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## Recent Case Summaries

### **Fourth Circuit Affirms Denial of Motion to Compel Arbitration But Directs District Court to Determine Reinsurance Contract Question**

*Minneland Private Day School, Inc. v. Applied Underwriters Captive Risk Assur. Co., Inc.*, No. 16-1511, 2017 U.S. App. LEXIS 14916 (4th Cir. Aug. 11, 2017).

The Fourth Circuit Court of Appeals affirmed in part and denied in part a decision denying a motion to compel arbitration and a finding of waiver concerning the characterization of a reinsurance participation agreement.

Whether a reinsurance participation agreement is a reinsurance contract or an insurance contract in the context of a comprehensive workers' compensation program has been a matter of controversy between providers of workers' compensation programs and their insureds. In this case, the district court denied the insurer's motion to compel arbitration under the arbitration clause contained in the reinsurance participation agreement. The court also applied judicial estoppel to hold that the reinsurance participation agreement was an insurance contract for purposes of Virginia law.

In affirming the denial of the motion to compel arbitration, the circuit court concluded that the court, not an arbitrator, should determine whether the reinsurance participation agreement is an insurance contract under Virginia law. This decision, argued the insurer, was in conflict with the Sixth and Third circuits, which have allowed the arbitrability issue to be decided by an arbitrator and not the courts. The distinction, according to the circuit court, was that those cases did not address whether the relevant state law rendered unenforceable the delegation provision in the reinsurance participation agreement.

In reversing in part, the circuit court found that judicial estoppel was inapplicable. The court found that, because the insurer's assertion that the reinsurance participation agreement was not an insurance contract for purposes of Virginia law was not inconsistent with any position it took in other similar litigation, there was no basis for judicial estoppel. Accordingly, the court directed the parties to brief the issue of whether the reinsurance participation agreement is an insurance contract for purposes of Virginia law and remanded the matter back to the district court to make that determination.

### **First Circuit Affirms Holding That an Arbitrator Did Not Manifestly Disregard the Law or Exceed the Arbitrator's Powers in Ruling a Dispute Was Not Arbitrable**

*Mountain Valley Prop., Inc. v. Applied Risk Servs., Inc.*, No. 16-2189, 2017 U.S. App. LEXIS 12575 (1st Cir. Jul. 13, 2017).

The First Circuit Court of Appeals affirmed an order denying a motion to vacate an arbitration award. The insured entered into a comprehensive insurance program with a series of affiliated companies, which included a three-year reinsurance participation agreement. That reinsurance participation agreement included an arbitration clause and a mandatory Nebraska choice of law clause.

The insured was unhappy with the program and brought suit against all the affiliated companies, including the counterparty to the reinsurance participation agreement for breach of contract and various tort claims. The case was removed to federal court and a motion was made to compel arbitration of the claims against and by the parties to the reinsurance participation agreement. The district court referred the claims under the reinsurance participation agreement to a single arbitrator to determine whether the claims were arbitrable. The arbitrator found that the claims under the reinsurance participation agreement were not arbitrable because of reverse preemption under the Nebraska Uniform Arbitration Act, Neb. Rev. Stat., §§ 25-2601-22, which precludes arbitration under an insurance policy (preempting the Federal Arbitration Act).

A motion to vacate the arbitrator's award was denied by the district court and this appeal ensued. In affirming the denial of the motion to vacate, the circuit court rejected the claims under the manifest disregard of the law ground for vacatur (which the court assumed was still valid, but made no finding). The court found that the arbitrator carefully analyzed the cases and determined that the dispute was not arbitrable as a matter of law. The court noted that it was not determining whether the arbitrator's decision was correct, because the courts are not in the business of hearing claims of factual or legal error by an arbitrator.

The court also rejected the argument that the arbitrator exceeded his powers. The court stated that the arbitrator decided the precise question asked by the district court – whether the dispute was arbitrable. Given that the arbitrator produced a well-reasoned award, the motion to vacate was properly denied.

### **New York Federal Court Appoints Umpire in Spite of ARIAS•U.S. Affiliation**

*National Union Fire Ins. Co. of Pittsburgh, PA v. Beelman Truck Co.*, No. 17-CV-2946 (VEC), 2017 U.S. Dist. LEXIS 111136 (S.D.N.Y. Jul. 17, 2017).

A New York federal court, in a non-reinsurance case, appointed a third arbitrator consistent with the criteria mandated by the arbitration clause in the insurance contract, but one who was opposed by a party because of the arbitrator's affiliation with ARIAS•U.S.

The insurance contract between the policyholder and the insurer had an arbitration clause that had two relevant provisions. First, it provided that if the two arbitrators fail to agree on a third party arbitrator within 30 days of their appointment, either party may make an application to a court of competent jurisdiction in New York. Second, the arbitration clause required that the arbitrators be executive officers or former executive officers of property or casualty insurance or reinsurance companies or insurance brokerage companies or risk management officials in an industry similar to that of the policyholder (in this case, trucking).

The parties reached an impasse on umpire selection and the court agreed to break the impasse under section 5 of the Federal Arbitration Act (FAA). Section 5 allows the court, upon application of one of the parties, to appoint an arbitrator or umpire following a lapse in the naming of the arbitrator or umpire. The impasse was caused, in part, because the policyholder objected to all the carrier's candidates because they were all certified ARIAS•U.S. arbitrators. The policyholder felt that affiliation with ARIAS•U.S. skews the candidates in favor of the insurance industry and makes them more likely to be partial to the carrier. On the other hand, the carrier rejected all of the policyholder's candidates because none appeared to have any arbitration experience.

While the court agreed with the policyholder that ARIAS•U.S. certification was not required, nor was specific arbitration experience required, "[n]evertheless, reason dictates that the umpire, who, by virtue of being the neutral in the panel, needs to manage the arbitration 'in an organized, efficient, and fair manner.'" Accordingly, the court appointed one of the insurer's candidates, who, in the court's view, was the most qualified to serve as umpire in this case.

Notably, the court stated that there was no evidence that ARIAS•U.S. certified arbitrators are partial to insurance companies because of their backgrounds. Also, the court suggested to the policyholder that if alleged partiality was a real concern (rather than just delay), then the policyholder should have proposed candidates with arbitration experience that were not ARIAS•U.S. certified. "It is hard for the Court to believe that [the policyholder] could not have found someone at [the AAA or JAMS] who has experience in trucking or insurance and has arbitration experience."

ARIAS•U.S. is in the process of exploring with policyholder lawyers, brokers and others the expansion of ARIAS•U.S. to include arbitrators and members who are not from the insurance and reinsurance industries in an effort to continue to serve as a viable and fair source of arbitrators and umpires in insurance and reinsurance disputes, including disputes between policyholders, brokers and others and insurance or reinsurance companies.

### **New York Federal Court Compels Arbitration and Refuses to Consider Speculative Request Relating to Identity of Alleged Real-Party-In-Interest**

*Nat'l Fire Ins. Co. of Pittsburgh, PA v. Fed. Ins. Co.*, No. 16-CV-8821 (VEC), 2017 U.S. Dist. LEXIS 88470 (S.D.N.Y. Jun. 8, 2017).

A New York federal court compelled arbitration and stated that it would not rule on a speculative question relating to the real-party-in-interest when it was not clear how the parties were planning to raise that question. The parties had executed three agreements, between 1986 and 1989, under which defendant reinsured certain excess workers' compensation policies. The reinsurer argued that it was a "front" for a syndicate or pool of reinsurers.

A dispute arose relating to the payment of a claim. Although the parties disagreed over which agreement applied, all three agreements contained an arbitration provision. The parties began negotiating the terms of the arbitration proceedings. But the parties' discussions broke down when the reinsurer wanted to identify the syndicate members as other interested entities on a questionnaire to be sent to potential neutrals. As a result, cedent filed a petition to compel the reinsurer to proceed with the arbitration, arguing that the reinsurer was trying to add or substitute the syndicate as a party. The reinsurer filed a cross-petition to compel arbitration seeking, among other things, to compel the parties to arbitrate who were the real parties in interest.

The court noted that the real-party-in-interest issue could present a question of arbitrability, but that it would depend on if and how the reinsurer presented the real-party-in-interest issue in the arbitration proceedings, which was, at that time, entirely speculative. Indeed, it was not clear if the reinsurer wanted to add the syndicate as a party, raising a question of procedure, or substitute them as a party, raising a question of arbitrability. Thus, given the federal policy favoring arbitration, the court granted the cedent's petition to compel arbitration and granted in part the reinsurer's petition to compel arbitration.

### **New York Bankruptcy Court Orders Bermuda Insurer to Post US\$15 Million Bond Before Considering Its Motion to Compel Arbitration**

*MF Global Holdings Ltd. v. Allied World Assur. Co. (In re MF Global Holdings Ltd.)*, Chapter 11, No. 11-15059 (MG), (Jointly Administered), Adv. Proc. No. 16-01251 (MG), 2017 Bankr. LEXIS 1585 (Bankr. S.D.N.Y. Jun. 12, 2017).

In this adversary proceeding in a non-reinsurance case, a New York bankruptcy court ordered a Bermuda insurer to pay a US\$15 million bond as an unauthorized foreign insurance company under N.Y. Ins. Law § 1213(c) before the court would consider the insurer's motion to compel arbitration in Bermuda. The insurer issued an errors and omissions policy to the policyholder, obligating the insurer to contribute up to the US\$15 million policy limit in the event of a covered loss. The policy was solicited, negotiated, issued, delivered and all premiums were paid through policyholder's Bermuda-based broker. The policy was then delivered to the policyholder in New York. The court, however, rejected each of the insurer's arguments, seeking to skirt the bond requirement.

First, the court found that a motion to compel arbitration is a pleading that triggers the bond requirement. Second, the court found that, when drafting § 1213(c), the New York legislature was concerned with New York residents holding insurance policies issued by unauthorized foreign insurance companies issuing and delivering policies into New York and that the Bermuda insurer fully expected that the policy would be delivered into New York. Thus, the policyholder had satisfied the issued and delivered requirement of § 1213(c). Third, the court rejected the insurer's argument that the New York Convention on the Recognition and Enforcement of Foreign Arbitral Awards (the Convention) preempted § 1213(c)'s bond requirement. The Convention seeks to further the aim of federal policy favoring arbitration. The court found no conflict between the Convention and § 1213(c), noting that the bond requirement helps effectuate that goal "by ensuring that should a matter be sent to arbitration, particularly in a foreign country . . . , sufficient funds to satisfy a judgment will be available to a plaintiff in New York."

The court rejected the policyholder's request for a US\$60 million bond, finding that the amount was not warranted based on the facts and circumstances and that a US\$15 million bond based on the policy limit was more appropriate.

### **Connecticut Federal Court Confirms Arbitration Award as Clarified**

*General Re Life Corp. v. Lincoln Nat'l Life Ins. Co.*, No. 15-cv-1860 (VAB), 2017 U.S. Dist. LEXIS 48860 (D. Ct. Mar. 31, 2017).

A Connecticut federal court had to answer the challenging question of whether confirmation of an arbitration award, as clarified, was warranted after the panel had finished its work. The arbitration panel issued a majority award and then subsequently clarified an important aspect of the award concerning the relief granted after the parties reached an impasse on how to calculate a recapture. Each party had a different interpretation on what the court described as an award that "may have appeared to provide clear guidance on the parties' obligations."

After noting the several exceptions to the *functus officio* doctrine, the court focused on whether an ambiguity arose that required clarification where the award, although seemingly complete, left doubt whether the issue submitted had been fully executed. Importantly, the court stated that an arbitration panel's clarification or correction must not modify or alter the original award. The court held that for the arbitrators to have had authority to issue a clarification, the provision of the final award must have been found ambiguous and the clarification must merely clarify the ambiguity and not substantively change the award.

In finding that the clarification was warranted and in confirming the final award as clarified, the court noted that no Second Circuit case had yet to analyze whether an arbitration award is ambiguous so that it may be clarified under the exception to the *functus officio* doctrine. The court held that the ambiguity identified in this case was consistent with case law discussing ambiguity in the context of remanding an award to the arbitration panel. The court found that the parties' inability to agree as to the meaning of the award supported a finding that the original award was ambiguous. The court held that the award was ambiguous in the context of the treaty because of a potential contradiction between the operative paragraph of the award and a section of the treaty that the court found was relevant to the interpretation of the relief granted in the award.

In so holding, the court noted that it was important to defer to the panel's conclusion, which was that an ambiguity required clarification. The court also held that the award, as clarified, was consistent with the original award and merely clarified the relief awarded rather than the substance of the underlying dispute and did not impermissibly modify the spirit and basic effect of the award. A motion for reconsideration is pending.

### **Seventh Circuit Affirms Dismissal of Case Seeking to Collect Reinsurance Proceeds Assigned Out of Liquidation**

*Pine Top Receivables of Ill., LLC v. Banco de Seguros del Estado*, No. 16-3499, 2017 U.S. App. LEXIS 14492 (7th Cir. Aug. 7, 2017).

The Seventh Circuit Court of Appeals affirmed the dismissal of a complaint as untimely by the assignee of receivables from a cedent in liquidation against a non-US reinsurer. The treaties were entered into between 1977 and 1984 and the cedent stopped writing business in 1985. After going into liquidation in 1987, the liquidator would comply with the treaties by calculating balances quarterly and billing the reinsurer on a net basis. After 1993, however, the treaty accounting stopped.

After 15 years of silence, the liquidator billed the reinsurer for amounts due from 1993 to 1999. The reinsurer did not respond for almost two years (claiming it did not receive the bills until 2010) and rejected the 2008 bill as untimely.

After the liquidator sold all its receivables to an assignee, the assignee sued the reinsurer to collect the balance. The district court granted the reinsurer's motion to dismiss the claim as untimely and the assignee appealed.

In affirming the dismissal on timeliness grounds, the circuit court rejected the assignee's argument that Illinois law allowed the liquidator to ignore the statute of limitations and the terms of the treaties because Illinois insolvency law allows the offsetting of mutual debits and credits and provides no time limitation for doing so in a liquidation. The court held that there is "no statutory basis for thinking that a liquidator has *carte blanche* to do the netting any time he pleases and thus to deprive reinsurers of the benefit of negotiated deadlines and extend the statute of limitations for well, potentially forever."

The court also rejected the assignee's second contention that the 2008 bill was an account stated. The court stated that failure to respond to a proposal differs from acceptance. The liquidator made a proposal, the reinsurer did not accept and the account stated argument fails.

### **Illinois Federal Court Fails to Find Genuine Issue of Bad Faith in Indemnity Reinsurance Transaction**

*Midco Int'l, Inc. Emples. Profit Sharing Trust v. Metro. Life Ins. Co.*, No. 14 CV 9470, 2017 U.S. Dist. LEXIS 103296 (N.D. Ill. Jul. 5, 2017).

An Illinois federal court granted a motion for summary judgment on the ground that the insurer's conduct in selling its retirement administration business through a 100% indemnity reinsurance transaction did not amount to a breach of the duty of good faith. That was because the contract was silent about discretion, assignment and disclosure regarding the responsibility to set a declared rate for retirement plans.

This case involved a fixed investment option contract between an insurer and a retirement trust. The trust administered employee retirement plans and the insurer provided investment options. From 1980 to 1996, the declared rate at which participants received interest each year was set by the performance of the assets in the insurer's general investment account. In 1999, the contract was renegotiated and provided that the insurer would have discretion in determining the declared rate. In 2006, the insurer sold its 401(k) administration business to a third party as a 100% indemnity reinsurance transaction, whereby transferring to the third party 100% of the insurance risk and the assets supporting those liabilities. Administrative control of the assets was also transferred, thereby giving the third party discretion to set the declared rate just as the insurer previously had. Insurer informed the policyholder that the business had been transferred to the third party. The declared rate set by the third party continued to decrease. Each year, the third party generated summary reports that showed the third party now held the insurer's assets, but did not explicitly state the third party was now setting the declared rate. The summaries were reviewed by the trust and distributed to plan participants. The third party attempted to repaper with the trust, but was turned down. The trust filed suit against insurer in November 2014, alleging that the insurer breach the parties' contract for failure to set the declared rate in good faith.

The court found that the parties' contract was silent on whether the insurer could delegate the duty to set the declared rate to a third party. When a contract is silent on an issue it is filled in by the implied duty of good faith and fair dealing. The court stated that the record lacked any evidence from which a jury could conclude that the insurer would never assign its assets or delegate rate-setting responsibility to a third party. The court found no evidence on the record at all of the parties' expectations with respect to rate setting and disclosures of any change in administrative oversight. Further, there was no evidence on the record that the reinsurance transaction was unusual. In conclusion, the court held that the insurer's conduct fell short of the arbitrary and capricious conduct required to prove breach of the duty of good faith and, thus, granted the insurer's motion for summary judgment.

### **Illinois Federal Court Denies Motion to Dismiss Counterclaims Alleging Offshore Reinsurance Company Was Not Established**

*Am. Guardian Warranty Servs. V. JCR-Wesley Chapel, LLC*, No. 16 C 11407, 2017 US Dist. LEXIS 77100 (N.D. Ill. May 22, 2017).

A warranty services and financing company (Company) and a car dealership (Dealership) entered into a warranty claims servicing agreement. The Dealership was required to sell a minimum number of warranty and service contracts each month for a five-year period and 95% of the warranty and service contracts sold had to be the Company's contracts. The Company advanced funds to the Dealership for the projected amount of earnings through the sale of its contracts. A representative of the Company allegedly promised the Dealership it would set up an offshore reinsurance company that would allow the Dealership to retain the warranty payments paid by customers and earn investment income on them. This never happened. Three years later, the parties' relationship deteriorated and the Dealership stopped selling the contracts. The Dealership attempted to pay off its loan balance, but the Company sued for breach of contract and sought a preliminary injunction enjoining the Dealership from selling warranties of its competitors. The Dealership counterclaimed for fraud in the inducement and breach of contract.

The court held that the Dealership had adequately invoked the "fraudulent scheme" exception to the general prohibition on recovery for promises of future conduct based on the Company's numerous promises to set up an offshore reinsurance company for the Dealership's benefit without an intent to honor it in order to lull the Dealership into continuing to sell its contracts. The court did not accept the Company's argument that the "Entire Agreement" clause in the parties' agreement precluded the Dealership's alleged reasonable reliance. The court clarified that it is a "no reliance clause" and not an "integration clause" that bars a fraud suit and that the parties' agreement did not contain language that suggested the parties contracted in a vacuum without reliance on prior representations. Similarly, the court disagreed with the Company's argument that the Dealership failed to allege particulars of when the Company had made the promise of setting up an offshore reinsurance company, finding that a general timeframe is sufficient.

The court denied the Company's motion for preliminary injunction on the ground that the Company produced no evidence that it would likely succeed on the merits of its breach of contract claim. Additionally, the court found that the Company failed to show irreparable harm if the Dealership sold its competitors' warranties, as any loss could be compensated purely by money and a serious risk to goodwill, above mere speculation, is not sufficient to constitute irreparable harm.

THIS REVISED SUMMARY CORRECTS THE PRIOR TITLE, WHICH INADVERTENTLY SUGGESTED A DEFINITIVE RULING BY THE COURT.

### **Pennsylvania Federal Court Grants Discovery of Cedent's Reserve and Other Reinsurer Information**

*R&Q Reins. Co. v. St. Paul Fire & Marine Ins. Co.*, No. 16-1473, 2017 U.S. Dist. LEXIS 120858 (E.D. Pa. Aug. 1, 2017).

A Pennsylvania federal court, embroiled in an asbestos-related reinsurance dispute, has granted a motion to compel the cedent disclose historical loss reserves for the underlying insured and information about other reinsurers that also reinsured the same underlying policies. The court, however, granted the reinsurer's motion to obtain the cedent's proprietary information because that information was protected under the court's protective order.

The dispute involves asbestos losses ceded to two facultative certificates. The discovery dispute involves the cedent's proprietary business information, its historical loss reserves for the underlying insured and information concerning other reinsurers that reinsured the same underlying policies.

As to the proprietary information, the court held that it is discoverable, albeit protected under the protective order issued in the case. Because the cedent agreed to the protective order, the court held that it could not withhold that information without further justification just because it was proprietary.

Concerning the historical loss reserves, the court found that they were relevant to the reinsurer's claim that the cedent did not give prompt notice of loss. The court also found that reserves do not fall under the attorney-client or work product privileges. The court also distinguished disclosure of reserve information to counsel for policyholders and disclosure at the request of a reinsurer.

Finally, on other reinsurer information, the court found that this information was relevant to the reinsurer's late notice claim. Whether and when the cedent gave notice of the same loss to other reinsurers was relevant and discovery was compelled.

### **New York State Court Denies Motion to Dismiss for *Forum Non Conveniens***

*R&Q Reins. Co. v. Allianz Ins. Co.*, No. 653744/2014, 2017 N.Y. Misc. LEXIS 2721 (N.Y. Sup. Ct., Jul. 17, 2017).

A New York state court denied a cedent's motion to dismiss for *forum non conveniens* in a contest as to whether to hear a reinsurance contract claim in New York or California based, in part, upon the cedent's own actions in the course of the litigation.

The reinsurer was a Pennsylvania corporation, while the cedent was an Illinois corporation. The reinsurer initiated a suit in New York state court for breach of contract and other related claims (later expanded to include fraudulent misrepresentation). In support of its choice of venue, the reinsurer alleged that: (a) all relevant party employees and insurance brokers were located in New York at the time of the transactions; (b) the underlying insured was a New York corporation; (c) the underlying coverage action was litigated in New York; (d) the reinsurance policies were negotiated, brokered, issued, and delivered in New York; and (e) the alleged misrepresentation was made in New York. The cedent, while contesting these claims and the case's connections to New York, unsuccessfully attempted to remove the case to New York federal court twice, only to have the case remanded back to state court on procedural grounds. Both parties produced large volumes of documents in New York as the case progressed.

The New York court concluded that the cedent had not met its burden of proof as to the inconvenience of New York as a forum. The court noted that the reinsurer's complaint established a number of clear connections between the case and New York. The court considered the parties' out-of-state domiciles and the need for the New York court to apply foreign law as irrelevant to the issue. The court also rejected the cedent's claim of undue burden in holding discovery in New York, as more than 100,000 pages of relevant documents had already been produced in New York, and a California venue would be just as inconvenient for certain witnesses as a New York venue would be for others. The court pointed out that the cedent had already filed counterclaims in the New York state court action and attempted to remove the case to New York federal court, further undermining its claim that New York was an inconvenient forum.

### **Massachusetts State Court Uses Reinsurance Contracts to Interpret Coverage Under Excess Policies**

*Xu v. Donovan*, No. 1584 CV 01625-BLS2, 2017 Mass. Super. LEXIS 66 (Supr. Ct. Mass., Jun. 2, 2017).

A Massachusetts state court awarded summary judgment in favor of a medical center, its captive insurer and the claims administrator who signed a high/low agreement on its behalf, rejecting claims of fraudulent inducement, fraud, unfair/deceptive practices and negligence based upon the alleged misrepresentation of the contents of an excess policy. The case hinged upon the interpretation of complex policy language.

This case arose out of an earlier tort case in which two doctors and a nurse were sued for medical malpractice. The parties in that case agreed, prior to a jury verdict, that the plaintiffs would receive a maximum of US\$2.5 million for each defendant found liable, plus a flat US\$300,000 recovery for each defendant found not liable. The jury found two of the individuals liable and awarded US\$24.43 million in damages, resulting in the plaintiffs receiving US\$5.3 million under the agreement. The plaintiffs then initiated this action, alleging that the agreement was fraudulently induced by misrepresentations that insurance coverage was capped at US\$2.5 million per defendant, while in reality, an excess policy provided coverage of up to US\$30 million with no individual cap.

The excess policy in question was a "follow form" policy, incorporating by reference various terms and conditions from specified reinsurance contracts. The reinsurance contracts stated that: (a) the reinsurer was only liable in excess of "Underlying Amounts" of US\$5 million per medical incident; (b) the contracts covered a maximum of US\$30 million of liability in the aggregate for each medical incident; (c) the maximum coverage limit was US\$2.5 million per insured individual; and (d) only aggregate losses that exceeded the "applicable underlying amount" of US\$5 million would be covered.

The court found that this combination of policy language was "unambiguous" in covering only up to US\$2.5 million in liability per individual defendant and refused to allow plaintiffs to challenge this interpretation using witness testimony. Based on this interpretation, the court concluded that there was no fraudulent misrepresentation, as the coverage limited had been accurately conveyed to the plaintiffs (as required by state statute).

### **Illinois Federal Court Dismisses Claims Against Captive Reinsurer**

*Illinois v. AAMBG Reinsurance, Inc.*, No. 16 C 7477, 2017 U.S. Dist. LEXIS 84231 (N.D. Ill. Jun. 1, 2017).

An Illinois federal court dismissed claims by an insurer under state rehabilitation against a captive reinsurer and originating bank concerning private mortgage insurance (PMI). The claims alleged that: (1) the bank's failure to disclose benefits received from the agreement constituted a breach of contract by the reinsurer; (2) the reinsurer and bank breached their duty of good faith and fair dealing by only referring high-risk borrowers to the insurer; and (3) kickbacks were paid in violation of the Real Estate Settlement Procedures Act, 12 U.S.C. 2601 et seq. (RESPA).

The court considered the first two claims to be "implausible" based upon the pleadings. The insurer alleged that the reinsurer and bank failed to satisfy their contractual obligation to disclose to each borrower, as required by HUD, any premiums, kickbacks and other benefits that they were receiving. The complaint did not allege further details such as specific borrowers involved, specific regulatory violations and specific damages to the insurer, and, as a result, the court deemed it "conclusory."

The allegations that the reinsurer and bank only referred high-risk borrowers to the insurer were dismissed as "totally implausible," on the basis that: (1) even if this occurred, the reinsurer would bear most of the net loss under the risk sharing provisions in the reinsurance policy; (2) the insurer did not allege what the bank and reinsurer did with lower-risk borrowers; and (3) the insurer did not explain why it only accepted high-risk borrowers for PMI.

The insurer's RESPA claims stated, in essence, that premiums received by the reinsurer constituted illegal kickbacks under Sections 8(a) and 8(b) of RESPA. The reinsurer argued that these premiums constituted bona fide payments subject to the safe harbor under Section 8(c) of RESPA, as interpreted by HUD public guidance, and the insurer failed to rebut this argument. In addition, the court found that the three-year RESPA statute of limitations ran from the time the primary insurance was initially obtained, not from the time of the most recent distribution from the insurer's trust account, thus time-barring the claim.

### **Pennsylvania Federal Court Rejects Amendment to Complaint Against Captive Reinsurer**

*Menichino v. Citibank*, No. 2:12-cv-00058, 2017 U.S. Dist. LEXIS 86380 (W.D. Pa. Jun. 6, 2017).

A Pennsylvania federal court rejected a borrower group's request to amend its RESPA claims, and to add Racketeer Influenced and Corrupt Organizations Act (RICO) claims, in ongoing litigation against two mortgage lenders and their reinsurer. The claims revolved around allegations of illegal kickbacks paid by third-party insurers for non-existent reinsurance services under a captive reinsurance program.

The timeline of the litigation was key to the result, as the underlying loans were obtained between 2005 and 2007, but the RESPA claims were not filed until 2012 and the RICO claims were not added to the suit until 2016.

In order to address RESPA's one-year statute of limitations, which runs from the time of the "triggering violation," the borrowers had previously argued that the lenders and reinsurer fraudulently concealed information, thereby justifying equitable tolling of the statute of limitations. After the court accepted the legal basis of this argument and allowed discovery to proceed, the Third Circuit issued an opinion in 2016, *Cunningham v. M&T Bank Corp.*, 814 F.3d 156 (3rd Cir. 2016), which rejected a similar equitable tolling argument in a similar RESPA case. The borrowers sought to change their argument in the wake of this ruling, and argued that each mortgage payment constituted an independent violation of RESPA and reset the one-year clock. The borrowers cited a 2015 CFPB advisory decision that endorsed this legal position. The court rejected this amendment as "futile" in light of the Third Circuit opinion, pointing out that the CFPB decision was only advisory, and was published months before the Third Circuit opinion.

The court also rejected the borrowers' RICO claims on the basis that they were "unduly delayed." The borrowers admitted that they were on notice of these claims as early as 2011, yet did not seek leave to file the RICO claims until 2016 – four years after the RESPA claims were first filed. The court found no justification for the five-year delay, as no change in law and no recently discovered facts were alleged, and the borrowers had already amended their RESPA complaint twice without adding the RICO claims.

### **Illinois Federal Court Dismisses Case Filed By Rehabilitator Against Reinsurer**

*Illinois ex rel. Hammer v. Twin Rivers Ins. Co.*, No. 16 C 7371, 2017 U.S. Dist. LEXIS 103833 (N.D. Ill. Jul. 5, 2017).

An Illinois federal court dismissed a complaint filed by the Illinois Director of Insurance, in her capacity as rehabilitator of a defunct cedent, against a reinsurer alleging breach of contract, breach of the implied covenant of good faith and fair dealing, unjust enrichment and violation of RESPA. Finding the complaint did not state a claim upon which relief could be granted, the court dismissed the claims with prejudice, provided however that the court granted the Director an opportunity to amend her complaint to state a breach of contract claim.

According to the complaint, the defunct cedent sold PMI that was reinsured by the reinsurer. The reinsurer was affiliated with the banks that originated the underlying mortgages. In the course of originating mortgages, the affiliated banks would refer borrowers to the cedent and the reinsurer would reinsure PMI only on those loans originated by the affiliated banks. Under the reinsurance agreement, the cedent would pay a percentage of premium to the reinsurer, which was deposited in trust accounts. The trust accounts were used to pay reinsurance claims and dividends to the reinsurer and the affiliated banks.

The Director alleged that the reinsurer breached its agreement by failing to provide disclosures to referred borrowers as to the benefits the reinsurer derived from the captive reinsurance arrangement consistent with disclosure requirements imposed by HUD. In its motion to dismiss, the reinsurer argued no provision of the agreement obligated it to provide HUD disclosures to borrowers and, even if there were a contractual obligation to do so, the Director sustained no harm. In response, the Director pointed to a warranty provision in the agreement that stated that the reinsurer would not violate any "agreement with, or condition imposed by, or consent required by... any governmental... body" in executing or performing the agreement. Finding that this warranty only related to specific and individual legal constraints precluding the reinsurer from executing or performing the agreement, and did not require the reinsurer to provide HUD disclosures to borrowers, the court held the complaint failed to state a breach of contract claim. Nonetheless, the court granted the Director 60 days to amend her claim, giving her the chance to assert a cognizable claim.

In her claim for breach of the implied covenant of good faith and fair dealing, the Director alleged that the reinsurer selectively referred borrowers to the cedent that had the highest risk of default. In dismissing this claim, the court noted that a breach of good faith and fair dealing claim could only succeed where an agreement vests a party with discretion to perform an obligation and that discretion is exercised in bad faith, unreasonably or inconsistent with the expectation of the parties. In reviewing the complaint, the court found the Director did not allege that the agreement vested the reinsurer with discretion to refer borrowers selectively to the cedent. In addition, it was undisputed that the cedent had the right to reject any borrower referred to it for coverage. For these reasons and others, the court dismissed the good faith and fair dealings claim with prejudice.

The Director also alleged that the reinsurer violated RESPA on the ground that the premium ceded to the reinsurer constituted kickbacks paid in exchange for the reinsurer referring borrowers to the cedent. This claim was dismissed with prejudice based on the statute of limitations applicable to RESPA claims. The court also dismissed the Director's unjust enrichment claim on the ground that unjust enrichment cannot be asserted in circumstances where an express contract governs the relationship of the parties.

## Illinois Appellate Court Addresses Reinsurance Proceeds and the Collateral Source Rule

*Developers Sur. & Indemn. Co. v. Lipinski*, No. 1-15-2658, 2017 Ill. App. LEXIS 545 (Ill. App. 1st Dist., Aug. 22, 2017).

The collateral source rule is a rule that allows an injured party to recover undiminished damages from the tortfeasor even if the injured party recovered benefits from independent sources for the loss. The question in this case was whether a reinsurance recovery arising out of a failed construction project was a collateral source that applied in a subsequent legal malpractice action brought by the surety company.

The original underlying dispute resulted in the surety paying a large settlement amount. The surety sued its retained counsel for legal malpractice because of a lost opportunity to settle the case for much less. The lawyer sought information about the surety's reinsurance recoveries on the underlying settlement. The court granted discovery and the surety was forced to admit that it had recovered 100% of the provable damages.

The trial court dismissed the complaint with prejudice and denied a motion to amend the complaint to add a subrogation count because the surety, as cedent, had an obligation to seek a recovery from the lawyer for amounts paid by the reinsurers.

Unfortunately, on appeal, the issue of whether reinsurance was a collateral source was never reached because the court affirmed the motion to dismiss. The affirmance, however, was based on a statutory provision that required the joinder of the real parties in interest – the reinsurers – where the action is being brought based on subrogation.

A concurring opinion did get into the collateral source issue, but never resolved it. The open question was whether the collateral source rule applied in legal malpractice cases. Because there was no possibility that the surety could obtain a windfall recovery, it argued that the collateral source rule should apply and it should recover its damages even if it did receive a reinsurance recovery. While the concurrence stated that the surety had a meritorious argument, because the surety resisted until the eve of trial disclosing that it had received reinsurance recoveries, dismissal was proper.

## Featured Article: Discovery of Reserve and Reinsurance Communications

### Introduction

In cases where an insurer is a party to an action, numerous discovery disputes have centered on a litigant's ability to discover the insurer's loss reserve information and communications with its reinsurers. The litigant (generally the insured or a co-insurer) may request this information in discovery, hoping to find something in the insurer's internal communications and information that comports with the litigant's theory of the case. There is no clear rule as to the discoverability of reserves and reinsurance communications. Many courts have noted that this information often has little, if any, relevance, because they reflect the insurer's compliance with statutory reserving requirements and internal business decisions. Typically, this information is not relevant to coverage determinations. A number of courts, however, have held that this information can be relevant and discoverable particularly in bad faith cases, depending on the allegations, as issues related to the insurer's subjective opinions and knowledge may be implicated. While the results of similar discovery disputes cannot be predicted with crystal clarity, examining rulings from various jurisdictions and case circumstances provides some guidance.

### I. Discovery of Reserves

The unique nature of loss reserves has led to countless discovery disputes in insurance litigation. Often required under state laws, reserves are funds insurers set aside to cover payment in the event of future liability. They reflect estimates of potential exposure on a claim; they do not reflect actual settlement authority. Courts have noted that reserves generally do not represent "an evaluation of coverage based upon a thorough factual and legal consideration." Reserves are often impacted by considerations other than a pure factual and legal analysis of the claim, such as state law regulations and business and tax considerations. In practice, most companies will put some value towards any case, because it is a best practice to generally consider a compromise if it is found fair and reasonable.

In seeking to protect its reserve information from discovery, an insurer may argue that its internal business decisions regarding the amount of funds to set aside for a claim have nothing to do with legal issues such as actual liability. After all, reserves are only an estimate of potential exposure – often established early at the first notice of an insured's claim, before any detailed factual analysis – and not a thorough evaluation of the insurer's actual obligations. An insurer may cry unfairness at being mandated by regulation to set reserve amounts, only to have those amounts used against it in litigation; regularly requiring production of reserves would only undermine the purpose of setting them, incentivizing underestimation rather than a conservative approach to setting aside sufficient funds. On the other hand, an insured seeking production of reserve information may argue that, while a reserve may not represent the most in-depth analysis of a claim's value, it certainly has some tie to the insurer's evaluation of the claim. The insurer's internal assessment may be relevant, particularly in bad faith cases where the insurer's state of mind is at issue. The insured may hark back to the generally broad leeway for discovery.

An insurer may object to discovery of its reserves based on relevance grounds. In deciding whether reserves are sufficiently relevant to compel discovery, courts generally look to the type of claim being brought. Where parties are seeking a coverage determination, courts typically hold that reserves are not relevant. Reserves do not constitute an admission of liability or the existence of coverage. Reserves can only evidence an insurer's subjective view of the claim, which is not at issue in a coverage action.

In bad faith cases, the relevance of reserves becomes a more difficult question. Some courts have made blanket holdings that reserves are relevant in bad faith cases, where the insurer's subjective beliefs and actions are at issue. Many courts look to the bad faith allegations to make an individualized determination as to whether issues are raised that render the reserves relevant. Issues for which courts have found that reserves may be relevant include:

- Whether the insurer thoroughly investigated the claim (making the thoroughness of the reserve evaluation relevant)
- Whether the insurer acted in bad faith by making a settlement offer to the insured for less than the insurer's understanding as to the value of the claim
- Whether there was a difference between what the insurer believed it owed on a claim and what it communicated to its insured
- Whether the insurer was unreasonable in refusing to accept a settlement offer in an underlying case, where it had assigned a higher value to the claim

Some courts have differentiated bad faith claims where the insurer issued a "first party" policy (where the insurer compensates the insured directly for its losses) versus a "third party" liability policy (where the insurer defends and indemnifies the insured against third party claims). In a "first party" case the issues are usually limited to the existence of coverage and whether the insurer's actions were in good faith, rendering reserves largely irrelevant. In a "third party" case reserves may be more relevant, because the insurer has a duty to defend as long as there is potential coverage; evidence that an insurer believed there was potential liability (such as may be found in reserve information) may be probative where the insurer denied a defense of the claim.

Discovery disputes over reserves may also raise privilege issues. There is a split in authority as to whether reserves may be privileged under the work product doctrine. Courts that held reserves privileged found that they were prepared in anticipation of litigation – a party's evaluation of the amount it may pay in litigation seems anathema to discovery. Other courts, however, have held that reserves were not privileged, recognizing that insurance companies may establish reserves as a matter of course at the first notice of an insured's loss claim, as part of regular claims adjusting and before the start of any litigation.

The result of a discovery dispute over reserve information is often fact- and jurisdictional-dependent.

## II. Discovery of Reinsurance Documents and Communications

Federal Rule of Civil Procedure 26(a)(1)(A)(iv) requires, as part of the parties' initial disclosures, the production of "any insurance agreement under which an insurance business may be liable to satisfy all or part of a possible judgment in the action or to indemnify or reimburse for payments made to satisfy the judgment." Most federal courts have held that reinsurance agreements must be produced under Rule 26(a) where the primary insurer is a named party, because the reinsurer may have a duty to indemnify the primary insurer. Reinsurance agreements, however, need not be produced under Rule 26(a) when the primary insurer is not a party. They also may not need to be produced in state court actions where Rule 26(a) does not apply.

Most courts hold that communications and other documents between an insurer and its reinsurer are generally not relevant and not discoverable. Reinsurance information reflects a business decision by the primary insurer to spread risk or to satisfy statutory reserve requirements, so it is not typically relevant to the claims in a case. As with loss reserves, reinsurance communications are discoverable in certain cases where they may have relevance to the issues raised. Courts have held that they may be relevant (and are thus discoverable) to show the insurer's interpretation of the policies at issue, whether the insurer believed the claims were covered by the policies, the thoroughness of the insurer's claims investigations, or to combat defenses such as lost policy, late notice or misrepresentation. In arguing that reserves are not relevant, an insurer may choose to describe the contents of the communications or request an in camera review to demonstrate lack of relevance.

Insurers may also object to the production of reinsurance communications if they are protected by the attorney-client or work product privileges.

*A version of this article, along with a table of cases and footnoted citations, was presented at the FDCC Annual Meeting on July 27, 2017. If you would like a copy of the full paper with all citations and the table of cases, please contact the editor or the author, Tania Rice.*

## Recent Regulatory Developments

### US Trade Representative and Treasury Department Announce US Intends to Sign the Covered Agreement

Negotiations between the US and the European Union (EU) for a "Covered Agreement" addressing reinsurance, group supervision and information exchange concluded on January 13, 2017. The agreement goes into force seven days following written certification by each side to the other that they have completed their respective requirements and procedures.

Under the Dodd-Frank Act, one of the US requirements was that the Covered Agreement must be sent to Congress for review for 90 days. The language was sent to Congress, hearings and other discussions were held, and the 90-day waiting period expired on April 13, 2017. Until this summer, there had been no further visible action by the US government to finalize the Covered Agreement.

On July 14, 2017, the US Department of the Treasury and the Office of the US Trade Representative [issued a press release](#) stating their intention to sign the Covered Agreement between the US and the EU "in the coming weeks." The press release also noted that the US Administration intends to issue a policy statement on implementation of the Covered Agreement. No further public action has been taken by the administration and that policy statement has not yet been issued. The Covered Agreement becomes effective seven days after both the EU and the US issue written notifications certifying that they have completed the respective internal requirements or procedures. Neither the US nor the EU have issued that notice to each other.

It appears that there have been some behind the scenes discussions between April and July involving the National Association of Insurance Commissioners (NAIC). Notably, the July US press release also expressly indicates that the Covered Agreement "benefits the U.S. economy by affirming America's state-based system of insurance regulation. . ." Also on July 14, the NAIC President, Ted Nickel (Wisconsin Insurance Commissioner), [issued a statement](#) expressly noting the NAIC's appreciation that, in its statement, Treasury "affirmed the primacy of the state insurance regulation and intend[s] to clarify key elements of the agreement".

Commissioner Nickel's statement also noted the significant role that US state regulators will play in implementation of the Covered Agreement. Nickel said the NAIC will issue a full statement on the Covered Agreement once the US implementation policy statement is issued and the agreement is signed.

The final steps for EU review of the Covered Agreement are approvals by both the EU Council and the European Parliament. The EU Council approved the Covered Agreement on May 29, 2017, and indicated that the Covered Agreement would be submitted to the European Parliament for approval. There has been no indication of when the European Council will consider the Covered Agreement. The EU will not be able to send to the US the EU's written certification that the EU has completed its internal requirements until this final European Parliament approval is issued.

Following publication of the final Covered Agreement negotiated language, Germany's BaFin wrote to the US FIO that BaFin would not impose its local presence requirement on US reinsurers in Germany, unless the EU or the US indicates that the Covered Agreement will not come into effect. To date, there is no indication that the BaFin position has changed.

Stay tuned.

## Recent Speeches and Publications

- John Nonna will be speaking on "Cyber Liability Insurance: Costs, Coverage and Things You Need to Know," at The Knowledge Group's webinar, September 25, 2017.
- Larry Schiffer spoke on "Insurance Coverage Litigation: Recent Trends and Developments Explored!" at The Knowledge Group's webinar, August 24, 2017.
- Dave Godwin moderated the panel "Can We Talk? The Importance of Communication When Dealing With Excess and Reinsurers," at the annual meeting of the Federation of Defense and Corporate Counsel, July 27, 2017, Montreux, Switzerland. Tania Rice submitted a paper for that session titled "Discovery of Reserve and Reinsurance Communications," the text of which is in this newsletter.
- Larry Schiffer's article, "Relationship? What Relationship? Evident Partiality and Arbitrator Disclosure," was published as a Lorman Educational Services White Paper in July 2017.
- Larry Schiffer's articles, "The Struggle to Maintain the Attorney-Client Privilege for In-House Insurance Counsel," "Liability Insurance: Notice to Carrier Means Notice to Carrier" and "Battle of Other Insurance Clauses In CGL Policies for Contractors," were published as Lorman Educational Services White Papers in June 2017.
- Larry Schiffer's Reinsurance Commentary, "Is It over Yet? 'Functus Officio' in Reinsurance Arbitrations," was published on IRMI.com in June 2017.

**Congratulations to the following firm insurance lawyers named in *The Best Lawyers in America 2018*: Peter Kramer and John Nonna.**

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