WIGGIN AND DANA *A Newsletter from the Insurance Practice Group at Wiggin and Dana LLP*

INSURANCE NEWS

SPRING 2017

We are pleased to share this latest issue of the Wiggin and Dana Insurance Practice Group Newsletter. We circulate this newsletter by e-mail periodically to bring to the attention of our colleagues in the insurance industry reports on recent developments, cases and legislative/regulatory actions of interest, and happenings at Wiggin and Dana. We welcome your comments and questions.

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IN THIS ISSUE

Concurrent Causation – Jurisdictional Differences and Anti-Concurrent Causation Clauses

By Michael Menapace

Every first party property insurance coverage analysis includes an examination of whether the policy has been triggered. It is not uncommon for policies to include a provision stating that coverage is being afforded "against all direct loss caused by" specified perils. To determine whether a policy is triggered, we must, therefore, consider the cause of the loss. However, determining the "cause" can become complicated when multiple causes combine in sequence or simultaneously to create the loss. Courts (and some state legislatures) have adopted three different approaches for dealing with the issue of concurrent causation when the contract is silent, however, insurers generally can adjust policy language to adopt a specific approach to control losses under the policy at issue. A recent case in Florida, *Sebo v. Am. Home Assurance Co.,* 2016 WL 7013859 (Fla. 2016), highlighted the different approaches that courts can take on this issue and provides a reminder that state rules (whether judicially or statutorily enacted) can, in some cases, be circumvented by carefully drafting policies.

Tort versus Insurance – At the outset of any consideration of causation, however, we need to make sure we are properly oriented. In tort law, causation is examined to assign blame in a fault-based context. But, the construction of

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Concurrent Causation CONTINUED

an insurance policy is based in contract and, as a result, we are not as concerned with assigning blame or with the tort-based inquiry of proximate cause and negligence. Causation, as the concept is considered in insurance, controls whether an insurer has a contractual obligation to pay for a loss. If a loss occurs, the inquiry focuses primarily on whether the loss is the result of a covered peril, for example, when a building collapses because the ground beneath it shifted. The insurance inquiry is not focused on who, if anyone, is to blame for the ground shifting. If the building collapsed, the policy covers the loss unless there is an applicable exclusion. Nevertheless, courts sometimes confuse or inadvertently combine the two different concepts of causation simply because tort and insurance law both use the term. Litigants would be well-served to make certain that judges are properly oriented when ruling on causation in the insurance context, lest the concept of blame creep into what should be a purely contractual analysis.

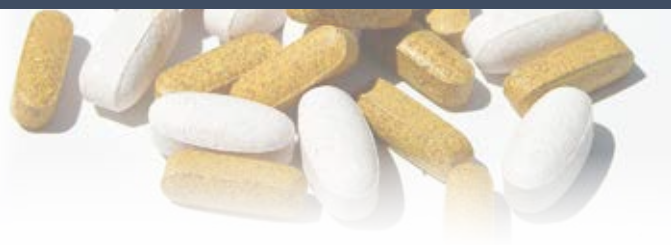
Three Approaches – If multiple concurrent causes contribute to a loss, and if the dominant, most significant, or most important cause is a covered peril, then the insurance policy would respond to the entire loss, even if some of the other causes were not a covered peril. This approach is called the Dominant Cause approach, sometimes referred to as the Proximate Cause or Efficient Proximate Cause approach, and is the rule in the majority of jurisdictions, including New York and Massachusetts. Indeed, some jurisdictions have enacted statutes requiring the Dominant Cause approach. California is one such state, although it treats property and liability coverages slightly differently in this regard.

A minority of states apply a rule that if a covered cause combines with a non-covered cause, there is no recovery under the policy. Michigan is a jurisdiction that follows this so-called "conservative" rule.

The third "liberal" approach, also a minority rule, is that the entire loss is covered if even one cause in the causal chain is a covered peril. New Jersey is a state that has adopted this policyholder friendly rule. The *Sebo* case, mentioned at the beginning of this article, effectively adopts this approach in Florida. There the court stated: "there is no reasonable way to distinguish the proximate cause of Sebo's property loss — the rain and construction defects acted in concert to create the destruction of Sebo's home. As such, it would not be feasible to apply the [efficient proximate cause] doctrine because no efficient cause can be determined." This approach is often called the Concurrent Cause doctrine and avoids some of the fact-intensive inquiry required in the Dominant Cause approach because the actual cause of a loss, or the predominant cause of a loss, is often a judgment call and up for debate among experts. This fact-intensive inquiry makes adjudication by summary judgment challenging, often requiring that these cases proceed to a full jury trial.

Anti-Concurrent Causation Clauses – In light of the default rules set forth by courts, some insurers have adjusted policy language to ensure that a particular approach is applied in the case of a loss under their policy. For example, at least one insurer uses the following language in its bacteria/fungi exclusion – the loss is excluded "regardless of whether any other cause, event, material or product contributed concurrently or in any sequence to such injury or damage." Another standardized policy provision is: "We do not insure for loss caused directly or indirectly by any of the following. Such loss is excluded regardless of any other cause or event contributing concurrently or in any sequence to the loss. . . ." By including a similar "anti-concurrent causation" clause, insurers can gain more assurance that the rule they expect to be applied in a coverage dispute will be applied.

Including an anti-concurrent clause in a policy, however, does not provide absolute protection. Courts in a few states, including California, Mississippi, Washington, and West Virginia, have tried to limit the effect of such express clauses. We would expect that policyholders will continue to seek to undermine the ability for insurers to include anti-concurrent causation provisions in policies, primarily on public policy and consumer protection grounds. In the meantime, anti-concurrent causation provisions can provide insurers with some protection from finding themselves having to pay claims based on risks they intended to exclude from coverage.



FROM
TheCOURTS

Among the services that the Wiggin and Dana Insurance Practice Group provides to its clients is appellate advocacy. Insurance clients will turn to Wiggin and Dana to handle appeals even when they have engaged other counsel at the trial court level on matters concerning insurance coverage, business practices and defense of insureds. Here are two significant appeals in which Wiggin and Dana prevailed for its client.

Vitamin Health – Sixth Circuit Court of Appeals

Jonathan Freiman and Ivana Greco successfully represented Hartford Casualty Insurance Company in an appeal in the Sixth Circuit in the case of *Vitamin Health, Inc. v. Hartford Casualty Insurance Co.,* No. 16-1724, where the Sixth Circuit held that the Hartford had no duty to defend a policyholder in an underlying suit alleging false advertising.

Vitamin Health manufactures eye health supplements that it claimed were AREDS-2-complaint, meaning they contained a formula of vitamins and minerals recommended by the National Institutes of Health's second Age-Related Eye Disease Study ("AREDS-2"). Bausch & Lomb (which also manufacturs eye health supplements) sued Vitamin Health for false advertising, claiming Vitamin Health's supplements contained less zinc than recommended by the AREDS-2 study. Vitamin Health sought coverage from the Hartford, saying the false advertising claim was covered by the policy's definition of "personal and advertising injury," which includes product disparagement. After the Hartford denied coverage, Vitamin Health filed suit in the U.S. District for the Eastern District of Michigan. The District Court found in the Hartford's favor, ruling on summary judgment that the Hartford had no duty to defend or indemnify Vitamin Health.

On appeal, the Sixth Circuit affirmed. Vitamin Health argued that the underlying suit fell within the policy's coverage for, "Oral, written or electronic publication of material that . . . disparages a person's or organizations goods, products, or services." The Court disagreed. Because Vitamin Health was alleged to have misrepresented its *own* product, rather than a competitor's, the Sixth Circuit held that there was no disparagement. While Bausch & Lomb advertised its product as the only AREDS-2 complaint supplement on the market, the Sixth Circuit found this did not support Vitamin Health's claim of implied disparagement. It saw no support in Michigan law or elsewhere that an implied disparagement claim could be based on misrepresentations about the insured's own product without any comparison to a competing product. "Simply put," the Court ruled, "Bausch & Lomb's claim is for false advertising, not product disparagement." Because the policy did not cover false advertising, there was no duty to defend.

Takemoto and Hayes – Second Circuit Court of Appeals

Jonathan Freiman and Ivana Greco successfully represented Hartford Casualty Insurance Company, Hartford Accident and Indemnity Company and The Hartford Financial Services Group in two Second Circuit appeals; *United States ex rel.*

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Takemoto v. Nationwide Mutual Insurance Company et al., No. 16-365, and *United States ex rel. Hayes v. Allstate Insurance Company et al.*, No. 16-705, in both of which the Second Circuit affirmed the dismissal of cases alleging that several insurers and self-insured corporations had failed to meet repayment obligations under the Medicare Secondary Payer Act (MSP).

In *Takemoto*, the relator was a doctor who owned a company that offered MSP compliance services. He sued a number of companies that he had done business with, or tried to do business with. The Second Circuit found that his complaint was properly dismissed with prejudice because Takemoto did not allege facts showing any single defendant was required to reimburse the government. Takemoto tried to support his complaint with statistics, alleging that 17% of the population is Medicare beneficiaries, and the defendants settle thousands of claims annually, so some of these settlements must trigger MSP repayment obligations. However, the Second Circuit found this was not enough. There were no allegations that defendants in any of these cases were obligated to reimburse the government and didn't: there was just "low-octane fuel for speculation about the requisite reimbursement obligation."

In *Hayes*, the relator was a lawyer who sued more than 60 companies, mostly insurers. Hayes is a personal injury attorney, and alleged in his complaint that he knew from personal experience that the defendants had not complied with their MSP obligations. But when faced with a Rule 11 motion, he filed a motion for expedited discovery in which he admitted that some of the defendants might not have done anything wrong and should be dismissed from the case. The Magistrate Judge ordered Hayes to show cause why he had not violated Rule 11. After several conferences, the Magistrate recommended dismissal as a sanction under Rule 11 because the complaint had said Hayes knew that the defendants all participated in the alleged scheme, but the expedited-discovery motion later admitted that Hayes had no such personal knowledge. The district court agreed, and the Second Circuit affirmed. Hayes argued on appeal that he was confused by "corporate complexities." The Second Circuit rejected that argument: "Even if we were to credit Hayes's explanation, confusion about corporate complexities would not justify falsely purporting to have personal knowledge as to more than sixty defendants' involvement in wrongdoing."

Wiggin and Dana participated in joint defense groups in both of the MSP appeals. At the trial level, Jonathan Freiman, Kim Rinehart and Ivana Greco represented The Hartford and its affiliate insurers, also as part of a joint defense group.

Fifth Circuit Addresses Enforceability of Indemnification Provision

The U.S. Court of Appeals for the Fifth Circuit recently affirmed a trial court's decision to enforce indemnification provision in a master services contract. The owner of our offshore gas well and its insurers had asked the court to find that the provision was unenforceable under the Louisiana Oilfield Indemnity Act. However, the court held that because the claim involved maritime activity, federal admiralty law (under which such indemnity provisions are enforceable) applied in lieu of the Louisiana statute.

The case involved a claim for personal injuries by an employee of a contractor who was working on a fixed energy production platform. When the employee sued the contractor, the owner of the platform refused the contractor's request for defense and indemnification pursuant to the indemnity provision in the MSA, on the basis that such provisions are barred by the Louisiana statute. However, because the work being performed on the platform involved the use of a barge-mounted crane, the court found that federal admiralty law applied, and that such indemnity provisions are enforceable under admiralty law.

The court applied a six-factor test in determining whether the contract at issue (for the work on the platform) was a maritime contract, and therefore subject to federal admiralty law. The court found that 4 of the 6 factors militated in favor of finding that the contract was maritime nature, with the "gravamen" of the court's inquiry being "whether the execution of the contract required a vessel." Since the accident occurred during operation of a barge-mounted crane, the court found that the contract was sufficiently maritime in nature to apply admiralty law, and to enforce the indemnity provision in the MSA.

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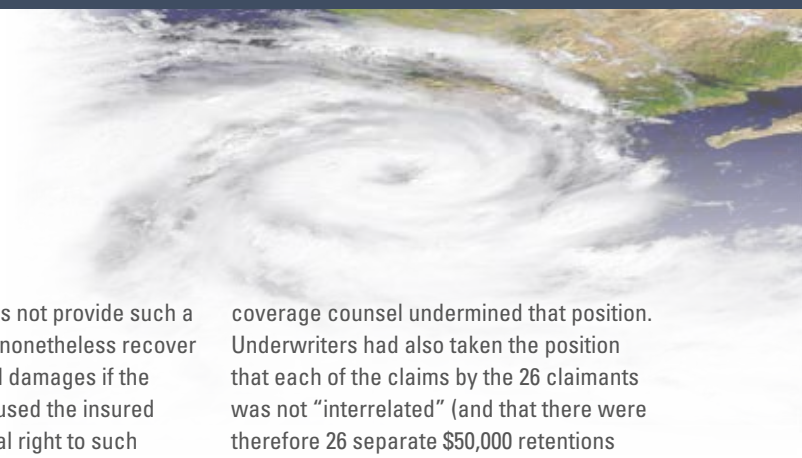

FROM
TheCOURTS CONTINUED

Texas Supreme Court "Clarifies" Circumstances Under Which Insureds May Recover Policy Benefits

On April 7th, the Texas high court issued a decision announcing five new rules addressing the interplay between claims for breach of an insurance contract and claims under the Texas Insurance Code. The case involved a claim by a homeowner for damage caused by Hurricane Ike in 2008. The claim was declined by the insurer following two inspections by two different adjusters working for the insurer. The homeowner therefore sued the insurer, seeking benefits under the policy and claiming that the insurer breached the terms of the policy and also engaged in unfair settlement practices in violation of the Texas Insurance Code. Following a jury trial, the jury awarded the homeowner just over $11,000, in spite of finding that the insurer had not breached the terms of the policy. The jury nonetheless found that the insurer had violated the Texas Insurance Code and awarded the homeowner the benefits it sought under the policy.

On appeal, the court announced five new rules governing the relationship between contractual and extra-contractual claims in Texas:

- An insured cannot recover policy benefits for an insurer's violation of the insurance code if the policy does not provide a right to such benefits, i.e., if there is no coverage for the claim in question;
- If the policy does provide such a right, the insured can recover the benefits as actual damages if the insurer's violation caused the loss of such benefits;
- Even if the policy does not provide such a right, an insured can nonetheless recover the benefits as actual damages if the insurer's violation caused the insured to lose the contractual right to such benefits;
- If an insurer's violation of the insurance code causes injury independent from the loss of policy benefits, the insured can recover damages for such injury; and
- An insured cannot recover any damages if it is not entitled to any benefits under the policy and the insured suffered no independent injury.

Editor's Note: While this decision reaffirms the private right of action under the Texas Insurance Code, it is difficult to imagine a scenario where an insurer could violate the Texas Insurance Code without the insured being entitled to any benefits under the policy, i.e., rule 3, above. The new rules articulated by the court therefore seem to conflate the concepts of breach of contract and violation of the insurance code and may well cause confusion among lower courts going forward.

Tenth Circuit Holds that Lloyd's Underwriters were Estopped from Denying Coverage

The U.S. Court of Appeals for the Tenth Circuit recently held that Lloyd's underwriters were on the hook for a settlement by Brecek & Young Advisors in an arbitration brought by 26 investors in 2007. While Underwriters had taken the position that the conduct complained of by the investors related to an "interrelated" prior wrongful act, Underwriters' own coverage counsel undermined that position. Underwriters had also taken the position that each of the claims by the 26 claimants was not "interrelated" (and that there were therefore 26 separate $50,000 retentions involved), but they defended BYA in the arbitration under a reservation of rights.

Following conclusion of the arbitration through settlement, BYA commenced a coverage action against Underwriters; and Underwriters asserted not only the application of 26 retentions, but also that the arbitration was in fact interrelated with prior arbitrations (which occurred prior to attachment of the Lloyd's policy).

After abandoning its argument that the 26 claims were not interrelated, Underwriters pursued its argument that there was no coverage because the claims were interrelated with the prior arbitration. BYA argued that Underwriters had waived that argument and/or that they were estopped from asserting it. While the court found that Underwriters had not waived the argument, it found that it was estopped from doing so, based on a showing of detrimental reliance by BYA (i.e. that BYA had foregone attempting to seek coverage under a prior policy). Thus, because BYA had shown prejudice as a result of Underwriters' shifting positions as to coverage, Underwriters was estopped from denying coverage.

The case highlights the importance of thorough and timely reservations of rights, and the pitfalls that may result from inconsistent coverage positions taken by Underwriters.

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FROM
TheCOURTS CONTINUED

Criminal Fraud Conviction Means Anesthesiologist Must Repay Health Insurers $7.4m

After a recent jury trial, a Dallas anesthesiologist was found guilty of seven counts of fraud on health insurers. He will now spend 3 1/2 years in prison and is required to pay $7.4 million in restitution. The doctor, Dr. Richard Ferdinand Toussaint Jr., will serve 41 months in jail and be subject to one year of supervised release. The sentences for each of the seven counts will run concurrently. He had been indicted on charges of defrauding Blue Cross Blue Shield of Texas, UnitedHealthcare, the Federal Employees Health Benefits Program, The Aetna, Cigna, and others by submitting false invoices claiming that he personally directed anesthesia services. Instead, he was, at the same time he was supposedly administering the anesthesia, flying on his private jet, in another state, at another hospital miles away, or undergoing surgery himself.

Indiana Appeals Court Rules that Additional Insured Not Entitled to Defense Because Named Insured Had Not Paid SIR

In a dispute between Walsh Construction Co. and Zurich American Insurance Company, Zurich obtained summary judgment against Walsh, which had been claiming entitlement to coverage as an additional insured. Walsh was sued in a personal injury action. The summary judgment ruling held that Walsh cannot access additional-insured coverage under subcontractor Roadsafe Holdings Inc.'s CGL policy with Zurich, because Roadsafe had not paid the $500,000 SIR. An Indiana appeals court has now affirmed that Walsh is not entitled to defense coverage under Roadsafe's policy, ruling as a matter of first impression. It held that Walsh cannot tap into the policy because the subcontractor/policyholder has not paid the deductible. This is the first time an Indiana appeals court considered whether an SIR endorsement governs an insurer's obligations to additional insureds. Interestingly, it appears that Walsh has little recourse or options because Roadsafe has not been sued nor has it requested coverage under the Zurich policy.

ANNOUNCEMENTS

Benchmark Litigation Names Wiggin and Dana's Litigation Department as 2017 Litigation Department of the Year

Connecticut Law Tribune Names Wiggin and Dana as 2016 Litigation Department of the Year

Several Wiggin and Dana insurance lawyers will be editing the **Second Edition of The Handbook on Additional Insureds**, published by ABA Publishing. The original edition of t he handbook was a great success. Demand for the book was very strong and it has been cited in legal briefs and judicial opinions. The second edition is expected to be published in late 2017.

About Wiggin and Dana's Insurance Practice Group

The Wiggin and Dana Insurance Practice Group provides 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 represent clients in arbitrations and mediations as well as in the courts. 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 145 attorneys serving clients domestically and abroad from offices in Connecticut, New York, Philidelphia, Washington, DC and Palm Beach. For more information on the firm, visit our website at www.wiggin.com.

AttorneyNOTES

Michael Menapace was recognized as a Super Lawyer – Connecticut Insurance Coverage, in the most recent Connecticut Super Lawyers Magazine. Michael presented a session on cyber security and breach response for the small and medium-size business at the February 2017 StaffLeader workshop, and in March he presented a session on cyber security and third-party service providers at the Insurance Technology Association conference. As a member of the ARIAS-U.S. Task Force on Data Security in Arbitration, he presented workshops at the ARIAS-U.S. Spring 2017 Conference. In May, Michael will become the President-Elect of the Hartford County Bar Association – the oldest bar association in the United States.

Joe Grasso attended the U.S. MLA spring meetings during the week of May 1 in NYC, (he currently serves on the Board of Directors); and he will attend the IMUA Annual Meeting in Braselton, Georgia May 21-23.

Joe Grasso was again recognized as a leading lawyer in 2017 in *"Who's Who Legal – Transport".*

Tim Diemand was recognized as a Super Lawyer – Connecticut Civil Litigation: Defense, in the most recent Connecticut Super Lawyers Magazine.

Michael Thompson – served on a panel at the ARIAS-U.S. Spring 2017 Conference discussing the most significant cases in the insurance/reinsurance industry during the past three years.