

INSURANCE NEWS

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IndustryNEWS



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*Insurance
Practice Group
Newsletter.*



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to bring to the*

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on recent developments, cases
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your comments and questions.*

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In Re: Deepwater Horizon Insurance Litigation – Fifth Circuit Reverses in Favor of BP's Additional Insured Claim

By Charles Platto, Joseph G. Grasso, and Michael Menapace

The following is excerpted from a recently published Feature Article in the Insurance Litigation Reporter, Vol. 35, No. 4, Mar. 18, 2013 (Thompson Reuters).

During the very same week in which the trial of the multibillion dollar claims by the U.S. Government and private parties against BP and the other parties involved with the Deepwater Horizon drilling rig was just getting under way in Federal Court in New Orleans, the Fifth Circuit Court of Appeals was putting the finishing touches on its decision in the declaratory judgment case brought by Transocean's primary and excess insurers against BP, involving BP's claim for coverage as an additional insured under Transocean's policies. In a major victory for BP, the Fifth Circuit ruled that BP was entitled to coverage as an additional insured under the Transocean policies. *In Re: Deepwater Horizon, Ranger Ins., Ltd., Transocean Offshore Deepwater Drilling, Inc., et al. and Certain Underwriters at Lloyd's London v. BP P.L.C. et al.*, No. 12-30230, 2013 WL 776354.

In its decision issued on November 15, 2011, the District Court, applying Texas Law, held that the additional insured coverage was only as broad as the indemnity requirements in the underlying contract and, therefore, denied coverage to BP and issued judgment on the pleadings in favor of the insurers. 2011 WL 5547259 at 75.

The Fifth Circuit ruled to the contrary: "Applying Texas law, especially as clarified since the district court's decision, we find that the umbrella insurance policy [and the primary insurance policy as well]—not the indemnity provisions of Transocean's and BP's contract—controls the extent to which BP is covered for its operations under the Drilling Contract. Because we find the policy imposes no relevant limitations upon the extent to which BP is covered, we REVERSE the judgment of the district court and REMAND the case for entry of an appropriate judgment in accordance with this opinion." ___ F.3d ___, 2013 WL 776354, at *1.

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FROM
TheCOURTS**First Ruling on New York's 2008
Notice-of-Claim Law Favors
Insurers**

In 2008, New York's "notice prejudice" insurance statute was amended. Under New York's amended notice prejudice rule, an insurer can no longer disclaim coverage on late notice grounds absent proof that it has been prejudiced by the delay. In the first decision following enactment of that law, a New York federal court ruled in favor of an insurer fighting coverage for a roof collapse. In January, Judge Denise Cote (Southern District of New York) held that Value Waterproofing Inc.'s delay in notifying its insurer about the roof collapse was serious enough to bar coverage for an underlying lawsuit. *Atl. Cas. Ins. Co. v. Value Waterproofing, Inc.*, (No. 11 Civ. 7565 (DLC) January 15, 2013).

Shortly after the insured completed repair work on a non-residential building, a major winter storm left significant snow accumulations on the roof, causing it to collapse. The property owner reported the collapse to the insured contractor immediately after discovery. The contractor, however, failed to report the incident to its CGL insurer. The building owner, in contrast, immediately filed a notice of loss with its own insurer. After a short period of time, The New York City Building Department ordered the demolition of the second floor of the property where the roofing repair work had occurred, and demolition work began while the property owner's insurer was still in the process of inspecting the collapse.

Six months after the demolition work was completed, the property owner's insurer informed the contractor's CGL carrier that

the collapse had occurred. Less than two weeks later, the contractor's CGL carrier denied coverage.

The property owner's insurer commenced a subrogation suit against the contractor, alleging breach of contract and negligence in connection with the contractor's roofing repair work. After receiving notice of the suit, the contractor's CGL insurer retained counsel to defend the contractor but also filed a declaratory judgment action seeking a ruling that it owed no coverage to the contractor for several reasons, including that it was prejudiced by the late notice. The court concluded that the contractor's insurer had no duty to defend or indemnify the property owner's subrogation suit because the insurer was prejudiced by the late notice.

The court noted that the law provides that when notice is untimely but is given within two years of the relevant accident or occurrence, the insurer has the burden of showing that it was prejudiced by the delay. The court further noted that in order to carry this burden, the statute requires an insurer to prove that the late notice "materially impairs the ability of the insurer to investigate or defend the claim."

Under the facts of the case, the court found that neither the property owner nor the contractor acted to notify the contractor's insurer of the loss until nearly six months after the collapse, which the court said was unreasonable as a matter of law. The insured raised four arguments to excuse the late notice: (1) a good-faith belief that it had no liability; (2) it was impractical to provide timely notice because the demolition occurred within 3 weeks of the collapse;

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(3) the insurer could not claim prejudice because its investigation was inadequate; and (4) the insurer was required to rely on the investigation of the property owner's insurer. The court rejected all of those arguments and held: "Here, where the best physical evidence was available only to one side, but not the other, because of an unreasonable failure to provide notice, prejudice has been shown."

Connecticut Supreme Court Rules in Insurer's Favor on Duty to Defend When the Four Corners of the Complaint Do Not Connect the Injuries and the Insured Premises

The Connecticut Supreme Court recently issued a decision concerning an insurer's duty to defend an additional insured where the complaint in the underlying personal injury action drew no connection between the injured person's use of the insured premises and her injuries, and undisputed extrinsic facts indicated that the underlying action fell outside of the scope of coverage. *Misiti, LLC v. Travelers Prop. Cas. Co. of Am.*, 308 Conn. 146 (2013).

Misiti was an additional insured on a CGL policy issued to Misiti's tenant, Church Hill Tavern, LLC, by Travelers. Misiti sought to invoke Travelers' duty to defend under the policy after a person was injured in a fall on Misiti's property. Misiti sought a judgment declaring that Travelers had a duty to defend Misiti in the underlying action and that Travelers was obligated to reimburse its own insurer for all or part of the defense costs.

The court acknowledged the breadth of an insurer's duty to defend, but clarified the broad rule and held that it will not predicate the duty to defend on "a reading of the complaint that is ... conceivable but tortured and unreasonable." Thus, although an insurer "is not excused from its duty to defend merely because the underlying complaint does not specify the connection between the stated cause of action and the policy coverage, the insurer has a duty to defend only if the underlying complaint *reasonably* alleges an injury that is covered by the policy." "Simply because we ... often interpret coverage ambiguities in favor of the insured does not mean that we will obligate an insurer to extend coverage based ... [on] a reading of the complaint that is ... conceivable but tortured and unreasonable."

Although it was undisputed that the premises on which the tavern operated was part of Misiti's overall premises, to which the underlying complaint referred, the justices were not persuaded that this fact alone, in the absence of any alleged connection to the tavern, justified an inference that the injuries alleged in the underlying complaint arose out of the use of the leased premises. In fact, reviewing the underlying complaint, finding coverage would have required "significant conjecture." Thus, the court ruled that, "in the absence of an allegation tying the injuries to the particular lot leased to the tavern, for which the insurance policy was issued, the requisite causal connection in the policy's 'arising out of' language cannot be established."

Second Circuit Rules that Environmental Damage Outside the Policy Period May Trigger Coverage

The Second Circuit Court of Appeals recently held that the language in two excess policies may provide coverage for property damage that occurred outside the policy periods notwithstanding New York's endorsement of pro rata allocation. *Olin Corp. v. Am. Home Assurance Co.*, 2012 WL 6602909 (2d Cir. Dec. 19, 2012).

The insured, Olin, maintained general liability policies and layered excess policies. A dispute arose concerning Olin's long-term environmental contamination at a California manufacturing site. American Home issued two three-year term policies, excess of approximately \$30 million underlying insurance. The excess policies followed form to underlying Lloyd's policies that provided, "in the event that personal injury or property damage arising out of an occurrence covered hereunder is continuing at the time of termination of this Policy, Underwriters will continue to protect the Assured for Liability"

Olin argued that American Home must indemnify it for continuing damage after the three-year terms, such that the policies' attachment points would be met. The district court rejected Olin's argument and applied the pro rata allocation scheme (attributing \$3.3 million to each year of property damage between 1957 and 1987), which meant the \$30 million attachment points of American Home's three-year policies were not met.

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The Second Circuit reversed and held that policies provided continuing coverage beyond the end of American Home's policy periods if there was: (1) personal injury or property damage, (2) arising out of a covered occurrence, and (3) continuing at the time of policy termination. The Court ruled in the affirmative on all three elements and concluded that American Home could be obligated to indemnify Olin up to the limits of its policies for damage that occurred during and after the termination of each policy until 1987, thereby exceeding the policies' attachment points. (The court noted, however, that a "prior insurance" clause in the policy limited coverage to only one (not both) of American Home's excess policies and remanded the matter for further proceedings, noting the possibility that the policies' attachment points might not be met for other reasons.)

This decision does not disturb New York's established law that, in the absence of policy language to the contrary, liability for damages arising out of continuous property damage should be allocated pro rata based on the "time on the risk." Nevertheless, where a policy includes specific language that deviates from New York's default pro rata rule, courts will enforce the contract as written.

Triable Issues Remain In \$262M Reinsurance Dispute

In a well-publicized decision, New York's highest court recently modified, in part, a lower court's ruling in a major reinsurance dispute and found that there are issues of

fact as to whether an insurer, in allocating a settlement amount, reasonably attributed nothing to so-called bad faith claims made against it and whether certain claims were given unreasonable values for settlement purposes. *U.S. Fid. & Guar. Co. v. Am Re-Ins. Co.*, 2013 NY Slip Op 784, 2013 WL 451666 (N.Y. Feb. 7, 2013). The New York Court of Appeals, however, also held that the intermediate appellate court correctly rejected the reinsurers' other defenses, sustaining summary judgment on the cedent's allocation of the entire settlement to a single policy year.

USF&G insured Western Asbestos Co. for losses arising out of the sale, distribution and installation of asbestos-containing materials. AmRe and Excess Casualty Reinsurance Association (ECRA) agreed to reinsure portions of USF&G's risk. USF&G agreed to settle with the insured, Western MacArthur (the successor of Western Asbestos), for nearly \$1 billion concerning claims for bodily injury due to asbestos exposure in the 1970s. USF&G billed AmRe and ECRA \$40 million each and notified them that there would also be future billings.

In 2010, the New York trial court found for the insurer under the follow-the-fortunes doctrine and ordered AmRe to pay approximately \$203 million, plus interest, and ECRA (and other reinsurers) to pay approximately \$60 million, plus interest. The reinsurers appealed and the intermediate court of appeals held that the trial judge correctly applied the follow-the-fortunes doctrine.

The reinsurers appealed to the New York Court of Appeals, which held that "almost all courts to consider the question have

held, and we join them in holding, that a follow the settlements clause does require deference to a cedent's decisions on allocations." Moreover, "objective reasonableness should ordinarily determine the validity of an allocation," and cedents "are not required to put the interests of reinsurers ahead of their own." "In sum, under a follow the settlements clause like the one we have here, a cedent's allocation of a settlement for reinsurance purposes will be binding on a reinsurer if, but only if, it is a reasonable allocation, and consistency with the allocation used in settling the underlying claim does not by itself establish reasonableness."

Nevertheless, in this case, the court found it "impossible to conclude, as a matter of law, that parties bargaining at arm's length, in a situation where reinsurance was absent, could reasonably have given no value to the bad faith claims. This issue must be decided at trial." USF&G might have faced a "significant risk of an adverse verdict on the bad faith claims" in the coverage case. And, "it could be found that USF&G, in allocating the settlement, assigned inflated values to claims other than bad faith claims — i.e., to claims that were covered in part by reinsurance."

However, USF&G could reasonably allocate all of the losses in the settlement to the policy in force in 1959, the last full year in which USF&G was the liability insurer. The court concluded that USF&G reasonably assumed that California courts would follow the continuous trigger, all sums and no stacking rules. Therefore, the court affirmed summary judgment in favor of USF&G on the issue.

FROM
TheCOURTS CONTINUED

The following summary was included in a recent Wiggins and Dana U.S. Supreme Court Update. See here <http://www.wiggins.com/14221> to read or subscribe to the Appellate Practice Group's email summaries of all the decisions from the SCOTUS.

A Stipulation by a Class Representative Must Be Ignored When Determining the Amount in Controversy

In *Standard Fire Insurance Co. v. Knowles* (11-1450), the Court unanimously held that a named plaintiff cannot defeat federal court jurisdiction under the Class Action Fairness Act ("CAFA") by purporting to limit the damages of the putative class to less than \$5 million in his complaint or in a stipulation. CAFA expanded federal court jurisdiction to cover class actions involving more than 100 individuals, minimal diversity, and an amount in controversy in excess of \$5 million. In determining the amount in controversy, "the claims of the individual class members shall be aggregated" and "class members" includes persons "who fall within the definition of the proposed or certified class." An individual plaintiff can avoid federal court jurisdiction by limiting his claimed damages to an amount below the federal jurisdiction threshold via a binding stipulation. In light of this general rule, plaintiffs' counsel who preferred litigating in state court attempted the same maneuver in class cases, purporting to limit damages to less than CAFA's \$5 million jurisdictional threshold.

Writing for the Court, Justice Breyer explained the problem with this approach. "Stipulations must be binding," but a

plaintiff "who files a proposed class action cannot legally bind members of the proposed class before the class is certified." "[H]is precertification stipulation does not bind anyone but himself." Indeed, the district court might later certify a class, but excise the damage limitation, or might find that the particular named plaintiff who signed the stipulation is not a good class representative because he artificially attempted to limit the amount in controversy. Other class members could intervene and seek to file an amended complaint eliminating the stipulation. In sum, there is a "very real possibility that a nonbinding, amount-limiting, stipulation may not survive the class certification process." Such a stipulation should therefore be "ignored" when determining the amount in controversy under CAFA.

Missouri Court Applies "All Sums" Allocation to Long-Tail Environmental Coverage Dispute

On April 16, a Missouri appeals court held that excess liability insurers were jointly and severally liable under policies issued to Doe Run in the 1950s for "all sums" it paid to investigate and remediate environmental contamination that occurred during a period of more than 90 years. *Doe Run Resources Corp. v. Certain Underwriters at Lloyd's London*, ED98086, 2013 Mo. App. LEXIS 468 (April 16, 2013). Doe Run has spent more than \$62 million in environmental remediation costs related to properties it operated since the late 1880s and has been seeking coverage for those costs under various excess insurance policies in

effect from 1952 through 1961. Rejecting the argument that New York's pro rata allocation scheme should apply (and therefore limiting the insurer's obligations to approximately \$5 million), the appeals court held that under Missouri law, the insurers were jointly and severally liable for "all sums" of Doe Run's losses. The court based its "all sums" allocation on the "plain language" of the policies, which provide that the insurers are to pay "all sums which the Assured shall be obligated to pay by reason of the liability . . . for damages . . . on account of property damage, caused by or arising out of each occurrence happening during the policy period." The court also looked at the definition of "occurrence" as "one happening or series of happenings, arising out of, or due to one event taking place during the term." Of note, the court stated "[w]e do not reach the issue of whether Missouri law requires an all sums approach or a pro rata approach as the plain language of the policies governs here." Finally, the court ruled that each "separate and distinct cause[] of contamination" at each location was a separate occurrence because Missouri law applies the "causation" test to determine the number of occurrences. Because the policies did not contain aggregate limits, therefore, Doe Run was entitled to coverage under each triggered policy for multiple per occurrence limits at each site.

FROM
TheREGULATORS**Connecticut**

Connecticut recently amended its statutes to align its requirements for insurers to be certified as reinsurers in the states with the NAIC model law. This bulletin sets forth the requirements to become a certified reinsurer. BULLETIN FS-25 (3/1/2013) - Requirements to Become a Connecticut Certified Reinsurer [HYPERLINK "http://www.ct.gov/cid/cwp/view.asp?a=1255&Q=254256"](http://www.ct.gov/cid/cwp/view.asp?a=1255&Q=254256) <http://www.ct.gov/cid/cwp/view.asp?a=1255&Q=254256>

Federal Insurance Office

The Federal Insurance Office ("FIO") was established at the end of 2010 by the Dodd-Frank Wall Street Reform and Consumer Protection Act. It is part of the Department of Treasury. The Current FIO director, appointed by the Secretary of the Treasury, is Michael McRaith, who formerly served as Illinois insurance director and secretary/treasurer of the National Association of Insurance Commissioners.

The FIO monitors all aspects of the insurance industry, including identifying issues or gaps in the regulation of insurers that could contribute to a systemic crisis in the insurance industry or the U.S. financial system. The FIO coordinates and develops federal policy on prudential aspects of international insurance matters, including representing the U.S. in the International Association of Insurance Supervisors. The FIO also assists the Secretary in negotiating (with the United States Trade Representative) certain international agreements.

One of the main functions of the FIO is to issue reports to Congress. A number of reports which were due more than a year ago are expected to be out by July 2013.

The Federal Advisory Committee of Insurance ("FACI") is the private-public consultancy branch of the FIO. In its public meeting of August 2012, FACI signaled that it is viewing U.S. insurance regulation in the context of increasing internationalization of insurance. In March 2013, the FACI held its fourth meeting. The topics discussed were: Superstorm Sandy; affordability of non-health insurance products; reinsurance captives; and international work streams. Further FACI meetings are scheduled for this summer and autumn.

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Applying this analysis, the Court of Appeals looked first to the policy language, and applied Texas law as set forth in *Evanston Ins. Co. v. ATOFINA Petrochemicals, Inc.*, 256 S.W.3d 660 (Tex. 2008) and *Aubris Resources LP v. St. Paul Fire & Marine Ins. Co.*, 566 F.3d 483 (5th Cir. 2009), which the District Court had distinguished, and *Pasadena Refining System, Inc. v. McCraven*, Nos. 14-10-00837-CV, 14-10-00860-CV, 2012 WL 1693697 (Tex. App. May 15, 2012), which came down after the District Court's opinion, in concluding that even if the indemnity obligations of Transocean were limited under the Drilling Contract, only the policy itself may establish limits upon the extent to which an additional insured is covered.

The Court of Appeals' final conclusion was as follows: "Because we find that the umbrella policies [and the underlying policy] between the Insurers and Transocean do not impose any relevant limitation upon the extent to which BP is an additional insured, and because the additional insured provision in the Drilling Contract is separate from and additional to the indemnity provisions therein, we find BP is entitled to coverage under each of Transocean's policies as an additional insured as a matter of law."

Thus, the bottom line is quite simple. Even if the obligations of an additional insured are limited in an underlying contract, if the insurance policy is broader than those obligations, unless the policy provides specific limitations on coverage to the additional insured—by specific reference to the limitations in the underlying contract, or otherwise, at least under Texas law, the policy will provide the full extent of coverage to the additional insured.

Wiggin and Dana Insurance Practice Group

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About Wiggin and Dana's Insurance Practice Group

The Wiggin and Dana Insurance Practice Group provides international, national and regional insurers, reinsurers, brokers, other professionals and industry trade groups with effective and efficient representation. Our group members regularly advise clients in connection with coverage issues, defense and monitoring of complex claims, regulatory proceedings, policy wordings, internal business practices, and state and federal investigations. We also represent clients in insurance and reinsurance arbitrations. We have broad experience in many substantive areas, including property, commercial general liability, inland and ocean marine, reinsurance, E&O, D&O and other professional liability, environmental, energy and aviation. A more detailed description of the Insurance Practice Group, and biographies of our attorneys, appear at www.wiggin.com.

About Wiggin and Dana LLP

Wiggin and Dana is a full service firm with more than 140 attorneys serving clients domestically and abroad from offices in Connecticut, New York and Philadelphia. For more information on the firm, visit our website at www.wiggin.com.

Attorney Notes

John Kennedy recently joined Wiggin and Dana's Technology and Outsourcing and Privacy and Information Security practice. For many years, John has advised businesses, including P&C and Life & Health insurers and Reinsurers, on technology transactions, outsourcing and cloud services arrangements and e-commerce services. He has also advised insurance industry clients on policies and compliance programs addressing state and federal data privacy and security laws, including GLBA, FCRA, CAN SPAM and emerging laws on data breach notification, minimum security requirements and mobile e-commerce. For the past 14 years Mr. Kennedy has co-chaired Practising Law Institute's national Privacy and Data Security Law Institute, and he frequently speaks and writes on legal developments and commercial trends in data privacy.

Joe Grasso and **Michael Menapace**, along with former colleague Chuck Platto, recently authored a Feature Article – *In Re: Deepwater Horizon Insurance Litigation – Fifth Circuit Reverses in Favor of BP's Additional Insured Claim* – published in the Insurance Litigation Reporter, Vol. 35, No. 4, March 18, 2013.

Tim Diemand will be speaking at the May 2013 IMUA Annual Meeting on construction management risks.

Joe Grasso will be a presenter at IMCC 2013.

Joe Grasso participated in a panel presentation on recent Supreme Court and Circuit Court decisions at the American Conference Institute's Maritime Claims Conference in Houston and he was a speaker at the Biennial Admiralty Law Institute at Tulane Law School in March.

Michael Thompson and **Joe Grasso** presented a market briefing to members of the International Underwriting Association in London on recent case law developments in New York regarding bad faith and extra-contractual damages against underwriters. Mike also recently attended the annual IACP conference in Orlando.

Michael Menapace is currently teaching Insurance Law at Quinnipiac University School of Law. Michael recently completed the revised edition of the ABA Reference Handbook on the Commercial General Liability Policy, Chapter 9 - Principal Exclusions (Coverage A), which will be published this autumn.

This Newsletter is a periodic newsletter designed to inform clients and others about recent developments in the law. Nothing in the Newsletter constitutes legal advice, which can only be obtained as a result of personal consultation with an attorney. The information published here is believed to be accurate at the time of publication, but is subject to change and does not purport to be a complete statement of all relevant issues. In certain jurisdictions this may constitute attorney advertising.

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