Simpson Thacher

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In This Issue

Ohio Court Rules That Salmonella Claims Against Peanut Butter Manufacturer Arise From A Single Occurrence Under Liability Policies

An Ohio district court ruled that thousands of claims for bodily injury arising from potential salmonella contamination in peanut butter products constituted a single occurrence under general liability policies. *J.M. Smucker Co. v. Ace American Ins. Co.,* 2024 U.S. Dist. LEXIS 53135 (N.D. Ohio Mar. 26, 2024). (Click here for full article)

California Court Rules That Fraudulent Wire Transfer Claims Give Rise To Possibility Of Coverage Under D&O Endorsement

A California district court denied an insurer's motion to dismiss, finding that a policyholder sufficiently alleged breach of contract and breach of the implied duty of good faith and fair dealing based on the insurer's refusal to defend an underlying suit arising out of a fraudulent email hacking scheme. *Bridlewood Estates Prop. Owners Assoc. v. State Farm General Ins. Co.,* 2024 U.S. Dist. LEXIS 47593 (S.D. Cal. Mar. 18, 2024). (Click here for full article)

Colorado Supreme Court Rules That Notice-Prejudice Rule Governs Untimely Notice Analysis In First-Party Property Cases

Addressing a matter of first impression under Colorado law, the Colorado Supreme Court ruled that the notice-prejudice rule applies in the context of first-party property insurance policies. *Gregory v. Safeco Ins. Co. of Am.*, 2024 Colo. LEXIS 202 (Colo. Mar. 11, 2024); *Runkel v. Owners Ins. Co.*, 2024 Colo. LEXIS 212 (Colo. Mar. 11, 2024). (Click here for full article)

Texas Court Declines To Imply "Reasonableness" Requirement In Reinsurance Treaty's Notice Provision

A Texas district court granted a cedent's summary judgment motion, ruling that it did not breach a notice provision in a reinsurance treaty and that the reinsurer was therefore obligated to pay a portion of an underlying settlement. *United States Fire Ins. Co. v. Unified Life Ins. Co.*, 2024 U.S. Dist. LEXIS 58560 (N.D. Tex. Mar. 29, 2024). (Click here for full article)

South Carolina Court Applies All Sums Allocation and Continuous Trigger To Asbestos-Related Coverage Dispute

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Judicial Panel Approves First Official Rule Relating To Multi-District Litigation

This month, the Judicial Conference's Advisory Committee on Civil Rules approved a new rule aimed at promoting fairness and efficiency in the context of multi-district litigation. (Click here for full article)

Simpson Thacher News

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– *Chambers USA* 2023 (quoting a client)

Ohio Court Rules That Salmonella Claims Against Peanut Butter Manufacturer Arise From A Single Occurrence Under Liability Policies

HOLDING

An Ohio district court ruled that thousands of claims for bodily injury arising from potential salmonella contamination in peanut butter products constituted a single occurrence under general liability policies. *J.M. Smucker Co. v. Ace American Ins. Co.*, 2024 U.S. Dist. LEXIS 53135 (N.D. Ohio Mar. 26, 2024).

BACKGROUND

Smucker recalled 225 lots of its Jif-brand products due to possible exposure to salmonella. After the recall, Smucker faced thousands of claims from consumers alleging bodily injury from consuming the contaminated products. Smucker sought coverage from ACE, its general liability insurer, for its defense costs under two policies that included a retained limit of $250,000 per occurrence. Smucker argued that the claims arose from a single occurrence, the alleged salmonella outbreak, and that it only had to pay one retained limit before ACE's duty to reimburse defense costs was triggered. In turn, ACE contended that each claimant's exposure to the contaminated products was a separate occurrence, and that Smucker had to pay 225 retained limits, or $56,250,000, before coverage was available.

DECISION

The court granted partial summary judgment to Smucker, finding that the claims arose from a single occurrence as defined by the policies, and that ACE had to reimburse Smucker for its defense costs once Smucker had paid a single retained limit. The court applied a cause-based test to determine the number of occurrences under the policies, holding that the claims arose from a "singular alleged salmonella outbreak." The court rejected ACE's argument that a batching endorsement in the policies required each lot of contaminated products to be treated as a separate occurrence. The court found that the batching endorsement was ambiguous, and that ACE's interpretation would eviscerate Smucker's coverage. The court noted that the Delaware Supreme Court, faced with a similar fact pattern, deemed a batching clause ambiguous and construed it in favor of the policyholder. *See ConAgra v. Lexington Ins. Co.*, 21 A.3d 62 (Del. 2011).

COMMENTS

While the court's decision aligns with certain other decisions holding that claims arising out of the distribution of a defective or contaminated product arise from a single occurrence, the number-of-occurrences determination is a fact-driven one, dependent on specific policy language and the evidentiary record as well as applicable state law. For instance, in cases where contamination arises from several distinct sources or at different locations, courts may conclude that the claims constitute multiple occurrences. Similarly, where underlying claims involve property damage at numerous locations at different points in time due to defective or contaminated products, courts have found multiple occurrences under a cause-based analysis.

California Court Rules That Fraudulent Wire Transfer Claims Give Rise To Possibility Of Coverage Under D&O Endorsement

HOLDING

A California district court denied an insurer's motion to dismiss, finding that a policyholder sufficiently alleged breach of contract and breach of the implied duty of good faith and fair dealing based on the insurer's refusal to defend an underlying suit arising out of a fraudulent email hacking scheme. *Bridlewood Estates Prop. Owners Assoc. v. State Farm General Ins. Co.*, 2024 U.S. Dist. LEXIS 47593 (S.D. Cal. Mar. 18, 2024).

BACKGROUND

The dispute arose when a homeowners association fell victim to an email hacking scheme. As a result of the scheme, the Treasurer of the association issued a wire transfer to an entity that he believed was a paving company that had performed work for the association, but in fact was a hacker's bank account. After the fraud was discovered, the paving company demanded payment and filed a mechanic's lien on the subject property.

The association tendered the demand and lien to State Farm, which had issued a Residential Community Association Policy. The policy included a Directors and Officers Liability Endorsement ("DO Endorsement") that provided coverage for the wrongful acts of the association's directors and officers. State Farm denied coverage, arguing that the underlying claims were outside the scope of coverage because they failed to allege any wrongful acts. The association sued and State Farm moved to dismiss. The court denied State Farm's motion.

DECISION

The court ruled that the association sufficiently alleged claims for breach of contract, breach of the implied covenant of good faith and fair dealing, and declaratory relief so as to withstand a motion to dismiss. The court reasoned that the underlying claims against the association alleged a "wrongful act," defined in the endorsement as "any actual or alleged error, misstatement, misleading statement, act, omission, neglect, or breach of duty . . . arising solely out [ ] of his or her capacity as director, officer 'manager' or trustee . . . ." In particular, the court explained that extrinsic facts known to State Farm suggested a potential claim based on the Treasurer's error, negligence, or breach of duty, including his failure to notice a difference in email addresses or to contact the paving company to confirm the wiring instructions prior to issuing payment.

The court noted that to the extent that the underlying claim against the association is a breach of contract claim, it is not necessarily excluded from coverage under the DO Endorsement. The court stated: "The DO Endorsement does not expressly exclude contractual liabilities from coverage. Indeed, it delineates nineteen different exclusions; none are for contractual violations."

Importantly, the court did not rule that the underlying claims were covered under the DO Endorsement. Rather, denying State Farm's motion to dismiss, the court found only that the underlying facts did not conclusively negate coverage. In so ruling, the court relied not only on the allegations in the underlying complaint, but also on extrinsic facts known to State Farm in reaching its decision—including the contents of an email chain between

the fraudster and the Treasurer, which was attached to the policyholder's tender letter and various "discovery exchanges in the underlying action" related to the cause of the Treasurer's mistaken payment.

COMMENTS

The decision is noteworthy in several respects. First, most decisions in the emerging body of insurance coverage law arising out of email schemes and fraudulently induced wire transfers involve coverage under "computer fraud" provisions. As discussed in previous Alerts, those decisions often turn on whether the losses at issue arose "directly" from computer fraud or, conversely, were caused by intervening acts of negligence by innocent parties. This case presents the question of whether losses arising from a fraudulent email scheme arise from an executive's "wrongful act" for purposes of D&O coverage.

Second, the decision does not alter the principle that, under California law, an insured's failure to pay amounts due under a contract does not qualify as a "wrongful act" for policy coverage purposes. Rather, the court deemed this case distinguishable from scenarios in which "an insured simply refused to pay amounts due under a contract" and then looked to its insurer for a "bailout." As the court explained, the association's failure to pay arose out of the potential negligence and/or breach of duty on the part of the Treasurer—which the court found may constitute a "wrongful act" under the DO Endorsement.

Finally, the decision serves as an important reminder that in some jurisdictions, such as California, an insurer's duty to defend is determined not only by the allegations in the underlying complaint, but also by "extrinsic facts known to the insurer."

Colorado Supreme Court Rules That Notice-Prejudice Rule Governs Untimely Notice Analysis In First-Party Property Cases

HOLDING

Addressing a matter of first impression under Colorado law, the Colorado Supreme Court ruled that the notice-prejudice rule applies in the context of first-party property insurance policies. *Gregory v. Safeco Ins. Co. of Am.,* 2024 Colo. LEXIS 202 (Colo. Mar. 11, 2024); *Runkel v. Owners Ins. Co.,* 2024 Colo. LEXIS 212 (Colo. Mar. 11, 2024).

BACKGROUND

In two cases, first-party property insurers denied homeowners' claims for property damage based on untimely notice. While the language in each policy differed somewhat, both polices covered losses that occurred during the policy period, and both contained time-specific notice provisions that required notice to be provided within one year after the date of loss.

Following the insurers' denials of coverage based on untimely notice, each homeowner filed suit. The trial courts in both cases ruled in favor of the insurer, finding that the notice provisions required the homeowners to provide notice within one year of damage, which they did not do, and that coverage was therefore unavailable, regardless of prejudice to the insurers. Both decisions were affirmed by intermediate appellate courts. Reviewing both cases *de novo*, the Colorado Supreme Court reversed.

DECISION

The Colorado Supreme Court held that, under Colorado law, an insurer must establish prejudice in order to defeat coverage on the basis of untimely notice under a third-party liability policy or an uninsured/underinsured motorist policy. Finding that the justifications for a prejudice requirement in those contexts applied with equal force to first-party property policies, the Colorado Supreme Court held that the lower courts erred in failing to conduct a prejudice analysis. More specifically, the court ruled that, for first-party, occurrence-based policies, such as those at issue here, public policy considerations relating to the adhesive nature of certain insurance contracts, the goal of compensating tort victims, and the inequity of coverage defenses based on "technicalities" mitigate in favor of the notice-prejudice rule.

COMMENTS

The decision does not disturb the well-established principle that a showing of prejudice is not required in the context of claims-made policies. As the court noted, the notice requirement in claims-made policies is a "material term that is to be strictly enforced." In this case, the court noted that the operative distinction in evaluating whether prejudice is required is whether a policy is occurrence-based or claims-made—not whether the policy contains a "date-certain" for providing notice.

Texas Court Declines To Imply "Reasonableness" Requirement In Reinsurance Treaty's Notice Provision

HOLDING

A Texas district court granted a cedent's summary judgment motion, ruling that it did not breach a notice provision in a reinsurance treaty and that the reinsurer was therefore obligated to pay a portion of an underlying settlement. *United States Fire Ins. Co. v. Unified Life Ins. Co.*, 2024 U.S. Dist. LEXIS 58560 (N.D. Tex. Mar. 29, 2024).

BACKGROUND

Pursuant to a quota share reinsurance agreement between Unified Life and United State Fire Insurance ("USF"), USF agreed to accept 50% of Unified's "Net Loss" and to cover any "Extra Contractual Obligations" arising from claims incurred under certain medical insurance policies issued by Unified. The treaty provided that Unified "shall . . . advise the Reinsurer promptly of all Claims which, in the opinion of [Unified], may result in a Claim hereunder and of all subsequent developments thereto which, in the opinion of [Unified], may materially affect the position of the Reinsurers."

The reinsurance dispute arose out of a 2017 lawsuit filed by Butler, a policyholder, against Unified, alleging improper claims handling. In 2018, after the expiration of the deadline to amend pleadings, Butler filed a motion for leave to file an amended complaint, which sought to add a class action claim on behalf of all Unified policyholders. A Montana district court granted leave to amend. In 2019, a magistrate judge recommended granting summary judgment on Butler's individual breach of contract claim, but denying class certification. The district court granted Butler partial summary judgment on his individual claim, but rejected the magistrate judge's recommendation regarding the class claim and granted the motion for class certification. Unified sought interlocutory review from the Ninth Circuit, which denied the request. One month after the Ninth Circuit denied the request, Unified notified USF of the Butler litigation.

The Butler litigation was ultimately settled for $8 million, and Unified sought payment from USF for its share of the settlement. USF refused to pay and sought a declaration that Unified provided unreasonably late notice of the Butler litigation and that USF therefore had no duty to pay. Both parties moved for summary judgment and the court ruled in Unified's favor.

DECISION

The court ruled that Unified complied with its obligations under the treaty's notice provision. The court reasoned that the treaty does not require prompt notice "in the abstract." Rather, the notice obligation arises only when—in Unified's subjective opinion—the underlying litigation might result in a claim under the treaty. Further, the court held that Unified had no such subjective belief until the Ninth Circuit denied its request for interlocutory appellate review. Prior to that point, "Unified subjectively believed that the Butler litigation was meritless and would not result in a reinsurance claim."

The court rejected USF's contention that it had no obligation to pay because notice was "unreasonably late." In support of that assertion, USF argued that, because the quota-share

treaty provided coverage to the first dollar of liability, Unified should have provided notice when Butler filed the initial complaint in 2017 and when Unified began incurring legal expenses. Rejecting this argument, the court explained that the notice provision failed to include any reasonableness requirement and that under Texas law, courts must be wary of implying unwritten terms into a contract.

Further, the court ruled that even if Unified had provided late notice, USF's late-notice defense would fail because USF was not prejudiced by any late notice. As a preliminary matter, the court rejected USF's contention that it need not establish prejudice because Unified acted in bad faith, finding no factual support for that assertion. Turning to the existence of prejudice, the court held that a showing of "actual prejudice" is required—*i.e.*, a "substantial likelihood of avoiding or minimizing the covered loss [had the insured provided earlier notice]." The court concluded that USF failed to meet this standard because it had notice of the litigation well before the settlement and in time to at least partially contribute to Unified's defense.

COMMENTS

With respect to the issue of prejudice, the court employed a stringent standard. USF offered specific bases substantiating its claims of prejudice, including the loss of ability to recommend expert witnesses to support Unified's claims handling practices in the Butler litigation. Even construing the facts in USF's favor, the court rejected USF's argument, finding that it raised, at most, a genuine issue of fact as to "theoretical prejudice" rather than "actual prejudice." However, that finding was likely driven, at least in part, by the particular factual record in this case, including the fact that Unified (who had ultimate control over the underlying defense) had originally considered utilizing such experts even prior to notifying USF, but had ultimately decided against it. As such, in other cases with different factual records, the inability to recommend expert witnesses or contribute to other strategic decisions in the defense of an underlying claim may be deemed to constitute actual prejudice.

Finally, the court acknowledged the absence of authority as to whether Texas law requires prejudice in context of reinsurance, as opposed to direct insurance, but "discern[ed] no rationale for treating reinsurers differently than insurers in the context of asserting a late notice defense." This view appears to align with the majority of courts that have addressed this issue in the reinsurance context. However, such reasoning would be inapplicable to reinsurance agreements that include condition-precedent notice language.

South Carolina Court Applies All Sums Allocation and Continuous Trigger To Asbestos-Related Coverage Dispute

HOLDING

A South Carolina trial court ruled that all sums allocation and a continuous trigger applied to determine coverage obligations for progressive bodily injury claims arising out of exposure to asbestos. *Covil Corp. v. Penn. Nat'l Mutual Cas. Ins. Co.*, No. 2020-CP-40-02098 (S.C. Ct. Common Pleas Mar. 1, 2024).

BACKGROUND

This case involved a dispute over the existence, scope and limits of insurance coverage for asbestos personal injury claims against Covil Corporation, a former insulation contractor. After being named as a defendant in numerous lawsuits, Covil sought coverage from Penn National under various policies issued in the 1980s. The parties disputed several key issues, including the appropriate trigger for coverage and the proper method for allocating losses. Following a non-jury trial, the court issued findings of fact and conclusions of law.

DECISION

As to allocation, the court endorsed an all sums method, deeming that approach consistent with the policy language. In particular, the court cited language stating that the policies provided coverage for "all sums which the insured shall become legally obligated to pay as damages because of . . . bodily injury . . . [to] which this insurance applies" and defined "bodily injury" to mean "bodily injury, sickness, or disease sustained by any person which occurs during the policy period, including death at any time resulting therefrom."

In rejecting a pro rata approach, the court found that none of the operative policy provisions "impose a temporal or proportionate limit on Penn National's obligation to defend or indemnify Covil for a progressive bodily injury claim." The court further stated that the inclusion of the phrase "at any time" in the definition of bodily injury supported the conclusion that coverage should not be temporally restricted by policy periods.

With respect to trigger, the court ruled that a continuous trigger applied, such that all policies in effect from a claimant's first exposure to asbestos through manifestation of disease, and ultimately death, provide coverage unless otherwise excluded. The court reached this conclusion based its reading of on the aforementioned policy language defining "bodily injury," as well as the definition of "occurrence," as "an accident including continuous or repeated exposure to conditions."

COMMENTS

The court expressly distinguished South Carolina precedent endorsing a pro rata allocation approach to progressive property damage claims that spanned multiple policy periods. *Crossman Cmtys. Of N.C., Inc. v. Harleysville Mut. Ins. Co.*, 395 S.C. 40 (2011). The court explained that the policy in *Crossman* provided coverage for property damage that occurred "during the policy period," whereas the policies in the present case did not contain such verbiage in the "Insuring Agreement" provision.

It should be noted that in the present case, the phrase "during the policy period" was, in fact, included in the definition of bodily injury ("bodily injury, sickness, or disease

sustained by any person which occurs during the policy period, including death at any time resulting therefrom"). However, the court found that within that clause, "during the policy period" conflicted with "at any time," and that in order to "give meaning to all words" and "harmonize[] all elements of the definition," the phrase "during the policy period" should be interpreted to refer to the trigger of coverage, rather than a temporal limitation on coverage. In other words, the court held that the "during the policy period" clause required only that "some part of the bodily injury must occur during the policy period to trigger the policy."

Judicial Panel Approves First Official Rule Relating To Multi-District Litigation

This month, the Judicial Conference's Advisory Committee on Civil Rules approved a new rule aimed at promoting fairness and efficiency in the context of multi-district litigation ("MDL").

Rule 16.1 provides guidance to judges presiding over MDL, offering a framework for the initial management of cases, including matters related to discovery and settlement conferences, and the appointment of and compensation for lead plaintiffs' attorneys, among other things. The Rule maintains significant judicial flexibility in the oversight of MDL.

Additionally, while the new Rule does not directly address the pressing concern of meritless claims in MDL, it does specify that judges should discuss "how and when the parties will exchange information about the factual bases for their claims and defenses," which might allow for a more efficient dismissal of insufficient or frivolous claims. *See* Rule 16.1(b)(3)(B).

Rule 16.1 marks the first rule in the Federal Rules of Civil Procedure dedicated to multi-district litigation. The comprehensive rule, which comes after a five-year period of significant debate and public comment, must still be endorsed by the Committee on Rules of Practice and Procedure, which is expected to occur in upcoming weeks. Following such endorsement, Rule 16.1 is scheduled for adoption by the United States Supreme Court and transmittal to Congress in 2025, with a target effective date of December 1, 2025.

Simpson Thacher News

The Firm was honored with the National Insurance Firm of the Year award at Euromoney's *Benchmark Litigation* 2024 Awards for the tenth time, and Andy Frankel was shortlisted for Insurance Litigator of the Year. The *Benchmark Litigation* Awards honor those firms and attorneys that have emerged as leaders in their particular areas of law over the past year.

Joshua Polster was named to *Law360*'s 2024 Editorial Advisory Board for Insurance Authority and General Liability. Board members provide valuable feedback to *Law360* about its news coverage and offer insights to editors and reporters on how best to shape future coverage.

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Simpson Thacher has been an international leader in the practice of insurance and reinsurance law for more than a quarter of a century. Our insurance litigation team practices worldwide.

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