Simpson Thacher

Insurance Law Alert

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New Jersey Appellate Court Reinstates Consumer Fraud Act Claim Based On Delayed Payment to Homeowner

A New Jersey appellate court ruled that a homeowner was entitled to pursue a Consumer Fraud Act claim against his mortgage company based on a delay in payment of insurance proceeds for storm-related losses. *Abbas v. PennyMac Corp.*, 2015 WL 4275962 (N.J. Super. Ct. App. Div. July 16, 2015) (unpublished decision). (click here for full article)

Statute of Limitations For Declaratory Judgment Action Begins To Run When Insurer Has Sufficient Basis for Denying Defense, Says Pennsylvania Court

The Superior Court of Pennsylvania ruled that the statute of limitations for a declaratory judgment action regarding an insurer's duty to defend does not start to run until the insurer has sufficient factual basis for denying a defense. *Selective Way Ins. Co. v. Hospitality Grp. Servs., Inc.*, 2015 WL 4094398 (Pa. Super. Ct. July 7, 2015). (click here for full article)

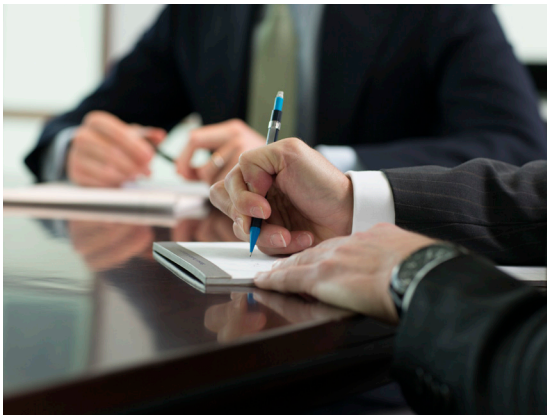
Cyber Coverage Alert:

New York Court of Appeals Limits Scope of Cyber Coverage to Hacking Incidents

The New York Court of Appeals ruled that coverage for the "fraudulent entry" of data is limited to losses caused by unauthorized access into the policyholder's computer system and does not encompass losses caused by an authorized user's entry of such information into the system. *Universal Am. Corp. v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA*, 2015 WL 3885816 (N.Y. June 25, 2015).

National Union issued a policy to Universal, a health care company, that covered losses "resulting directly from a fraudulent … entry of Electronic Data or Computer Program into … the Insured's proprietary Computer System." When Universal discovered $18 million in losses from the payment of fraudulent claims, it sought indemnification from National Union. National Union denied coverage on the ground that the policy did not provide coverage for fraudulent claims entered into Universal's computer system by authorized users.

A New York trial court agreed, ruling that the provision unambiguously provided coverage only "for an unauthorized entry into the computer system by a hacker or through a computer virus." The appellate court modified and affirmed the ruling, holding that the policy covered losses from "wrongful acts in the manipulation of the computer system" but did not cover losses from fraudulent content entered by authorized users, as was the case here. The New York Court of Appeals affirmed, reasoning that the term "fraudulent" modified the word "entry," and that the policy therefore covered only losses from improper entry or access into the computer system (*i.e.*, hacking), but not losses caused by the submission of fraudulent content by authorized users. The decision illustrates the importance of policy language in this context, as the court expressly distinguished cases involving broader policy language, including explicit definitions of "computer fraud."



Consent-to-Settle Alerts:

Consent-to-Settle Provision Not Void as Against Public Policy, Rules New York Court

A New York federal district court refused to invalidate a consent-to-settle provision on public policy grounds, noting that to do so would "revolutionize" New York insurance law. *SI Venture Holdings, LLC v. Catlin Specialty Ins.*, 2015 WL 4191453 (S.D.N.Y. July 10, 2015).

SI Venture Holdings discovered soil contamination at its property. Based on its understanding of applicable environmental law, SI transported the contaminated soil to an out-of-state disposal site. Thereafter, it sought coverage for the clean-up costs from Catlin Specialty Insurance. Catlin denied coverage, citing SI's failure to comply with the policy's "Consent Provision," which required SI to obtain consent prior to incurring clean-up costs. SI brought suit, arguing that the Consent Provision was unenforceable as against public policy because it "impede[d] compliance with environmental regulations." The court disagreed.

Addressing this issue of first impression under New York law, the court concluded that the Consent Provision should be enforced as written. Emphasizing that consent-to-settle clauses are routinely enforced, the court declined to take the "radical step" of invalidating the unambiguous provision absent any supporting precedent. In addition, the court noted that voiding the Consent Provision would be inequitable because it would "effectively strip Catlin—and, by extension, all insurers—of the ability to reasonably object to compliance-related expenditures that an insured party intends to

make." The court therefore granted Catlin's summary judgment motion, but noted that on appeal, SI could request certification of the issue to the New York Court of Appeals. We will keep you posted on further developments in this matter.

Pennsylvania Supreme Court Endorses Modified "Fair and Reasonable" Standard for Determining Insurer's Duty to Indemnify Settlement

Our July/August 2013 Alert reported on a Pennsylvania decision holding that where an insurer is defending subject to a reservation of rights, the insurer's duty to indemnify an underlying unauthorized settlement turns on whether the insurer acted in bad faith in rejecting settlement. *Babcock & Wilcox Co. v. Am. Nuclear Insurers*, 76 A.3d 1 (Pa. Superior Ct. 2013). The ruling vacated a trial court decision that endorsed a more lenient standard under which an insurer's indemnity obligations in the reservation-of-rights context turned on whether the unauthorized settlement was "fair and reasonable." Last month, the Pennsylvania Supreme Court reversed and reinstated the trial court decision. *Babcock & Wilcox Co. v. Am. Nuclear Insurers*, 2015 WL 4430352 (Pa. July 21, 2015).

The coverage dispute arose out of bodily injury and property damage claims against Babcock & Wilcox and Atlantic Richfield Company ("ARCO") as owners and operators of two nuclear fuel processing facilities. American Nuclear Insurers ("ANI"), Babcock's and ARCO's nuclear liability insurer, defended under a reservation of rights. Babcock and ARCO settled the claims over ANI's objection and then sought reimbursement. ANI argued that the insureds had forfeited their right to reimbursement by violating the policy's consent-to-settlement clause. The insureds claimed that ANI breached its duty to settle and was therefore obligated to indemnify any fair and reasonable settlement. The trial court agreed with the insureds, holding that ANI must reimburse them for all "fair and reasonable" settlement costs. The appellate court reversed, reasoning that an insurer does not forfeit the right to enforce a consent-to-settlement clause by defending under a reservation of rights where the insured accepts the defense. The appellate court therefore held that an insurer's duty to indemnify an unauthorized settlement under such circumstances turns on whether the insurer acted in bad faith in rejecting the settlement. The Pennsylvania Supreme Court reversed.

Acknowledging that courts across jurisdictions are split on this issue, the Pennsylvania Supreme Court ruled in a 3-2 decision that under the factual record presented, ANI's duty to indemnify the unauthorized settlement turned on whether it was fair and reasonable. The court stated:

> [W]e adopt a variation on the ... fair and reasonable standard limited to those cases where an insured accepts a settlement offer after an insurer breaches its duty by refusing the fair and reasonable settlement while maintaining its reservation of rights and, thus, subjects an insurer to potential responsibility for the judgment in a case where the policy is ultimately deemed to cover the relevant claims.

The court emphasized the fact-specific nature of its analysis, stating that "a determination of whether the settlement is fair and reasonable necessarily entails consideration of the terms of the settlement, the strength of the insured's defense against the asserted claims, and whether there is any evidence of fraud or collusion on the part of the insured." The

court also noted that "not all reservations of rights are equal" and that "[p]arties and courts may need to consider whether a particular reservation of rights justifies diverging from the contract's cooperation clause," an issue that the court said was not before it.

Insurance Fraud Alert:

Defendants Have Right to Jury in Private Suits Under Insurance Fraud Prevention Act, Says New Jersey Supreme Court

The New Jersey Supreme Court ruled that a defendant facing a private civil suit brought under the Insurance Fraud Prevention Act is entitled to a jury trial. *Allstate N.J. Ins. Co. v. Lajara*, 2015 WL 4276162 (N.J. July 16, 2015).

Allstate sued numerous doctors, billing companies and other entities, alleging fraud under New Jersey's Insurance Fraud Prevention Act ("IFPA"), N.J.S.A. 17:33A-1-30. A trial court denied the defendants' request for a jury trial, and an intermediate appellate court affirmed on the bases that IFPA does not explicitly confer a right to a jury trial and that private IFPA claims seek only equitable relief. Under New Jersey law, the right to a jury trial attaches only to claims that are legal in nature. The New Jersey Supreme Court reversed.

First, the court reasoned that the remedies in a private IFPA action—which include compensatory and treble damages and attorneys' fees—are "typical form[s] of legal [as opposed to equitable] relief" and therefore give rise to a jury trial right. Second, the court explained that in determining whether a cause of action is legal in nature, New Jersey courts consider whether a statutory action is similar to a common law action. The court concluded that an IFPA cause of action is comparable to common law fraud, and that the right to a jury trial is thus implied in IFPA.

Notably, the decision is limited to IFPA claims brought by private plaintiffs and does not address whether a jury trial right exists when an IFPA action is brought by the Commissioner of Banking and Insurance.

Duty to Defend Alerts:

Texas Supreme Court Rules That EPA Proceedings Constitute a "Suit" Under General Liability Policy

The Texas Supreme Court ruled that proceedings initiated by the Environmental Protection Agency pursuant to CERCLA constitute a "suit" for purposes of triggering an insurer's duty to defend. *McGinnes Indus. Maint. Corp. v. Phoenix Ins. Co.*, 2015 WL 4080146 (Tex. June 26, 2015).

After investigating environmental contamination at a waste disposal site used by McGinnes Industrial Waste Corporation, the EPA identified McGinnes as a potentially responsible party ("PRP") and demanded compensation for cleanup costs pursuant to CERCLA. In addition, the EPA issued an administrative order directing McGinnes to conduct a remedial investigation and feasibility study, warning that a failure to

comply would result in civil penalties and punitive damages. McGinnes requested a defense from its liability insurers. The insurers refused on the ground that the EPA proceedings were not a "suit" under their policies. A Texas trial court agreed and granted the insurers' summary judgment motion. *See* May 2013 Alert. On appeal, the Fifth Circuit certified the following question to the Texas Supreme Court: "Whether the EPA's PRP letters and/or unilateral administrative order, issued pursuant

to CERCLA, constitute a 'suit' within the meaning of the CGL policies, triggering the duty to defend."

Answering the certified question in the affirmative, the Texas Supreme Court ruled that the insurers were required to defend the EPA proceedings. The court reasoned that the EPA's CERCLA enforcement proceedings are not merely the "functional equivalent" of a suit (a standard used in several jurisdictions in evaluating an insurer's duty to defend administrative agency proceedings; *see* June 2014 Alert; January 2013 Alert) but rather "are the suit itself, only conducted outside a courtroom." The court explained that because CERCLA effectively redefined a "suit," a policyholder's right to a defense "should not be emasculated by the enactment of [CERCLA]." However, the court emphasized that simple demand letters or threats of litigation do not constitute "suits" because they do not command compliance, backed by the threat of fines and penalties. In reaching its holding, the court noted that the "overwhelming majority of jurisdictions" have held that EPA CERCLA proceedings constitute a suit for purposes of an insurer's duty to defend.

Fourth Circuit Rules That Insurer Has No Duty to Defend Suit Alleging Vicarious Liability for Intentional Acts, Notwithstanding Separation of Insureds Provision

Reversing a Virginia district court decision, the Fourth Circuit ruled that an insurer had no duty to defend a suit alleging that a university was vicariously liable for the intentional acts of its agents. The Fourth Circuit held that a separation of insureds provision does not require an insurer to provide coverage for claims alleging the insured's vicarious liability for the intentional acts of its agents. *Liberty Univ., Inc. v. Citizens Ins. Co. of Am.*, 2015 WL 4153840 (4th Cir. July 10, 2015).

The coverage dispute arose from an alleged kidnapping. The underlying plaintiff claimed that Liberty University and its agents helped a parent abscond with a child to Nicaragua. The complaint alleged that Liberty University was directly liable for its involvement in the kidnapping scheme and vicariously liable for the intentional acts of its agents. A Virginia district court ruled that Citizens Insurance Company was required to defend Liberty University. The district court explained that a Separation of Insureds provision requires each insured to be treated as if it had separate coverage, so that excluded conduct by one insured does not preclude coverage for other insureds. The court reasoned that although the complaint alleged intentional conduct against the individual agents of Liberty University, a Separation of Insureds provision prohibited the court from imputing that intent to Liberty University. The Fourth Circuit reversed.

The Fourth Circuit ruled that the underlying complaint did not plead an "occurrence" notwithstanding the Separation of Insureds provision. The court explained that the intentions of the individual defendants were imputed to Liberty University because, under Virginia law, the expectations and intent of agents are imputed to their principal. The court further held that the Separation of Insureds provision does not alter this rule of law, stating that, "[a]lthough the Separation of Insureds provision requires the coverage claims of each named insured to be evaluated separately ..., it does not displace Virginia's rule that an agent's intentionally tortious act cannot be 'unexpected' by the principal who is vicariously liable for the act."

Significantly, the court distinguished cases in which an underlying complaint alleges liability for intentional acts based on a principal's negligent supervision. In such cases, a separation of insureds provision may give rise to coverage if the principal's liability sounds in negligence, rather than vicarious liability for the agent's intentional acts.

Bad Faith Alert:

California Court Rules that Policy-Limits Settlement Demand is Not Prerequisite to Bad Faith Failure-to-Settle Claim

Our November 2013 Alert reported on a California appellate court decision holding that an insurer was not liable for bad faith failure to settle where the underlying plaintiff had not made a settlement demand or otherwise indicated an interest in settling, even though there was a significant risk of judgment that would exceed policy limits. *Reid v. Mercury Ins. Co.*, 162 Cal. Rptr. 3d 894 (Cal. Ct. App. 2013). A California federal court recently distinguished *Reid* and ruled that that the absence of a policy-limits settlement demand from an underlying plaintiff is not fatal to a bad faith failure-to-settle claim against an insurer. *Aspen Specialty Ins. Co. v. Willis Allen Real Estate*, 2015 WL 3765008 (S.D. Cal. June 15, 2015).

Homeowners sued Willis Allen, a real estate company, after a landslide resulted in significant damage to their property. Aspen agreed to defend Willis Allen pursuant to a liability policy. After participating in settlement negotiations and mediation, Willis Allen determined that the claims could be resolved for substantially less than policy limits. However, Willis Allen claimed that Aspen thwarted settlement efforts by making "lowball" settlement offers. A settlement was eventually reached, but it exhausted policy limits. Willis Allen sued Aspen, alleging bad faith based on Aspen's "gamesmanship" and refusal to give policy-limits settlement authority despite the potential liability exposure. Citing *Reid*, Aspen moved to dismiss on the basis that there was no policy-limits settlement demand in the underlying litigation. Aspen argued that absent a policy-limits demand, it had no affirmative duty to settle. The court disagreed and refused to dismiss the claim.

The court held that *Reid* does not stand for the proposition that an injured party must make a settlement demand or express an interest in settlement in order to trigger an insurer's duty to pursue good faith settlement discussions. Rather, the court explained that "[a]ll that's required is *some circumstance* showing that [the insurer] knew settlement within policy limits was feasible." The court concluded that this standard was met because Willis Allen allegedly informed Aspen that the underlying claims could likely be resolved for substantially less than policy limits. Accepting that allegation as true, the court held that dismissal was not warranted. As reported in our May 2015 Alert, the Louisiana Supreme Court also recently held that an insurer may be liable for bad faith failure to settle even if the insurer did not receive a firm settlement offer.

Arbitration Alert:

Alabama Supreme Court Compels Non-Signatories to Arbitrate Homeowner Insurance Claims

The Supreme Court of Alabama ruled that homeowners were bound by an arbitration provision in their property policies even though they had not signed the arbitration forms and had allegedly not received notice of the arbitration requirement. *Am. Bankers Ins. Co. of Fla. v. Tellis*, 2015 WL 3935260 (Ala. June 26, 2015).

Several homeowners sued American Bankers, alleging breach of contract, negligence and

fraud based on excessive premium charges. In each case, American Bankers moved to compel arbitration pursuant to an arbitration provision in the homeowners' policies. The homeowners opposed the motions, arguing that they had not consented to arbitration. More specifically, the homeowners claimed that they had not received the two particular "forms" in the policies that expressly referenced arbitration. In addition, it was undisputed that none of the homeowners had signed the arbitration forms even though they contained a policyholder signature line. The trial courts denied American Bankers' motions to compel arbitration. On appeal, the Alabama Supreme Court reversed.

The Alabama Supreme Court ruled that notwithstanding the absence of signed consent to the arbitration provision, the homeowners "manifested their assent to arbitration … by accepting and acting upon the insurance policies containing the arbitration provision." The court further reasoned that even if the homeowners did not receive the particular forms that referenced arbitration, they presumably received the policy's declarations page, which explicitly referenced the list of "forms and endorsements" that comprised the policy, including the two forms that contained the arbitration provision. The court held that the homeowners therefore "had some duty to investigate the contents of those forms." In so ruling, the court noted that under Alabama law, a signature or express consent is not required to enforce an arbitration provision where the factual record establishes implied consent via the parties' continued adherence to other contract terms.

Bankruptcy Alert:

Delaware Court Rejects Debtor's Attempt to Limit Insurers' Audit Rights Under Settlement Agreement

A Delaware chancery court ruled that a settlement agreement afforded insurers a broad right to audit payments made by a bankruptcy trust, rejecting the argument that the audit right was limited to the purpose of verifying that Trust payments were actually made. *AIU Ins. Co. v. Philips Elecs. N. Am. Corp.*, 2015 WL 3526976 (Del. Ch. June 4, 2015).

T H Agriculture & Nutrition ("THAN"), a company facing substantial asbestos liability, commenced Chapter 11 bankruptcy proceedings. While the bankruptcy proceedings were pending, THAN reached a settlement with its insurers. The Settlement Agreement gave the insurers the right to audit payments and distributions made by a post-bankruptcy Trust at their own expense, no more than once per year. The audit provision further stated that the insurers were to keep all information confidential and prohibited use of "any information for anything other than to assess whether the Trust in fact made payments to the claimants."

Several years later, the insurers sought to audit Trust payments in accordance with the Settlement Agreement. THAN refused to provide the requested information, arguing that the insurers' audit rights were limited solely to verifying that payments were actually made. In support of its position, THAN cited to a Cooperation Agreement between THAN and the Trust, which contained a more restrictive audit provision. The insurers countered that they were not party to the Cooperation Agreement, and that the Settlement Agreement contained no "limitation on what may constitute a proper purpose for inspection." The insurers filed suit, alleging breach of contract and tortious interference on the basis that the Cooperation Agreement impermissibly impaired their audit rights under the Settlement Agreement.

The court held that the insurers' audit rights were governed solely by the Settlement Agreement and that the insurers' audit rights were not limited to the verification of payments. The court explained that the

Settlement Agreement's clause prohibiting the insurers from "utiliz[ing] any information for anything other than to assess whether the Trust in fact made payments to the claimants" restricted how the insurers could use the information obtained through an audit, but did not limit the insurers' broad right to conduct audits. Therefore, the court issued a declaratory judgment in the insurers' favor.

Superstorm Sandy Coverage Alert:

New Jersey Appellate Court Reinstates Consumer Fraud Act Claim Based On Delayed Payment to Homeowner

Reversing a trial court decision, a New Jersey appellate court ruled that a homeowner was entitled to pursue a Consumer Fraud Act claim against his mortgage company based on a delay in payment of insurance proceeds for storm-related losses. *Abbas v. PennyMac Corp.*, 2015 WL 4275962 (N.J. Super. Ct. App. Div. July 16, 2015) (unpublished decision).

Abbas's home was damaged during Superstorm Sandy. His homeowner's insurance company assessed the damage at approximately $12,000 and sent a check to PennyMac, Abbas's mortgage company. Abbas claimed that although he made repeated requests for payment from PennyMac, he was forced to pay out-of-pocket for repair costs. After approximately six months without payment, Abbas sued PennyMac, alleging common law fraud and violation of New Jersey's Consumer Fraud Act ("CFA"), N.J.S.A. 56:8-1-20, based on the wrongful withholding of the insurance funds. Shortly thereafter, PennyMac issued Abbas the insurance proceeds, which Abbas returned as a rejected settlement offer. PennyMac moved for summary judgment, arguing that Abbas did not suffer an ascertainable loss as required by the CFA because the insurance funds had been released to him. The trial court agreed and granted the motion. The appellate court reversed.

To prevail on a CFA claim, a plaintiff must establish wrongful conduct, an ascertainable loss, and a causal relationship between the two. *See* N.J.S.A. 56:8-19. The appellate court concluded that Penny Mac lacked a good-faith basis for the delay and that Abbas suffered an ascertainable loss when PennyMac failed to release the insurance funds in a timely manner. The court explained that PennyMac's "decision to send the proceeds at a time of its choosing does not eliminate liability under the CFA because the $12,277.43 in insurance proceeds became the ascertainable loss the moment the funds were wrongly withheld." The court noted that allowing PennyMac to escape CFA liability by issuing delayed payment could "leave[ ] the door ajar for unscrupulous operators to use unconscionable commercial practices, so long as [they] can close the door before the victimized consumer initiates legal action." Pursuant to the appellate court's decision, full reimbursement may not insulate a defendant from CFA liability if there has been an unjustified delay in issuing payment.

Statute of Limitations Alert:

Statute of Limitations For Declaratory Judgment Action Begins To Run When Insurer Has Sufficient Basis for Denying Defense, Says Pennsylvania Court

Addressing a matter of first impression under Pennsylvania law, the Superior Court of Pennsylvania ruled that the statute of limitations ("SOL") for a declaratory judgment action regarding an insurer's duty to defend does not start to run until the insurer has sufficient factual basis for denying a defense. The court expressly rejected the argument that the SOL begins to run when the insurer receives the complaint in the underlying action against the policyholder. *Selective Way Ins. Co. v. Hospitality Grp. Servs., Inc.*, 2015 WL 4094398 (Pa. Super. Ct. July 7, 2015).

The insurance dispute arose out of a fatal car accident. The deceased driver's family sued his employer, alleging negligence and negligent supervision. The employer forwarded notice of the suit to Selective, which defended subject to a reservation of rights. Approximately five years later, Selective filed suit, seeking a declaration that it had no duty to defend. The policyholder moved to dismiss on several bases, including that the applicable four-year SOL had expired. The trial court agreed and dismissed Selective's complaint. The trial court reasoned that the SOL began to run when Selective received the underlying complaint and had the opportunity to compare the allegations to the insurance policy. The Superior Court of Pennsylvania reversed.

The court held that a SOL begins to run when a cause of action accrues, and that a cause of action for a declaratory judgment accrues when an "actual controversy exists between the parties." The court explained that "[t]his requires a determination of when the insurance company had a sufficient factual basis to present the averments in its complaint for declaratory judgment that the insurance policy at issue does not provide coverage for the claims made in the third party's action." Emphasizing the fact-specific nature of this analysis, the court observed that "[i]t is possible for the insurance company to possess sufficient information at the time it receives a complaint to cause the [SOL] to begin to run; or that may not occur until the case develops and the claim is winnowed down to a recovery the insurance company believes is not covered by the policy of insurance." In adopting this fact-driven approach, the court rejected bright-line rules at either extreme (*i.e.*, that the SOL automatically begins to run when an insurer receives a complaint, or conversely, that it does not begin to run until an insurer issues an official coverage denial). The court remanded the matter for a factual determination of when Selective had a sufficient basis for denying coverage.

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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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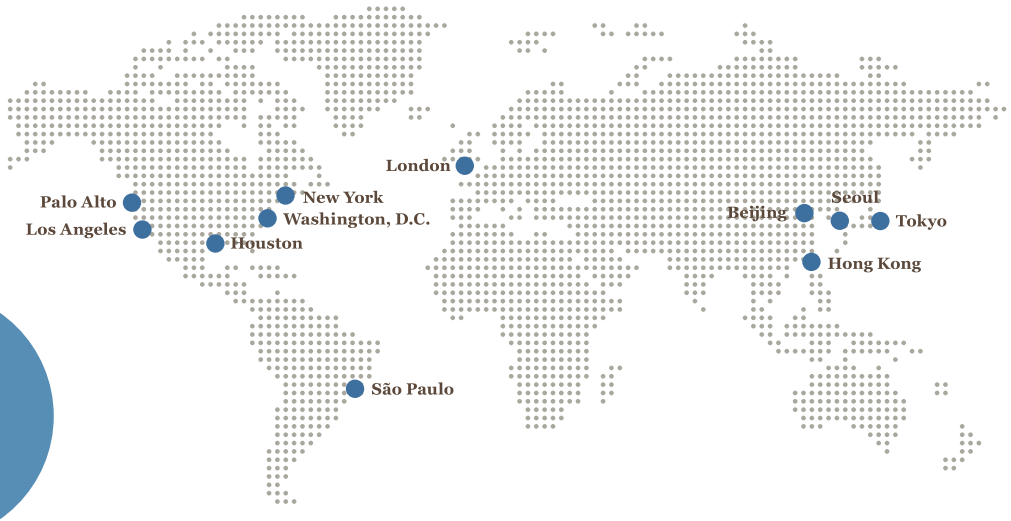

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