RECENT DEVELOPMENTS IN EXCESS, SURPLUS LINES, AND REINSURANCE LAW

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I. EXCESS INSURANCE

In the past year, appellate courts across the country addressed a variety of issues in the excess insurance arena, including issues regarding the impact of insureds' failure to maintain underlying insurance, which provisions of underlying policies get incorporated into "follow form" excess policies, whether a policy is a true excess policy, and how damages are allocated over consecutive policy years.

A. *Maintenance of Underlying Insurance*

Courts in Connecticut and Louisiana considered whether an excess or umbrella policy attached where the insured failed to maintain specified underlying insurance. In both cases, the courts held that the insured's failure to maintain the required underlying insurance did not negate coverage under the excess/umbrella policy.

In *Gabriel v. Mount Vernon Fire Insurance Co.*,[1] the Connecticut Appellate Court considered whether an umbrella policy attached upon the exhaustion of a primary policy that provided limits less than the minimum required by the umbrella policy. Domingos Pires was involved in an auto accident while driving a van owned by his employer, Pools Plus, and a passenger in the van was injured.[2] Pires was insured under a primary business insurance policy issued by National Grange Mutual Insurance Company ("National Grange"), with a $300,000 limit of liability, and an umbrella policy issued by Mount Vernon Fire Insurance Co. ("Mount Vernon"), with a $1 million limit of liability.[3] The passenger and his wife sued Pires and Pools Plus and obtained judgments totaling $1.8 million.[4] National Grange paid its $300,000 limits towards the claimants' judgments, but Mount Vernon disclaimed coverage on the grounds that its umbrella policy was not triggered because National Grange's primary policy's limit was less than the $500,000 minimum of underlying insurance required by Mount Vernon's umbrella policy.[5] Mount Vernon relied on several provisions of the umbrella policy that, Mount Vernon argued, required Pires to maintain underlying insurance with $500,000 limits.[6]

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1. 199 A.3d 79 (Conn. App. 2018), cert. denied, 201 A.3d 1023 (Conn. 2019).
2. *Id.* at 82.
3. *Id.* The National Grange policy was issued to Pools Plus, Pires' employer.
4. *Id.*
5. *Id.*
6. *Id.* at 84. The relevant provisions of the National Grange umbrella policy are (**a**) the definition of underlying insurance, *i.e.*, "the policy with the greater limit of . . . [t]he limit shown for that policy in the DECLARATIONS in Item 6., Required Underlying Insurance Coverage"; (**b**) Item 6 of the policy declarations, which states: "Required Underlying Insurance Coverage: You agree that the higher of the MINIMUM UNDERLYING LIMITS below . . . (1) is in force and will continue in force; and (2) insures all . . . automobiles . . . owned by, leased by or regularly furnished to you"; and (**c**) a policy condition stating:

In an action by the injured claimant and his wife against Mount Vernon, the court found that National Grange's primary policy satisfied Pires' obligation to maintain "underlying insurance," so Mount Vernon's umbrella policy was triggered. The court explained that Mount Vernon's umbrella policy did not expressly state that a primary policy with minimum coverage of $500,000 is a condition precedent to coverage, and an insured would not understand that it needed to obtain primary insurance with the minimum required limits to make the umbrella policy effective.[7] The court also noted that the umbrella policy contained a savings provision stating that the insured's failure to comply with the requirement to procure underlying insurance would not invalidate the umbrella policy, but in the event of such failure, the policy would cover defense and/or indemnity expense only to the extent that the insurer would have been liable had the insured obtained the required insurance.[8] The court held that Mount Vernon's approach would impermissibly read the savings clause out of the policy.[9] Accordingly, the court held that the umbrella policy was triggered and Mount Vernon was responsible for the loss in excess of the required underlying limit of $500,000; however, the insured was required to pay the gap between the underlying National Grange primary policy's limit of $300,000 and the required minimum limit of $500,000.[10]

In *Ellis v. McDonald*,[11] the insured, Water Works, cancelled the primary auto insurance policy listed in its excess policy's schedule of underlying insurance and replaced the coverage with a different carrier, but did not inform its excess carrier, Aspen Specialty Insurance Co. ("Aspen"), or request that the change be noted in the Aspen excess policy's schedule of underlying insurance.[12] After a vehicle driven by a Water Works employee was involved in an accident, Water Works' primary auto insurer tendered

> These are things you must do for us. We may not provide coverage if you do not . . . [A] . . . maintain your *underlying insurance*. You agree to maintain all insurance policies affording in total the coverage and the greater of the limits shown in the DECLARATIONS in Item 6., Required Underlying Insurance Coverages. If Required Underlying Limits are not maintained at the greater of the limit of liability shown in Item 6., Required Underlying Insurance Coverages . . . you will be responsible for paying the amount of loss or loss adjustment expense that would have been paid by that policy had its full limit of liability been available. . . . Your failure to comply with the foregoing paragraphs *will not invalidate this policy*, but in the event of such failure, we shall be liable under this policy for indemnity and/or defense expense only to the extent that we would have been liable had you complied with these obligations.

Id. (emphasis added by court).

7. *Id.* at 85.
8. *Id.*
9. *Id.*
10. *Id.*
11. 265 So. 3d 982 (La. Ct. App. 2019).
12. *Id.* at 985.

its limits and the claimant pursued Aspen to recover the balance of its monetary claim under Aspen's excess policy.[13] Aspen disclaimed coverage on grounds that its excess policy was not triggered because the underlying primary auto policy identified in Aspen's schedule of underlying insurance had not been exhausted, since it had been cancelled and replaced.[14] Aspen acknowledged that its excess policy did not expressly negate coverage if the insured fails to notify it of a change in underlying coverage.[15]

The court resolved the coverage question based upon the provision in Aspen's excess policy requiring the insured to maintain underlying coverage. The court found in the first instance that the insured's cancellation of the first policy amounted to "failure to maintain" that policy as required by the excess policy.[16] Nevertheless, the court applied the excess policy's savings provision, which stated that the insured's failure to maintain a policy listed in the schedule of underlying insurance does not invalidate the policy but instead limits Aspen's liability to the same extent as it would have been if the insured had maintained the underlying policy.[17] Since both the original, cancelled policy and the replacement policy had $1 million limits and Aspen was only asked to pay in excess of that amount, the court found that Aspen was "in the same position it bargained for as an excess carrier."[18] Accordingly, the Court held that the underlying auto policy limits were exhausted and Aspen's excess policy was triggered.[19]

B. *Follow Form*

Courts in California, New York, and North Dakota considered whether provisions of underlying primary policies were incorporated into "follow form" excess policies.

In *Deere & Co. v. Allstate Insurance Co.*,[20] the Court of Appeal of California held that self-insured retentions ("SIR") contained in Deere & Co.'s first-layer umbrella policies were not incorporated into Deere's higher layer follow-form excess policies. Deere maintained a multi-layered insurance program including first-layer umbrella policies that were subject to SIRs, followed by several layers of follow-form excess policies for each policy year.[21] Deere was sued in numerous actions alleging bodily injury

13. *Id.* at 984.
14. *Id.* at 985.
15. *Id.* at 987.
16. *Id.* at 990.
17. *Id.* at 991.
18. *Id.* at 993.
19. *Id.*
20. 244 Cal. Rptr. 3d 100 (Ct. App. 2019).
21. *Id.* at 106. Deere also maintained primary policies that did not cover products liability claims such as the asbestos claims at issue. Thus, the first layer of insurance to respond to the subject asbestos claims was Deere's umbrella policy layer.

from certain asbestos-containing products, and Deere sought coverage from its carriers.[22] For each claim, Deere paid its applicable SIR and then sought coverage under its first-layer umbrella policy.[23] Once the first-layer umbrella policy was exhausted, Deere would seek coverage under the next layer of coverage under its ladder of excess policies.[24]

Deere filed a declaratory judgment action seeking coverage under more than 100 umbrella and excess general liability policies issued to Deere from 1958 through 1986.[25] Deere's excess insurers argued that the follow-form provisions incorporated the SIRs from the first-layer umbrella policies so that Deere was required to pay an additional SIR for each occurrence before the excess policies would attach.[26] The trial court agreed with the insurers, finding that the SIRs were part of the "terms, definitions, exclusions and conditions" of the first-layer umbrella policies that were incorporated into the higher-layer excess policies by virtue of their follow-form provisions.[27]

On appeal, the Court of Appeal rejected the trial court's reasoning and reversed. The court explained that the excess policies were triggered upon exhaustion of the underlying limits, and the policies made no mention of further payments of additional SIRs.[28] The court also rejected the excess carriers' argument that the follow-form provisions of the excess policies incorporated the SIRs in the underlying umbrella policies.[29] The court explained that the follow-form provisions did not apply to limits of liability, and Deere's SIRs were set forth in the "Limit of Liability" section of the underlying umbrella policies.[30]

In *Chen v. Insurance Corp. of the State of Pennsylvania*,[31] the New York Supreme Court, Appellate Division held that an excess insurer was not liable for pre- or post-judgment interest that is covered as supplementary payments under an underlying primary policy. Chen, the claimant, filed a direct action against Insurance Corp. of the State of Pennsylvania ("Inscorp") to enforce a $2.33 million judgment he had obtained against Inscorp's insured.[32] Inscorp's policy was excess and followed form to a $1 million primary policy issued by Arch, which had been rescinded. Chen

22. *Id.* at 104.
23. *Id.* at 106.
24. *Id.*
25. *Id.* at 104.
26. *Id.* at 109–10.
27. *Id.* at 111.
28. *Id.*
29. *Id.* at 112.
30. *Id.*
31. 165 A.D.3d 588 (N.Y. App. Div. 2018), *leave granted*, 127 N.E.3d 317 (2019).
32. The factual background for the case is provided in documents filed publicly with the court.

argued that Inscorp was obligated to pay amounts in excess of the $1 million primary limits plus pre- and post-judgment interest because Inscorp's excess policy followed form to the supplementary payments provisions in the underlying primary policy.[33]

The court held that Inscorp's excess policy covered amounts in excess of the first $1 million of Chen's judgment against Inscorp's insured, but not any sums that would have been covered under the rescinded Arch primary policy's supplementary payments provision, including pre- and post-judgment interest.[34] The court explained that pursuant to the "Maintenance of Underlying Insurance" provision in the Inscorp excess policy, Inscorp's excess coverage was triggered upon exhaustion of the underlying primary policy's "limits," which were not reduced by—and thus included—the interest payments set forth in the supplementary payments provision.[35] The court concluded by noting that Inscorp's excess policy was meant to be excess to "all aspects of coverage afforded by the primary policy" including both the $1 million in coverage per occurrence and the supplementary payments benefits.[36]

In contrast, in *Houston Casualty Corp. v. Strata Corp.*,[37] the U.S. Court of Appeals for the Eighth Circuit held that an exclusion contained in an endorsement to an underlying primary policy was incorporated into Houston Casualty Company's excess policy by virtue of the excess policy's "follow form" provision. The underlying action involved a claim by the estate of a decedent employee against the decedent's employer, Strata Corp.[38] The estate alleged that the employee's death was caused by Strata's intentional failure to maintain a safe workplace, which triggers an exception to the exclusivity provisions of Montana's workers' compensation law.[39] The underlying primary policy contained a "Montana Intentional Injury Exclusion Endorsement" that precluded coverage for "bodily injury caused by [Strata's] intentional, malicious or deliberate act . . . ."[40]

Strata's primary insurer defended Strata in the action under a reservation of rights and contributed a portion of the primary policy limits towards a settlement in exchange for a release, whereas Houston Casualty, the excess insurer, disclaimed coverage and declined to contribute to the settlement.[41] Houston Casualty filed a declaratory judgment action seeking a declaration

33. 165 A.D.3d at 589.
34. *Id.*
35. *Id.*
36. *Id.* at 590.
37. 915 F.3d 549 (8th Cir. 2019).
38. *Id.* at 550.
39. *Id.*
40. *Id.* at 550–51.
41. *Id.* at 551.

of no coverage under the excess policy, and Strata counterclaimed.[42] The Eighth Circuit found in favor of Houston Casualty and held that it did not have a duty to indemnify Strata because the Montana Intentional Injury Exclusion Endorsement was incorporated into the excess policy by virtue of the excess policy's follow-form provision, which stated that the excess policy was "subject to the same terms, conditions, agreements, exclusions and definitions" as the underlying primary policy.[43] The court explained that it made no difference that the exclusion was contained in an endorsement and that Houston Casualty's excess policy did not expressly state that it was subject to the underlying policy's endorsements.[44] The court held that "[a]n exclusion is no less an exclusion because it is incorporated into the underlying policy through an endorsement."[45]

C. *True Excess Policies*

In *Oregon Mutual Insurance Co. v. Those Certain Underwriters at Lloyd's Subscribing to Policy Number OROAKG2-CNE*,[46] the Oregon Court of Appeals addressed the distinction between a true excess policy and a primary policy with an excess "other insurance" clause. Oregon Mutual Insurance Company insured a driver in his individual capacity under a primary automobile policy, and Certain Underwriters at Lloyd's ("Lloyd's") insured the driver in his capacity as a volunteer for a non-profit medical transport organization under an excess automobile policy.[47] The driver was sued after a person fell while trying to enter the driver's car in order to get to a medical appointment. *Id.* at 233. The claimant settled the suit for $180,000, with Oregon Mutual paying its $100,000 policy limit and Lloyd's paying the balance.[48] Oregon Mutual then sued Lloyd's for contribution, claiming that Lloyd's should have contributed to the settlement on a pro-rata basis with Oregon Mutual because it qualified as a co-insurer, not an excess insurer, based upon Oregon's Financial Responsibility Law.[49] Lloyd's argued that the Lloyd's policy was an excess policy which fell within an exception to the statute.[50]

The Lloyd's policy, which was denominated as a "Volunteer Excess Auto Liability" policy, provided coverage to the medical transport organization's volunteer drivers (but did not provide coverage for the organization

42. *Id.*
43. *Id.*
44. *Id.*
45. *Id.*
46. 437 P.3d 232 (Or. Ct. App. 2019).
47. *Id.* at 234.
48. *Id.* at 233.
49. *Id.* at 234.
50. *Id.*

itself).[51] The Lloyd's policy also stated that it provided coverage in excess of a "retained limit," which was defined as the greater of the limits of all other insurance collectible by the insured or the minimum limit required under motor vehicle financial responsibility laws or $50,000, whichever is less.[52]

Oregon Mutual, citing a federal court case,[53] argued that a policy must meet three conditions in order to be a "true" excess policy: (1) it must be written with an underlying primary policy in mind; (2) it must require maintenance of the underlying policy and mention its limits; and (3) it must be purchased and maintained by the insured that holds the underlying policy.[54] Oregon Mutual argued that the Lloyd's policy was not a "true" excess policy because it did not have any of these three features.[55] Lloyd's argued that the parties' intentions, based upon the terms and conditions of the policy, should determine whether the policy is a true excess policy.[56]

The court rejected Oregon Mutual's attempt to impose an inflexible test to assess whether a policy is a true excess policy, noting that it would be difficult to frame any categorical rule because policies may be written in any number of ways with different obligations on the insured.[57] Instead, the court held that the "defining feature" of an excess policy is that it only provides coverage above primary policy limits.[58] The court noted that the Lloyd's policy, unlike a primary policy with an excess clause, was titled an excess policy, was excess of a specified sum (either the limits of other available insurance, statutory minimums or $50,000), and the premium paid for the policy was significantly less than the premium for Oregon Mutual's primary policy.[59] The court concluded that the factors that Oregon Mutual identified may be useful in certain cases, but they are not required for a policy to be deemed a true excess policy.[60]

D. *Allocation*

In *National Union Fire Insurance Co. of Pittsburgh, PA v. Scapa Dryer Fabrics*,[61] the Court of Appeals of Georgia applied a vertical allocation method to hold that excess policies are triggered upon exhaustion of all underlying policies with policy periods overlapping the excess policies, even if primary policies for other policy periods remain unexhausted. Scapa Dryer Fabrics ("Scapa"), a supplier of asbestos-containing dryer felts, was sued

51. *Id.* at 233.
52. *Id.*
53. Hanson v. St. Paul Fire & Mar. Ins. Co., 2011 WL 1086528 (D. Or. Mar. 22, 2011).
54. 437 P.3d 232, 234–35 (Or. Ct. App. 2019).
55. *Id.* at 235.
56. *Id.*
57. *Id.* at 237.
58. *Id.*
59. *Id.* at 237–38.
60. *Id.* at 237.
61. 819 S.E.2d 920 (Ga. Ct. App. 2018), *cert. denied*, 2019 Ga. LEXIS 453 (July 1, 2019).

in numerous actions alleging bodily injury from products manufactured by Scapa from 1958 to 1976.[62] Scapa sought coverage from its carriers, including under certain excess liability policies issued by New Hampshire Insurance Co. ("New Hampshire") from 1983 to 1987.[63] The underlying asbestos bodily injury claims were subject to a continuous trigger under which each liability policy in effect from exposure to manifestation provides coverage and is responsible for the loss.[64]

New Hampshire's excess policies contained an "other insurance" provision which stated that the policies do not cover any loss or damage which at the time of the happening of such loss or damage is insured by any valid and collectible insurance.[65] New Hampshire argued that, under the "other insurance" provision in its excess policies, it did not have a duty to defend or to indemnify Scapa until every other primary policy issued to Scapa for any time period is exhausted, including any primary policies issued for other policy periods.[66] Scapa, on the other hand, argued that each New Hampshire policy was required to drop down upon exhaustion of the concurrent underlying policy.[67] The court found that the New Hampshire excess policies were triggered upon exhaustion of the underlying primary policies that overlapped in time with the New Hampshire excess policies, and exhaustion of primary policies in other policy periods was not necessary to trigger the excess policies.[68] In reaching this result, the court held that the "other insurance" language does not state that Scapa must exhaust all other policies issued at any other time before New Hampshire's excess policies are triggered, and that language in the New Hampshire excess policies' "other insurance" provision requiring Scapa to "maintain the underlying policies in force at the commencement of this insurance" requires only that overlapping underlying policies had to be exhausted.[69]

62. *Id.* at 922.
63. *Id.*
64. *Id.* at 924 n.8.
65. *Id.* at 924. New Hampshire's policies' "other insurance" clause provides in relevant part:

> The insurance afforded by this [p]olicy is primary insurance, except when stated to apply in excess of or contingent upon the absence of other insurance. . . . This insurance does not cover any loss or damage which at the time of the happening of such loss or damage is insured by any valid and collectible insurance or would but for the existence of this [p]olicy, be insured by any other existing valid and collectible [p]olicy or [p]olicies except in respect of any excess beyond the amount which would have been payable under such other [p]olicy or [p]olicies had this insurance not been effected.

The excess policies also required the insured to "maintain the underlying policies which are in force at the commencement of this insurance." *Id.*
66. *Id.* at 924–25.
67. *Id.* at 924.
68. *Id.* at 925.
69. *Id.*

II. DEVELOPMENTS IN REINSURANCE LAW

In 2019, courts continued to demonstrate their commitment to upholding the principles of the Federal Arbitration Act, validating agreements to arbitrate effected through text messages, and broadly interpreting arbitration agreements to sweep threshold issues of arbitrability within their scope. The courts have demonstrated, however, that arbitration agreements will be construed in the same manner as any other contract. Accordingly, courts have refused to permit class arbitrations to proceed where the plain language of the arbitration agreement at issue does not allow for class arbitrations and refused to imply follow-the-settlements or follow-the-fortunes provisions into facultative certificates. Further, the confidentiality historically afforded to reinsurance information appears to be eroding.

A. *Agreement to Arbitrate*

In *Starace v. Lexington Law Firm*,[70] the Eastern District of California found that a valid agreement to arbitrate existed where the parties had entered into that agreement via text message.[71] In *Starace*, the plaintiff had asserted that: (1) the parties had not entered into a valid agreement, and (2) even if an agreement to arbitrate arguably existed, that agreement was unconscionable.[72] The court ruled that the parties had entered into a valid agreement as there was mutual assent to the arbitration clause when the plaintiff texted "Agreed" in response to the texted agreement,[73] and the arbitration clause was clearly and effectively communicated to him.[74] As to unconscionability, the court noted that "the party opposing arbitration must demonstrate that the contract as a whole or a specific clause in the contract is both procedurally and substantively unconscionable."[75] The court then found that although the arbitration agreement was arguably procedurally unconscionable because it was a contract of adhesion, the arbitration agreement was not substantively unconscionable because it was not overly broad, overly harsh, or oppressive.[76] Thus, the court granted Defendants' motion to compel arbitration and dismissed the action.[77]

70. 2019 U.S. Dist. LEXIS 108155 (E.D. Cal. June 27, 2019).
71. *Id.* at *10, *12.
72. *Id.* at *5.
73. *Id.* at *10.
74. *Id.* at *12.
75. *Id.* at *14
76. *Id.* at *14–22.
77. *Id.* at *23.

B. *Arbitrability*

In *Henry Schein, Inc. v. Archer and White Sales, Inc.*,[78] the Supreme Court ruled that, where so provided in an agreement to arbitrate, the threshold question of arbitrability rests with the arbitrators notwithstanding whether the purported reason for demanding arbitration under the agreement is "wholly groundless."[79] Prior to the Court's decision, the federal circuits were split on that question.[80] In a unanimous decision, the Court concluded that the "wholly groundless" exception was inconsistent with the text of the Federal Arbitration Act, 9 U.S.C. § 1 *et seq.*, and, accordingly, "[w]hen the parties' contract delegates the arbitrability question to an arbitrator, the courts must respect the parties' decision as embodied in the contract."[81]

In *McDonnel Group, LLC v. Great Lakes Insurance SE*,[82] the U.S. Court of Appeals for the Fifth Circuit found that a "conformity to statute" provision did not apply because the Louisiana statute to which the party sought to conform the contract was pre-empted by the United Nations Convention on the Recognition and Enforcement of Foreign Arbitral Awards (the "Convention").[83] At issue in the case were three conflicting sources of law: (1) Louisiana's insurance code, which provided that no insurance agreement could restrict the courts of jurisdiction;[84] (2) the Convention, an international commercial treaty acceded to by the United States that requires that valid international arbitration agreements be upheld by the courts of the signatories;[85] and (3) the McCarran-Ferguson Act, a federal law that "permits states to reverse-preempt an otherwise applicable 'Act of Congress' by enacting their own regulations of the insurance industry."[86] The Fifth Circuit found the Convention, an international treaty, pre-empted the Louisiana statute; thus, the conformity to statute provision did not apply and the decision of the trial court dismissing the case in favor of arbitration was affirmed.[87]

In *In re Platinum-Beechwood Litigation*,[88] the Southern District of New York addressed whether a reinsurance agreement requiring the parties to arbitrate "all disputes or differences between the Parties arising under or relating to" the agreement requires an arbitration panel to resolve disputes

78. 139 S. Ct. 524 (2019).
79. *Id.* at 529.
80. *Id.*
81. *Id.*.
82. 923 F.3d 427 (5th Cir. 2019).
83. *Id.* at 432–33.
84. *Id.* at 431.
85. *Id.*
86. *Id.*
87. *Id.* at 432–33.
88. 2019 U.S. Dist. LEXIS 114645 (S.D.N.Y. July 10, 2019).

over prior arbitration orders.[89] The parties disputed whether a motion for payment of security, or in the alternative for default judgment, filed in court, was precluded by the arbitration panel's prior decisions related to the security, which were previously confirmed by the Southern District of New York.[90] Following prior Second Circuit precedent, the court determined that the arbitration provision was "sufficiently broad to encompass disputes about what was decided in a prior arbitration," and thus, the parties were precluded from bringing the dispute to the Court until the arbitration panel determined whether the motion was precluded by the panel's prior decisions.[91]

C. *Arbitrator Authority*

In *American International Specialty Lines Insurance Co. v. Allied Capital Corp.*,[92] a New York state intermediate appellate court held that where the parties agreed to bifurcate arbitration proceedings and further agreed that the arbitration panel would make a determination as to liability first, once the panel made a decision as to liability, the panel had no further authority to revisit or modify that decision under the doctrine of *functus officio*.[93]

In a settlement of a separate litigation, Allied agreed to pay the government $10.1 million and turned to its insurer, American International Specialty Lines Insurance Co. ("AISLIC"), for indemnification of that payment plus recoupment of defense costs.[94] AISLIC refused to pay and the parties proceeded to arbitration.[95] Allied sought a determination that its payment to the government was a covered "loss" under its policy with AISLIC, and sought recovery of the $10.1 million plus incurred defense costs.[96] After both parties moved for summary judgment, the arbitration panel issued a Partial Final Award and held that the $10.1 million payment was not a covered loss, that AISLIC would be required to indemnify Allied for defense costs, and that the quantum of defense costs could only be determined after an evidentiary hearing.[97] Allied subsequently moved for reconsideration of the panel's ruling that Allied's $10.1 million payment was not a covered loss.[98] The panel later issued a corrected Final Award in

89. *Id.* at *28.
90. *Id.* at *18, *29.
91. *Id.* at *29 (citing *Nat'l Union Fire Ins. Co. of Pittsburgh, Pa. v. Beico Petroleum Corp.*, 88 F.3d 129, 136 (2d Cir. 1996).
92. 167 A.D.3d 142, 86 N.Y.S.3d 472 (Sup. Ct. N. Y., App. Div. 2018).
93. *Id.* at 143–44.
94. *Id.* at 144.
95. *Id.*
96. *Id.*
97. *Id.* at 145.
98. *Id.*

which, among other holdings, it reversed its initial decision and held that Allied's $10.1 million payment was a covered loss.[99]

AISLIC filed a petition seeking to confirm the Partial Final Award and vacate the subsequent Final Award. Allied opposed.[100] The court denied AISLIC's petition and AISLIC appealed.[101] By a 4-1 majority, the Appellate Division of the Supreme Court of New York overruled the trial court decision.[102] Under the doctrine of *functus officio*, "after an arbitrator renders a final award, the arbitrator may not entertain an application to change the award," except under certain specified exceptions.[103] The court reasoned that because the parties themselves requested that the arbitration panel make an immediate and binding determination as to liability, leaving the calculation of damages for a later time, under the *functus officio* doctrine, the arbitration panel had no authority to reconsider its decision as to liability.[104]

In *Williamson Farm v. Diversified Crop Insurance Services*,[105] the U.S. Court of Appeals for the Fourth Circuit vacated an arbitration award on the grounds that an arbitrator exceeded her powers in a crop insurance dispute between an insured and a crop insurance company.[106] The arbitrator found that had Diversified Crop Insurance Services ("Diversified") correctly included in its policies the information it knew regarding the insured's crops, the insured's losses would have been covered.[107] The arbitrator awarded the insured damages for breach of contract, treble damages for breach of the North Carolina Unfair and Deceptive Trade Practices Act, and also awarded attorneys' fees.[108]

Diversified sought to vacate the arbitration award on the grounds that the arbitrator exceeded her authority.[109] The district court vacated the arbitration award and held that the arbitrator exceeded her powers by (1) impermissibly interpreting the policy rather than obtaining an interpretation from the Federal Crop Insurance Corporation ("FCIC"), as

99. *Id.*
100. *Id.* at 145–-46.
101. *Id.* at 146.
102. *Id.* One judge dissented, disagreeing with the factual predicate that the parties requested that the panel make an immediate final decision on liability and leave the calculation of damages for a later time. *Id.* at 150. The dissent noted that the arbitration panel itself concluded that the there was no agreement by the parties to bifurcate issues, and reasoned that the Court is bound by the factual findings made by the arbitration panel. *Id.* at 153.
103. *Id.*
104. *Id.* at 147–48.
105. 917 F.3d 247 (4th Cir. 2018).
106. *Id.* at 249.
107. *Id.* at 251–52.
108. *Id.* at 252.
109. *Id.*

required by the policies, and (2) awarding extra-contractual damages.[110] The insured appealed.[111]

The Fourth Circuit affirmed the district court decision.[112] The court explained that all crop insurance in the United States is issued by "approved insurance providers" that are reinsured and administered by the FCIC.[113] The FCIC controls all aspects of the federal crop insurance program.[114] Accordingly, all approved insurance providers issue a uniform "Common Crop Insurance Policy" drafted by the FCIC, including the insureds' policies.[115] Because the uniform policy provided that "no award in . . . arbitration . . . can exceed the amount of liability established . . . under the policy," the court held that the arbitrator exceeded her authority by awarding attorneys' fees and extra-contractual damages.[116] Moreover, the policy provided that in any dispute that involved "policy or procedure interpretation," the parties "must obtain an interpretation from the FCIC," and further, that the failure to obtain an FCIC interpretation "will result in the nullification of any agreement or award."[117] Because neither the parties nor the arbitrator obtained an interpretation from the FCIC prior to the arbitrator's award, the court held that the arbitrator exceeded her powers.[118] Finally, the court could not distinguish between contract damages (which were within the arbitrator's authority to award) and non-contract damages (which were not), because it found that the arbitrator did not provide a breakdown of the arbitration award damages.[119] Accordingly, the court vacated the entire award.[120]

D. *Class Arbitration*

In *Lamps Plus, Inc. v. Varela*,[121] the U.S. Supreme Court resolved whether a party could be forced to submit to class-wide arbitration under an ambiguous arbitration agreement. The Court had previously held in *Stolt-Neilsen S.A. v. AnimalFeeds International Corp.* that a court could not compel arbitration when an agreement is silent on the availability of class arbitration.[122]

110. *Id.* at 252–53.
111. *Id.* at 253.
112. *Id.* at 259.
113. *Id.* at 249–50.
114. *Id.* at 250.
115. *Id.* at 249–50.
116. *Id.* at 254–55.
117. *Id.*
118. *Id.* at 256.
119. *Id.* at 258–59.
120. *Id.* at 259.
121. 138 S. Ct. 1407 (2019).
122. 559 U.S. 662 (2010).

In *Lamps Plus*, a 5-4 majority of the Court held that a court could not compel class-wide arbitration under an ambiguous agreement.[123]

In 2016, a hacker tricked a Lamps Plus employee into disclosing tax information for 1,300 company employees.[124] When a fraudulent tax return was filed in the name of respondent Frank Varela, Varela filed a putative class action against Lamps Plus in federal district court.[125] Lamps Plus sought to compel individual arbitration pursuant to an arbitration agreement signed by Varela as a condition of employment.[126] The district court compelled arbitration, but authorized arbitration on a class-wide basis. Lamps Plus appealed and the Ninth Circuit affirmed.[127] The Ninth Circuit found the agreement between Varela and Lamps Plus to be ambiguous as to the availability of class-wide arbitration, and held that the agreement permitted class-wide arbitration, because under the doctrine of *contra proferentem* the court was required to construe the agreement against the drafter, in this case Lamps Plus.[128]

Lamps Plus appealed again, and the Supreme Court reversed. The Court accepted the Ninth Circuit's finding that the agreement between Lamps Plus and Varela was ambiguous as to the availability of class-wide arbitration, but held that because arbitration is "strictly a matter of consent," a court could not infer consent to participate in class arbitration absent an affirmative "contractual basis for concluding that the party agreed to do so."[129] The Court reasoned that converting an individual arbitration to a class-wide arbitration was a fundamental change, which exposed the defendants to increased risk and sacrificed what the Court considered to be the principal advantages of arbitration: "lower costs, greater efficiency and speed, and the ability to choose expert adjudicators to resolve specialized disputes."[130] Thus, the Court held "ambiguity does not provide a sufficient basis to conclude that the parties to an arbitration agreement agreed to sacrifice the principal advantage of arbitration."[131]

Justices Ginsburg, Breyer, Sotomayor, and Kagan each wrote dissenting opinions. All dissenting justices joined Justice Kagan's dissent, either in full or, with respect to Justice Sotomayor, in part.[132] Justice Kagan observed that contract construction is a matter of state law, noting that California

123. 138 S. Ct. at 1412.
124. *Id.*
125. *Id.*
126. *Id.* at 1413.
127. *Id.*
128. *Id.*
129. *Id.* at 1414–15.
130. *Id.* at 1416.
131. *Id.*
132. *Id.* at 1428.

construes ambiguous contracts against the drafter to promote clarity in drafting contracts.[133] Justice Kagan reasoned that had Lamps Plus wanted to expressly ban class arbitration, it could have done so.[134] Justice Kagan further stated that California's rule of *contra proferentem* was "even handed," and therefore did not discriminate against arbitration.[135] Justice Ginsburg also argued that the Federal Arbitration Act was intended "to enable merchants of roughly equal bargaining power to enter into binding agreements to arbitrate commercial disputes," but that the Act "was not designed to govern contracts 'in which one of the parties characteristically has little bargaining power.'"[136] Justice Ginsburg contended that the Court's ruling meant "curtailed enforcement of laws 'designed to advance the well-being of [the] vulnerable.'"[137]

In *20/20 Communication, Inc. v. Crawford*,[138] the U.S. Court of Appeals for the Fifth Circuit held that the availability of class arbitration is a gateway issue that a court must decide, absent clear and unmistakable language in the arbitration clause to the contrary.[139]

Field sales managers of 20/20 Communications, Inc., a national direct-sales and marketing company, signed arbitration agreements as a condition of their employment.[140] *Crawford* was a consolidated appeal of district court holdings in two separate cases that the arbitration agreements in question authorized the arbitrator, rather than the court, to determine class arbitrability.[141] The Fifth Circuit overruled the district court holdings.[142] First, the court observed that every appellate court to have considered the issue of class arbitrability had held it to be a gateway issue for courts to decide.[143] The court reasoned that because absent parties had to be afforded notice, an opportunity to be heard, and a right to opt out of the class, this raised the costs and reduced the efficiency of the arbitration, thereby frustrating the expectations of the parties.[144] The court also noted that parties to an arbitration clause valued privacy and confidentiality and these expectations were threatened in a class arbitration.[145]

133. *Id.* at 1430.
134. *Id.*
135. *Id.* at 1431–32.
136. *Id.* at 1420.
137. *Id.* at 1422 (quoting Epic Sys. Corp. v. Lewis, 138 S. Ct. 1612 (2018) (Ginsburg, J., dissenting)).
138. 930 F.3d 715 (5th Cir. 2019).
139. *Id.* at 717.
140. *Id.*
141. *Id.*at 718.
142. *Id.* at 717.
143. *Id.* at 718.
144. *Id.* at 719.
145. *Id.*

Second, the court held that there was nothing in the arbitration agreements at issue that clearly and unmistakably showed that the parties agreed to allow an arbitrator to decide the issue of class arbitrability.[146] Citing contract language prohibiting the arbitrator from consolidating the claims of others into one proceeding "to the maximum extent permitted by law," the court reasoned that this language foreclosed any possibility that the parties intended for class arbitrability to be decided by arbitrators, as opposed to courts.[147]

E. *Confidentiality/Discovery of Reinsurance Information*

In *99 Wall Development, Inc. v. Allied World Specialty Insurance Co.*,[148] the Southern District of New York was asked to rule on the discoverability of reinsurance contracts and related correspondence, among other document disputes. Allied had denied any coverage for claims of water damage made by the plaintiff.[149] The plaintiff brought suit for breach of contract. Allied initially withheld as privileged or irrelevant a large number of documents in different categories.[150] One of the categories withheld as irrelevant was Allied's reinsurance contracts and related correspondence.[151] The court found that "the relevance of reinsurance information is determined on a case-by-case basis."[152] The court also ruled that such evidence was more likely to be relevant where, as in this case, the plaintiff was alleging bad faith denial of coverage.[153] Even though New York law did not provide a separate cause of action for bad faith, the plaintiff's complaint alleged elements of bad faith, which was sufficient to render the documents discoverable.[154]

Theriot v. Northwestern Mutual Life Insurance Co.[155] involved a situation where the court refused to permit the defendant insurance company to shield from disclosure a copy of a reinsurance agreement, which the insurance company had filed under seal as an exhibit to its reply in support of a motion to dismiss.[156] In so holding, the court found that the defendant's contention that the exhibits to the reinsurance agreement "'contain[ed] sensitive and confidential business information' such as 'acquisition expenses and

146. *Id.* at 719–21.
147. *Id.* at 719–20.
148. 2019 U.S. Dist. LEXIS 100454, 18-CV-126 (S.D.N.Y. June 14, 2019).
149. *Id.* at *2–3.
150. *Id.* at *3.
151. *Id.* at *12.
152. *Id.*
153. *Id.*
154. *Id.*
155. 382 F. Supp. 3d 1255 (M.D. Ala. 2019).
156. *Id.* at 1259–60.

claim administration expenses'" did not suffice to establish the "good cause" needed to override the public's right to access to civil trial proceedings.[157]

F. *Consolidation*

In *Pennsylvania National Mutual Insurance Co. v. Everest Reinsurance Co.*,[158] a dispute arose when Penn National demanded arbitration from one of its reinsurers, Everest Reinsurance Company. Everest refused to participate in the arbitration because it contended that the dispute should have been brought as part of an earlier arbitration pursuant to the consolidation provision in the arbitration agreement at issue.[159] Everest further contended that the question whether the dispute between Penn National and Everest should have been consolidated with the earlier arbitration ought to be decided by the arbitration panel that presided over the prior arbitration.[160] The Middle District of Pennsylvania ruled that it only had the ability to determine the validity of the arbitration clause in the contract at hand, and that the contract at hand only provided for a new panel.[161] The parties agreed that the clause was valid and applied to the dispute, so the court's only recourse was to order the parties to convene a new panel and submit the question of consolidation to that panel.[162]

In *Employer's Insurance Co. of Wausau v. The Hartford*,[163] the Central District of California analyzed whether it could order the parties to convene a panel of arbitrators on the issue of whether to consolidate some or all of eight pending reinsurance disputes. Hartford and three of its affiliates had billed Wausau under nineteen reinsurance treaties, and Wausau denied any reimbursement under any of them.[164] Hartford then sent a demand to collectively arbitrate all of the disputes in one proceeding.[165] Wausau refused, and proposed four proceedings, essentially dividing the proceedings by contracting entity (Hartford or one of its affiliates).[166] Hartford again demanded one arbitration, and filed suit under one of the treaties, asking the district court to compel Wausau to participate in choosing a panel that would decide whether or not to consolidate the proceedings.[167] Wausau responded, asking the court to order Hartford to move forward

157. *Id.* at 1259.
158. 2019 U.S. Dist. LEXIS (M.D. Pa. Mar. 14, 2019).
159. *Id.* at *3.
160. *Id.*
161. *Id.* at *6–7.
162. *Id.* at *4, *7.
163. 2018 U.S. Dist. LEXIS 205345 (C.D. Cal. Dec. 3, 2018).
164. *Id.* at *2.
165. *Id.* at *2–3.
166. *Id.* at *3.
167. *Id.* at *4.

with the one panel required by the single treaty before the court.[168] The court agreed that the question whether to consolidate was a decision to be made by an arbitration panel.[169] The court also ruled that it did not have the power to order the parties to do anything other than what was provided for in the treaty before the Court, which did not speak to consolidation, but merely contemplated arbitration of the dispute arising under that treaty.[170] The court therefore ordered Hartford to proceed with the single arbitration panel, specifically noting that Hartford could raise the question of consolidation before that panel.[171]

G. *Follow-the-Fortunes/Follow-the-Settlements*

In *Utica Mutual Insurance Co. v. Munich Reinsurance America, Inc.*,[172] after a ten-day trial that included expert testimony, the U.S. District Court for the Northern District of New York held that the facultative certificates at issue did not include either an implied follow-the-settlements provision or an implied follow-the-fortunes provision. Munich Re had issued two facultative certificates to Utica in the 1970s, which reinsured Utica for a share of the amounts paid by Utica pursuant to certain umbrella policies that Utica issued to its policyholder, Goulds Pump.[173] Goulds Pump became a defendant in a number of lawsuits by third parties alleging asbestos injuries.[174] While Utica agreed that one of the umbrella policies required Utica to pay defense expenses in addition to limits, there was a dispute between Goulds Pump and Utica as to whether an endorsement to the other umbrella policy required Utica to pay expenses in addition to limits on that policy as well.[175] That dispute was ultimately settled.[176]

Utica billed Munich Re not only for its share of the losses on the umbrella policies, exhausting the limits on the facultative certificates that Munich Re had issued, but also for Munich Re's purported share of defense expenses in excess of those limits.[177] Munich Re asserted that it was not liable for defense costs in excess of the limits of the facultative certificates because both underlying umbrella policies included expenses within limits.[178] In addition, Munich Re sought reimbursement of expense amounts that it *had* paid in addition to its limits prior to receiving a copy of the

168. *Id.* at *6.
169. *Id.* at *9.
170. *Id.* at *13.
171. *Id.* at *14.
172. 381 F. Supp. 3d 185 (N.D.N.Y. Mar. 29, 2019).
173. *Id.* at 189–90.
174. *Id.* at 190.
175. *Id.* at 192.
176. *Id.*
177. *Id.* at 198, 201.
178. *Id.* at 203–04.

endorsement to the umbrella policy referenced above and determining that the endorsement did *not* require Utica to pay expenses in addition to limits.[179] Among other arguments, Utica countered that Munich Re bore liability for expenses in addition to limits because each facultative certificate contained an implied follow-the-settlements provision.

In finding that the facultative certificates at issue did not include either an implied follow-the-settlements provision or an implied follow-the-fortunes provision, the court asserted that the ceding company had "failed to prove that follow the fortunes or follow the settlements was so fixed and invariable at the time the parties agreed to the [facultative certificates] that it is implied in their agreement."[180] The court acknowledged that expert testimony had established that cedents and reinsurers "endeavor to work together" and that reinsurers "whenever possible, will defer to reasonable determinations by cedents in interpreting policies and paying or settling claims," but noted that the experts also conceded that not all facultative certificates issued during the relevant time period included follow-the-settlements or follow-the-fortunes provisions.[181] The court therefore declined to imply either obligation into the facultative certificates at issue.[182] The court then found that expenses were included within limits on both underlying umbrella policies and that the facultative certificates did not contain any independent obligation requiring Munich Re to pay expenses in addition to limits, such that Munich Re was not liable for such expenses.[183] However, the court also ruled that the voluntary payment doctrine barred Munich Re from recovering any such amounts that it had already paid.[184]

H. *Functus Officio*

In *General Reinsurance Life Corp. v. Lincoln National Life Insurance Co.*,[185] the U.S. Court of Appeals for the Second Circuit addressed whether the doctrine of *functus officio*—which limits the power of arbitrators to alter an award once it has been entered—prevents an arbitration panel from later clarifying the amount of the award.[186] In that case, the reinsurer disputed the arbitration panel's authority to issue a clarification of a final award to a ceding company.[187] The Second Circuit acknowledged that the doctrine of *functus officio* mandates that, "once arbitrators have fully exercised their

179. *Id.*
180. *Id.* at 206.
181. *Id.* at 207–08.
182. *Id.* at 208.
183. *Id.* at 213, 216.
184. *Id.* at 221–22.
185. 909 F.3d 544 (2d Cir. 2018).
186. *Id.* at 548.
187. *Id.*

authority to adjudicate a dispute . . . arbitrators have no further authority . . . to redetermine those issues."[188] In disagreeing with the reinsurer's argument that clarifying an award fundamentally changes the original remedy,[189] the Court found an exception to the doctrine when an award "fails to address a contingency that later arises or when an award is susceptible to more than one interpretation."[190] Therefore, the Second Circuit, aligning itself with the Third, Fifth, Sixth, Seventh, and Ninth Circuits,[191] reasoned that the arbitration panel's clarification did not rewrite the original award, but merely stated the award was to be applied in a manner consistent with the parties' original agreement and did not violate the doctrine of *functus officio*.[192]

I. *Payment of Defense Costs*

In *Utica Mutual Insurance Co. v. Clearwater Insurance Co.*, the Northern District of New York considered whether umbrella policies issued to the policy holder obligated the ceding company to pay the policyholder's defense costs.[193] In that case, reinsurer Clearwater issued facultative reinsurance to cedent Utica.[194] The reinsurance policy covered asbestos-related losses and expenses incurred by the ceding company under umbrella policies pursuant to a settlement agreement with the policyholder.[195] The umbrella policy stated that the ceding company would cover defense costs for "any occurrence *not covered by* the policies listed in the schedule of underlying insurance . . . but covered by the terms and conditions of the [umbrella policies] (including damages wholly or partly within the amount of the retained limit)."[196] In its motion for summary judgment, Clearwater argued that Utica was only obligated to pay the policyholder's defense costs when a claim arose from an occurrence outside the scope of the underlying primary policies' coverage but within the scope of the umbrella policies' separate, broader coverage.[197] Conversely, Utica argued the "not covered by" language meant that once the primary policies had been exhausted, any additional occurrence automatically fell within the umbrella policy's defense provision.[198] In denying the reinsurer's motion for summary judgment, the Northern District of New York found a dispute of fact as to the

188. *Id.*
189. *Id.* at 549–50.
190. *Id.*
191. *Id.* at 548.
192. *Id.* at 548–50.
193. 2019 U.S. Dist. LEXIS 124077 (N.D.N.Y. July 25, 2019).
194. *Id.* at *2.
195. *Id.* at *3.
196. *Id.*
197. *Id.* at *3–4.
198. *Id.* at *4.

ambiguous meaning of "not covered by" in the policy[199] and suggested the parties present evidence of "customs, practices, usages, and terminology as generally understood in the [insurance] business" so that the ambiguity could be resolved by the finder of fact at trial.[200]

J. *Reverse Pre-emption*

In *Luxor Cabs, Inc. v. Applied Underwriters Captive Risk Assurance Co.*,[201] a California appellate court affirmed the non-arbitrability of a reinsurance participation agreement ("RPA").[202] In that case, Luxor, a taxi company, entered into a workers' compensation insurance agreement with Applied Underwriters.[203] Per the terms of the agreement, Luxor was required to execute an RPA with Applied Underwriters Captive Risk Assurance ("AUCRA"), a subsidiary of Applied Underwriters.[204] When Luxor grew dissatisfied with increasing premiums and poor claims administration, it filed a complaint against AUCRA in California state court.[205] The trial court denied AUCRA's motion to compel arbitration pursuant to the RPA.[206] The California appellate court affirmed, agreeing that the RPA's delegation provision and arbitration clause were void and unenforceable as a matter of California insurance law.[207] In further support of its opinion, the appellate court held that, pursuant to the McCarran-Ferguson Act, the applicable insurance law of California pre-empted the Federal Arbitration Act, providing a separate basis for upholding the trial court's determination that the dispute was not arbitrable.[208]

In a similar case, *Minnieland Private Day School, Inc. v. Applied Underwriters Captive Risk Assurance Co.*,[209] the U.S. Court of Appeals for the Fourth Circuit held that disputes regarding the RPA accompanying Applied Underwriter's workers' compensation insurance program were not arbitrable under Virginia law.[210] There, Minnieland Private Day School, Inc., a childcare service provider, entered into the same insurance program as in *Luxor*.[211] When Minnieland was unable to pay increasing premiums, Applied Underwriters

199. *Id.* at *11.
200. *Id.* at *13.
201. 242 Cal. Rptr.3d 87 (Ct. App. Dec. 4, 2018), *review denied*, 2019 Cal. LEXIS 1822 (Cal., Mar. 13, 2019).
202. *Id.* at 90.
203. *Id.*
204. *Id.*
205. *Id.* at 92.
206. *Id.*
207. *Id.* at 98–101.
208. *Id.* at 101.
209. 913 F.3d 409 (4th Cir. 2019).
210. *Id.* at 411.
211. *Id.* at 412–13.

Captive Risk Assurance Co. ("AUCRA") terminated the program.[212] Minnieland sued in the Eastern District of Virginia, and AUCRA moved to compel arbitration, which was denied by the trial court.[213] On appeal, the Fourth Circuit held that the RPA was an insurance contract under Virginia law.[214] Although the claim was theoretically arbitrable under the Federal Arbitration Act, the Act was preempted by Virginia's insurance statute pursuant to the McCarran-Ferguson Act.[215] Therefore, because the insurance statute voids arbitration clauses in insurance contracts, the Fourth Circuit affirmed the District Court's holding that the arbitration provision found in the RPA was invalid.[216]

212. *Id.* at 413.
213. *Id.* at 413–15.
214. *Id.* at 411.
215. *Id.* at 422.
216. *Id.* at 423.