Simpson Thacher

Insurance Law Alert

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Trial Court Erred In Ruling That Asbestos-Related Injury-In-Fact Occurs From Date Of First Exposure Through Death, Says New York Appellate Court

A New York appellate court ruled that a trial court erred in holding that injury-in-fact in an asbestos action occurs from the date of first exposure through death or filing of suit, thereby triggering every policy during that time frame. *Carrier Corp. v. Allstate Ins. Co.*, 2020 WL 5987010 (N.Y. App. Div. 4th Dep't Oct. 9, 2020). (Click here for full article)

"[Simpson Thacher is] able to handle both direct insurance and reinsurance matters with equal flair, and also adept at handling the most complex of disputes regarding insurers' business practices."

– Chambers USA 2020

Deeming Excess Policy's "Exhaustion" Requirement Ambiguous, New York Court Rules That Reinsurer Is Bound By Cedent's Underlying Allocation

A New York district court ruled that a "follow the settlements" clause obligates a reinsurer to indemnify its cedent's settlement payments, rejecting the reinsurer's assertion that the underlying settlement was outside the scope of coverage under the cedent's excess policy because the "exhaustion" requirement was not met. *Fireman's Fund Ins. Co. v. OneBeacon Ins. Co.*, 2020 WL 6135101 (S.D.N.Y. Oct. 19, 2020). (Click here for full article)

Delaware Court Rules That Insurer Must Defend Opioid-Related Litigation Against Rite Aid

A Delaware trial court ruled that an insurer is obligated to defend Rite Aid in certain lawsuits relating to its distribution of opioids, finding that the suits alleged bodily injury and that policy exclusions do not bar coverage. *Rite Aid Corp. v. Ace American Ins. Co.*, 2020 WL 5640817 (Del. Super. Ct. Sept. 22, 2020). (Click here for full article)

Courts Continue To Weigh In On Viability Of Covid-Related Coverage Claims, Most Siding With Insurer

Courts across the country continue to address whether and under what circumstances Covid-related business loss claims may proceed against insurers. (Click here for a jurisdictional chart that summarizes recently-issued decisions)

NAIC Adopts Guiding Principles On Insurers' Use Of Artificial Intelligence

In August 2020, the National Association of Insurance Commissioners unanimously adopted guiding principles on the use of artificial intelligence that emphasize the importance of accountability, compliance and transparency in the use of artificial intelligence in insurance operations. (Click here for full article)

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On October 1, 2020, the U.S. Department of the Treasury's Office of Foreign Assets Control and Financial Crimes Enforcement Network concurrently issued formal advisories warning cyber insurance firms and others of the regulatory risks relating to ransomware payments. (Click here for full article)

Addressing Matter Of First Impression, Connecticut Supreme Court Dismisses Asbestos-Related Medical Monitoring Claim

The Connecticut Supreme Court dismissed a putative class action seeking medical monitoring relief, finding that even if Connecticut law recognized such a claim, plaintiffs failed to establish a genuine issue of material fact as to whether medical monitoring was "reasonably necessary." *Dougan v. Sikorsky Aircraft Corp.,* No. 2020 WL 5521391 (Conn. Sept. 14, 2020). (Click here for full article)

STB News Alerts

Click here to read about the Firm's recent insurance-related honors.

Trigger Alert:

Trial Court Erred In Ruling That Asbestos-Related Injury-In-Fact Occurs From Date Of First Exposure Through Death, Says New York Appellate Court

A New York appellate court ruled that a trial court erred in holding that injury-in-fact in an asbestos action occurs from the date of first exposure through death or filing of suit, thereby triggering every policy during that time frame. *Carrier Corp. v. Allstate Ins. Co.*, 2020 WL 5987010 (N.Y. App. Div. 4th Dep't Oct. 9, 2020).

In this asbestos-related coverage suit, a New York trial court granted the insured's partial summary judgment motion, ruling that all policies in effect from first exposure through death or commencement of suit were triggered. The appellate court reversed, ruling that an issue of fact exists as to the appropriate trigger under New York's injury-in-fact standard. More specifically, the appellate court held that the insurer raised a factual dispute as to whether injury-in-fact occurs only when "a threshold level of asbestos fiber or particle burden is reached that overtakes the body's defense mechanism." The appellate court rejected the insured's contention that the insurer was estopped from asserting this argument because it was party to a case in California in which the issue was litigated and decided against it. Dismissing the collateral estoppel argument, the court noted that the issues in the two cases were not identical and that New York and California apply different substantive laws in determining what event triggers asbestos-related coverage, or when asbestos-related injury occurs.

The appellate court also ruled on several other issues, including allocation. Relying on *Matter of Viking Pump, Inc.*, 27 N.Y.3d 244 (2016) (discussed in our May 2016 Alert), the court ruled that the non-cumulation and prior insurance clauses in the policy at issue "plainly contemplated" all sums allocation and vertical exhaustion.

Reinsurance Alert:

Deeming Excess Policy's "Exhaustion" Requirement Ambiguous, New York Court Rules That Reinsurer Is Bound By Cedent's Underlying Allocation

A New York district court ruled that a "follow the settlements" clause obligates a reinsurer to indemnify its cedent's settlement payments, rejecting the reinsurer's assertion that the underlying settlement was outside the scope of coverage under the cedent's excess policy because the "exhaustion" requirement was not met. *Fireman's Fund Ins. Co. v. OneBeacon Ins. Co.*, 2020 WL 6135101 (S.D.N.Y. Oct. 19, 2020).

Fireman's Fund issued excess liabilities to Asarco. The policies conditioned payment on exhaustion of underlying insurance, stating "[i]t is a condition that the insurance afforded under [the policy] shall apply only after all the underlying insurance has been exhausted." One of the excess policies was reinsured by General Accident Insurance Company, with OneBeacon as General Accident's successor-in-interest. The facultative certificate included a follow the settlements provision, which, under New York law, obligates OneBeacon to accept Fireman's Fund's good faith payment decisions that are arguably within the scope of coverage.

OneBeacon denied coverage, claiming that the follow the settlements provision does not "cure [Fireman's Fund's] failure to comply with the exhaustion requirements in the underlying Policies." More specifically, OneBeacon argued that Fireman's Fund violated the exhaustion requirement of its excess policies because it allocated a portion of its settlement payment to a policy without first paying the full policy limits of underlying excess policies.

The court deemed the undefined term "exhaustion" ambiguous because it did not expressly address whether the exhaustion requirement could be met by settlement payments or conversely, whether it required actual payments by underlying insurers. Having found ambiguity, the court adhered to New York precedent holding that ambiguous "exhaustion" provisions are not construed to require direct payment by underlying insurers as a condition precedent to recover excess insurance. As such, the court concluded that OneBeacon was bound by Fireman's Fund's settlement allocation.

The court distinguished decisions holding that, for purposes of triggering excess coverage, exhaustion requires actual payment by underlying insurers, noting that those cases involved different policy language or jurisdictional law. *See Ali v. Fed. Ins. Co.*, 719 F.3d 83 (2d Cir. 2013) (*see* June 2013 Alert); *Citigroup Inc. v. Federal Ins. Co.*, 649 F.3d 367 (5th Cir. 2011) (*see* September 2011 Alert); *Forest Labs., Inc. v. Arch Ins. Co.*, 38 Misc. 3d 260 (N.Y. Sup. Ct. 2012), *aff'd*, 116 A.D.3d 628 (1st Dep't 2014) (*see* October 2012 Alert). As discussed in previous Alerts, courts have issued mixed decisions in this context, driven largely by applicable "exhaustion" policy language. *See* April 2018 Alert, June 2016 Alert, November 2015 Alert, September 2014 Alert, May 2014 Alert, December 2013 Alert, June 2013 Alert, October 2012 Alert, April 2012 Alert, and October 2011 Alert.

Opioid Alert:

Delaware Court Rules That Insurer Must Defend Opioid-Related Litigation Against Rite Aid

A Delaware trial court ruled that an insurer is obligated to defend Rite Aid in certain lawsuits relating to its distribution of opioids, finding that the suits alleged bodily injury and that policy exclusions do not bar coverage. *Rite Aid Corp. v. Ace American Ins. Co.*, 2020 WL 5640817 (Del. Super. Ct. Sept. 22, 2020).

According to the court, certain government entities alleged that Rite Aid knowingly distributed opioids to its local pharmacies and improperly dispensed prescription opioids to its customers, which contributed to and perpetuated drug addiction, resulting in injuries or death. Rite Aid sought a defense under a 2015 policy issued by Chubb. The insurer denied a duty to defend because, among other things, the underlying claims alleged economic loss rather than damages "because of personal injury," required to trigger a duty to defend under the policy. Both parties moved for summary judgment on the duty to defend, and the court ruled in Rite Aid's favor.

Addressing choice of law, the court declined to decide whether Delaware or Pennsylvania law governed the dispute, holding that both states have significant interests in the litigation and that the laws of the two states do not differ materially with respect to the relevant issues. The court then ruled that the underlying claims sought damages "because of personal injury" because the policy defined personal injury to include "bodily injury." The court rejected Chubb's assertion that the claims alleged only economic loss because the underlying plaintiffs were not the individuals who actually suffered from opioid addiction. In so ruling, the court relied on *Cincinnati Ins. Co. v. H.D. Smith LLC*, 829 F.3d 771 (7th Cir. 2016) (discussed in our July/August 2016 Alert) and *Acuity v. Masters Pharmaceutical Inc.*, 2020 WL 3446652 (Ohio Ct. App. June 24, 2020) (discussed in our June 2020 Alert), which held that the policy's use of the phrase "because of bodily injury" encompassed claims brought by the state to recover damages incurred due to the opioid epidemic. Those courts reasoned that even though the government entities were seeking damages for their own economic losses, some of those losses were arguably "because of bodily injury."

The court also concluded that the underlying claims alleged only one occurrence and thus that the policy's "Retained Limit" was satisfied. Applying a cause-based analysis, the court explained that the tortious distribution and/or dispensing of opioids arose from a single occurrence because all injuries and damage resulted from the same proximate cause—Rite Aid's alleged negligent action in failing to implement proper controls. The court rejected Chubb's contention that distribution and dispensing are separate occurrences because they constitute distinct activities that may result in distinct economic losses.

Additionally, the court rejected a "manifestation" trigger. Chubb argued that under Pennsylvania law, the only potentially applicable policy is the one in effect when harmful effects first manifest themselves, and thus that it has no duty to defend because here, any alleged personal injury first manifested before 2015. *See Pennsylvania National Mutual Cas. Ins. Co. v. St. John*, 106 A.3d 1 (Pa. 2014). However, the court ruled that a "multiple trigger" applies for "latent injury" cases, noting that "such injuries many not manifest themselves until a considerable time after the initial exposure causing injury occurs." The court ruled that the personal injury of opioid abuse falls into the category of such "latent injury." Finally, the court rejected "known loss" or "loss in progress" defenses, explaining that the allegation that Rite Aid had "mere knowledge of a risk" prior to the policy period is not sufficient to bar coverage. Alternatively, the court reasoned that the policy applies to "each separate person's bodily injury occurring during the policy period," such that even if "Rite Aid knew it injured certain persons before 2015, this does not necessarily demonstrate that it also knew it injured different persons in 2015."

Courts in other jurisdictions have declined to find coverage for opioid-related claims by government entities. *See, e.g. Travelers Prop. Cas. Co. of Am. v. Actavis, Inc.*, 2017 WL 5119167 (Cal. App. Ct. Nov. 6, 2017); *Cincinnati Ins. Co. v. Richie Enterprises LLC*, 2014 WL 3513211 (W.D. Ky. 2014) (discussed in our November 2017 Alert).

Covid Alert:

Courts Continue To Weigh In On Viability Of Covid-Related Coverage Claims, Most Siding With Insurer

Courts across the country continue to address whether and under what circumstances Covid-related business loss claims may proceed against insurers. In this issue and in upcoming months, we keep you updated through a jurisdictional chart that summarizes recently-issued decisions.

Case	Jurisdictional Law	Key Holdings and Notable Findings
Hilcrest Optical, Inc. v. Continental Casualty Co., 2020 WL 6163142 (S.D. Ala. Oct. 21, 2020)	Alabama	• Optometrist office's coverage suit dismissed based on failure to allege "direct physical loss of or damage to property." Temporary inability to use property due to government actions does not constitute a direct physical loss of property. • Court rejects policyholder's assertion that "extra expense" provision, which refers to "period of restoration," contemplates an inability to use property as a direct physical loss. • Court refuses to certify to the Alabama Supreme Court the question of whether Covid-related shut down orders allege "direct physical loss."
Seifert v. IMT Ins. Co., 2020 WL 6120002 (D. Minn. Oct. 16, 2020)	Minnesota	• Hair salon's coverage suit dismissed based on failure to allege "direct physical loss of or damage to" property, noting that mere "loss of use or function" is not sufficient. "Actual physical contamination" of the insured property must be alleged. • Civil authority coverage claims fail for the additional reason that policyholder was not prohibited from entering insured property because of any "actual contamination or damage." • Claims are also barred by virus exclusion that applies to any loss caused "directly or indirectly" by a virus. Thus, salon's assertion that loss was caused by government orders rather than virus is unpersuasive. "Pursuant to the anti-concurrent loss provision, if a virus is any part of the casual chain causing a loss, then the loss is not covered."

Case	Jurisdictional Law	Key Holdings and Notable Findings
It's Nice, Inc. v. State Farm Fire and Casualty Co., No. 2020L000547 (Ill. Cir. Ct. Sept. 29, 2020) (Oral Transcript)	Illinois	• Restaurants' coverage suit dismissed based on absence of allegations asserting "direct physical loss," emphasizing that complaint did not allege presence of actual virus on the premises. • Direct physical loss unambiguously requires "some form of actual physical damage to the insured premises." Under Illinois law, interpretation of the word physical in insurance contracts "is widely held to exclude alleged losses that are intangible or incorporeal . . . such as detrimental economic impact unaccompanied by a distinct demonstrable physical alteration of the property." • Even if insured alleged direct physical loss, coverage would be barred by virus exclusion.
North State Deli, LLC v. Cincinnati Ins. Co., No. 20-CVS-02569 (N.C. Superior. Ct. Durham Cnty. Oct. 7, 2020)	North Carolina	• Restaurants are entitled to lost business income and extra expense coverage stemming from government orders, based on court's determination that "accidental physical loss or accidental physical damage" is ambiguous. • Court concludes that "direct physical loss" includes "the inability to utilize or possess something in the real, material, or bodily world" and thus encompasses a business owner's loss of use or access to its business property.
Oral Surgeons, P.C. v. Cincinnati Ins. Co., 2020 WL 5820552 (S.D. Iowa Sept. 29, 2020)	Iowa	• Dental office's coverage suit seeking business interruption coverage dismissed based on failure to allege "physical" or "accidental" loss. • Court references recent decisions holding that "virus-related closures of businesses do not amount to direct loss to property by the Cincinnati policy of insurance."
Harvest Moon Distributors, LLC v. Southern-Owners Ins. Co., 2020 WL 6018918 (M.D. Fla. Oct. 9, 2020)	Florida	• Wine and beer distributor's claim for coverage for losses incurred after Disney refused to accept shipment or make payment during Covid-related closure of park stated a plausible claim of "direct physical loss of or damage to" property based on allegations that beer spoiled and became undrinkable. • Business income and extra expense claims nonetheless fail based on failure to allege "suspension" of business operations. While Disney may have suspended its operations, complaint fails to allege the policyholder terminated all of its business activities. • Exclusion for losses caused by "[a]cts or decisions . . . of any person, group, organization or governmental body" bars coverage because Disney's decision to refuse to accept product or issue payment was cause of policyholder's loss.
Urogynecology Specialist of Florida, LLC v. Sentinel Ins. Co., Ltd., 2020 WL 5939172 (M.D. Fla. Sept. 24, 2020)	Florida	• Medical office's breach of contract claim against insurer is a "plausible claim at this juncture" given lack of "binding case law on the issue of the effects of COVID-19 on insurance contracts[']virus exclusions." • Court deems exclusion ambiguous based on missing portions of policy that were not submitted to the court.
Infinity Exhibits, Inc. v. Certain Underwriters at Lloyd's London known as Syndicate PEM 4000, 2020 WL 5791583 (M.D. Fla. Sept. 28, 2020)	Florida	• Trade shows' coverage claims dismissed with prejudice based on failure to allege "direct physical loss or damage to" property, noting that further amendment of complaint would be futile. • Court relies on Eleventh Circuit's decision in *Mama Jo's* (a non-Covid coverage decision denying coverage for cleaning expenses based on lack of "direct physical loss") and a series of recent Covid-related decisions across jurisdictions, including *Turek, 10E, LLC, Malube, Mudpie*, and *Pappy's*) (discussed in last month's Alert).

Case	Jurisdictional Law	Key Holdings and Notable Findings
Travelers Casualty Ins. Co. of Am. v. Geragos and Geragos, 2020 WL 6156584 (C.D. Cal. Oct. 19, 2020)	California	• Law firm's counterclaims for business income and civil authority coverage dismissed with prejudice based on lack of "direct physical loss of or damage to property." • Civil authority coverage is also barred by virus exclusion.
Franklin EWC, Inc. v. Hartford Financial Servs. Grp., Inc., 2020 WL 5642483 (N.D. Cal. Sept. 22, 2020)	California	• Salon's coverage claims dismissed based on virus exclusion, which applies to "presence, growth, proliferation, spread or any activity of 'fungi,' wet rot, dry rot, bacteria or virus." • Insured's argument that civil authority coverage exists notwithstanding virus exclusion because the government closure orders (rather than the virus) prohibited access to their property is deemed "nonsense."
Henry's Louisiana Grill, Inc. v. Allied Ins. Co. of Am., 2020 WL 5938755 (N.D. Ga. Oct. 6, 2020)	Georgia	• Restaurant's claims for coverage under business loss and civil authority provisions dismissed based on absence of "direct physical loss of or damage to" covered property. • Construing government orders as constituting a direct physical loss "exceeds any reasonable bounds of possible construction" and "would potentially make an insurer liable for the negative effects of operational changes resulting from any regulation or executive decree, such as a reduction in a space's maximum occupancy." • Civil authority coverage also rejected because insured failed to allege a prohibition on access to the premises.
Mark's Engine Co. No. 28 Restaurant, LLC v. Travelers Indem. Co. of Conn., 2020 WL 5938689 (C.D. Cal. Oct. 2, 2020)	California	• Restaurant's claims for coverage under business income and civil authority provisions dismissed based on lack of "direct physical loss [of] or direct physical damage [to]" property. • Under California law, "losses from inability to use property do not amount to 'direct physical loss of or damage to property.'" • Government's characterization of insured's business as "non-essential," resulting in economic consequences, does not satisfy physical alteration requirement. • "Whatever physical alteration the virus may cause to property in general, nothing in the [pleadings] plausibly supports an inference that the virus physically altered Plaintiff's property, however much the public health response to the virus may have affected business conditions for Plaintiff's restaurant. Even if Plaintiff could somehow recover for physical loss or damage to other property, such loss or damage could hardly qualify as 'direct.'" • Even assuming the insured alleged direct physical loss, coverage is barred by a virus exclusion.
Vandelay Hospitality Grp. v. Cincinnati Ins. Co., 2020 WL 5946863 (N.D. Tex. Oct. 7, 2020)	Texas	• Restaurant's complaint dismissed based on failure to plausibly plead "direct physical loss or damage." Dismissal is without prejudice, allowing policyholder opportunity to re-plead.
Rhonda Hill Wilson v. Hartford Casualty Co., 2020 WL 5820800 (E.D. Pa. Sept. 30, 2020)	Pennsylvania	• Law office's coverage claims dismissed as a matter of law. Even assuming (without deciding) that Covid-related claims allege direct physical loss, coverage is barred by a virus exclusion. • Virus exclusion, which applies to "loss or damage caused directly or indirectly by . . . fungi, wet rot, dry rot, bacteria or virus" "regardless of any other cause or event that contributes concurrently or in any sequence to the loss" is unambiguous and applies to Covid-related claims, notwithstanding policyholders' allegation that government orders were the direct cause of loss.

Case	Jurisdictional Law	Key Holdings and Notable Findings
Blue Springs Dental Care, LLC v. Owners Ins. Co., 2020 WL 5637963 (W.D. Mo. Sept. 21, 2020)	Missouri	• Dental care clinics' claims for coverage under business income and civil authority provisions raise issues of fact as to whether complaint alleges "direct physical loss." • Policyholders' allegations, accepted as true for purposes of ruling on the dispositive motion, claim that customers and employees were likely affected with virus, that there was "actual contamination by COVID-19," and that the virus is "physically transmitted by air and surfaces through droplets, aerosols, and fomites that remain infectious for extended periods of time." • Court relies on *Studio 417, Inc. v. Cincinnati Ins. Co.*, 2020 WL 4692385 (W.D. Mo. Aug. 12, 2020) (discussed in July/August 2020 Alert). • Court declines to rule as a matter of law that "necessary suspension" of business, as set forth in business income provision, requires a total cessation of business activity. • With respect to civil authority coverage, policyholders sufficiently alleged a prohibition on access based on government stay-at-home orders, noting that three clinics were closed entirely and that one clinic limited its operations to emergency services. • Policyholders' designation as an "essential business" (and therefore arguably exempt from the restrictions imposed by the stay-at-home orders) is not fatal to civil authority coverage claims, because issues of fact exist as to scope, applicability and impact of orders.
Francois Inc. v. Cincinnati Ins. Co., No. 20CV201416 (Ohio Ct. Comm. Pl. Sept. 29, 2020) (Summary Order)	Ohio	• Restaurants' "complaint states claims which arguably fit the terms and conditions of the insurance policy."
In re: National Ski Pass Ins. Litig., 2020 WL 5884793 (JPML Oct. 2, 2020)		• The Judicial Panel on Multidistrict litigation created two multidistrict litigations ("MDL") to centralize cases arising out of insurers' refusal to cover ski trips that were canceled due to Covid. One MDL, in Missouri, is comprised of cases against Arch Insurance Company. The other, in California, is comprised of cases against United Specialty Insurance Company. The court declined to create a single nationwide MDL, citing a lack of factual commonality across the actions against each insurer.
In re: Society Insurance Co. COVID-19 Business Interruption Protection Ins. Litig., 2020 WL 5887444 (Ill. Oct. 2, 2020)		• The Judicial Panel on Multidistrict Litigation centralized more than 30 lawsuits against Society Insurance Company in Illinois, finding MDL to be an efficient path for resolution based on common legal and factual questions. • The litigation includes individual claims and putative class actions, and application of six states' laws.

Regulatory Alerts:

NAIC Adopts Guiding Principles On Insurers' Use Of Artificial Intelligence

In August 2020, the National Association of Insurance Commissioners unanimously adopted guiding principles on the use of artificial intelligence ("AI"). The guidelines, which are "aspirational guideposts" rather than binding regulations, emphasize the importance of accountability, compliance and transparency in the use of AI in insurance operations. One significant goal in enacting the principles is to avoid "proxy discrimination against protected classes" when using AI platforms within the insurance industry. The principles also address concerns about consumer privacy and digital security.

The use of AI technology in the insurance sector is still relatively new, and these general guideposts may ultimately be the first step in the future of AI regulation. Next steps may involve reporting or certification requirements for insurance companies, similar to regulations imposed in the cybersecurity context last year. *See* March 2019 Alert. For now, an NAIC Executive Committee member notes that insurers "should be responsible for the creation, implementation and impacts of any AI system, even if the impacts are unintended."

OFAC And FinCEN Warn Of Risks Relating To Ransomware Payments

On October 1, 2020, the U.S. Department of the Treasury's Office of Foreign Assets Control ("OFAC") and Financial Crimes Enforcement Network ("FinCEN") concurrently issued formal advisories warning cyber insurance firms and others of the regulatory risks relating to ransomware payments. Ransomware is a form of malware designed to extort ransom payments from victims by encrypting data or programs on their information technology systems and demanding payment in return for the decryption key. Over the last few years, ransomware has become increasingly sophisticated, targeting major corporations and demanding virtual currency payments such as bitcoin in amounts that are equivalent to millions of U.S. dollars.

These attacks are perpetrated by a number of global bad actors, including certain persons and entities that have been designated on OFAC's Specially Designated Nationals and Blocked Persons ("SDN") List pursuant to cyber-related sanctions implemented by the U.S. government. Cybercriminals designated as SDNs include the criminal organization appropriately named Evil Corp and many of its constituents. OFAC's advisory reiterates and reinforces informal guidance that it has offered to the cybersecurity industry recently, cautioning that, absent a license, it is a violation of law for a U.S. person or entity to pay or facilitate a ransomware payment to a party designated by OFAC on the SDN List. Under some circumstances, even non-U.S. persons may be penalized by OFAC for their involvement in ransomware payments. OFAC's guidance explains that it may impose penalties for sanctions violations based on strict liability, meaning that penalties may be imposed on parties even if they did not know or have reason to know that they were engaging in or facilitating a transaction involving an SDN. For that reason, OFAC is encouraging victims of ransomware attacks, as well as those involved in providing cyber insurance, digital forensics and incident response, and ransom payment processors, to implement risk-based compliance and diligence procedures to ensure that ransom payments are not directed to SDNs and other sanctioned parties. Ransomware victims and related parties are also encouraged to report ransomware attacks to law enforcement during the event or immediately thereafter.

Relatedly, FinCEN's advisory explains of the regulatory risks for entities that process ransomware payments. Ordinarily, payments are effected through a multi-step process involving at least one depository institution and one or more money services businesses ("MSBs"). The ransomware victim's fiat currency is typically transferred to a virtual

currency exchange, converted to a particular virtual currency specified in the ransom note, and then transferred to the perpetrator's virtual currency wallet. The perpetrator will then launder these funds through a variety of means and often through foreign-located exchanges in jurisdictions with weak anti-money laundering controls. Cyber insurance providers should take note of three points raised in the advisory. First, entities involved in making ransomware payments should reevaluate whether they are required to register as an MSB with FinCEN and comply with applicable anti-money laundering provisions of the Bank Secrecy Act. This may include, for example, ransomware negotiators that are responsible for transferring ransom funds. Second, FinCEN offers in the advisory ten "red flags" for financial institutions—including the victim's depository institution from which funds are originally drawn—to identify, prevent, and report ransomware and associated payments. To that end, we expect there to be an increased focus in the financial industry on these types of issues. Third, FinCEN reminds financial institutions of their obligations to file Suspicious Activity Reports for certain suspicious transactions. While insurance companies are not required to file such reports except in specific limited circumstances, there may be instances where doing so may be prudent or required by certain parties involved in the ransomware payment.

These advisories should serve as a bellwether for the cyber insurance industry, demonstrating that relevant regulatory agencies are becoming increasingly focused on ransomware payments as a hot button issue that may usher in an era of increased enforcement in this space. Insurance companies offering cyber insurance products that reimburse insureds for ransomware payments should take heed of these warnings and the shifting regulatory landscape, and consider whether they are taking adequate steps to mitigate the regulatory risks described in both advisories. While consideration of the reasonableness and sufficiency of any such efforts is highly contextual and fact-specific, these advisories reinforce the need to ensure that insurance companies have appropriately considered the risks of making those payments, and the processes by which those payments are made.

Medical Monitoring Alert:

Addressing Matter Of First Impression, Connecticut Supreme Court Dismisses Asbestos-Related Medical Monitoring Claim

The Connecticut Supreme Court dismissed a putative class action seeking medical monitoring relief, finding that even if Connecticut law recognized such a claim, plaintiffs failed to establish a genuine issue of material fact as to whether medical monitoring was "reasonably necessary." *Dougan v. Sikorsky Aircraft Corp.,* 2020 WL 5521391 (Conn. Sept. 14, 2020).

Several workers sued Sikorsky Aircraft Corporation and others after being exposed to asbestos during a construction project. The complaint alleged negligence, battery, recklessness and violations of the Clean Air Act. Plaintiffs sought compensatory and punitive damages, as well as medical monitoring expenses. A Connecticut trial court granted the defendants' summary judgment motion, citing the lack of evidence demonstrating any issue of fact as to physical injury. The trial court declined to recognize a cause of action for medical monitoring that would allow recovery for increased risk of future injury absent present injury. The Connecticut Supreme Court affirmed on different grounds.

The Connecticut Supreme Court assumed, without deciding, that Connecticut law would recognize a remedy for medical monitoring absent a present manifestation of physical harm where a "subclinical cellular injury" "substantially increase[s] the plaintiffs' risk of cancer and other asbestos related diseases." The court nonetheless dismissed plaintiffs' claims based on their inability

to prove that medical monitoring was "reasonably necessary." In so ruling, the court rejected plaintiffs' contention that the necessity of medical monitoring could be established through generalized expert testimony concerning the harmful effects of asbestos exposure. Instead, the court held that expert evidence must speak to the plaintiffs' specific conditions. The court stated: "[i]n the absence of expert testimony demonstrating the necessity of future testing, a fact finder would be unable to accurately conclude whether a plaintiff should recover for medical monitoring."

As discussed in previous Alerts, there is no judicial consensus on whether medical monitoring claims are recognizable or the elements necessary to substantiate such claims. Even where such claims are recognized, plaintiffs often encounter obstacles in seeking medical monitoring relief, including, in particular, issues associated with exposure and causation. *See* January 2012 Alert, September 2011 Alert.

STB News Alerts

Bryce Friedman was profiled in *Law360* as an "MVP" in Insurance for 2020. Bryce was recognized for his work advising insurers in obtaining favorable rulings on Covid-related claims and serving as national litigation counsel to challenge legislation that would retroactively change insurance contracts to require insurers to cover pandemic losses despite virus exclusions.

Lynn Neuner was selected for the third consecutive year by *Euromoney's Benchmark Litigation* as one of the "Top 100 Trial Lawyers in America." The list highlights elite trial attorneys in the U.S. selected based on client and peer review. *Benchmark* calls Lynn a "major player in insurance, commercial and securities cases," and noted that she has "emerged as one of New York's few authorities in the false advertising capacity."

Susannah Geltman was profiled as a 2020 "Rising Star" by the New York Law Journal. Susannah was recognized for advising clients across a wide range of high-stakes, complex litigation matters. Her pro bono work, including leading teams in two high profile impact cases, along with NRDC, and ACLU and AIC, was also highlighted. The honorees are selected for their influence in their practice areas in New York and beyond, demonstrating strong leadership qualities, showing expertise in litigation and committing themselves to pro bono, charitable and professional volunteer work.

Euromoney's Benchmark Litigation 2021 recognized Simpson Thacher's Litigation Department as Tier 1 across five practice areas, including Insurance. *Benchmark* notes that Simpson Thacher "boasts a long history as one of New York's, and the country's, most esteemed full-service legal brands," that is "more comprehensive in terms of national coverage." The publication also quotes a client saying, "Simpson Thacher is a go-to firm for any type of legal dispute . . . [a]ny individual or entity that retains them is going to get the best counsel possible."

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.

Mary Beth Forshaw
+1-212-455-2846
mforshaw@stblaw.com

Andrew T. Frankel
+1-212-455-3073
afrankel@stblaw.com

Lynn K. Neuner
+1-212-455-2696
lneuner@stblaw.com

Chet A. Kronenberg
+1-310-407-7557
ckronenberg@stblaw.com

Bryce L. Friedman
+1-212-455-2235
bfriedman@stblaw.com

Michael J. Garvey
+1-212-455-7358
mgarvey@stblaw.com

Tyler B. Robinson
+44-(0)20-7275-6118
trobinson@stblaw.com

George S. Wang
+1-212-455-2228
gwang@stblaw.com

Craig S. Waldman
+1-212-455-2881
cwaldman@stblaw.com

Susannah S. Geltman
+1-212-455-2762
sgeltman@stblaw.com

Elisa Alcabes
+1-212-455-3133
ealcabes@stblaw.com

Summer Craig
+1-212-455-3881
scraig@stblaw.com

Jonathan T. Menitove
+1-212-455-2693
jonathan.menitove@stblaw.com

Isaac M. Rethy
+1-212-455-3869
irethy@stblaw.com

This edition of the Insurance Law Alert was prepared by Mary Beth Forshaw mforshaw@stblaw.com /+1-212-455-2846 and Bryce L. Friedman bfriedman@stblaw.com /+1-212-455-2235 with contributions by Karen Cestari kcestari@stblaw.com.

Simpson Thacher Worldwide

UNITED STATES

New York
425 Lexington Avenue
New York, NY 10017
+1-212-455-2000

Houston
600 Travis Street, Suite 5400
Houston, TX 77002
+1-713-821-5650

Los Angeles
1999 Avenue of the Stars
Los Angeles, CA 90067
+1-310-407-7500

Palo Alto
2475 Hanover Street
Palo Alto, CA 94304
+1-650-251-5000

Washington, D.C.
900 G Street, NW
Washington, D.C. 20001
+1-202-636-5500

EUROPE

London
CityPoint
One Ropemaker Street
London EC2Y 9HU
England
+44-(0)20-7275-6500

ASIA

Beijing
3901 China World Tower A
1 Jian Guo Men Wai Avenue
Beijing 100004
China
+86-10-5965-2999

Hong Kong
ICBC Tower
3 Garden Road, Central
Hong Kong
+852-2514-7600

Tokyo
Ark Hills Sengokuyama Mori Tower
9-10, Roppongi 1-Chome
Minato-Ku, Tokyo 106-0032
Japan
+81-3-5562-6200

SOUTH AMERICA

São Paulo
Av. Presidente Juscelino
Kubitschek, 1455
São Paulo, SP 04543-011
Brazil
+55-11-3546-1000