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BRIEFING

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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.

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