SIMPSON THACHER

INSURANCE LAW ALERT

JANUARY 2012

This Alert discusses a variety of rulings relating to minimum statutory requirements for property insurance under New York law, the transferability of certain insurance coverage rights despite an anti-assignment clause, the scope of advertising injury, and the insurability of SEC disgorgement payments. We also address recent decisions relating to the consolidation of arbitrations, pro rata allocation of indemnity costs, the viability of contribution claims among insurers, and an insurer's right to select defense counsel. Finally, we summarize significant recent changes to federal statutory law governing jurisdiction and venue. Best wishes to you in the New Year.

- ***Second Circuit Affirms Dismissal of Homeowners' Class Action***

  The Second Circuit affirmed a district court opinion dismissing a putative class action against Allstate Fire and Casualty Company, rejecting assertions that Allstate's fire insurance policy was inconsistent with New York statutory law and that Allstate's denial of payments for certain repairs violated the terms of the insurance policy. *Woodhams v. Allstate Fire & Cas. Co.*, 2012 WL 5834 (2d Cir. Jan. 3, 2012) (Summary Order). *Click here for full article*

- ***Finding That Reservation of Rights Does Not Create a Conflict of Interest, Texas Court Rules That Insurer Is Entitled to Select Policyholder's Defense Counsel***

  A federal court in Texas ruled that because there was no conflict of interest between a professional liability insurer and the law firm it insured, the insurance company was entitled to select counsel to represent the law firm in an underlying malpractice suit. *Coats, Rose, Yale, Ryman & Lee, P.C. v. Navigators Specialty Ins. Co.*, 2011 WL 5870066 (N.D. Tex. Nov. 21, 2011). *Click here for full article*

- ***Consolidation of Arbitrations Is Issue for Arbitration Panel, Not Court, Says Seventh Circuit***

  The Seventh Circuit ruled that the question of whether multiple arbitrations should be consolidated in a single proceeding must be decided by an arbitration panel, rather than a court. *Blue Cross Blue Shield of Massachusetts, Inc. v. BCS Ins. Co.*, 2011 WL 6382203 (7th Cir. Dec. 16, 2011). *Click here for full article*

- ***Illinois Appellate Court Enforces Contractual Transfer of Rights under Insurance Policies Despite Policies' Anti-Assignment Clause***

  An Illinois appellate court ruled that a policyholder's transfer of liability insurance benefits to a successor company was valid despite anti-assignment clauses in the relevant policies because the losses at issue had already occurred prior to the transfer. *Illinois Tool Works, Inc. v. Commerce & Industry Ins. Co.*, 2011 WL 6247399 (Ill. Ct. App. Dec. 12, 2011). *Click here for full article*

- ***Disgorgement Payments to SEC Are Not Insurable Losses, Says New York Appellate Court***

  Reversing a lower court decision, a New York appellate court ruled that a disgorgement payment to the Securities and Exchange Commission in settlement of fraud-based charges did not constitute an insurable loss under primary and excess professional liability policies. *J.P. Morgan Securities Inc. v. Vigilant Ins. Co.*, 2011 WL 6155586 (N.Y. App. Div. 1st Dep't Dec. 13, 2011). *Click here for full article*

- ***New York Court Endorses Pro Rata Allocation with Pro Ration to Insured for Uninsured Periods***

  A federal district court in New York adopted a pro rata allocation scheme to divide indemnity costs among insurers for asbestos-related losses, and held that the insured was responsible for its share of indemnity costs for a period of no insurance. *Fulton Boiler Works, Inc. v. American Motorists Ins. Co.*, 2011 WL 6117946 (N.D.N.Y. Dec. 9, 2011). *Click here for full article*

- ***Nevada Court Dismisses Insurer's Contribution Claim, Citing Lack of Allegations That Insurers Shared Common Duty to Mutual Insured***

  A federal district court in Nevada dismissed a complaint against National Fire & Marine Insurance Company seeking contribution for defense and settlement costs in 116 underlying lawsuits and a declaration that National owed a defense in those matters. *Assurance Co. of America v. National Fire & Marine Ins. Co.*, 2011 WL 6181928 (D. Nev. Dec. 13, 2011). *Click here for full article*

- ***Allegations of Harm to a Third Party's Product Do Not Constitute Advertising Injury, Says California Appellate Court***

  A California appellate court held that a business insurance company did not owe coverage for "advertising injury" where claims against the policyholder alleged only harm to and/or infringement of another's product, rather than infringement of another's advertising ideas. *Oglio Entertainment Group, Inc. v. Hartford Cas. Ins. Co.*, 200 Cal. App. 4th 573 (2d Dist. 2011). *Click here for full article*

- ***West Virginia Supreme Court Affirms Dismissal of Medical Monitoring Claim***

  The Supreme Court of Appeals of West Virginia affirmed a grant of summary judgment in favor of defendants in a class action asserting, among other things, a medical monitoring claim. *Acord v. Colane Co.*, 2011 WL 5827610 (W. Va. Nov. 16, 2011). *Click here for full article*

- ***Congressional Act Creates Significant Changes to Federal Jurisdictional Statutes***

  The Federal Courts Jurisdiction and Venue Clarification Act of 2011, which became effective on January 6, 2012, clarifies, and in some instances significantly changes, the rules governing federal court jurisdiction and venue. *Click here for full article*

Property Insurance Alert:

Second Circuit Affirms Dismissal of Homeowners' Class Action

The Second Circuit affirmed a district court opinion dismissing a putative class action against Allstate Fire and Casualty Company. The Second Circuit held that plaintiffs' tort and breach of contract claims failed as a matter of law, rejecting assertions that Allstate's fire insurance policy was inconsistent with New York statutory law and that Allstate's denial of payments of certain repairs violated the terms of the insurance policy. *Woodhams v. Allstate Fire & Cas. Co.*, 2012 WL 5834 (2d Cir. Jan. 3, 2012) (Summary Order).

The putative plaintiff class consisted of policyholders who had filed claims with Allstate following fire damage to their homes. Allstate had paid plaintiffs the actual cash value of their damaged property, but denied additional reimbursement for repairs in excess of the damaged property's actual cash value. Allstate refused to pay the additional repair costs because plaintiffs had not completed the repairs within 180 days of the actual cash value payment—a requirement under the policy. According to plaintiffs, Allstate's refusal to pay the additional repair costs violated both New York statutory law and the terms of the contract itself. The district court disagreed and dismissed the complaint, and the Second Circuit affirmed.

New York statutory law requires a fire insurance policy to provide coverage, at a minimum, for the lesser amount of either the actual cash value of the property at the time of loss or the amount that it would cost to repair or replace the property within a reasonable time following the loss. N.Y. Ins. Law §§ 3404(e), 3404(f)(1)(A). The Second Circuit held that Allstate's policy complied with this requirement. In particular, the court held that because the statute requires payment of actual cash value *or* repair costs (the lesser of the two), Allstate had satisfied the minimum statutory requirements by paying plaintiffs the actual cash value of their damaged property. The court further held that Allstate complied with the terms of the contract itself and was justified in refusing to pay repair costs that were not completed within the 180 day period. In so ruling, the court rejected plaintiffs' argument that the contract required only that the repairs commence (rather than be completed) during the 180 day period. In any event, the court noted, plaintiffs offered no proof that repairs had, in fact, commenced within 180 days. Having found the contract unambiguous in this and all other respects, the Second Circuit affirmed dismissal of the complaint against Allstate in its entirety.

Defense Alert:

Finding That Reservation of Rights Does Not Create a Conflict of Interest, Texas Court Rules That Insurer Is Entitled to Select Policyholder's Defense Counsel

A federal court in Texas ruled that because there was no conflict of interest between a professional liability insurer and the law firm it insured, the insurance company was entitled to select counsel to represent the law firm in an underlying malpractice suit. *Coats, Rose, Yale, Ryman & Lee, P.C. v. Navigators Specialty Ins. Co.*, 2011 WL 5870066 (N.D. Tex. Nov. 21, 2011).

The law firm was sued by former clients alleging malpractice and breach of fiduciary duty. The law firm tendered the suit to Navigators, which agreed to

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defend under a reservation of rights. However, the law firm argued that any attorney selected by Navigators would have a conflict of interest, and thus hired its own counsel and sought reimbursement of defense costs. Navigators refused to pay.

Under Texas law, an insurance company may be precluded from enforcing its contractual right to select counsel if the insurer's reservation of rights creates an actual (rather than potential) conflict of interest. An actual conflict of interest exists "when the facts to be adjudicated in the liability lawsuit are the same facts upon which coverage depend" because under such circumstances, "the attorney appointed by the insurance company would have an incentive to act for the insurance company's interest rather than the insured's interest, and therefore deprive the insured of its right to 'independent counsel.'" Here, the court held that no such conflict existed, finding that the interests of Navigators and the law firm were aligned because both had "the incentive to vigorously contest liability on both [underlying] claims." The court noted that Navigators had explicitly represented that it would not deny coverage for claims based on the policy's dishonesty exclusion. Accordingly, there was no risk that counsel selected by Navigators would seek a finding of fraud rather than mere negligence, and thus no conflict of interest.

As *Navigators Specialty* illustrates, a reservation of rights does not automatically give rise to a conflict of interest sufficient to divest an insurer of its contractual right to control the defense of its insured.

Arbitration Alert:

Consolidation of Arbitrations Is Issue for Arbitration Panel, Not Court, Says Seventh Circuit

The Seventh Circuit ruled that the question of whether multiple arbitrations should be consolidated in a single proceeding must be decided by an arbitration panel, rather than a court. *Blue Cross Blue Shield of Massachusetts, Inc. v. BCS Ins. Co.*, 2011 WL 6382203 (7th Cir. Dec. 16, 2011).

The dispute arose when BCS Insurance Company denied coverage under errors and omissions policies issued to several Blue Cross and Blue Shield plans (the "Plans") in connection with class action suits against the Plans. The Plans demanded arbitration and initiated a consolidated proceeding. Both sides appointed their own party-arbitrators, but failed to agree on a third panel member. Several of the Plans then filed a motion in district court to appoint a neutral arbitrator pursuant to § 5 of the Federal Arbitration Act. In response, BCS filed a petition to "compel a de-consolidated arbitration." The district court ruled that consolidation was a procedural issue to be decided by the arbitration panel. BCS appealed.

The Seventh Circuit dismissed BCS's appeal for want of jurisdiction. The court explained that although BCS captioned its petition as one to "compel" a de-consolidated arbitration pursuant to 9 U.S.C. § 16(a)(1)(B) (which provides an appeal from any order denying a petition to order arbitration), the petition in fact sought to disrupt the already-pending arbitration and have a court decide a procedural issue (consolidation). Therefore, the court reasoned, there was no statutory basis for an appeal. Jurisdictional defects aside, the court additionally noted that even if a valid petition to compel arbitration had been made, the issue of whether a consolidated arbitration was appropriate would be for the arbitration panel to decide, not the court.

BCS Insurance is significant for at least two reasons. First, the decision illustrates the broad powers given to arbitration panels to decide ancillary issues during the pendency of arbitration—without piecemeal review

by a district court—under Seventh Circuit precedent. Citing to another Seventh Circuit ruling, *Trustmark Ins. Co. v. John Hancock Life Ins. Co.*, 631 F.3d 869 (7th Cir. 2011) (discussed in our March 2011 Alert), in which the circuit court reversed a district court ruling disqualifying an arbitrator, the Seventh Circuit noted that once arbitration is underway, parties are not entitled to seek mid-arbitration review. The court stated, "[r]eview comes at the beginning [of arbitration] or the end, but not in the middle." Second, *BCS Insurance* highlights the limits of the Supreme Court's ruling in *Stolt-Nielsen S.A. v. AnimalFeeds International Corp.*, 130 S. Ct. 1758 (2010). In *Stolt-Nielsen*, the Supreme Court ruled that arbitrators may entertain class actions only if the parties had contractually agreed to such procedures. Interpreting *Stolt-Nielsen* narrowly, the Seventh Circuit held that the decision had no application to the question of consolidation of arbitrations. In this context, the court observed that unlike class certification, consolidation of multiple proceedings does not dramatically change the nature of the litigation or arbitration proceedings.

Successor Liability Alert:

Illinois Appellate Court Enforces Contractual Transfer of Rights under Insurance Policies Despite Policies' Anti-Assignment Clause

An Illinois appellate court ruled that a policyholder's transfer of liability insurance benefits to a successor company was valid despite anti-assignment clauses in the relevant policies because the losses at issue had already occurred prior to the transfer. *Illinois Tool Works, Inc. v. Commerce & Industry Ins. Co.*, 2011 WL 6247399 (Ill. Ct. App. Dec. 12, 2011).

Two insurers had issued policies to Binks Manufacturing covering the period from December 1976 to December 1984. In 1998, Binks entered into an asset purchase agreement with Illinois Tool Works, Inc. Under the agreement, Illinois Tool Works was assigned "[t]he benefits, including all rights to defense and indemnity coverage, under any and all policies of liability insurance issued to [Binks] prior to the Closing Date." In 2003, a lawsuit was filed against Binks and Illinois Tool Works alleging, among other things, CERCLA violations. The insurers defended Binks in the action, but refused to defend Illinois Tool Works, claiming that the purported transfer of rights under the insurance policies was ineffective given Binks' failure to comply with the policies' consent-to-assignment clauses. The trial court agreed, and granted judgment on the pleadings in favor of the insurers. The appellate court reversed.

The appellate court ruled that the asset purchase agreement effectively transferred Binks' defense and indemnity rights under the liability policies. The court reasoned that anti-assignment clause notwithstanding, insurer consent is not necessary when the benefits are assigned after a loss has already occurred because "the assignment is essentially the assignment of payment of a claim already accrued, a claim consisting of the right to a defense and indemnification." Here, the covered loss—the property damage—allegedly occurred during the relevant policy periods, long before the transfer of assets. As such, the court concluded, the assignment did not increase the risk to the insurer and did not require the insurers' consent. In reaching its decision, the court made several noteworthy findings. First, the court held that the relevant loss in this context was the alleged contamination of the property, not the filing of the underlying complaint against the policyholder and/or successor company. Second, the court held that because the insurance rights were effectively assigned to Illinois Tool Works, Binks was no longer entitled to a defense from the insurers. The court stated: "The idea that an insurer would have to defend both the transferor and the transferee for the same risk is not sound.… The right cannot both be transferred and retained." Finally, the court acknowledged that there may be cases in which the transfer of pre-assignment losses does increase the risk to the insurers. For example, where a policyholder purports to assign insurance benefits to multiple parties, insurers may be asked

to defend the same action multiple times. Under the court's reasoning, such scenarios would presumably require insurer consent.

Illinois Tool Works comports with other decisions holding that even where a policy contains an anti-assignment clause, coverage for losses that have already occurred may be transferred to another company without the insurer's consent. *See, e.g., Pilkington N. Am., Inc. v. Travelers Cas. & Sur. Co.*, 861 N.E.2d 121 (2006). However, at least one state supreme court has held that insurance companies may bar the assignment of coverage for such pre-assignment losses by utilizing "clear and explicit" policy language to that effect. *See In re Katrina Canal Breaches Litig.*, 2011 WL 1774330 (La. May 10, 2011) (discussed in June 2011 Alert). Furthermore, a number of courts have strictly enforced anti-assignment clauses in the face of policyholder arguments that policy rights have been transferred "by operation of law" rather than by contract. *See, e.g., Ford, Bacon & David, L.L.C. v. Travelers Ins. Co.*, 2011 WL 856642 (5th Cir. Mar. 14, 2011) (discussed in April 2011 Alert); *Lockheed Martin Corp. v Goodyear Tire and Rubber Co.*, 2011 WL 611662 (N.D. Ohio Feb. 11, 2011) (discussed in March 2011 Alert); *Keller Foundations, Inc. v. Wausau Underwriters Ins. Co.*, 626 F.3d 871 (5th Cir. 2010) (discussed in December 2010 Alert). *See also Continental Ins. Co. v. Wheelabrator Technologies, Inc.*, No. 49A02-1010-PL-1110 (Ind. Ct. App. Dec. 6, 2011) (rejecting successor company's attempt to access coverage under predecessor's policies, noting that Indiana Supreme Court has rejected arguments that insurance rights transferred by assignment or by operation of law, and has carved out only narrow exception for losses that are fixed "chose in action" at time of assignment).

Coverage Alert:

Disgorgement Payments to SEC Are Not Insurable Losses, Says New York Appellate Court

Reversing a lower court decision, a New York appellate court ruled that a disgorgement payment to the Securities and Exchange Commission in settlement of fraud-based charges did not constitute an insurable loss under primary and excess professional liability policies. *J.P. Morgan Securities Inc. v. Vigilant Ins. Co.*, 2011 WL 6155586 (N.Y. App. Div. 1st Dep't Dec. 13, 2011).

In 2006, the SEC notified Bear Stearns & Co., Inc. that it intended to initiate proceedings against the company seeking injunctive relief and monetary sanctions for allegedly fraudulent conduct and regulatory violations. Although Bear Stearns denied the allegations, it made an offer of settlement, which the SEC accepted. Without admitting or denying the SEC's findings, Bear Stearns agreed to disgorge $160 million and pay civil penalties in the amount of $90 million. Bear Stearns sought indemnification from its primary and excess professional liability insurers for the disgorgement payment. The insurers refused, arguing that the payment was not an insurable loss and/or was excluded from coverage. Bear Stearns filed an action against the insurers alleging breach of contract and seeking a declaration of coverage. The trial court denied the insurers' motion, finding that because Bear Stearns had neither admitted nor denied guilt, it was entitled to dispute the SEC's findings in insurance coverage litigation.

The appellate court reversed. The court held that the "disgorgement of ill-gotten gains or restitutionary

damages does not constitute an insurable loss." The court held that it was clear, based on the offer of settlement, the SEC Order and other related documents, that the disgorgement payment represented restitution of funds gained through illegal activity, regardless of Bear Stearns' refusal to admit or deny such conduct. Furthermore, the court held that disgorgement payments cannot be re-classified as "compensatory" for insurance coverage purposes simply because part of the disgorgement payment would ultimately be distributed to compensate harmed investors. Where, as here, the primary purpose of the payment is to require a wrongdoer to return illegally obtained proceeds (rather than to compensate victims), insurance coverage is unavailable. Therefore, the court dismissed the claims for coverage against the insurers.

Allocation Alert:

New York Court Endorses Pro Rata Allocation with Pro Ration to Insured for Uninsured Periods

A federal district court in New York adopted a pro rata allocation scheme to divide indemnity costs among insurers for asbestos-related losses, and held that the insured was responsible for its share of indemnity costs for a period of no insurance. The court also held, however, that pro ration to the insured was not appropriate for periods in which insurance was unavailable in the marketplace. *Fulton Boiler Works, Inc. v. American Motorists Ins. Co.*, 2011 WL 6117946 (N.D.N.Y. Dec. 9, 2011).

Under New York and Second Circuit law, indemnity and defense costs are typically allocated on a pro rata basis with pro ration to the insured for periods of under insurance or no insurance. Here, the parties disputed whether the policyholder had obtained insurance for the period from 1949 to 1976. Despite an inability to produce actual policies for this time frame, the policyholder submitted secondary evidence attempting to establish the existence of coverage. Applying a "clear and convincing" standard, the court concluded that the policyholder had failed to meet its burden. The court also rejected the policyholder's argument that the insurers should be equitably estopped from seeking contribution from the policyholder. Under the doctrine of equitable estoppel, an insurer may be barred from denying coverage where it has assumed the defense or indemnification of the policyholder without disclaiming coverage or reserving its rights, and the policyholder has detrimentally relied on such conduct. However, estoppel cannot be invoked to create coverage where it does not otherwise exist, and does not apply where, as here, there was no insurance coverage in the first place. In any event, the court noted, the insurers had repeatedly reserved their right to seek partial indemnification for that time period. The court reached a different conclusion with respect to post-1993 indemnity costs. The court reasoned that because asbestos liability coverage was no longer available at that time, allocation to the policyholder for those years was inappropriate.

The court also issued two significant notice rulings. First, the court held that letters from one insurer to another insurer which had attached copies of underlying complaints, constituted proper notice for the claims referenced in the complaints, but did not constitute blanket notice for the more than 14,000 complaints filed against the policyholder. Similarly, letters from one insurer to another which provided details of claims (such as docket numbers, filing

dates, and names of injured parties) also constituted sufficient notice to the recipient insurer as to the claims specifically referenced. Second, the court held that New York Insurance Law § 3240(d), which requires a written disclaimer of coverage within a "reasonable time" after the insurer receives notice of a claim, applied to contribution claims between insurers. Therefore, to the extent that an insurer sought to avoid its contribution obligations on the basis of late notice, it must have complied with the "reasonable time" requirement set forth in § 3240(d).

Contribution Alert:

Nevada Court Dismisses Insurer's Contribution Claim, Citing Lack of Allegations That Insurers Shared Common Duty to Mutual Insured

A federal district court in Nevada dismissed a complaint against National Fire & Marine Insurance Company seeking contribution for defense and settlement costs in 116 underlying lawsuits and a declaration that National Fire owed a defense in those matters. *Assurance Co. of America v. National Fire & Marine Ins. Co.*, 2011 WL 6181928 (D. Nev. Dec. 13, 2011). Dismissal was warranted, the court held, because the insurer seeking contribution failed to allege any specific property damage, indentify any specific polices, or even claim that National Fire's policies were in effect at the time property damage occurred. Similarly, the complaint failed to allege that the two insurers shared the same level of coverage on the same risk to the same insureds—facts necessary to assert a valid contribution claim. Although the dismissal was without prejudice, the court cautioned that even if the contribution claims were properly pleaded, the court intended to sever the claims rather than allow litigation of all 116 claims in one proceeding. National Fire was represented by Simpson Thacher partners Mary Beth Forshaw and Deborah L. Stein.

Advertising Injury Alert:

Allegations of Harm to a Third Party's Product Do Not Constitute Advertising Injury, Says California Appellate Court

A California appellate court held that a business insurance company did not owe coverage for "advertising injury" where claims against the policyholder alleged only harm to and/or infringement of another's product, rather than infringement of another's advertising ideas. *Oglio Entertainment Group, Inc. v. Hartford Cas. Ins. Co.*, 200 Cal. App. 4th 573 (2d Dist. 2011).

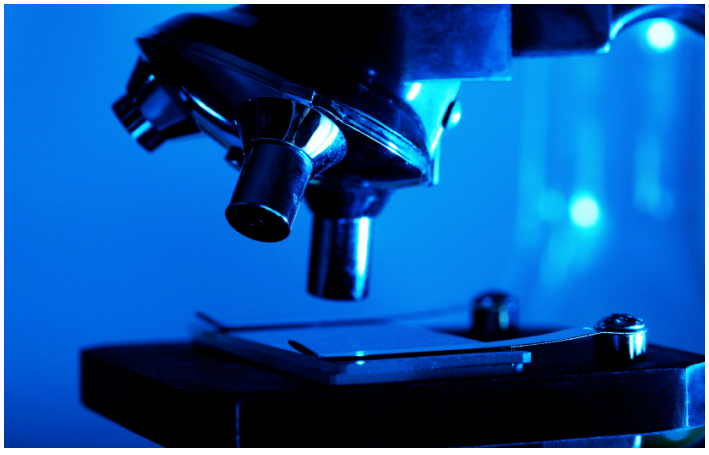
In the underlying complaint, a recording artist alleged that the policyholder, an independent record label, caused the artist to suffer economic harm by hiring and promoting other artists to record similar music in order to "trade on the good will and public recognition" and unfairly compete with the plaintiff recording artist. Plaintiff alleged, among other things, breach of contract, intentional interference with prospective economic advantage and the breach of the covenant of good faith and fair dealing. The music label tendered defense of the suit to Hartford, which disclaimed coverage. Coverage litigation ensued, and the trial court ultimately sustained Hartford's demurrer to the music label's complaint without leave to amend. The appellate court affirmed. The court explained that the allegations in the complaint alleged only harm to and copying of the artist's product, rather than any advertising style or idea in connection with the promotion of that product. As such, there were no allegations of advertising injury, the court concluded. *Oglio* illustrates the critical distinction between injury to a competitor's product and injury to a competitor's style or method of advertising its products—only the latter of which may constitute covered "advertising injury."

Medical Monitoring Alert:

West Virginia Supreme Court Affirms Dismissal of Medical Monitoring Claim

The Supreme Court of Appeals of West Virginia affirmed a grant of summary judgment in favor of defendants in a class action asserting, among other things, a medical monitoring claim. *Acord v. Colane Co.*, 2011 WL 5827610 (W. Va. Nov. 16, 2011). Plaintiffs alleged that the property on which their elementary school had been located was contaminated as a result of waste disposal at the site. According to the complaint, plaintiffs' exposure to toxic chemicals while attending the school increased their risk of contracting serious illnesses. As such, the complaint alleged a cause of action for medical monitoring, as well as claims of negligence, strict liability and public nuisance. Following discovery, defendants moved for summary judgment, which the circuit court granted. The Supreme Court of Appeals affirmed.

In order to assert a medical monitoring claim under West Virginia law, a plaintiff must establish: "(1) that [plaintiff], relative to the general population, has been significantly exposed; (2) to a proven hazardous substance; (3) through the tortious conduct of the defendant; (4) as a proximate result of the exposure, plaintiff has suffered an increased risk of contracting a serious latent disease; (5) the increased risk of disease makes it reasonably necessary for the plaintiff to undergo periodic diagnostic medical examinations different from what would be prescribed in the absence of the exposure; and (6) monitoring procedures exist that make the early detection of a disease possible." Here, the court found that plaintiffs had failed to establish the third and fourth requirements. In particular, the court concluded that the complaint failed to establish any cognizable theory of tort liability against the defendants, and that scientific studies had failed to find any health hazards at the school site.



As discussed in previous Alerts, there is no judicial consensus on whether medical monitoring claims are recognizable, and if so, what elements are necessary to substantiate such claims. Even where such claims are recognized, plaintiffs often encounter several critical obstacles in seeking medical monitoring relief, including in particular issues relating to exposure and causation. Additionally, as discussed in our September 2011 Alert, the practical viability of such actions often turns on class certification, which may prove improper in many medical monitoring claims. *See Gates v. Rohm and Haas Co.*, 2011 WL 3715817 (3d Cir. Aug. 25, 2011) (denying class certification in medical monitoring action because individual issues relating to exposure, causation and the need for medical monitoring predominated over common issues).

Jurisdictional Alert:

Congressional Act Creates Significant Changes to Federal Jurisdictional Statutes

Effective January 6, 2012, the Federal Courts Jurisdiction and Venue Clarification Act of 2011 clarifies, and in some instances changes, the rules governing federal court jurisdiction and venue. Because the Act implements a significant number of changes, litigators are advised to consult the Act and the corresponding Report of the Committee on the Judiciary, which provides a comprehensive explanation of the Act's modifications and revisions. Several noteworthy changes are summarized below.

- *Removal*: Resolving a federal circuit split, the Act holds that each defendant in a case has 30 days from his/her own date of service to seek removal. This provision abrogates case law holding that each defendant had 30 days from the date on which the first defendant was served to seek removal. Notably, the provision does not alter the "rule of unanimity," which requires all properly-joined defendants to consent to removal. The Act also creates a narrow exception to the one-year limitation on removal in diversity actions for cases in which the plaintiff acted in bad faith to prevent removal.

- *Citizenship*: The Act clarifies that resident aliens who are domiciled in the United States are not deemed citizens for diversity jurisdiction purposes. Therefore, a federal court will not have diversity jurisdiction over a case involving two resident aliens domiciled in different states. The Act also clarifies that all corporations (including insurance companies in the context of direct action litigation) are citizens of both their place of incorporation and their principal place of business—an issue that has been the subject of frequent litigation.

- *Supplemental State Law Claims*: The Act eliminates district court discretion to hear unrelated state law claims in a matter that has been removed on the basis of federal question jurisdiction. Under the Act, a district court must sever and remand unrelated state law claims over which it does not have original or supplemental jurisdiction. However, the Act does not affect a district court's ability to exercise supplemental jurisdiction over substantially related state law issues.

- *Amount in Controversy*: The Act clarifies that for diversity jurisdiction purposes, the amount in controversy is determined by the sum demanded in good faith in the initial pleading. However, the Act creates a procedure by which a defendant seeking removal pursuant to diversity jurisdiction may assert an amount in controversy if the plaintiff had not done so in the pleading (i.e., declaratory judgment action) or if applicable state law permits damages in excess of the amount sought by the plaintiff. Under the new provision, a defendant must establish the requisite amount in controversy (an amount in excess of $75,000) by a preponderance of the evidence.

- *Venue*: In an attempt to provide greater uniformity of venue determinations in federal question and diversity cases, the Act clarifies and changes numerous venue rules, including the following: (1) The Act permits a district court to transfer a civil action to any district to which all parties have consented, even if the action could not have been brought in that district as an original matter; (2) the Act eliminates the "local action" rule, which provided that certain real property actions could be brought only in the district in which the property was located; (3) the Act synthesizes venue rules for cases involving federal question jurisdiction and diversity jurisdiction, such that both instances are governed by the same venue provisions; and (4) new provisions in the Act define venue for natural persons, non-resident defendants, and incorporated and unincorporated entities. Notably, the Act does not displace specialized venue rules that govern under various federal statutes.

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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—Chambers USA 2011, Nationwide Insurance: Dispute Resolution: Insurer (quoting a client)

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