Insurance & Reinsurance

CLARK HILL

www.clarkhill.com

BRIEFING

Summer 2013

Supreme Court Restricts Applicability of "Exceeded Powers" Basis To Vacate Arbitral Award

SUMMARY: In *Oxford Health Plans LLC v. Sutter*, 133 S. Ct. 2064 (June 10, 2013), the U.S. Supreme Court ruled that an arbitrator had not "exceeded [his] powers" under § 10(a)(4) of the Federal Arbitration Act ("FAA") in ruling that a contract's arbitration clause required class action claims to be arbitrated.

John Sutter, a pediatrician, entered into a contract with Oxford Health Plans, a health insurance company. He agreed to provide medical care to members of Oxford's network, and Oxford agreed to pay for those services at prescribed rates. When a dispute arose concerning whether Oxford had made the required payments, Sutter filed suit on behalf of himself and a proposed class of other physicians who also had contracts with Oxford. Oxford moved to compel arbitration, relying on the following arbitration clause:

> No civil action concerning any dispute arising under this Agreement shall be instituted before any court, and all such disputes shall be submitted to final and binding arbitration.

The court granted the motion, and the dispute was sent to arbitration. The parties agreed that the arbitrator should decide whether their contract authorized class arbitration, and he ruled that it did. The arbitrator concluded that the arbitration clause obligated the parties to arbitrate the "same universal class of disputes" that it barred the parties from bringing "as civil actions." He held that the intent of the arbitration clause was "to vest in the arbitration process everything that is prohibited from the court process." Since class action is a type of civil action that could be brought in court, the arbitrator concluded it was within the scope of disputes covered by the arbitration clause.

Oxford filed a motion in federal court to vacate the arbitrator's decision on the grounds that he had exceeded his powers under § 10(a)(4) of the FAA. The trial court denied the motion, and the Third Circuit affirmed. The Supreme Court granted *certiorari* to address a split in the federal circuit courts on whether § 10(a)(4) allows a court to vacate an arbitral award in similar circumstances. The Court affirmed the Third Circuit's decision.

The Supreme Court framed the issue for decision as "whether the arbitrator (even arguably) interpreted the parties' contract, not whether he got its meaning right or wrong." The Court began by noting the limited scope of judicial review of an arbitrator's decision, stating that it is not enough to show the arbitrator committed an error, "even a serious error." Because the parties bargained for the arbitrator's construction of their agreement, an arbitral decision, even arguably construing or applying the contract, must stand regardless of a court's view of its merits. A court may overturn an arbitrator's determination only if he acts outside the scope of his contractually delegated authority by issuing an award that simply reflects his own notions of economic justice rather than drawing its essence from the contract.

In this case, the Court found that the arbitrator had focused on the language of the arbitration clause

CONTINUED ON PAGE 2

Arizona

Delaware

Illinois

New Jersey

Michigan

Pennsylvania

West Virginia

Washington, DC

Inside this Briefing

Supreme Court Restricts Applicability of "Exceeded Powers" Basis To Vacate Arbitral Award

CONTINUED FROM PAGE 1

in determining what disputes were to be resolved by arbitration and in concluding that class action claims were covered by the agreement to arbitrate. Since the arbitrator construed the contract, the Court ruled that sufficed to show he had not exceeded his powers. Oxford chose arbitration, and it must live with that choice, the Court said.

The Court broadly hinted it thought the arbitrator had incorrectly interpreted the contract in deciding the arbitration clause encompassed class actions. But under § 10(a)(4), the question for a court is not whether the arbitrator construed the parties' contract correctly, but whether he construed it at all. The Court held that § 10(a)(4) permits courts to vacate an arbitral decision only when the arbitrator "strayed from his delegated task of interpreting a contract, not when he performed that task poorly." The Court also said that "convincing a court of an arbitrator's error – even his grave error – is not enough" so long as the arbitrator was arguably construing the contract. "The arbitrator's construction holds, however good, bad, or ugly."

The Court stated it is the arbitrator's construction of the contract which was bargained for, and the potential for an arbitrator to make mistakes is the price for agreeing to arbitration. Courts have no business overruling such constructions simply because their interpretation of the contract is different from the arbitrator's.

It was critically important to the Court's decision that the parties had agreed the arbitrator should decide whether their contract authorized class arbitration. The Court noted it would have faced a different issue if Oxford had argued the availability of class arbitration was not an issue that was covered by the arbitration clause since, the Court said, "gateway" issues, including whether parties have a valid arbitration agreement or whether a certain type of dispute is covered by that agreement, are presumptively for courts to decide.

IMPORT OF DECISION: This decision from the U.S. Supreme Court reinforces the well-known point, in most emphatic and even colorful terms, that it is very difficult to overturn an arbitrator's decision. Even if an arbitrator wrongly construes a contract, an arbitral award will not be vacated on the grounds that the arbitrator "exceeded [his] powers" under § 10(a)(4) of the FAA.

After First Arbitration Award Was Vacated As Irrational Because Arbitrators Ignored Contract Provision And Granted Relief Not Sought By Either Party, Court Confirms Second Award Concluding It Was Rational And Reasonable

SUMMARY: Parties to a reinsurance contract engaged in an arbitration that resulted in an award a federal district court concluded disregarded a key provision of the contract and granted relief neither party had sought. The court vacated the award. The parties then re-arbitrated their dispute. The second arbitration panel (different from the first) issued an award agreeing with one party's interpretation of the agreement and disagreeing with the other's. The parties then applied to the federal court in the Eastern District of Pennsylvania to review the second award. The court confirmed the award, contrasting it with the earlier "irrational" award, because it drew its essence from the contract.

In *Platinum Underwriters Bermuda, Ltd. v. Excalibur Reinsurance Corp.*, Misc. No. 12-70, (E.D. Pa. July 15, 2013), a petition to confirm and a counter-petition to vacate were filed by the parties, asking the court for a second time to review an arbitration award arising from a reinsurance agreement entered into between Excalibur, formerly known as PMA Capital Insurance Company, the reinsured, and Platinum, the reinsurer. The parties disputed the application of the agreement's "experience account" and "deficit carry forward" provisions. The experience account tracked the premium paid by Excalibur to Platinum. As claims came due, the reinsured debited the account. If the account became depleted, the reinsurer was required to pay any remaining obligations from its own funds. The deficit carry forward provision allowed Platinum to "carry forward" to a subsequent year any loss incurred in a prior year by applying funds remaining in the subsequent year's experience account to offset losses from the earlier year. The reinsurance agreement stated that upon commutation, Platinum would relinquish to Excalibur any balance remaining in the experience account less any projected paid loss deficit.

When a disagreement arose over the operation of the agreement's experience account and deficit carry forward provisions, the parties engaged in arbitration. In the first arbitration, the arbitrators issued an award that deleted the deficit carry forward provision from the agreement and ordered Excalibur to immediately pay $6 million to Platinum (relief Platinum had not specifically sought). The arbitrators offered no reasoning or explanation for

their decision. Excalibur's petition to vacate the award was granted by the trial court which held that the award could not rationally be derived from the contract. The Third Circuit affirmed.

The parties then engaged in a second arbitration regarding the operation of the deficit carry forward provision and Platinum's rights to retain certain funds upon commutation. Following a hearing, the arbitration panel issued an award interpreting and applying the deficit carry forward provision and determining the parties' respective rights upon commutation. The award provided that upon commutation, Platinum was entitled to retain 25% of the deficit under an earlier contract before the remainder of the experience account under a later contract was relinquished to Excalibur. This required Excalibur to pay monies to Platinum which then brought an action in the Eastern District of Pennsylvania seeking to confirm the award. Excalibur requested that it be vacated.

The court concluded that the Convention on the Recognition and Enforcement of Foreign Arbitral Awards applied because the award arose from a commercial relationship between a Bermuda citizen (Platinum) and a U.S. citizen (Excalibur). The court considered whether the award should be vacated on the grounds that "the arbitrators exceeded their powers" under 9 U.S.C. § 10(a)(4). Discussing relevant case law, the court noted that judicial review of arbitration awards is extremely deferential and that a court cannot vacate an award simply because it disagrees with the arbitrator's decision. Rather, to do so, the court must conclude there is absolutely no support in the record justifying the award which the court must find to be completely irrational.

The court said that Excalibur challenged one portion of the award on the basis that it was too literal an interpretation of the contract and another portion on the grounds it was not literal enough. The court observed that it could not vacate an award for over or under "literality," but only for irrationality. The court reviewed the arbitrators' decision and concluded they had rationally interpreted the agreement's provisions.

The court then contrasted the two arbitration awards. In the first award, the arbitrators not only eliminated a key contractual provision (the deficit carry forward provision), "they appeared to have conjured their award from the vapors" since neither party had asked the arbitrators to remove that provision or to award Platinum an immediate payment. In the second award, however, the arbitrators accepted the contractual interpretations Platinum urged and rejected those advocated by Excalibur. The arbitrators did not eviscerate the contract, but grounded their decision in the language of the agreement. In short, the court concluded, the second award drew its essence from the contract. Accordingly, the court confirmed the award.

IMPORT OF DECISION: The two decisions evidence the limits of arbitrators' authority, on the one hand, and the restrictions applicable to judicial review of arbitral awards, on the other. As long as arbitrators interpret a contract, their decision will be upheld, even if they reach the wrong conclusion. If, however, arbitrators seek to effectuate their own notion of "rough justice," which has no relationship to any contractual provision, their award may be subject to being vacated.

Sixth Circuit Rules Insurer Not Liable For Insured's Pre-Tender Legal Fees

SUMMARY: In *AMI Entertainment Network, Inc. v. Zurich Am. Ins. Co.*, 2013 FED App. 0504N (6th Cir. 2013), the Sixth Circuit Court of Appeals affirmed the district court's grant of summary judgment in favor of an insurer, holding that where the insured did not notify the insurer about a suit against the insured for 16 months, the insurer was not required to pay defense fees and costs the insured incurred before notice to the insurer because the policy squarely supported the insurer's lack of liability for such fees and costs.

In July 2010, AMI Entertainment Network, Inc. ("AMI") was sued in Michigan state court by RDI Of Michigan, Inc. ("RDI") ("RDI Suit"). RDI alleged that AMI's executives made disparaging remarks in 2008 about RDI's ownership of a license to distribute a video-poker gaming product. Between July 2010 and November 1, 2011, AMI incurred approximately $1,300,000 in defense fees and costs defending itself against the RDI Suit in both state and federal court.

On November 1, 2011, AMI tendered the suit to its liability insurance carrier, Zurich American Insurance Company ("Zurich"), and requested a defense and indemnity. By letter dated December 20, 2011, Zurich agreed to defend on a going-forward basis, but specifically disclaimed liability for fees and costs AMI incurred to defend itself against the RDI Suit prior to November 1, 2011, when the insured provided notice to Zurich ("Pre-Tender Fees").

AMI filed suit against Zurich in May 2012 in the Federal District Court for the Eastern District of Michigan, alleging Zurich's breach of contract for failing to pay the Pre-Tender Fees. The parties filed cross-motions for summary judgment. AMI argued Zurich was liable for these fees because under Michigan law the duty to defend begins when the complaint is filed against the insured and is independent of tender. AMI also contended that before Zurich could disclaim liability for the Pre-Tender Fees based on its lack of notice of the RDI Suit, Zurich was required to establish that it had been prejudiced. In addition, AMI argued that because a conflict of interest arose between AMI and Zurich,

CONTINUED ON PAGE 4

Sixth Circuit Rules Insurer Not Liable For Insured's Pre-Tender Legal Fees

CONTINUED FROM PAGE 3

AMI was entitled to control its own defense, and Zurich was required to pay AMI's defense fees and costs.

Zurich cited to Michigan law that held an insurer has no duty to defend until its insured requests a defense. Zurich also relied on the "voluntary payments" clause in its policy to negate its liability for the Pre-Tender Fees and case law holding that where the insured's breach of the "voluntary payments" clause is at issue, prejudice to the insurer is not relevant. Zurich further argued that no conflict of interest existed until December 2011 when Zurich sent its reservation of rights letter to the insured.

The trial court granted summary judgment to Zurich, holding the carrier had no liability for the Pre-Tender Fees because the duty to defend requires a request by the insured to defend, and AMI did not make that request to Zurich until November 1, 2011. *AMI Entertainment Network, Inc. v. Zurich Am. Ins. Co.*, 2012 U.S. Dist. LEXIS 151543. The court also held the "voluntary payments" clause in the policy further insulated Zurich from liability. In addition, the court held that as a matter of law there was no conflict between Zurich and AMI prior to notice to Zurich.

AMI appealed to the Sixth Circuit. Deciding the appeal without oral argument, the Sixth Circuit affirmed the Eastern District. 2013 FED App. 0504N (6th Cir. 2013). The court said the "appeal presents one question: Must Zurich pay the defense costs AMI incurred before it told Zurich about the underlying litigation? The answer is no, as the district court correctly recognized." *Id.* at *2. The court first addressed Zurich's policy language, which (1) required AMI to notify Zurich "as soon as practicable" in the event of suit against it; (2) prohibited AMI from making "voluntary payments"; and (3) stated that if AMI failed to comply with reporting requirements, Zurich would not need to establish prejudice but would be relieved of all liability with respect to the claim. The court concluded that based on the policy language alone, "[w]hen all is said and done, the language of the policy squarely supports Zurich's decision not to pay for defense expenses incurred before AMI told Zurich about the underlying lawsuit and incurred without Zurich's permission." *Id.* at *3.

The court then turned to the insurer's duty to defend which it said begins under Michigan law upon the filing of a suit. *Id.* The court stated that "[a]n insurer cannot, however, breach that duty before it knows about a lawsuit." *Id.* at *4. The court held: "AMI does not dispute that Zurich did not know about the RDI Suit until November 2011. Before then, Zurich could not have breached any duty to defend, and in the absence of a breach Zurich cannot be liable for AMI's defense costs." *Id.*

Finally, the court addressed AMI's prejudice and conflict of interest arguments. As to prejudice, the court observed that AMI ignored the plain policy language stating Zurich was not required to show prejudice. The court then held that, regardless, Zurich could show prejudice because (1) it was deprived of "the opportunity to manage the litigation efficiently or for that matter settle it"; and (2) AMI's counsel's rates were much higher than Zurich's approved counsel rates, and to require Zurich to pay the higher rates incurred before notice would transform its duty to defend into a duty to reimburse, without affording it the opportunity to control the defense. *Id.* at *6-*7.

The court agreed with Zurich that no conflict of interest could have arisen prior to Zurich's receipt of notice of the RDI Suit. Accordingly, even if AMI had the right to control its defense once a conflict of interest arose, "it had no bearing on Zurich's liability for money AMI spent *before* it notified Zurich. As the district court correctly concluded, AMI alone bears responsibility for those costs." *Id.* at *8.

IMPORT OF DECISION: This decision is important for several reasons. First, it adds to the body of case law holding that a liability insurer is not liable for fees and costs the insured incurs to defend against a suit when those fees and costs are incurred prior to tender or notice of the suit to the carrier. Second, the case is a good example of the applicability of the "voluntary payments" clause in liability policies, which precludes the insured from voluntarily incurring any payments, fees, or other liabilities. Third, the decision provides a good indication of the Sixth Circuit's belief that under Michigan law an insurance carrier's duty to defend arises when suit is filed against its insured.

Coverage Under CGL Policy For Wrongful Eviction May Not Be Available If Claimant Is Corporate Tenant As Opposed To Natural Person

SUMMARY: Coverage B of the standard commercial general liability ("CGL") policy form provides coverage for "personal and advertising injury," which includes claims of wrongful eviction of a "person." What constitutes a "person" is an open issue in the majority of U.S. jurisdictions. The few courts that have dealt with this issue have reached opposing conclusions.

Some courts have held wrongful eviction coverage under CGL policies is limited to claims asserted by natural persons and that claims brought by corporations are not covered. Others have ruled that coverage exists for claims asserted by both natural persons and corporations.

The standard CGL policy form includes the Coverage B insuring agreement which provides coverage for "personal and advertising injury." Typical policy language provides:

> "Personal and advertising injury" means injury, including consequential "bodily injury", arising out of one or more of the following offenses: . . .
>
> c. The wrongful eviction from, wrongful entry into, or invasion of the right of private occupancy of a room, dwelling or premises that a person occupies, committed by or on behalf of its owner, landlord or lessor. . . .

(This definition of "personal and advertising injury" is referred to in this article as the "wrongful eviction offense.") In a typical claim, an insured property owner or landlord is sued for wrongful eviction by a tenant. If the claimant is a natural person, the claim of a wrongful eviction offense will usually be covered. If the claim is brought by a corporation, however, coverage is less clear. There is little relevant case law, and those decisions that have been rendered are conflicting.

On one side of the issue is *Mirpad, LLC v. California Ins. Guar. Ass'n*, 34 Cal. Rptr. 3d 136 (Cal. Ct. App. 2005), decided under California law. In *Mirpad*, a corporate tenant filed a lawsuit against the insured property manager claiming wrongful eviction from a commercial premises. The property manager tendered the claim under its CGL policy, which provided coverage for claims alleging "wrongful eviction from . . . (a) a room; (b) a dwelling; (c) or premises; that a person occupies by or on behalf of its owner, landlord or lessor." The carrier denied coverage, contending the CGL policy only covered claims for wrongful eviction that were asserted by a tenant who was a natural person, not a corporate entity.

The insured filed a declaratory judgment against the carrier, arguing that, based on the definition of "person" as used in various contexts under state law, a corporation can be a "person," and thus the claim asserted against the insured by the corporate tenant should fall within the wrongful eviction offense. The *Mirpad* court rejected the insured's argument, however, finding that the CGL policy's use of the term "person" clearly referred only to a natural person. In reaching this conclusion, the court recognized that under California law it was required "to glean the meaning of the words [in the policy] *from the context and usage of the words in the contract itself*." *Id.* at 144 (emphasis in original). Reviewing the CGL policy as a whole, the court noted that every reference in the policy to a "person" clearly referred to a natural person, with a corporate entity being separately identified in the policy as an "organization." Accordingly, the court held that the claim for wrongful eviction asserted against the insured was not covered by the CGL policy. "Since the policy only provided 'personal injury' coverage for 'wrongful eviction from . . . [a room, dwelling or premises] that a person occupies . . .' it would seem that such coverage should not extend to the wrongful eviction of 'organizations'. . . ." *Id.* at 144. The *Mirpad* court also found support for its decision based on its conclusion that "the places from which the eviction must take place are places where people live" *i.e.*, a room, dwelling or premises. *Id.*

Three years after *Mirpad* was decided, a contrary result was reached in *Supreme Laundry Service, LLC v. Hartford Cas. Ins. Co.*, 521 F.3d 743 (7th Cir. 2008) (applying Illinois law). The insured in *Supreme Laundry* installed and maintained laundry machines in leased space at condominium and apartment complexes. The insured was sued for wrongful eviction by one of its competitors after the insured replaced the competitor as the lessee of a laundry facility at a condominium complex. The insured tendered the competitor's lawsuit to its CGL carrier for a defense under the wrongful eviction offense section of Coverage B. The insurer denied coverage, claiming the wrongful eviction offense only provided coverage of claims asserted against the insured by a natural person, not a corporate entity.

While the insurer won at the trial court level, the Seventh Circuit reversed. The appeals court held the CGL policy failed to provide a definition for the word "person," and thus, under Illinois law, standard dictionary definitions must be applied to determine the meaning of the word. The court said dictionaries defined the word "person" to include corporate entities and, therefore, held the wrongful eviction offense included claims brought by both natural persons and corporations, "which, at the very least, means that the use of 'person' in the policy is ambiguous." *Id.* at 747. The court further rejected the argument (which was successfully asserted in *Mirpad*) that usage of the term "person" in the CGL policy solely referred to a natural person. While the *Supreme Laundry* court recognized that some provisions of the CGL policy clearly were meant to apply only to a natural person (such as the policy's definition of "bodily injury"), both a natural person and a corporate entity could be wrongfully evicted from the premises. Therefore, "[g]iven that neither 'person' nor 'organization' is defined by the policies, we will not read 'person' in this CGL policy to refer to simply natural persons when it can plausibly apply to a corporate entity, especially where the drafters never expressed any intent that usage of the term was meant only to refer to natural persons." *Id.* at 748.

Since *Mirpad* and *Supreme Laundry* have been decided, a few other courts have addressed the issue of whether "person" as used in the wrongful eviction offense refers only to a natural person or whether it also applies to a

CONTINUED ON PAGE 6

Coverage Under CGL Policy For Wrongful Eviction May Not Be Available If Claimant Is Corporate Tenant As Opposed To Natural Person

CONTINUED FROM PAGE 5

corporate entity. These decisions have come out on both sides of the issue. *See, e.g., 47 Mamaroneck Ave. Corp. v. Hartford Fire Ins. Co.*, 50 A.D.3d 952 (N.Y. App. Div. 2008) (following *Mirpad*); *Alco Iron & Metal Co. v. American Int'l Specialty Lines Ins. Co.*, 2012 U.S. Dist. LEXIS 166692 (N.D. Cal. 2012) (following *Mirpad*); *City of Glendale v. National Union Fire Ins. Co. of Pittsburgh, PA*, 2013 U.S. Dist. LEXIS 45468 (D. Ariz. 2013) (following *Supreme Laundry*). The issue remains undecided in many jurisdictions.

IMPORT OF ISSUE: Depending on the jurisdiction, insurance carriers may be able to successfully deny coverage of wrongful eviction offense claims brought by corporations against insureds. In a few jurisdictions, that position may not be available since courts have ruled CGL policies *do* cover such claims. In some other jurisdictions, judicial decisions exist supporting a denial of coverage. There is no governing case law, however, in the large majority of jurisdictions. In those states, carriers will need to rely on the case law that precludes coverage of claims brought by corporate claimants to support a denial of coverage.

Court Holds Reinsurance Certificate's Follow-The-Form Clause Obligates Reinsurer To Pay Expense Even Though No Indemnity Payment Made To Insured

SUMMARY: In *ACE Prop. & Cas. Ins. Co. v. Global Reinsurance Corp. of America*, Case No. 11-2838 (E.D. Pa. Mar. 31, 2013), the court ruled a reinsurance certificate's follow-the-form clause required a reinsurer to pay its share of expense even though the reinsured made no indemnity payment to its insured for the associated claims. The court held that since the certificate did not define "loss," the underlying policy's definition of "ultimate net loss" should apply and that under that definition "loss" included expense.

ACE Property & Casualty Insurance Co., as successor to Central National Insurance Company of Omaha ("ACE"), sued Global Reinsurance Corporation of America, as successor to Constitution Reinsurance Corporation ("Global"), for breach of a facultative reinsurance certificate ("Certificate") that reinsured an umbrella liability policy ACE issued to Wylain, Inc. ("Umbrella Policy"). Global raised several defenses, including that the Certificate did not require it to pay defense costs (or expense) associated with claims for which ACE made no indemnity payments.

The pertinent language of the Certificate regarding reinsurance coverage of defense costs or expense provided:

> Upon receipt of a definitive statement of loss, the Reinsurer shall promptly pay its proportion of such loss as set forth in the Declarations. In addition thereto, the Reinsurer shall pay its proportion of expenses . . . incurred by the Company in the investigation . . . in the ratio that the Reinsurer's loss payment bears to the Company's gross loss payment. If there is no loss payment, the Reinsurer shall pay its proportion of such expenses only in respect of business accepted on a contributing excess basis . . . .

The Certificate provided that the reinsurance was on an excess of loss, not a contributing excess, basis.

Global argued that because ACE paid no indemnity for the claims in question, ACE had not paid any "loss" to the insured. Accordingly, Global said, it had no liability to ACE for the defense costs ACE had paid for such claims since the Certificate was not written on a contributing excess basis.

ACE countered that since the Certificate did not define "loss," the court should look to the Umbrella Policy for a definition of that term. The Umbrella Policy did not include a definition of "loss," but did define "ultimate net loss" as follows:

> the total sum which the Insured . . . become[s] obligated to pay by reason of personal injury, property damage or advertising liability claims, either through adjudication or compromise, and **shall also include . . . all sums paid as expenses for . . . lawyers . . ., and for litigation**, settlement, adjustment and investigation of claims and suits which are paid as a consequence of any occurrence covered hereunder . . . .

(Emphasis added). ACE argued that this definition should be used for purposes of defining "loss" under the Certificate and that "loss," therefore, included defense costs.

ACE also contended that the Certificate's "follow-the-form" provision required the reinsurance coverage provided by the Certificate to be concurrent with the coverage of the Umbrella Policy. The Certificate's "follow-the-form" term provided as follows:

> [t]he liability of the Reinsurer . . . shall follow that of the Company and shall be subject in all respects to all the terms and conditions of the Company's policy except when otherwise specifically provided herein or designated as non-concurrent reinsurance in the Declarations.

The Certificate was not designated non-concurrent. Since the Umbrella Policy covered defense, ACE asserted that the Certificate did as well.

The court agreed with ACE and held Global was obligated to pay defense costs under the Certificate even though ACE had not paid any indemnity for the corresponding claims. The court held the follow-the-form clause required the Certificate's coverage to be concurrent with that of the Umbrella Policy. Although the terms "loss" and "ultimate net loss" are not the same, the court nevertheless held that in the absence of a definition of "loss" in the Certificate, under the follow-the-form clause that term should mean the same as "ultimate net loss" in the Umbrella Policy. Since defense costs were included in the definition of "ultimate net loss," such costs were also covered by the Certificate.

IMPORT OF DECISION: A reinsurer's obligation to pay a share of the expense incurred by its cedent is often a hotly contested issue that may involve a substantial amount of money. The resolution of the issue usually depends on the applicable language of the reinsurance contract. Here, the language of the Certificate appeared to support the reinsurer's position that it had no liability for defense since its reinsured had not paid any indemnity loss. The court's decision, however, was driven by its conclusion that the Certificate's follow-the-form clause required the reinsurance coverage under the Certificate to be concurrent with the coverage of the Umbrella Policy. The court relied on the follow-the-form provision to support its ruling that the "ultimate net loss" definition in the Umbrella Policy should be used to define "loss" in the Certificate since "loss" was not defined in the reinsurance agreement.

Sixth and Second Circuits Reach Different Decisions On Whether To Compel Arbitration Of Dispute Under Contract Lacking Arbitration Clause When Related Contract Has Such A Clause

SUMMARY: Two federal courts of appeals reached opposite decisions regarding whether a party may be compelled to arbitrate a dispute arising under a contract without an arbitration clause when that contract was one of several relating to an overall transaction. In the first case, the Sixth Circuit denied arbitration in a dispute involving a service agreement which did not have an arbitration clause, rejecting the argument that an arbitration provision in a related asset purchase agreement was sufficient to require arbitration. Conversely, the Second Circuit ordered parties to arbitrate a dispute brought by one law firm against a co-counsel firm to recover attorney's fees under a joint representation agreement (which did not have an arbitration clause) because a related client agreement (which had such a clause) provided the basis for the firm's claimed entitlement for legal fees.

In *Dental Assocs., P.C. v. American Dental Partners of Michigan, LLC*, No. 12-1008 (6th Cir. Mar. 28, 2013), American Dental Partners, Inc. ("ADPI") provided assets, personnel, and non-clinical services to dentists throughout the United States. Its wholly owned subsidiary, American Dental Partners of Michigan, LLC ("ADPM"), entered into the following contracts with Dental Associates, P.C. ("Associates"), a professional corporation of dentists: (1) an asset purchase agreement ("APA") through which ADPI purchased assets used in Associates' dental practices; and (2) a service agreement under which ADPM provided administrative and other non-clinical services to Associates. The service agreement required Associates to enter into employment agreements with certain of its dentists. ADPM and ADPI were not parties to the employment agreements but were referred to as third party beneficiaries.

The APA and employment agreements both contained broad arbitration clauses. The service agreement contained an arbitration provision limited to a narrow issue not involved in the litigation. The APA and the service agreement each provided that the other agreements were incorporated by reference. The employment agreements did not incorporate the other agreements by reference.

Associates brought an action against ADPI and ADPM, alleging claims of breach of fiduciary duty, breach of contract, tortious interference with contract and/or prospective economic advantage, and unjust enrichment. ADPI and ADPM filed a motion to dismiss and compel arbitration, arguing that the dispute should be arbitrated under the arbitration clauses of the APA and employment agreements. The trial court denied the motion, finding that the parties' dispute could be resolved without reference to the APA or the employment agreements and therefore was not subject to arbitration. ADPI and ADPM appealed.

The Sixth Circuit said that the "critical inquiry in determining whether a dispute falls under an arbitration clause is whether the action can be maintained without reference to the agreement containing the arbitration clause." Where there are multiple contracts between parties, a dispute is arbitrable pursuant to an arbitration clause in a related contract if the clause is part of an umbrella agreement governing the parties' overall relationship.

ADPI and ADPM argued that the APA was an umbrella agreement governing the parties' relationship and that the dispute was thus arbitrable pursuant to the APA. The Sixth Circuit disagreed, holding that the APA only governed the one-time purchase and transfer of assets and did not create the relationship between the parties.

CONTINUED ON PAGE 8

Sixth and Second Circuits Reach Different Decisions On Whether To Compel Arbitration Of Dispute Under Contract Lacking Arbitration Clause When Related Contract Has Such A Clause

CONTINUED FROM PAGE 7

Rather, the court said, the service agreement defined the parties' ongoing business relationship. The fact that the APA incorporated the service agreement and employment agreements by reference was not dispositive because the service agreement also incorporated the APA and employment agreements by reference.

The court also held that the dispute could be maintained without reference to the APA. Associates' claim of breach of fiduciary duty arose under the service agreement which created that duty. Associates' breach of contract claim related solely to the breach of the service agreement. Furthermore, the service agreement contained its own definitions and could be interpreted without reference to the APA. Lastly, the action could be maintained without reference to the employment agreements.

In *Robinson Brog Leinwand Greene Genovese & Gluck P.C. v. John M. O'Quinn & Assocs., L.L.P.*, No. 12-2915-cv (2d Cir. Apr. 22, 2013), three law firms agreed to jointly represent plaintiffs in a stock fraud case on a contingency fee basis. One of the firms, the O'Quinn firm, agreed to finance the litigation. The other two firms agreed to handle the majority of the legal work. Three documents defined the terms of the representation. A client agreement provided for a 50% contingency fee and stated that all disputes were to be submitted to arbitration. A joint responsibility referral fee letter agreement provided that the three firms would jointly prosecute the litigation and specified how they would share attorney's fees. The third agreement set out the terms of the fee splitting arrangement among the law firms and was signed by the clients.

One of the firms filed suit seeking to recover fees from another firm which sought to dismiss the case on the grounds that the claims were required to be arbitrated. The firm that instituted the action argued that there was no arbitration provision in the joint representation agreement and that its claims were not within the scope of the arbitration clause of the client contingency fee agreement which it did not sign. The trial court granted the motion to dismiss, and the law firm appealed.

The Second Circuit stated that a non-signatory may be bound by an arbitration clause, even without signing the agreement, when it has knowingly accepted the benefits of an agreement with an arbitration clause. The court concluded that only by virtue of all three agreements functioning together was there a basis for generating a potential recovery, and only from such recovery would the firm be paid any attorney's fees. The court said that the client agreement, which established the attorney-client relationship between the plaintiffs and the law firms, was the foundation of these interdependent documents. Without a client to represent, there could be no settlement or recovery and thus no basis for distributing attorney's fees.

The law firm seeking attorney's fees argued that the sole source of its entitlement to a recovery was the joint agreement. The court said, however, that while that agreement apportioned fees among the law firms, it did not contain an independent means of generating the funds from which those fees would be paid. According to the court, the firm could not limit the basis for its claim only to the joint agreement, but necessarily must rely on the client agreement as the basis for the payment of fees to the firms. The court held that the firm could not seek to benefit from the portion of the client agreement that created the pool of funds for payment of attorney's fees without also subjecting itself to the arbitration clause contained in the same agreement.

The firm also argued that even if it were bound by the client agreement's arbitration clause, the dispute fell outside the scope of the clause because its claims were not based directly on the client agreement. The court gave this argument short shrift, holding that under the Federal Arbitration Act, any doubts concerning the scope of arbitrable issues should be resolved in favor of arbitration.

IMPORT OF DECISIONS: If it is intended that all disputes concerning a transaction or series of related transactions are to be arbitrated, lawyers involved in drafting interconnected contracts or documents should include an identical arbitration clause in all documents or at least clearly provide that an arbitration clause is incorporated by reference in all documents. Otherwise, a court may decide that a particular dispute is not subject to arbitration as the Sixth Circuit did in *Dental Associates v. American Dental Partners*.

Eighth Circuit Holds Arbitration Clause In Excess Insurance Policy Is Trumped By Service-Of-Suit Provision In Policy Endorsement And That Dispute Should Be Litigated, Not Arbitrated

SUMMARY: Do your insurance and reinsurance contracts require arbitration of disputes? The answer may not be as clear as you think. A recent decision by the Eighth Circuit Court of Appeals held that, despite terms of an excess insurance policy clearly stating that any dispute shall be resolved by binding arbitration, the service-of-suit provision in a later endorsement overrode the arbitration clause and arbitration was not required.

In *Union Elec. Co. v. Aegis Energy Syndicate 1225*, No. 12-3546, 2013 WL 1688859 (8th Cir. Apr. 19, 2013), the assured, Union Electric, filed suit to recover from its excess insurer, Aegis, for losses sustained in an accident at its hydroelectric power plant in Missouri. The excess policy provided for a three-step process of negotiation, mediation, and arbitration to resolve all disputes. The policy also included a provision stating:

> [a]ny controversy or dispute arising out of or relating to this . . . [policy], or the breach, termination, or validity thereof, which has not been resolved by non-binding means, . . . shall be settled by binding arbitration.

The insurer responded to the lawsuit by moving to compel arbitration under the above arbitration clause.

The policy also contained an endorsement that provided:

> [n]otwithstanding anything contained in the Policy to the contrary, any dispute related to this Insurance or to a CLAIM (including but not limited thereto the interpretation of any provision of the Insurance) shall be governed by and construed in accordance with the laws of the State of Missouri **and each party agree [sic] to submit to the jurisdiction of the Courts of the state of Missouri.** (Emphasis added.)

The assured argued that this service-of-suit language superseded the mandatory arbitration language in the policy and that the dispute could be litigated in Missouri courts. The trial court agreed and the Eighth Circuit affirmed, holding that the case was to be decided in Missouri courts and not in arbitration. Citing to Missouri law, the Eighth Circuit reasoned that endorsements "supplant conflicting general provisions in the main body of a contract" and thus the endorsement's language in which the parties submitted to the jurisdiction of Missouri courts replaced the policy language requiring arbitration.

In so ruling, the court rejected the insurer's arguments that the two provisions should be construed together unless they were in such conflict that they could not be reconciled and that the endorsement complemented the arbitration provision and was meant to give Missouri courts personal jurisdiction over the parties to enforce the arbitration provisions.

In contrast with the *Union Electric v. Aegis* decision, the District Court of New Jersey held in *New Jersey Physicians United Reciprocal Exchange v. ACE Underwriting Agencies, Ltd.*, No. 12-04397, 2013 U.S. Dist. LEXIS 52035 (D.N.J. Apr. 11, 2013) that a service-of-suit provision similar to the one in *Union Electric* could be read in harmony with an arbitration provision and did not limit or undermine the effect of the arbitration clause.

In *New Jersey Physicians v. ACE*, the reinsurer ("ACE") and cedent ("NJ Pure") had entered into a first excess of loss reinsurance agreement in 2004 ("2004 contract") pursuant to which ACE alleged NJ Pure owed $1.9 million for a premium adjustment. The parties also entered into another first excess of loss reinsurance agreement in 2007 ("2007 contract") under which NJ Pure alleged (and ACE did not dispute) it was owed approximately $2.1 million arising from losses and premium owed under that contract.

ACE relied on an offset provision in the 2007 contract to offset what it owed NJ Pure under the 2007 contract by the amount it claimed it was owed under the 2004 contract. NJ Pure filed suit in federal court alleging ACE breached the 2007 contract by failing to pay the entire amount due under that agreement. ACE initiated arbitration under the arbitration provision of the 2007 contract which provided that:

> all disputes or differences arising out of or connected with this Contract . . . shall, upon written request of either party, be submitted to three arbitrators . . . .

ACE moved to dismiss or stay the lawsuit based on this arbitration clause.

The 2007 contract also contained the following service-of-suit provision:

> It is agreed that in the event of the failure of the Reinsurers hereon to pay any amount claimed to be due hereunder, the Reinsurers hereon, at the request of the Reinsured, **will submit to the jurisdiction of a Court of competent jurisdiction within the United States**. (Emphasis added.)

CONTINUED ON PAGE 10

Eighth Circuit Holds Arbitration Clause In Excess Insurance Policy Is Trumped By Service-Of-Suit Provision In Policy Endorsement And That Dispute Should Be Litigated, Not Arbitrated

CONTINUED FROM PAGE 9

ACE argued that the service-of-suit provision should be read in harmony with the arbitration clause which should be enforced. Otherwise, ACE said, its effect would be undermined if the lawsuit were to be allowed to continue. The court agreed and stayed the lawsuit and ordered the parties to arbitrate their dispute despite the service-of-suit clause. Relying in part on federal case law providing that service-of-suit clauses do not negate arbitration provisions in the same contract, the court reasoned that the service-of-suit language acts as a forum selection clause and complements the arbitration provision by providing a forum for litigation in the event either party "should need to turn to the courts to compel arbitration or enforce an arbitration award, or [if] the parties opt out of arbitration." These same arguments were rejected by the court in *Union Electric*.

IMPORT OF DECISIONS: Most courts have held that a service-of-suit clause does not negate an arbitration clause in an insurance or reinsurance contract and have interpreted the two provisions to require disputes to be arbitrated. The service-of-suit clause is held to apply to any litigation the parties may engage in, such as suits to compel arbitration or enforce arbitral awards or actions not covered by the arbitration clause. The *New Jersey Physicians v. ACE* decision is consistent with this majority line of cases. In that case, both the service-of-suit and arbitration provisions were in the original policy. The *Union Electric* case may be distinguished on the basis that the service-of-suit provision was in a policy endorsement issued subsequent to the original policy. The Eighth Circuit concluded that the later issued endorsement, which included language that the endorsement applied "[n]otwithstanding anything contained in the Policy to the contrary," supplanted the arbitration clause. The two clauses might still have been read to give meaning to each, as courts generally have done in similar situations. The holding demonstrates that an arbitration clause may not always be enforced as a party intended. If parties to insurance and reinsurance contracts intend that *all* disputes are to be arbitrated, they must clearly so state in their agreements, leaving no ambiguity.

CLARK HILL | THORP REED's Insurance and Reinsurance Practice Group has an established reputation for its work in the global insurance and reinsurance industry. The firm represents major United States, London Market, European, and Bermuda insurers and reinsurers in commercial litigation, coverage disputes, and major business transactions. Our practice encompasses all types of insurance, and every kind of underlying risk. We have the capacity to efficiently handle any (re) insurance matter, from individual to class action claims, and each assignment undertaken by the firm is afforded the same personal attention of partners having expertise with respect to the issues.

Philadelphia

Joseph M. Donley
Insurance & Reinsurance Practice Group Leader

Christopher M. Brubaker
William E. Cox
Christopher J. Day
Douglas M. Chapman
Peter B. Kupelian
Carol G. Schley
Karolien M. Vandenberghe

For more information, please contact Joseph M. Donley at jdonley@clarkhill.com, or call 215.640.8500.

To subscribe to *Insurance & Reinsurance Briefing*, please contact Connie Lojewski at 215.640.8543 or clojewski@clarkhill.com.

Insurance & Reinsurance

CLARK HILL

www.clarkhillthorpreed.com

BRIEFING

Spring 2013

New York Court Of Appeals Issues An Important Decision On A Number Of Allocation Issues

SUMMARY: In *United States Fidelity & Guaranty Company v. American Re-Insurance Company*, NY Slip Op 00784 (Court of Appeals, Feb. 7, 2013), the New York Court of Appeals reversed a lower court's decision that had upheld the reasonableness of a cedent's allocation of an asbestos settlement on summary judgment, concluding that there were sufficient factual disputes to warrant a trial. The court held the reasonableness of a cedent's allocation is not determined by whether the insured and insurer agreed to a specific allocation in a settlement agreement, but whether the parties would have agreed to such an allocation in an arm's length negotiation in the absence of reinsurance. But, the court said, when several reasonable allocations are possible, the cedent may choose the one most favorable to it. It is unrealistic to expect a cedent not to be guided by its own interests in choosing how to allocate a loss. A cedent is not a fiduciary of its reinsurers, need not disregard its own interests in allocating a settlement, and is not required to put its reinsurers' interests ahead of its own. Nonetheless, the Court of Appeals held there were disputed questions of fact about whether the cedent had acted reasonably in allocating none of the settlement to bad faith claims that had been asserted by the insured.

United States Fidelity & Guaranty Company ("USF&G") was a liability insurer of Western Asbestos Company, a distributor of asbestos-containing products. The policies USF&G issued to Western contained "per person" and "per accident" limits in varying amounts, the highest being $200,000, but the policies contained no aggregate limits. Western's business was taken over by Western MacArthur Company ("MacArthur"). MacArthur was sued for claims arising out of Western's business. After its own coverage was exhausted, MacArthur demanded a defense from Western's insurers, including USF&G which declined to defend on two grounds. First, USF&G raised a "lost policy"defense, contending that the insured had not produced copies of the policies which evidently had been lost over time. Second, USF&G argued that it only insured Western, not MacArthur, and therefore had no liability to MacArthur. After USF&G (and Western's other insurers) refused to defend MacArthur, the insured agreed not to oppose the entry of default judgments against it in favor of asbestos claimants. In exchange, the claimants agreed not to execute against MacArthur on the judgments. More than a thousand such default judgments were entered against McArthur, totaling $1.4 billion.

In coverage litigation between MacArthur and USF&G, MacArthur also alleged that by refusing to defend the asbestos claimants' lawsuits, USF&G engaged in bad faith. These bad faith claims, if successful, could have led to a judgment against USF&G for the portion of MacArthur's liability that was attributable to USF&G's failure to defend. USF&G and MacArthur settled the coverage action for $975 million to resolve all of MacArthur's claims (including those for bad faith), plus $12.3 million in attorney's fees for the asbestos claimants.

After the settlement, USF&G sought to bill its reinsurers under an excess of loss treaty which provided that USF&G's retention was $100,000 per loss. Because the policies USF&G issued to Western provided (at most) coverage of $200,000 per claimant, the reinsurers' liability was capped at $100,000 per loss. Since the treaty had no aggregate limit, reinsurers could be liable for an indeterminate number of losses, up to $100,000 each. After

CONTINUED ON PAGE 2

Arizona

Delaware

Illinois

New Jersey

Michigan

Pennsylvania

Washington, DC

West Virginia

Inside this Briefing

New York Court Of Appeals Issues An Important Decision On A Number Of Allocation Issues

CONTINUED FROM PAGE 1

allocating the settlement based on several assumptions, discussed below, USF&G calculated the reinsurers' obligation to be $391 million. The reinsurers refused to pay, and USF&G filed suit to recover its reinsurance.

Reinsurers argued that three of USF&G's allocation decisions were not reasonable: (1) the entire settlement amount was assigned to claims within the limits of USF&G's policies and none to the bad faith claims; (2) lung cancer claims were allocated a value of $200,000 each while certain other claims were given values of $50,000; and (3) USF&G's entire settlement payment was allocated to the 1959 policy year. The reinsurers asserted that USF&G's allocation minimized the burden on the cedent and maximized the cost to reinsurers. USF&G responded that under the "follow-the-settlements" doctrine, the reinsurers were obligated to honor its billings.

The Court of Appeals noted that almost all courts that have considered the question have held that a follow-the-settlements clause requires deference to a cedent's allocation decisions. The court agreed with those decisions, stating that if a court were to review each allocation decision *de novo*, that would invite long litigation over complex issues that courts may not be well equipped to resolve, creating costs and uncertainty and making the reinsurance market less efficient.

Since the interests of a cedent and its reinsurers will often conflict, courts generally hold that a reinsurer is bound only by a cedent's "good faith" decisions which must be reasonable. Objective reasonableness should ordinarily determine the validity of an allocation. Reasonableness does not imply disregard of a cedent's own interests. Cedents are not fiduciaries of their reinsurers and are not required to put the reinsurers' interests ahead of their own. A cedent's motive should generally be unimportant. When several reasonable allocations are possible, the cedent may choose the one most favorable to it. It is unrealistic to expect that a cedent will not be guided by its own interests in making the choice.

The Court of Appeals said, however, that a cedent's allocation decisions are not immune from scrutiny. The court rejected USF&G's argument that its allocation should be considered to be reasonable because it had been agreed to with MacArthur and the asbestos claimants. The court held that reasonableness cannot be established merely by showing that the allocation used for reinsurance billing purposes was the allocation the cedent and the insured (and the claimants) actually adopted in settling the underlying insurance claims. To demonstrate reasonableness, the cedent must prove the allocation would have been adopted if reinsurance did not exist.

With respect to whether any of the settlement should have been allocated to MacArthur's bad faith claims, the Court of Appeals held that, while USF&G did have plausible defenses to those claims, there were disputed issues of fact such that summary judgment in the carrier's favor was not appropriate. The court noted that the decision to allocate all of the settlement to claims within the policy limits and nothing to the bad faith claims worked to USF&G's advantage because the bad faith claims were not covered by reinsurance. The court held a fact finder could conclude that an allocation giving no value to the bad faith claims was unreasonable since USF&G faced a significant risk of an adverse verdict on those claims. Arguably, USF&G knew its litigation position was an irresponsible attempt to exploit the fact that the policies it had issued had been lost with the passage of time. It could also be found that USF&G's refusal to defend MacArthur resulted in the many large default judgments. Indisputably, when the coverage case went to trial in California, USF&G was faced with the possibility of a very large jury verdict against it on the bad faith claims.

In allocating the settlement, it could also be found that USF&G assigned inflated values to claims other than the bad faith claims, that is, to claims that were covered in part by reinsurance. USF&G valued each lung cancer claim at $200,000, thus allocating the maximum payment to each such claim. Although USF&G, MacArthur, and the claimants agreed to this allocation, the court did not assign dispositive weight to their agreement. At an earlier stage of the coverage litigation, an expert retained by the asbestos claimants estimated MacArthur's liability for each lung cancer claim at about $90,000. The court noted that it was unusual for claims to be settled for more than twice what the claimants' expert asserted they were worth. A fact finder could conclude, the court said, that the lung cancer claims were allocated an unreasonably high amount and included values that should have been attributed to the bad faith claims.

Furthermore, while those who negotiated the settlement of the coverage litigation agreed that the settlement gave no value to the bad faith claims, a demand made shortly before the settlement did include such value. One of MacArthur's pre-settlement demands ascribed $167 million of its $2 billion claim to bad faith claims. The final settlement was for $975 million, almost exactly one-half of MacArthur's demand. A fact finder might infer that this was a simple 50% settlement, and that $83.5 million of it was attributable to bad faith claims. In sum, the court held it was impossible to conclude that parties bargaining at arm's length in the absence of reinsurance would reasonably have given no value to the bad faith claims.

With respect to the second allocation decision challenged by the reinsurers – the relative valuation of lung cancer and other claims – the court first noted that there was evidence

(discussed above) that the $200,000 value assigned by USF&G to lung cancer claims was unreasonably high. While one possible inference is that some of the value should have been attributed to the bad faith claims, another possible inference is that claims falling below the reinsurers' $100,000 retention were undervalued. If some of the value attributed to the lung cancer claims were reassigned to other types of claims, the result might be to decrease the reinsurers' liability. If, for example, the lung cancer claims were reduced to $100,000 each, and if the values for other types of claims were doubled, there would be no reinsurance coverage for any claims since none of them would have met the treaty's retention. Considering all of this evidence, the court concluded that a fact finder could infer that USF&G's valuations of the various types of claims was unreasonable.

The Court of Appeals ruled in favor of USF&G on the reasonableness of its allocation of all of the losses in the settlement to the 1959 policy year. The court recognized that if the claims had been prorated over all the policy years, few if any losses would have exceeded the $100,000 treaty retention. USF&G's decision to allocate all of the losses to one policy year was based on the reasonable assumption that California courts would have followed the "continuous trigger," "all sums," and "no stacking" rules. Applying those rules to this case, the claimants could have chosen any one of the policies that USF&G issued to Western and attributed all of their injuries to that policy. It was undisputed that, given such a choice, they would have picked the 1959 policy year because there was no other policy with higher limits, and all claimants who were exposed to asbestos-containing products in 1959 or earlier could claim to have suffered some injury in that year.

IMPORT OF DECISION: This very important decision from a leading court contains a number of significant holdings: (1) a follow-the-settlements clause requires deference to a cedent's allocation decisions; (2) the test for the reasonableness of a cedent's allocation is not whether the insured and insurer agreed to a specific allocation in a settlement agreement, but whether the parties would have agreed to such an allocation in an arm's length negotiation in the absence of reinsurance; (3) a cedent need not disregard its own interests in allocating a settlement; (4) a cedent is not a fiduciary of its reinsurers and is not required to put their interests ahead of its own; (5) it is unrealistic to expect a cedent to not be guided by its own interests in choosing how to allocate a loss; (6) when several reasonable allocations are possible, the cedent may choose the one most favorable to it; (7) if there is evidence that bad faith claims have appreciable value, a cedent may be obligated to allocate some portion of a settlement to those claims even if they are not covered by reinsurance; and (8) a cedent's decision on how much to allocate to specific types of claims must be objectively supportable by the facts of the case.

Insurance Issues Relating To Fracking

What Is "Fracking"?

"Fracking" is the commonly used term for hydraulic fracturing, which is a method used to extract underground oil or natural gas trapped in underground shale rock formations. The process involves injecting a mixture of pressurized water, sand, and chemicals deep into the ground to create or expand pre-existing pathways (known as "fractures") in the gas-bearing rock through which the oil or gas may flow and thereby be extracted for commercial use. To do this, deep wells must be drilled and constructed through which the liquid mixture is injected under high pressure. For many decades, fracking was only performed vertically; however, advancements in technology in the past decade or so have allowed for fracking to be carried out horizontally. Horizontal fracking involves vertical downward drilling followed by horizontal drilling. This allows access to much larger underground areas from a single well pad than was possible from vertical wells.

What harm or damage may be caused by fracking?

Whether or not fracking causes environmental property damage or bodily injury is disputed and probably still largely unknown at this point in time. The principal alleged types of damages include groundwater contamination, contamination of surface waters and soils, ground subsidence (including sinkholes), air and noise pollution, and even earthquakes.

Potentially toxic chemicals are included among the mixture of liquids pumped into the wells. Acids may be used to clean the wellbores.

Water contamination may occur from equipment failures or leakages from well casings caused by fractures or breakages or even blowouts. Some of the liquids injected into wells may return to the surface (referred to as "flowback") where they become wastewater, potentially containing pollutants. The wastewater may be stored in tanks or open pits or it may be trucked to off-site locations for disposal. Tank ruptures or accidental spills could occur. Linings of open pits may be defective and could tear, resulting in spills or leakages. Storage pits or tanks could be overfilled.

Some of the chemicals may remain underground and potentially contaminate aquifers. Serious health effects may arise from the consumption of contaminated drinking water. The most common method of disposal is injecting the wastewater into deep wells. This may cause ground subsidence or pollute the groundwater. Also, the process may lubricate fault lines, conceivably causing earthquakes.

CONTINUED ON PAGE 4

Insurance Issues Relating To Fracking

CONTINUED FROM PAGE 3

In addition, spills of toxic materials may occur at any point in the process.

Withdrawing water from streams, lakes, and aquifers for drilling and fracking could adversely affect water sources by lowering water levels thereby depleting water supplies.

There have even been cases in which claimants have asserted that natural gas has been found in aquifers.

There have also been air pollution claims, allegedly due to engine exhaust from increased truck traffic, emissions from diesel-powered pumps used to operate equipment, and natural gas that is burned off or vented during drilling operations.

Silica sand, commonly used as a proppant,[1] may pose a risk to human health (silicosis) if not properly handled.

The fracturing process may result in erosion.

Who are the claimants?

Property owners, homeowners, nearby residents, and workers are the most likely claimants. A property owner who sold mineral rights to contractors may claim his property was damaged by the fracking process, or he may allege he suffered bodily injuries. Property damage claims could include surface or groundwater contamination or subsidence damage. Bodily injury claims may arise from consuming contaminated drinking water or from exposure to toxic chemicals or other substances used in the fracking process. Homeowners and nearby residents may assert similar claims. Workers exposed to toxic materials may bring claims. In addition, governmental entities may assert regulatory claims or file lawsuits to recover damages for spills or other environmental harm.

Who are the potentially responsible parties?

Entities that may be potentially liable for fracking-related exposures include owner-operators of sites, non-operating site owners, drilling contractors, design professionals, chemical companies that prepared components used in fracking fluids, contractors who built or maintained wells, contractors who built retention ponds, equipment suppliers, wastewater transporters, and storage and recycling facilities.

Theories of liability

Based on the types of cases brought and those threatened, the theories of liability may include strict liability (alleging fracking is an "ultra-hazardous" or "abnormally dangerous" activity), trespass (alleging the intrusion of fracking fluid into adjacent property), medical monitoring, negligence (alleging well casings were improperly or inadequately designed or constructed, thereby allowing fracking fluid to leak from well bores), negligence *per se* (alleging violations of state or federal regulations), breach of contract (alleging drilling companies violated agreements pertaining to safety procedures), fraudulent misrepresentation (alleging drilling companies misled landowners or the public), and employer liability.

Types of insurance policies that may be implicated

First party property, general commercial liability, umbrella, environmental/pollution liability, errors and omissions, directors and officers, business interruption, operator's extra expense, homeowners, workers compensation, earthquake, and products.

Insurance coverage issues

Coverage issues typically associated with environmental claims likely will apply to fracking claims, including trigger (manifestation, injury in fact, continuous or triple trigger), number of occurrences, aggregate limits, notice, and allocation. Fracking claims may arise from one-time events, such as sudden spills of toxic chemicals, or they may involve allegations of gradual harm, for example, that well casings leaked over time or that wastewater polluted the groundwater for extensive periods, implicating many years of coverage. Assuming multiple years of coverage are triggered involving more than one carrier, issues of how to allocate the loss between policies and carriers will arise. Carriers may seek to enforce notice provisions in policies. Generally speaking, a carrier must demonstrate that it has been prejudiced by any late notice in order to avoid liability.

Potentially applicable policy exclusions

Known loss, expected or intended, and absolute pollution exclusions may apply to preclude coverage. A carrier may assert that the loss was known or expected or intended from the standpoint of the insured. Pollution exclusions are less likely to be enforced in cases involving traditional property damage and personal injury claims, and more likely to be enforced where bodily injury or property damage is directly caused by the release of a pollutant specifically defined in the policy. The form of the insurance industry's pollution exclusion has evolved over time. The terms of a particular exclusion in effect when the damage occurred may be dispositive of whether or not coverage exists.

Reinsurance issues

Fracking claims have the potential to give rise to reinsurance claims similar in many respects to those that have arisen from asbestos and environmental claims. There may be issues concerning whether the claims arose from single or multiple occurrences and whether claims may be aggregated to meet reinsurance retentions. Depending on the circumstances, reinsurers may raise late notice defenses. As is true with other long-tail claims, allocation issues may be important for reinsurance purposes if multiple policies are involved.

[1] A proppant is a solid material, typically treated sand or man-made ceramic materials, designed to keep an induced hydraulic fracture open, during or following a fracturing treatment.

New York State Court Establishes Novel Umpire Selection Procedure In Reinsurance Arbitrations

SUMMARY: In *American Home Assurance Company v. Clearwater Insurance Company*, 958 N.Y.S.2d 870 (Sup. Ct. 2013), a New York trial court devised a method to appoint an umpire in a reinsurance arbitration which called for each side to nominate five candidates. Three were then to be stricken by the other side. Each side was then to rank the remaining four candidates in order of preference. The individual with the highest ranking would become the umpire. If there was a tie, the umpire was to be drawn by random lot from among the two candidates with the highest ranking.

The cedents – American Home Assurance Company and National Union Fire Insurance Company of Pittsburgh – commenced arbitrations against their reinsurer, Clearwater, under three reinsurance treaties. All three treaties provided for each party to appoint an arbitrator. One of the treaties said the dispute was to be submitted to the two arbitrators and that if they failed to agree, then the dispute was to be decided by an umpire to be chosen by the arbitrators. The treaty also said that if the arbitrators failed to agree on the umpire, either party could petition the New York state court to appoint the umpire. The other two treaties provided that the two party appointed arbitrators were to choose the umpire, but contained no provision concerning how the umpire was to be appointed if the two party arbitrators could not agree. New York state law provides that the court may appoint an arbitrator if the contract does not have a selection method or if the method fails.

In this case, the cedents petitioned the New York Supreme Court (the trial court) to appoint an umpire from among the three individuals whom the cedents' arbitrator had proposed. Alternatively, the cedents suggested that the court use the ranking method prescribed by ARIAS-US. Clearwater said the court should use the "strike and draw" method which it claimed was the usual and customary procedure for umpire selection in the insurance industry. In the alternative, the reinsurer argued the court should appoint the umpire from among the three individuals whom it had proposed.

The court first addressed the reinsurer's challenge to the court's power to appoint the umpire since two of the treaties did not expressly provide for the court to do so. Citing to state law granting the courts power to appoint an arbitrator if the agreement does not provide for the method of appointment or if the method in the contract fails, the court dismissed the challenge to its power to appoint, noting that the statutory mechanism providing this power to the court was in existence long before the applicable treaties were entered into.

Next, the court determined that neither the treaties nor state law provided a procedure for selecting the umpire. Instead of adopting an approach proposed by one party or the other, the court decided to combine the "ranking" and "strike and draw" methods to create a new procedure. The court ruled that each side was to select five candidates and then strike three from the opponent's list, leaving two candidates from each side. The parties were then to rank the remaining four individuals, with the highest ranking candidate being named umpire. In the event two individuals tied, the umpire would be determined by the drawing of lots between those two candidates, similar to the "strike and draw" method.

The court ordered the parties to adopt this new method to determine the umpire in all three disputes even though one of the treaties provided that the dispute was to be submitted to the umpire only in the event the two party appointed arbitrators could not agree upon a finding in the underlying arbitration. The court determined that the parties' disagreement upon the method of selecting an umpire created the need for an umpire under the treaty, and that appointing the umpire before the arbitration would save time and expenses and would avoid the need for a second arbitration at which the umpire would need to hear the evidence again.

IMPORT OF DECISION: The New York Supreme Court's decision illustrates the value of an agreed-upon umpire selection method in a reinsurance contract in order to avoid litigation over umpire selection. The case serves as a good example of the gaps that often exist in treaties, state law, and federal law with respect to reinsurance arbitration procedure. Finally, in addition to providing a new method for umpire selection, this decision demonstrates how the courts may fashion their own solutions to the parties' disputes in ways not advocated or anticipated by either party or by the express terms of the governing treaty.

Second Circuit Rules Federal Common Law, Not State Law, Applies To Determine Whether Parties Agreed To "Arbitration" Under Federal Arbitraion Act

SUMMARY: In *Bakoss v. Certain Underwriters at Lloyds of London*, 707 F.3d 140 (2d Cir. 2013), the Second Circuit held that federal common law, not state law, should be used to determine whether a contractual dispute resolution mechanism constitutes "arbitration" under the Federal Arbitration Act ("FAA").

Imad John Bakoss and Certain Underwriters at Lloyds of London entered into a Certificate of Insurance ("Certificate") that provided disability coverage to Bakoss if he became "permanently totally disabled."

CONTINUED ON PAGE 6

Second Circuit Rules Federal Common Law, Not State Law, Applies To Determine Whether Parties Agreed To "Arbitration" Under Federal Arbitration Act

CONTINUED FROM PAGE 5

The Certificate provided that each party had the right to have Bakoss examined by a physician of its choice to determine if Bakoss met the Certificate's disability requirements. In the event of a disagreement between the physicians over whether Bakoss was "permanently totally disabled," the Certificate provided that the two physicians "shall [jointly] name a third Physician to make a decision on the matter which shall be final and binding."

After Lloyds declined to agree to pay disability benefits to Bakoss, he filed suit seeking coverage in New York state court. Lloyds removed the case to federal court, asserting that the "third physician" clause was an arbitration provision, thus providing federal subject matter jurisdiction under 28 U.S.C. § 1331 (federal question jurisdiction), the Convention on the Recognition and Enforcement of Foreign Arbitral Awards, and the FAA. Section 2 of the FAA (9 U.S.C. § 2) provides that a "written provision in . . . a contract . . . to settle by arbitration a controversy thereafter arising out of such contract . . . shall be valid, irrevocable, and enforceable."

The District Court applied federal common law to the issue of whether the "third physician" clause constituted an agreement to arbitrate. The court relied upon the federal common law decisions in *McDonnell Douglas Fin. Corp. v. Pa. Power & Light Co.*, 858 F.2d 825 (2d Cir. 1988) (provision calling for appointment of independent tax counsel where language of agreement clearly manifests intention by parties to submit certain disputes to third-party for binding resolution constitutes enforceable agreement to arbitrate) and *AMF Inc. v. Brunswick Corp.*, 621 F. Supp. 456 (E.D.N.Y. 1985) (agreement by parties to submit dispute for decision by third party constitutes agreement to arbitrate) in concluding that the "third physician" clause was an agreement to arbitrate since the parties agreed to submit a medically-related policy dispute to a third-party to make a final and binding decision.

The District Court denied Bakoss' motion to dismiss for lack of subject matter jurisdiction and granted Lloyds' motion for summary judgment. Bakoss appealed, arguing that because the FAA does not provide a definition of "arbitration," the District Court should have looked to New York state law, rather than federal common law, to define that term.

On appeal, the Second Circuit noted it had not directly addressed whether federal courts should look to state law or federal common law for the definition of "arbitration" under the FAA. The court stated that while Congress sometimes intends a statutory term be defined by state law, absent a clear indication to the contrary, it is presumed that the application of a federal law is not dependent on state law. The court noted the split in the Circuits on whether state law or federal common law applied to the *FAA: Evanston Ins. Co. v. Cogswell Properties, LLC*, 683 F.3d 684 (6th Cir. 2012) (applying federal law); *Salt Lake Tribune Pub'l Co. v. Mgmt. Planning, Inc.*, 390 F.3d 684 (10th Cir. 2004) (applying federal law); *Fit Tech, Inc. v. Bally Total Fitness Holding, Corp.*, 374 F.3d 1 (1st Cir. 2004) (applying federal law); *Hartford Lloyd's Ins. Co. v. Teachworth*, 898 F.2d 1058 (5th Cir. 1990) (applying state law); and *Wasyl, Inc. v. First Bos. Corp.*, 813 F.2d 1579 (9th Cir. 1987) (applying state law).

The Second Circuit said that the decisions applying federal common law to determine whether the parties agreed to "arbitration" relied on congressional intent to create a uniform national arbitration policy. In contrast, the courts that applied state law articulated few reasons for doing so, the court said. The Second Circuit also noted that while the *Wasyl* decision remained good law in the Ninth Circuit, it had been questioned in *dicta* in later decisions. The Second Circuit agreed with the rationale expressed by the courts holding that federal common law should apply. The court said there was no indication that in passing the FAA, Congress intended to create a patchwork system whereby the FAA would mean one thing in one state and something different in another. The court, therefore, concluded that federal common law applied to determine what the term "arbitration" means under the FAA.

IMPORT OF DECISION Although the federal Circuit Courts are divided on the issue of whether state or federal law applies to interpret the term "arbitration" under the FAA and while the Supreme Court has yet to step in to resolve the split, the Second Circuit's decision in *Bakoss* may bring an end to the debate. For one thing, the Second Circuit is generally considered to be the leading federal appellate court on arbitration issues. Also, only two Circuits have ruled state law applies, and one of those – the Ninth – has indicated it would likely change course if the issue were to arise again. This case also shows how broadly courts will define the term "arbitration." Here, the Second Circuit concluded that even though the contract did not use the word "arbitrate" or "arbitration," a provision under which the parties agreed to submit the resolution of a disagreement to a third-party for a final decision constituted an agreement to arbitrate disputes. *Bakoss*, thus, is consistent with the strong federal policy favoring arbitration agreements.

Clark Hill PLC And Thorp Reed & Armstrong LLP Announce Merger Agreement, Creating 300 Attorney, 12 Office Firm

Detroit, Mich. and Pittsburgh, Pa. – The law and professional service firms of Clark Hill PLC and Thorp Reed & Armstrong, LLP announce an agreement to merge the two firms, each with more than 100 years of history. The firms expect the merger to close in the second quarter of this year.

The combined firm includes more than 300 attorneys in a wide variety of practice areas. The firm will operate in 12 offices in seven states plus the District of Columbia. Office locations are in Birmingham, Mich., Chicago, Ill., Detroit, Mich., Grand Rapids, Mich., Lansing, Mich., Philadelphia, Pa., Phoenix, Ariz., Pittsburgh, Pa., Princeton, N.J., Washington, D.C., Wheeling, W.Va. and Wilmington, Del.

The combined firm will utilize the brand name Clark Hill Thorp Reed in chosen markets, including all geographic markets where Thorp Reed & Armstrong has a presence today. However, its legal name will remain Clark Hill and the Clark Hill name will continue to be used in all of Clark Hill's current markets. The combined firm's decentralized structure empowers local offices to make business decisions in close proximity to clients in ways that meet the needs of their individual markets, while remaining consistent with the firm's culture and values.

"This merger allows us to provide more value to our clients, with more expertise and capabilities in more places," said John J. Hern, Jr., CEO of Clark Hill PLC and the combined firm. "We're investing in client relationships of all sizes while staying core to the common DNA which has made both firms successful for more than a century."

The combined firm will offer clients specialized legal knowledge and extensive experience and resources in practice areas such as:

- Banking and Finance Law
- Energy, Environment and Natural Resources Law
- Technology and Intellectual Property Law
- Corporate Law
- Litigation
- Employment Law
- Insurance and Reinsurance
- Employee Benefits and Executive Compensation
- Construction and Real Estate Law
- Manufacturing and Distribution
- Bankruptcy and Financial Reorganization

Additionally, the merger will provide a strong foundation in which to develop new legal practice areas.

"The Clark Hill Thorp Reed merger provides our current clients with increased depth and services," said Jeffrey J. Conn, who will assume a seat on the Executive Committee of the combined firm and will serve as Partner in Charge of the firm's Pittsburgh office. "Our two firms have similar cultures, governance and business structures, which creates a solid platform to continue to provide value to our clients and allows for a seamless transition. For example, the combined firm's servicing rates will remain consistent at our current levels. The merger provides our firm with opportunities to grow in our current markets, as well as expand into new markets. I am confident our clients will be pleased with the additional capacity and expertise that will come with the combined firm."

James K. Goldberg, partner at Thorp Reed & Armstrong, will also join the combined firm's Executive Committee when the merger is completed.

Founded in 1895 in Pittsburgh, Thorp Reed and its nearly 100 attorneys have gained a reputation as lawyers who exemplify the profession's best practices, and lawyers who other lawyers turn to when they need counsel. The Firm supports a wide variety of clients' needs within the practice areas of corporate law, litigation, and financial and real estate transactions. Businesses, financial institutions, contractors, public and governmental entities, healthcare and not-for-profit organizations of all sizes, ranging from Fortune 500 companies to the middle market and entrepreneurs, rely on Thorp Reed for quality legal services.

Founded in 1890 in Detroit, Clark Hill PLC is an entrepreneurial, full-service law firm serving clients in all areas of business legal services, government and public affairs, and personal legal services. Its more than 200 experienced attorneys and other professionals consistently deliver the results and solutions that its clients have come to trust.

www.clarkhill.com | www.thorpreed.com

CLARK HILL | THORP REED's Insurance and Reinsurance Practice Group has an established reputation for its work in the global insurance and reinsurance industry. The firm represents major United States, London Market, European, and Bermuda insurers and reinsurers in commercial litigation, coverage disputes, and major business transactions. Our practice encompasses all types of insurance, and every kind of underlying risk. We have the capacity to efficiently handle any (re) insurance matter, from individual to class action claims, and each assignment undertaken by the firm is afforded the same personal attention of partners having expertise with respect to the issues.

Philadelphia

Joseph M. Donley
Insurance & Reinsurance Practice Group Leader

Christopher M. Brubaker
William E. Cox
Christopher J. Day
Joseph Friedman
Deborah P. Powell
Karolien M. Vandenberghe
William M. Wycoff

For more information, please contact Joseph M. Donley at jdonley@clarkhillthorpreed.com, or call 215.640.8500.

To subscribe to *Insurance & Reinsurance Briefing*, please contact Connie Lojewski at 215.640.8543 or clojewski@clarkhillthorpreed.com.

Insurance & Reinsurance

CLARK HILL

www.clarkhill.com

BRIEFING

Fall 2013

Connecticut Federal Court Rules Reinsurer Entitled To Discovery Relevant To Cedent's Allocation Decision

SUMMARY: In *Travelers Indemnity Co. v. Excalibur Reinsurance Corp.*, No. 3:11-CV-1209, 2013 U.S. Dist. LEXIS 50134 (D. Conn. April 8, 2013), a Connecticut federal district court granted a reinsurer's motions to compel discovery seeking evidence probing the reasonableness of its cedent's post-settlement allocation even though the reinsurance contract had a standard follow the settlements clause.

Travelers issued four annual errors and omissions claims made policies to its insured. The policies were covered by a reinsurance program on which Excalibur participated in all but the first year. The treaties provided that they were governed by New York law. Travelers settled an underlying claim with its insured which it allocated to the second and third coverage years and billed Excalibur accordingly. Excalibur objected, contending a portion of the loss should be allocated to the first policy year, and sought to challenge the reasonableness of the allocation.

Travelers filed suit and asserted that under the treaties' follow the settlements clause, Excalibur was bound by Travelers' allocation of the settlement and was not permitted to make any further inquiry into the allocation, including in discovery. Excalibur contended that the follow the settlements clause did not preclude it from arguing Travelers' allocation was unreasonable or that the underlying claims were not covered by the treaties.

Since it did not reinsure the first of the four policy years, Excalibur argued it was entitled to challenge whether Travelers' reinsurance billings included claims that properly should have been allocated to the first policy year. Excalibur sought discovery relating to the dates on which the underlying claims were first asserted as well as other evidence concerning Travelers' allocation of the settlement. Travelers responded that, as cedent, it had the discretion to determine to which policy years the claims should be assigned. Travelers objected to the discovery, contending it was irrelevant since Excalibur was bound by Travelers' allocation under the follow the settlements clause of the treaties.

Excalibur then filed two motions seeking to compel Travelers to produce the requested discovery.

The court noted that, although Excalibur's motions to compel discovery were filed before the New York Court of Appeals rendered its opinion in *United States Fidelity & Guaranty Co. v. American Re-Insurance Co.*, 20 N.Y.3d 407 (2013) ("USF & G"), that case was decided before oral argument on Excalibur's motions. As a decision of New York's highest court, the case was binding on the court in the *Travelers v. Excalibur* matter. After discussing the *USF & G* decision at some length, the court held that: (1) a follow the settlements clause in a reinsurance contract requires that deference be given to a cedent's allocation decision; (2) a cedent's allocation is not immune from scrutiny; (3) a cedent's allocation is reasonable if the parties to

CONTINUED ON PAGE 2

Inside this Briefing

Connecticut Federal Court Rules Reinsurer Entitled To Discovery Relevant To Cedent's Allocation Decision

CONTINUED FROM PAGE 3

the settlement of the underlying claim might reasonably have arrived at it if reinsurance did not exist; and (4) an allocation that violates or disregards provisions in a reinsurance contract is invalid.

The court granted Excalibur's motions to compel discovery. The court held that Excalibur was entitled to challenge the reasonableness of Travelers' post-settlement allocation decision and to argue that the economic consequences of the allocation violated or disregarded provisions in the reinsurance treaties. Since Excalibur did not reinsure the first policy year, its obligation to contribute to the loss depended on the year in which a claim was asserted. The court said an allocation that imposed a reinsurance liability on Excalibur for a claim made against the insured in the first year of coverage would exceed Excalibur's obligations under the reinsurance treaties, a result that as a matter of law was beyond the scope of the follow the settlements clause. The court held it was plausible that a claim made against an insured during the first year could not validly give rise to reinsurance liability on the part of Excalibur. Accordingly, discovery seeking evidence relevant to those arguments was permissible.

IMPORT OF DECISION: This case is one of the first decided after the New York Court of Appeals' seminal *USF & G* decision. That case laid out guidelines for the types of arguments reinsurers could make in challenging their cedents' allocations. *Travelers v. Excalibur* implements *USF & G* in the discovery context, holding that a reinsurer is entitled to discovery of evidence that may bear on the reasonableness of its cedent's allocation. As a practical matter, in order to obtain such discovery, a reinsurer may need to make a plausible showing that the allocation is unreasonable in specific respects.

Michigan Court of Appeals Holds Insurance Agent Liable To Insured For Failing To Procure Adequate Coverage, But Verdict Reduced Because Insured Was Comparatively Negligent In Failing To Read Policy

SUMMARY: In *Zaremba Equipment, Inc. v. Harco National Insurance Co.*, Nos. 298221, 298755, 2013 Mich. App. LEXIS 1313 (July 25, 2013), an insured filed a lawsuit against its insurance agent, claiming the agent negligently procured inadequate insurance coverage for the insured's building and its contents. While recognizing that an insured may not always have a viable negligence claim against its agent, the Michigan Court of Appeals held that the course of dealings between the insured and the agent gave rise to a "special relationship" pursuant to which the agent owed a duty of care to the insured. The court held the duty was breached when the agent obtained insurance coverage for the insured. The court also held that the insured had a duty to read and understand the policy and that the insured could be found comparatively negligent if it failed to fulfill this duty.

Harco issued an insurance policy to Zaremba which provided coverage of $525,000 for the insured's commercial building and $700,000 for its contents. A fire destroyed the building and its contents. The policy was obtained through Patrick Musall, Zaremba's long-time insurance agent, who was employed by Harco. In connection with the procurement of the policy, Zaremba had asked Musall to "meet or beat" a proposal from a competing insurance company that had a "guaranteed replacement cost" feature and had also informed Musall that it wanted to be "fully insured." In response, Musall utilized a software program to determine an appraisal value of Zaremba's property and used that information to determine the policy's limits. Zaremba purchased a policy through Musall with the limits he recommended.

After the fire, Zaremba realized that these limits were inadequate to repair and replace the property that was destroyed. Zaremba sued Musall and Harco, alleging that Musall negligently advised Zaremba with respect to its insurance needs and also negligently appraised the building and its contents. Musall responded that if Zaremba had read the policy upon receipt, it would have known its policy limits and could have requested any needed changes.

A jury awarded Zaremba $2,353,778 in damages, plus costs, interest, attorney's fees, and sanctions. The Michigan Court of Appeals reversed and remanded for a new trial because the trial court had erroneously refused to instruct the jury that Zaremba had a duty to read its insurance policy and question its agent about any coverage concerns, which, the appellate court said, could constitute comparative negligence. The court also held that, based upon the advice provided to Zaremba by Musall with respect to its insurance needs, Zaremba and Musall had a "special relationship" which required Musall to exercise reasonable care in fulfilling his duties to Zaremba.

After the first appeal, the case was remanded to the lower court for a second trial, where the jury awarded Zaremba $1,556,448 based upon claims of negligence and innocent misrepresentation against Musall. The jury

also found Zaremba was 30% comparatively negligent for failing to read its policy and 20% comparatively negligent as to the innocent misrepresentation claim. The trial court determined that Zaremba was entitled to a single satisfaction from the alternative theories and entered judgment in Zaremba's favor based on the higher figure which came to $1,245,265.40 after reduction for the comparative negligence.

In the second appeal, the defendants argued that Zaremba's failure to read its policy should have been a complete bar to the insured's recovery at trial. The court rejected this argument, reiterating its holding on the first appeal that Zaremba's failure to read the policy could constitute comparative fault to be weighed against Musall's negligence. The court found that the jury properly did this comparative analysis. Further, the court found that Zaremba's failure to read its policy had no bearing on Musall's inadequate appraisal of the property as, "[n]either the policy language nor any documents provided by defendants regarding the policy would have shed light on the accuracy of the [] estimate or Musall's representation that the $525,000 coverage limit constituted adequate replacement coverage."

In addition, the Court of Appeals rejected the defendants' argument that no "special relationship" between Musall and Zaremba was proven at trial which would give rise to a duty of care owed by Musall to Zaremba. The court recognized that typically an insurance agent, whose principal is the insurer, has no duty to advise the insured regarding the sufficiency of the insurance coverage procured and acts as an "order taker" for the policy. However, the court recognized that a "special relationship" between an agent and an insured can arise where: (1) the agent misrepresents the coverage available to the insured; (2) the insured makes an ambiguous request to the agent that requires clarification by the agent; (3) advice is sought from the agent by the insured and the advice given is inaccurate; or (4) the agent expressly agrees to assume duties to the insured.

Applying these factors, the Court of Appeals held that a "special relationship" was proven at trial since Musall made specific recommendations to Zaremba on its coverage needs and performed an appraisal of the property in order to fulfill Zaremba's request to be "fully insured." The court held: "[b]y making coverage recommendations, misrepresenting the coverage provided in the policy, and assuming the obligation to 'appraise' or 'survey' the property to calculate its replacement value, Musall established a duty of care quite different from that of an ordinary insurance agent." Therefore, in light of the special relationship between the parties, the Court of Appeals affirmed the jury's finding that Musall was negligent in the performance of his duties to Zaremba.

IMPORT OF DECISION: Situations sometimes arise where an insured learns after a loss that its insurance is inadequate to cover the loss. Depending on the course of dealings between the insured and the agent who procured the policy at issue, the insured may have a viable negligence claim against the agent for failing to obtain adequate insurance coverage. However, not all agent/insured relationships will support such a claim, and the specific circumstances concerning the procurement of the coverage and the nature of the relationship between the insured and the agent must be analyzed. Factors that may give rise to a duty of care owed by the agent to the insured (and thus lay the grounds for a negligence claim against the agent) include whether the insured deferred to the agent on the type and scope of coverage needed, whether the agent proactively advised the insured on coverage matters, and whether coverage advice provided by the agent was incorrect. Even where the circumstances demonstrate a duty of care is owed by the agent to the insured, however, an insured still has an obligation to review the policy that is issued, and the insured's failure to do so may be found to constitute comparative negligence on the part of the insured which may limit the insured's ability to recover against its agent.

New York Federal Court Predicts California Court Would Recognize Bad Faith Exception To Requirement That Late Notice Cause Prejudice

SUMMARY: In *Insurance Co. of the State of Pennsylvania v. Argonaut Insurance Co.*, No. 12 Civ. 6494, 2013 U.S. Dist. LEXIS 110597 (Aug. 6, 2013), the U.S. District Court for the Southern District of New York ruled that under California law a reinsurer may seek to avoid liability for a late-reported reinsurance claim without showing prejudice if the cedent acted in bad faith in providing untimely notice.

The reinsured, Insurance Company of the State of Pennsylvania ("ICSOP"), an AIG company, issued an excess umbrella policy to Kaiser Cement Corporation in 1974 that provided $5 million per occurrence coverage excess of $500,000 per occurrence primary coverage. Neither the primary nor the umbrella policy had aggregate limits. Argonaut Insurance Company issued a facultative certificate to ICSOP, reinsuring 20% of ICSOP's Kaiser umbrella policy.

Kaiser manufactured products containing asbestos and was sued in thousands of lawsuits alleging bodily injury and property damage caused by its products. In 1988 ICSOP was notified by a representative of another AIG company that it should create a file and issue a reservation of rights with respect to the Kaiser umbrella policy. In 1989 an employee of a different AIG company wrote a

CONTINUED ON PAGE 4

New York Federal Court Predicts California Court Would Recognize Bad Faith Exception To Requirement That Late Notice Cause Prejudice

CONTINUED FROM PAGE 3

memorandum stating that AIG's excess policies faced a very real possibility of some impairment and noting that reinsurance notices had not been sent out. In 1996 AIG created a master claim file for the Kaiser umbrella policy.

In 2001, the primary carrier notified ICSOP and the other excess carriers that its primary limits had been exhausted. The primary insurer then brought a declaratory judgment action against Kaiser alleging it had no further obligation to provide coverage under the primary policy. In April 2002, Kaiser filed a cross-complaint against ICSOP and its other excess insurers. In early 2006, the trial court ruled that the asbestos claims asserted against Kaiser arose from a single occurrence, which dramatically increased the exposure to ICSOP's umbrella policy. In August 2006, ICSOP increased its reserves under the policy from $5 to $249,995.

In 2007 the appellate court reversed the trial court's ruling, holding the asbestos claims constituted one occurrence per claimant. Under California law, Kaiser then selected the 1974 year to cover its asbestos claims. In 2008 the trial court held that once Kaiser's 1974 primary policy was exhausted, the ICSOP umbrella policy would attach. Thereafter, Kaiser, ICSOP, and another excess carrier engaged in mediation. In March 2009, ICSOP increased its reserves for the umbrella policy to $5 million. The following month, Kaiser and its excess insurers (including ICSOP) reached a settlement pursuant to which ICSOP agreed to pay millions of dollars for past claims.

ICSOP did not give Argonaut any notice of the Kaiser loss until April 2009. The notice provision in the facultative certificate stated:

> [ICSOP] shall notify [Argonaut] promptly of any occurrence which in the Company's estimate of the value of injuries or damages sought, without regard to liability, might result in judgment in an amount sufficient to involve this certificate of reinsurance. [ICSOP] shall also notify [Argonaut] promptly of any occurrence in respect of which [ICSOP] has created a loss reserve equal to or greater than fifty (50) percent of [ICSOP's] retention specified in Item 3 of the Declarations; or, if this reinsurance applies on a contributing excess basis, when notice of claim is received by the Company.

Argonaut contended ICSOP did not provide timely notice of the Kaiser loss and that it was prejudiced as a result. Argonaut also argued that ICSOP was guilty of bad faith in providing untimely notice. Accordingly, the reinsurer said it had no liability for the Kaiser claims.

When Argonaut refused to pay, ICSOP filed suit. Discovery was limited to the existence of prejudice. Both parties moved for summary judgment. Argonaut argued that it should have received notice in 1989 but in any event no later than April 2000. The court found that ICSOP was required to give notice no later than 2002, when Kaiser filed a cross-claim against ICSOP in the coverage action. ICSOP conceded that notice was late, but argued Argonaut needed to prove prejudice to be relieved from its obligation to pay. Argonaut responded that it had been prejudiced by the late notice because it had been deprived of the opportunity to associate in the defense of the underlying claims. The reinsurer argued its participation would have resulted in an earlier and more advantageous settlement.

Argonaut also asserted it was prejudiced because it had entered into a number of commutation agreements between 2001 and 2009 with retrocessionaires that would have had responsibility for a portion of Argonaut's liability to ICSOP for the Kaiser claims. Argonaut contended that, had it been aware of the Kaiser loss, it either would not have entered into some of the commutations or would have sought a higher price. The court ruled that triable issues of fact existed regarding Argonaut's prejudice arguments sufficient to preclude entry of summary judgment for either party.

The court also held that Argonaut would be relieved of the burden to show prejudice if it could demonstrate ICSOP acted in bad faith in not providing timely notice. A reinsured owes a duty of utmost good faith to its reinsurer because it has almost exclusive possession of the information surrounding the underlying risk. The court relied on the Second Circuit's decision in *Unigard Security Insurance Co. v. North River Insurance Co.*, 4 F.3d 1049 (2d Cir. 1993) which held that a reinsurer is entitled to relief on the basis of late notice when a ceding insurer fails to implement routine practices and controls to ensure notification of its reinsurer. The court also cited with approval language from *Unigard* that if a ceding company does not implement such practices and controls, it has willfully disregarded the risk to reinsurers and is guilty of bad faith.

Starting in the 1980s, ICSOP used an automated system to provide notice to reinsurers. Under the system, notice to reinsurers should have been generated as soon as a claim file was opened. The Kaiser policy was issued in 1974, before the adoption of the automated notice system. At some point, the appropriate reinsurance information should have been coded into the system. Evidently, it was not. As a result, notice was not given to

Argonaut when a claim file for the Kaiser umbrella claims was opened in 1996, or at any other time until 2009.

The New York federal court predicted California courts would follow the *Unigard* decision for two reasons. First, the California Insurance Code has codified the duty of the reinsured to convey all information material to the underlying risk to the reinsurer. Cal. Ins. Code § 622. Second, California courts have recognized that reinsureds are sophisticated parties familiar with the practice of giving and receiving notice. Thus, the court held a requirement that a reinsured implement adequate controls to ensure notice is given to reinsurers is within the expectations of the parties entering into a reinsurance agreement.

ICSOP argued California courts would be unlikely to adopt this approach because California has traditionally required an insurer to prove prejudice in connection with a late notice defense while New York has not. The court rejected this argument, noting that the differences between direct insurance and reinsurance did not make this a meaningful distinction.

The parties had taken no discovery on the bad faith issue at the time of the summary judgment hearing. The court ruled the parties would be allowed to do so before proceeding to trial at which Argonaut would be permitted to argue its bad faith defense.

IMPORT OF DECISION: This case evidences what may be a growing trend to expand the types of circumstances in which a reinsurer may be excused from liability due to late notice. Typically, a reinsurer must prove prejudice, which often can be an insurmountable hurdle. This decision holds that even if a reinsurer cannot establish prejudice, it may be relieved from responsibility for a reinsurance claim if its cedent has failed to implement and adhere to appropriate internal procedures calculated to ensure that timely notice is given to reinsurers.

California Appellate Court Holds Insurer Not Liable For Bad Faith In Absence Of Policy Limits Settlement Demand Even Though Insured's Liability Was Clear And There Was Substantial Likelihood Of Verdict In Excess Of Limits

SUMMARY: In *Reid v. Mercury Insurance Co.*, 2013 Cal. App. LEXIS 798 (Oct. 7, 2013), the California Court of Appeal held that even when an insured's liability for an automobile accident was clear and there was a substantial likelihood the claimant would obtain a verdict in excess of policy limits, the insurer was not liable for bad faith for not offering policy limits in the absence of a settlement demand from the claimant or evidence the claimant was interested in settlement.

Mercury Insurance Company issued an automobile policy to its insured with bodily injury limits of $100,000 per person and $300,000 per accident. The insured ran a red light and collided with the claimant who sustained major injuries. Within a month of the accident, Mercury accepted liability. Shortly after that, the claimant's son asked the carrier to disclose the insured's policy limits. The carrier declined to do so without its insured's permission. Mercury then wrote to the claimant stating that the carrier's investigation was incomplete and that it was not in a position to resolve liability or to settle the claim without a recorded interview with the claimant. In addition, Mercury wrote to its insured stating that its preliminary investigation indicated the claims exceeded the insured's policy limits. The carrier also advised the insured that she had the right to consult legal counsel at her own expense regarding her uninsured interest, but that the carrier would continue to attempt to resolve the matter within policy limits.

After having his request that Mercury disclose the insured's policy limits rebuffed, the claimant's son hired an attorney because he thought he was "being jerked around" by the carrier. He authorized the attorney to settle the case on behalf of his mother as quickly as possible but did not authorize any specific amount.

About six weeks after the accident, Mercury's claims manager noted in the file that the carrier would need to tender policy limits to the claimant as soon as it had enough medical records to do so. Two weeks later, the carrier disclosed the insured's policy limits to the claimant's attorney, but advised that it was not prepared to settle or offer policy limits. Although the claimant's counsel later claimed he would have accepted policy limits to settle the case, he did not send a demand so stating.

The claimant filed suit about 3 1/2 months after the accident and sent her medical records to the carrier about three months after that. Three months later, Mercury tendered its policy limits. The claimant rejected the offer. Two years later, following a bench trial, judgment was entered in the claimant's favor in the amount of $5.9 million. The insured filed for bankruptcy, and the bankruptcy trustee assigned the insured's rights against Mercury to the claimant.

The claimant then sued Mercury for $6.9 million, asserting a bad faith failure to settle. The complaint alleged that Mercury not only failed to make a reasonable

CONTINUED ON PAGE 6

California Appellate Court Holds Insurer Not Liable For Bad Faith In Absence Of Policy Limits Settlement Demand Even Though Insured's Liability Was Clear And There Was Substantial Likelihood Of Verdict In Excess Of Limits

CONTINUED FROM PAGE 5

offer within a reasonable time, but that the carrier had rejected and discouraged any efforts at settlement. Mercury moved for summary judgment, contending the claimant could not prove a bad faith claim because she never made a demand for settlement within policy limits. The trial court granted Mercury's motion, concluding that the claimant had never made a settlement demand or otherwise informed the carrier that she would accept policy limits in settlement. The court said there was no California authority holding there is a duty to settle a claim that is vastly in excess of policy limits regardless of whether a settlement demand has been made.

The claimant appealed to the California Court of Appeal which affirmed the trial court's ruling.

The court said that when a claimant offers to settle an excess claim within policy limits, an opportunity to settle exists, and a conflict of interest arises because a divergence exists between the insurer's interest in paying less than the policy limits and the insured's interest in avoiding liability beyond the limits. A conflict may also arise without a formal settlement offer when a claimant clearly conveys to the insurer an interest in discussing settlement, but the insurer ignores the opportunity to explore settlement to the insured's detriment. An opportunity to settle does not arise simply because there is a significant risk of an excess judgment.

The court reviewed California case law, noting that a carrier may be liable for bad faith if the insurer refuses to settle after having unreasonably refused an offered settlement. An insurer may also be liable for bad faith refusal to settle even if a formal settlement offer has not been made if there is evidence the insurer knew of the claimant's interest in settlement and ignored it. But none of the cases suggests that an insurer has a duty to initiate settlement discussions in the absence of any indication from the injured party that he or she is inclined to settle within policy limits. The court held that nothing in California law supports the proposition that bad faith liability for failure to settle may attach if an insurer fails to initiate settlement discussions or offer its policy limits as soon as an insured's liability in excess of policy limits has become clear.

The court said none of the evidence suggested that the claimant conveyed to the carrier any interest in settlement, at policy limits or otherwise, at any time before Mercury offered its policy limits. Thus, there was no evidence of a bad faith failure to settle. The court held that for bad faith liability to attach to an insurer's failure to pursue settlement discussions in a case where the insured is exposed to a judgment beyond policy limits, there must be some evidence either that the injured party has communicated to the insurer an interest in settlement or some circumstance demonstrating the insurer knew that settlement within policy limits could be feasibly negotiated. In this case, the court said, the claimant did not make a settlement offer, and there was no evidence from which a reasonable juror could infer that Mercury knew or should have known the claimant was interested in settlement.

The Court of Appeal also rejected the argument that California Insurance Code § 790.03(h)(5) supported the claimant's bad faith case. That section defines certain "unfair" insurance practices to include "[n]ot attempting in good faith to effectuate prompt, fair, and equitable settlements of claims in which liability has become reasonably clear." The court noted that there is no private civil cause of action against an insurer for allegedly violating the statute, although violations may evidence the insurer's breach of the duty to its insured under the implied covenant of good faith and fair dealing. The court held that § 790.03 does not purport to define the circumstances that give rise to a breach of the insurer's obligation to attempt to settle in good faith and that nothing in the statute requires insurers to *initiate* settlement negotiations in the absence of an expression of interest in settlement from the claimant in order to avoid liability for a bad faith claim.

IMPORT OF DECISION: Insurance companies are often concerned about potential bad faith exposure in cases in which their insurerds' liability may substantially exceed policy limits. In holding that a carrier is not subject to bad faith liability for an excess verdict if the claimant never made a policy limits settlement demand, this case provides carriers with some measure of protection, although the holding that a carrier could be liable for bad faith if it knew or should have known the claimant was interested in settlement usually will make the issue of the insurer's "knowledge" an issue of fact.

New Jersey Supreme Court Rules All Solvent Insurance Coverage Must Be Exhausted Before Claim May Be Made On Guaranty Fund

SUMMARY: In *Farmers Mutual Fire Insurance Co. of Salem v. New Jersey Property-Liability Insurance Guaranty Ass'n*, No. A-42-11 (068824), 2013 N.J. LEXIS 902 (Sept. 24, 2013), the New Jersey Supreme Court held that when one of several insurance carriers liable for a continuous trigger loss is insolvent, the limits of the policies issued by all solvent insurers in all other years must first be exhausted before the New Jersey Property-Liability Insurance Guaranty Association is obligated to pay statutory benefits. The ruling, in effect, requires solvent carriers to pick up the shares of insolvent carriers and relieves both the Guaranty Association and the policyholder from any responsibility for the insolvents' shares until the solvent carriers' limits have been exhausted.

This case involved two consolidated actions concerning remediation of contaminated properties owned by two different policyholders. For several successive one-year periods, Newark Insurance Company issued homeowner's insurance policies covering two separate residential properties. The policies each provided property damage coverage of $300,000. Immediately following the expiration of the Newark policies, each property was insured by Farmers for property damage with limits of $500,000. In 2003, within the first year of Farmers' coverage, both properties were found to have soil and groundwater contamination caused by fuel oil leaks from underground storage tanks. Although it was undisputed that the contamination began during periods insured by Newark, Farmers paid all of the remediation costs: $112,165.13 for one property and $25,958.39 for the other.

Newark was declared insolvent in 2007, and an order was entered placing the carrier in liquidation. The Guaranty Association then took over the administration of Newark's claims. In 2009, Farmers filed suit, seeking reimbursement from the Guaranty Association, claiming that under the allocation scheme adopted in *Owens-Illinois, Inc. v. United Insurance Co.*, 138 N.J. 437 (1994), the Guaranty Association was responsible for Newark's share of the cleanup costs. Under *Owens-Illinois*, in cases involving progressive and indivisible damage, a continuous coverage trigger applies, and damages are allocated among the insurers based on their policies' time on the risk and the available limits.

The Guaranty Association moved for summary judgment, arguing that the New Jersey Property-Liability Insurance Guaranty Association Act ("PLIGA Act"), N.J.S.A. 17:30A-1 to -20, required insureds to exhaust their claims through solvent carriers prior to applying for statutory benefits from the Guaranty Association. The trial court rejected that argument, concluding that the Spill Compensation and Control Act, N.J.S.A. 58:10-23.11, provided Farmers with a right to contribution from the Guaranty Association.

On appeal to the Appellate Division, the trial court's decision was reversed. The appellate court held that a 2004 amendment to the PLIGA Act required the exhaustion of all insurance benefits from solvent insurers before the Guaranty Association was obligated to pay statutory benefits. Since Farmers had not exhausted its policy limits, it could not seek contribution from the Guaranty Association for a share of the remediation costs.

The New Jersey Supreme Court granted Farmers' petition for certification and affirmed the Appellate Division's decision. The court held that in long tail, continuous trigger cases where an insolvent insurer is on the risk along with solvent carriers, the PLIGA Act's exhaustion provision mandates that an insured first exhaust the policy limits of the solvent carriers before seeking statutory benefits from the Guaranty Association. Only after those limits have been exhausted is the Guaranty Association required to contribute to the loss.

The court stated that the case hinged on the effect the 2004 amendment to the PLIGA Act had on the *Owens-Illinois* decision. The court noted that the PLIGA Act was enacted to mitigate the financial distress to insureds and claimants resulting from an insurance company's insolvency. The Guaranty Association was created to stand in the place of insolvent insurers. To conserve resources and to achieve the PLIGA Act's core purposes, the Guaranty Association's responsibility to pay insolvent insurers' claims is limited. The statutory objective of conserving the Association's assets is evident in N.J.S.A. 17:30A-12(b) which requires a claimant to exhaust the policy of a solvent insurer prior to seeking benefits from the Association.

In 2004, the New Jersey legislature amended the PLIGA Act to define "exhaust" in the context of continuous, indivisible property damage losses. The amendment states that exhaustion occurs only after "a credit for the maximum limits under all other coverages, primary and excess, if applicable, issued in all other years has been applied." The court held that "other coverages" refers to policies issued by solvent insurers, thereby requiring exhaustion of the policy limits of solvent insurers before obligating the Guaranty Association to pay statutory

CONTINUED ON PAGE 8

New Jersey Supreme Court Rules All Solvent Insurance Coverage Must Be Exhausted Before Claim May Be Made On Guaranty Fund

CONTINUED FROM PAGE 7

benefits. This conclusion is consistent with the principle that the Guaranty Association is an insurer of last resort. The court also held that legislative enactments are never subservient to the common law. A statute must be honored unless constitutionally infirm. Thus, the 2004 amendment to the PLIGA Act takes precedence over the common law proration scheme enunciated in the Supreme Court's earlier (1994) *Owens-Illinois* decision.

The court also rejected the position of *amicus curiae* Zurich American Insurance Company that the 2004 amendment did not alter the *Owens-Illinois* formula because the insured, not its other insurers, remains responsible for periods where one of its insurers becomes insolvent. Zurich contended that the PLIGA Act does not control how losses are allocated between an insurer and its insured. Thus, Zurich argued, even if the Guaranty Association is correct that the 2004 amendment prevents an insured from recovering statutory benefits before the policies of its solvent insurers are exhausted, the insured – not the solvent insurer – is compelled to make payments under the *Owens-Illinois* allocation scheme before accessing statutory benefits under the PLIGA Act. The court said this position would stand the PLIGA Act on its head since the Guaranty Association was created to provide benefits to insureds who, through no fault of their own, lost coverage due to the insolvency of their carriers.

Lastly, the court held that the exhaustion definition in the 2004 amendment to the PLIGA Act did not unconstitutionally impair Farmers' insurance contracts with its insureds. In a highly regulated industry such as insurance, there is no "contractual expectation" that the regulatory scheme will remain unalterably fixed.

IMPORT OF DECISION: In some states, an insured is obligated to bear the cost of an insolvent carrier's allocable share of a long-tail loss subject to a continuous coverage trigger. In other states, state guaranty funds must pick up an insolvent's portion. This decision holds that in New Jersey, solvent carriers, not the insured or the state Guaranty Association, must pay the portion of a loss allocated to insolvent carriers up to the solvent carriers' policy limits.

California Federal Court Rules Parties Must Proceed With Selection Of Umpire And That Arbitration Panel Should Decide Whether There Would Be One Or Three Arbitrations

SUMMARY: In *Granite State Insurance Co. v. Clearwater Insurance Co.*, No. C 13-2924, 2013 WL 4482948 (N.D. Cal. Aug. 19, 2013), two AIG companies, as cedents, commenced one arbitration against one reinsurer under three reinsurance agreements and appointed one arbitrator. The reinsurer contended there should be three separate arbitrations and appointed two arbitrators, one regarding the disputes under two of the reinsurance agreements and a second for the dispute under the third. When the reinsurer declined to proceed with the appointment of an umpire, the AIG companies filed suit and requested that the court appoint one umpire for a consolidated arbitration. The reinsurer sought separate arbitrations. The court ruled the parties were to proceed with the reinsurance agreements' umpire selection process and that the single arbitration panel should decide whether there were to be one or three arbitrations.

Clearwater Insurance Company reinsured Granite State Insurance Company and New Hampshire Insurance Company under two separate reinsurance agreements. Clearwater also reinsured New Hampshire under a third reinsurance agreement. Granite State and New Hampshire are both AIG companies. In 2006, Granite State and New Hampshire (together "cedents") entered into a settlement with one of their mutual insureds (Kaiser Aluminum Chemical Corporation) in which they agreed to cover a portion of Kaiser's thousands of asbestos-related losses. The cedents then billed Clearwater for its share of the settlement payments pursuant to the three reinsurance contracts. After paying some of the billings, Clearwater stopped making payments. The cedents then (together) made a single demand for arbitration regarding Clearwater's obligations to reimburse them for its shares of the Kaiser losses under the three reinsurance agreements.

The parties agreed that the three reinsurance contracts contained identical arbitrator selection provisions requiring each party to select an arbitrator. The two arbitrators would then select an umpire. If the arbitrators could not agree on an umpire, each arbitrator was to submit two names. The parties would then each strike one name from the other party's umpire list. The umpire would be selected from among the remaining two candidates by the drawing of lots.

The AIG companies appointed one arbitrator. Clearwater refused to appoint just one arbitrator, contending the cedents' demand for one arbitration was improper. Instead, Clearwater appointed one arbitrator under the first two reinsurance agreements and a second under the third. Clearwater asserted there should be three separate arbitrations. Each side then exchanged the names of two potential umpire candidates, but at that point the umpire selection process stalled.

When the parties were unable to resolve their dispute, the cedents initiated an action in the Northern District of California seeking an order appointing one umpire in a single arbitration from among the two candidates they had proposed. Clearwater cross-petitioned for an order to compel the AIG companies to participate in three separate arbitrations, one for each agreement. Clearwater said the issue of consolidation could be addressed later, after three separate panels were convened.

The district court said it would not grant the relief sought by either party because to do so would overstep the court's authority under the Federal Arbitration Act. Instead, the court ordered that the reinsurance agreements' umpire selection process continue from where it had stalled and that one umpire be selected. The court held the resulting arbitration panel should decide whether the disputes under the three reinsurance agreements should be heard in one or three arbitrations.

The court noted that "disputes as to the scope of the parties' agreement to arbitrate . . . [are] for the arbitrator, not the Court." The court said that under Sections 4 and 5 of the FAA, its authority was limited to either requiring the parties to arbitrate as agreed or to appoint arbitrators under certain impasse conditions. Noting that numerous courts have held the question of whether arbitrations should be consolidated is for arbitrators to decide, the court concluded the propriety of the cedents' demand for a single arbitration was outside the court's authority. The court further noted that Section 4 of the FAA empowers a court to enforce arbitration agreements "where there has been a proper demand," but Clearwater conceded that only one demand for arbitration had been made in this case. Clearwater, itself, had not served any separate arbitration demands. Therefore, the court had no authority to order three separate arbitral panel appointments since three separate arbitration demands had not been issued.

As to the cedents' request that the court appoint the umpire, the court noted that a court may appoint an umpire only where the circumstances are such that it is impossible to follow the parties' arbitration clause dictating the method of selecting an umpire. In this case, the court said the umpire selection process was already underway, and the only obstacle was Clearwater's insistence on three panels and three arbitrations. Having decided that that issue was to be resolved by the arbitration panel, the court ordered the parties to arbitrate as agreed and the umpire selection process to continue so that an umpire would be appointed. The single arbitration panel would then have the authority to decide whether the cedents' demand for one arbitration was an improper consolidation.

IMPORT OF DECISION: This decision reinforces the limitation on a court's jurisdiction to decide issues related to arbitration agreements and umpire selection. Under the FAA, questions regarding the scope of an agreement to arbitrate – including whether one or multiple arbitration proceedings are required – are for arbitrators to decide, not the courts. Furthermore, the courts cannot compel multiple arbitrations under separate reinsurance contracts where the parties have only made one arbitration demand. Finally, unless the umpire selection process is impossible to follow under the circumstances of the case, the court will not appoint an umpire, but will order the parties to adhere to the selection process provided in the parties' agreement.

CLARK HILL | THORP REED's Insurance and Reinsurance Practice Group has an established reputation for its work in the global insurance and reinsurance industry. The firm represents major United States, London Market, European, and Bermuda insurers and reinsurers in commercial litigation, coverage disputes, and major business transactions. Our practice encompasses all types of insurance, and every kind of underlying risk. We have the capacity to efficiently handle any (re) insurance matter, from individual to class action claims, and each assignment undertaken by the firm is afforded the same personal attention of partners having expertise with respect to the issues.

Philadelphia

Joseph M. Donley
Insurance & Reinsurance Practice Group Leader

Christopher M. Brubaker
William E. Cox
Christopher J. Day
Douglas M. Chapman
Peter B. Kupelian
Carol G. Schley
Karolien M. Vandenberghe

For more information, please contact Joseph M. Donley at jdonley@clarkhill.com, or call 215.640.8500.

To subscribe to *Insurance & Reinsurance Briefing*, please contact Connie Lojewski at 215.640.8543 or clojewski@clarkhill.com.

Insurance & Reinsurance

CLARK HILL

www.clarkhill.com

BRIEFING

Spring 2014

Insurance And Reinsurance Cyber Risk Issues

Virtually all companies have potential cyber risk exposure, whether limited to the costs of retrieving and recreating lost data or as massive as the multi-million dollar losses suffered by Target. From the Target data breach, to the indictment of Chinese military officers for cyber espionage, to the international raids on the developers and users of the Blackshades malware, threats of data breaches and cyber-attacks impacting both businesses and individuals are very real. The last 15 years have seen exponential growth in the use of computers, computer networks and "smart" devices that interact with computers and computer networks. Sensitive personal information is electronically transmitted through retail, banking, investment and other types of transactions, many of which are on-line. Much of the data is stored on companies' servers. The large majority of states have laws requiring notification to individuals when personal information is exposed in a cyber-attack. Data breaches and cyber-attacks have increased almost 50% in recent years. And it is not just large companies that are at risk. Almost three-quarters of incidents occur at companies with fewer than 100 employees.

The term "cyber risk" is used to describe all risks associated with computers, computer networks and smart devices. Forms of cyber risk include lost data, the loss of data to third parties, damage to cyber infrastructure, malware, viruses, hacking, and the use/misuse of social media and the internet. Employees and other insiders are particularly vexing sources of exposure. Their activities may range from "innocent" (if somewhat naive) clicking on suspect links, to carelessness with passwords, to "rogue" actions utilizing hacking and/or malware to obtain unauthorized access to systems and information.

It is little wonder that the insurance market has stepped in to offer an expanding line of insurance products to address these evolving risks. Available coverages for cyber risk include costs of notification and credit monitoring for privacy breaches; third-party liability (sometimes including regulatory enforcement and violation costs); restoring/replacing lost data; business interruption coverage; liability for libel, slander, copyright infringement and other similar claims related to websites or social media; and cyber extortion/terrorism. Generally, cyber risk policies are written on a claims made and reported basis. It has been estimated that over 30% of businesses, representing $1.3 billion in premium, had some form of cyber risk coverage in 2013. That premium figure is expected to rise significantly in the next two to three years. This in turn should trigger a rise in demand for reinsurance for cyber risk policies.

Given the evolving nature of cyber risks and the numerous risk factors at play, risk management and underwriting are particularly important to successfully writing cyber risk coverage. Cyber-attacks that result in the most harm often involve multiple causes such as hacking, malware, or actions by rogue employees. The level and type of risks also vary widely between industries and size of the business. Coverages and limits will vary widely as well. Policyholders should carefully consider how to tailor their cyber risk coverages to address the specific types of exposures their companies may face.

In the Target case, vendors were given remote access, not just to the limited portion of Target's systems necessary for them to perform tasks relevant to their work, but to much wider segments of Target's network. Notwithstanding this obvious security gap, Target had very proactive data security procedures in place and had invested in the latest technology

CONTINUED ON PAGE 2

Inside this Briefing

Insurance And Reinsurance Cyber Risk Issues

CONTINUED FROM PAGE 1

designed to detect and block cyber-attacks. The technology apparently worked properly; alarms were sent in a timely manner that could have prevented data from leaving Target's systems. However, those alarms were apparently ignored by the personnel tasked with monitoring the systems. Information was stolen from about 110 million of Target's customers' debit and credit cards. The Target breach starkly demonstrates the potential for devastating losses as Target has reported spending $61 million as of February 1, 2014, less than two months after the breach was reported.

All indications are that cyber risk will continue to increase as technology evolves. Legislation and the courts are only just catching up to what has been happening for the last several years. The recent opinion from the New Jersey federal district court in *Federal Trade Commission v. Wyndham Worldwide Corp.*, No. 13-1887, 2014 U.S. Dist. LEXIS 47622 (D.N.J. April 7, 2014) concerned three data breaches at Wyndham hotels between April 2008 and January 2010 and illustrated how risk exposure is still evolving. The FTC brought charges of unfair and deceptive trade practices against Wyndham related to the company's data security. The FTC alleged Wyndham engaged in unfair acts or practices under the FTC Act by failing to employ reasonable and appropriate measures to protect personal information from unauthorized access. The FTC further alleged that this failure caused or was likely to cause substantial injury to consumers who were not able to avoid the injury on their own. Wyndham tried to have the case dismissed, arguing that the FTC's jurisdiction in the data security field was preempted and that, even if it was not preempted, the FTC was required to engage in rule making before bringing an enforcement action. The court overruled Wyndham's objections and allowed the case to proceed. It remains to be seen if the court's decision will stand and if liability will ultimately be found, but the case serves as a good example of how the legal landscape surrounding cyber risk is only beginning to emerge.

Many of the types of exposures and losses common to cyber-attacks and data breaches are not covered by standard CGL policies. All companies, regardless of size or nature of business, need to seriously evaluate their potential exposure to losses resulting from cyber-attacks and data breaches and to procure the type and level of cyber risk coverage necessary to protect their businesses.

Claims Arising From Recording Customers' Calls May Not Be Covered Under CGL Policies

SUMMARY: In *Defender Security Co. v. First Mercury Ins. Co.*, 2014 U.S. Dist. LEXIS 33318 (S.D. Ind., Mar. 14, 2014), a federal district court in Indiana held allegations that an insured unlawfully recorded its customers' telephone calls did not constitute "[o]ral or written publication of material that violates a person's right of privacy" under Coverage B of a commercial general liability ("CGL") policy. Thus, the CGL insurer was not required to provide a defense to the insured for a lawsuit based upon such allegations. The court held that merely recording and storing customer telephone calls did not constitute a "publication" by the insured, as required for Coverage B to be triggered. Further, the court reviewed and expressly rejected a recent decision by another federal district court, which had reached a contrary conclusion under similar facts.

The insured, Defender Security Company, sought coverage for a class action complaint filed against it in California. The plaintiff, Kami Brown, said she had made telephone calls to Defender regarding the purchase of home security services, during which she allegedly "shared personal information" with Defender, including her name, address, date of birth and social security number. Brown asserted that her conversations with Defender were recorded by Defender without her knowledge and consent, and that Defender systematically recorded and stored all of its telephone conversations with customers without obtaining consent as required by California law, which makes it a crime to record a telephone conversation unless all parties to the call consent.

Defender tendered the defense of the California lawsuit to its CGL insurer, First Mercury Insurance Company, but First Mercury denied coverage. Defender then filed a declaratory judgment action against First Mercury, claiming that coverage was available under Coverage B of its CGL policy, which provided coverage for "personal and advertising injury," defined to include "[o]ral or written publication of material that violates a person's right of privacy."

First Mercury filed a motion to dismiss the coverage lawsuit, arguing that Defender's recording and storing of customer telephone calls, without any allegation that the recordings had been disseminated to a third party, did not constitute a "publication" as required by Coverage B. Defender, however, argued that disclosure to just one person constituted a "publication" and that the allegation in the California lawsuit that Defender stored the telephone

call recordings "for various business purposes" implied that the recordings were disclosed to at least one person.

The court agreed with First Mercury, finding that no "publication" of the telephone call recordings was alleged in the California lawsuit and, thus, no coverage existed under Coverage B of the CGL policy. The court held that:

> [T]he allegation that Ms. Brown shared personal information with Defender during her call establishes at most only that *she* published information about *herself*, not that *Defender* published information about *her*. Assuming the truth of Ms. Brown's allegation that Defender utilized "Call Recording Technology" to store the recording of her telephone call likewise shows merely that Defender maintained a record of the call, not that it communicated the content of the recording to anyone.

In reaching this decision, the *Defender* court reviewed and rejected the holding of another federal trial court which involved similar facts. *Encore Receivable Management, Inc. v. ACE Property & Cas. Ins. Co.*, 2013 U.S. Dist. LEXIS 93513 (S.D. Ohio, July 3, 2013), concerned a call center that recorded customer telephone calls without the customers' knowledge and consent. Such calls were alleged to have been "distributed internally" within the insured's operations for training and quality control. The *Encore* court found that these allegations were sufficient to demonstrate that the recordings were "published" and, thus, to trigger Coverage B of the insured's CGL policy. According to the *Encore* court, "this Court need not find that the communications were actually disseminated to third parties, because the initial dissemination of the conversation constitutes a publication at the very moment that the conversation is disseminated or transmitted to the recording device." Despite the factual similarity between the two cases, the *Defender* court rejected *Encore* in reaching its decision because that case was decided by a different federal district court and because it considered "its analysis to be contrary to the manner in which we believe Indiana courts would decide this issue."

Both *Defender* and *Encore* have been appealed, *Defender* to the Seventh Circuit and *Encore* to the Sixth Circuit.

IMPORT OF DECISION: It is not uncommon for companies to record their customers' telephone calls for quality control, training, and other business purposes. Since the law on recording telephone conversations varies from state to state, companies that engage in this practice may find themselves on the receiving end of a lawsuit by aggrieved customers alleging that their rights were violated. However, whether a company faced with such a lawsuit will be provided a defense by their CGL insurer is unclear, as evidenced by the *Defender* and *Encore* decisions. Whether or not coverage will be afforded for such a claim will not only turn on the specific factual allegations of the underlying lawsuit for which a defense is sought by the insured, but also on whether the court hearing the coverage matter is inclined to follow the reasoning of *Defender* or *Encore* (or neither). Further, with two different federal appeals courts now considering essentially the same question, how the law will develop on this Coverage B issue is still very much up in the air.

Sixth Circuit Reverses Injunction Entered By Michigan Trial Court That Had Enjoined Arbitration To Address Allegations Of Misconduct By Arbitrator, Umpire, and Counsel

SUMMARY: In our Winter 2014 Newsletter, we commented on a Michigan federal district court case in which the court enjoined an ongoing arbitration to allow one of the parties to pursue allegations of impermissible conduct by the umpire, one of the arbitrators, and one of the attorneys involved in the arbitration. *Star Ins. Co. v. Nat'l Union Fire Ins. Co.*, 2013 U.S. Dist. LEXIS 130379 (E. D. Mich. Sept. 12, 2013). The case was appealed to the Sixth Circuit which has now reversed the trial court's decision and dissolved the injunction, holding that judicial review of the interim arbitral decision in this matter is not permissible. *Savers Property and Cas. Ins. Co. v. Nat'l Union Fire Ins. Co.*, 2014 U.S. App. LEXIS 6488 (6th Cir. Apr. 9, 2014).

Star Insurance Company, Savers Property & Casualty Insurance Company, Ameritrust Insurance Corporation, and Williamsburg National Insurance Company ("Cedents") and National Union Fire Insurance Company, the reinsurer, entered into a reinsurance treaty covering workers' compensation business that contained an arbitration provision under which disputes were to be submitted to a panel of two party-appointed arbitrators and an umpire who were not under the control of either party.

A dispute arose, and the Cedents commenced an arbitration against National Union. Party arbitrators and an umpire were appointed. The arbitrators issued a scheduling order that provided *ex parte* communications with panel members were to cease upon the filing of the parties' initial pre-hearing briefs. The order did not say when or if *ex parte* communications could resume. Following a hearing, the panel issued an "Interim Final Award" resolving liability but leaving open issues relating to damages. Thereafter, National Union's counsel and its arbitrator had *ex parte* communications, and the umpire and National Union's arbitrator issued two orders, allegedly without the knowledge or participation of the Cedents' arbitrator.

CONTINUED ON PAGE 4

Sixth Circuit Reverses Injunction Entered By Michigan Trial Court That Had Enjoined Arbitration To Address Allegations Of Misconduct By Arbitrator, Umpire, and Counsel

CONTINUED FROM PAGE 3

The Cedents then filed a lawsuit seeking to enjoin the arbitration and to obtain appropriate relief for alleged breaches of the treaty which they asserted included the *ex parte* communications, various relationships between National Union's arbitrator and its counsel and between that arbitrator and the umpire, and the issuance of panel orders without the participation of the Cedents' arbitrator.

The court agreed with the Cedents and entered an order enjoining the arbitration to allow the Cedents an opportunity to investigate their allegations of misconduct. National Union appealed. The Sixth Circuit first addressed the choice of law issue. The parties disagreed whether the Federal Arbitration Act ("FAA") or the Michigan Arbitration Act ("MAA") controlled the dispute. In resolving this issue, the court noted the treaty stated that any arbitration would be subject to the laws of the State of Michigan. Thus, the court found that the MAA applied. However, it further observed that the FAA and the MAA were identical in all relevant respects, and therefore it employed FAA-based precedent to help in its analysis.

The Sixth Circuit next considered whether the district court's review of the Interim Final Award was improper. The court analyzed the history and purpose behind the FAA and MAA and held that the laws contemplated "only two stages at which courts may become involved in arbitration proceedings." First, at the outset of any dispute, courts are authorized to decide certain "gateway matters" of arbitrability. Second, at the conclusion of an arbitration proceeding, courts are authorized "to enter an order confirming, vacating, or modifying the award." Between those two stages, however, the court said "the laws are largely silent with respect to judicial review." The Sixth Circuit and several other circuits have previously interpreted that silence "to preclude the interlocutory review of arbitration proceedings and decisions." The court noted there were sound policy reasons for withholding judicial review until the conclusion of an arbitration proceeding. The court further observed that the Cedents and National Union expressly agreed to be bound by Michigan law and thereby "agreed to defer judicial review until after conclusion of the [a]rbitration." Finally, the court noted that the Interim Final Award only addressed liability and that the panel had retained jurisdiction to compute damages. Thus, the court said, the arbitration was not complete because there was no "final" award. Accordingly, the court held that the Cedents' "request that the district court intervene to halt this ongoing arbitration proceeding was plainly improper."

The Sixth Circuit then considered the district court's employment of 9 U.S.C. § 2 to intervene in the arbitration, noting first that it was not required to review this aspect of the district court's decision because the Cedents never raised the issue before the district court. Section 2 provides that an arbitration clause in a contract is valid and enforceable except "upon such grounds as exist at law or in equity for the revocation of any contract." The court nevertheless proceeded to analyze 9 U.S.C. § 2, noting first that it "pertains only to the revocability of an arbitration agreement under traditional contract defenses." The court held that "[c]hallenging the fairness of an arbitration proceeding or the partiality of an arbitrator is different in kind than challenging the underlying contract that contained the agreement to arbitrate" and that the district court erred in relying on 9 U.S.C. § 2 to entertain the Cedents' "premature challenge to the fairness of the proceedings and the partiality of the arbitrators."

The Sixth Circuit addressed the Cedents' reliance on certain cases involving arbitration agreements that permitted interlocutory review and concluded that those cases were not persuasive because the treaty did not include such language:

> Absent express or implied consent in the underlying agreement to arbitrate, federal courts may not graft a provision for interlocutory judicial review onto the otherwise straight-forward regime contemplated by the FAA and the Michigan Arbitration Act. Both laws generally call for judicial review only at the beginning of an arbitration, to decide certain gateway matters of arbitrability, or at the end of an arbitration, to confirm, vacate, or modify a final arbitration award. Where the parties agree to arbitrate a matter under either the FAA or the Michigan Arbitration Act *alone*, as [the parties] did here, we must enforce their contract according to its terms.

The Sixth Circuit ended its opinion by noting that the Cedents were not without a remedy. The court said the Cedents will be entitled to challenge the fairness of the arbitration proceeding and the partiality of the arbitrators after the panel has "concluded its work and issued a final award."

IMPORT OF DECISION: The Sixth Circuit's decision upholds the strong public policy favoring arbitration, but disfavoring judicial intervention in the arbitration process prior to the issuance of a final arbitral award. While there is a public interest in the integrity of the arbitration system and valid arbitration provisions in contracts, interlocutory challenges made while an arbitration proceeding is ongoing are permitted in only limited circumstances not present in *Savers*.

Broker's Motion For Summary Judgment Against Client/Insured Denied Because Factual Issue Existed Regarding Whether Parties Had Special Relationship

SUMMARY: In *Voss v. Netherlands Insurance Company*, 2014 N.Y. LEXIS 384 (N.Y. Ct. App. Feb. 25, 2014), an insurance broker's motion for summary judgment on a negligence claim brought by its client was denied because issues of material fact existed regarding whether there was a special relationship between the parties.

Deborah Voss owned several companies. She purchased property, professional liability, and business interruption insurance through CH Insurance Brokerage Services Co., Inc. ("CHI") for herself and her companies. When Voss initially discussed business interruption insurance with CHI, the broker asked her for sales figures and other pertinent information to enable it to calculate an appropriate level of business interruption coverage. Voss claimed that CHI said it would reassess her coverage needs as her businesses grew.

Based on the information Voss provided, the broker proposed business interruption coverage of $75,000 per incident. When Voss questioned whether the $75,000 limit was adequate, the broker allegedly assured her that it would suffice. According to Voss, the broker also said he calculated the amount of coverage at a threshold level, emphasizing that CHI would "take it up" each year as the businesses evolved. Voss accepted the broker's recommendations and purchased a policy with The Netherlands Insurance Company with $75,000 of business interruption coverage.

When Voss moved one of her companies to new premises and opened two more businesses at the same location, she discussed these developments with CHI. The Netherlands policy was renewed with the same $75,000 business interruption limit. Voss then incurred a loss caused by multiple leaks in the roof. The roof was replaced, but a month later, the new roof failed, resulting in more extensive water damage. Voss was forced to close all three of her businesses for various periods of time.

Voss filed claims with Netherlands which treated the two roof leaks as separate occurrences under the business interruption policy. Voss contended the carrier delayed making payments. While dealing with the roof repairs, Voss met with another individual at CHI to discuss renewal of the policy. When she received a proposal indicating that the business interruption coverage would be reduced from $75,000 to $30,000, she questioned the broker about the reduction. According to Voss, the broker responded that she "would take a look at it." Voss did not follow up because, she said, she was preoccupied with the building's extensive damage. When the policy was renewed, it contained a $30,000 per occurrence limit for business interruption coverage.

A short while later, the roof failed a third time, causing significant damage to the premises and further disrupting Voss's businesses. While her claims stemming from the third loss were pending, Voss commenced an action against CHI, Netherlands, and the roofing contractor.

With respect to her claim against the broker, Voss alleged that a special relationship existed with CHI and that CHI had negligently secured inadequate levels of business interruption insurance for all three losses. Following discovery, CHI moved for summary judgment, asserting that no special relationship was created and that in the absence of a specific request by the insured for coverage that went unfulfilled, CHI could not be held liable for failing to recommend or obtain higher limits. In addition, CHI argued that it could not be held liable for negligence because Voss had admitted she was fully aware of the initial $75,000 business interruption limits and the subsequent reduced limits of $30,000. Finally, CHI claimed that even if a special relationship existed, any breach of duty was not the proximate cause of Voss's damages which CHI alleged resulted from Netherlands' failure to pay the policy limits to Voss.

The Supreme Court of New York agreed with all three of CHI's arguments and granted the broker's motion for summary judgment, dismissing the complaint. The Appellate Division, with one justice dissenting, affirmed. The majority upheld the dismissal, but disagreed with the Supreme Court with regard to the special relationship issue, finding that CHI had failed to meet its burden of demonstrating the absence of a special relationship. The majority agreed with the trial court, however, on the other two arguments. The dissent agreed with the majority on the special relationship issue, but said that, assuming a special relationship existed, it was irrelevant to whether Voss was aware of the policy limits and that the proximate cause issue could not be decided as a matter of law. The Court of Appeals granted leave to appeal.

CHI contended that the Court of Appeals did not need to address the other two issues, but could resolve the case (favorably to CHI) by finding the record did not support the existence of a special relationship between CHI and Voss. The broker asserted the evidence showed that the parties only had an ordinary broker-client relationship.

The Court of Appeals held that CHI failed to demonstrate the absence of any material issues of fact regarding the existence of a special relationship between the parties. The

CONTINUED ON PAGE 6

Broker's Motion For Summary Judgment Against Client/Insured Denied Because Factual Issue Existed Regarding Whether Parties Had Special Relationship

CONTINUED FROM PAGE 5

court said that as a general rule insurance brokers have a common law duty to obtain coverage requested by their clients or to inform them of their inability to do so. Brokers, however, have no continuing duty to advise clients to obtain additional coverage. In an ordinary broker-client case, the client may prevail in a negligence claim only where it can establish that it made a particular request to the broker and the requested coverage was not procured.

Voss did not contend she specifically requested higher business interruption limits. Rather, she claimed the existence of a special relationship with CHI. Under New York law, where a special relationship develops, a broker may be liable, even in the absence of a specific request for coverage, for failing to advise the client to obtain additional coverage. Voss maintained that CHI failed to advise her to obtain additional business interruption coverage.

New York courts have identified three situations that may give rise to a special relationship thereby creating an additional duty of advisement: (1) the broker received compensation for consultation apart from payment by the client of premium; (2) there was some interaction regarding a question of coverage such that the insured relied on the expertise of the broker; or (3) there was a course of dealing over an extended period of time which would have put an objectively reasonable insurance broker on notice that its advice was being sought and specifically relied on.

The Court of Appeals held that the proof submitted by CHI in support of its summary judgment motion—Voss's deposition testimony—did not satisfy its burden of establishing the absence of a material issue of fact as to the existence of a special relationship. To the contrary, the court said the evidence suggested there was some interaction regarding the question of business interruption coverage, with the insured relying on the expertise of the broker in agreeing to the amount of coverage the broker recommended. Voss also testified that the broker repeatedly pledged that CHI would review coverage annually and recommend adjustments as Voss's businesses grew. Therefore, the court concluded that sufficient factual issues existed to preclude granting summary judgment on the question of whether a special relationship arose between the parties.

The Court of Appeals also rejected CHI's other two arguments. The court held that Voss's awareness of the business interruption limits was wholly irrelevant to her claim that CHI was negligent in failing to recommend higher limits. The court also rejected CHI's argument that any negligence on its part was not the proximate cause of Voss's damages, holding that questions of proximate cause and foreseeability should generally be resolved by the factfinder.

IMPORT OF DECISION: When an insurance policy does not cover an occurrence or when the amount of coverage is insufficient to make an insured whole, the insured sometimes tries to blame its insurance broker for the lack of coverage. Under the common law, an insurance broker has a duty to obtain the coverage its client requests or to inform the client of its inability to procure the coverage. An insurance broker, as a rule, does not have an affirmative and continuing duty to advise, guide or direct a client to obtain additional coverage. If a special relationship develops between the broker and the client, however, a broker may be liable—even in the absence of a specific request—for failing to advise a client to obtain additional coverage.

Kansas Federal Court Grants Request That Non-Party Broker Be Compelled To Produce Documents In Coverage Dispute

SUMMARY: In *Black & Veatch Corp. v. Aspen Ins.* (UK) Ltd., 2014 U.S. Dist. LEXIS 25896 (D. Kan. Feb. 28, 2014), the court ruled that a non-party broker must produce documents subpoenaed by insurance carriers in a coverage dispute with their insured, holding that the insured had failed to establish the documents were covered by the attorney-client privilege or work-product doctrine.

Black & Veatch Corporation ("B&V") entered into a series of contracts to construct several gas desulfurization systems for American Electric Power Service Corporation. Prior to construction, B&V obtained commercial general liability coverage from several insurers. B&V contended that AON co-brokered an umbrella policy for B&V with Aspen Insurance (UK) Ltd., Catlin Lloyd's Syndicate 2003, and Liberty Mutual Insurance Europe (UK) Ltd. (the "Liability Insurers"). The Liability Insurers asserted AON was not the broker for the umbrella policy.

After the desulfurization systems were built, American Electric alleged they had significant defects, which B&V repaired for several million dollars. B&V then submitted claims to the Liability Insurers and followed up with a declaratory judgment action seeking damages under the various policies.

The Liability Insurers served a subpoena on AON seeking the production of certain documents. AON produced some but not all of the subpoenaed documents. B&V prepared a privilege log for the withheld documents and objected to their production on the grounds that the documents were covered by the work-product doctrine and the attorney-client privilege. B&V asserted that AON was a representative of B&V's when the documents were created, was acting as its broker, and was a member of its advisory team. B&V said AON participated in strategy discussions with B&V and its legal counsel and took action in furtherance of such strategies in attempting to recover monies from the Liability Insurers. An AON executive vice president and chief broking officer submitted a declaration in support of B&V's position, stating that he had acted as B&V's representative.

The court held that, while the work-product doctrine may cover documents created by an attorney's investigator or other agents, it only protects documents prepared in the ordinary course of business if they were created as a result of the imminent threat of litigation. The court said B&V failed to provide sufficient details regarding the creation of the documents to establish that the requirements for work-product protection had been met. Among other deficiencies, B&V did not provide job titles or identifying information for the majority of the individuals listed on B&V's privilege log. Also, information was not provided to show AON was acting as B&V's representative as opposed to simply working as a broker in the ordinary course of its business.

The court also held B&V failed to show the documents were prepared in anticipation of litigation rather than in the ordinary course of AON's business. Many of the documents were handwritten notes as to which there was no showing they pertained to litigation. Others were routine broker communications relating to B&V's coverage claims. Also, B&V did not prove the notes were ever provided to B&V or its counsel, which the court said demonstrated they were unlikely prepared for litigation. The court said the fact that many of the notes were undated prevented it from determining if they were created after litigation was anticipated.

B&V countered that the withheld documents were prepared in anticipation of litigation because they were created after the Liability Insurers sent B&V a reservation of rights letter and B&V hired counsel. The court said, however, that it could not tell whether the undated documents had been prepared after those two events. Also, the court said, documents created after an insurer declines coverage are not automatically deemed to have been prepared in anticipation of litigation. Rather, documents must be examined individually on a case-by-case basis. The court held that in an insurance investigation setting, whether documents are created in anticipation of litigation depends on whether there has been "a definite shift made by the insurer or adjuster from acting in its ordinary course of business to acting in anticipation of litigation." Concluding that the same principle applied to documents created by a broker, the court found that B&V did prove there was a definitive shift from AON's acting as a broker to its acting as B&V's representative in the litigation.

B&V also objected to the production of three documents on attorney-client privilege grounds. Initially, the court rejected the Liability Insurers' argument that the privilege did not apply since the documents did not involve an attorney. Rather, the court held, the lack of attorney involvement does not necessarily preclude a party from demonstrating the privilege's applicability. Nonetheless, the court held B&V failed to provide sufficient information for it to determine whether each element of the attorney-client privilege had been satisfied. B&V did not prove the documents were made in confidence for the primary purpose of obtaining legal advice from a lawyer. In addition, B&V failed to show the documents were sent by B&V to counsel seeking legal advice or by counsel to the client containing such advice.

IMPORT OF DECISION: It is not uncommon for brokers to have documents relevant to disputes between insureds and insurers or reinsureds and reinsurers. Such documents may relate to contract formation and shed light on what the parties intended certain terms to mean. Brokers may have documents concerning the calculation and payment of premium. Also, brokers may have claims-related documents. Generally, broker documents will not be privileged or covered by the work-product doctrine. It is possible, however, that specific documents could be protected if the applicable requirements are met. In this case, the court strictly applied the rules relating to the work-product doctrine and attorney-client privilege and concluded the requirements had not been satisfied. It is possible this court might have ruled some of the documents were exempt from production if the insured had been able to make a more particularized showing that the elements of the work-product doctrine or attorney-client privilege had been met.

CLARK HILL'S Insurance and Reinsurance Practice Group has an established reputation for its work in the global insurance and reinsurance industry. The firm represents major United States, London Market, European, and Bermuda insurers and reinsurers in commercial litigation, coverage disputes, and major business transactions. Our practice encompasses all types of insurance, and every kind of underlying risk. We have the capacity to efficiently handle any (re)insurance matter, from individual to class action claims, and each assignment undertaken by the firm is afforded the same personal attention of partners having expertise with respect to the issues.

Philadelphia

Joseph M. Donley
Insurance & Reinsurance Practice Group Leader

Christopher M. Brubaker
Douglas M. Chapman
William E. Cox
Christopher J. Day
Peter B. Kupelian
Carol G. Schley
Robert W. Tomilson
Karolien M. Vandenberghe

For more information, please contact Joseph M. Donley at jdonley@clarkhill.com, or call 215.640.8500.

To subscribe to *Insurance & Reinsurance Briefing*, please contact Connie Lojewski at 215.640.8543 or clojewski@clarkhill.com.

Insurance & Reinsurance

CLARK HILL

www.clarkhill.com

BRIEFING

Fall 2014

Eleventh Circuit Holds That If Parties Wish To Allow Additional Grounds For Judicial Review Of Arbitral Award Beyond Those Provided In FAA, They Must Expressly Designate State Statutory Or Common Law Alternatives To FAA In Their Arbitration Agreement

SUMMARY: Generally, where the Federal Arbitration Act (9 U.S.C. § 1 *et seq.* ("FAA")) applies, a court may vacate an arbitration award only if at least one of four statutory grounds under 9 U.S.C. § 10(a) is satisfied, *i.e.*, where 1) the award was procured by corruption, fraud, or undue means; 2) where there was evident partiality or corruption by any of the arbitrators; 3) where the arbitrators were guilty of misconduct or misbehavior; or 4) where the arbitrators exceeded their powers or imperfectly executed them. *Hall Street Associates, L.L.C. v. Mattel, Inc.*, 552 U.S. 576, 584 (2008). However, where an arbitration agreement provides that review of an arbitral award may take place under state statutory or common law, the Supreme Court held in *Hall Street* that the grounds for vacating an award may be expanded beyond those set forth in 9 U.S.C. § 10(a).

These were the issues addressed by the U.S. Court of Appeals for the Eleventh Circuit in *Campbell's Foliage, Inc. v. Federal Crop Insurance Corporation*, 2014 U.S. App. LEXIS 6132 (11th Cir. Apr. 3, 2014). In that case, Campbell's Foliage, a nursery, purchased Multiple Peril Crop Insurance ("MPCI") from Rural Community Insurance Company ("RCIC") to insure its crops against loss caused by excess moisture. The risk was underwritten by the Federal Crop Insurance Corporation ("FCIC") and managed by Risk Management Agency ("RMA"). After an "adverse weather event," Campbell's Foliage made a claim under its policy with RCIC. RCIC and RMA denied the claim because they concluded the policy was void.

Campbell's Foliage sued in federal court for breach of contract and a declaratory judgment. RCIC moved to compel arbitration pursuant to the arbitration clause of the MPCI policy. The district judge found that the clause fell within the FAA and granted RCIC's motion. The arbitrator determined that Campbell's Foliage had no coverage under the MPCI policy and ruled in favor of FCIC and RCIC.

Campbell's Foliage filed a motion in federal court seeking to vacate the arbitration award. Campbell's Foliage conceded that none of the statutory grounds under 9 U.S.C. § 10(a) were applicable, but contended that the MPCI policy's arbitration clause expanded the scope of judicial review beyond the grounds set forth in 9 U.S.C. § 10(a). The clause at issue stated:

> Any decision rendered in arbitration is binding on you and us unless judicial review is sought in accordance with section 20(b)(3). Notwithstanding any provision in the rules of [the American Arbitration Association], you and we have the right to judicial review of any decision rendered in the arbitration.

Campbell's Foliage argued this language meant that the arbitration was non-binding and that the court was authorized to review the entire arbitration award and all factual and legal determinations made by the arbitrator, essentially on a *de novo* basis. The district court denied Campbell's Foliage's motion

CONTINUED ON PAGE 2

Inside this Briefing

Arizona

Delaware

Illinois

Michigan

New Jersey

Pennsylvania

Washington, DC

West Virginia

Eleventh Circuit Holds That If Parties Wish To Allow Additional Grounds For Judicial Review Of Arbitral Award Beyond Those Provided In FAA, They Must Expressly Designate State Statutory Or Common Law Alternatives To FAA In Their Arbitration Agreement

CONTINUED FROM PAGE 1

to vacate, holding that the four statutory grounds in 9 U.S.C. § 10(a) are the only bases on which an arbitration award may be vacated. Relying on *Hall Street*, the court concluded that the phrase "judicial review" in the MPCI policy's arbitration clause meant the kind of limited review contemplated by 9 U.S.C. § 10(a). Since Campbell's Foliage had not raised any of the FAA's four statutory grounds for vacatur, the court found it was not entitled to relief.

Campell's Foliage appealed to the Eleventh Circuit, arguing the district court erred in holding that the four statutory grounds were the only bases on which the court could vacate the arbitration award. The appellate court first considered whether the dispute resolution mechanism in the MPCI policy constituted "FAA arbitration." In concluding that it did, the court relied on the fact that the arbitration clause called for the appointment of an independent adjudicator who was to consider evidence and argument and to apply substantive legal standards before rendering a decision awarding relief to resolve the rights and duties of the parties.

The court next addressed Campbell's Foliage's claim that the MPCI policy's arbitration clause empowered the court to reconsider and vacate the arbitral award. The Eleventh Circuit said that the Supreme Court held in *Hall Street* that 9 U.S.C. § 10(a) provided the FAA's exclusive grounds for vacatur and that parties may not supplement the statutory grounds by contract. The court noted that the Supreme Court had qualified its decision by saying section 10 did not exclude more "searching review" based on authority outside the FAA. The court quoted from the Supreme Court's decision as follows: "The FAA is not the only way into court for parties wanting review of arbitration awards: they may contemplate enforcement under state statutory or common law, for example, where judicial review of different scope is arguable." Nonetheless, the Eleventh Circuit noted that it had previously held the "manifest disregard of law" and "incorrect legal conclusion" grounds were no longer valid bases to vacate arbitral awards following *Hall Street*.

Campbell's Foliage contended that the arbitration clause of the MPCI policy provided for non-binding arbitration, which it asserted allowed more expansive judicial review of arbitration awards than was permitted under the FAA. The Eleventh Circuit rejected that position since the clause provided that "[a]ny decision rendered in arbitration is binding . . . unless judicial review is sought." The court held this language called for binding arbitration, subject to judicial review, which meant the arbitration agreed to by the parties was within the scope of the FAA.

Campbell's Foliage also argued that because the FCIC drafted the arbitration clause pursuant to the Federal Crop Insurance Act, the clause constituted "outside authority providing for more searching review." The Eleventh Circuit disagreed, holding that the MPCI policy "is a contract, and the Supreme Court did not mean a contract could provide an independent basis for the enforcement of an arbitration award." Rather, the court said, "[p]arties that want their arbitration agreements enforced by an authority that allows for more expansive judicial review must specifically designate such state statutory or common law alternatives to the FAA in their arbitration agreements." Because the FCIC did not designate state or common law as "the controlling law for enforcing arbitration awards," the "FAA alone applies to enforce the arbitration agreement" in the MPCI policy. Further, "[b]ecause Campbell's Foliage admits it did not move for vacatur based on any of the grounds listed in [9 U.S.C. § 10(a), the trial court] did not err by denying the motion to vacate the arbitration award[.]"

IMPORT OF DECISION: The general rule is that an arbitral award subject to the FAA may only be vacated on the grounds set forth in 9 U.S.C. § 10(a). Arbitration clauses occasionally, however, include language purporting to broaden the bases for judicial review. In *Hall Street*, the Supreme Court held that parties cannot by contract expand the grounds for vacating an arbitration award beyond those specified in the FAA, although the Court carved out an exception to this rule. The Court held that since the FAA is not the only basis on which parties may seek judicial review of arbitral awards, they may provide in their contracts for enforcement of awards under "state statutory or common law" where review of a different scope may be available. But to avail themselves of these alternatives, parties must expressly state in their contract that arbitral awards may be enforced under state statutory or common law, which authority should be specifically mentioned in the arbitration clause.

Declaratory Judgment Action Cannot Be Filed By Party Seeking Relief That Is Contrary To Its Economic Interests

SUMMARY: It seems axiomatic that a plaintiff would not file a lawsuit seeking a declaratory judgment that would be detrimental to its own financial interests. However, the plaintiff did just that in *Meisner Law Group, P.C. v. Krispin*, 2014 Mich. App. LEXIS 977 (May 27, 2014), a recent case decided by the Michigan Court of Appeals. In this case, a plaintiff law firm sued a former client and its officer after it was fired as counsel for the client. The law firm then filed a separate declaratory judgment action, seeking a declaration that the former client and officer were *not* entitled to insurance coverage for the claims asserted in the law firm's first lawsuit. Finding that the plaintiff did not allege an "actual controversy" as required for a valid declaratory judgment claim (and apparently unmoved by the law firm's retaliatory motive), the court dismissed the second lawsuit.

The Meisner firm was retained by Island Lake North Bay Association ("North Bay"), a condominium association, to represent it in a construction defect lawsuit against the condominium developer. Midway through the litigation against the developer, North Bay fired Meisner as its counsel. Meisner then brought a lawsuit (the "First Lawsuit") against North Bay and one of its officers, Krispin, alleging it was wrongfully terminated and that Krispin defamed Meisner and tortiously interfered with its relationship with North Bay. Upon being sued, North Bay tendered the First Lawsuit to Travelers, its commercial general liability insurer. Travelers agreed to defend both North Bay and Krispin under a reservation of rights.

After Travelers assumed the defense of North Bay and Krispin, Meisner filed a separate declaratory judgment action against Travelers, North Bay and Krispin (the "Second Lawsuit"). In the Second Lawsuit, Meisner asserted that its allegations in the First Lawsuit "are expressly excluded from coverage" under the Travelers' policy and requested a declaratory judgment from the court holding that Travelers had no duty to defend or indemnify North Bay or Krispin in the First Lawsuit.

Travelers moved to dismiss the Second Lawsuit, arguing that it did not allege an actual case or controversy, and instead was "a stratagem to extract further retribution . . . by attempting to ensure that Krispin and [North Bay] will be punished by having to pay their own defense costs and any judgment rendered against them . . . o*ut of their own pockets*." (Original emphasis.) The trial court agreed and dismissed the Second Lawsuit.

On appeal, the parties addressed whether Meisner's claims in the Second Lawsuit asserted valid grounds for a declaratory judgment. The Court of Appeals noted that declaratory judgments may only be entered by a court where an "actual controversy" is alleged, and that an "actual controversy" exists where a judgment is needed to guide the plaintiff's future conduct in order to "preserve" or "protect" its rights. Noting that the complaint in the Second Lawsuit expressly requested a declaration that Travelers had no obligation to provide a defense or indemnity to North Bay and Krispin, the Court of Appeals held that a "casual reading of the allegations" failed to identify an actual controversy.

According to the court:

> Meisner did not allege that it had a potential future right to seek payment under the policy that Travelers issued to North Bay and Krispin. Rather, it alleged that Travelers had *no obligation* to defend North Bay or Krispin and had *no obligation* to pay any judgment that Meisner might secure against them. . . . Meisner effectively pleaded that it had *no right* to seek enforcement of the policy. Once Meisner conceded that it has and will have no right to seek enforcement of the policy, it necessarily conceded that it had no standing to seek a declaration of rights concerning that policy.

(Original emphasis.)

The court further found that Meisner could not force Travelers to cease providing a defense or indemnity to North Bay and Krispin under the policy because, even if the court granted the declaratory relief sought by Meisner, Travelers could still "gratuitously" provide coverage to North Bay and Krispin. The court said: "Accordingly, one can only assume that Meisner has sought a declaration contrary to its own interests in order to cause Travelers – for whatever reason – to abandon its insured."

One issue not addressed by the Court of Appeals was whether Meisner could have validly asserted its claim for declaratory relief had it sought a judgment in favor of coverage for the First Lawsuit. Most likely, Meisner would not have been able to do so, as in Michigan, plaintiffs like Meisner typically do not have the ability to directly sue the defendant's liability insurer unless and until the plaintiff obtains a judgment against the defendant.

IMPORT OF DECISION: *Meisner* presents an unusual situation, where the plaintiff sought a declaratory judgment seeking relief that was contrary to its economic interests. If the court had granted the relief sought by Meisner, there would have been no indemnity coverage available under the Traveler's liability policy to satisfy any judgment Meisner might have obtained in the First Lawsuit. Further, the relief Meisner sought in the Second Lawsuit would have required North Bay and Krispin to pay their own defense costs in the First Lawsuit, thus potentially negatively impacting their ability to satisfy any subsequent judgment in Meisner's favor. Thus, while the Court of Appeals based its decision on Meisner's failure to allege an "actual controversy" under Michigan law, the decision also reflects an apparent desire by the court to discourage lawsuits, like Meisner's, that have a vindictive and retaliatory purpose.

Captive Industry Speaks Out On NAIC Committee's Proposed Definition Of "Multi-State Reinsurer"

On March 24, 2014 the NAIC's Financial Regulation Standards and Accreditation (F) Committee ("F Committee") released for comment proposed revisions to the definition of "multi-state reinsurer" contained in the preambles to Part A and Part B of the NAIC standards for state accreditation. Part A addresses laws and regulations governing "traditional insurers" and is designed to ensure that the accrediting jurisdiction has sufficient authority to effectively regulate a domestic multi-state insurance company. Part B is focused on regulations and regulatory practices and provides a base-line to supplement and implement a jurisdiction's financial solvency laws.

The revisions came about in response to comments made by John Torti, Insurance Commissioner for the State of Rhode Island, who expressed concern about the regulation of captive insurance companies involved in reinsuring life insurance and annuity business involving excess reserves (the so-called XXX and AXXX transactions). Torti's concern was that traditional multi-state insurers were avoiding scrutiny of certain transactions by ceding them to captives.

The proposed revisions would expose many captive arrangements to the full accreditation process that has to this point only applied to insurance companies. The revisions would both add a definition of multi-state insurer that would encompass many traditional non-life captive arrangements and strike language that would exempt these same types of arrangements from accreditation requirements.

The proposed definition states: "A multi-state reinsurer is an insurer assuming business that is directly written in more than one state and/or in any state other than its state of domicile. This includes but is not limited to captive insurers, special purpose vehicles and other entities assuming business." The proposal includes the following exception: "Captive insurers owned by non-insurance entities for the management of their own risk will continue to be exempted from both the Part A and Part B accreditation requirements."

F Committee received 34 comments which are overwhelmingly against the proposed changes. Nine different insurance departments (AZ, DE, DC, HI, NV, NC, UT, VT and WA) submitted comments, with eight of them against the proposed revisions. Only Washington State's insurance department supported the proposals. The captive industry was consistent in its objections. Two life insurance companies supported the revisions while one such company objected.

Most of the comments said the exception (quoted above) is unclear as to its exact scope and too narrow since it only exempts 100% pure captives. Also, it can be read as only applying to a captive owned by Company A that only insures/reinsures Company A's own risk and not risks from any other entity whether affiliated or not.

In its comments, the Captive Insurance Companies Association ("CICA") recommended that the proposed changes to the definition of "multi-state reinsurer" not be adopted because they would impose an unreasonable and unneeded regulatory burden on the captive industry. The CICA said the definition previously excluded "insurers that are licensed, accredited or operating in only their state of domicile but assuming business from insurers writing that business that is directly written in a different state." The CICA said the proposal would eliminate that exclusion and would define "multi-state reinsurers" to include insurers (and captives) assuming business that is directly written in more than one state.

Noting that the changes were designed to address the use of captives as reinsurance mechanisms by life and annuity insurers regarding excess reserves, the CICA said the proposed definition, which would be applicable not only to life captives but also to captives writing property and casualty risks, would sweep in numerous alternative risk structures that have nothing to do with life insurance.

The CICA also objected to the fact that the proposal would impose NAIC accreditation standards on most captive reinsurers, which are not necessary. The CICA asserted that captives, which reinsure risks written by their parents or affiliates, should not have to meet financial tests relating to non-life business designed to protect insureds who are members of the general public. This would impose an unnecessary financial burden that would greatly increase their costs of operation. Thus, the CICA said, the language should be revised to exclude non-life captives. The CICA also objected to the proposal to empower states other than the state of a captive's domicile to regulate the captive even though the captive only transacts insurance business in its own domicile.

Overall, the comments express four main concerns: 1) the revised definition is overly broad and leaves key terms undefined such that it would apply to many captives beyond those involved in XXX and AXXX transactions and would be subject to inconsistent interpretation and implementation; 2) the changes would require states allowing captives to substantially change and overhaul their policies through both legislative and regulatory processes, a lengthy and unpredictable process;

3) the perceived problem could be better addressed through existing regulations (*e.g.* credit for reinsurance requirements) or changes that are contemplated in other areas such as risk based capital; and 4) treating captives as subject to the accreditation standards of traditional insurers would drive captives off-shore. Other concerns include unrealistic time-frames for compliance and failure to follow proper procedures for adopting the changes. Many also said there is already adequate oversight of captives and no reason to include all captives in an effort to improve oversight of life insurance captives.

F Committee was supposed to consider the proposed definition of "multi-state reinsurer" at the NAIC's August meeting, but did not do so. Some regulators commented at the meeting that there is no intent to regulate captives other than those writing XXX and AXXX business. The "multi-state reinsurer" subject will be on F Committee's agenda at the NAIC's fall meeting in November. At the August meeting, the NAIC's Executive Committee did adopt the NAIC task force's report that included the "XXX/AXXX Reinsurance Framework," which addresses reserve funding.

How the NAIC handles the "multi-state reinsurer" issue moving forward bears watching because the proposed revisions as written would dramatically impact the captive industry. Given the importance of the captive industry and the strong opposition to the proposal from the leading captive jurisdictions as well as the industry itself, it would be surprising if the proposal is not revised to address what appear to be unintended consequences on traditional non-life insurance company-owned captives. Conceivably, the proposal may be abandoned all together in favor of instituting some of the different approaches suggested for addressing XXX and AXXX transactions.

Arbitrators, Not Court, Should Decide Whether Cut-Through Claim Asserted Following Commutation Agreement Should Be Arbitrated

SUMMARY: In *Trenwick America Reinsurance Corporation v. CX Reinsurance Company Limited*, 2014 U.S. Dist. LEXIS 70823 (D. Conn. May 23, 2014), a Connecticut federal trial court held that arbitrators must decide whether claims asserted by a third-party beneficiary under a cut-through clause of a reinsurance agreement containing an arbitration provision are to be arbitrated when the parties to the reinsurance agreement had subsequently entered into a commutation agreement.

Commercial Casualty Insurance Company of Georgia ("CCIC"), as reinsured, and Trenwick America Reinsurance Corporation, as reinsurer, entered into a reinsurance agreement which contained a cut-through clause providing that in the case of CCIC's insolvency, any amounts owed by Trenwick to CCIC would be payable directly to CX Reinsurance Company. CCIC became insolvent and entered liquidation. Thereafter, Trenwick and the estate of CCIC entered into a commutation agreement under which all reinsurance obligations between Trenwick and CCIC were commuted and extinguished.

Before the commutation agreement was executed, CX invoked the cut-through clause of the reinsurance agreement and billed Trenwick for a claim that had not been settled until after CCIC had gone into liquidation. After Trenwick failed to pay the claim, CX sent Trenwick a demand for arbitration. Trenwick instituted legal proceedings seeking to enjoin the arbitration. CX moved to compel arbitration.

In considering whether CX's cut-through claim should be arbitrated, the court looked first at the cut-through provision in the reinsurance agreement which provided that Trenwick's obligation to CX was subject to "all terms, conditions, retentions and limits of liability" under the reinsurance agreement, which contained an arbitration clause. Trenwick had contended in a prior lawsuit against a different cut-through holder that it was not required to arbitrate a cut-through dispute on the grounds that the holder was not a party to the reinsurance agreement, but the court rejected that position. Based on that ruling, Trenwick conceded in this case that it would have been obligated to arbitrate cut-through disputes with CX had the reinsurance agreement not been commuted. But, Trenwick said, the reinsurance agreement's arbitration clause ceased to exist after the commutation agreement was entered into terminating the reinsurance agreement.

Trenwick relied on language in the commutation agreement that provided it constituted the "entire [a]greement," and superseded all prior agreements, between the parties concerning the subject matter of the commutation. Trenwick asserted that CX no longer had a right to arbitrate its cut-through claim because the reinsurance agreement (which contained the arbitration provision on which CX relied) had been extinguished by the commutation agreement.

CX countered that the commutation agreement provided it superseded prior agreements "between the [p]arties" to the commutation agreement (which did not include CX) and only with respect to the "subject matter" of the agreement, which CX argued was the commutation and not the obligations under the reinsurance agreement. Thus, CX contended that Trenwick's cut-

CONTINUED ON PAGE 6

Arbitrators, Not Court, Should Decide Whether Cut-Through Claim Asserted Following Commutation Agreement Should Be Arbitrated

CONTINUED FROM PAGE 5

through obligations to CX survived the termination of the reinsurance agreement because nothing in the commutation agreement purported to extinguish CX's cut-through rights. CX also asserted that, since it was not a party to the commutation agreement, that agreement could not have affected its cut-through rights.

The cut-through provision of the reinsurance agreement provided that it was "subject to termination in the event of cancellation or termination" of the reinsurance agreement and that upon the occurrence of either such event, CX was to be notified by Trenwick not less than 30 days before the effective date of cancellation or termination. The provision also stated that cancellation or termination did not affect Trenwick's obligation to pay amounts due CX under the cut-through clause, except that "[c]ommutation of the [reinsurance agreement] . . . shall relieve [Trenwick] . . . of all liability, known or unknown, under" the reinsurance agreement. Trenwick relied on this provision in contending that it was relieved of all cut-through liability to CX due to the commutation.

CX responded that the reinsurance agreement did not provide Trenwick with a unilateral right to terminate the cut-through provision and that cancellation or termination of the reinsurance agreement did not affect Trenwick's cut-through obligations to CX. Also, CX said, commutation would relieve Trenwick of liability only if the commutation was "in accordance with the terms" of the reinsurance agreement. CX asserted the commutation was not in accordance with the reinsurance agreement because: (1) only CCIC and Trenwick had the option to commute; (2) CX was not given the required 30 days' notice of termination; and (3) CX billed the cut-through claim to Trenwick before the commutation agreement was executed.

Acknowledging that the parties disputed how the reinsurance agreement should be interpreted with respect to CX's cut-through claim, the court next addressed whether the dispute was required to be arbitrated. The court cited authority that under a broad arbitration clause, such as the one in the reinsurance agreement, an arbitrator must resolve whether claims under a contract with an arbitration clause are to be arbitrated when the contract has been terminated.

Trenwick argued CX had the right to *litigate* its cut-through claim in court, but contended its right to *arbitrate* had been extinguished. Trenwick sought to distinguish the authority cited by the court, arguing the commutation agreement was not a "termination" of the reinsurance contract, but rather an "extinguishment" of the contract such that it could no longer form the basis for CX's demand for arbitration.

The court held that since CX was not a party to the commutation agreement, its effect on CX's rights must be determined by interpreting the original reinsurance agreement. Regardless of the arguments Trenwick made that the arbitration clause was no longer operable, that issue required interpretation of the reinsurance agreement, which was properly to be decided by an arbitrator. Thus, the court granted CX's motion to compel arbitration.

IMPORT OF DECISION: This case illustrates the importance of following any applicable provisions in the reinsurance agreement affecting termination and carefully drafting the terms of a commutation agreement. If parties intend such an agreement to extinguish any cut-through rights provided in a reinsurance agreement, language must be included in the commutation agreement to ensure that those rights have been effectively terminated and that the entity holding the rights is bound by such termination. Parties should also expressly provide in their commutation agreement whether or not disputes are to be arbitrated. If they intend disputes to be subject to arbitration, the commutation agreement should either state that the arbitration clause of the reinsurance agreement is to govern disputes or the commutation agreement, itself, should contain its own arbitration provision. If parties do not wish commutation disputes to be arbitrated, they should include express language in their agreement so stating and should also state that any arbitration clause in the reinsurance agreement being commuted does not apply to such disputes.

Colorado, Maryland, And Vermont Adopt Amendments To Credit For Reinsurance Rules

Colorado, Maryland, and Vermont recently revised their credit for reinsurance rules based on amendments to the National Association of Insurance Commissioners' ("NAIC") Credit for Reinsurance Model Law, adopted by the NAIC in 2011. Vermont's law became effective on May 9, 2014. Maryland's new regulations went into effect on August 17, 2014. Colorado's law will become effective on January 1, 2015. (The NAIC amendments do not automatically become law in the various states. Rather, each state must enact legislation or promulgate regulations making the amendments part of that state's law.)

Prior to the adoption of the amendments to the NAIC Credit for Reinsurance Model Law, most states required unauthorized reinsurers to collateralize 100% of their liabilities to cedents in order for their cedents to be able to take credit for the reinsurance. In revising its Model Law,

the NAIC sought to modernize reinsurance regulation in the United States to address whether the 100% collateralization requirement is necessary in view of the fact that some unauthorized reinsurers have strong financial balance sheets and may be domiciled in jurisdictions that rigorously test insurers' financial solvency.

The Colorado, Maryland, and Vermont revisions allow a cedent to take credit for reinsurance ceded to a "certified reinsurer." To be "certified," an unauthorized reinsurer must meet certain eligibility requirements in the cedent's and the reinsurer's domiciliary jurisdictions. Certified reinsurers are assigned financial ratings. Depending on the rating given to a reinsurer, the reinsurer may be permitted to post reduced or no collateral in order for its cedent to receive credit for reinsurance.

Claimant Barred From Asserting Claims For Additional Injuries After Release Executed And Settlement Proceeds Paid

SUMMARY: In *Hicks v. Sparks*, 2014 Del. LEXIS 142 (Mar. 25, 2014), an injured claimant accepted $4000 in settlement of a negligence claim arising from an automobile accident and executed a release. Later, she alleged she had further injuries and sought additional compensation. The Delaware Supreme Court upheld the release and denied her claim that there had been a mutual mistake of fact concerning the extent of her injuries at the time the release was signed.

Patricia Hicks, 72, was a passenger in a car operated by her husband that was rear-ended by Debra Sparks in March 2011. She went to the emergency room after the accident and followed up with her family physician a few days later complaining of neck pain and headaches. She received medical treatment and physical therapy for approximately 15 visits.

By April 2011, Hicks had stopped physical therapy. She presented her claim to Sparks' insurance carrier, Progressive Northern Insurance Company. Although she was still having some problems, she said she was happy with her progress and was ready to negotiate a settlement. Progressive offered her $2000 for the full and final resolution of the claim, which Hicks refused.

In May 2011, Hicks told Progressive she was still having headaches. She said she had spoken to an attorney and demanded $7000. Progressive countered with an offer of $2500. Hicks said she wanted more time to consider the offer. In June 2011 Hicks demanded $5000 and said she had spoken to two attorneys who had advised her to wait to settle for at least a year after the incident to be sure her injuries had resolved. Progressive offered $3000.

In October 2011, Hicks reiterated her $5000 demand. Progressive offered $4000 which Hicks and her husband accepted. They received a settlement check in that amount and executed a full and final release ("Release").

After signing the Release, and about a year after the accident, Hicks began to experience pain in both her arms and tingling and numbness in her hands. An MRI revealed a cervical disc herniation. Hicks underwent surgery to repair it.

In 2013 Hicks filed suit in Delaware state court alleging that Sparks' negligence caused her injuries. The court granted Sparks' motion for summary judgment. Hicks appealed to the Delaware Supreme Court where she argued the trial court erred in granting summary judgment because her post-Release injuries were materially different from those covered by the Release. Hicks asserted summary judgment was improper because material issues of fact existed regarding whether there was a mistake of fact and whether she assumed the risk of the mistake. Accordingly, she said, the Release should be rescinded.

The Supreme Court affirmed the trial court's decision, holding that Hicks failed to show there was a mutual mistake of fact at the time of the Release. The court also said Hicks assumed the risk of mistake.

The court began its discussion by explaining the usefulness of releases to litigation, noting that Delaware courts generally uphold releases unless they are the product of fraud, duress, coercion, or mutual mistake of fact. The court said that to establish mutual mistake, a plaintiff must show: 1) both parties were mistaken as to a basic assumption; 2) the mistake materially affected the agreed-upon exchange of performances; and 3) the party adversely affected did not assume the risk of the mistake. The court explained that a release is voidable if a mutual mistake existed at the time of its signing, but only if the mutual mistake was related to a past or present fact material to the release and not to an opinion of future conditions.

The court held that mutuality of mistake in the insurance context can exist only where neither the claimant nor the carrier is aware of the existence of personal injuries. A release will bar suit for a plaintiff's subsequently discovered injuries unless the injuries are materially different from the parties' expectations at the time the release was signed. Mutual mistake will invalidate the release where both parties are mistaken as to the presence or extent of the plaintiff's injuries at the time they executed the release. But if the plaintiff knew that an *indicia* of injuries existed when she signed the release, the release will preclude a finding of mutual mistake and will bar suit even if the exact degree of the injury is unknown at the time the release is signed.

Additionally, mutual mistake does not exist if the adversely affected party assumed the risk of mistake. A

CONTINUED ON PAGE 8

Claimant Barred From Asserting Claims For Additional Injuries After Release Executed And Settlement Proceeds Paid

CONTINUED FROM PAGE 7

party assumes the risk of mistake where he consciously performs under a contract aware of his limited knowledge regarding the facts as to which the mistake relates.

Hicks contended that her injuries were materially different from those the parties believed she had sustained at the time the Release was signed. She asserted that she and Progressive were aware she had suffered a cervical sprain requiring treatment, but that surgery for a herniated disk is materially different from the minor head and neck injuries contemplated at the time of the Release. She said the herniated disk was a new, undiscovered injury for which she did not assume the risk of mistake.

The court held that Hicks failed to demonstrate that a mutual mistake of fact by both parties existed at the time the Release was signed. Hicks admitted she told Progressive when she signed the Release that she had not fully recovered and continued to experience headaches and neck pain. The court said that although Hicks may have been mistaken as to the future effect of her injury, both parties were aware she injured her neck. Hicks had ample opportunity to consult additional doctors and obtain further diagnoses to discover the herniated disk. The court held that her later diagnosis was not a materially different fact but an injury of which Hicks and Progressive had some awareness. Thus, there was no mutual mistake.

The court also held that Hicks assumed the risk of mistake. The Release she signed contained language acknowledging the possibility of permanent injury. Hicks signed the clear and unambiguous Release in exchange for settlement compensation. As such, she assumed the risk of mistake when she executed the Release without obtaining a more thorough medical exam to fully discover the extent of her injuries related to her neck pain. Hicks assumed the risk that her injuries were more serious than she believed and that her symptoms could worsen and require further treatment. Because she assumed this risk, she was precluded from arguing that a mutual mistake existed at the time the Release was signed.

IMPORT OF DECISION: It is critical to insurance companies that releases signed by claimants who receive settlement proceeds be upheld and enforced. Otherwise, carriers could be exposed to further liability for possibly fraudulent claims after having paid settlements in good faith. As to non-fraudulent claims, the evidence regarding whether a claimant has suffered further injuries is largely within his knowledge and control. A plaintiff and his doctor know best whether he has recovered or reached maximum medical improvement. An insurance carrier is at a distinct disadvantage in attempting to evaluate claims of "new injuries." If a claimant agrees to a settlement and signs a release, it is not unfair to hold him to the terms of a release. The *Hicks* decision correctly enforces these principles.

CLARK HILL'S Insurance and Reinsurance Practice Group has an established reputation for its work in the global insurance and reinsurance industry. The firm represents major United States, London Market, European, and Bermuda insurers and reinsurers in commercial litigation, coverage disputes, and major business transactions. Our practice encompasses all types of insurance, and every kind of underlying risk. We have the capacity to efficiently handle any (re)insurance matter, from individual to class action claims, and each assignment undertaken by the firm is afforded the same personal attention of partners having expertise with respect to the issues.

Philadelphia

Joseph M. Donley
Insurance & Reinsurance Practice Group Leader

Christopher M. Brubaker
Douglas M. Chapman
William E. Cox
Christopher J. Day
Peter B. Kupelian
Carol G. Schley
Robert Tomilson
Karolien M. Vandenberghe

For more information, please contact Joseph M. Donley at jdonley@clarkhill.com, or call 215.640.8500.

To subscribe to *Insurance & Reinsurance Briefing*, please contact Connie Lojewski at 215.640.8543 or clojewski@clarkhill.com.

Insurance & Reinsurance

CLARK HILL

www.clarkhill.com

BRIEFING

Winter 2014

The Federal Insurance Office's Report: Road to Modernization Of Insurance Regulation: Heavy Lifting For The States

On December 13, 2013, the Federal Insurance Office ("FIO") issued its long-awaited report entitled: "How to Modernize and Improve the System of Insurance Regulation in the United States."[1] The Report sets 18 performance goals for the states, while proposing nine federal action points. It is expected that insurance regulation will evolve as a hybrid model, where state and federal oversight play complementary roles.

The FIO was created in response to the financial crisis by the Dodd-Frank Act. The Dodd-Frank Act[2] also established the Financial Stability Oversight Council ("Council"), a new government department that identifies risks and responds to emerging threats to financial stability. The FIO has the following authorities:

1. Monitor 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 United States financial system.
2. Monitor the extent to which traditionally under-served communities, consumers, minorities, and low and moderate income persons have access to affordable insurance products regarding all lines of insurance, except health insurance.
3. Recommend to the Council that it designate an insurer, including the affiliates of such insurer, as an entity subject to regulation as a nonbank financial company supervised by the Federal Reserve.
4. Assist the Secretary of the Treasury (the "Secretary") in administering the Terrorism Insurance Program established under the Terrorism Risk Insurance Act of 2002.
5. Coordinate federal efforts and develop federal policy on prudential aspects of international insurance matters, including representing the United States, as appropriate, in the International Association of Insurance Supervisors and assisting the Secretary in negotiating "covered agreements." Covered agreements are defined as bilateral or multilateral agreements regarding prudential measures with respect to the business of insurance or reinsurance that – (A) are entered into between the United States and one or more foreign governments, authorities, or regulator entities; and (B) relate to the recognition of prudential measures with respect to the business of insurance or reinsurance that achieve a level of protection for insurance or reinsurance consumers that are substantially equivalent to the protection achieved under state insurance or reinsurance regulation.[3]
6. Determine whether state insurance measures are preempted by "covered agreements."
7. Consult with the states (including state insurance regulators) regarding insurance matters of national importance and prudential insurance matters of international importance; and
8. Perform such other related duties and authorities as may be assigned to the FIO by the Secretary.

CONTINUED ON PAGE 2

Arizona

Delaware

Illinois

Michigan

New Jersey

Pennsylvania

Washington, DC

West Virginia

Inside this Briefing

The Federal Insurance Office's Report: Road to Modernization Of Insurance Regulation: Heavy Lifting For The States

CONTINUED FROM PAGE 1

In July 2013, the Council effectively designated three companies outside of the banking industry—AIG, GE, and Prudential Financial—as "systematically important financial institutions," meaning that these insurers are put under the supervision of the Federal Reserve System and must meet enhanced prudential standards.[4]

The FIO Report is structured in five sections. The first section contains the recommendations for modernizing insurance regulation in the United States, represented in the table below. The additional sections cover the history of insurance regulation in the U.S. (Section II), analysis with regard to the state recommendations on prudential oversight (Section III), analysis with regard to the state recommendations on marketplace oversight (Section IV), and basic principles of regulatory reform (Section V).

The recommendations for modernizing insurance regulation are of two kinds:

1) Recommendations regarding areas that need to be reformed by the states in the near term;
2) Recommendations regarding areas that need direct federal involvement.

The table below lists the 18 areas of reform to be addressed by the states and the nine identified areas of federal involvement.

Table: FIO's Recommendations for Modernizing Insurance Regulation

Areas of Reform for the States	Areas of Federal Involvement in Regulation
CAPITAL ADEQUACY AND SAFETY/SOUNDNESS	
1. Material solvency oversight decisions of a discretionary nature: develop and implement a process that obligates the appropriate state regulators to first obtain the consent of regulators from other states in which the subject insurer operates.	(1) Develop federal standards and oversight for mortgage insurers.
2. Solvency oversight: establish independent, third-party review mechanism for NAIC's Financial Regulation Standards Accreditation Program.	(2) Recommend that Treasury and United States Trade Representative pursue a "covered agreement" for reinsurance collateral requirements based on the NAIC's Credit for Reinsurance Model Law and Regulation.
3. Develop uniform and transparent solvency oversight regime for transfer of risk to reinsurance captives.	(3) FIO to engage in supervisory colleges to monitor financial stability and identify issues in regulation of large national and internationally active insurers.
4. Solvency oversight and capital adequacy regimes to converge to best practices and uniform standards.	(4) Adopt the National Association of Registered Agents and Brokers Reform Act of 2013; its implementation to be monitored by FIO.
5. Move cautiously with implementation of principle-based reserving and condition it on (1) consistent, binding guidelines and (2) attracting supervisory resources and developing uniform guidelines to monitor supervisory review.	(5) FIO to work with agencies, state regulators to develop auto insurance policies for U.S. military enforceable across state lines.
6. Develop corporate governance principles: impose character and fitness expectations on directors and officers.	(6) FIO to work with state regulators to establish pilot programs for rate regulation that seek to maximize number of insurers offering personal lines products.
7. Develop approaches to group supervision.	(7) FIO to study and report on how personal information is used for insurance pricing and coverage.
8. Build toward group supervision by attention to supervisory colleges.	(8) FIO to consult with Tribal leaders to identify alternative to improve accessibility and affordability of insurance on sovereign Native American and Tribal lands.

Areas of Reform for the States	Areas of Federal Involvement in Regulation
REFORM OF INSURER RESOLUTION PRACTICES	
9. (1) Adopt uniform approach to address closing out and netting of qualified contracts with counterparties; (2) develop requirements for transparent financial reporting regarding the administration of a receiver estate.	(9) FIO will continue to monitor state progress on implementation of Subtitle B of Title V of the Dodd-Frank Act, requiring states to simplify the collection of surplus lines taxes, and determine whether federal action may be warranted in the near term.
10. Adopt uniform policyholder recovery rules so that policyholders receive the same maximum benefits from guaranty funds.	
MARKETPLACE REGULATION	
11. Consider whether marital status is an appropriate underwriting or rating consideration.	
12. Improve state-based product approval processes (participation in the Interstate Insurance Product Regulation Commission ("IIPRC") and expanding products subject to approval of the IIPRC).	
13. Adopt the NAIC's Suitability in Annuities Transactions Model Regulation.	
14. Reform market conduct examination and oversight practices.	
15. Monitor impact of different rate regulation regimes on market to best foster competitive markets for personal lines insurance consumers.	
16. Develop standards for use of data for pricing of personal lines insurance.	
17. Extend regulatory oversight to vendors that provide insurance score products to consumers.	
18. Identify, adopt, and implement best practices to mitigate losses from catastrophes.	

The FIO Report points to the inefficiencies of the state-based insurance regulatory system for consumers and insurers, the need for uniformity, and the international dimension of the insurance market in support of its recommendations.

Importantly, at the end of Section I, the FIO Report addresses the fact that many of the state recommendations relate to issues that the states have been addressing, but that progress has been uneven "despite the absence of any dispute about the need for change." The FIO Report states: "As a result, should the states fail to accomplish necessary modernization reforms in the near term, Congress should strongly consider direct federal involvement." The final paragraphs address two options in this regard: the development of federal standards implemented by the states and direct federal regulation. In other words, in the short term, the FIO Report proposes to modernize the U.S. system of insurance regulation through a combination of state action—the bigger part—and federal action. In the long term, additional federal involvement may depend on the success of state reform.

[1] http://www.treasury.gov/press-center/press-releases/Pages/jl2245.aspx; 31 U.S.C. § 313(p): congressional directive.

[2] 31 U.S.C. §§ 313-14.

[3] 31 U.S.C. 313§ r(2).

[4] http://www.treasury.gov/initiatives/fsoc/designations/Pages/default.aspx.

Sixth Circuit Rules Holder Of Insurance Certificate May Assert Negligence Claim Against Broker For Failure To Obtain Correct Coverage Requested By Named Insured

SUMMARY: In *Cleveland Indians Baseball Co., L.P. v. New Hampshire Insurance Company*, 727 F.3d 633 (6th Cir. 2013), the Sixth Circuit Court of Appeals found that a holder of an insurance certificate could assert a viable negligence claim against the insurance broker that issued the certificate where the broker failed to obtain the correct coverage requested by the named insured. The case expansively interpreted Michigan law to find potential tort liability by the broker, opening up avenues of recovery for additional insureds and insurance certificate holders where the insurance policy at issue does not provide expected coverage due to a mistake by the broker.

National Pastime Sports agreed to produce a "Kids Fun Day" event in conjunction with a Cleveland Indians home game. As part of this undertaking, National Pastime procured a commercial general liability ("CGL") policy through its insurance broker, CSI Insurance Group, under which the Cleveland Indians were named as additional insureds. On the insurance application submitted to the broker, National Pastime checked a box that stated inflatables would be used at the event. The broker then provided the Cleveland Indians with an insurance certificate for the policy.

Once the CGL policy was purchased and the insurance certificate was issued, but before the policy was provided to either National Pastime or the Cleveland Indians, the Fun Day event took place. During the event, two attendees, Douglas Johnson and David Brown, were injured when an inflatable slide collapsed on them. Johnson died nine days later.

National Pastime notified CSI of the accident shortly after it occurred. At that time, National Pastime learned that the CGL policy it had purchased included an "amusement device" exclusion which, among other things, excluded coverage for inflatable slides like the slide involved in the accident. When National Pastime informed the broker that it had checked a box on the policy application noting that inflatables would be used during the event, a CSI employee responded, "Oh, ok. Sorry, I guessed I missed it. I'm so used to quoting up your events I think I hardly look at anything but the dates and the details of the event."

Brown's and Johnson's representatives subsequently sued National Pastime and the Cleveland Indians. The CGL insurer denied coverage of the lawsuit based upon the amusement device exclusion. Coverage lawsuits subsequently ensued between the various parties, including claims brought by the Cleveland Indians against CSI alleging that CSI was negligent in failing to procure the requested insurance coverage for the Fun Day event. The federal district court dismissed the Cleveland Indians' claims on CSI's motion for summary judgment, finding there was no duty owed to the Cleveland Indians by CSI which could give rise to tort liability.

On appeal, the Sixth Circuit reversed the trial court. While the court acknowledged that there "is no Michigan case law directly on the issue of an insurance broker's duty to an additional insured," the court found that there was case law supporting a claim of negligence against CSI in this instance. Specifically, the court noted that in various contexts, Michigan courts have imposed "an independent duty of care" on those who provide professional services "towards third parties where the harm was foreseeable and where the defendant had specific knowledge that its actions might harm a specific third party." Relying on this general proposition, the court found:

> Here, it is reasonably foreseeable that an additional insured such as the Indians will be harmed if an insurance agency or other intermediary fails to procure the intended coverage, just as the primary insured would be. While it is understandable that the law should not allow the insurance broker to be held liable to a virtually limitless class of claimants who are total strangers to the relationship between the insurance agency and the insured, or parties who were unknown to the insurance broker before the filing of a suit, this is not that case.

The court further found that to the extent Michigan law required a "special relationship" between CSI and the Cleveland Indians in order for a tort claim to exist, such a relationship "certainly exists here" since CSI knew the specific purpose of the CGL policy, and CSI sent the Cleveland Indians an insurance certificate naming the team as an additional insured.

Accordingly, the court held that the Cleveland Indians had a viable negligence claim against CSI as "CSI was well aware that the Indians could be harmed if the proper insurance was not procured." The court also found that the Cleveland Indians could assert a claim of negligent misrepresentation against CSI since the Cleveland Indians reasonably relied upon the insurance certificate provided by CSI and believed adequate insurance coverage had been procured for the Fun Day

event. The court held this reliance was reasonable in light of the fact that the insurance policy itself (which contained the "amusement device" exclusion) had not yet been provided to the Cleveland Indians at the time of the accident.

One judge dissented, asserting that the majority opinion was contrary to established Michigan law. The dissent said there was no independent duty owed by CSI to the Cleveland Indians separate and distinct from CSI's contractual duty to procure insurance for National Pastime. Absent such a distinct duty, the dissent said, CSI should not be held liable in tort to the Cleveland Indians. The dissent also found fault with the majority opinion because it could potentially result in a windfall recovery to the Cleveland Indians. "The rule proposed by the majority would permit double recovery, because under the majority's approach CSI could be liable to [National Pastime] for breach of its contract to obtain insurance, and to the Indians for negligence, even though the damages due to each would be the same."

IMPORT OF DECISION: The *Cleveland Indians* case expansively interpreted Michigan tort law to find that an insurance broker can be held liable to third parties with which it did not contract if the harm to such parties was foreseeable by the broker. The holding of the case seems to conflict somewhat with a Michigan Court of Appeals case, *West American Ins. Co. v. Meridian Mutual Ins. Co.*, 230 Mich. App. 305, 583 N.W.2d 548 (1998), in which the court held that insurance certificates only show that an insurance policy has been issued, but cannot be used to prove the specific terms of the policy referenced in the certificate. Because the *Cleveland Indians* case was decided by a federal court, it is not binding on Michigan state courts. It is unclear whether Michigan courts will reject its holding or follow its lead in future broker liability cases. As issuing insurance certificates is a common function of insurance brokers, it remains to be seen if this activity will be the basis for an increase in claims by certificate holders who find out that the policy referenced in the certificate does not provide the coverage the certificate holder expected.

Michigan Federal Court Enjoins Ongoing Arbitration To Allow Party To Raise Issues Concerning Improper Conduct Of Opposing Counsel And Party-Appointed Arbitrator

SUMMARY OF DECISION: In *Star Insurance Company v. National Union Fire Insurance Company of Pittsburgh*, PA, 2013 U.S. Dist. LEXIS 130379 (E. D. Mich. Sept. 12, 2013), a federal trial court in Michigan enjoined an arbitration after the panel issued an interim final award that left open certain damages issues when the cedents alleged counsel for the reinsurer and its arbitrator engaged in impermissible *ex parte* communications and the panel entered orders without the participation of the cedents' arbitrator in order to allow the cedents an opportunity to prove their claims of improper conduct.

Generally, courts have no jurisdiction to review arbitration proceedings unless a final award has been issued. There are few exceptions to this rule, and one of those was at issue in this case. Star Insurance Company, Savers Property & Casualty Insurance Company, Ameritrust Insurance Corporation, and Williamsburg National Insurance Company ("Cedents") and their reinsurer, National Union Fire Insurance Company ("National Union"), entered into a reinsurance treaty covering workers' compensation business that contained an arbitration provision under which disputes were to be submitted to a panel of two party-appointed arbitrators and an umpire not under the control of either party.

The Cedents commenced an arbitration against National Union, and a three member arbitration panel was appointed. During the umpire selection process, it was disclosed that the umpire had a "close friendship" with National Union's arbitrator. The Cedents also contended that National Union's counsel and its arbitrator had participated together on various unrelated panel discussions sponsored by that counsel's law firm during the pendency of the arbitration.

The arbitrators issued a scheduling order that provided *ex parte* communications with panel members were to cease upon the filing of the parties' initial pre-hearing briefs. Following a hearing, the panel issued an Interim Final Award resolving liability but leaving open issues relating to damages. On the day the award was issued, and then on two other occasions within two weeks, National Union's counsel had *ex parte* communications about the Interim Final Award with National Union's arbitrator, as evidenced by entries in counsel's billing records that were submitted to the panel in support of a petition for attorney's fees and costs.

The Interim Final Award required the Cedents to submit additional documentation, which they did. National Union filed a motion to strike the Cedents' submission on the grounds that it was insufficient. The umpire and National Union's arbitrator granted the motion. The Cedents alleged this was done without their arbitrator's knowledge or participation.

The Cedents filed a motion for clarification with the panel and for more time to file replacement submissions. The umpire and National Union's arbitrator, again

CONTINUED ON PAGE 6

Michigan Federal Court Enjoins Ongoing Arbitration To Allow Party To Raise Issues Concerning Improper Conduct Of Opposing Counsel And Party-Appointed Arbitrator

CONTINUED FROM PAGE 5

allegedly without the input of the Cedents' arbitrator, granted the request for more time and clarified what documentation was to be submitted.

The Cedents then filed a complaint in state court seeking to vacate, correct and/or modify the panel's Interim Final Award. They also filed an emergency motion with the panel seeking to stay all proceedings. The umpire and National Union's arbitrator denied the motion, with the Cedents' arbitrator dissenting. In his dissent, he stated that both prior orders had been rendered without his participation, input or consultation and "had the effect of disenfranchising me from participation in decisions on very important issues in the arbitration."

After the panel denied their emergency motion, the Cedents filed a motion in their state court action seeking review and appeal of the panel's Interim Final Award. National Union removed the action to federal court.

The Cedents then filed a motion for preliminary injunction seeking to stay the arbitration so they could investigate whether the *ex parte* communications breached the treaty and whether the various relationships between National Union's counsel and its arbitrator and between National Union's arbitrator and the umpire breached the treaty's requirement that the panel be comprised of disinterested arbitrators under the control of no party. The Cedents did not request the court to vacate the Interim Final Award.

In ruling on the motion for preliminary injunction, the district court acknowledged that generally courts have no jurisdiction to review arbitration proceedings until they are final. However, the district court observed that the issue was whether National Union had, through its counsel's *ex parte* communications with National Union's arbitrator and the various relationships described above, breached the provision in the treaty requiring that disputes be decided by a three party panel of disinterested arbitrators who are not under the control of any party. The court further observed that under the Federal Arbitration Act, a court may intervene in ongoing arbitration proceedings if the arbitration agreement is subject to attack under general contract principles. The court concluded that although a court may be generally prohibited from reviewing arbitration proceedings before a final award, it nevertheless has jurisdiction to determine if the arbitration agreement has been breached by a party's and an arbitrator's actions preceding the final award.

The district court examined the elements necessary for the issuance of injunctive relief: (1) whether the Cedents would suffer irreparable harm if an injunction were not granted; (2) whether they were likely to succeed on the merits; (3) whether there was substantial harm to others, including National Union; and (4) whether public policy weighs against injunctive relief.

National Union argued that the Cedents had an adequate remedy at law: money damages. The Cedents responded that the anticipated adverse arbitration award would damage their business reputation and good will. The court agreed this would be irreparable injury.

As to whether the Cedents were likely to succeed on the merits of their claim, the court described the claim as seeking additional time to investigate the relationship between National Union's counsel and its arbitrator and to determine whether that conduct and the relevant circumstances violated the treaty's arbitration clause. The court appeared to be influenced by the fact that National Union "failed to meaningfully address" the alleged *ex parte* communications and, in fact, seemed not to dispute their occurrence. The court said that while courts generally do not have jurisdiction over disputes involving allegations of bias until after an arbitration has concluded, an exception to that rule allows a court to intervene if the agreement is subject to attack under general contract principles. Courts have authority to remove an arbitrator before arbitration proceedings have ended where the arbitrator's relationship to one party is not disclosed or is unanticipated and unintended.

The court found that these factors weighed in favor of injunctive relief and granted the Cedents' motion. Factoring heavily in the district court's decision was the fact of the *ex parte* communications, the close friendship between the umpire and National Union's arbitrator, the relationship between National Union's counsel and its arbitrator (as evidenced by their appearance together on the unrelated panels during the course of the arbitration), and the fact that the Cedents' arbitrator was not involved in two key decisions impacting the Cedents' liability.

The court said the parties entered into a contract that required disinterested officials, not under the control of any party, to serve as arbitrators. The Cedents raised substantial questions going to the heart of this contractual provision. The court held the Cedents' prospects for success on the merits turned on whether National Union violated the terms of the Treaty

through *ex parte* communications with National Union's arbitrator. The court held that the Cedents need only prove the fact of the *ex parte* communications to prevail on the merits of a request to remove a panel member which would in effect vacate the arbitration award.

The court also held the Cedents were likely to prevail on their breach of contract claim for the failure to submit disputes before a three member panel since the Cedents' arbitrator was not involved in two major decisions which impacted whether the Cedents would be liable for over $25 million. The court rejected National Union's argument that the Cedents could not prevail because their arbitrator was copied on emails and the umpire participated in the process. The Cedents' arbitrator said there was no urgency in the decisions which were made while he was on a two day vacation during which National Union's arbitrator and the umpire knew he would have no or limited ability to communicate.

The district court felt that additional time was needed to examine the impact of these factors and, therefore, granted the Cedents' motion for a preliminary injunction. The court said National Union would not suffer any harm if the arbitration were stayed. The court acknowledged the strong federal policy favoring arbitration, but concluded the public's interest in the integrity of the arbitration process and in upholding contracts favored the issuance of an injunction to preserve the status quo.

IMPORT OF DECISION: While courts will generally not entertain allegations of arbitrator bias until after an arbitration has concluded, the court found this case to be an exception. The court was troubled by what had transpired and was very concerned that the integrity of the arbitral process may have been compromised. The court concluded that: (a) the *ex parte* communications between National Union's arbitrator and its counsel; (b) the relationship between those two individuals as well as the one between National Union's arbitrator and the umpire; and (c) the fact that important decisions had been made by only two of the arbitrators without the input of the Cedents' arbitrator were sufficient to warrant enjoining the arbitration to allow the Cedents to have time to present their arguments that the treaty had been violated.

Credit for Reinsurance—The Emergence of Reduced Collateral Requirements

The move towards reduced collateral requirements for alien reinsurers (non-U.S. companies that are not admitted in any U.S. jurisdiction) continues to gather momentum. As most people in the industry know, in 2011 the National Association of Insurance Commissioners ("NAIC") adopted amendments to its credit for reinsurance statutes and regulations to create a system whereby alien reinsurers could get "certified" and become eligible to post reduced collateral in connection with their assumed U.S. business. The amendments marked a rather dramatic shift in policy from what had been the *de facto* default rule that alien reinsurers needed to post 100% collateral in order for U.S. ceding companies to be able to take credit for reinsurance on their financial statements. While several states were quick to adopt the new statutes and regulations, only two states, Florida and New York, implemented the procedures and actually certified reinsurers for reduced collateral. Connecticut and New Jersey began certifying reinsurers in 2013.

One of the main reasons for the slow implementation of the NAIC's amendments was that in order for a state that had adopted these provisions to certify an alien reinsurer, the state first had to qualify a foreign jurisdiction (and more specifically the regulatory body governing insurance companies in that jurisdiction) as meeting certain fundamental regulatory requirements related to the solvency of insurance companies in that jurisdiction. This obstacle has now been overcome with the NAIC's adoption of its *Process for Developing and Maintaining the NAIC List of Qualified Jurisdictions* ("Process") on August 27, 2013, whereby it will serve as a clearing house for granting the regulatory authorities of foreign jurisdictions qualified status.

The NAIC then began an expedited review process and on December 18, 2013 announced that it had granted preliminary qualification to four jurisdictions: the Bermuda Monetary Authority; the German Federal Financial Supervisory Authority; the Swiss Financial Market Supervisory Authority; and the United Kingdom's Prudential Regulation Authority of the Bank of England. The preliminary qualifications became effective January 1, 2014 and help pave the way for several other states to start certifying alien reinsurers for reduced collateral. While the qualification of these jurisdictions is only preliminary at this point, all are expected to receive full qualification in 2014. In addition, other foreign jurisdictions are expected to begin the qualification process.

It has been fairly widely reported that as of the NAIC's adoption of the Process in August 2013, 18 states representing 53% of the written premium in the U.S. have adopted the reduced collateral provisions. There are notable exceptions, including Illinois and Texas. The NAIC is clearly committed to pushing this process along, which should help continue the momentum for this initiative. Things to look for as this process develops include the following:

CONTINUED ON PAGE 8

Credit for Reinsurance—The Emergence of Reduced Collateral Requirements

CONTINUED FROM PAGE 7

- Now that the NAIC has granted preliminary approval to four jurisdictions, how quickly will the states that have adopted these provisions begin to certify reinsurers? Early indications are that the states are ready to move forward. Missouri on January 17, 2014 and Pennsylvania on January 25, 2014 both announced that they have now approved two reinsurers under these procedures.
- Will reciprocity be granted by other jurisdictions to companies once they are certified by one state? The NAIC model provisions include an optional reciprocity provision that a state can defer to another state's certification of a particular reinsurer. There are some indications that a system is being established to co-ordinate this in practice, but it cannot yet be confirmed that such a system is in place.
- How is the reinsurance market impacted in these states? This is the true test of the system and an issue that will be watched closely.
- How quickly will other jurisdictions look to become approved as qualified jurisdictions?
- How quickly will additional states adopt the new reduced collateral provisions? This remains to be seen and will likely be impacted by the above factors and how smoothly the process works in practice.

District Court Refused To Implement Alternative Umpire Selection Procedure Not Provided In Reinsurance Agreements After Reinsurance Dispute Was Transferred From Western District Of Wisconsin To Southern District Of New York

SUMMARY: In *Employers Insurance Company of Wausau v. Arrowood Indemnity Company*, No. 12-cv-08005-LLS (S.D.N.Y. Oct. 25, 2013), a consolidated dispute between a cedent and three of its reinsurers over the reinsurers' obligations to reimburse the cedent for claims, the U.S. District Court for the Southern District of New York refused the cedent's request that the court order the selection of an umpire in a manner not provided for by the reinsurance agreements. Instead, the court determined that the agreements should be enforced, and that the arbitrators already appointed must select an umpire in accordance with the terms of the agreements.

Arrowood Indemnity Company ceded various claims to its reinsurers, Employers Insurance Company of Wausau, Nationwide Mutual Insurance Company, and National Casualty Company ("Reinsurers") under separate reinsurance agreements. When the Reinsurers failed to pay Arrowood's claims, Arrowood initiated arbitration. The agreements provided that the party arbitrators would select the umpire. Following the parties' selection of arbitrators, the parties arrived at an impasse over appointment of an umpire in each dispute. The Reinsurers petitioned the federal court in the Western District of Wisconsin to enforce the agreements by ordering compliance with the agreements' mechanism for selection of umpires.

Arrowood responded that not all of the agreements contained the same umpire selection mechanism. Because the parties were not able to agree on an umpire, Arrowood argued the court should choose an arbitrator from a list of three it had submitted. *See Employers Ins. Co. of Wausau v. Arrowood Indem. Co.*, 2012 U.S. Dist. LEXIS 154140 (W.D. Wisc. Oct. 26, 2012). Arrowood further argued that the case should be dismissed for improper venue citing the forum selection clause in each agreement that provided: "arbitration shall take place in New York, New York unless some other place is mutually agreed upon." The Reinsurers argued that the forum selection clauses were permissive rather than mandatory and therefore did not preclude the case from proceeding outside New York.

The Wisconsin federal court disagreed with the Reinsurers' argument that the action should remain in Wisconsin. The court ruled that the forum selection clauses were mandatory, requiring the dispute to be heard in New York. The court agreed that under the Federal Arbitration Act, 9 U.S.C. § 4, the forum selection clause must be enforced in the context of a petition to compel arbitration, which was to be heard by the court in the forum selected by the parties through the agreements' forum selection clause.

Arrowood also argued that its underlying case for breach of the agreements should not be transferred because it was attempting to enforce the agreements under § 5 of the FAA which does not contain the same venue limitations as does § 4. The court disagreed that some claims could be selected by Arrowood for transfer of venue while others would be decided separately. Accordingly, the court transferred the entire case to the Southern District of New York to consider the umpire selection process as well as Arrowood's underlying claims.

The Southern District of New York considered whether the mechanism for selection of an umpire in the agreements should be enforced or whether the court should apply a different selection approach. Although the reinsurance agreements specified a procedure whereby the appointed arbitrators would select a neutral umpire, Arrowood instead proposed an alternative approach, claiming the method stipulated in the agreements would not lead to appointment of an agreed upon umpire. Arrowood suggested the parties instead each nominate up to eight candidates from which the umpire would be selected after a voir dire style objection process.

However, the Court, acting under authority granted by Section 5 of the Federal Arbitration Act, denied that alternative, ordering that the present arbitrators select an umpire in accordance with the agreements' requirements. Though the court simply entered a two page order without a written opinion, we note that its decision is consistent with the decision of the Northern District of California in *Granite State Insurance Co. v. Clearwater Insurance Co.*, No. C 13-2924 SI, 2013 WL 4482948 (N.D. Cal. Aug. 19, 2013) where, faced with a similar stalemate over arbitrator selection, the court ruled the parties must follow the arbitrator selection process provided by the agreements. Citing to Sections 4 and 5 of the FAA, the district court there held that these sections limit the court's authority to require the parties to arbitrate as agreed or to appoint arbitrators under certain conditions. It also noted that a court may appoint an umpire only where the circumstances render it impossible to follow the parties' arbitration clause dictating the method of selecting an umpire. The ruling by the Southern District of New York in *Arrowood* supports these propositions.

IMPORT OF DECISION: While the FAA empowers courts to appoint arbitrators or umpires if the selection method in the parties' agreement fails, the FAA also clearly says courts are to enforce an agreement's appointment provisions. This decision underscores the point that courts will require parties to follow the approach set out in their contract, even if it may not be ideally tailored to a particular situation.

Virginia Supreme Court Rules Unavailability Of Entity Specified In Contract To Administer Arbitration Does Not Render Arbitration Provision Unenforceable

SUMMARY: In *Schuiling v. Harris*, 286 Va. 187 (2013), the Virginia Supreme Court ruled that a provision in an arbitration clause of an employment agreement stating that any disputes were to be resolved by arbitration administered by a specifically named entity was not unenforceable when the entity was no longer in existence at the time the dispute arose.

William Schuiling hired Samantha Harris to be his full-time, live-in housekeeper. As a condition of employment, Harris signed an arbitration agreement which required all claims, disputes, or controversies arising out of, or related to, her employment to be resolved "exclusively by arbitration administered by the National Arbitration Forum ["NAF"]."

Several years after the contract was entered into, Harris filed suit against Schuiling in Virginia state court alleging multiple torts, statutory violations, and breach of contract. Schuiling filed a motion to enforce arbitration, stating that the NAF was no longer available to administer the arbitration and requesting that the trial court appoint a substitute arbitrator. Harris opposed the motion, arguing that the NAF was exclusively designated as the arbitrator. She contended that the parties' agreement to arbitrate was conditioned on the NAF conducting the arbitration. Since the NAF was unavailable, and since the agreement did not provide for the appointment of a substitute arbitrator, Harris argued the agreement was unenforceable. The trial court agreed. The Virginia Supreme Court granted Schuiling's interlocutory appeal.

The Supreme Court reversed, concluding that the agreement's severability clause required that the term providing that an arbitration was to be administered by the NAF could be severed from the agreement. In addition to the language of the severability clause itself, the court stated that the sole object of the entire agreement was to require arbitration. Since the agreement contained no other provisions that would survive failure of the arbitration requirement, a determination that the NAF's designation was not severable would defeat the entire agreement.

The court also held that the parties were presumed to know that under Virginia law, the trial court was empowered to appoint an arbitrator when the method of arbitrator appointment in the agreement fails or cannot be followed.

CONTINUED ON PAGE 10

Virginia Supreme Court Rules Unavailability Of Entity Specified In Contract To Administer Arbitration Does Not Render Arbitration Provision Unenforceable

CONTINUED FROM PAGE 9

The court stated that nothing in the agreement indicated that the parties contemplated the contingency that the NAF might be unavailable and intended the arbitration requirement itself to terminate if that contingency occurred. The court held that the inclusion of the word "exclusively" indicated nothing more than a designation of the single arbitrator to decide a dispute presuming that arbitrator would be available if called upon.

The court concluded that the severability clause reflected that the parties intended the NAF to be the exclusive arbitrator so long as it was available. If the NAF's unavailability made its appointment unenforceable, however, the designation would be severed. The absence of a provision for the appointment of a substitute arbitrator indicates nothing more than the parties' presumed knowledge that the Virginia Code provided the necessary mechanism for the appointment of an arbitrator.

IMPORT OF DECISION: Although this case does not involve a reinsurance agreement, its holding may be applicable to arbitrations under reinsurance contracts. It is not uncommon for a reinsurance agreement to provide that an arbitrator or umpire is to be selected by an organization specifically named in the agreement. It sometimes occurs that the organization is no longer in existence or may not be available to appoint an arbitrator. Most state arbitration statutes, as well as the Federal Arbitration Act, contain provisions authorizing courts to appoint arbitrators if the method provided in the arbitration agreement fails for any reason. This case is authority for the proposition that if the appointing entity is no longer available to appoint an arbitrator, the parties' agreement to arbitrate remains enforceable, and a court may be requested to make the appointment.

CLARK HILL'S Insurance and Reinsurance Practice Group has an established reputation for its work in the global insurance and reinsurance industry. The firm represents major United States, London Market, European, and Bermuda insurers and reinsurers in commercial litigation, coverage disputes, and major business transactions. Our practice encompasses all types of insurance, and every kind of underlying risk. We have the capacity to efficiently handle any (re)insurance matter, from individual to class action claims, and each assignment undertaken by the firm is afforded the same personal attention of partners having expertise with respect to the issues.

Philadelphia

Joseph M. Donley
Insurance & Reinsurance Practice Group Leader

Christopher M. Brubaker
William E. Cox
Christopher J. Day
Douglas M. Chapman
Peter B. Kupelian
Carol G. Schley
Karolien M. Vandenberghe

For more information, please contact Joseph M. Donley at jdonley@clarkhill.com, or call 215.640.8500.

To subscribe to *Insurance & Reinsurance Briefing*, please contact Connie Lojewski at 215.640.8543 or clojewski@clarkhill.com.

CLARK HILL

Briefing

Spring 2015

Insurance & Reinsurance

Discoverability Of Reinsurance Communications

SUMMARY: There have been a number of recent cases dealing with the discoverability and privileged nature of cedent/reinsurer communications in actions between the ceding company and the underlying insured. While the common interest doctrine often is invoked in these situations, only one of these cases directly addresses the applicability of the doctrine to the cedent/reinsurer relationship. The other cases turn on issues such as whether the documents are exempt from production because of the attorney-client privilege or work-product doctrine or the propriety of the document requests at issue. To the extent these cases suggest a trend in this area, it is that courts impose a high burden on the party resisting discovery (typically the cedent) to prove a factual basis exists for classifying documents as privileged or work-product or to establish the applicability of the common interest doctrine.

National Union Fire Insurance Co. of Pittsburgh, Pennsylvania v. TransCanada Energy USA, Inc., 990 N.Y.S.2d 510 (App. Div. 2014) involved a discovery dispute in a declaratory judgment action where the insureds challenged the insurers' privilege designations of documents created prior to the carriers' rejection of the insureds' claims. The insurers had retained legal counsel to prepare a coverage opinion. The court said the record showed counsel was primarily engaged in claims handling, which the court said was "an ordinary business activity for an insurance company." The court held that documents created in the ordinary course of business do not become privileged simply because they were created by an attorney. The court did not address the applicability of the common interest doctrine because it found the documents were not privileged.

In *National Union Fire Insurance Co. of Pittsburgh, PA v. Donaldson Co.*, 2014 U.S. Dist. LEXIS 85621 (D. Minn. June 24, 2014), the insured contended the carriers engaged in bad faith by waiting eight years, until just before mediation, to raise the issue that more than one deductible applied to the insured's claims under a batch clause. A Magistrate Judge had allowed discovery of reinsurance communications between the primary insurers and their reinsurers. On review by the District Court, the insurers argued that reinsurance information was not discoverable for purposes of interpreting an unambiguous policy, but did not address the insured's argument that the information sought was discoverable in relation to the bad faith claim. The District Court noted that there was conflicting case law as to the discovery of reinsurance information in the context of a bad faith claim, but found that the split in authority was not enough to conclude the Magistrate Judge's decision to allow the discovery was contrary to law or clearly erroneous. The

INSIDE THE BRIEFING

District Court also said the reinsurance information could potentially be relevant to what and when the insurer knew about the handling of one of the underlying lawsuits. This made the information sufficiently relevant to the insured's bad faith claim to be discoverable. The common interest doctrine was not at issue.

Harleysville Lake States Insurance Co. v. Lancor Equities, Ltd., 2014 U.S. Dist. LEXIS 154685 (N.D. Ill. Oct. 31, 2014) involved a discovery dispute in a declaratory judgment action brought by Harleysville which sought a ruling that a property damage claim was not covered because the insured failed to properly maintain its building's sprinkler system. The insured countered with a claim under Illinois insurance law (215 Ill. Comp. Stat. § 5/155(1)) providing for attorney's fees, costs and a penalty in cases where the insurer's action or delay was vexatious or unreasonable. The insured sought discovery of all reinsurance contracts and communications relating to Harleysville's reinsurance coverage of all first-party property claims beginning in 2009. The insured did not provide much in the way of rationale for why it needed the requested documents; it simply contended the reinsurance agreements were discoverable and the remaining documents may lead to the discovery of admissible evidence. The insurer responded that the reinsurance information was not admissible to vary the unambiguous terms of the policy and that the common interest doctrine protected the communications. The court allowed discovery of any reinsurance agreement that applied to the claim at issue, citing F.R.C.P. 26(a)(1)(A) which requires the disclosure of any insurance agreement that may indemnify a party for the claim being litigated, but denied the request for other reinsurance documents because it was "plainly too broad." The court agreed with Harleysville's assertion that communications with its reinsurers may be protected by work-product or the "common interest extension of the attorney-client privilege." The court said it would not compel Harleysville to produce the communications since to do so would likely generate disputes about privilege and work-product. While the court recognized the potential application of the common interest doctrine in seeking to avoid what it considered unnecessary privilege disputes, it did not analyze whether or not the doctrine applied in this case.

Progressive Casualty Insurance Co. v. Federal Deposit Insurance Corp., 2014 U.S. Dist. LEXIS 140709 (N.D. Iowa Oct. 3, 2014) involved a declaratory judgment action in which Progressive sought a ruling that its Directors & Officers policy did not cover claims asserted by the FDIC against former officers and directors of a bank. Progressive challenged a Magistrate Judge's ruling that it had improperly redacted on work-product and attorney-client privilege grounds certain communications between Progressive and its reinsurers. The Magistrate Judge held the work-product doctrine did not apply because the documents were created and distributed to reinsurers in the ordinary course of business for business purposes.

The District Court held that the Magistrate Judge did not clearly err in rejecting work-product protection for the documents at issue, concluding that communications between Progressive and its reinsurers were prepared in the ordinary course of business and not in anticipation of litigation. The court said Progressive admitted that the documents were prepared in the ordinary course of business, that they were business planning documents, that neither Progressive nor the reinsurers were involved in giving legal advice or mapping litigation strategy in any individual case, and that the communications served numerous business functions. Progressive argued some specific documents or portions of documents were prepared in anticipation of litigation and hence were subject to work-product protection. Specifically, Progressive said some documents were prepared by claims attorneys at the managing general agent for the agent's and Progressive's internal use. Progressive provided these documents to reinsurers in case updates required by the reinsurance agreements or in response to reinsurers' requests. The documents contained assessments of coverage and liability issues, reserve data, and plans for future handling of the claims.

The District Court noted that the Magistrate Judge had not considered Progressive's argument for "piecemeal" application of the work-product doctrine to specific documents or parts of documents. Nevertheless, the District Court concluded the Magistrate Judge's ruling had encompassed Progressive's objection. The fact that specific documents or sections of documents were prepared by claims attorneys does not necessarily establish that they are entitled to work-product protection. Also, preparation of documents by claims attorneys for internal use does not necessarily prove the internal use was in anticipation of litigation. In addition, given that Progressive conceded the documents were provided to reinsurers as case updates pursuant to the reinsurance agreements, the District Court held Progressive had acknowledged the specific documents and parts of documents were prepared in the ordinary course of business.

The District Court recognized that in certain situations opinion work-product that was incorporated into a document prepared in the ordinary course of business could retain its protected status, but found there was no basis to conclude that the Magistrate Judge's decision was clearly erroneous in holding Progressive failed to carry its burden of showing work-product protection was warranted. In short, there was no basis to overrule the

Magistrate Judge's finding that the documents, in their entirety, were created in the ordinary course of business.

The District Court then turned to the applicability of the attorney-client privilege to the disputed discovery. Progressive acknowledged it had voluntarily disclosed privileged communications to reinsurers and a broker, but contended the privilege was preserved under the common interest doctrine. The Magistrate Judge rejected this argument, holding that even if the doctrine was available under Iowa law, it only applied if the parties share a common legal interest. According to the Magistrate Judge, the relationship between Progressive and its reinsurers and broker was commercial and financial in nature, not legal. The Magistrate Judge noted that the unique circumstances of the reinsurance business do no automatically create a common legal interest. He found Progressive did not show that the reinsurers were actively participating in its litigation and legal defense or had any obligation to do so. Also, Progressive did not present any evidence establishing a joint strategy or legal enterprise with its reinsurers. Thus, the Magistrate Judge held, Progressive waived any privilege by providing the documents to third parties.

The District Court agreed with the Magistrate Judge's analysis and findings. The District Court noted that the common interest doctrine requires a two part showing that: 1) the common interest is legal, not solely commercial, and evidenced by an agreement, though not necessarily in writing; and 2) the exchange of privileged information was done in the course of formulating a common legal strategy. The District Court held that Progressive failed to show the Magistrate Judge was clearly erroneous on either point. The District Court cited to other cases that had rejected a categorical finding that the common interest doctrine applies in the cedent/reinsurer relationship. In so concluding, the District Court noted reinsurers do not have a duty to defend their reinsureds while insurers have such a duty with respect to their insureds. The District Court held that Progressive and its reinsurers did not have a common legal interest merely because the reinsurers may be obligated to pay Progressive's losses. Rather, the relationship between the parties was commercial and financial. The mere fact that the reinsurers had the right to participate in the defense of the underlying claim was not enough to establish a common legal interest given the lack of evidence of any joint legal strategy or legal enterprise. The District Court also concluded Progressive failed to establish that any exchange of documents was in furtherance of a common legal interest or was a matter of legal necessity, rather than in furtherance of Progressive's commercial or financial relationship with its reinsurers.

IMPORT OF PROGRESSIVE DECISION: Courts around the country are split on whether the common interest doctrine applies to attorney-client communications sent by a cedent to its reinsurers. While some courts have held the doctrine does apply to preserve the privilege, others have held the doctrine is not applicable and the privilege is waived if a cedent sends documents to its reinsurers (or allows them to be reviewed) that contain privileged attorney-client communications.

Cedents are understandably desirous of explaining to their reinsurers why they paid an underlying claim; indeed, the reinsurance relationship may compel them to do so. In this regard, insurers commonly send communications to their reinsurers containing the insurers' attorneys' evaluations of the insureds' claims, sometimes in the form of letters prepared by the insurers' coverage counsel. In fact, coverage counsel's candid assessments of the strengths and weaknesses of a cedent's case may be the best way to communicate such information to reinsurers. In addition, reinsurance agreements typically have terms allowing reinsurers to audit their cedents' claims files. In either case, reinsurers may receive or review privileged communications between cedents and their counsel.

In coverage actions against their carriers, insureds regularly seek discovery of communications between insurers and their reinsurers because the insureds think they will contain a treasure trove of information, including the cedents' candid assessments of their coverage positions. Since the law on the common interest doctrine varies by jurisdiction, the takeaway for cedents is that they must assume their insureds may be able to obtain in discovery in coverage litigation privileged communications the carriers send to their reinsurers.

Nevertheless, there are some steps cedents can take to maximize the chance a court will find the common interest doctrine applies to protect the cedents' attorney-client communications. One, the cedent may require its reinsurers to sign confidentiality and non-waiver agreements. Two, a cedent could request its reinsurer to invoke its right to associate (if present in the reinsurance agreement) (although many reinsurers may be reluctant to do so). Three, the communications could be sent to reinsurers directly by the cedent's coverage counsel with a letter expressly acknowledging the common legal interest and need to develop a common legal strategy with regard to the underlying claim. Four, the cedent could wait until the underlying coverage action is concluded before sending privileged

communications to its reinsurers.

None of these steps will guarantee a court will rule the common interest doctrine protects the cedent's attorney-client communications, however, which is something cedents need to always bear in mind.

Sixth Circuit Rules Arbitrator, Not Court, Is To Decide Whether Arbitration Clause Is Enforceable

SUMMARY: In *Milan Express Co. v. Applied Underwriters Captive Risk Assurance Co.*, 2014 U.S. App. LEXIS 20637 (6th Cir. Oct. 23, 2014), the Sixth Circuit held that the threshold issue of arbitrability was to be decided by an arbitrator under the parties' broad arbitration agreement. Thus, the arbitrator, not the court, was to decide whether the arbitration clause was enforceable under Nebraska law.

Milan and Applied Underwriters entered into a reinsurance participation agreement which contained an arbitration clause that said: "[a]ny dispute or controversy . . . shall be fully determined in the British Virgin Islands under the provisions of the American Arbitration Association." The clause also provided that "all" disputes between the parties relating "in any way to" the construction, enforceability, or breach of the agreement "shall be . . . finally determined exclusively by binding arbitration." The agreement also stated that it was to be governed by Nebraska law.

A dispute arose regarding the payment of premiums and fees. Milan filed a lawsuit against Applied Underwriters in the U.S. District Court for the Western District of Tennessee, together with a motion seeking to prevent arbitration of the dispute. As support for its motion, Milan asserted that the arbitration provision was unenforceable under a Nebraska statute that invalidated arbitration provisions contained in "an agreement relating to an insurance policy other than a contract between insurance companies." In response, Applied Underwriters filed a motion seeking to compel arbitration.

The district court granted Milan's motion. The court held it, not an arbitrator, had the authority to decide the threshold question of whether the dispute was arbitrable. The court also ruled the arbitration clause was unenforceable under Nebraska law. Applied Underwriters appealed.

On appeal to the Sixth Circuit, Applied Underwriters argued the express terms of the arbitration provision required the question of arbitrability to be decided by an arbitrator, not the court. The Court of Appeals agreed, finding that the parties "mutually and comprehensively agreed" to resolve all of their disputes by arbitration. Following the U.S. Supreme Court's decision in *Rent-A-Center, West, Inc. v. Jackson,* 561 U.S. 63 (2010), the Sixth Circuit held the agreement demonstrated "the parties manifestly intended to submit the threshold question of arbitrability to the arbitrator. This agreement, too, is enforceable like any other contract in accordance with its terms."

The appellate court noted a court must first resolve any challenge to the *validity* of an arbitration agreement before it may compel arbitration if the challenge is on common law grounds for rescinding contracts, such as unconscionability or fraud. However, the court noted Milan did not raise this argument. "Rather, Milan's challenge, to the arbitration clause as a whole, is limited to the argument that it is unenforceable under Nebraska law. Milan *may* be right about this, but enforceability is a question the parties expressly agreed to submit to arbitration, an agreement Milan has not challenged on fraud or unconscionability grounds." (Interestingly, the court did not address whether Milan's challenge to the arbitration clause under Nebraska law was preempted by the Federal Arbitration Act.)

Finding that the question of arbitrability should be decided by an arbitrator, not a court, the Sixth Circuit vacated the district court's decision, but did not decide whether Applied Underwriters was entitled to an order compelling arbitration. Since the parties' agreement provided that arbitration proceedings were to be conducted in the British Virgin Islands, the court said the district court lacked authority to specifically enforce the arbitration clause. The Court of Appeals also observed that two counts in Milan's complaint sought relief (for fraudulent and negligent misrepresentation) that did not arise under the agreement and, thus, arguably were not subject to arbitration. Rather than dismissing Milan's complaint in its entirety, the Sixth Circuit said the district court could have decided to stay proceedings pending arbitration of the arbitrable claims. Since the parties had not briefed how the matter should proceed on remand, the Court of Appeals directed the district court to "take up afresh the question of how best to move forward."

IMPORT OF DECISION: The Milan case demonstrates that courts will enforce a broad arbitration clause provided it is clear and unambiguous. If the parties expressly agree an arbitrator is to decide whether their dispute is subject to arbitration, courts will uphold their agreement. However, where the validity of the arbitration clause, itself, is in dispute, for example, where a party alleges the clause was induced by fraud or is subject to rescission, such issues will be decided by a court.

Delaware Supreme Court Clarifies "Manifest Disregard" Standard Used When Determining Whether To Vacate Arbitrator's Award

SUMMARY: While arbitration remains the primary battleground when wars between reinsurers and cedents are waged, the fight sometimes spills into the courts where an arbitrator's decision may be called into question and either upheld or overturned by a judge. The standard used by a court to determine whether an award should be overturned is a strict one where even apparent error by the arbitrator may not be enough to vacate the decision. Drawing on the Federal Arbitration Act ("FAA") and relevant federal case law, the Supreme Court of Delaware clarified this in *SPX Corporation v. Garda USA, Inc.,* 94 A.3d 745 (Del. 2014), holding that to vacate an arbitral award based on "manifest disregard of the law," a court must find the arbitrator "consciously chose to ignore a legal principle, or contract term, that is so clear that it is not subject to reasonable debate."

SPX Corp. ("SPX") and Garda USA ("Garda") entered into a stock purchase agreement pursuant to which SPX sold its subsidiary to Garda. The purchase price was subject to adjustment based upon differences in SPX's pre-closing and post-closing balance sheets. Under the agreement, incurred but not reported claims ("IBNR") related to workers' compensation liabilities were required to be included by SPX when calculating its liabilities and loss reserves on its balance sheets. SPX did not include its workers' compensation IBNR on its post-closing balance sheet. Garda contended SPX improperly undervalued the subsidiary's loss reserves on its balance sheet leading up to the sale and therefore inflated the price to be paid for the subsidiary under the stock purchase agreement.

The parties agreed to arbitrate their dispute about how the figures on SPX's balance sheet were calculated on the date of the acquisition. The arbitrator determined, without explanation, that Garda had not demonstrated that SPX failed to comply with the terms of the stock purchase agreement in calculating the loss reserves and was not required to restate its balance sheets.

Garda then filed suit in the Delaware Chancery Court – a court of equity within the Delaware State Court system – seeking to have the arbitral award vacated. SPX argued it had used actual reserves and that IBNR was unnecessary since the claims were closed. Garda pointed out that the closed claims remained subject to potential new payments arising from recurrence or worsening of claimants' injuries, and that immediately after closing, SPX's own actuary and an independent consultant estimated the reserves were between $3 million and $3.9 million, as opposed to the $1.336 million amount included by SPX on its balance sheet used for the sale. The Chancery Court found the arbitrator had manifestly disregarded the terms of the stock purchase agreement and vacated the arbitrator's decision because the agreement unambiguously required inclusion of IBNR in the reserves. SPX appealed to the Delaware Supreme Court.

The Supreme Court reversed the Chancery Court's ruling. In doing so, the Court invoked the Delaware Arbitration Act and equated the relevant section of this Act to the FAA. The Delaware Arbitration Act (§ 5714(a)(3)) provides that an arbitration award will be vacated when "[t]he arbitrators exceeded their powers, or so imperfectly executed them that a final and definite award upon the subject matter submitted was not made." Federal cases turning on the language in the FAA that tracks this provision establish that vacatur is authorized when the arbitrator acts in "manifest disregard" of the law, meaning that the arbitrator "(1) knew of . . . [a clearly defined] relevant legal principle, (2) appreciated that this principle controlled the outcome of the disputed issue, and (3) nonetheless willfully flouted the governing law by refusing to apply it." Furthermore, as long as the arbitrator is "even arguably construing or applying the contract and acting within the scope of his authority, that a court is convinced that he committed serious error does not suffice to overturn his decision."

According to the Supreme Court, the arbitrator's decision in this case "rationally can be derived from either the agreement of the parties or the parties' submissions to the arbitrator" since the parties' arbitration briefs establish that they presented two potential interpretations of the stock purchase agreement's relevant provision to the arbitrator. SPX had argued its calculation of loss reserves was done in a manner that was consistent with the methods used to prepare the subsidiary's financial statements, as required by the stock purchase agreement. Garda argued the agreement expressly required inclusion of IBNR. The Supreme Court found that a reasonable inference existed that the arbitrator adopted SPX's interpretation of the stock purchase agreement and, while that interpretation may have been wrong, it was not wholly without basis in either the contract or the parties' submissions. Accordingly, the arbitrator's decision was not subject to vacatur under the "manifest disregard of the law" standard.

IMPORT OF DECISION: Drawing from federal case law interpreting the FAA and the relevant language of the Delaware Arbitration Act, the Delaware Supreme Court made clear in this case that to vacate

an arbitrator's award, a party must be able to jump over the perilously high bar of proving the arbitrator showed a "manifest disregard" of a known principle of law when deciding a dispute. If the arbitrator's decision can somehow be rationally derived from the evidence or even from the parties' submissions and arguments to the arbitrator, the arbitrator's award is not in manifest disregard of the law and is not subject to vacatur. Such is the landscape when entering the battlefield of arbitration.

Michigan Federal Court Denies Motion To Seal Arbitration Award, But Agrees To Seal Portion Of Award Identifying Non-Parties

SUMMARY: **In *Amerisure Mutual Insurance Company v. Everest Reinsurance Company,* 2014 U.S. Dist. LEXIS 153013 (E. D. Mich. Oct. 29, 2014), the court denied a motion to seal an arbitration award and the parties' briefs relating to a motion to confirm the award, holding that the longstanding tradition of public access to the courts required such documents be in the public domain. The court did, however, order the portion of the award identifying non-parties to be sealed.**

Amerisure Mutual Insurance Company and Everest Reinsurance Company entered into a confidentiality agreement in their reinsurance arbitration which required the final award to be kept confidential. The agreement also required that certain court filings be sealed. After the arbitration panel issued an award in its favor, Amerisure brought an action seeking to confirm the award. Everest opposed confirmation and sought to have the award vacated.

Amerisure filed a motion asking the District Court for permission to file its brief in support of confirmation under seal, citing the parties' confidentiality agreement. Everest opposed the motion to seal in part, contending the District Court should only seal portions of the award that 1) identified and contained testimony of non-parties to the arbitration and 2) reflected substantive rulings of the panel majority. Everest argued that public disclosure of the substantive rulings could harm its financial interests. Everest claimed that disclosure of the "unhelpful" panel rulings might lead to future litigation between Everest and its other reinsureds. This would be unfair, Everest said, because those rulings were supposed to remain confidential.

The District Court granted Amerisure's motion to seal in part and denied it in part. In reaching its decision, the District Court cited the Sixth Circuit's "long-established legal tradition" of public access to court documents, and observed that "[o]nly the most compelling reasons can justify non-disclosure of judicial records." The District Court noted that sealing portions of the Final Award that identified and related to non-parties was "consistent with these governing principles" and was appropriate to protect the privacy rights of the third parties. The District Court further stated that while the risk of disclosure of confidential business data or trade secrets might justify sealing court records, the risk of "embarrassment, incrimination, or exposure to further litigation" did not justify sealing the records. Accordingly, the District Court refused to grant Amerisure's motion to file the award under seal in its entirety, but instead permitted only certain aspects of it relating to third parties to be filed under seal. The remainder, including the substantive rulings of the panel majority, was not permitted to be filed under seal.

IMPORT OF DECISION: **While it is very common for parties to a reinsurance arbitration to enter into a confidentiality agreement providing that any related court filings be sealed, courts will not always grant motions to seal. Frequently, courts will deny or limit such motions based on the public's right to access court documents.**

New York Federal Court Reproaches Party Seeking To Vacate Arbitration Award For Agreeing To Arbitration But Then Asking Court To Strictly Apply The Law

SUMMARY: **In *Associated Industries Insurance Company, Inc. v. Excalibur Reinsurance Corporation,* 2014 U.S. Dist. LEXIS 169163 (S.D.N.Y. Nov. 26, 2014), an arbitration panel granted a cedent most of the relief it had sought. Unsatisfied with a partial victory, the cedent filed a petition to vacate the award, arguing the panel had not properly applied the follow the fortunes doctrine. A federal district court in New York denied the petition and upheld the panel's compromise decision. The court also admonished the cedent for, on the one hand, agreeing to arbitrate disputes while, on the other, seeking the level of judicial review only available in court.**

Associated, as the reinsured, and Excalibur, as the reinsurer, entered into two reinsurance treaties that contained provisions relieving the arbitrators from following judicial formalities or the rules of evidence. The treaties provided that the arbitrators were to make their decisions according to the practice, customs, and usage of the insurance and reinsurance businesses. The

opinion does not say whether the treaties contained express follow the fortunes provisions, but the discussion makes clear the court found the doctrine applied to the case.

The arbitration panel issued an award giving Associated substantially all the relief it had requested. Nevertheless, the cedent sought to vacate the award, arguing the panel exceeded its powers by manifestly disregarding the law (the follow the fortunes doctrine) in reducing (or compromising) the amounts of certain of its claims. In the arbitration, Excalibur had argued that two exceptions to the doctrine existed: (1) Associated handled certain claims in a grossly negligent manner; and (2) two of Associated's claims payments were *ex gratia*.

The court first held that the "manifest disregard of law" ground for vacating an award remains available in the Second Circuit based on *Stolt-Nielsen S.A. v. AnimalFeeds Int'l Corp.*, 548 F.3d 85 (2nd Cir. 2008). The court next turned to the standard of review. Noting that the arbitrators did not explain the reasons for their award, the court stated that in such case, a court will uphold the award if it can discern any valid ground for it. The court also cited various decisions holding that the "manifest disregard of law" standard is exceedingly difficult to satisfy.

The court observed that since all of the members of the arbitration panel were experienced industry professionals, there could be no question that they were aware of the follow the fortunes doctrine. Thus, the court reasoned, the only question was whether the modest discounts awarded by the panel resulted from some egregious impropriety on the arbitrators' part. To prevail, the court said, Associated must prove, not that the arbitrators reached the wrong result, but that they disregarded the follow the fortunes doctrine entirely.

The court then discussed the panel's resolution of five specific Associated claims. The first claim was disallowed in its entirety. Excalibur argued Associated's claims payment was *ex gratia* because the insured's late notice to Associated voided coverage. The court said if the arbitrators found the payment was gratuitous, then the follow the fortunes doctrine did not apply. Noting that the arbitrators were not required to follow "judicial formalities," the court ruled the panel's decision to deny the claim was consistent with the panel's acceptance of Excalibur's *ex gratia* argument. The court refused to consider the merits of the parties' arguments because the claim was for the arbitrators to decide. The court said the panel's decision to disallow the claim did not demonstrate any manifest disregard of the follow the fortunes doctrine.

With respect to a second claim, the panel awarded Associated 50% of what it had sought. Excalibur argued the claim payment was *ex gratia* because it arose in 2004, not 2003. Excalibur only participated in the 2003 treaty year. The court said it was possible the panel concluded the 2003 treaty year was answerable for only a portion of the claim, which would explain why the panel awarded Associated 50% of the claim and denied the balance because it was *ex gratia*.

Excalibur argued Associated did not conduct a reasonable investigation of a third claim, contending it should be disallowed in its entirety. The panel, however, only gave Excalibur a 15% discount. Although the court did not expressly say so in its opinion, it appears the court believed the panel gave Excalibur a 15% discount because it felt there was some merit to the reinsurer's contention Associated had not reasonably investigated the claim.

The panel also discounted a fourth claim by about 13% because, the court assumed, the arbitrators were persuaded Associated's conduct was "tinged with bad faith." The panel gave Excalibur a $150,000 discount on Associated's fifth claim, evidently because it concluded there was some merit to the reinsurer's argument that Associated's grossly negligent claims handling resulted in a higher cost to resolve the claim.

The court recognized that the panel evidently compromised certain of Associated's claims because Excalibur had demonstrated some degree of bad faith or gross negligence in the claims handling. The court held that arbitrators, unlike the courts, "are entitled to reach equitable compromise solutions as long as they do not entirely disregard the law." Even if courts, constrained by strict legal principles, could not have awarded Associated "a partial loaf" under the follow the fortunes doctrine, arbitrators are not restricted by judicial formalities and are permitted to do so.

The court found that the panel did not disregard or misapply the follow the fortunes doctrine. Rather, the court concluded the panel likely applied certain of the doctrine's exceptions. The court said the fact that the arbitrators granted almost all of Associated's claims actually suggests they demonstrated a healthy respect for the follow the fortunes doctrine.

The court said it failed to see why the panel's conclusion that the evidence suggested some degree of bad faith, which warranted reductions to the cedent's claims, constituted misconduct, let alone a manifest disregard of the law. It also appears the court was somewhat annoyed by the fact that Associated had largely prevailed in the arbitration, yet refused to accept the minor compromise discounts ordered by the panel.

In its conclusion the court said:

> If parties want the luxury of judicial review and

reasoned results that require strict application of the law, without the sort of compromises that often characterize arbitral awards, they should not agree to arbitration clauses. Having done so, they should not be heard to complain when the arbitrators do what arbitrators so often do – reach compromise verdicts that can easily be justified by taking a particular view of the evidence.

IMPORT OF DECISION: This decision is important for several reasons. One, it holds the "manifest disregard of law" ground for vacating an arbitral award remains viable in the Second Circuit. Two, it recognizes (and upholds) a panel's right to render compromise decisions. Three, it reinforces that parties who agree to arbitrate their disputes have no right to *de novo* judicial review applying strict rules of law.

CLARK HILL'S Insurance and Reinsurance Practice Group has an established reputation for its work in the global insurance and reinsurance industry. The firm represents major United States, London Market, European, and Bermuda insurers and reinsurers in commercial litigation, coverage disputes, and major business transactions. Our practice encompasses all types of insurance, and every kind of underlying risk. We have the capacity to efficiently handle any (re)insurance matter, from individual to class action claims, and each assignment undertaken by the firm is afforded the same personal attention of partners having expertise with respect to the issues.

Philadelphia

Joseph M. Donley
Insurance & Reinsurance Practice Group Leader

Christopher M. Brubaker
Douglas M. Chapman
William E. Cox
Christopher J. Day
Peter B. Kupelian
Carol G. Schley
Robert Tomilson

For more information, please contact Joseph M. Donley at **jdonley@clarkhill.com**, or call **215.640.8500**.

To subscribe to Insurance & Reinsurance Briefing, please contact Connie Lojewski at **215.640.8543** or **clojewski@clarkhill.com**.