Simpson Thacher

Insurance Law Alert

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Fifth Circuit Upholds Excess Insurer's Failure-To-Settle Claim Against Primary Insurer

The Fifth Circuit ruled that a primary insurer violated its common law duty under Texas law to accept a settlement offer within primary policy limits. *American Guarantee & Liability Ins. Co. v. ACE American Ins. Co.*, 983 F.3d 203 (5th Cir. Dec. 21, 2020). (Click here for full article)

Connecticut Appellate Court Reverses Trial Court Rulings On Exhaustion And Per-Occurrence Limits

A Connecticut appellate court ruled that a trial court erred in holding that excess policies did not attach based on the policyholder's failure to exhaust primary policies, explaining that the trial court incorrectly determined the per-occurrence limits of the primary policies. *Continental Cas. Co. v. Rohr, Inc.*, 201 Conn. App. 636 (2020). (Click here for full article)

Wave Of Dismissals Of COVID-19-Related Coverage Suits Continue, With Few Exceptions

While courts across the country continue to dismiss suits seeking insurance coverage for COVID-19-related business losses, an Ohio federal district court ruled that the phrase "direct physical loss of or damage to" was ambiguous and must be construed in favor of coverage. *Henderson Road Rest. Sys., Inc. v. Zurich Am. Ins. Co.*, 2021 WL 168422 (N.D. Ohio Jan. 19, 2021). In addition, a Pennsylvania federal district court denied an insurer's motion to dismiss based on the reasonable expectations doctrine, notwithstanding the policyholder's failure to allege direct physical loss or damage. *Humans & Resources, LLC v. Firstline National Ins. Co.*, 2021 WL 75775 (E.D. Pa. Jan. 8, 2021). (Click here for full article)

In Test Case, United Kingdom's Highest Court Rules That Insurers Must Cover COVID-19-Related Business Interruption Losses

The United Kingdom's top court ruled that insurers were required to pay business interruption losses incurred by companies that were forced to shut down during the mandated lockdown. *Financial Conduct Authority v. Arch Ins. (UK) Ltd.*, No. UKSC 2020/0177 (U.K.). (Click here for full article)

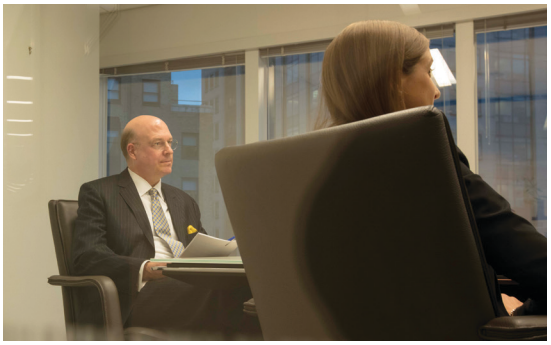
Ninth Circuit Asks Washington Supreme Court To Address Applicability Of Filed Rate Doctrine To Rates Charged By Intermediaries, Rather Than Regulated Entities

The Ninth Circuit asked the Washington Supreme Court to decide whether the filed rate doctrine extends to a situation in which an intermediary, rather than the regulated entity, charges the filed rate to its customers. *Alpert v. Nationstar Mortgage LLC*, 983 F.3d 1129 (9th Cir. Dec. 31, 2020). (Click here for full article)

Defense Cost Alert:

Insurer Not Entitled To Recoup Defense Costs After No Duty To Defend Ruling, New York Appellate Court Rules

Reversing a lower court, a New York appellate court ruled that an insurer is not entitled to reimbursement of defense costs following a ruling that it had no duty to defend or indemnify the underlying claims. *American Western Home Ins. Co. v. Gjonaj Realty & Management Co.*, 2020 WL 7767944 (N.Y. App. Div. 2nd Dep't Dec. 30, 2020).



The insured was sued in a personal injury action, but failed to notify its insurer for more than four years after the accident and after a default judgment had been entered against it. The insurer initially denied coverage, but after a court vacated the default judgment, the insurer agreed to defend under a reservation of rights. In particular, the insurer sought to investigate whether it was prejudiced by the delay in notice. Thereafter, an appellate court reinstated the default judgment against the insured. The insurer again denied coverage and reserved its right to recover any fees and costs it had incurred in defending the insured. In the present suit, the insurer sought a declaration that it had no duty to defend or indemnify the insured and that it was entitled to recover the fees and costs incurred on the insured's behalf. A New York trial court granted the insurer's summary judgment motion on all issues.

The appellate court reversed in part, ruling that although the insurer had no duty to defend or indemnify, it was not entitled to reimbursement of defense costs already spent. Addressing this "novel issue" under New York law, the appellate court held that there was no contractual basis for recoupment of defense costs. The court expressly rejected the assertion that an "implied contract" establishes a right of reimbursement where the insurer expressly reserves a right to reimbursement in a reservation of rights, stating that a "unilateral reservation of rights 'cannot create rights not contained in the insurance policy.'" In addition, the court rejected reimbursement based on unjust enrichment, finding that "New York law precludes claims of unjust enrichment where an insurance policy governs the subject matter at issue." Finally, the court held that even if an unjust enrichment claim were available, it would fail because the insured was not unjustly enriched given the broad duty to defend provided by the policy.

The court acknowledged that a few New York federal district and state trial courts and at least one appellate court applying New York law (and courts in other jurisdictions) have allowed such reimbursement following a ruling that the insurer has no duty to defend or indemnify, but deemed those cases unpersuasive or factually distinguishable.

Excess Alerts:

Fifth Circuit Upholds Excess Insurer's Failure-To-Settle Claim Against Primary Insurer

Our December 2020 Alert discussed an Eleventh Circuit decision holding that under Georgia law, a primary insurer was liable to an excess insurer for negligently failing to settle underlying claims against the policyholder. Last month, the Fifth Circuit followed suit, ruling that a primary insurer violated its common law duty under Texas law to accept a settlement offer within primary policy limits. *American Guarantee & Liability Ins. Co. v. ACE American Ins. Co.*, 983 F.3d 203 (5th Cir. Dec. 21, 2020).

The suit against the policyholder, the Brickman Group, arose out of a fatal car accident. Brickman was insured under an ACE primary policy with a $2 million limit and an American Guarantee excess policy with a $10 million limit. On the eve of trial, plaintiffs made a $2 million settlement demand. ACE countered at $500,000, which plaintiffs rejected. At trial, the judge issued several evidentiary rulings adverse to Brickman. During jury deliberations, plaintiffs made

two more settlement demands. The first was a high/low offer of $1.9 to $2.0 million "with costs." ACE rejected the demand, believing it was outside of its settlement valuation because the inclusion of costs would put the value beyond its policy limit. A third offer renewed plaintiffs' original offer to settle for $2 million. Brickman declined and the next day, the jury returned a verdict of nearly $40 million. The parties ultimately settled for $10 million. ACE and American Guarantee each paid their policy limits.

Thereafter, American Guarantee sued ACE for equitable subrogation, alleging that ACE violated its duty under *G.A. Stowers Furniture Co. v. Am. Indem. Co.*, 15 S.W.2d 544 (Tex. Comm'n App. 1929) by rejecting the settlement offers. Under Texas law, a primary insurer has a *Stowers* duty to "exercise ordinary care in the settlement of claims." However, the *Stowers* duty arises only if the claim is within the scope of coverage, the demand is within policy limits, and a prudent insurer would accept the terms of the demand. In addition, the settlement terms must be clear and unconditional. The district court ruled that all three settlement offers satisfied the *Stowers* requirements and therefore triggered ACE's duty to settle. The district court further ruled that ACE's first rejection was reasonable, but that the other two were not.

The Fifth Circuit affirmed on different grounds. The Fifth Circuit ruled that the second offer did not trigger ACE's *Stowers* duty because it was not "clear." The court explained that inclusion of "costs" in the high/low offer rendered it ambiguous. However, the Fifth Circuit agreed that the third offer triggered ACE's *Stowers* duty. Addressing this matter of first impression under Texas law, the Fifth Circuit rejected ACE's contention that the third offer was conditional. ACE claimed that there were adverse interests among the plaintiffs—the parent of the deceased, alongside her minor children whom she represented as "next friend." ACE argued that those potentially adverse interests required settlement approval by a court and/or guardian ad litem, which in turn, rendered the offer inherently conditional. The Fifth Circuit disagreed, noting the lack of evidence that the settlement offer was more favorable to the parent plaintiff than the minor children. In addition, the court emphasized Texas law does not require third-party

approval in every case in which a parent serves as next friend for minor children. The court explained: "because such appointments are not required, we cannot conceive that every settlement generated in a case involving claims of a parent on behalf of herself and children violates *Stowers* because of a bare potential conflict of interest."

Having concluded that the third offer triggered ACE's *Stowers* duty, the court addressed whether an "ordinarily prudent insurer" would have accepted it. The court ruled that, based on the developments at trial, ACE should have recognized the potential exposure of an excess judgment and had a duty to accept the offer.

Connecticut Appellate Court Reverses Trial Court Rulings On Exhaustion And Per-Occurrence Limits

A Connecticut appellate court ruled that a trial court erred in holding that excess policies did not attach based on the policy's failure to exhaust primary policies, explaining that the trial court incorrectly determined the per-occurrence limits of the primary policies. *Continental Cas. Co. v. Rohr, Inc.*, 201 Conn. App. 636 (2020).

Excess insurers filed suit against Rohr and several of its insurers, seeking a declaration of their coverage obligations for environmental remediation claims stemming from Rohr's manufacturing facilities. The court, applying California law, issued the following rulings:

Annualization of Per-Occurrence Limits

Royal issued two three-year primary policies with limits of $2 million per occurrence and $2 million aggregate. The policies also included endorsements stating that the policy

period "is comprised of three consecutive annual periods." Both primary policies were extended for an additional three years.

The appellate court rejected the notion that the per-occurrence limits could be annualized, such that the two three-year primary policies and each of their three-year extensions provided a total of $24 million in per-occurrence coverage. The court reasoned that endorsement language stating that the policy period "is comprised of three consecutive annual periods" is only "relevant in that rates are based on annual periods." Emphasizing that the word "comprised" means "to be made of up," the court concluded that the language did not support an interpretation in which each year constitutes a separate policy period. As such, the court ruled that each Royal primary policy provided coverage of $2 million per-occurrence during the three-year policy period.

Policy Extensions

The appellate court also ruled that the three-year extensions of the two Royal policies did not result in additional per-occurrence limits. The court explained that the extensions were not new "stand-alone policies," but rather extensions of the original policy periods, creating "continuous contract[s]." In so ruling, the court relied on language in the certificate that stated: "It is hereby understood and agreed that the *term* of [the] above policy is extended for a period of three years." (Emphasis in original). Having ruled that the extensions were mere continuations of the original Royal policies, the court ruled that the $2 million limits for each policy applied "regardless of the number of years the coverage has been in force."

Horizontal vs. Vertical Exhaustion

Emphasizing that under California law, "horizontal exhaustion is the rule . . . in long-tail cases unless specific policy language both describes and limits the underlying policies," the appellate court ruled that horizontal exhaustion (which requires exhaustion of all primary policies across the relevant time period) applied to determine excess coverage obligations. The court explained that policy language defining "ultimate net loss" to include "all recoveries" and "other valid and collectible insurance" requires horizontal exhaustion, even if the excess policy makes reference to a specific primary policy as well.

The appellate court also addressed whether certain excess policies issued by Harbor and London contained language that rendered them "specific" to a particular underlying policy, thus warranting vertical exhaustion. The excess policies at issue conditioned attachment "only after the Primary and Underlying Excess Insurers have paid or have been held liable to pay the full amount of the Primary and Underlying Excess Limit(s)." Based on this language, the court ruled that the excess policies were not triggered until Rohr "has recovered all proceeds from all valid and collectible underlying insurance." The court rejected the argument that the excess policies were "specific" to certain Royal primary policies because the excess policies "referenced" the Royal policies.

Actual Payment as Prerequisite to Exhaustion

The appellate court ruled that Royal was required to actually pay its policy limits in order to satisfy the exhaustion requirement of excess policies. The court relied on language sating that excess liability did not attach "unless and until the Assured has by final judgment been adjudged to pay an amount which exceed such Primary and Underlying Excess Limit(s) and then only after the Primary and Underlying Excess Insurers have paid or have been held liable to pay the full amount of the Primary and Underlying Excess Limit(s)."

The court rejected Rohr's assertion that exhaustion could be established through evidence that the loss attributable to a single occurrence was greater than the attachment point of the excess policies. Similarly, the court rejected the contention that exhaustion was satisfied by virtue of the fact that Royal and other primary insurers continued to be defendants in this litigation, subject to

liability through contribution claims of other insurers. Here, because Rohr's settlement payment from Royal exceeded the combined $4 million limits of its two policies, the court ruled that the exhaustion requirement was satisfied.

Below Limits Settlements

With respect to certain excess policies issued by Federal and Century, the court ruled that where, as here, an excess policy specifically names certain underlying policies in its schedule of insurance, the policyholder must exhaust the limits of the policies listed in the underlying schedule. The court ruled that excess coverage under Federal's and Century's policies was not available because Rohr's underlying settlement did not exceed the combined limits of policies directly underlying the Federal and Century policies (and listed in their respective schedules of insurance).

COVID-19 Alerts:

Wave Of Dismissals Of COVID-19-Related Coverage Suits Continue, With Few Exceptions

Courts across the country continue to dismiss suits seeking insurance coverage for COVID-19-related business losses, largely on the basis that the policyholder has not alleged the requisite "direct physical loss of or damage to property" and/or that a virus exclusion bars coverage. In the past month, more than two dozen courts have dismissed such claims.

However, an Ohio federal district court ruled in the policyholder's favor, finding that the phrase "direct physical loss of or damage to" was ambiguous and must be construed in favor of coverage. *Henderson Road Rest. Sys., Inc. v. Zurich Am. Ins. Co.*, 2021 WL 168422 (N.D. Ohio Jan. 19, 2021).

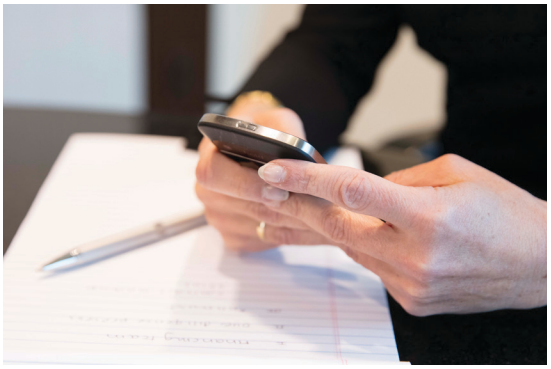
The restaurant operator sought coverage for losses incurred after it was forced to shut down several of its restaurants, and restrict operations to take-out services for the few that remained open. Zurich denied coverage, arguing that the restaurants did not suffer direct physical loss of or damage to property because, among other things, the parties had stipulated that there was no physical alteration or structural damage to any insured property. In addition, Zurich argued that coverage was barred by a microorganism exclusion.

The court disagreed and granted the policyholder's summary judgment motion. The court deemed the phrase "direct physical loss of or damage to real property" ambiguous, holding that use of the disjunctive "or" suggests that physical loss can mean something different than damage to real property. Construing this ambiguity in the policyholder's favor, the court reasoned that physical loss could include the inability to use property for its intended purpose. In so ruling, the court distinguished cases involving "physical loss to" verbiage, suggesting that physical loss "to" property may be different than physical loss "of" property.

In addition, the court rejected the insurer's contention that there was no physical loss "of" property because the policyholder was still able to conduct take-out service at its restaurants. The court emphasized that the insured properties were used almost exclusively for in person dining and that the insurer failed to assert facts demonstrating that the policyholder could have reasonably transitioned to take-out. The court also rejected the notion that the loss of property must be permanent, noting that the word "loss" is not limited to permanent disposition.

Notably, in another Ohio decision, in which the policyholder likewise argued that identical policy language was ambiguous, the court dismissed the coverage claims, ruling that the complaint failed to allege a threshold claim of "direct physical loss of or damage to" property. *Santo's Italian Café LLC v. Acuity Ins. Co.*, 2020 WL 7490095 (N.D. Ohio Dec 21, 2020). Recognizing that "differing interpretations of Ohio contract law by different courts threaten to undermine the

uniform application of that law to similarly situated litigants," and the lack of controlling Ohio precedent, a different federal district court in Ohio certified the following question of law to the Ohio Supreme Court: "Does the general presence in the community, or on surfaces at a premises, of the novel coronavirus known as SARS-CoV-2, constitute direct physical loss or damage to property; or does the presence on a premises of a person infected with COVID-19 constitute direct physical loss or damage to property at that premises?" *Neuro-Communication Servs., Inc. v. Cincinnati Ins. Co.*, No. 4:20-CV-1275 (N.D. Ohio Jan. 19, 2021).



The court in *Henderson Road* also ruled that the microorganism exclusion did not bar coverage, explaining that the loss was caused by the government orders, not by the presence or spread of microorganisms at insured premises. The court emphasized that the parties had stipulated that none of the insured premises were closed as a result of the known presence of COVID-19 particles. Additionally, the court rejected Zurich's contention that the anti-concurrent language (stating that the exclusion applies "regardless of any other cause or event . . . that contributes concurrently or in any sequence to the loss") operated to exclude coverage, explaining that "this argument is dependent on a finding that Microorganisms caused, at least in part, damage to Plaintiffs' property"—a finding contrary to the parties' stipulation.

However, the court dismissed the policyholder's bad faith claim, finding that Zurich had a reasonable basis for denying coverage, particularly in light of the "growing consensus of courts" that have rejected COVID-19-related business interruption claims.

A Pennsylvania federal district court also recently denied an insurer's motion to dismiss on the pleadings, notwithstanding the policyholder's failure to allege direct physical loss or damage. In *Humans & Resources, LLC v. Firstline National Ins. Co.*, 2021 WL 75775 (E.D. Pa. Jan. 8, 2021), the court agreed with the insurer that the complaint "did not allege facts which plausibly suggest that Plaintiff's forced suspension of its operations and resulting loss of business income was caused by a direct physical loss of or damage to property." In addition, the court ruled that a virus exclusion would have barred coverage in any event, rejecting the policyholder's regulatory estoppel argument. Notwithstanding these findings, the court declined to dismiss the suit, citing Pennsylvania's reasonable expectations doctrine. The court explained that the doctrine applies even where the expectations are in direct conflict with the unambiguous terms of the policy. The court concluded that dismissal was not warranted because the policyholder alleged that it purchased the policy with a reasonable expectation of coverage for the business interruption losses at issue.

However, even after *Humans & Resources*, Pennsylvania federal courts have dismissed other COVID-19-related coverage suits raising similar reasonable expectations arguments.

In Test Case, United Kingdom's Highest Court Rules That Insurers Must Cover COVID-19-Related Business Interruption Losses

The United Kingdom's top court ruled that insurers were required to pay business interruption losses incurred by companies that were forced to shut down during the mandated lockdown. *Financial Conduct Authority v. Arch Ins. (UK) Ltd.*, No. UKSC 2020/0177 (U.K.).

The case was brought by the Financial Conduct Authority under the Financial Markets Test Case Scheme, which allows a claim "raising issues of general importance to financial markets to be determined in a test case without the need for a specific dispute between the parties where immediately relevant and authoritative English law guidance is needed." Importantly, the policies in this test case included specific English "disease clause" extensions, which eliminated

the standard "physical damage" requirement of all-risk property policies.

The court ruled that such policies provide coverage if the "occurrence" of COVID-19 was within the geographic vicinity of the insured property and caused business interruption losses. The court rejected a more stringent causation requirement, under which the policyholder would need to establish that a particular case of COVID-19 caused the specific business to shut down.

In addition, the court held that a government-mandated lockdown was not necessarily a prerequisite to coverage under "Prevention of Access Clauses," and that businesses that shut down prior to such legislative action could potentially recover. The court explained that instructions given by public authority, such as warnings by government officials, could constitute a "restriction imposed" if they carry "the imminent threat of legal compulsion."

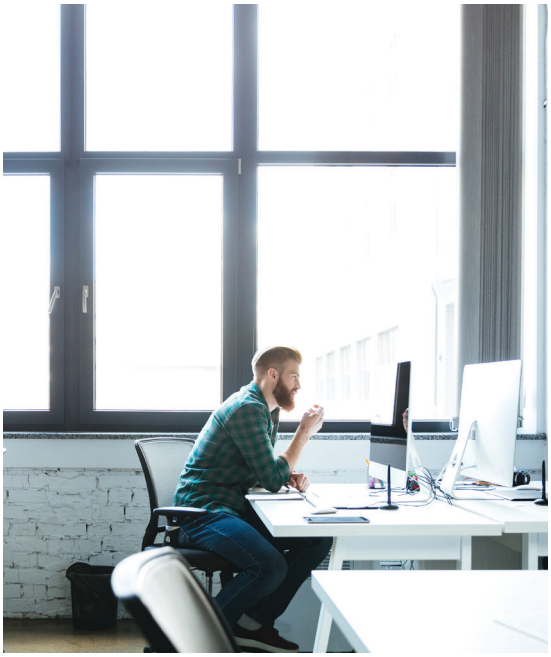
The court also ruled that a policyholder can satisfy a "denial of access" clause even where its business remains partially open, so long as the policyholder is unable to use the premises for a "discrete business activity" or is unable to use "a discrete part of the premises for its business activities." This ruling directly affects business such as restaurants, which were able to remain open for take-out business, but were required to cease in-house dining services.

Finally, the court addressed the extent to which business interruption coverage may be limited if a business would have experienced financial loss due to other circumstances beyond the scope of the policy (*i.e.*, the pandemic in general, rather than the particular policyholder's business closure). The insurers argued that under the policies' "Trends Clauses," recovery is unavailable (or significantly limited) because the policyholders would have suffered the same or similar business interruption losses even if the insured risk had not occurred, because such losses would have arisen regardless of the operation of the insured perils based on the wider consequences of the COVID-19 pandemic. The court rejected this contention, stating that "the aim of such clauses is to arrive at the results that would have been achieved but for the insured peril *and circumstances arising out of the same underlying or originating cause*." (Emphasis added). As such, the court held:

> [T]he court below was wrong to hold that the indemnity for business interruption loss sustained after cover was triggered should be reduced to reflect a downturn in the turnover of the business due to COVID-19 which would have continued even if cover had not been triggered by the insured peril. The court had correctly concluded that losses should be assessed on the assumption that there was no COVID-19 pandemic. Consistently with that conclusion, the court should have held that, in calculating loss, the assumption should be made that pre-trigger losses caused by the pandemic would not have continued during the operation of the insured peril.

In so ruling, the court expressly overturned precedent which held that business interruption coverage may be limited if the policyholder would have incurred losses even if the particular insured risk had not occurred. *See Orient-Express Hotels Ltd v. Assicurazioni Generali SpA*, [2010] EWHC 1186 (Comm); [2010] Lloyd's Rep IR 531.

The decision was based on a representative sample of standard form business interruption policies that contained the disease clause extension in light of agreed and assumed facts. The court estimated that, in addition to the particular policies chosen for the test case, approximately 700 types of policies issued by more than 60 different insurers and 370,000 policyholders could potentially be affected by the ruling.



Filed Rate Alert:

Ninth Circuit Asks Washington Supreme Court To Address Applicability Of Filed Rate Doctrine To Rates Charged By Intermediaries, Rather Than Regulated Entities

The filed rate doctrine may prevent policyholders from suing insurance companies and other regulated entities based on allegedly unreasonable rates if those rates were approved by a regulator. *See* September 2020 Alert, October 2018 Alert, September 2015 Alert, May 2011 Alert, October 2010 Alert. In a recent case, the central issue in dispute was whether the filed rate doctrine extends to a situation in which an intermediary, rather than the regulated entity, charges the filed rate to its customers. *Alpert v. Nationstar Mortgage LLC*, 983 F.3d 1129 (9th Cir. Dec. 31, 2020).

A homeowner was required by his mortgage company (Nationstar) to maintain a hazard insurance policy. When his policy lapsed, Nationstar purchased insurance and charged the homeowner a rate approved by the Washington Insurance Commissioner. The homeowner sued, alleging that although the rate he was charged accurately reflected the rate approved by state authority, it did not represent Nationstar's true cost of insurance. He claimed that Nationstar received kickbacks in the form of commissions, such that the actual cost of the policy to Nationstar was substantially less than what he was charged. Nationstar argued that the homeowner's claims are barred by the filed rate doctrine.

Noting issues of unsettled state law, the Ninth Circuit certified the following questions to the Washington Supreme Court:

1. Should the filed rate doctrine apply to claims by a Washington homeowner against a loan servicer arising from the placement of lender placed insurance . . . where the servicer purchased the insurance from a separate insurance company who filed the insurance product with the Washington State Office of the Insurance Commissioner?

2. In the event the filed rate doctrine does apply to this type of transaction, do the damages requested by Plaintiff fall outside the scope of the filed rate doctrine, or rather do they "directly attack agency-approved rates," such that they are barred . . . ?

We will keep you apprised of further developments in this matter.

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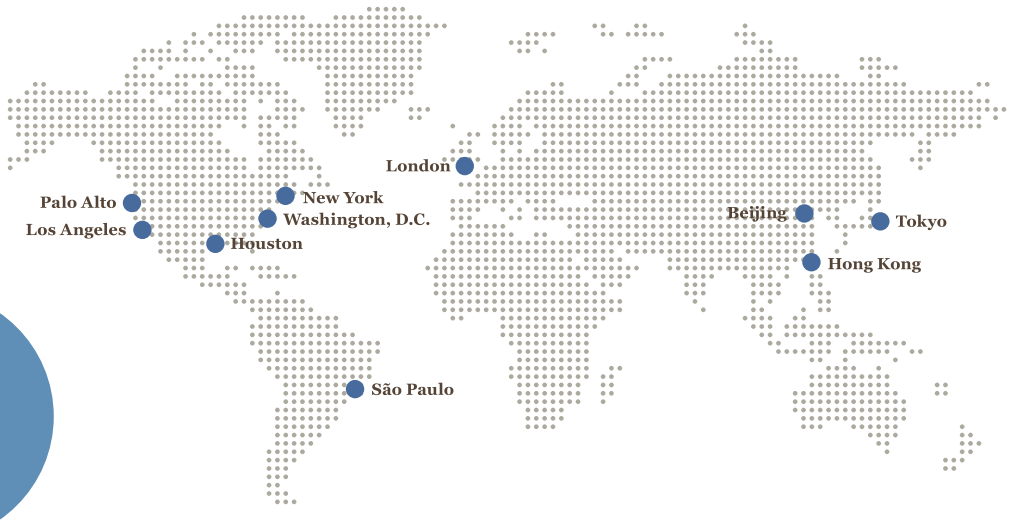

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