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Insurance Law Alert

March 2016

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Two courts reached opposing conclusions as to whether a pollution exclusion bars coverage for claims arising out of exposure to noxious fumes. *Shaw v. Liberty Mutual Fire Insurance Co.*, 2016 WL 561409 (M.D. Fla. Feb. 12, 2016); *Nat'l Fire Ins. Co. of Hartford v. James River Ins.*, 2016 WL 613964 (D. Ariz. Feb. 16, 2016). (Click here for full article)

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The United States Supreme Court ruled that the reporting requirements set forth in the Employee Retirement Income Security Act preempt those of individual states. *Gobeille v. Liberty Mutual Ins. Co.*, 136 S. Ct. 936 (2016). (Click here for full article)

Three Courts Address The Scope of a "Claim" in Claims-Made Policies

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An Arizona appellate court denied D&O coverage based an exclusion for claims arising out of Interrelated Wrongful Acts alleged in a prior claim made outside the applicable policy period. *SP Syntax LLC v. Federal Ins. Co.*, 2016 WL 831532 (Ariz. Ct. App. Mar. 3, 2016). (Click here for full article)

A California federal district court ruled that seven lawsuits pending against the policyholder constituted a single claim for the purposes of the per-claim limit in the applicable policy. *Liberty Ins. Underwriters, Inc. v. Davies Lemmis Raphaely Law Corp.*, 2016 WL 741837 (C.D. Cal. Feb. 23, 2016). (Click here for full article)

Property Damage Alert:

Wisconsin Supreme Court Rules That Incorporation of Defective Ingredient In Product Is Not "Property Damage"

The Wisconsin Supreme Court ruled that the incorporation of a defective ingredient into a nutritional supplement tablet is not "property damage" caused by an "occurrence" under Wisconsin or California law. *Wisconsin Pharmacal Co., LLC v. Nebraska Cultures of California, Inc.*, 2016 WL 785203 (Wis. Mar. 1, 2016).

Pharmacal supplied probiotic supplements to retailers. One such supplement was a tablet that was supposed to contain LRA, a probiotic bacterial species. However, after the tablets were shipped to retailers, it was discovered that the tablets contained LA, a different bacterial species. The tablets were recalled and the remaining inventory was destroyed. Pharmacal sued several of its suppliers and their insurers. The insurers moved for summary judgment, arguing that there was no coverage for the underlying claims. A Wisconsin trial court agreed and ruled that the insurers had no duty to defend. An intermediate appellate court reversed. The Wisconsin Supreme Court reversed the appellate ruling.

The Wisconsin Supreme Court ruled that under Wisconsin law, the question of whether the incorporation of a defective ingredient constitutes property damage turns on "whether the product is to be treated as a unified whole or whether a defective component can be separated out such that the claimed damage constitutes damage to property other than the defective component itself." The court concluded that because all of the ingredients were permanently blended together in the manufacturing process, the tablet constituted an "integrated system." The court therefore held that damage to the tablet was damage to the product itself and not damage to other property. The court also held that there was no "physical injury to tangible property" because there was no physical alteration of other ingredients, the container, or any other packaging component. Additionally, the court held that there was no "loss of use of tangible property" because the destruction of the products constituted a permanent economic loss rather than a temporary loss of use of property. Finally, the court ruled that there was no "occurrence" even though incorporation of the incorrect ingredient was accidental. Citing to faulty workmanship coverage precedent, the court reasoned that just as defective construction, standing alone, does not constitute an occurrence, use of a defective ingredient, in and of itself without resulting property damage, does not constitute an occurrence.

Applying California law to a second insurance policy that was at issue, the court concluded that the failure of a product to perform as intended does not constitute property damage. Although California courts have held that the incorporation of a hazardous component can constitute property damage, the court deemed such precedent inapplicable because the incorrect ingredient was not hazardous. The court further held that there was no "occurrence" under California law because the supply and incorporation of LA was deliberate, rather than accidental, even though the provision of the defective ingredient "may have been occasioned by negligence."

Number of Occurrences Alerts:

New York Court of Appeals Rules That Policyholder Must Pay Deductible for Each Claimant in Class Action Settlement

The New York Court of Appeals ruled that improper strip searches of each arrestee over a four-year period constituted separate occurrences subject to separate deductible payments. *Selective Ins. Co. of Am. v. County of Rensselaer*, 2016 WL 527098 (N.Y. Feb. 11, 2016).

Class action suits against Rensselaer County alleged that the County jail's strip search policy violated arrestees' civil rights. Selective Insurance defended the County and ultimately reached a settlement with the underlying plaintiffs. The County refused to pay Selective more than a single $10,000 deductible payment. Selective filed suit, arguing that harm to each class member constituted a separate occurrence and was therefore subject to a separate deductible. A New York trial court agreed and ruled in Selective's favor. An intermediate appellate court, and the Court of Appeals both affirmed.

The policy defined "occurrence" as "an event, including continuous or repeated exposure to substantially the same general harmful conditions, which results in . . . 'personal injury' . . . by any person or organization." The court reasoned that this language "makes clear that [the policy] covers personal injuries to an individual person as a result of a harmful condition." The court further explained that this language does not permit the grouping of multiple individuals who were harmed by the same condition unless that group is an organization. The court therefore concluded that the harm experienced by each individual arrestee constituted a "separate and distinct" occurrence subject to a separate deductible.

Washington Appellate Court Rules That Several Collisions Constitute One Accident as a Matter of Law

Reversing a trial court decision, a Washington appellate court ruled that a series of automobile collisions constituted a single accident as a matter of law. *State Farm Mut. Auto. Ins. Co. v. Glover-Shaw*, 2016 WL 687180 (Wash. Ct. App. Feb. 16, 2016).

Shortly after crossing an intersection, an intoxicated driver struck three different vehicles. Those vehicles, in turn, hit or were hit by other nearby vehicles. State Farm sought a declaration that all of the collisions constituted a single accident under its insurance policy, subject to a single $100,000 per-accident limit. A trial court denied State Farm's summary judgment motion, and the matter was tried before a jury, which decided against State Farm. State Farm moved for a new trial, which the court denied. The appellate court ruled that the trial court erred in denying State Farm's summary judgment motion.

Under Washington law, "[a]ll injuries or damage within the scope of a single 'proximate, uninterrupted, and continuing cause' must be treated as arising from a single accident." The appellate court ruled that the intoxicated driver's loss of control of the vehicle was the sole, uninterrupted proximate cause of all of the collisions at issue. In so ruling, the court noted that the record established that the collisions occurred within a span of 160 feet and within four or five seconds. The court further emphasized that the driver never "regained control" of her vehicle during that time frame. As reported in our October 2015 Alert, the Second Circuit, applying New York's "unfortunate event test," reached a different conclusion in a motor vehicle case, holding that a series of related automobile accidents caused by a common origin and within a short time span constituted three separate accidents for purposes of policy coverage. *National Liab. & Fire Ins. Co. v. Itzkowitz*, 2015 WL 5332109 (2d Cir. Sept. 15, 2015), as amended (Sept. 22, 2015).

Bad Faith Alert:

Delaware Supreme Court Addresses Accrual of Bad Faith Failure-to-Settle Claims

Addressing a matter of first impression under Delaware law, the Delaware Supreme Court ruled that a bad faith failure-to-settle claim against an insurer accrues when a judgment against the policyholder in excess of policy limits becomes final and non-appealable. *Connelly v. State Farm Mutual Auto. Ins. Co.*, 2016 WL 836983 (Del. Mar. 4, 2016).

The bad faith claim arose out of an automobile accident between Brown and Connelly. Connelly sued Brown and subsequently offered to settle for $35,000. State Farm, which had the exclusive right to control Brown's defense, rejected the offer. A trial later awarded Connelly approximately $224,000. State Farm paid part, but not all of the judgment. Connelly, as Brown's judgment creditor, sued State Farm alleging bad faith based on its refusal to settle for $35,000 given the policy's $100,000 limit. State Farm moved to dismiss the complaint on the ground that it was barred by the applicable three-year statute of limitations. *See* 10 Del. C. §8106. State Farm argued that the statute of limitations began to run either on the date Connelly made her settlement offer, or one month later, when the offer expired. A Delaware trial court granted State Farm's motion to dismiss, finding that the bad faith claim accrued at the time that State Farm allegedly breached its contractual duties, which was the date State Farm denied Connelly's settlement offer. The Delaware Supreme Court reversed.

Joining "the majority rule of courts in other states," the Delaware Supreme Court ruled that the accrual date for a bad faith failure-to-settle claim is when an excess judgment becomes final and non-appealable. The court noted that this holding promotes judicial economy (*i.e.*, avoiding bad faith litigation if there is no excess judgment against the policyholder) and reduces potential conflicts of interest between insurers and policyholders (*i.e.*, avoiding a bad faith claim during the pendency of an underlying suit defended by an insurer). In addition, the court explained that using the date of final judgment as the accrual date comports with Delaware bad faith law, because in order to state a bad faith claim, a policyholder must plead damages, which it cannot do until a final excess judgment is issued.

Coverage Alert:

No Coverage Where Insured Was Not "Legally Obligated" to Remediate Mold, Says Eighth Circuit

The Eighth Circuit ruled that a property manager was not legally obligated to remediate mold damage and was therefore not entitled to coverage under general liability policies. *Busch Props., Inc. v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA*, 2016 WL 722950 (8th Cir. Feb. 24, 2016).

Busch Properties, Inc., a property manager and rental agent, discovered mold trapped in condominium walls, which arose from the use of vinyl wallpaper. Busch notified unit owners of its intention to remediate. Busch issued a consent form to each unit owner indicating that Busch would fund the mold abatement and repair, but was not admitting liability. The consent form did not purport to release any claims that unit owners might have had against Busch. Although no lawsuits were filed against Busch, Busch sought coverage for the remediation expenses from National Union, its liability insurer. National Union denied coverage on the basis that Busch was not "legally obligated to pay by reason of liability imposed by law." A Missouri federal district court agreed and granted National Union's summary judgment motion. The Eighth Circuit affirmed.

The Eighth Circuit ruled that the policy phrase "legally obligated to pay by reason of liability imposed by law" (and the corresponding phrase "legally obligated to pay as damages for liability imposed upon the Insured by law," as contained in another applicable policy) may be satisfied by either a court judgment, or alternatively, a claim and settlement agreement. Because neither existed here, the court concluded that the policies did not provide coverage. Busch had argued that notwithstanding the absence of a judgement or settlement, it "faced liability to unit owners and the associations for the damage it caused." Rejecting this argument, the court explained that even if Busch acted to satisfy a preexisting

contractual duty, its remediation expenses "did not truly spring from 'liability imposed by law' but rather from a duty it voluntarily assumed." In addition, the court rejected Busch's attempt to secure coverage under a policy provision for "damages for . . . liability assumed by the Insured under contract." The court concluded that this clause provides coverage for indemnity or hold harmless contracts, and not the consent or maintenance agreements at issue here.

Data Breach Alerts:

Business Owner's Policy Does Not Cover Data Breach Losses, Says New York Appellate Court

A New York appellate court ruled that a business owner's policy does not provide coverage for third-party damages stemming from a data breach. *RVST Holdings, LLC v. Main St. Am. Assurance Co.*, 2016 WL 634611 (N.Y. App. Div. 3d Dep't Feb. 18, 2016).

Restaurant operators stored customers' credit card information on their computer network. The network was hacked and the credit card information was used to make numerous fraudulent charges. Thereafter, a bank sued the restaurant operators, alleging that they negligently failed to exercise reasonable care in safeguarding the information. When the restaurant operators sought coverage under their business owner's policy, the insurer refused to defend or indemnify, arguing that the policy excluded coverage for third-party claims arising out of the loss of electronic data. In ensuing litigation, a New York trial court ruled in favor of the restaurant operators. The appellate court reversed.

The policy provided coverage for sums the policyholder is legally obligated to pay because of "property damage," defined as "[p]hysical injury to tangible property . . . or . . . [l]oss of use of tangible property that is not physically injured." However, the policy further stated that "electronic data is not tangible property" and expressly excluded "[d]amages arising out of the loss of . . . electronic data." The court held that in light of this unambiguous language, the alleged negligent handling of electronic data is not a claim for "property damage," and is, in any event, excluded from coverage. The court rejected the assertion that coverage was provided by a separate policy provision that provided coverage for "direct physical loss of or damage to" the policyholder's own property. Although that provision did not exclude electronic data, the court reasoned that it was inapplicable to the third-party claims because it related to first-party coverage.

Illinois Court Declines to Dismiss Data Breach Suit Against Insurance Company

An Illinois federal district court denied an insurer's motion to dismiss a putative class action suit alleging improper handling of policyholders' personal information. *Dolmage v. Combined Ins. Co. of Am.*, 2016 WL 754731 (N.D. Ill. Feb. 23, 2016).

The insurer issued disability, health, life, and accident policies to the plaintiff and putative class members. In connection with issuance of the policies, the insurer sent each enrollee a document entitled "Our Privacy Pledge to You," along with other materials relating to the policies. The Privacy Pledge describes the insurer's handling of policyholders' personal information and states, among other things, that it maintains safeguards that comply with federal regulations to protect personal data, and that to the extent personal information is shared with other entities, it will "require them to abide by the same privacy standards as indicated here."

The insurer retained Enrolltek, a vendor that performs enrollment and other administrative functions, and provided it with the proposed class members' personal information for those purposes. According to the complaint, Enrolltek stored the personal information "online, unsecure and unprotected." The information was allegedly "accessible to anyone with an Internet connection." The insurer was allegedly aware of these security lapses but took no immediate action. The insurer later issued a formal notification to the plaintiff and potential class members that their personal information had been stored without proper security measures. Based on these allegations, plaintiff asserted a breach of contract claim, alleging that the data breach was a direct and foreseeable result of the insurer's failure to ensure that Enrolltek implemented appropriate security measures, as represented in the Privacy Pledge. The

insurer moved to dismiss the complaint, which the court denied.

The court concluded that the complaint stated a viable cause of action for breach of the insurance contracts. The court held that the complaint sufficiently alleged that the Privacy Pledge was incorporated into the class members' insurance contracts because each policy was defined as "this policy with any attached application(s), and any riders and endorsements." The court therefore reasoned that the Privacy Pledge could arguably be considered an endorsement, explaining that it could "be read to supplement the policy by providing additional benefits to insureds regarding the handling of their personal information." In this context, the court noted that the insurer "could have avoided any ambiguity by clearly labeling the documents sent with the policy that were intended to be incorporated by reference, but it did not do so." The court also rejected the insurer's argument that the Privacy Pledge does not give rise to a contractual right because it is "nothing more than a statement that [Defendant] is complying with its preexisting duties to follow applicable federal regulations." The court explained that, in addition to promising compliance with federal regulations, the Privacy Pledge also made other assurances about the safeguarding of enrollees' personal information.

False Claims Act Alert:

New Jersey Court Refuses to Dismiss *Qui Tam* Action Against Insurer

A New Jersey federal district court denied an insurer's motion to dismiss a *qui tam* complaint, finding that it sufficiently alleged a fraud claim pursuant to the False Claims Act. *Negron v. Progressive Cas. Ins. Co.*, 2016 WL 796888 (D.N.J. Mar. 1, 2016).

Relator Elizabeth Negron brought a *qui tam* action against Progressive, alleging that it allowed enrollees to select a certain automobile insurance policy which caused health care providers to submit medical claims to Medicare and Medicaid in violation of state and federal "secondary payer" laws. Under the Medicare Secondary Payer ("MSP") Act and applicable New Jersey statutory law, private health care plans are considered primary and Medicare serves as the secondary payer, available only when the primary payer does not provide coverage. Relator alleged that Progressive's online policy application system allowed Medicare and Medicaid beneficiaries to enroll in a "health first" automobile insurance policy even though doing so would result in the submission of reimbursement claims to Medicare and/or Medicaid as a primary payer, in violation of the MSP Act. Progressive moved to dismiss the complaint, which the court denied.

To state a claim under the False Claims Act, a plaintiff must show that: (1) the defendant presented or caused to be presented to a government entity a claim for payment; (2) the claim was false or fraudulent; and (3) the defendant knew that the claim was false or fraudulent. The court held that the complaint sufficiently alleged each of these requirements. In particular, the court held that the complaint alleged fraud based on an "implied false certification theory," which is premised on the notion that "the act of submitting a claim for reimbursement itself implies compliance with governing federal rules that are a precondition to payment." The court explained that Progressive had numerous opportunities to prevent the sale of the "health first" policies to Medicare and Medicaid enrollees, or to prevent the submission of claims to Medicare and Medicaid as primary payers, but did not do so. In so ruling, the court noted that Progressive's choice to "remain[ ] ignorant" of Relator's qualifications caused Relator's health care providers to submit claims to Medicare in violation of the MSP Act. Finally, the court held that the complaint sufficiently pleaded "knowledge" by Progressive by alleging that the insurer "failed to make reasonable and prudent inquiries to ensure compliance with the MSP Act."

Shortly before the court ruled on Progressive's motion to dismiss, Progressive moved to stay pending the United States Supreme Court's decision in *Universal Health Services Inc. v. United States ex. Rel. Escobar*, No. 15-7 (U.S. 2016), arguing that the Supreme Court will soon decide the viability and scope of the "implied certification" theory of liability under the False Claims Act. Oral arguments in *Escobar* are scheduled for April 19, 2016.

Pollution Exclusion Alert:

Courts Disagree on Whether Pollution Exclusion Encompasses Non-Traditional Noxious Odor Claims

In *Shaw v. Liberty Mutual Fire Insurance Co.*, 2016 WL 561409 (M.D. Fla. Feb. 12, 2016), the court ruled that Texas law does not limit a pollution exclusion to claims arising out of traditional environmental pollution. The coverage dispute arose out of an insurer's denial of coverage for carbon monoxide-related injuries based on a pollution exclusion. The court granted the insurer's summary judgment motion, finding that the pollution exclusion unambiguously barred coverage. In so ruling, the court expressly rejected the policyholder's argument that the exclusion should not apply because the underlying injuries were caused by ventilation, plumbing, and detection system failures, rather than a "pollutant." The court explained: "The Shaws' injuries arose out of the migration of carbon monoxide, a pollutant, from the parking garage to their room, on account of improperly maintained systems, and the failure to use appropriate detection equipment. Thus, the pollution exclusion applies, even if the other failures . . . contributed to their injuries."

In contrast, a court applying Arizona law ruled that claims arising out of exposure to hydrogen sulfide (a foul odor produced by a sewage leak) were not barred by a pollution exclusion. *Nat'l Fire Ins. Co. of Hartford v. James River Ins.*, 2016 WL 613964 (D. Ariz. Feb. 16, 2016). The court ruled that Arizona law limits application of the pollution exclusion to traditional environmental pollution. Although the Arizona Supreme Court has not definitively ruled on the issue, the court reasoned that under appellate court precedent, an absolute pollution exclusion does not bar coverage for all injuries arising from exposure to toxic substances. Rather, application of the exclusion must be determined "in light of the historical purpose of the pollution exclusionary clause." The court therefore concluded that, even assuming that hydrogen sulfide gas was a "contaminant" or "irritant," the exclusion was inapplicable because faulty plumbing pipe installation does not constitute traditional pollution. Notably, the pollution exclusion at issue in *James River* was broader than standard form language, containing an additional "blanket exclusion" that barred coverage for all "[p]ollution/environmental impairment/contamination." However, the court rejected this provision as overbroad, stating that those terms "must be tethered to some limiting principle" to prevent the exclusion from eviscerating coverage.

Preemption Alert:

United States Supreme Court Rules That ERISA Preempts State Claims-Reporting Statutes

The United States Supreme Court ruled that the reporting requirements set forth in the Employee Retirement Income Security Act ("ERISA") preempt those of individual states. *Gobeille v. Liberty Mutual Ins. Co.*, 136 S. Ct. 936 (2016).

Vermont statutory law requires health insurers to report payments relating to health care claims and services to a state agency for compilation in a database. The law encompasses health plans established by employers and regulated by ERISA. Liberty Mutual's health plan, which provides insurance benefits in all fifty states, is an "employee welfare benefit plan" under ERISA. The plan's third-party administrator, Blue Cross Blue Shield of Massachusetts, Inc., is subject to Vermont's disclosure statute. However, Liberty Mutual directed Blue Cross to withhold claim data from the state agency on the basis that it might violate its fiduciary duties with respect to customers' confidential information. Liberty Mutual filed suit seeking a declaration that ERISA preempted the Vermont statute, and an injunction preventing Vermont from seeking to obtain data about the plan or its members. A Vermont district court ruled in favor of the state, finding that there was no preemption. The district court reasoned that although the state scheme might have "some indirect effect" on health benefit plans, the effect is "so peripheral that the regulations cannot be considered an attempt to interfere with the administration or structure of a welfare benefit plan." The Second Circuit reversed, concluding that Vermont's reporting statute

was preempted by ERISA because the state regime interferes with the uniformity of ERISA. The Supreme Court affirmed.

The Supreme Court emphasized that reporting and record-keeping are integral aspects of ERISA. Therefore, state regulations governing these same functions (whether the regulations are "[d]iffering or even parallel") could "create wasteful administrative costs and threaten to subject plans to wide-ranging liability." The Court therefore concluded that preemption is "necessary to prevent the States from imposing novel, inconsistent, and burdensome reporting requirements on plans."

Claims-Made Coverage Alert:

Three Courts Address The Scope of a "Claim" in Claims-Made Policies

In *Weaver v. Axis Surplus Insurance Co.*, 2016 WL 860363 (2d Cir. Mar. 7, 2016), the Second Circuit ruled that an insurer was not obligated to defend a policyholder in an action brought by the Department of Justice ("DOJ") because it related to a claim first made prior to the policy's effective period.

Axis insured Multivend, a vending machine sales company, under a claims-made policy. The policy was in effect from 2010 to 2014, with a "Pending or Prior Claim" date of February 20, 2008. In 2007, the Office of the Attorney General of Maryland sent a letter to Multivend requesting information relating to potential statutory violations. The letter requested that Multivend immediately cease all offers and sales of business opportunities, noting that failure to respond could result in formal legal action. In 2012, Weaver, Multivend's President/CEO, advised Axis that he had received a DOJ letter identifying him as a target of a grand jury investigation. Shortly thereafter, Weaver was indicted. Weaver sought coverage from Axis, which denied the claim. In ensuing coverage litigation, a New York federal district court granted Axis's summary judgment motion, finding that the indictment was based on the same or "Interrelated Wrongful Acts" as the 2007 Maryland AG letter, and therefore constituted a claim "first made" prior to the policy period. The district court also ruled that the coverage was excluded because the 2007 Maryland AG letter constituted a "demand" made prior to the February 20, 2008 "Pending or Prior Claim" date. The Second Circuit, addressing only the latter holding, affirmed.

The policy excluded coverage for "any Claim . . . in any way involving . . . any demand, suit or other proceeding pending . . . against any Insured on or prior to [February 20, 2008], or any Wrongful Act, fact, circumstances or situation underlying or alleged therein." The parties did not dispute that the DOJ action constituted a "claim" involving the same facts and circumstances as the 2007 Maryland AG letter. However, Weaver argued that the 2007 Maryland AG letter was not a "demand." The court disagreed. Although the policy did not define "demand," the court held that it requires "an imperative solicitation for that which is legally owed," as opposed to a mere "request carrying no legal consequences." The court concluded that the 2007 Maryland AG letter met this standard because it requested information, directed a cessation of business activities, and indicated that a failure to comply could result in formal legal action. In so ruling, the court noted that neither the polite tone nor the lack of "specific consequences" in the letter negated the "demand" status of the letter. Weaver filed a petition for rehearing to the Second Circuit on March 21.

An Arizona appellate court similarly denied D&O coverage based an exclusion for claims arising out of Interrelated Wrongful Acts alleged in a prior claim made outside the applicable policy period. *SP Syntax LLC v. Federal Ins. Co.*, 2016 WL 831532 (Ariz. Ct. App. Mar. 3, 2016).

SBC, a television developer and distributer, was insured under two "towers" of D&O coverage. Tower 1 was effective from November 30, 2006 through November 30, 2007, and Tower 2 was effective from November 30, 2007 through November 30, 2008. Federal Insurance participated in two excess coverage layers in Tower 2—an excess policy and a "Side A Policy."

SBC was sued in a securities fraud class action on November 14, 2007. The Tower 1 insurers accepted coverage for this action. Approximately three months later, a second complaint was filed against SBC alleging fraud

and misrepresentations in connection with a credit facility agreement. SBC tendered the second complaint to all its insurers. Federal and the other Tower 2 insurers denied coverage. An Arizona trial court dismissed SBC's coverage claims against Federal, finding that exclusions in both Federal policies barred coverage. The appellate court affirmed.

Federal's excess policy barred coverage for any claim "alleging, arising out of, based upon, attributable to or in any way related directly or indirectly, in part or in whole, to an Interrelated Wrongful Act." The term "Interrelated Wrongful Act" included any wrongful act "which is the same as, similar, or related to" any wrongful act alleged in the prior securities fraud class action. The appellate court ruled that the exclusion applied because the second complaint included many of the same allegations set forth in the prior securities fraud class action. In so ruling, the court deemed it insignificant that the second complaint contained allegations not included in the first complaint, noting that all allegations were "related." For the same reasons, the court ruled that coverage was unavailable under Federal's Side A Policy, which provided that "[a]ll related claims shall be treated as a single Claim first made on the date the earliest of such Related Claims was first made."

A California federal district court ruled that seven lawsuits pending against the policyholder constituted a single claim for the purposes of the per-claim limit in the applicable policy. *Liberty Ins. Underwriters, Inc. v. Davies Lemmis Raphaely Law Corp.*, 2016 WL 741837 (C.D. Cal. Feb. 23, 2016).

Between 2011 and 2013, seven lawsuit were filed against a real estate firm (DLR) and a real estate investment broker (AMC). The suits alleged that DLR and AMC made fraudulent misrepresentations relating to commission payments in connection with property acquisitions. Each property acquisition was completed on a different date, purchased from a separate seller, and on different terms. Liberty, DLR's professional liability insurer, funded the defense of the underlying actions. Liberty sought a declaration that all seven suits constituted a single claim under a 2010-2011 claims-made-and-reported policy, and were thus subject to a single per-claim limit. The court agreed and granted Liberty's summary judgment motion.

The policy provided that "[c]laims alleging, based upon, arising out of or attributable to the same or related wrongful acts shall be treated as a single claim." The court held that because the underlying suits arose out of 23 distinct transactions, they were not based on the "same" wrongful act. However, the court concluded that the underlying alleged wrongful acts were sufficiently "related" to be considered a single claim. In particular, the court reasoned that although each underlying suit was brought by a different plaintiff, "they all arise from a single course of conduct, a unified policy of making alleged misrepresentations to investors in order to induce them to invest in commercial real estate acquisitions facilitated by AMC." The court therefore concluded that a single per-claim limit applied to all underlying claims.

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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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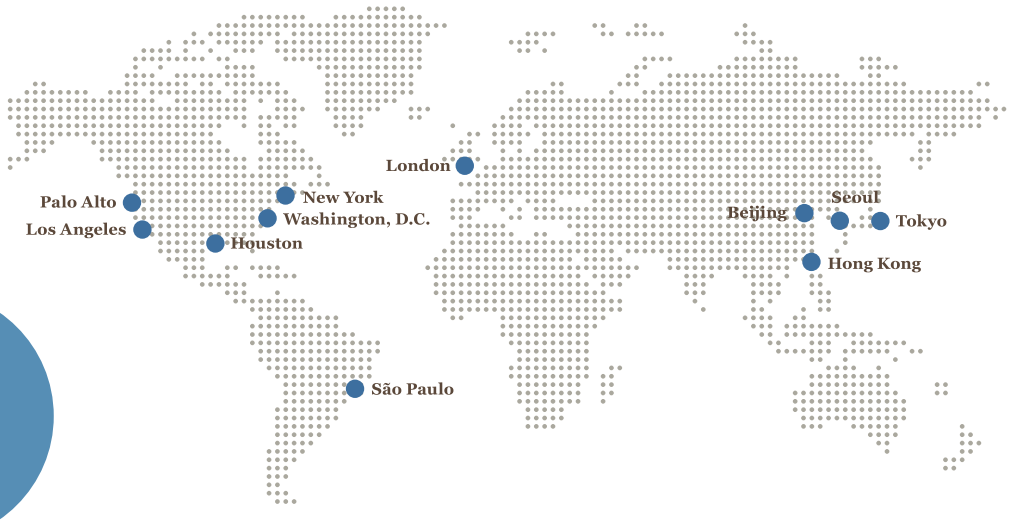

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