary and excess insurers. *Ward Sand and Materials Co. v. Transamerica Ins. Co.*, 2016 WL 237781 (N.J. Sup. Ct. App. Div. Jan. 12, 2016).

Ward, a municipal waste operator, was sued for environmental contamination. Ward was insured under a series of primary and excess policies during the relevant time frame. While litigation against Ward was pending, several insurers became insolvent. The New Jersey Property Liability Insurance Guaranty Association ("PLIGA") contributed to defense costs on behalf of the insolvent insurers. Ward ultimately settled the underlying litigation and sought indemnification from PLIGA and its primary and excess insurers. A New Jersey trial court ruled that costs must be allocated pro rata among insurers and that Ward was responsible for sums allocated to its insolvent insurers to the extent that such sums exceeded settlement payments made by PLIGA. The appellate court affirmed.

The appellate court ruled that under well-established state law, Ward was responsible for the pro rata shares of its insolvent insurers to the extent that such sums were not paid by PLIGA. *See Carter-Wallace, Inc. v. Admiral Ins. Co.*, 154 N.J. 312 (1998); *Owens-Illinois, Inc. v. United Ins. Co.*, 138 N.J. 437 (1994); *Sayre v. Ins. Co. of N. Am.*, 305 N.J. Super. 209 (1997). Ward argued that a 2004 amendment to the PLIGA Act (N.J.S.A. 17:30A-5) required the solvent insurers to cover those costs. The appellate court acknowledged that the amendment shifts responsibility for an insolvent carrier's pro rata share to solvent insurers rather than the policyholder. However, the court held that the amendment was inapplicable because it applied prospectively and here, the insurer insolvencies had occurred prior to the amendment's December 2004 effective date. The court rejected Ward's assertion that the amendment should be applied retroactively on the basis that it is "ameliorative" or "corrective."

Reinsurance Alert:

Reinsurer Required to Follow the Fortunes, Says New York Court

A New York federal district court ruled that a reinsurer is bound by a ceding insurer's settlements pursuant to the follow-the-fortunes doctrine. *Utica Mut. Ins. Co. v. Clearwater Ins. Co.*, 2016 WL 254770 (N.D.N.Y. Jan. 20, 2016).

Utica insured Goulds, a pump manufacturer, under primary and umbrella policies. Clearwater issued reinsurance certificates for the umbrella policies, which required Clearwater to "follow [Utica's] liability in accordance with the terms and conditions of the policy reinsured hereunder." Goulds was sued in several suits alleging asbestos-related injuries and, pursuant to a settlement agreement between Goulds and Utica, Utica provided defense and indemnity coverage to Goulds. Utica sought reimbursement from Clearwater pursuant to the reinsurance certificates. Clearwater made some, but not all payments, and Utica brought suit alleging breach of contract. The court granted Utica's summary judgment motion.

The court ruled that Clearwater was bound by Utica's underlying settlement with Goulds under the follow-the-fortunes doctrine, which requires a reinsurer to accept a cedent's reasonable, good faith settlement decisions. The court rejected Clearwater's assertion that Utica settled in bad faith because Utica purportedly shifted liability from its primary policies to its umbrella policies, which purportedly had more reinsurance and which Clearwater reinsured. In so ruling, the court noted that "a cedent has no obligation to strictly align its interests with the reinsurer" and that knowledge of a settlement's impact on reinsurance recovery, standing alone, does not amount to gross negligence or recklessness. Additionally, the court concluded that Utica's settlement was reasonable under the circumstances presented.

Finally, the court held that Clearwater was obligated to cover various billings, including defense costs, declaratory judgment expenses, and orphan share payments. The court ruled that all such payments were within the scope of "loss expenses," defined as "all expenses incurred in the investigation, adjustment, settlement or litigation of claims, awards or judgments." The court reasoned that Utica's declaratory judgment expenses constituted "loss expenses" because the factual record established that those costs were incurred to resolve the underlying coverage dispute. In so ruling, the court noted that Clearwater's own claims handlers testified that they understood declaratory judgment expenses to be "loss expenses." With respect to defense costs, the court rejected Clearwater's assertion that Utica, as an umbrella insurer, had no obligation to fund the underlying policyholder's defense. The court ruled that Utica's position that it was obligated to defend the policyholder based on purported exhaustion of primary policies was reasonable. Therefore, under the follow-the-fortunes "at least arguably within the scope of insurance coverage" standard, Clearwater was obligated to cover those costs. The case has been appealed to the Second Circuit. We will keep you posted on developments in this matter.

Assignment Alert:

Florida Appellate Court Rules That Post-Loss Assignment of Policy Benefits Is Valid Notwithstanding Lack of Insurer Consent

A Florida appellate court upheld a homeowner's post-loss assignment of policy benefits to a water removal company despite her failure to obtain insurer consent. *Bioscience W., Inc. v. Gulfstream Prop. & Cas. Ins. Co.*, 2016 WL 455723 (Fla. Dist. Ct. App. Feb. 5, 2016).

When a homeowner suffered water damage, she hired Bioscience to perform emergency water removal services. She executed an "Assignment of Insurance Benefits" authorizing Bioscience to bill and to collect payment directly from Gulfstream, her property insurer. When Gulfstream denied the homeowner's claim, Bioscience, as assignee of the right to recover policy benefits, sued for breach of contract. A Florida trial court granted Gulfstream's motion for summary judgment, finding that state law and the insurance policy prohibited the assignment of benefits without insurer consent. The appellate court reversed.

The policy provided that "[a]ssignment of this policy will not be valid unless we give our written consent." The appellate court ruled that this provision prohibited assignment of the entire policy but not the assignment of financial proceeds derived from a benefit of the policy. On this basis, the court upheld the assignment because it involved an "assignment of a benefit under the policy to Bioscience, namely a right to seek payment for the mitigation services it rendered." In addition, the court noted that the "loss-payment" provision of the policy supported its holding because the provision recognized the potential need to pay third parties that might be "legally entitled" to payment under the policy. Finally, the court noted that even where policies contain specific anti-assignment clauses, courts routinely allow the assignment of policy benefits after a loss has occurred.

Bad Faith/ Discovery Alert:

Hawaii Supreme Court Clarifies Scope of Work-Product Protection and Insurer Bad Faith

In *Anastasi v. Fidelity National Title Insurance Co.*, 2016 WL 462380 (Haw. Feb. 4, 2016), the Supreme Court of Hawaii ruled that issues of fact precluded summary judgment on an insurer bad faith claim, and that application of the work-product doctrine to documents prepared by a dual capacity in-house attorney/claims adjuster turns on whether the documents were prepared "because of" litigation.

Anastasi sued Fidelity for bad faith and breach of contract after Fidelity allegedly delayed payments under a title insurance policy. In particular, Anastasi alleged that Fidelity knew early on that the deed to the property was forged, but continued to litigate the issue in order to delay payment. A trial court granted Fidelity's summary judgment motion on the bad faith claim, finding that its actions were reasonable as a matter of law. The trial court also ruled that Fidelity was entitled to withhold certain documents as protected by the attorney-client privilege and the work-product doctrine. An intermediate appellate court vacated the bad faith ruling, finding that issues of fact existed as to whether Fidelity acted reasonably. The appellate court also ruled that the trial court abused its discretion in ruling that certain documents, which were prepared by an individual that acted in a dual capacity as in-house counsel and claims adjuster, were protected by the work-product doctrine or by attorney-client privilege. The Hawaii Supreme Court affirmed in part and vacated in part.

With respect to the bad faith claim, the Hawaii Supreme Court agreed that issues of fact precluded summary judgment. Viewing the evidence in the light most favorable to Anastasi, the court held that a question existed as to whether Fidelity acted reasonably given the information it had as to the underlying forgery and the time at which it obtained that information. The court rejected Fidelity's arguments that (1) it should not be found to have acted in bad faith, because it was exercising its rights under the policy; and (2) the enhanced standard of good faith under Hawaii law should not apply to title insurers.

As to the discovery ruling, the Hawaii Supreme Court held that the relevant inquiry for determining if a document is protected by the work-product doctrine is whether the document was prepared in anticipation of litigation. Where, as here, an attorney performs both legal duties and claims adjusting, the test is whether materials were created "because of" litigation. The Hawaii Supreme Court ruled that the appellate court erred in focusing on whether the materials were prepared before or after a formal determination had been made on the claim. The court stated that "the rule clearly focuses on the purpose of the prepared material and not on when it is prepared." Similarly, it found error in the appellate court's use of a presumption that materials prepared before a final determination on the insured's claim are not work product. The court remanded the discovery matter to the trial court for a determination of work-product protection based on the "because of" litigation test.

Property Insurance Alert:

Minnesota Supreme Court Rules That Depreciated Labor Costs May Be Considered in Calculating Actual Cash Value

Last month's Alert reported on an Arkansas Supreme Court decision holding that state law prohibits including the depreciation of labor costs in calculating the actual cash value of a covered loss even where a policy provision expressly allows for such depreciation. *Shelter Mut. Ins. Co. v. Goodner*, 2015 WL 8482788 (Ark. Dec. 10, 2015). In *Shelter Mutual*, the court relied solely on a prior decision in which the term "actual cash value" was undefined and thus deemed ambiguous. *See Adams v. Cameron Mut. Ins. Co.*, 430 S.W.3d 675 (Ark. 2013). This month, the Minnesota Supreme Court reached the opposite conclusion, ruling that where a policy does not define "actual cash value," the trier of fact may determine whether the depreciation of labor costs should be considered. *Wilcox v. State Farm Fire & Cas. Co.*, 2016 WL 516707 (Minn. Feb. 10, 2016).

The Minnesota Supreme Court ruled that the "actual cash value" provision was not ambiguous, notwithstanding the absence of a definition or specified calculation method. The court reasoned that "actual cash value" is a legal term of art that refers to the "actual loss" incurred by the policyholder. The court held that a trier of fact is afforded broad discretion to adopt a "flexible approach" that considers "every fact and circumstance which would logically tend to the formation of a correct estimate of the loss." Where, as here, labor depreciation is not expressly precluded from consideration, the court held that there is no basis for disallowing it as a relevant factor. In endorsing a fact-specific approach, the court emphasized that labor cost depreciation "is only one of many factors to be considered by the trier of fact; and its relevance depends on the facts and circumstances of the particular case."

STB News Alerts

Mary Beth Forshaw received the Insurance Lawyer of the Year Award at the 2016 *Benchmark Litigation* Awards dinner.

For the fourth consecutive year, Simpson Thacher was also named the Insurance Practice of the Year.

Benchmark also recognized **David Woll** and Simpson Thacher with a National Impact Case Award for their victory in a closely-watched appeal before the New York Court of Appeals on behalf of DB Structured Products, Inc., in which the Court of Appeals upheld the dismissal of a suit alleging breaches of representations and warranties with respect to several hundred millions of dollars in mortgage loans as time-barred. *Benchmark Litigation* honors firms and attorneys that have emerged as leaders in their particular areas of law over the past 12 months.

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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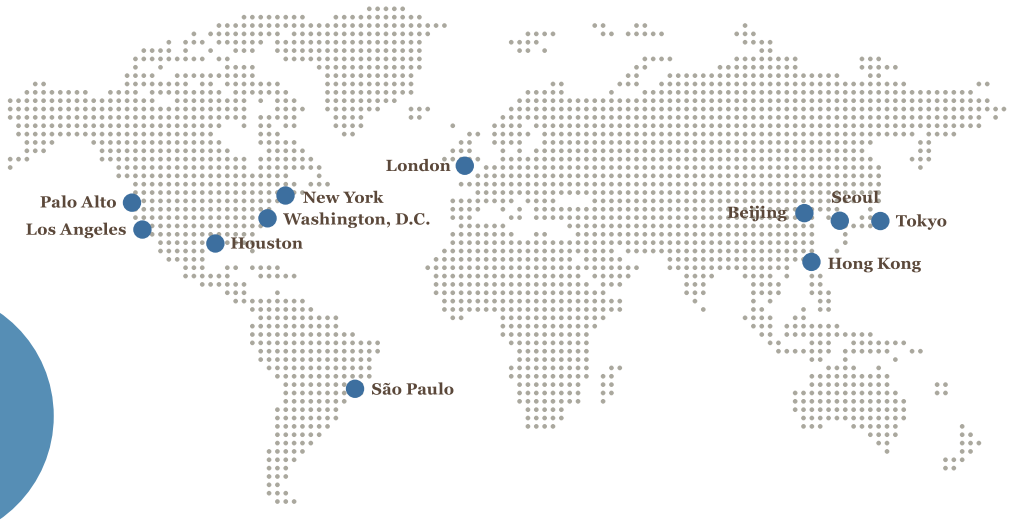

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