Simpson Thacher

Insurance Law Alert

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***–Chambers USA* 2017, quoting a client**

Ninth Circuit Reverses Class Action Dismissal Relating To "Program Business," Finding Sufficient Allegations Of Soliciting And Transacting Insurance By AARP

The Ninth Circuit ruled that a California federal district court erroneously dismissed a putative class action against the American Association of Retired Persons alleging violations of California statutory law based on the organization's alleged solicitation and transaction of insurance. *Friedman v. AARP, Inc.*, 2017 WL 1657553 (9th Cir. May 3, 2017). (Click here for full article)

Reversing District Court, Third Circuit Holds That Asbestos Exclusion Unambiguously Bars Coverage

The Third Circuit ruled that an asbestos exclusion unambiguously precluded coverage for claims alleging injury caused by asbestos-containing products. *General Refractories Co. v. First State Ins. Co.*, 855 F.3d 152 (3d Cir. Apr. 21, 2017). (Click here for full article)

New York Appellate Court Rules That Statute Does Not Eliminate Insurer's Burden To Prove All Elements Of Fraud

A New York appellate court ruled than a bond insurer cannot rely on state statutory law to avoid proving loss causation in its fraud-based suit against Countrywide Financial Corporation. *Ambac Assurance Corp. v. Countrywide Home Loans, Inc.*, 2017 WL 2115841 (N.Y. App. Div. May 16, 2017). (Click here for full article)

Eighth Circuit Rules That RICO Claims Against Insurance Entities Are Reverse Preempted By State Insurance Regulations

The Eighth Circuit dismissed federal RICO claims against an insurance company and its affiliates, finding that allowing the claims to proceed would impair state regulation of insurance. *Ludwick v. Harbinger Grp., Inc.*, 854 F.3d 400 (8th Cir. Apr. 13, 2017). (Click here for full article)

Fourth Circuit Rules That Claims Against Insurer Are Time-Barred And Preempted By National Flood Insurance Program

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Eleventh Circuit Rules That Policyholder's Failure To Allocate Settlement Between Covered And Non-Covered Claims Precludes Indemnification

The Eleventh Circuit rejected a policyholder's demand for indemnification based on its failure to allocate an underlying settlement between covered and non-covered claims. *Highland Holdings, Inc. v. Mid-Continent Cas. Co.*, 2017 WL 1628953 (11th Cir. May 2, 2017). (Click here for full article)

Iowa Supreme Court Rules That Breach Of Contract Is Not Prerequisite To First-Party Bad Faith Claim

The Iowa Supreme Court ruled that a workers' compensation insurer was liable for bad faith even though it did not breach the insurance policy. *Thornton v. American Interstate Ins. Co.*, 2017 WL 2200461 (Iowa May 19, 2017). (Click here for full article)

Simpson Thacher News Alerts

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Pollution Exclusion Alert:

Washington Supreme Court Rules That Pollution Exclusion Does Not Bar Coverage For Carbon Monoxide Claims Based On Lack Of Proximate Causation

The Washington Supreme Court ruled that carbon monoxide claims were not barred by a pollution exclusion because the efficient proximate cause of the underlying injuries was a covered negligent act. *Xia v. ProBuilders Specialty Ins. Co.*, 2017 WL 1532219 (Wash. Apr. 27, 2017).

A homeowner sustained carbon monoxide injuries as a result of the improper installation of an exhaust vent. The homeowner, as assignee of the builder, sued the builder's general liability insurer. The insurer denied coverage based on an absolute pollution exclusion and a townhouse exclusion. A Washington trial court granted the insurer's summary judgment motion, finding that the townhouse exclusion barred coverage. An appellate court reversed, finding that the townhouse exclusion did not apply, but that the pollution exclusion did. The Washington Supreme Court reversed.

The Washington Supreme Court ruled that carbon monoxide is a pollutant within the meaning of the pollution exclusion and thus the carbon monoxide leak was an occurrence barred by the exclusion. However, the court held that the insurer owed coverage because the efficient proximate cause of the injuries was a covered occurrence – namely, the negligent installation of the exhaust vent. The court stated: "The exclusion cannot eviscerate a covered occurrence merely because an uncovered peril appeared later in the causal chain."

This opinion appears to run counter to a well-established body of law. In determining the scope of a policy's coverage, courts typically analyze coverage provisions, and then turn to exclusionary clauses. Here, however, the court first determined that the pollution exclusion applied, but then deemed it inapplicable based on an initial coverage grant for negligent occurrences. Moreover, as the court noted, the efficient proximate cause doctrine has not previously been applied in this context. Typically, the doctrine is implicated in the first-party property context when a covered and uncovered peril both contribute to a loss. As the insurers argued (and the dissenting opinion emphasized), application of the proximate causation doctrine in this context operates to defeat the pollution exclusion almost entirely because most acts of unintentional pollution begin with negligence. Finally, the decision ignores the plain policy language. In applying the proximate causation doctrine, the court reasoned that "emphasis must be given to the phrase 'caused by'" in the pollution exclusion. However, the exclusion is not limited to injuries or damages "caused by" pollution. Rather, the exclusion also encompasses injuries or damage "resulting from, attributable to, contributed to, or aggravated by the actual, alleged or threatened discharge, dispersal, seepage, migration, release or escape of pollutants." The court similarly declined to enforce a provision that stated that the pollution exclusion "applies whether any other cause of the bodily injury, property damage, or personal injury would otherwise be covered under this insurance," finding that the clause improperly attempted to circumvent the efficient proximate cause rule.

Insurance Alert:

Ninth Circuit Reverses Class Action Dismissal Relating To "Program Business," Finding Sufficient Allegations Of Soliciting And Transacting Insurance By AARP

The Ninth Circuit ruled that a California federal district court erroneously dismissed a putative class action against the American Association of Retired Persons ("AARP") alleging violations of California statutory law based on the organization's alleged solicitation and transaction of insurance. *Friedman v. AARP, Inc.*, 2017 WL 1657553 (9th Cir. May 3, 2017).

The complaint alleges that AARP serves as the group policyholder for Medigap coverage sold by UnitedHealth, and that pursuant to a contractual arrangement, AARP participates in the solicitation of new members and the collection of premiums for UnitedHealth. In turn, AARP retains 4.95% of each dollar paid by enrollees prior to remitting the premiums

to UnitedHealth. The complaint asserts that this fee is a commission on the sale of insurance, and that by collecting this fee, AARP violated the California Insurance Code, which provides that a person "shall not solicit, negotiate or effect contracts of insurance" without a proper license. AARP moved to dismiss the complaint, which the district court granted. The district court concluded that the complaint did not plausibly allege that AARP acted as an "unlicensed insurance agent" or that the 4.95% fee was an improper "commission." The district court also held that AARP did not "solicit" insurance because the marketing materials did not allow potential enrollees to directly purchase insurance coverage from AARP. The Ninth Circuit reversed.

The Ninth Circuit ruled that, at the motion to dismiss stage, the complaint sufficiently alleges that AARP solicits and transacts insurance. In particular, the court reasoned that allegations that the 4.95% fee is a commission sufficiently plead the transaction of insurance. In so ruling, the court rejected the argument that the method of fee calculation conclusively establishes that it is a royalty rather than a commission. The court also held that the complaint sufficiently alleges the solicitation of insurance because, among other things, AARP's marketing materials expressly state: "This is a solicitation of insurance." The Ninth Circuit rejected the district court's reasoning that solicitation was not alleged because AARP's website did not permit direct purchase or enrollment.

The Ninth Circuit also addressed an issue not reached by the district court – the "filed-rate" doctrine. AARP had argued that the claims were barred by the "filed-rate" doctrine, under which "rates duly adopted by a regulatory agency are not subject to collateral attack in court." Because the district court concluded that the complaint failed to state a claim, it did not reach this issue. However, the Ninth Circuit noted that in light of its reinstatement of the complaint, the "filed-rate" doctrine reemerges as a relevant issue. The court therefore remanded the matter to the district court.

Asbestos Alert:

Reversing District Court, Third Circuit Holds That Asbestos Exclusion Unambiguously Bars Coverage

Reversing a Pennsylvania federal district court decision, the Third Circuit ruled that an asbestos exclusion unambiguously precluded coverage for claims alleging injury caused by asbestos-containing products. *General Refractories Co. v. First State Ins. Co.*, 855 F.3d 152 (3d Cir. Apr. 21, 2017).

The parties disputed whether two excess policies covered claims arising out of exposure to asbestos-containing products manufactured by General Refractories. The sole issue on appeal was whether a policy exclusion that bars coverage for losses "arising out of asbestos" applies to injury claims derived from exposure to asbestos-containing products. A Pennsylvania federal district court deemed the exclusion latently ambiguous, finding that "asbestos" was subject to two reasonable interpretations—raw asbestos only or asbestos-containing products—and thus held that the policies were obligated to cover the losses. The Third Circuit reversed.

The Third Circuit ruled that the phrase "arising out of," when used in an insurance exclusion, is unambiguous under Pennsylvania law. It means that the exclusion applies when the excluded act or thing is a but for cause of the injury or damage. Because the losses at issue would not have occurred but for asbestos (either raw or within finished products), the exclusion squarely applies. The Third Circuit explained that the district court's analysis of the term "asbestos" was misplaced because the phrase "arising out of" has "an unambiguous legal meaning that renders any uncertainty concerning the meaning of the word 'asbestos' immaterial."

Fraud Alert:

New York Appellate Court Rules That Statute Does Not Eliminate Insurer's Burden To Prove All Elements Of Fraud

Reversing in part a New York trial court decision, an appellate court ruled than a bond insurer cannot rely on state statutory law to avoid proving loss causation in its fraud-based suit against Countrywide Financial Corporation. *Ambac Assurance Corp. v. Countrywide Home Loans, Inc.*, 2017 WL 2115841 (N.Y. App. Div. May 16, 2017).

The suit arose out of securitizations consisting of over 375,000 pooled residential mortgage loans with an original principal balance of approximately $25 billion. Ambac provided insurance for the securitizations, under which it agreed to insure payments of principal and interest due to investors. Following the failure of the securities to perform, Ambac paid more insurance claims than it anticipated and ultimately entered statutory rehabilitation. Ambac then sued Countrywide, alleging that it fraudulently induced Ambac to insure the securitizations and breached representations and warranties made in transaction documents. Both parties moved for summary judgment on various issues.

The appellate court ruled that to recover, Ambac is required to prove all elements of its fraudulent inducement claim, including justifiable reliance and loss causation. The court rejected Ambac's argument that New York Insurance Law § 3105 dispenses with the common law requirement of proving those elements. The court explained that Section 3105, which provides that a material misrepresentation "shall avoid [a] contract of insurance" and "defeat recovery thereunder," does not create a separate cause of action, but rather codifies common law insurance principles. The court further reasoned that Section 3015 is inapplicable because it generally applies to rescission claims (rather than claims seeking monetary damages), and Ambac's policies are expressly unconditional and irrevocable. Notably, other New York courts, addressing the same issue, have reached a different conclusion. *See MBIA Ins. Corp. v. Countrywide Home Loans, Inc.*, 963 N.Y.S.2d 21 (1st Dep't Apr. 2, 2013) (rejecting Countrywide's argument that Insurance Law §§ 3105 and 3106 bar the "recovery of payments made pursuant to an insurance policy without resort to rescission"); *MBIA Ins. Corp. v. Countrywide Home Loans, Inc.*, 39 Misc.3d 1220(A) (N.Y. Sup. Ct. N.Y. Cnty. Apr. 29, 2013) (insurer need not demonstrate justifiable reliance for fraudulent inducement claim under § 3015).

The court also ruled on the scope of permissible damages against Countrywide. Among other things, the court ruled that Ambac was not entitled to damages for all past and future claims paid under the policies, reasoning that Ambac "accepted the risk that an economic downturn could cause the loans to default and trigger its obligation to pay." However, the court held that the trial court should not have dismissed Ambac's reimbursement claim, finding that the relevant transaction agreements entitled Ambac to reimbursement for claims paid as a result of Countrywide's failure to abide by the repurchase protocol, and that a separate remedy-limiting provision did not apply to such reimbursement claims.

Preemption Alerts:

Eighth Circuit Rules That RICO Claims Against Insurance Entities Are Reverse Preempted By State Insurance Regulations

The Eighth Circuit dismissed federal RICO claims against an insurance company and its affiliates, finding that allowing the claims to proceed would impair state regulation of insurance. *Ludwick v. Harbinger Grp., Inc.*, 854 F.3d 400 (8th Cir. Apr. 13, 2017).

Ludwick sued Fidelity & Guaranty Insurance Company and several affiliates, alleging RICO violations. The complaint asserted that Fidelity misled her into overpaying for an annuity by disseminating inaccurate reports and marketing materials and by transferring billions of dollars of liabilities off its books to affiliate companies. According to Ludwick, if Fidelity had properly accounted for certain transactions, it would have had to report a negative balance instead of the billion dollar surpluses reported during the relevant time period. A Missouri federal district court granted Fidelity's motion to dismiss, finding that the claims were reverse preempted under the McCarran-Ferguson Act. The Eighth Circuit affirmed.

The McCarran-Ferguson Act provides that federal law may not be construed to "invalidate, impair or supersede any law enacted by any State for the purpose of regulating the business of insurance." 15 U.S.C. § 1012(b). The court concluded that enforcement of federal RICO claims in this case would impair state insurance regulation because the claims involved transactions that were approved by state regulators. Further, the court reasoned that questions about an insurance company's solvency fall squarely within the regulatory oversight of state insurance departments. In so ruling, the Eighth Circuit rejected the argument that the RICO claims were based on Fidelity's bookkeeping rather than the propriety of the state-approved transactions. The court explained: "To decide whether F&G's reported financials reflected a significant departure from the accounting principles it claimed to have followed, a federal court would need to ask what the result of the transactions should have been under those principles. That would drag the court right back into second-guessing state regulators' oversight of F&G's solvency and stability."

Fourth Circuit Rules That Claims Against Insurer Are Time-Barred And Preempted By National Flood Insurance Program

The Fourth Circuit ruled that homeowners' claims against their property insurer were time barred and, in any event, preempted by federal law relating to flood insurance. *Woodson v. Allstate Ins. Co.*, 855 F.3d 628 (4th Cir. May 3, 2017).

The Woodsons sought coverage from Allstate for hurricane-related damage to their home. Following an inspection of the damage, Allstate denied most of the claim. Less than one year after the denial, the Woodsons filed suit against Allstate in North Carolina state court, alleging breach of contract and bad faith. Shortly thereafter (but more than one year after the claim denial), Allstate removed the case to federal court and argued that the suit was barred by the applicable one-year statute of limitations. The district court did not address the limitations issue and entered judgment for the Woodsons on both claims. The Fourth Circuit reversed, ruling that the claims were time barred and that the bad faith claim was preempted by federal law.

The National Flood Insurance Program governs all flood insurance, whether issued by FEMA directly or by authorized private insurers that use the standardized agreement. Under the standard form policy, a homeowner must sue in federal court within one year after the date of claim denial. The Fourth Circuit held that the Woodsons' suit was time barred because more than one year had elapsed between the claim denial and Allstate's removal of the case to federal court. The court rejected the notion that the federal statute of limitations should be equitably tolled by the filing of a complaint in state court.

The court also ruled that the bad faith claim was preempted by federal law, noting that the policy expressly provided that "all disputes arising from the handling of any claim under the Policy are governed exclusively by the flood insurance regulations issued by FEMA, the National Flood Insurance Act of 1968 . . . and federal common law."

Settlement Alert:

Eleventh Circuit Rules That Policyholder's Failure To Allocate Settlement Between Covered And Non-Covered Claims Precludes Indemnification

The Eleventh Circuit rejected a policyholder's demand for indemnification based on its failure to allocate an underlying settlement between covered and non-covered claims. *Highland Holdings, Inc. v. Mid-Continent Cas. Co.*, 2017 WL 1628953 (11th Cir. May 2, 2017).

Home Design sued Highland Holdings for copyright infringement of architectural designs. The suit alleged that Highland infringed upon Home Design's copyright by advertising, designing, and constructing residences with house plans that were exact duplicates of plans registered by Home Design. Mid-Continent, Highland's liability insurer, initially defended the action. Thereafter, Highland rejected the defense and settled with Home Design, agreeing to pay $650,000 as a full and final settlement of "all claims raised or that could have been raised." When tendered the settlement, Mid-Continent refused to indemnify because Highland failed to allocate its damages between covered and non-covered claims. A Florida district court agreed with Mid-Continent's denial, granting its summary judgment motion. The Eleventh Circuit affirmed.

The Eleventh Circuit explained that the settlement encompassed both covered claims (for advertising injury) as well as non-covered claims (for copyright infringement and advertising injuries committed knowingly, after receipt of a cease and desist order). Because the settlement did not address allocation to each category of claims, the court concluded that Mid-Continent had no duty to indemnify. In so holding, the court rejected Highland's argument that all of its liability "arose out of" covered advertising injury because the schematic house plans were advertisements, whose very purpose was to attract customers, distinguishing *Mid-Continent Cas. Co. v. Kipp Flores Architects, L.L.C.*, 602 F. App'x 985 (5th Cir. 2015) (discussed in our March 2015 Alert). In *Kipp Flores*, the court held that houses, with a design based on an infringed copyright, constituted advertisements for the purposes of liability coverage. However, in that case, the policyholder had established that it used its model homes as its primary marketing means.

The Eleventh Circuit also rejected Highland's argument that a logical method of allocating the settlement is to divide the payment among the number of homes constructed using an infringing house plan. That method is inadequate, the court explained, because it fails to account for the portion of the settlement that reimbursed Home Design for its attorneys' fees or for the excluded "knowing" advertising injuries that occurred after Highland's receipt of the cease and desist letter from Home Design.

Bad Faith Alert:

Iowa Supreme Court Rules That Breach Of Contract Is Not Prerequisite To First-Party Bad Faith Claim

The Iowa Supreme Court ruled that a workers' compensation insurer was liable for bad faith even though it did not breach the insurance policy. *Thornton v. American Interstate Ins. Co.*, 2017 WL 2200461 (Iowa May 19, 2017).

The dispute arose out of a work-related injury that left Toby Thornton partially paralyzed. His workers' compensation insurer paid weekly benefits, but contested whether he was permanently and totally disabled ("PTD"). Additionally, the insurer resisted Thornton's petition for a partial commutation award, which would have allowed him to obtain a lump sum payment in addition to reduced weekly payments. The Iowa Workers' Compensation Commissioner later determined that Thornton was PTD and granted his petition for partial commutation. Thereafter, Thornton sued the insurer for common law first-party bad faith. Ruling on cross-motions for summary judgment, a trial court held that the insurer acted in bad faith as a matter of law by contesting PTD and commutation. A jury awarded Thornton $25 million in punitive damages and $284,000 in compensatory damages.

On appeal, the insurer argued that it could not be liable for bad faith because it voluntarily

and continuously paid weekly benefits under its policy. The court rejected this argument, finding that bad faith may be established when an insurer lacks a reasonable basis for denying benefits under the policy. The court reasoned that "the requisite 'denial' may occur when an insurer unreasonably contests a claimant's PTD status or delays delivery of necessary medical equipment," even in the absence of a breach of a specific policy term. Because the record clearly established Thornton's PTD shortly after the accident, the court affirmed that the insurer lacked any reasonable basis to dispute that status.

However, the Iowa Supreme Court reversed the trial court's finding of bad faith as a matter of law based on the insurer's resistance to commutation. The court explained that unlike mandated weekly payments, commutation is a discretionary issue, based on the Commissioner of Insurance's consideration of various factors. As such, the court concluded that Thornton's petition for commutation was "fairly debatable" on its facts. Notably, the court declined to foreclose the possibility that a bad faith claim may arise for resisting commutation under different facts, but held that the present record did not establish bad faith and that the insurer was entitled to summary judgment on that issue.

Finally, the court ruled that Thornton was not entitled to fees incurred in prosecuting his bad faith action, noting the lack of statutory or common law support for such damages under Iowa law. The court distinguished such fees from costs incurred by Thornton in the workers' compensation proceedings to establish coverage, which are allowable as compensatory damages. The court reversed the trial court judgments for actual and punitive damages and remanded the case for a new trial on the remaining bad faith claims.

Simpson Thacher News Alerts

Bryce Friedman spoke at the New York Bar Association's Current Issues in Insurance Regulation 2017 program, held on April 21. Bryce participated in a panel discussion titled "Regulation of the National Flood Insurance Program," which addressed various emerging issues, including unresolved claims stemming from Superstorm Sandy, the insurance-related implications of bills pending in Congress and the impact of recent staffing changes at the National Association of Insurance Commissioners.

Euromoney has shortlisted Mary Beth Forshaw (Insurance and Reinsurance) and Lynn Neuner (Litigation) for Americas Women in Business Law Awards. The Americas Women in Business Law Awards celebrate the achievements of women leading the field in their respective practice areas across the Americas. Euromoney will announce the winners at an awards ceremony on June 8 in New York City.

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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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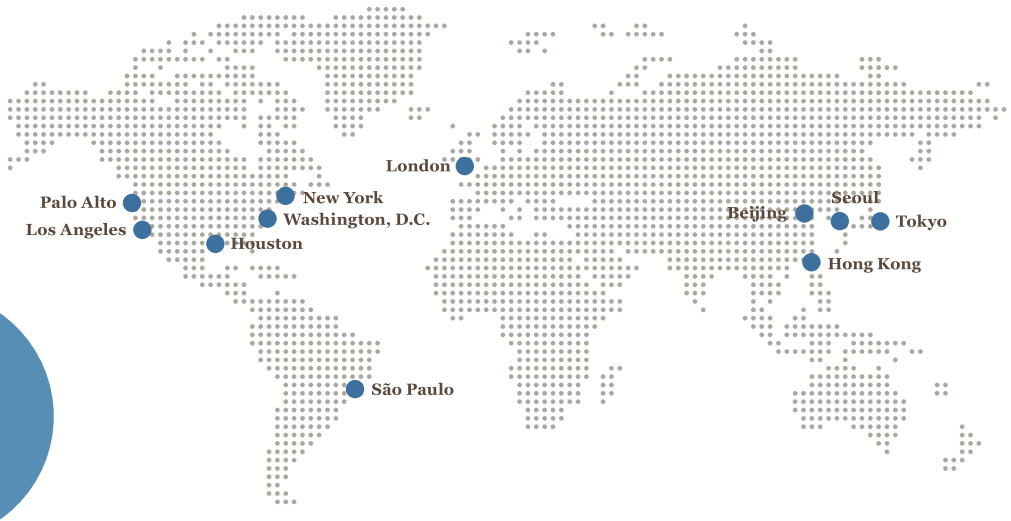

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