Simpson Thacher

Insurance Law Alert

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– *Chambers USA* 2025 (quoting a client)

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Following a remand order, an Oregon district court ruled that defense costs should be allocated on a time on the risk basis without regard to policy limits. *National Surety Corp. v. TIG Insurance Co.*, 2025 U.S. Dist. LEXIS 86041 (D. Ore. May 6, 2025). (Click here for full article)

Simpson Thacher News

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Fourth Circuit Rules That Bump-Up Exclusion Bars Coverage For Settlement Of Shareholder Actions, Including Attorneys' Fees

HOLDING

The Fourth Circuit ruled that a bump-up exclusion in a D&O policy unambiguously applied to settlement of shareholder suits brought against the insured entity. *Towers Watson & Co. v. National Union Fire Ins. Co. of Pittsburgh, PA*, 138 F. 4th 786 (4th Cir. May. 28, 2025).

BACKGROUND

In 2015, Towers Watson and Willis Group Holdings executed a merger agreement that involved a "reverse triangular merger"—a transaction in which a newly created corporation and wholly owned subsidiary of Willis merged into Towers Watson, leaving Towers Watson as the surviving entity. Following the merger, Towers Watson shares were canceled, and shareholders received the right to 2.649 shares of Willis stock for each canceled share. The surviving Towers Watson entity then issued the remaining newly created shares to Willis, resulting in Towers Watson becoming a wholly owned subsidiary of Willis.

Thereafter, former Towers Watson shareholders filed class actions in Virginia and Delaware, alleging federal securities and state law claims in which plaintiffs alleged that the Towers Watson shares received below-market valuation of Towers Watson shares due to alleged conflicted interest on Towers Watson's board. Both suits settled for a total of $90 million. The D&O insurers funded Towers Watson's defense but denied indemnity based on a "bump-up" exclusion that barred coverage for judgments or settlements stemming from a claim that "the price or consideration paid or proposed to be paid for the acquisition or completion of the acquisition of all or substantially all the ownership interest in or assets of an entity is inadequate."

A Virginia district court found ambiguity as to whether the merger constituted an "acquisition" under the exclusion. *See* November 2021 Alert. The Fourth Circuit vacated the ruling on the narrow ground that the reverse triangular merger constituted an "acquisition" within the meaning of the exclusion. *See* May 2023 Alert. The Fourth Circuit did not resolve the ultimate question of whether the bump-up exclusion barred coverage for the underlying settlements, remanding the matter for resolution of that issue. On remand, the district court ruled that the exclusion applied to the entire underlying settlement, including more than $17 million in plaintiffs' attorneys' fees paid from a common fund. The Fourth Circuit affirmed.

DECISION

The Fourth Circuit agreed with the district court that the "real result" of the underlying settlement was that the shareholders received additional consideration for their relinquished shares. The court explained: "The shareholders, claiming their shares were devalued in the merger process because of [a] conflict of interest, sued Towers Watson. Their lawsuit sought to rectify that perceived shortfall. That is, they sought what was effectively an increase (or 'bump-up') in the consideration paid for their shares."

The court rejected Towers Watson's assertion that the exclusion did not apply because the underlying suits alleged violations of Section 14(a) of the Securities Exchange Act, which governs inadequate disclosures, not inadequate consideration. The court explained that the question of whether Section 14(a) violations were alleged or established was irrelevant given that the parties had already settled the suit. Rather, the central issue was that the $90 million settlement effectively increased the per-share compensation paid to Plaintiffs and thus fell within the scope of the bump-up exclusion.

Finally, the Fourth Circuit affirmed the district court's ruling that coverage for the settlement portion designated as attorneys' fees was also barred by the bump-up exclusion. Under the common fund doctrine, a court may award a reasonable attorney's fee to "a litigant or lawyer who recovers a common fund for the benefit of persons other than himself or his client . . . from the fund as a whole." The court reasoned that the full $90 million settlement represented "in toto an increase in consideration paid for the merger," particularly given the structure of the settlement in which attorneys' fees were to be paid out of the common fund, rather than directly by Towers Watson.

COMMENTS

The Fourth Circuit's decision aligns with the emerging majority view, at least outside of Delaware, that bump-up exclusions preclude coverage in shareholder suits challenging the transaction price in a merger or acquisition. *See Komatsu Mining Corp. v. Colum. Cas. Co.*, 58 F.4th 305, 306 (7th Cir. 2023); *Onyx Pharms., Inc. v. Old Republic Insurance Co. et al.*, CIV 538248 (Cal. Super. Ct. Dec. 30, 2022). Like the latest Fourth Circuit holding, these decisions have broadly construed different shareholder claims, including for disclosure violations, as effectively as seeking an increase in per-share valuation.

As discussed in our January 2025 Alert, a Delaware state court ruled that a bump-up exclusion did not bar coverage for an underlying settlement because, among other things, the underlying action alleged violations of Sections 14(a) and 20 of the Securities Exchange Act, which do not provide for consideration of an inadequate deal price as a remedy. *Harman International Industries, Inc. v. Illinois National Insurance Co.*, 2025 Del. Super. LEXIS 3 (Del. Superior Ct. Jan. 3, 2025); *see also Viacom Inc. v. U.S. Specialty Ins. Co.*, 2023 Del. Super. LEXIS 728, at *1 (Super. Ct. Aug. 10, 2023).

Sixth Circuit Addresses Standard For Federal Court Abstention Over "Mixed" Action Seeking Declaratory Relief And Damages

HOLDING

The Sixth Circuit ruled that when an action seeks both damages and declaratory relief, and there is no basis for abstention as to the damages claims, it would "most likely" be an abuse of discretion for the court to abstain on the declaratory claims. *Fire-Dex, LLC v. Admiral Insurance Co.*, 2025 U.S. App. LEXIS 13372 (6th Cir. June 2, 2025).

BACKGROUND

Fire-Dex, a manufacturer of protective equipment for firefighters, was named as a defendant in suits alleging exposure to carcinogens including PFAS. Those suits were consolidated in multidistrict litigation in South Carolina federal court. Admiral, the insurer, brought a declaratory judgment action in a federal court in Ohio, seeking a ruling as to coverage under its general liability policies. Although the district court had diversity jurisdiction, the Declaratory Judgment Act provides that district courts "may" issue declaratory relief—permissive language that allows courts to decline to exercise jurisdiction under certain circumstances. *See* 28 U.S.C. § 2201(a). The district court did just that and the Sixth Circuit affirmed.

Shortly thereafter, Fire-Dex sued Admiral in state court, seeking both declaratory relief as well as compensatory damages and punitive damages. Admiral removed to federal court and Fire-Dex moved to remand. The court remanded the declaratory relief claim and stayed the damages claims pending state court litigation. The Sixth Circuit vacated and remanded the matter for further proceedings.

DECISION

The Sixth Circuit noted the complexity that arises in the abstention analysis where, as here, a "mixed action" seeks both coercive relief (damages) and declaratory relief. It set forth the following framework:

If the district court has jurisdiction over a claim for coercive relief, it must exercise jurisdiction over that claim unless a traditional abstention doctrine applies—regardless of whether that claim is paired with a declaratory claim. As to the other half of the mixed action, the district court retains its discretion under the Declaratory Judgment Act, but has "less discretion than normal" to refuse to hear a declaratory judgment claim in such mixed actions.

The court explained that when the coercive claim and the declaratory claim "hinge on the same substantive legal issue or issues," then the "declaration of rights and responsibilities will usually be a logical 'prerequisite' to the award of damages." Thus, abstaining under those circumstances would create a risk of piecemeal or duplicative litigation. The court therefore concluded that "when the coercive and declaratory claims in a mixed action are tightly linked, it would most likely be an abuse of discretion to abstain on the declaratory claims."

Applying this standard, the Sixth Circuit ruled that the district court erred in abstaining. It emphasized that there was no traditional basis for abstaining as to the coercive claims and that the declaratory claims turned on the exact same legal issues. Additionally, it rejected Fire-Dex's assertion that *Thibodaux* abstention applied here. *Thibodaux* abstention applies when a suit raises unsettled questions of state law that are "intimately involved" with a state's "sovereign prerogative." The court noted that the mere existence of unsettled areas

of state law in this case did not justify *Thibodaux* abstention—if it did, then *Thibodaux* abstention "would swallow diversity jurisdiction" in many cases.

COMMENTS

The Sixth Circuit's approach aligns with that endorsed by the First Circuit. In contrast, as the Sixth Circuit noted, the Second, Fourth and Fifth Circuits have applied traditional abstention doctrines to mixed actions (unless it is determined that the coercive claim was frivolous or brought to evade the more permissive standard governing declaratory claims). The Third, Seventh and Ninth Circuits have adopted an "independent claim" test which requires a determination of whether coercive claims are independent of the declaratory claims. The Eighth Circuit has adopted an approach that turns on whether the declaratory claim constitutes "the essence of the suit." The Sixth Circuit deemed such other approaches "unsatisfying and unmoored from Congress's mandates."

New York Appellate Court Rules That Late Notice Relieves Insurer Of Duty To Defend

HOLDING

Reversing a trial court, a New York appellate court ruled that an insurer had no duty to defend an underlying suit because the insurer was presumptively prejudiced by late notice of the suit. *Hartford Fire Insurance Co. v. Hudson Excess Insurance Co.*, 2025 N.Y. App. Div. LEXIS 3289 (N.Y. App. Div. May 29, 2025).

BACKGROUND

An employee of TS Group sustained injuries at a construction site located on property owned by Mayer Malbin Reality. The employee sued Mayer in 2017 and Mayer commenced a third-party action against TS Group in March 2018. Mayer was insured by Hartford, while TS Group obtained a policy from Hudson which provided additional insured coverage under certain circumstances.

Hudson was not notified of the suit until May 2020. Hudson denied coverage based on late notice and on the grounds that Mayer was not an additional insured under the policy. In ensuing litigation, a New York trial court ruled that Hudson was obligated to defend Mayer in the personal injury action. The appellate court reversed.

DECISION

Under New York insurance law, since notice was given more than two years after it was practical to do so, the plaintiff had the burden of providing that Hudson was not prejudiced by the delay. *See* N.Y. Ins. Law § 3420(c)(2)(A)(ii). The appellate court concluded that Mayer failed to meet this standard.

The court reasoned that Mayer's "vigorous[ ]" defense of the underlying suit was insufficient to establish a lack of prejudice and that the delay prevented Hudson from inspecting the accident site and interviewing witnesses while their memories were still fresh. Additionally, the court noted that Mayer's counsel failed to depose key witnesses from TS Group, including its owner and foreman.

Mayer argued that Hudson was not prejudiced because even if Hudson had been timely notified, it still would have denied coverage on the additional insured issue. Rejecting this assertion, the court explained that when Hudson issued that disclaimer, it was still awaiting a copy of the contract that supported Mayer's additional insured coverage claim, and that once it received such documentation, it did not pursue that ground for disclaimer. Thus,

the court held, "there is no basis for concluding that 'earlier notice would have resulted only in an earlier denial.'"

COMMENTS

This ruling highlights the protection afforded to insurers under New York statutory law when a policyholder fails to give notice within two years after it was practical to do so. Under such circumstances, the insurer does not bear the burden of establishing prejudice. Moreover, this case shows that a policyholder cannot easily satisfy its burden to show an absence of prejudice, even in instances when there is some evidence showing that the insurer may have denied coverage for reasons other than late notice.

New York Appellate Court Addresses Late Notice and Per-Occurrence Limits in Multi-Year Policies

HOLDING

Following a jury trial in an environmental coverage dispute, a New York appellate court ruled on the parties' appeals relating to late notice and the annualization of per-occurrence limits in multi-year policies. *Century Indemnity Company v. Brooklyn Union Gas Company*, 2025 N.Y. App. Div. LEXIS 3446 (N.Y. App. Div. June 5, 2025).

BACKGROUND

The coverage dispute arose out of contamination stemming from three manufacturing plants bordering the Gowanus Canal in Brooklyn, New York. Brooklyn Union Gas Company, the owner and operator of the sites, was insured under six excess policies issued by Century Indemnity Company during the relevant time frame. Each policy had a one-year term and contained a $100,000 self-insured retention. Four policies required notice "[u]pon the happening of an occurrence or accident that appears reasonably likely to involve liability on the part of [defendant]." The court referred to these policies as containing an "objective standard." Two policies contained a "subjective standard," requiring notice "upon [defendant] learning of any occurrence which in its judgment is likely to result in a claim in excess of the retained limit."

In 1993, New York City issued notice of its intent to sue based on contamination at a different site. One month later, Brooklyn Union sent Century Indemnity notices of occurrences for the three sites at issue. Remediation orders issued between 2002 and 2005 for the three sites indicated costs in excess of the $100,000 self-insured retentions.

Century Indemnity sought a declaration that it lawfully disclaimed coverage based on untimely notice of an occurrence. A New York trial court issued numerous rulings on various motions for partial summary judgment, resulting in two appeals to the Appellate Division. In 2009, the Appellate Division affirmed the denial of Century Indemnity's motion for summary judgment based on untimely notice, finding issues of fact as to whether Brooklyn Union's analysis regarding whether the costs of remediation at the three sites were reasonably likely to implicate excess coverage prior to 1993, if at all.

In 2019, the Appellate Division affirmed the trial court's ruling that Century Indemnity's successive policies were subject to pro rata allocation for losses resulting from long term, continuous contamination. However, the Appellate Division deemed the policies ambiguous as to whether per-occurrence limits in multi-year policies were for the entire term of those policies or were annual per-occurrence limits.

In 2022, the matter proceeded to trial and a jury returned a verdict in Brooklyn Union's favor, finding that it was entitled to excess coverage for the three sites at issue. Century Indemnity appealed, challenging several pretrial and trial rulings. Brooklyn Union cross-appealed, challenging the court's ruling that the per-occurrence limits for multi-year policies were for the entire period and did not reset annually.

DECISION

The Appellate Division ruled that the trial court erred when it instructed the jury to deem pro rata allocation of damages and retention amounts "a reasonably likely factor comprising defendant's notice analysis . . . when determining whether defendant provided a timely notice of occurrence." Instead, the jury should have been instructed to consider "all factors relevant to when the original retention amounts were reasonably likely to be exceeded," including "motive and other evidence that the trial court erroneously excluded regarding the timely notice issue." Additionally, the Appellate Division concluded that the trial court should have left it for the jury to decide whether Brooklyn Gas was on inquiry notice of an occurrence and whether it adequately investigated such occurrences.

However, the Appellate Division upheld the trial court's apportionment of coverage equally among the three sites, finding a "rational basis" for such apportionment. Further, the Appellate Division upheld the trial court's refusal to apply the *contra proferentem* doctrine to resolve ambiguities regarding per-occurrence limits in multi-year policies. In ruling that Brooklyn Gas was not entitled to inferences drawn in its favor as to policy terms, the Appellate Division emphasized Brooklyn Gas's "large in-house insurance department," sophistication in insurance matters, and bargaining power in negotiating the policies.

COMMENTS

Untimely notice disputes often turn on a determination as to when a policyholder is or should be reasonably aware of a covered "occurrence" or other event triggering its duty to provide notice. As this ruling highlights, such decisions are often case-specific, dependent upon the factual records as compared to the notice obligations in the operative policies.

Abrogating Precedent, Second Circuit Rules That State Law Precluding Arbitration Of Insurance Disputes Does Not Reverse Preempt The Convention

HOLDING

Reversing course on a previous ruling, the Second Circuit held that a state law that precluded arbitration of insurance disputes does not reverse preempt the Convention on the Recognition and Enforcement of Foreign Arbitral Awards (the "Convention"). *Certain Underwriters at Lloyds, London v. 3131 Veterans Blvd LLC*, 2025 U.S. App. LEXIS 11086 (2d Cir. May 8, 2025).

BACKGROUND

Two insurance policies each covered a commercial property that was damaged by a hurricane that struck Louisiana in 2021. The assignees of the rights under the policies (the "Respondents") sought to recover damages and filed suits in Louisiana against certain insurers. The insurers countersued in New York district court, invoking an arbitration clause in the policies, and arguing that arbitration was required under the Federal Arbitration Act ("FAA") and the Convention, an international treaty governing arbitration of disputes involving non-domestic parties. The insurers also sought to enjoin prosecution of the Louisiana suits. In response, the Respondents argued that Louisiana statutory law

precluding arbitration of insurance disputes reverse preempts the FAA and the Convention under the McCarren-Ferguson Act.

In the two New York district court cases, both judges denied the insurers' motions, ruling that under established Second Circuit precedent in *Stephens v. American International Insurance*¸ 66 F.3d. 41 (2d Cir. 1995), state law reverse preempts both the FAA and the Convention.

In a decision addressing both cases, the Second Circuit reversed.

DECISION

While federal law generally preempts state law, the McCarran Ferguson Act creates an exception of reverse preemption in the insurance context by providing that "[n]o act of Congress shall be construed to invalidate, impair or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . unless such Act specifically relates to the business of insurance."

The Second Circuit noted that the FAA was clearly reverse preempted by the Louisiana law under the McCarran-Ferguson Act because the FAA is unequivocally an "Act of Congress." However, the more complicated issue was whether the Convention was reverse preempted by state law—a question that turned on whether the Convention is "self-executing" or conversely, relies on an "Act of Congress" to take effect. If the Convention is self-executing, there is no reverse preemption under the McCarran-Ferguson Act, but if the Convention requires an Act of Congress to take effect, then reverse preemption applies.

When the Second Circuit previously addressed this question in 1995 in *Stephens*, the court concluded that the Convention was not self-executing, required an Act of Congress to take effect, and was therefore reverse preempted by state law. In the present case, the court abrogated its ruling in *Stephens*, reasoning that an intervening Supreme Court decision undermined its analysis in *Stephens*. In *Medellin v. Texas*, 552 U.S. 491 (2008), the Supreme Court identified several indicia of a self-executing treaty provision within a larger treaty, including language that indicates a "directive" to courts and use of "shall" or "must" verbiage.

With the benefit of *Medellin*'s guidance, the Second Circuit concluded that the relevant portion of the Convention was self-executing. The court relied on language stating that courts "shall" refer parties to arbitration, noting that such verbiage constituted a "directive" to courts to take particular action.

Respondents argued that other portions of the Convention, which lacked similar language, were not self-executing and therefore that the entire treaty should be deemed not self-executing. Rejecting this all-or-nothing approach, the court noted that treaties can contain both self-executing and non-self-executing provisions.

COMMENTS

Following the Supreme Court's ruling in *Medellin*, the Second Circuit joins the First and Ninth Circuits in ruling that the relevant portion of the Convention is self-executing and therefore is not reverse preempted by state law under the McCarran-Ferguson Act.

Tenth Circuit Rules That Thousands Of Patient Claims Are Not A Single "Medical Incident" Under Excess Policies

HOLDING

The Tenth Circuit ruled that the term "medical incident" in excess policies referred to the injuries of a single patient and therefore that the claims of thousands of patients could not be grouped together so as to trigger excess coverage. *AdHealth Limited v. PorterCare Adventist Health Systems*, 135 F. 4th 1241 (10th Cir. May 2, 2025).

BACKGROUND

The coverage dispute arose after a whistleblower notified authorities about PorterCare's inadequate surgical sterilization procedures. A subsequent investigation revealed numerous deficiencies and thousands of patients filed lawsuits, which were ultimately consolidated into four cases. PorterCare settled the actions and then sought coverage for the full limits under two excess policies issued by AdHealth.

The first-layer excess policy, above a $2 million self-retention ("SIR"), had a $25 million per medical incident limit. The second-layer excess policy covered liability exceeding the first-layer up to another $15 million per medical incident.

AdHealth issued a reservation of rights and then sued PorterCare, seeking a declaration that each patient's claim constituted a single medical incident and that it had no duty to pay until a claim's liability exceeded PorterCare's $2 million SIR. A district court granted AdHealth's summary judgment motion, and the Tenth Circuit affirmed.

DECISION

The Tenth Circuit rejected PorterCare's assertion that all sterilization patients constituted a single "medical incident" under the policies because they all stemmed from one act: "PorterCare's systemic breach of surgical-sterilization procedures." Additionally, the court rejected PorterCare's reliance on language in the "medical incident" definition that referred to the failure to provide care to "the participants' patients" (plural form).

The court emphasized that the operative language of the "medical incident" provision clearly states that: "Any such act or omission, together with all related acts or omissions in the furnishing of such services *to any one person,* shall be considered *one medical incident* . . ." (emphasis in original). The court concluded that such language unambiguously means that each patient's claim is a separate medical incident.

COMMENTS

Highlighting the importance of clear policy language, the Tenth Circuit noted that "if PorterCare desired a policy that covered systematically inadequate treatment procedures that caused injuries to thousands of patients, then it should have bartered for it." Faced with nearly identical policy language, courts in other jurisdictions, including Texas and Missouri, have reached the same conclusion.

Wisconsin Appellate Court Rules That Costs Of Building Razing, Required By Municipal Order, Are Not Covered By Business Owners Policy

HOLDING

A Wisconsin appellate court ruled that the costs incurred in complying with a raze order of a building following a fire were excluded from coverage under a business owners policy. *Distinguished Multiplying Buildings (D.M.B.), LLC v. Germantown Mutual Insurance Co.*, 2025 WI App. LEXIS 346 (Ct. App. Wisc. Apr. 22, 2025).

BACKGROUND

A fire caused extensive damage to part of a building owned by DMB. Following an inspection, a municipal agency deemed the building unsafe and unreasonable to repair, and therefore issued a raze order directing DMB to "raze and remove" the building or parts thereof.

DMB filed a claim with Germantown, whose policy covered "direct physical loss" to property unless otherwise excluded. DMB claimed that the fire, coupled with the raze order, constituted a "constructive total loss," requiring Germantown to pay the actual cash value to repair or replace the building. In response, Germantown acknowledged coverage for portions of the building and personal property destroyed by the fire but argued that an Ordinance or Law Exclusion barred coverage for the portions of the building ordered razed but not damaged by the fire.

DMB sued Germantown, alleging breach of contract and bad faith, among other claims. A trial court ruled that the exclusion unambiguously applied, but denied DMB's summary judgment motion, finding that issues of fact existed as to which costs were incurred as a result of the fire and which stemmed from the raze order. Thereafter, an appraisal panel issued a cost analysis, and the court issued a final order consistent with the panel's findings. The appellate court affirmed.

DECISION

The Ordinance or Law Exclusion states that it will not cover "loss or damage caused directly or indirectly by" an "Ordinance or Law," including "compliance with" any such ordinance or law that leads to "the tearing down of any property." The exclusion also applies if the "loss results from" an increase in "costs incurred to comply with an ordinance or law in the course of construction, repair, renovation, remodeling or demolition of a property or removal of its debris, following a physical loss to that property."

The appellate court ruled that the raze order (and costs resulting therefrom) fell squarely within the policy's Ordinance or Law Exclusion. In so ruling, the court rejected DMB's assertion that the municipal raze order, issued pursuant to state statutory law, was "merely a conclusion" that the structure was not repairable due to fire damage, and thus the sole loss at issue was the fire. DMB argued that the raze order was not a "loss in and of itself," but rather a recognition that the building should not be repaired due to extensive fire-related damage.

Concluding that this argument was without merit, the court held that the fire and subsequent raze order were separate losses for insurance coverage purposes. Therefore, even if the raze order rendered the building a total loss under the policy, the Ordinance or Law Exclusion barred coverage for the raze-related costs.

The court also rejected several other assertions by DMB, including that Germantown was obligated to cover the costs associated with the raze based on state statutory law relating to

a property insurer's duty to "provide for payment of any final settlement under the policy." The court explained that "final settlement" means an amount that an insurer owes and that here, Germantown did not owe payment associated with the raze order.

Finally, the court rejected DMB's contention that a reasonable insured would not understand the policy to exclude coverage for damages sustained because of a raze order because such an interpretation would render coverage "essentially illusory." The court emphasized the clear language of the exclusion and its breadth of application to loss "regardless of any other cause or event that contributes concurrently or in any sequence to the loss."

COMMENTS

A New Jersey appellate court, faced with a similar factual record and exclusionary language, reached a contrary conclusion. *See Danzeisen v. Selective Ins. Co. of Am.*, 689 A.2d 798 (Super. Ct. App. Div. 1997). However, the court deemed that decision unpersuasive, emphasizing that the New Jersey court failed to apply the plain meaning of the unambiguous exclusion.

Oregon Court Rules That Defense Costs Should Be Allocated Among Insurers Based On Time On The Risk

HOLDING

Following a remand order, an Oregon district court ruled that defense costs should be allocated on a time on the risk basis without regard to policy limits. *National Surety Corp. v. TIG Insurance Co.*, 2025 U.S. Dist. LEXIS 86041 (D. Ore. May 6, 2025).

BACKGROUND

McKay Investments, the owner of property on which a dry cleaner was located, faced enforcement action by the Oregon Department of Environmental Quality relating to environmental pollution. McKay tendered defense and indemnity of the claims to insurers which had issued policies during the relevant time frame. The policies at issue varied in policy limits and term length.

One insurer, National Surety, brought a declaratory judgment action against another insurer, TIG Insurance, seeking a determination as to the proper method of allocating defense and indemnity among the insurers. In 2022, the court ruled that the factors set forth in state statutory law (Or. Rev. Stat. § 465.480(5)) do not apply to the allocation of defense costs, policy limits are irrelevant in allocating defense costs in this action, and the most appropriate method for allocating defense costs is time on the risk ("TOR"). The Ninth Circuit reversed in part, finding that the district court erred in concluding that § 465.480(5) did not apply to the apportionment of defense costs. It then remanded the matter for consideration of the factors enumerated in that statute.

Section 465.480 creates a right to contribution for defense and indemnity costs and provides that allocation should be based on a number of factors, two of which are relevant here:

(a) The total period of time that each solvent insurer issued a general liability insurance policy to the insured applicable to the environmental claim;

(b) The policy limits, including any exclusions to coverage, of each of the general liability insurance policies that provide coverage or payment for the environmental claim for which the insured is liable or potentially liable.

Additionally, the statute gives courts "considerable discretion" in how to weigh the factors.

DECISION

On remand, the district court ruled that TOR was the proper method for allocating defense costs among the insurers. The court rejected TIG Insurance's contention that allocation should be based on the average of each insurer's share of the aggregate TOR and aggregate policy limits. TIG Insurance argued that because the Ninth Circuit remanded the matter for consideration of the statutory factors, the policy limits "must be given some weight."

The district court disagreed, noting that the Ninth Circuit did not direct that any specific weight be applied to any one factor and expressly acknowledged that "policy limits may have little, if any, relevance to the apportionment of defense costs," which were not subject to policy limits.

Additionally, the court distinguished the Oregon Supreme Court's ruling in *Lamb-Weston, Inc. v. Oregon Auto. Ins. Co.*, 219 Or. 110 (1959) and its progeny, which applied an allocation method that included consideration of policy limits. The court emphasized that *Lamb-Weston* involved allocation of indemnity (settlement) costs, not defense costs, involved two insurers with concurrent, rather than consecutive, policies, and arose out of a single car incident rather than losses that extended over a continuous period of time.

COMMENTS

The decision illustrates important differences between defense and indemnity in the context of allocation among insurers with consecutive policies covering an ongoing, continuous loss. While policy limits are likely to be relevant to each insurer's portion of risk with respect to indemnity, they may be a less important factor where, as here, insurers' defense obligations are not subject to policy limits. Courts in various other jurisdictions have also used a TOR method for apportioning defense costs among insurers for continuous losses that span multiple policy periods.

Simpson Thacher News

Simpson Thacher has once again been ranked among the leading law firms in the United States in *Chambers USA 2025*. The Firm was ranked #1 in the following practice areas: Insurance: Dispute Resolution; Insurer – Nationwide and Insurance; Dispute Resolution: Insurer – New York, and Lynn Neuner and Bryce Friedman were individually recognized in the rankings. In total, the Firm or its lawyers were named in more than 80 practice categories, including 40 firm rankings in the top two bands. In addition, the Firm's attorneys received a total of nearly 140 recognitions as leaders in their respective fields of practice.

Simpson Thacher

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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** In April 2025, Simpson Thacher announced plans to expand its Bay Area presence with an office in San Francisco.*

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