Simpson Thacher

Insurance Law Alert

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The Fifth Circuit ruled that a Texas district court erred in dismissing Southwest's breach of contract and bad faith suit, ruling that the cyber risk policy could potentially provide coverage for losses related to a computer system failure. *Southwest Airlines Co. v. Liberty Ins. Underwriters, Inc.*, 2024 U.S. App. LEXIS 996 (5th Cir. Jan. 16, 2024). (Click here for full article)

"Any 'bet the company' or 'bet the issue' litigation requires the best and [Simpson Thacher] is the best of the best."

– The Legal 500
(quoting a client)

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A California appellate court ruled that language in two policies created new aggregate limits for policy extension periods, whereas language in a third policy maintained a single aggregate limit notwithstanding a several-month extension of an annual policy. *The Pep Boys Manny Moe & Jack of California v. Old Republic Ins. Co.*, 2023 Cal. App. LEXIS 998 (Cal. Ct. App. Dec. 28, 2023). (Click here for full article)

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A California appellate court ruled that an insurance agent was not negligent in failing to offer or provide errors and omissions coverage to a policyholder-client despite a longstanding professional relationship between the parties. *Shin v. State Farm General Ins. Co.*, 2023 Cal. App. Unpub. LEXIS 7433 (Cal. Ct. App. Dec. 14, 2023). (Click here for full article)

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This month, the New York State Department of Financial Services issued proposed guidelines regulating the use of artificial intelligence systems by New York insurance companies. Click here to learn more about the proposal. (Click here for full article)

Simpson Thacher News

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Ninth Circuit Rules That Insurers Have No Duty To Defend Underlying Opioid Claims

HOLDING

The Ninth Circuit ruled that opioid-related suits brought by government entities against a pharmaceutical distributor do not allege a covered "occurrence" and that insurers have no duty to defend the underlying suit. *AIU Ins. Co. v. McKesson Corp.*, 2024 U.S. App. LEXIS 1806 (9th Cir. Jan. 26, 2024).

BACKGROUND

McKesson, a distributor of prescription drugs, was named as a defendant in underlying suits brought by government entities for its alleged role in contributing to the opioid crisis. The suits alleged that McKesson intentionally flooded the market with opioids, contravening various industry safeguards and ignoring or concealing risks associated with the use of opioid medications. McKesson's insurers sought a declaration of no coverage, arguing that the underlying claims did not allege an "occurrence" (defined as an accident) and did not seek damages "for" or "because of" bodily injury. A California district court ruled that coverage was unavailable because the underlying allegations failed to allege an "occurrence." The Ninth Circuit affirmed.

DECISION

Under California law, deliberate conduct is not an accident "unless some additional, unexpected, independent, and unforeseen happening occurs that produces the damage." The Ninth Circuit concluded that the claims against McKesson exclusively alleged deliberate conduct and did not include any allegations relating to independent or unforeseen happenings.

The court rejected McKesson's assertion that negligent causes of action in the underlying suits indicated at least some amount of unintentional conduct. The court emphasized that the appropriate focus is on the facts alleged, rather than theories of recovery, stating "[t]he mere fact that such intentional conduct gives rise to causes of action for negligence does not transform those allegations into allegations of merely accidental conduct." The court also rejected McKesson's contention that the conduct of "downstream actors including doctors, pharmacists, and opioid addicts" should be deemed additional, unexpected, independent and unforeseen happenings so as to give rise to an "occurrence." Because the court concluded that the underlying suits did not allege an accident, it did not reach the issue of whether the claims alleged covered "bodily injury."

COMMENTS

As the Ninth Circuit noted, a California appellate court has previously ruled that an insurer had no duty to defend underlying opioid claims. *See Travelers Prop. Cas. Co. of Am. v. Actavis, Inc.*, 225 Cal. Rptr.3d 5 (Cal. Ct. App. 2017). McKesson argued that *Actavis* was distinguishable because in that case, the insured policyholder was an opioid manufacturer (rather than a distributor) and that complaint alleged a deceptive marketing scheme (whereas the instant case arose out of distribution activities). However, the court deemed those factual differences immaterial for the purposes of determining coverage under California law.

Fifth Circuit Reverses And Remands Ruling In Favor Of Insurers In Southwest Airlines Cyber Dispute

HOLDING

The Fifth Circuit ruled that a Texas district court erred in dismissing Southwest's breach of contract and bad faith suit, ruling that the cyber risk policy could potentially provide coverage for losses related to a computer system failure. *Southwest Airlines Co. v. Liberty Ins. Underwriters, Inc.*, 2024 U.S. App. LEXIS 996 (5th Cir. Jan. 16, 2024).

BACKGROUND

Southwest suffered a computer failure in 2016, resulting in a three-day suspension of its flight schedule. Prior to this event, Southwest obtained a cyber risk policy that included "System Failure Coverage," as well as a tower of follow form excess policies. Southwest sought reimbursement of approximately $77 million it allegedly incurred as a result of the system failure. A primary insurer and the excess insurers in the first three tiers of coverage paid a total of $50 million, but Liberty, the fourth-tier excess insurer, denied coverage. Liberty argued that coverage under its policy (for losses exceeding $50 million) was not implicated because five categories of claimed losses—Fare Saver Promo codes, travel vouchers, Cover Refunds, Rapid Reward Points and advertising costs—were outside the scope of coverage because they were essentially voluntary payments not caused by the computer failure.

Southwest sued Liberty, alleging breach of contract and bad faith and seeking a declaration of coverage. The district court granted Liberty's summary judgment motion, ruling that Southwest's expenses were not caused by the system failure, but rather were the result of "various and purely discretionary customer-related rewards programs, practices and market promotions." It further held that coverage was barred under certain policy exclusions. The Fifth Circuit reversed.

DECISION

The System Failure Coverage provision applied to "all Loss . . . that an Insured incurs . . . solely as a result of a System Failure." Liberty argued that the system failure was not the "sole" cause of Southwest's claimed losses and that the "independent" and "more direct" causes of those losses were Southwest's business decisions to incur them. Rejecting this assertion, the court explained that those business decisions were not the precipitating cause of the costs, but rather "links in a causal chain that led back to the system failure."

With respect to policy exclusions, the Fifth Circuit ruled that the district court erred in concluding that coverage was barred as a matter of law. One exclusion applied to "any Loss . . . alleging, arising out of, based upon or attributable to contractual penalties or

consequential damages." The parties disputed interpretation of the term "consequential damages." Southwest argued that the phrase referred to harms that flow "naturally, but not necessarily" from the initial cause and that "are not the usual result of the wrong," and would include a customer's lost business opportunity due to a canceled flight. In contrast, Liberty argued that consequential damages included any damages that are not direct and immediate. Siding with Southwest, the Fifth Circuit held that Liberty's interpretation would render much of the policy coverage illusory, such as coverage for costs to repair damaged computer systems or otherwise undertaken to mitigate damage.

The Fifth Circuit also addressed application of an exclusion that applied to "any Loss . . . arising out of, based upon or attributable to . . . any liability to third-parties for whatever reason." The court rejected Liberty's assertion that the term "third-parties" included customers and thus encompassed refunds or other payment to customers. The court reasoned that such an interpretation would effectively eliminate coverage under other provisions relating to "pecuniary obligations" such as fines and employee payroll obligations.

COMMENTS

The court did not rule that Southwest's system failure was the sole cause of each of the five categories of costs incurred by the airline (and therefore subject to coverage), but rather remanded the matter for resolution of that and other issues. The Fifth Circuit was not persuaded by Liberty's argument that Southwest could "literally dictate the amount of its own 'loss'," but noted that basic insurance principles relating to business interruption coverage necessarily limited the type of expenses Southwest could recover under the policy and that Southwest would need to demonstrate, among other things, how its expenses would not result in a windfall "that would put Southwest in a better position than it would have occupied without the interruption."

California Appellate Court Addresses Whether Extensions Of Policy Periods Create New Aggregate Limits

HOLDING

A California appellate court ruled that language in two policies created new aggregate limits for policy extension periods, whereas language in a third policy maintained a single aggregate limit notwithstanding a several-month extension of an annual policy. *The Pep Boys Manny Moe & Jack of California v. Old Republic Ins. Co.*, 2023 Cal. App. LEXIS 998 (Cal. Ct. App. Dec. 28, 2023).

BACKGROUND

After being named as a defendant in asbestos-related bodily injury suits, Pep Boys sought coverage from its primary and excess insurers. Each of the relevant policies had been extended beyond its original term, at the request of Pep Boys. Pep Boys paid an additional prorated portion of the premium for each extension. The insurers took the position that their respective policies provided only one aggregate annual limit for the underlying claims, notwithstanding the extensions. In response, Pep Boys sought a declaration that each policy provided two aggregate limits: one for the first 12 months and one for the remaining extension period. The trial court ruled in the insurers' favor and the appellate court reversed in part and affirmed in part.

DECISION

A policy issued by Old Republic provided that it was subject to a limit of $10 million "in the aggregate for each annual period during the currency of this policy." The parties agreed that Old Republic was obligated to pay up to $10 million for the first 12 months of the term, but disagreed as to the meaning of the phrase "each annual period" with respect to a five-month extension of the policy term. Old Republic argued that "annual period" meant the entire 17-month term of the policy, whereas Pep Boys claimed that the policy term consisted of two annual periods, each with its own $10 million aggregate limit. Finding neither interpretation "more reasonable than the other," the court deemed the policy ambiguous. Turning to extrinsic evidence, the court noted that Pep Boys chose to extend its insurance policies for administrative convenience in order to align its insurance program with its fiscal year end accounting, not to reduce its costs or alter the scope of coverage. Further, the court noted that under Old Republic's approach, Pep Boys' coverage would be "diluted" by spreading the original aggregate limit over 17 months.

The court reached the same conclusion with respect to a policy issued by Fireman's Fund that was extended to 15 months and contained similar language. That policy contained a $15 million aggregate limit "for all damages sustained during each annual period of this policy." Employing the same reasoning used in interpreting the Old Republic policy, the court deemed the Fireman's Fund policy ambiguous and construed it as providing two aggregate limits.

However, the court reached a different conclusion with respect to an American Excess policy, which stated that the $5 million aggregate limit applied "with respect to loss excess of the Underlying Insurance which occurs during the term of this Certificate." The court ruled that this language was unambiguous and established an aggregate limit for the entire duration of the policy, not based on annual periods within the entire term. In so ruling, the court rejected Pep Boys' assertion that a reference to annual premiums in the extension endorsement indicated an intent to create an additional annual aggregate limit, finding such language "insufficient to overcome the policy's plain definition of its limits as applying to the entire policy period."

COMMENTS

Addressing this matter of first impression under California law, the court made several noteworthy observations. First, the court recognized that its consideration of the aggregate limit issue was "artificially constrained" because Pep Boys sought only a ruling on the policies at issue and the factual record did not reference the presence or absence of coverage for the period of time immediately following the policies' extensions. As the court noted, if Pep Boys obtained coverage for the period immediately following the partial-year extensions, then its ruling could result in Pep Boys receiving more coverage than expected for that calendar year. The court noted the unfairness of that result, but reasoned that the insurers' interpretation could lead to a gap in coverage, which would be an equally unfair result.

Second, the court acknowledged that the "most conceptually satisfying resolution" of this case might involve a pro rata calculation of aggregate limits in order to "bridge coverage between different policies." However, the court deemed such an approach impossible in practice, stating: "we interpret insurance policies, not multi-year, multi-layer insurance policy frameworks, and we must apply each policy's language as written." And in any event, no policy explicitly allowed for the proration of aggregate limits.

Finally, the court noted the lack of judicial consensus on this issue and the "even split" across jurisdictions.

Communications Between Policyholder And Insurance Agent Do Not Give Rise To "Special Duty" To Offer Specific Coverage, Says California Appellate Court

HOLDING

A California appellate court ruled that an insurance agent was not negligent in failing to offer or provide errors and omissions coverage to a policyholder-client despite a longstanding professional relationship between the parties. *Shin v. State Farm General Ins. Co.*, 2023 Cal. App. Unpub. LEXIS 7433 (Cal. Ct. App. Dec. 14, 2023).

BACKGROUND

Stemmler founded a medical billing company in 1998. In or around 2001, he began working with Johnson, a State Farm insurance agent. Stemmler requested insurance coverage "for all of his needs," including home, automobile and "all his business liabilities." In 2018, a group of physicians sued Stemmler, alleging negligence, breach of contract, fraud and breach of fiduciary duty. State Farm denied coverage, citing a professional services exclusion in Stemmler's business office liability policy. Thereafter, Stemmler sued Johnson and State Farm, alleging negligence based on Johnson's failure to exercise reasonable care, diligence and loyalty in procuring insurance coverage requested by Stemmler. A trial court granted the defendants' summary judgment motion and the appellate court affirmed.

DECISION

The appellate court ruled that Stemmler failed to establish a duty necessary to support the negligence claim. More specifically, the court explained that an insurance agent does not have a duty to volunteer additional or different coverage unless (1) the agent misrepresents the scope of the coverage being offered; (2) there is a request or inquiry by the insured for a particular type of coverage; or (3) the agent assumes an additional duty by express agreement or by holding him/herself out as having special expertise. The court rejected Stemmler's assertion that a duty arose as a result of the second scenario, noting that Stemmler's coverage requests were neither "targeted" nor "specific" so as to implicate a heightened duty of care. In this respect, the court emphasized Stemmler's failure to utilize the phrase "errors and omissions coverage" in his discussions with Johnson.

COMMENTS

The decision highlights the stringent standard courts utilize when deciding whether insurance agents should be held to a special duty with respect to the procurement of insurance coverage. The court acknowledged that Stemmler had purchased insurance from Johnson for many years and had followed his advice on certain insurance-related issues, but deemed those factors insufficient to impose a greater duty of care. Further, the court was not swayed by Stemmler's assertion that he had no experience in insurance matters and was unfamiliar with the term "errors and omissions coverage."

NYSDFS Releases Draft Circular Relating To Insurers' Use Of Artificial Intelligence

This month, the New York State Department of Financial Services issued proposed guidelines regulating the use of artificial intelligence systems by New York insurance companies. The circular, titled "Use of Artificial Intelligence Systems and External Consumer Data and Information Sources in Insurance Underwriting and Pricing," would apply to any insurer domiciled or licensed to conduct business in New York. The proposed framework includes requirements relating to numerous areas of concern implicated by the use of AI systems, including the following: violations of state insurance law, unfair discrimination, the implementation of sufficient internal controls and oversight, and transparency to policyholders. The proposed circular requires insurers to engage in comprehensive reviews of AI systems used in the underwriting and pricing contexts in order to ensure against "disproportionate adverse effects" on protected classes of policyholders. Further, the proposed guidelines include qualitative testing requirements that provide justification for the use of AI systems in risk assessment. The proposed circular also incorporates a list of documentation requirements, such as a the maintenance of materials describing the operations of the AI system and any monitoring or testing mechanisms, among other things.

Notably, the circular not only requires an insurer to comply with all regulations with respect to its own direct use of AI, but also as to third-party vendors with whom an insurer may contract. The guidelines warn that insurers may not "rely solely on a vendor's claim of non-discrimination" and should institute meaningful oversight of such third-party AI usage. One important limitation of the proposed circular is that it pertains to the use of AI in the pricing and underwriting contexts, but does not reference AI systems for marketing or claims management purposes.

The full text of the circular is available here. The deadline for comment is March 17, 2024.

Simpson Thacher News

Simpson Thacher was selected as a *Law360* "Practice Group of the Year" in seven categories, including Insurance, placing it among the publication's "Firms of the Year" for 2023. *Law360*'s "Practice Group of the Year" awards honor the law firms behind the major deals and litigation wins that resonated throughout the legal industry in 2023, with an eye towards landmark matters and general excellence.

Andy Frankel and Summer Craig authored the United States chapter in the sixth edition of *In-Depth: Insurance Disputes* (formerly *The Insurance Disputes Law Review*). The book provides a practical overview of recent developments in insurance disputes across 17 jurisdictions worldwide and examines the key features of the legal framework governing insurance-related disputes in each jurisdiction, including substantive and procedural issues and recent litigation trends, among other topics.

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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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