Simpson Thacher

Insurance Law Alert

November 2024

"[Simpson Thacher's] expertise ranges from direct insurance coverage of virtually all kinds, through to reinsurance matters and cases relating to insurance companies' business practices."

– *Chambers New York* 2024

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The Tenth Circuit affirmed that an increase in a monthly cost of insurance rate, which stemmed in part from the insurer's loss of reinsurance, did not violate the terms of the policy. *PHT Holding I LLC v. Sec. Life of Denver Ins. Co.*, 2024 U.S. App. LEXIS 28834 (10th Cir. Nov. 13, 2024). (Click here for full article)

Louisiana Supreme Court Answers Certified Questions Relating To Arbitration Of Insurance Disputes

The Louisiana Supreme Court ruled that a statutory amendment allowing forum or venue selection clauses in certain types of insurance contracts did not implicitly repeal Louisiana's statutory prohibition of arbitration clauses in insurance contracts. *Police Jury of Calcasieu Par. v. Indian Harbor Ins. Co.*, 2024 La. LEXIS 1582 (La. Oct. 25, 2024). (Click here for full article)

Simpson Thacher News

Click here to read more about the Firm's insurance-related news.

Florida Court Rules That Opioid Suits Do Not Allege Damages "Because Of Bodily Injury"

HOLDING

A Florida district court ruled that injuries alleged in underlying opioid suits brought by government entities against a pharmacy did not constitute damages "because of bodily injury," as required by the applicable policies. *Publix Super Mkts., Inc. v. Ace Prop. & Cas. Ins. Co.*, 2024 U.S. Dist. LEXIS 195956 (M.D. Fla. Oct. 29, 2024).

BACKGROUND

Publix, a supermarket chain that operates pharmacies, was named as a defendant in suits seeking damages related to the alleged unlawful sale of opioids without effective controls against diversion into illegal markets. The underlying suits, brought by various municipalities, also alleged that Publix knew or should have known that its conduct adversely affected the safety and welfare of local communities. In particular, the suits alleged that Publix's conduct resulted in an increase of emergency medical responses to overdoses and drug-related crimes, and the expenditure of significant resources on social programs relating to opioid abuse, among other things.

Publix sought defense and indemnity from its tower of insurers. When none of the insurers agreed to defend or indemnify, Publix sued, seeking a declaration of coverage. Thereafter, Publix filed a motion for partial summary judgment as to certain policies. The court denied the motion and issued an order for Publix to show cause as to why summary judgment should not be granted in favor of the insurers.

DECISION

Addressing a preliminary matter, the court ruled that Publix's summary judgment motion was ripe for adjudication under federal Constitutional standards. Courts have used different tests for ripeness with respect to disputes over insurance coverage under excess policies. Some courts have concluded that a coverage dispute is ripe when the excess insurer either denies coverage or formally declares that it has no duty to defend, regardless of whether the underlying policy has been exhausted. Other courts have held that ripeness for an excess insurance declaratory judgment action turns on the satisfaction of two elements: (1) a true dispute regarding coverage, and (2) a likelihood that resolution of the dispute will have a "tangible impact on defendants' obligations." The court adopted the latter standard, finding it more consistent with Eleventh Circuit precedent.

With respect to the first prong, the insurers argued that the motion was unripe because Publix had not shown the exhaustion of self-insured retentions (SIRs), a condition precedent to coverage. Rejecting this assertion, the court concluded that a justiciable controversy existed because all the insurers named in the motion for summary judgment had affirmatively denied coverage, thereby creating a "true dispute."

As to the second prong, the court ruled that resolution of the dispute would likely have a "tangible impact on the parties." Although it deemed the question a close call given that Publix had not paid any judgments or settlements in the underlying case and because defense costs did not count towards the exhaustion of underlying policies or the Druggists Policy's SIR, the court concluded that "on balance, it is likely that a ruling on the merits will have a tangible impact on the parties with respect to at least some of the excess policies." More specifically, the court emphasized that some layers of insurance would be implicated after $2.5 million or $5 million in settlement or judgments, and that Publix was facing dozens of suits and had already reached a settlement in principle in at least one of them. For these reasons, the court deemed the dispute ripe.

With respect to the substantive coverage issue, Publix argued that the policies provided coverage because the underlying suits included allegations relating to injury, sickness, disease and death related to opioid use. Publix further claimed that policy language referring to damages "claimed by any person or organization for care, loss of services, or death resulting at any time from the bodily injury" indicated an intention to provide coverage for claims brought by government entities for opioid-related harms. Alternatively, Publix asked the court to find the phrase "because of bodily injury" ambiguous and to construe it in favor of coverage.

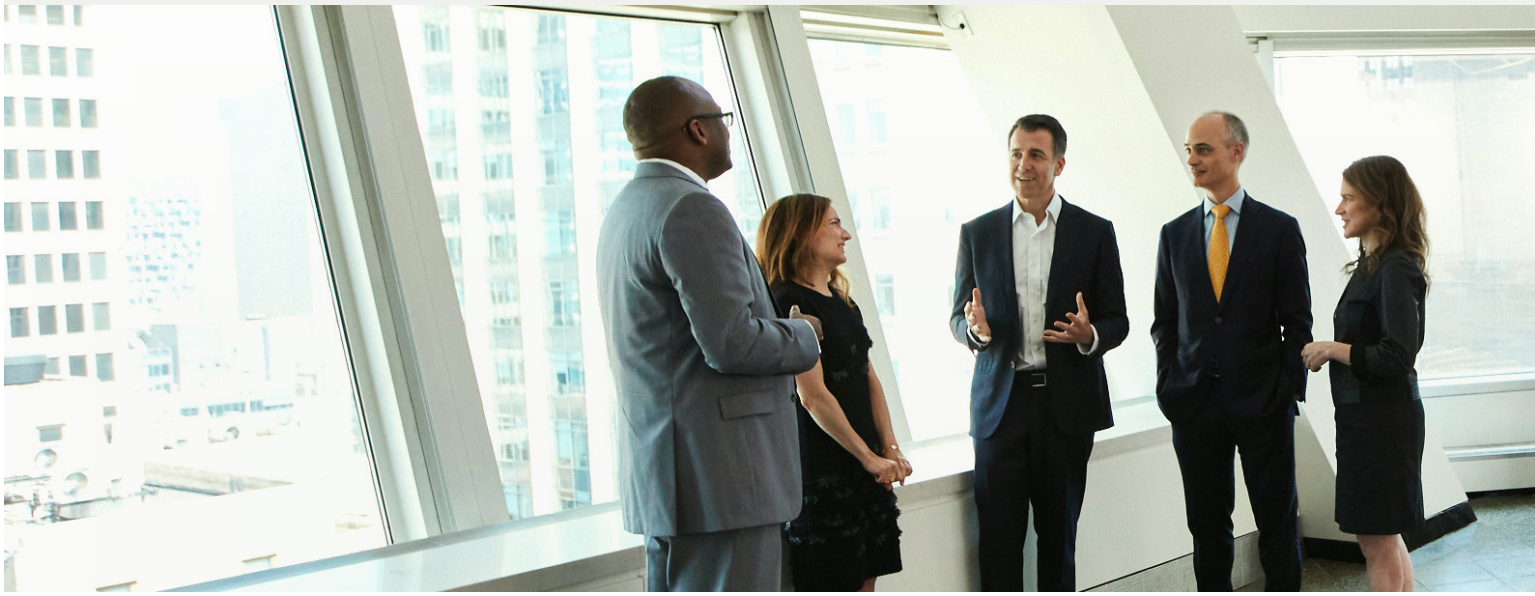
Rejecting these assertions, the court ruled that the injuries alleged in the underlying suits are not damages "because of bodily injury." As the court noted, Florida law interprets "because of" to require a direct causal connection. The court concluded that the causal connection between the injuries alleged and the damage sought in the underlying opioid suits was too attenuated to meet that standard. Emphasizing that the suits alleged, among other things, public nuisance in the form of "severe and far-reaching public health, social services, and criminal justice consequences," the court ruled that there was no direct causal connection between the damages the plaintiffs sought and any individual bodily injuries.

Finally, the court rejected Publix's argument that the addition of a specific opioid exclusion in later policies indicated that the earlier policies were intended to include coverage for underlying opioid claims. As the court stated: "An exclusion, or lack thereof, cannot be relied upon to create coverage where the plain language of a policy demonstrates that coverage does not exist."

COMMENTS

Publix aligns with other decisions holding that underlying opioid suits brought by government entities do not allege damages because of bodily injury. *See Westfield Nat'l Ins. Co. v. Quest Pharm., Inc.*, 57 F.4th 558 (6th Cir. 2023); *Acuity v. Masters Pharm., Inc.*, 205 N.E.3d 460 (Ohio 2022); *ACE Am. Ins. Co. v. Rite Aid Corp.*, 270 A.3d 239 (Del. 2022); *Allied Prop. Cas. Ins. Co. v. Bloodworth Wholesale Drugs, Inc.*, 2024 U.S. Dist. LEXIS 55499 (M.D. Ga. Mar. 27, 2024).

Simpson Thacher represents St. Paul Fire & Marine Insurance Company in this matter.



Fourth Circuit Affirms That Theft Of Cryptocurrency Is Not A "Direct Physical Loss" Under Homeowner's Policy

HOLDING

The Fourth Circuit affirmed a district court's dismissal of a policyholder's breach of contract suit, finding that the homeowner's policy did not cover the theft-related loss of cryptocurrency. *Sedaghatpour v. Lemonade Ins. Co.*, 2024 U.S. App. LEXIS 26924 (4th Cir. Oct. 24, 2024).

BACKGROUND

The policyholder owned cryptocurrency stored on a "hot wallet," a virtual storage option on a third-party server. When he realized that his cryptocurrency, worth $170,424.67, was stolen, he filed a claim with his property insurer. The insurer paid $500, the limit under a provision related to loss "resulting from theft or unauthorized use of an electronic fund transfer card or access device used for deposit." The homeowner sought coverage for the remaining amount of the loss, which the insurer denied as outside the scope of policy coverage. The homeowner sued and the insurer moved to dismiss based on the homeowner's failure to allege "direct physical loss." The district court granted the motion and the Fourth Circuit affirmed.

DECISION

Addressing this matter of first impression under Virginia law, the district court ruled that the loss of cryptocurrency did not constitute a "direct physical loss." *Ali Sedaghatpour v. Lemonade Ins. Co.*, 654 F. Supp. 3d 525 (E.D. Va. 2023). The court explained: "[C]ryptocurrency, by its nature, exists only virtually or digitally and has no physical or tangible existence. It follows, therefore, that the policy does not cover loss or theft of cryptocurrency because the loss or theft does not constitute a 'direct *physical* loss' to plaintiff's property."

The district court rejected the homeowner's assertions that the term "physical" was ambiguous and that the inclusion of a cryptocurrency exclusion in later policies indicated an intent to cover cryptocurrency losses under the present policy. As the court noted, a policy is not ambiguous simply because an insurer later amends coverage or exclusion provisions.

The Fourth Circuit affirmed the district court decision.

COMMENTS

Faced with a nearly identical fact pattern, a California district court reached the same conclusion in *Burt v. Travelers Com. Ins. Co.*, 621 F. Supp. 3d 1049 (N.D. Cal. 2022). The decisions in *Sedaghatpour* and *Burt* are consistent with cases involving the loss of computer data. In numerous cases, courts have concluded that the loss of non-physical data, without accompanying damage to computer systems, does not constitute direct physical loss within the meaning of a first-party property policy.

District Of Columbia Court Rules That SEC Subpoena Does Not Trigger Coverage Under D&O Policies

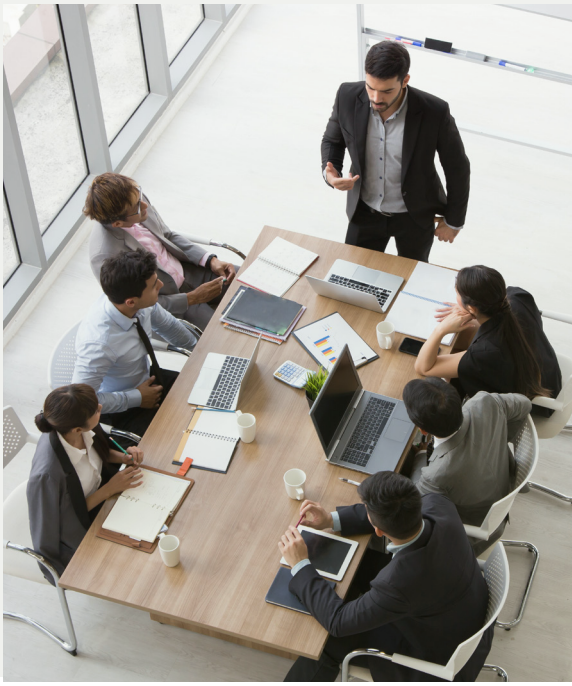
HOLDING

A district court for the District of Columbia ruled that a subpoena issued to an employee does not trigger a duty to defend absent allegations of wrongful conduct against that employee, separate and apart from claims against the insured company. *Fed. Home Loan Mortg. Corp. v. Twin City Fire Ins. Co.*, 2024 U.S. Dist. LEXIS 203703 (D.C. Dist. Ct. Nov. 8, 2024).

BACKGROUND

Freddie Mac, a shareholder-owned, government-sponsored entity that buys and sells mortgages, was named as a defendant in a securities class action in 2007. Over the next few years, it was also the subject of numerous civil suits arising from alleged misrepresentations related to its exposure to subprime mortgages, capital adequacy, risk control, and other business practices. In 2008, the SEC initiated an investigation into Freddie Mac's operations and in 2009 issued an "Order Directing Private Investigation and Designating Officers to Take Testimony in the Matter of Freddie Mac." According to the pleadings, the SEC thereafter served subpoenas on Freddie Mac employees, seeking documents and interviews. Freddie Mac alleged that in March 2011, the SEC issued "Wells Notices" stating that the SEC was recommending enforcement proceedings against the company and three employees. In 2011, the SEC ended its investigation, reached a non-prosecution agreement with Freddie Mac and filed suit against the three Freddie Mac employees.

Freddie Mac sought coverage for over $145 million it allegedly spent defending the civil suits, the SEC investigation and the SEC lawsuit. The primary insurer as well as several excess insurers paid their policy limits, which amounted to approximately $85 million. Freddie Mac filed suit against certain higher level excess insurers, seeking a declaration of coverage and damages for breach of contract.



Freddie Mac filed a motion for partial judgment on the pleadings on two issues: (1) that the receipt of an SEC subpoena by a Freddie Mac employee is sufficient to trigger coverage regardless of whether the SEC is investigating the company or the employee individually, and (2) that the excess insurers cannot refuse to pay on the basis that underlying insurance was not

properly exhausted by contesting a lower-layer insurer's coverage determination. The court denied Freddie Mac's motion as to the first issue but granted it as to the second.

DECISION

The court agreed with the insurers that for an SEC subpoena to trigger coverage, Freddie Mac must demonstrate that the employee recipient of the subpoena was the subject of an SEC investigation for a wrongful act. The policies' "Organization Insurance" section provided two types of coverage to Freddie Mac: (1) entity coverage, which pertained to claims made against Freddie Mac as a company, and (2) "indemnified employee coverage," which applied to costs resulting from "a Claim made against an Insured Person . . . for any Wrongful Act of such Insured Person."

The policies defined "Claim" as:

> a civil, criminal, administrative or regulatory investigation of an Insured Person:
>
> (i) Once such Insured Person is identified in writing by such investigating authority as a person against whom a proceeding described . . . [elsewhere] may be commenced; or
>
> (ii) in the case of an investigation by the SEC or a similar state or foreign government authority, after the service of a subpoena upon such Insured Person.

Freddie Mac argued that the second sub-section should be interpreted to mean that an SEC subpoena of an employee is automatically a "Claim" that triggers coverage. Rejecting this assertion, the court ruled that absent an investigation of the employee who is the subject of the subpoena (separate and apart from any investigation of Freddie Mac as a company), there is no coverage under the indemnified employee coverage provision. The court reasoned that this interpretation comports with "the context of the entire policy, which distinguishes between investigations of Freddie Mac employees and Freddie Mac the entity." In so ruling, the court also noted that on the pleadings alone, it was unclear whether the subpoenaed employees were themselves under investigation or whether the subpoenas even alleged a "Wrongful Act" so as to constitute a "Claim" in the first place.

With respect to the second issue, the court ruled that the higher-level excess insurers could not challenge a lower-layer insurer's payment as outside the scope of coverage. Ruling on this matter of first impression under Virginia law, the court concluded that absent indications of fraud or bad faith, excess insurers generally cannot avoid liability by contesting payments made at lower levels of insurance coverage.

COMMENTS

The defendant insurers argued that they were not actually second-guessing the decisions of the lower-level insurer, which made an "unallocated compromise payment" to Freddie Mac. Instead, they argued that they were contesting Freddie Mac's decision to allocate that payment to certain uncovered losses. The court noted that the caselaw in this context is "less clear," but concluded that "the same policy justifications bear on that situation as where an underlying insurer designates a specific purpose for a payment."

Additionally, the court held that standard exhaustion-related policy language—such as the provision in one policy stating that the "coverage hereunder shall attach only after all Underlying Insurance has been exhausted by actual payment of claims or losses thereunder"—was insufficient to override the default rule that excess insurers cannot challenge underlying insurers' payments.

Tenth Circuit Rules That Life Insurer's "Cost Of Insurance Rate" Increase Does Not Violate Policy

HOLDING

The Tenth Circuit affirmed that an increase in a monthly cost of insurance ("COI") rate, which stemmed in part from the insurer's loss of reinsurance, did not violate the terms of the policy. *PHT Holding I LLC v. Sec. Life of Denver Ins. Co.*, 2024 U.S. App. LEXIS 28834 (10th Cir. Nov. 13, 2024).

BACKGROUND

PHT Holding owned universal life insurance policies issued by Security Life. When Security Life originally priced the policies, it had reinsurance that that covered 90% of the death benefits payable under the policies. But when reinsurance premiums subsequently increased, Security Life's parent company cancelled some of the reinsurance policies, which resulted in Security Life "recapturing" certain liabilities it had previously ceded to reinsurers. With a resulting loss on its balance sheet, Security Life thereafter increased certain policies' COI rates—used to calculate monthly deductions from policyholders' accounts—which helps Security Life fund the payout of any death benefits. Security Life implemented a 9.25% increase in the COI rate applicable to one line of policies and a 42.3% increase in the COI rate applicable to another line of policies.

Advance Trust, the predecessor to PHT and owner of five policies that were affected by the increase, filed a putative class action against Security Life. The complaint alleged breach of contract based on three theories: (1) breach of the cost of insurance provision by relying on impermissible factors in setting the new COI rates, (2) breach of the nonparticipating provisions by increasing COI rates to recoup past losses, and (3) breach of the cost of insurance provision by raising COI rates on a non-uniform basis across all universal life policy lines.

A Colorado district court granted summary judgment to Security Life on the first two bases but denied it on the third. Thereafter, the parties settled the third issue and the district court entered final judgment as to the first two issues. PHT appealed only the ruling as to the second issue (breach of the nonparticipating provisions).

DECISION

Because PHT did not appeal the district court's ruling on the cost of insurance provision, the Tenth Circuit accepted the district court's conclusions that (1) the provision gives

Security Life "substantial discretion" to set COI rates (so long as the company considers "certain mortality factors" and rates are uniformly raised across premium classes and below established maximums), and (2) Security Life's increase in the COI rates did not violate the provision. The Tenth Circuit explained that because the cost of insurance provision is the only provision in the policy that addresses Security Life's authority to set COI rates, the fact that Security Life complied with that provision when it raised COI rates is fatal to PHT's appeal.

The nonparticipating provisions at issue on appeal state only that the policy is "nonparticipating," meaning that it "does not participate in [the insurer's] surplus earnings" and "is not eligible for dividends." The Tenth Circuit noted that these provisions are unambiguous, entirely distinct from and unrelated to the cost of insurance provisions and provide only that the policyholders do not receive dividends. As such, the court held the nonparticipating provisions do not restrict Security Life's ability to implement COI rate increases.

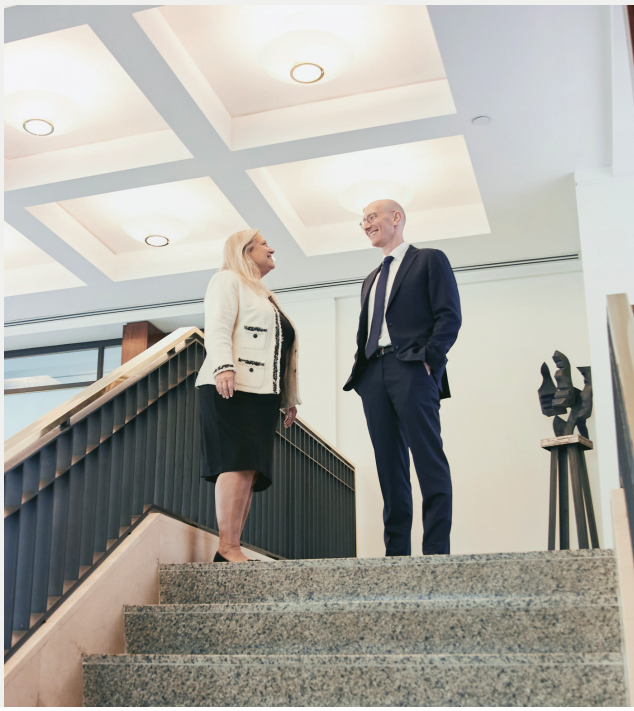
COMMENTS

The court pointed to the conceptual distinction between participating and nonparticipating insurance as further support for its conclusion that nonparticipating provisions do not concern COI rates. Participating insurance pays dividends to policyholders, which represents a share of the insurer's surplus earnings, whereas nonparticipating insurance makes no such payments. Thus, an insurer's profits or losses (such as Security Life's losses stemming from its reduction in reinsurance) are entirely irrelevant for a nonparticipating policy. However, where, as here, a cost of insurance provision in a nonparticipating policy gives the insurer discretion to set the COI rate, the insurer may consider its losses when adjusting the COI rate.

Louisiana Supreme Court Answers Certified Questions Relating To Arbitration Of Insurance Disputes

HOLDING

The Louisiana Supreme Court ruled that a statutory amendment allowing forum or venue selection clauses in certain types of insurance contracts did not implicitly repeal Louisiana's statutory prohibition of arbitration clauses in insurance contracts. *Police Jury of Calcasieu Par. v. Indian Harbor Ins. Co.*, 2024 La. LEXIS 1582 (La. Oct. 25, 2024).



BACKGROUND

Calcasieu Parish, a political subdivision of Louisiana, sustained hurricane-related damage in 2020. In a lawsuit that ensued, Calcasieu alleged that a syndicate of foreign and domestic insurers underpaid claims and made untimely payments. The only two foreign insurers were dismissed from the suit and the remaining domestic

insurers moved to compel arbitration pursuant to arbitration clauses in the foreign insurers' policies with Calcasieu.

A Louisiana district certified the following three questions to the Louisiana Supreme Court:

(1) Whether the 2020 amendment adding Subsection D (Act No. 307 § 1 of 2020) to La. R.S. 22:868 to allow forum and venue selection clauses in limited circumstances implicitly repealed Subsection A's longstanding prohibition of arbitration clauses in all insurance policies in Louisiana?

(2) Whether La. R.S. 9:2778 applies to all contracts with political subdivisions of the State, including insurance contracts, and thereby prohibits venue or arbitration outside of Louisiana or the application of foreign law in claims involving the State and its political subdivisions?

(3) If arbitration continues to be prohibited in all insurance policies delivered or issued for delivery in Louisiana, whether a domestic insurer may resort to equitable estoppel under state law to enforce an arbitration clause in another insurer's policy in contravention of the positive law prohibiting arbitration in La. R.S. 22:868 (A)(2); and related, whether estoppel can be applied to political subdivisions without satisfying the distinct and heightened standard otherwise required by the Louisiana Supreme Court for application of estoppel to public bodies?

DECISION

The court answered the first question in the negative, ruling that the amendment of La. R.S. 22:868 to allow for forum and venue selection clauses in certain circumstances does not constitute an implicit repeal of the state ban on the arbitration of insurance disputes set forth in the body of that statute. In so ruling, the court emphasized the distinction between the concepts of venue and forum on the one hand, and jurisdiction on the other, noting that the former relates to the location of litigation, whereas the latter concerns the method of dispute resolution. Thus, the court found no conflict between the amendment

allowing forum or venue selection and the existing statutory language prohibiting arbitration.

The court answered the second question in the affirmative, ruling that La. R.S. 9:2778 applies to the insurance policies at issue so as to preclude venue or arbitration outside the state of Louisiana. The determinative issue for this question was whether the insurance policies constituted "public contracts" within the meaning of the statute. In finding that they did, the court reasoned that an insurance policy is indisputably a contract, and that a contract with a political subdivision is a "public contract."

The court answered the first part of the third question in the negative, ruling that a domestic insurer may not use equitable estoppel to enforce an arbitration clause in another insurer's policy in contravention of state statutory law. The court cited the "anti-arbitration" nature of state statutory law and Louisiana's disfavor of estoppel as a "doctrine of last resort." Having reached that conclusion, the court deemed the second prong of the third certified question to be moot.

COMMENTS

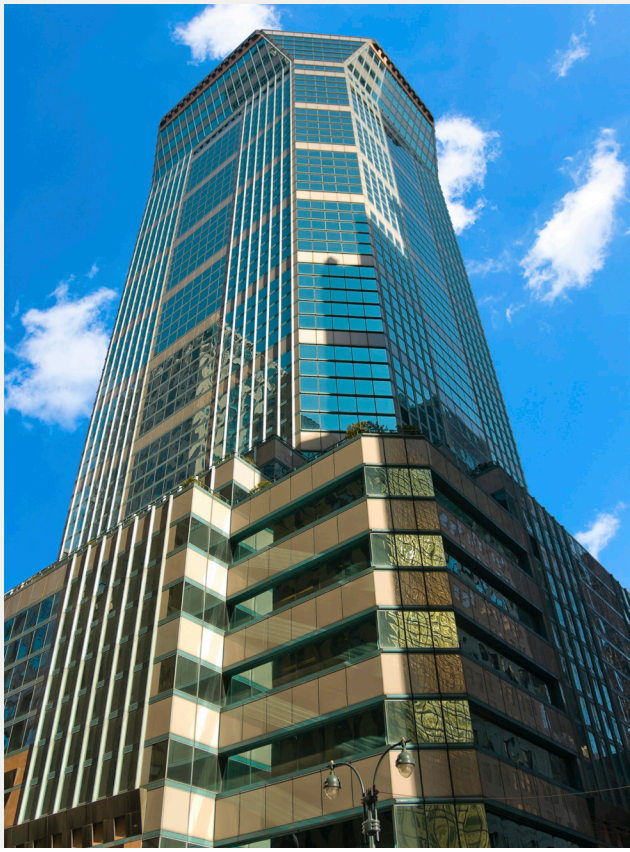
The Fifth Circuit reached a contrary conclusion in *Bufkin Enters., L.L.C. v. Indian Harbor Ins. Co.*, 96 F.4th 726 (5th Cir. 2024). There, the court ruled that non-signatory domestic insurers may use the doctrine of equitable estoppel to compel arbitration pursuant to policies with foreign insurers under the Convention on the Recognition and Enforcement of Arbitral Awards of 1958. The Louisiana Supreme Court deemed that ruling "flawed" and "not supported by Louisiana law."

Simpson Thacher News

Andy Frankel and Summer Craig authored the United States chapter in the seventh edition of *Lexology In Depth: Insurance Disputes* (formerly *The Insurance Disputes Law Review*). The chapter provides insights into significant insurance-related issues in U.S. courts, including equitable reimbursement of defense costs, the application of a 'bump-up' exclusion in a D&O liability insurance policy, an insurer's right to intervene in a policyholder's bankruptcy proceeding, and the availability of coverage for computer system failure under a cyber risk insurance policy.

Andy was profiled by Law360 as an Insurance "MVP" for 2024. Law360 highlighted Andy's successes "represent[ing] insurers in complex coverage disputes over mass tort litigation, including a PFAS case, talc injury claims against Johnson & Johnson and thorny receivership issues in South Carolina asbestos litigation" among the reasons for his selection.

Summer Craig was recently elevated to Partner, effective January 1, 2025.



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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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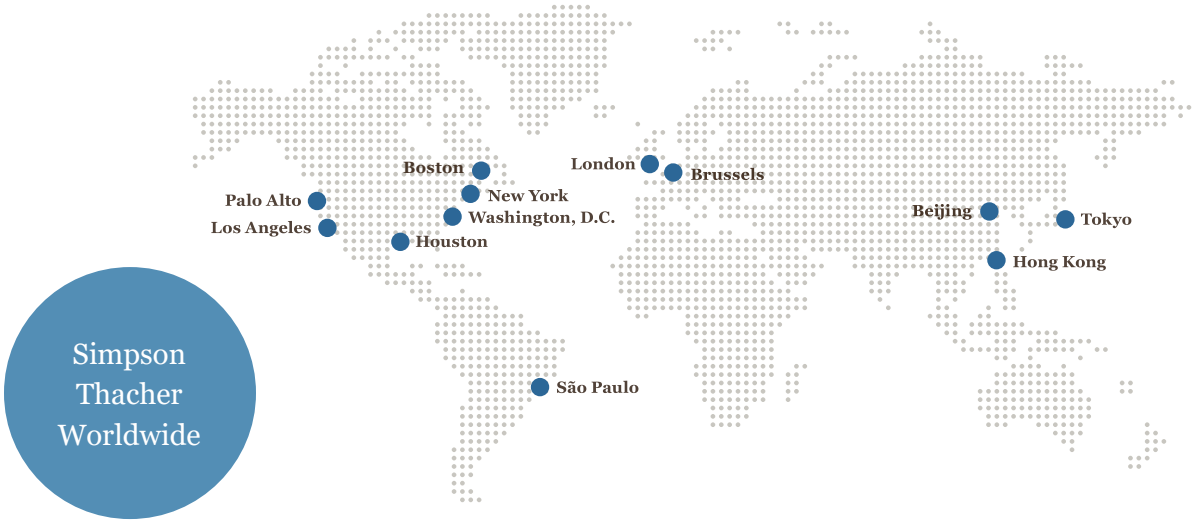

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