Simpson Thacher

Insurance Law Alert

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"They are just exceptional at what they do, they know coverage law backwards and forwards and they are excellent litigators."

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

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A New York trial court addressed arguments relating to late notice, warranty of retention and follow the fortunes in a reinsurance coverage dispute. *Granite State Ins. Co. v. Clearwater Ins. Co.*, No. 653546/11 (N.Y. Sup. Ct. New York Cnty. June 17, 2016). (Click here for full article)

Duty to Defend Alert:

In Pair of Decisions, Wisconsin Supreme Court Overrules Prior Case Law and Clarifies Insurer's Right to Deny Defense Based On Policy Exclusions

In two recent decisions, the Supreme Court of Wisconsin reinforced an insurer's right to refuse to defend or provide coverage based on unambiguous policy exclusions.

In *Marks v. Houston Casualty Company*, 2016 WL 3545848 (Wis. June 30, 2016), the court ruled that an insurer had no duty to defend underlying lawsuits based on a business enterprise exclusion, rejecting prior case law that suggested that an insurer that refuses to defend relinquishes its right to rely on policy exclusions in subsequent coverage litigation.

The coverage dispute arose out of lawsuits filed against David Marks and Titan Global Holdings, a holding company for which Marks was the principal shareholder and chairman. The suits alleged fraud, misrepresentation, negligence and statutory claims based on the collapse of various business arrangements. Marks tendered defense of the suits to Houston Casualty, his professional liability insurer. Houston refused to defend on several bases, including a business enterprise exclusion that excluded coverage for liability arising out of Marks' services and/or capacity as an officer, director, partner, trustee, or employee of a business enterprise not identified in the policy declarations. The only entities named in the declarations were two trusts for which Marks served as trustee. A Wisconsin trial court granted Houston's summary judgment motion, finding that the business enterprise exclusion precluded coverage.

The Wisconsin Supreme Court assumed, without deciding, that the policy provided an initial grant of coverage for the underlying claims. The court then held that the business enterprise exclusion unambiguously applied because all of the underlying allegations were based on Marks' position as director or officer at Titan. Any allegations relating to Marks' position as trustee for the trusts (which would fall outside the scope of the exclusion) were "conspicuously absent" from the underlying complaints.

Significantly, the court rejected the argument that an insurer that denies coverage and refuses to defend is estopped from relying on policy exclusions in subsequent coverage litigation. The court rejected holdings from a series of appellate court cases supporting this proposition, finding that they conflicted with well-established Wisconsin precedent and constituted a "stunted strand of law that conflicts with our four-corners jurisprudence." The court clarified that an insurer is estopped from contesting coverage only if a court has determined that it breached its duty to defend.

The court also dismissed Marks' assertion that the exclusion rendered the policy illusory because it "completely swallows the coverage granted in the insuring agreement" by excluding coverage for liability arising out of Marks' services as a trustee, among other things. In this context, the court held that even assuming a particular portion of the exclusion (relating to Marks' capacity as trustee) rendered the policy illusory, the appropriate remedy would be reformation of that specific clause rather than voiding the exclusion in its entirety.

In *Water Well Solutions Service Group Inc. v. Consolidated Insurance Company*, 2016 WL 3545838 (Wis. June 30, 2016), issued on the same day as *Marks*, the Wisconsin Supreme Court reinforced a strict "four-corners" rule governing an insurer's duty to defend and held that an insurer may refuse to defend based on a policy exclusion without resort to extrinsic evidence, even where it is undisputed that the policy provides an initial grant of coverage.

Water Well tendered defense of a negligence suit to Consolidated Insurance. Consolidated conceded that its general liability policy's grant of coverage encompassed the claims, but refused to defend based on two policy exclusions. A Wisconsin trial court and appellate court agreed, finding that policy exclusions barred coverage. On appeal to the Wisconsin Supreme Court, Water Well asked the court to "craft an exception to the four-corners rule allowing courts to consider extrinsic evidence when an insurer has unilaterally decided that no duty to defend exists based on exclusions in the insurance policy." The court declined to do so, stating

that "[w]e now unequivocally hold that there is no exception to the four-corners rule in duty to defend cases in Wisconsin."

The court also rejected Water Well's assertion that under the four-corners rule, the court's comparison of the complaint to the insurance policy should be limited to the portion of the policy providing the initial grant of coverage. Instead, the court ruled that in evaluating an insurer's duty to defend, the entire policy, including exclusions, should be examined. Specifically, the court concluded that a "Your Product" exclusion unambiguously barred coverage because the underlying complaint alleged only damage to Water Well's own products. Rejecting Water Well's argument that damage to other property could be reasonably inferred from the underlying allegations, the court refused to engage in "guess-work and supposition repeatedly rejected in Wisconsin's duty-to-defend jurisprudence."

Bodily Injury Alert:

Seventh Circuit Rules That Pill Mill Suit Against Pharmaceutical Distributors Alleges Bodily Injury Within Scope of General Liability Coverage

The Seventh Circuit ruled that allegations that a pharmaceutical distributor's involvement in a pill mill caused the State of West Virginia to pay millions of dollars for drug abuse care constituted a claim for bodily injury under a general liability policy. *Cincinnati Ins. Co. v. H.D. Smith, L.L.C.*, 2016 WL 3909558 (7th Cir. July 19, 2016).

West Virginia sued H.D. Smith and other pharmaceutical distributors for allegedly contributing to an epidemic of prescription drug abuse. The complaint alleged that Smith negligently or recklessly provided pharmacies with vast quantities of prescription drugs that fueled consumers' drug additions. Among other things, the State alleged that it spent millions of dollars caring for drug-addicted residents as a result of such pill mill operations. Smith tendered defense of the suit to Cincinnati Insurance pursuant to a general liability policy. Cincinnati refused to defend and sought a declaration that its policy did not cover the suit because it did not seek damages "because of bodily injury." An Illinois federal district court agreed and granted the insurer's summary judgment motion. The Seventh Circuit reversed.

The underlying complaint alleged that Smith negligently distributed drugs and therefore "interfered with the right of West Virginians to be free from unwarranted injuries, addictions, diseases and sicknesses." The Seventh Circuit reasoned that these allegations sufficiently alleged damages because of bodily injury. In so ruling, the court distinguished *Medmarc Cas. Ins. Co. v. Avent Am., Inc.*, 612 F.3d 607 (7th Cir. 2010) (discussed in our September 2010 Alert), which held that an insurer need not defend class action suits alleging that baby bottles and related accessories were contaminated with a toxic chemical. The court explained that the underlying claims in *Medmarc* did not allege damages because of bodily injury because there were no allegations that the plaintiffs ever used the products or were exposed to the harmful substances. In contrast, the underlying complaint here alleged that consumers ingested drugs that had been negligently distributed by Smith. The court therefore concluded that Cincinnati was required to defend the suit.

Ponzi Scheme Alert:

Texas Court Addresses Scope of Coverage for Ponzi Scheme Losses

A Texas federal district court ruled that a commercial crime policy does not cover losses arising out of a Ponzi scheme because the policyholder did not "own" the funds for which it sought indemnification. *Cooper Indus., Ltd. v. National Union Fire Ins. Co. of Pittsburgh, PA*, 2016 WL 3405295 (S.D. Tex. June 21, 2016).

Cooper invested approximately $175 million in Westridge Capital Management, a registered investment advisor. Unbeknownst to Cooper, Westridge was part of a Ponzi scheme orchestrated by individuals who owned a controlling share of Westridge, as well as two other related entities (WGTC,

a registered broker-dealer, and WGTI, an unregulated entity utilized to facilitate investments into WGTC). Before the scheme was discovered, Cooper recouped its investment plus earnings in Westridge's equity fund. However, Cooper did not redeem its investment in Westridge's bond fund. After the fraudulent activity was discovered, a receiver appointed to protect investors' interests initiated a claw back action against Cooper to recover its earnings from the equity fund investment. Cooper ultimately settled with the receiver, and then sought coverage from National Union for lost investments, earnings and interest. National Union denied coverage, and Cooper brought suit, claiming losses of nearly $20 million.

The court ruled that the policy did not provide coverage because Cooper did not "own" the funds it lost and the policy limited coverage to property "[t]hat you own or lease." National Union argued that Cooper did not own the funds because it did not invest directly in Westridge. Rather, Cooper loaned money to WGTI via promissory note, and WGTI then invested that money in WGTC. National Union argued that once Cooper loaned the money to WGTI, it no longer had an ownership interest in the property. The court agreed. The court explained that because both entities were limited liability partnerships, Cooper held, at most, a limited partnership interest in those entities, which under Delaware law, does not confer ownership in the underlying property. A Minnesota court reached the same conclusion in a coverage dispute arising out of the same Ponzi scheme. *See 3M Co. v. National Union Fire Ins. Co. of Pittsburgh, PA*, 2015 WL 5687879 (D. Minn. Sept. 28, 2015) (discussed in our October 2015 Alert).

Although the ownership issue was outcome-determinative, the court also addressed the availability of coverage for the lost earnings. The court held that "[t]o the extent that some of that money was Cooper's legitimate earnings, Cooper would be entitled to compensation under the Policy." The court rejected National Union's argument that Cooper was not entitled to compensation because it was a "net winner" overall in its investments. The court reasoned that the policy insured Cooper against theft regardless of whether it was theft of principal or earnings. The court distinguished *Horowitz v. Am. Int'l Grp., Inc.*, 2010 WL 3825737 (S.D.N.Y. Sept. 30, 2010), *aff'd*, 498 Fed. Appx. 51 (2d Cir. 2012) (discussed in our November 2010 Alert), which held that lost profits in the Madoff Ponzi scheme were fictitious and non-compensable, reasoning that *Horowitz* involved a "pure Ponzi scheme . . . in which there were no actual investments or earnings of any kind." Here, Westridge generated over $580 million in profits via legitimate trading strategies, notwithstanding the theft of funds.

Settlement Alerts:

When Insurer Denies Coverage, Policyholder Does Not Breach Cooperation Clause by Settling Without Insurer Consent, Says New York Court

A New York trial court ruled that Bear Stearns did not breach its duty to cooperate by settling underlying claims without insurer consent where the insurers had unequivocally denied coverage. *J.P. Morgan Sec. Inc. v. Vigilant Ins. Co.*, 2016 WL 3943731 (N.Y. Sup. Ct. New York Cnty. July 7, 2016).

Bear Stearns sought a declaration that its insurers were required to indemnify it for settlements reached with the SEC, the New York Stock Exchange and private litigants in connection with deceptive practices claims. The insurers argued that they had no duty to indemnify because Bear Stearns breached the consent to settle and cooperation provisions in the policies. Bear Stearns moved to dismiss the defenses, which the court granted.

The court held that a consent to settle provision is a condition precedent to coverage and that a policyholder's failure to comply is generally a defense to coverage under the policy. However, where an insurer repudiates liability on the ground that the loss is not covered under the policy, the policyholder does not need to obtain the insurer's consent to settle, so long as the settlement is reasonable. The court held that the factual record established that the insurers disclaimed coverage prior to Bear Stearns's settlement with the SEC because they "consistently asserted, from the inception of the regulatory investigations, that those investigations did not appear to constitute a claim." The court also found that the

insurers consistently argued that even if the investigations constituted a claim, the losses were uninsurable disgorgement claims. (*See* January 2015, March 2014, June 2013 Alerts).

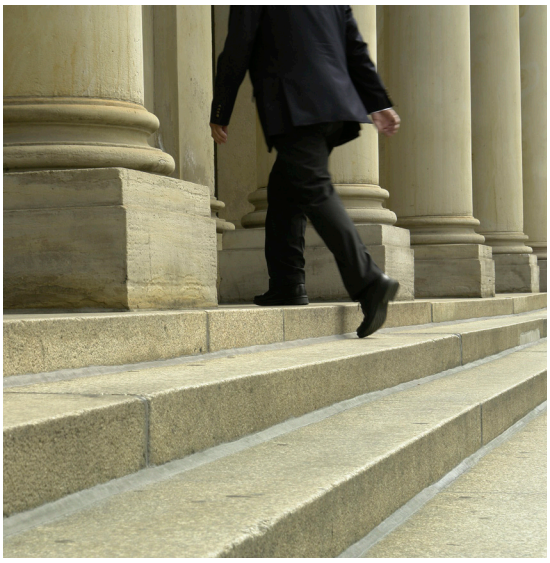
The court concluded that these factors established as a matter of law that the insurers disclaimed coverage prior to Bear Stearns's settlement.

Based on this factual finding, the court rejected the insurers' argument that they had not conclusively denied coverage because they continued to reserve their rights during litigation and advised Bear Stearns that their determination was "non-final." The court held that the insurers' other statements "left no doubt that they were disclaiming coverage." The court also dismissed the insurers' failure to cooperate defense, explaining that the burden of proving non-cooperation is "heavy" and that the factual record did not support the assertion that the insurers "diligently sought Bear Stearns's cooperation or that Bear Stearns willfully obstructed these efforts." Notably, the court held that an issue of fact existed as to whether the settlements were reasonable, a determination that will ultimately control the insurers' indemnity obligations.

District Court's Refusal to Vacate Orders Based on Settlement Was Erroneous, Says Eleventh Circuit

The Eleventh Circuit ruled that a Florida federal district court erred in refusing to vacate summary judgment orders following the parties' execution of a settlement agreement conditioned on the vacatur of those orders. *Hartford Cas. Ins. Co. v. Crum & Forster Specialty Ins. Co.*, 2016 WL 3741972 (11th Cir. July 12, 2016).

In a coverage dispute between Crum & Forster and Hartford, a Florida district court issued a series of orders granting summary judgment and assessing attorneys' fees and costs against Hartford. Hartford appealed, and the matter was thereafter settled in an agreement that was contingent upon the issuance of an order vacating the summary judgment and costs orders in their entirety. The district court refused to vacate the orders, relying on *Bancorp Mortgage Company v. Bonner Mall Partnership*, 513 U.S. 18 (1994), which sets out an "equitable approach that generally counsels against granting requests



for vacatur made after the parties settle" unless "exceptional circumstances" exist. The Eleventh Circuit reversed.

The Eleventh Circuit ruled that the district court applied *Bancorp* incorrectly. In particular, the Eleventh Circuit found that the district court's categorical denial that exceptional circumstances exist any time parties reach a settlement contingent on vacatur is inconsistent with *Bancorp*'s emphasis on equitable considerations. In addition, the Eleventh Circuit concluded that the district court's approach to determining the nature of the public interest in vacatur was overly narrow, stating that the district court "fail[ed] to recognize that the public interest is not served only by the preservation of precedent. Rather the public interest is also served by settlements when previously committed judicial resources are made available to deal with other matters, advancing the efficiency of the federal courts."

The Eleventh Circuit ruled that the propriety of granting vacatur is determined by "weighing the benefits of settlement to the parties and to the judicial system (and thus to the public as well) against the harm to the public in the form of lost precedent." Emphasizing the fact-specific nature of this analysis, the court explained that two unusual features of the settlement agreement mitigated in favor of vacating the district court orders in the present case: (1) that the settlement was the result of court-ordered mediation and was expressly contingent of vacatur; and (2) both parties to the settlement sought vacatur.

Coverage Alerts:

New Jersey Supreme Court Rules That Damage Caused by Subcontractors' Faulty Workmanship Is "Property Damage" and an "Occurrence" Under General Liability Policies

The New Jersey Supreme Court ruled that consequential damage caused by subcontractors' negligent workmanship is property damage and an occurrence for purposes of general liability coverage. *Cypress Point Condo. Assoc., Inc. v. Adria Towers, L.L.C.*, 2016 WL 4131662 (N.J. Aug. 4, 2016).

The coverage dispute arose after condominium residents sued a developer and several subcontractors. The underlying complaints alleged that interior portions of the building were damaged due to leaks and water infiltration. The developer's general liability insurers refused to defend or indemnify on the basis that the subcontractors' faulty workmanship was not an "occurrence" or "property damage" under the policies. A New Jersey trial court agreed, and granted the insurers' summary judgment motion. An appellate court reversed, ruling that unintended and unexpected consequential damages caused by defective work is property damage caused by an occurrence. The New Jersey Supreme Court affirmed.

The New Jersey Supreme Court reasoned that allegations of mold growth and other damage to parts of the building alleged "physical injury to tangible property." The court further held that the underlying claims alleged an "occurrence" (defined as "an accident, including continuous or repeated exposure to substantially the same general harmful conditions") because the subcontractors' negligent conduct resulted in unintended and unexpected harm. In so ruling, the court rejected the insurers' argument that a developer's failure to ensure the soundness of subcontractors' work arises from a breach of contract rather than a covered accident. The court distinguished New Jersey precedent that holds that faulty workmanship claims are not covered under general liability policies, noting that those cases involved different policy language from an earlier version of the standard general liability policy or allegations relating only to replacement costs rather than consequential damages.

Finally, the court ruled that the "Your Work" exclusion eliminated coverage for the alleged water damage, but that coverage was restored by an exception to the exclusion that provides that it does not apply where damage arises out of work performed by a subcontractor.

New Jersey Appellate Court Rules That Stunted Chicken Growth Is Property Damage Caused by an Occurrence

A New Jersey appellate court ruled that stunted chicken growth caused by the ingestion of a drug intended to control a common intestinal disease is a covered occurrence and constituted property damage under general liability policies. *Phibro Animal Health Corp. v. National Union Fire Ins. Co. of Pittsburgh, PA*, 2016 WL 3747538 (N.J. App. Div. July 14, 2016).

Phibro, a manufacturer of animal health products, sold Aviax, a chicken feed additive designed to prevent certain parasitic diseases. It was later discovered that Aviax stunted the growth of chickens, which resulted in lower meat production and increased feed costs. When customers sued Phibro, it sought coverage under liability and umbrella policies issued by National Union, which the insurer denied. In ensuing coverage litigation, a New Jersey trial court ruled that the alleged losses sustained by Phibro's customers did not constitute property damage caused by an occurrence within the meaning of the policies. The trial court reasoned that the chickens were not physically injured and were subsequently sold for human consumption. The appellate court reversed.

The appellate court ruled that the stunted growth is an "accident" insured by the policies because the record established that Phibro did not expect or anticipate that side effect. In so ruling, the court analogized the scenario to faulty workmanship, explaining that there was unexpected damage to something other than the insured's product (here, the chickens). The court further held that the diminished size and weight of the chickens constituted property damage, reasoning that the detrimental alteration in the chickens' size and shape represented "harm to the physical condition of the chickens." The court

noted that the fact that the chickens were ultimately sold for consumption was not dispositive of the property damage question, explaining that the term "physical injury" was not defined to require that property be unsalable. Alternatively, the court held that even if physical injury was lacking, the record established a "loss of use of tangible property that is not physically injured." The court explained that Phibro's inability to realize the chickens' full potential for sale due to diminished size constituted a partial "loss of use" of the chickens.

The court remanded the matter for a factual determination of whether an "impaired property" exclusion barred coverage. The appellate court explained that application of the exclusion turns primarily on whether the damaged property can be "restored to use." National Union argued that the chickens could have reached their full expected weight had they been given more time to grow, whereas Phibro contended that they could not be "restored to use" in that manner because of the chickens' pre-determined lifespans, which are based on commercial and economic considerations. The court concluded that "the most sensible reading of the phrase 'restored to use' . . . takes into account the cost and commercial feasibility of restoration." Therefore, the appellate court remanded the case so that the trial court could evaluate the cost of delaying slaughter to achieve expected weight as compared to damages incurred by adhering to the scheduled lifespan.

All Loss Attributable to Employee Misconduct Constitutes a Single Loss, Outside the Scope of Policy Period, Rules Sixth Circuit

The Sixth Circuit ruled that all loss caused by one employee's misconduct was a "single loss" under an employee-theft policy and that there was no coverage under the policy because the employer had "discovered" the loss prior to executing the insurance policy. *Constr. Contractors Emp'r Grp., LLC v. Federal Ins. Co.*, 2016 WL 3675572 (6th Cir. July 11, 2016).

Construction Contractors provided payroll, tax and other administrative services to subscribing construction companies. In 2012, various financial discrepancies were discovered, leading to an internal investigation. The investigation revealed that a particular employee had committed wire fraud and approximately $1 million remained unaccounted for. In 2013, Construction obtained a crime coverage policy from Federal. The policy covered losses "sustained at any time and Discovered during the Policy Period," but excluded "any loss that an Insured is aware of prior to the inception date of [the] policy." The policy also contained a "Limits of Liability" provision, which stated that all loss resulting from a single act or any number of acts from the same employee are treated as a single loss subject to the applicable limit of liability.

Several months after the policy incepted, Construction discovered that the same employee had committed check theft and was responsible for the missing $1 million. Based on this discovery, Construction submitted a claim to Federal, which denied coverage. An Ohio federal district court ruled in Federal's favor, concluding that all loss caused by the employee was a single loss under the policy and that Construction was aware of the loss before the policy's inception date. The Sixth Circuit affirmed, rejecting Construction's argument that the Limits of Liability provision operates only to cap covered losses to the $1 million policy limit, rather than define whether the policy covers a loss.

Maryland Court Rules That Insurer Must Defend Deceptive Marketing Claims Against Career Colleges

A Maryland federal district court ruled that an insurer was obligated to defend deceptive marketing claims, finding that a professional services exclusion did not apply and that a subpoena constituted a "claim." *Educ. Affiliates Inc. v. Federal Ins. Co.*, 2016 WL 4059159 (D. Md. July 28, 2016).

The coverage dispute arose out of a federal and state investigation of certain for-profit educational institutions owned by Education Affiliates. The colleges were also named as defendants in private lawsuits brought by former students. The complaints alleged that the colleges' recruiters made various false statements, including about the quality of education and facilities. Education Affiliates sought a defense from Federal under a D&O policy that covered wrongful acts during the policy period. Federal denied coverage on the basis of a "Professional Services" exclusion that barred coverage for claims arising in connection "with the rendering of

. . . professional services for others." The court rejected this assertion and ruled that Federal was obligated to defend.

The court ruled that the Professional Services exclusion did not apply as a matter of law because the "marketing of professional services is not the rendering of professional services." The court explained that the "fact that the marketing relates to the professional services to be rendered to others cannot be said to conflate the two because, in light of the fact plaintiffs' core business is the rendering of educational services to others, such conflation would provide an 'evisceration' of coverage."

The court also ruled that a subpoena issued by a state Attorney General's Office constitutes a "claim" under the policy because it is a "written demand for . . . non-monetary relief." As discussed in our October 2013 Alert, decisions addressing whether the issuance of a subpoena or other agency investigative measures constitute a claim turn primarily on applicable policy language as well as the particular factual record presented.

Ambiguity Alert:

Extrinsic Evidence Cannot Create Policy Ambiguity, Says Colorado Supreme Court

Reversing an appellate court decision, the Colorado Supreme Court ruled that a policyholder may not rely on extrinsic evidence to establish a policy ambiguity. Rather extrinsic evidence may only be used to determine the parties' intent if an ambiguity appears in the four corners of the document. *American Family Mutual Ins. Co. v. Hansen*, 2016 WL 3398507 (Colo. June 20, 2016).

The coverage dispute arose out of a motor vehicle accident, in which Jennifer Hansen was injured. She filed a claim with American Family under a policy that insured the car. American Family denied the claim on the basis that Hansen was not insured under a policy that listed Hansen's mother and stepfather as named insureds. Hansen sued, alleging breach of contract and statutory and common law bad faith. In support of her claims, she submitted lienholder statements issued to her by American Family's local agent that identified her as a named insured under the policy. A trial court ruled that the discrepancy between the declaration page and lienholder statement created an ambiguity which must be construed in Hansen's favor. A jury ruled in Hansen's favor on the statutory bad faith claim, finding that American Family had denied payment without a reasonable basis. An appellate court affirmed.

The Colorado Supreme Court reversed, holding that because the policy listed only two other individuals as named insureds at the time of the accident, the trial court and appellate court erred in relying on extrinsic evidence to find an ambiguity. The court stated that "[a]n ambiguity must appear in the four corners of the document *before* an extrinsic evidence can be considered." Therefore, the court held that American Family's denial of Hansen's claim in reliance on the unambiguous policy was reasonable and it could not be found liable for statutory bad faith. The court also rejected Hansen's reasonable expectations argument. Although Colorado law has allowed the reasonable expectations of an insured to "succeed[ ] over exclusionary policy language," the court deemed the doctrine inapplicable because Hansen was not an insured under the policy.

Reinsurance Alert:

New York Court Addresses Late Notice, Retention Warranty and Follow the Fortunes In Reinsurance Dispute

A New York trial court addressed arguments relating to late notice, warranty of retention and follow the fortunes in a reinsurance coverage dispute. *Granite State Ins. Co. v. Clearwater Ins. Co.*, No. 653546/11 (N.Y. Sup. Ct. New York Cnty. June 17, 2016).

Granite State issued an excess policy to Kaiser Aluminum. The policy was reinsured by Clearwater. When Kaiser was sued in thousands of personal injury asbestos-related suits, litigation between Kaiser and various insurers ensued. Granite State ultimately reached a policy-limits settlement with Kaiser, and Kaiser filed for Chapter 11 protection. Four years after a bankruptcy court approved

the settlement, Granite State billed reinsurer Clearwater for the loss. Clearwater refused to pay, arguing that Granite State knew that the underlying policy limits would be reached years before it notified Clearwater, and that Granite State's delay in providing notice violated the reinsurance certificate and substantially prejudiced Clearwater. A New York trial court ruled in Granite State's favor on the late notice defense, and issued several other rulings relating to interpretation of Clearwater's reinsurance certificate.

First, the court held that Clearwater did not waive its right to assert late notice notwithstanding a two-year delay in denying coverage on that basis. The court reasoned that there was no evidence of misconduct on Clearwater's part, and that Granite State failed to establish detrimental reliance based on the delay.

Second, the court found an actual conflict between New York and California law as to whether a reinsurer can obtain "constructive notice" of a potential claim. Under New York law, a cedent cannot contend that its reinsurer obtained knowledge of a claim through collateral sources, whereas California law permits such constructive notice. Applying California law (based on a "significant contacts" analysis), the court held that the record did not support a showing of constructive notice to Clearwater. Although certain documents evidenced Granite State's possible involvement in litigation, the court agreed with Clearwater that "[p]roviding general information about an underlying policyholder, and hoping that the reinsurer 'figures it out,' is not what the [Certificate] notice provision requires."

Third, the court held that California law requires a showing of "actual and substantial" prejudice stemming from late notice and that Clearwater failed to make such showing. Clearwater argued that it had reached a commutation agreement with a retrocessionaire, which it would not have entered had it known about the Kaiser reinsurance claim. Relying on Ninth Circuit precedent, the court concluded that the commutation agreement was a "collateral matter" that did not establish prejudice.

Fourth, the court rejected Clearwater's exhaustion argument—*i.e.*, that Granite State did not "actually pay" settlement amounts to Kaiser, as required by the certificates, because payment was made by related entities rather than Granite State itself. The court deemed this argument "overly simplistic" and ruled that Clearwater's obligations were triggered by virtue of the fact that payments were made up to the limits of Granite State's underlying policy, regardless of the source of payments.

Fifth, the court ruled that a factual issue existed as to whether Granite State's pooling agreement with other companies, under which all of Granite State's liability was transferred violated the "warranty of retention" provision in the reinsurance certificate. The warranty of retention clause required Granite State to "retain for its own account, subject to treaty insurance only, if any, the amount specified on the face of th[e] Certificate." The court explained that under California law, evidence of custom and usage can establish a latent ambiguity in otherwise facially unambiguous policy language. The court concluded that an ambiguity existed here because an expert testified that an inter-company pooling agreement among affiliates is not typically considered a violation of a retention warranty.

Finally, the court ruled that Clearwater was entitled to challenge Granite State's allocation of insurance proceeds to underlying claims. In so ruling, the court held that a reinsurance provision which states that Clearwater's liability "shall follow [Granite State's] liability in accordance with the terms and conditions of the policy reinsured hereunder," was a "follow form" clause, and not a follow the fortunes provision. Although other courts have reached a contrary conclusion when faced with similar language, the *Granite State* court "beg[ged] to differ."

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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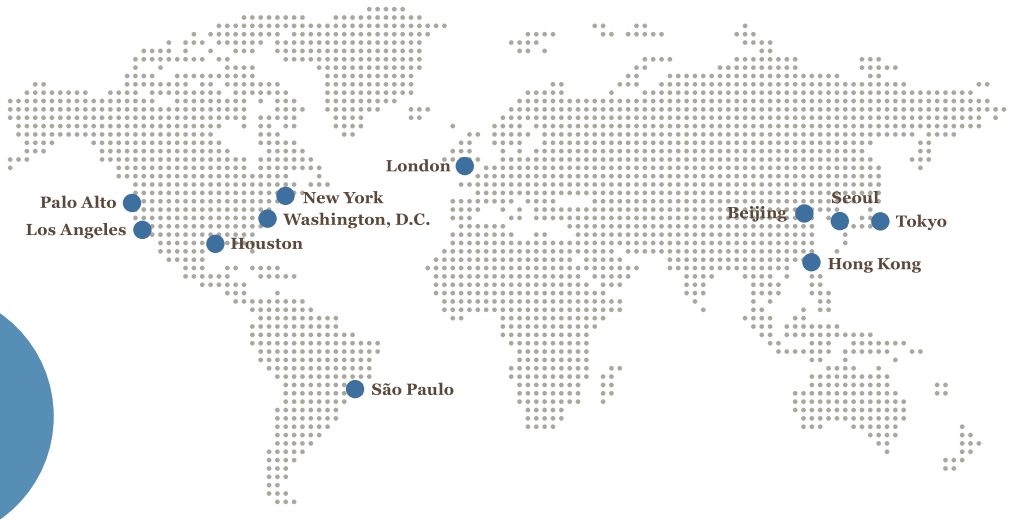

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