RECENT DEVELOPMENTS IN EXCESS INSURANCE AND REINSURANCE

Michael Carolan, Brendan Mullan, and Elizabeth C. Sackett

In excess insurance, this reporting period saw significant decisions in allocation and exhaustion. Other important excess insurance issues addressed this past year include drop down/trigger, defense costs, equitable subrogation, and unjust enrichment. Case law developments affecting the reinsurance industry addressed a number of issues in the last year, including discoverability of reinsurance information, the doctrines of follow the fortunes/follow the settlements, and arbitrator disclosures, conduct, and qualifications. Key decisions in each area are discussed below.

Michael Carolan (mcarolan@crowell.com) is a partner in the Washington D.C., office of Crowell & Moring LLP. Brendan Mullan (bmullan@crowell.com) is an associate in the San Francisco office of Crowell & Moring LLP. Elizabeth Sackett (esackett@hermesnetburn.com) is Senior Counsel at Hermes, Netburn, O'Connor & Spearing, P.C. in Boston, Massachusetts and is a Vice Chair of the Excess, Surplus Lines and Reinsurance Committee.

I. EXCESS INSURANCE

A. *Allocation and Exhaustion*

Allocation and exhaustion were the focus of certified questions sent to the New York Court of Appeals from the Delaware Supreme Court in *In re Viking Pump, Inc.*[1] Following rulings that Viking Pump, Inc. and Warren Pumps, LLC qualified as insureds under numerous insurance policies issued to Houdaille, Inc. and that New York law applied to the policies, the Court of Chancery and the Delaware Superior Court both ruled that "all sums" was the proper method for allocation of asbestos liabilities under numerous excess insurance policies issued from 1972–1985, relying on the policies' "non-cumulation" or "anti-stacking" language.[2] The Delaware Superior Court further relied on New York precedent to support its ruling that the policies should horizontally exhaust, even though the court acknowledged (and the Court of Chancery had ruled) that the policies' language supported vertical exhaustion.[3]

The insurers appealed, and the Delaware Supreme Court determined that New York law was unsettled regarding allocation and exhaustion of policies with non-cumulation clauses. It therefore certified two questions to the New York Court of Appeals:

1. Under New York law, is the proper method of allocation to be used all sums or pro rata when there are non-cumulation and prior insurance provisions?

2. Given the Court's answer to Question #1, under New York law and based on the policy language at issue here, when the underlying primary and umbrella insurance in the same policy period has exhausted, does vertical or horizontal exhaustion apply to determine when a policyholder may access its excess insurance?[4]

The New York Court of Appeals acknowledged that it applied the pro rata method of allocation to liabilities triggering multiple successive policies in *Consolidated Edison Co. of New York v. Allstate Insurance Co.*[5] It did so based on general contract interpretation rules and not on broad policy concerns.[6] In *Consolidated Edison*, the Court of Appeals examined the policy language and interpreted it according to common usage, construing the policy as a whole to "'afford[ ] a fair meaning to all of the language employed by the parties in the contract and leave[ ] no provision without

1. 52 N.E.3d 1144 (N.Y. 2016).
2. *Id.* at 1148.
3. *Id.*
4. *Id.* at 1149.
5. 774 N.E.2d 687 (N.Y. 2002).
6. *Id.*

force and effect.'"[7] The *Consolidated Edison* decision "turned exclusively" on the *all sums* language in the indemnity provision and the requirement that the occurrence take place *during the policy period*.[8] The Court of Appeals recognized that different policy language could compel a different result.[9]

The policies at issue and the arguments raised in *Consolidated Edison* did not include "non-cumulation" clauses, making the policies in *In re Viking Pump, Inc.* distinguishable.[10] The majority of the excess policies at issue contained "non-cumulation"[11] or "prior insurance and non-cumulation"[12] clauses. In certain circumstances, these clauses prevent an insured from receiving reimbursement of multiple policy limits where a third-party injury triggers multiple policy periods.[13] The Court of Appeals noted that the clauses were incorporated into policies when liability forms changed from being "accident-based" to "occurrence-based" in the 1960s and were intended to prevent insureds from recovering under two policies for the same injury. The court also acknowledged that it had recently twice enforced such provisions,[14] but conceded that it had never before addressed the interplay between non-cumulation clauses and allocation.[15]

The Court of Appeals surveyed other jurisdictions, finding some have concluded the all sums allocation methodology applies because the non-

7. *In re* Viking Pump, Inc., 52 N.E.3d 1144, 1151 (N.Y. 2016) (quoting Roman Catholic Diocese of Brooklyn v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa., 991 N.E.2d 666, 671–72 (N.Y. 2013)).

8. *Id.*

9. *Id.*

10. *Id.* at 1152.

11. The non-cumulation clause stated in relevant part:

> If the same occurrence gives rise to personal injury, property damage or advertising injury or damage which occurs partly before and partly within any annual period of this policy, the each occurrence limit and the applicable aggregate limit or limits of this policy shall be reduce by the amount of each payment by [insurer] with respect to such occurrence, either under a previous policy or policies of which this is a replacement, or under this policy with respect to previous annual periods thereof.

12. The prior insurance and non-cumulation clause states in relevant part:

> It is agreed that if any loss covered hereunder is also covered in whole or in part under any other excess Policy issued to the Insured prior to the inception date hereof[,] the limit of liability hereon . . . shall be reduced by any amounts due to the Insured on account of such loss under such prior insurance.
>
> Subject to the foregoing paragraph and to all the other terms and conditions of this Policy in the event that personal injury or property damage arising out of an occurrence covered hereunder is continuing at the time of termination of this policy the Company will continue to protect the Insured for liability in respect of such personal injury or property damage without payment of additional premium.

13. *In re* Viking Pump, Inc., 52 N.E.3d 1144, 1151 (N.Y. 2016).

14. *Id.* at 1152 (citing Nesmith v Allstate Ins. Co., 25 N.E.3d 924 (N.Y. 2014); Hiraldo v. Allstate Ins. Co., 840 N.E.2d 563 (N.Y. 2005)).

15. *Id.*

cumulation clause is incompatible with pro rata allocation,[16] while other pro rata jurisdictions have found non-cumulation clauses unenforceable based on policy reasons.[17] The Court of Appeals concluded "it would be inconsistent with the language of the non-cumulation clauses to use pro rata allocation here."[18] The court provided two main reasons.

First, the non-cumulation language clearly contemplates that a loss or occurrence can start before, or continue after, a policy period, thus triggering more than one policy.[19] By contrast, pro rata allocation is premised on the principle that a policy provides coverage only for the injury or occurrence that happens during the policy period.[20] Pro rata allocation is thus a "legal fiction designed to treat continuous and indivisible injuries as distinct in each policy period as a result of the 'during the policy period' limitation," and that legal fiction is undermined by the non-cumulation clause.[21] To ignore the non-cumulation provision in a pro rata allocation would render the clause "surplusage—a construction that cannot be countenanced under [New York's] principles of contract interpretation" and is contrary to prior rulings enforcing such clauses.[22]

Secondly, the prior insurance provisions in some of the policies likewise contemplate injuries or losses continuing beyond the expiration of the policy period.[23] To apply pro rata allocation would negate the continuing coverage provided by the prior insurance clause and again render such policy provisions surplusage.[24] "Thus, presence of that [continuing coverage] clause in the respective policies further compels an interpretation in favor of all sums allocation."[25]

The excess insurers argued that an all sums ruling would be contrary to the Second Circuit's holding in *Olin Corp. v. American Home Assurance Co.* and its progeny.[26] In *Olin III*, the insured argued that two excess policies were triggered because the underlying policies were exhausted due to the non-cumulation and prior insurance provision in the underlying poli-

16. *Id.* at 1152–53 (citing Chicago Bridge & Iron Co. v. Certain Underwriters at Lloyd's, London, 797 N.E.2d 434 (Mass. 2003); Plastic Eng'g Co. v. Liberty Mut. Ins. Co., 759 N.W.2d 613 (Wis. 2009)).

17. *Id.* at 1152 (citing Spaulding Composites Co., Inc. v. Aetna Cas. & Sur. Co., 819 A.2d 410 (N.J. 2003); Outboard Marine Corp. v. Liberty Mut. Ins. Co., 670 N.E.2d 740 (Ill. Ct. App. 1996), *leave denied*, 675 N.E.2d 634 (Ill. 1996)).

18. *In re* Viking Pump, Inc., 52 N.E.3d 1144, 1153 (N.Y. 2016).

19. *Id.*

20. *Id.*

21. *Id.*

22. *Id*. at 1154.

23. *Id.*

24. *Id.*

25. *Id.*

26. 704 F.3d 89 (2d Cir. 2012) (*Olin III*); Liberty Mut. Ins. Co. v. Fairbanks Co., 2016 WL 1169511 (S.D.N.Y. Mar. 22, 2016); Liberty Mut. Ins. Co. v. J. & S. Supply Corp., 2015 U.S. Dist. LEXIS 177124 (S.D.N.Y. June 29, 2015).

cies.[27] The insured argued that although prior decisions in the case required pro rata allocation of the environmental contamination damages,[28] the prior insurance clause in certain underlying umbrella policies required the pro rata allocation to the subsequent policies to be "swept back" into the policies containing the non-cumulation and prior insurance clauses.[29] The Second Circuit agreed. In effect, the *Olin III* court held that a policy containing a non-cumulation and prior insurance clause could be allocated pro rata losses incurred in later, but not earlier, periods.

The New York Court of Appeals distinguished *Olin III*, noting first that the Second Circuit's attempt to reconcile the plain language of the non-cumulation and prior insurance clause with pro rata allocation was based on the flawed premise that it was foreclosed from considering or applying all sums allocation either based on its reading of *Consolidated Edison* or its prior rulings in *Olin I* and *Olin II*.[30] In addition, the Second Circuit, in fashioning its allocation, rejected the insurer's argument that these clauses were inconsistent with pro rata allocation and should thus be ignored.[31] The Court of Appeals, therefore, recognized that *Olin III* more closely resembles an all sums allocation rather than a pro rata allocation.[32] Concluding that the policy language and persuasive authority demonstrate that pro rata allocation is inconsistent with non-cumulation and prior insurance clauses, the Court of Appeals held that "all sums allocation is appropriate in policies containing such [non-cumulation or non-cumulation and prior insurance] provisions."[33]

The court turned next to the issue of exhaustion and whether the policies exhaust horizontally or vertically. Horizontal exhaustion is where all triggered policies below the excess policies (all triggered primary and umbrella policies between 1972 and 1985) exhaust before the excess policies are triggered.[34] Vertical exhaustion is where the insured can trigger an excess policy by exhausting the policy limits of the underlying primary and umbrella policies that cover the same policy period.[35]

The Court of Appeals addressed only one argument raised by the excess insurers. The excess insurers argued that the excess policies' language required horizontal allocation because they were triggered only upon the exhaustion or payment of the "retained limit," which was defined as the

27. *In re* Viking Pump, Inc., 52 N.E.3d 1144, 1155 (N.Y. 2016).
28. *See* Olin Corp. v. Ins. Co. of N. Am., 221 F.3d 307 (2d Cir. 2000) (*Olin I*); Olin Corp. v. Certain Underwriters at Lloyd's, London, 468 F.3d 120 (2d Cir. 2006) (*Olin II*).
29. *In re Viking Pump, Inc.*, 52 N.E.3d at 1155.
30. *Id.*
31. *Id.* at 1156.
32. *In re* Viking Pump, Inc., 52 N.E.3d 1144, 1156 (N.Y. 2016).
33. *Id.*
34. *Id.*
35. *Id.*

limits of liability of the underlying policies in the same policy period "plus all amounts payable under other insurance, if any."[36] Other insurance includes "valid and collectible insurance (except under the underlying policy) which is available to the Insured, or would be available to the Insured in the absence of this policy."[37] The Court of Appeals acknowledged that the argument was "not completely baseless,"[38] but held that, under *Consolidated Edison*, "other insurance" provisions apply only where two or more policies provide coverage during the same policy period, not successive policies.[39] Absent any policy provisions to the contrary, the Court of Appeals held that vertical exhaustion "is more consistent" with the language of the excess policies and the concept of all sums allocation.[40]

Following *In re Viking Pump, Inc.*, the Fairbanks Company moved for reconsideration of the U.S. District Court for the Southern District of New York's ruling that pro rata allocation applied to the allocation of its asbestos liabilities under certain umbrella policies in *Liberty Mutual Insurance Co. v. Fairbanks Co.*[41] The district court's decision had relied on *Consolidated Edison* to apply pro rata allocation, notwithstanding the Liberty Mutual umbrella policies' non-cumulation clauses in policies issued from 1974 to 1982.[42] On reconsideration, the parties agreed that (1) all sums allocation applied to the umbrella policies containing the non-cumulation clauses under *In re Viking Pump, Inc.*; and (2) pro rata allocation applied to the primary policies, which did not contain non-cumulation clauses.[43] The issue presented on reconsideration was whether the non-cumulation clauses limit Fairbank's recovery under multiple policies, an issue that was not addressed in *In re Viking Pump, Inc.*[44]

The Liberty Mutual excess policies' non-cumulation clause provides as follows:

> If the same occurrence gives rise to personal injury . . . which occurs . . . partly within any annual period of this policy, the each occurrence limit and the applicable aggregate limit or limits of this policy shall be reduced by the amount of each payment made by the company with respect to such occurrence, either under a previous policy or policies of which this is a replacement, or under this policy with respect to previous annual periods thereof.[45]

36. *Id.* at 1157.
37. *In re* Viking Pump, Inc., 52 N.E.3d 1144, 1157 (N.Y. 2016).
38. *Id.* (citing Dow Corning Corp. v. Cont'l Cas. Co., Inc., 1999 WL 33435067, at *7–8 (Mich. Ct. App. Oct. 12, 1999), *leave denied*, 617 N.W.2d 554 (Mich. 2000)).
39. *Id.* (citing Consol. Edison Co. v. Allstate Ins. Co., 774 N.E.2d 687 (N.Y. 2002)).
40. *Id.*
41. 2016 WL 4203543 (S.D.N.Y. Aug. 8, 2016).
42. *Id.*
43. *Id.* at *1–2.
44. *Id.* at *2.
45. *Id.* at *3.

Liberty Mutual argued that the non-cumulation clauses operate so that every asbestos liability payment made under its first year of coverage reduces the limits of liability under the subsequent policies.[46] Fairbanks argued that because the non-cumulation clause applied to occurrence limits and each individual asbestos claim is a separate "occurrence," the aggregate limits of subsequent policies are not reduced by each individual claim.[47] Fairbanks further argued that the court must first determine the number of "occurrences" before it can rule on the application of the non-cumulation clause.[48]

Liberty Mutual countered that the number of occurrences is irrelevant because the aggregate limit is reduced by each payment made for occurrences.[49] Liberty Mutual relied on *Endicott Johnson Corp. v. Liberty Mutual Insurance Co.*[50] and *Liberty Mutual Insurance Co. v. Treesdale, Inc.*,[51] but the district court concluded that both cases had determined that there was only one occurrence before evaluating that the non-cumulation clause.[52] They also did not address whether, or how, the non-cumulation clause affected subsequent policies' aggregate limits.

The district court observed that the non-cumulation clause "explicitly refers to 'the same occurrence,' making it necessary to determine how many occurrences are at issue."[53] Thus, the district court denied summary judgment finding the motion premature because, among other reasons, the parties had not conducted any discovery on the number of occurrences.[54]

B. *Drop Down and Trigger of Coverage*

Two courts addressed trigger and whether excess insurance policies should "drop down" to provide defense and indemnity coverage. In *Continental Insurance Co. v. Honeywell International, Inc.*,[55] Honeywell appealed several rulings to the New Jersey Superior Court, Appellate Division in a multi-party asbestos coverage suit, including the Superior Court's ruling that Aetna Casualty & Surety Company (Travelers)[56] and American Insurance Company (AIC) did not have to drop down to fill in the gaps

46. *Id.*
47. *Id.*
48. *Id.*
49. *Id.* at *4.
50. 928 F. Supp. 176 (N.D.N.Y. 1996).
51. 418 F.3d 330 (3d Cir. 2005).
52. Liberty Mut. Ins. Co. v. Fairbanks Co., 2016 WL 4203543, at *5 (S.D.N.Y. Aug. 8, 2016).
53. *Id.*
54. *Id.*
55. 2016 WL 3903530 (N.J. Super. Ct. App. Div. July 20, 2016).
56. Travelers Casualty & Surety Company is the successor to Aetna.

within the underlying quota share layer of coverage[57] where certain quota share participants were exhausted by payment of defense costs while other participant policies did not cover defense costs.[58] The trigger of coverage and whether the excess policies dropped down to participate in the quota share layer was an issue of first impression in New Jersey.[59]

Honeywell argued that when a participating quota share policy exhausts, the excess policy is triggered and drops down to pay the exhausted quota share insurer's percentage of liability.[60] Travelers responded that the policy language was clear that it was not triggered until all underlying quota share participating policies exhausted. The Aetna policy provided coverage for "Excess Net Loss," which was defined to mean "the total of all sums which the insured becomes legally obligated to pay or has paid . . . which is in excess of any self-insured retention and the total of the applicable limits of liability of all policies described in Section 3. Schedule of Insurance; whether or not such policies are in force."[61] The AIC policy provided coverage subject to the "Limits of Liability," which stated that AIC would be liable only for the policy's limits of liability "in excess of the limits of liability of the applicable underlying insurance policy or policies all as stated in the declarations of this policy."[62] Additionally, the AIC policy stated that "it is a condition of this policy that the insurance afforded under this policy shall apply only after all underlying insurance has been exhausted."[63] Both policies identified all of the quota share participating insurers in their respective schedules of underling insurance.[64] The insurers argued that the plain language of the policies preclude drop down coverage, and the court agreed.

Next, Honeywell argued that the Superior Court failed to understand that "applicable" underlying policies means only those policies that are not yet exhausted. Honeywell maintained that an exhausted quota share policy was not "applicable" and therefore the Aetna policy should drop down to fill the gap of coverage.[65] The court rejected this argument because the term "applicable" when read within the context of the policy as a

57. A quota share layer of coverage is where several insurers agree to a percentage of the total risk (the limit of liability for the layer) and issue separate policies for that percentage risk.

58. *Honeywell*, 2016 WL 3903530, at *18.

59. *Id.*

60. Cont'l Ins. Co. v. Honeywell Int'l, Inc., 2016 WL 3903530, at *18 (N.J. Super. Ct. App. Div. July 20, 2016).

61. *Id.*

62. *Id.*

63. *Id.*

64. *Id.* at *19.

65. Cont'l Ins. Co. v. Honeywell Int'l, Inc., 2016 WL 3903530, at *19 (N.J. Super. Ct. App. Div. July 20, 2016).

whole referred not to applicable policies, but applicable policy limits of liabilities of all the underlying policies identified in the policy's schedule.[66] The court determined that the policy language was unambiguous and noted that several other jurisdictions had reached the same conclusion.[67]

Honeywell's final argument was that New Jersey public policy and the principles underlying New Jersey law are inconsistent with the policies and therefore the court should not enforce the policies as written.[68] The court first responded that enforcing the plain meaning of the policies was consistent with New Jersey law, which proscribes enforcing unambiguous policy provisions and ascribing the "plain and ordinary meaning" to the policy language.[69] Next, the court concluded that its ruling was not contrary to *Owens-Illinois v. United Insurance Co.*[70] and its progeny, where insureds are often required to participate in costs and indemnity payments in the shoes of insolvent insurers.

In a notable Tenth Circuit decision, the court evaluated whether excess policies had an obligation to drop down where the underlying policies were issued by an insolvent insurer. In *Canal Insurance Co. v. Montello, Inc.*,[71] Montello faced numerous claims arising out of its distribution of asbestos-containing drilling products from 1966 to 1985.[72] Montello purchased primary insurance from Home Insurance Co. from March 1975 to March 1984. Home failed to pay any claims on Montello's behalf before it was declared insolvent in 2003.[73] Canal Insurance Co. and Houston General Insurance Co. (collectively, the insurers) issued umbrella policies above Home's policies and, upon Home's insolvency, filed suit seeking a declaration that they had no present duty to defend or indemnify Montello in connection with its asbestos liabilities.[74] Montello counterclaimed seeking a declaration of present coverage and breach of contract.[75] The U.S. District Court for the Northern District of Oklahoma ruled that the insurers had no obligation to drop down and had not breached their contracts. Montello appealed.[76]

Montello asserted several arguments against Canal, which applied equally to the policy issued by Houston.[77] First, Montello focused on

66. *Id.*
67. *Id.*
68. *Id.* at *20.
69. *Id.*
70. 650 A.2d 974 (N.J. 1994).
71. 632 F. App'x 448 (10th Cir. 2015).
72. *Id.* at 449.
73. *Id.* at 450.
74. *Id.*
75. *Id.*
76. Canal Ins. Co. v. Montello, Inc., 632 F. App'x 448, 450 (10th Cir. 2015).
77. *Id.* at 455.

the Canal policy language that indemnified Montello for "all sums which the insured shall become legally obligated to pay as damages and expenses, all as hereinafter defined as included within the term ultimate net loss."[78] It argued that Home's insolvency caused it to incur defense costs and it may become legally obligated to pay damages.[79] The Tenth Circuit looked to the complete policy language, which provided coverage for damages as a result of an "occurrence," defined as "an accident, which takes place during the policy period . . . which causes personal injury, property damage or advertising injury."[80] The Tenth Circuit affirmed the district court's ruling that Home's insolvency did not qualify as an occurrence under the policies.[81]

Next, Montello argued that because of Home's insolvency, there were no "applicable" underlying limits to exhaust before the Canal policy was triggered and no policy language that prevented Canal from dropping down. Therefore, the insolvency must trigger the excess insurers' drop down obligation.[82] The Tenth Circuit did not find this argument persuasive and further noted that courts have refused to require an insurer to drop down even when there was no contract language expressly prohibiting it.[83]

Montello also argued that Canal's policy provided coverage for claims that were not covered by the underlying primary policy and because Home was not providing coverage, Canal's umbrella coverage had a present defense and indemnity obligation.[84] The Tenth Circuit also dismissed this argument, finding that the asbestos liabilities qualified as covered occurrences under Home's policy, thus rendering the umbrella coverage inapplicable.[85] The court affirmed the district court's ruling that there was no basis to require the Canal policy to drop down and provide coverage to Montello.

C. *Defense Costs*

The year also saw cases continuing to evaluate whether and when an excess or umbrella policy is obligated to provide defense coverage. In *Canal Insurance*,[86] even though the Tenth Circuit ruled that the excess policies did not drop down to cover the insolvent Home policy layer, Montello

78. *Id.* at 451.
79. *Id.* at 452.
80. *Id.*
81. 632 F. App'x 448, 452 (10th Cir. 2015).
82. *Id.* at 453.
83. *Id.*
84. *Id.*
85. *Id.*
86. Canal Ins. Co. v. Montello, 632 F. App'x 448 (10th Cir. 2015).

still argued that the policies provided defense coverage under a defense coverage endorsement,[87] which provided defense coverage if there was a covered claim and "no underlying insurer obligated to defend."[88] Montello argued Home was not obligated to defend because Home had no such obligation after the New Hampshire court canceled its contracts, thus triggering the policy's defense obligation.[89] The Tenth Circuit relied on the reasoning in *Harville v. Twin City Fire Insurance Co.*,[90] which focused on the fact that excess insurance policies provide additional coverage at a reasonable price because the cost of the duty to defend is born by the primary insurer.[91] Additionally, excess policies generally only provide defense coverage when a loss is outside the scope of the primary policy's coverage, not because the primary became insolvent.[92] For these reasons, the Tenth Circuit affirmed the district court's ruling that the insolvency of Home does not trigger the excess policies' defense coverage endorsement.

The New Jersey Superior Court, Appellate Division also addressed a claim for defense costs under certain excess insurance policies, including those issued by St. Paul Fire & Marine Insurance Co. and AIC in *Honeywell International*.[93] The St. Paul policies agreed to indemnify Honeywell against "loss," defined to exclude "all expenses and costs," which were further defined as legal expenses.[94] Nevertheless, Honeywell sought St. Paul's participation in its defense of asbestos claims, arguing that the condition in the policies that allowed St. Paul to participate in the Honeywell's defense "create[d] a 'mutual consent' obligation and St. Paul [could not] unreasonably withhold consent without violating its implied duty of good faith. . . ."[95] That condition provided that St. Paul "at its own option, may, but [was] not required to, participate in the investigation, settlement or defense of any claim or suit."[96] In addition, if it elected to participate, St. Paul would pay costs and expenses in an amount proportionate to the amount its indemnity payment was to the entire loss.[97]

The Appellate Division found no need to read implied covenants into the St. Paul policies because the express policy language provided St. Paul

87. *Id.* at 454.
88. *Id.*
89. *Id.* at 455.
90. 885 F.2d 276, 279 (5th Cir. 1989).
91. *Id.* at 454.
92. *Id.* at 455.
93. *See* Cont'l Cas. Co. v. Honeywell Int'l, Inc., 2016 WL 3903530 (N.J. Super. Ct. App. Div. July 20, 2016).
94. *Id.* at *13.
95. *Id.* at *14.
96. *Id.*
97. *Id.* at *13.

with the unilateral option to participate in Honeywell's defense.[98] The plain reading of the language negated a finding of any "mutual consent" obligation. Moreover, to the extent that the condition addressed mutual consent, it referred to the managing of defense costs, investigations, and settlements of claims and suits where St. Paul had exercised its option to participate.[99] St. Paul did not exercise that option here.

Honeywell next argued that the St. Paul policies followed the form of the primary policies and the language in the primary policies included a defense obligation.[100] The Appellate Division quickly dispensed with this argument, noting that the St. Paul policies followed the primary insurance "except as herein stated" and the St. Paul policies specifically excluded defense costs.[101] The Appellate Division affirmed that St. Paul owed Honeywell no present defense obligation.

Honeywell also appealed a summary judgment ruling that AIC owed no defense obligation under certain excess policies. AIC's policies agreed to indemnify Honeywell for its ultimate net loss, which did not include defense costs.[102] The policies also contained a condition that permitted AIC to consent to the payment of defense costs and to share the expenses proportionately to each party's share of the loss as it bore on the total amount of the loss.[103] Honeywell argued that AIC had a defense obligation based on its course of conduct and their settlement agreements, in which AIC agreed to pay defense costs as long as they eroded the policy limits.[104] The Appellate Division found that there was no course of conduct of consenting to the payments of defense costs because the settlement agreements acknowledged the parties' dispute whether the payment of defense costs eroded the policy limits.[105] Moreover, because the policies' limits of liability were reduced only by the payment of ultimate net loss, which does not include defense costs, AIC had no obligation to pay defense costs.

D. *Equitable Subrogation and Unjust Enrichment*

The U.S. District Court for the Northern District of California and the Ninth Circuit both addressed issues of first impression under California law concerning an excess insurer's ability to recoup payments from primary insurers. In *St. Paul Fire & Marine Insurance Co. v. Insurance Co. of*

98. Cont'l Cas. Co. v. Honeywell Int'l, Inc., 2016 WL 3903530, at *14 (N.J. Super. Ct. App. Div. July 20, 2016).
99. *Id.*
100. *Id.* at *15.
101. *Id.*
102. *Id.* at *16.
103. *Id.*
104. *Id.* at *17.
105. *Id.*

Pennsylvania,[106] four insurers funded a construction defect settlement under a reservation of rights and one of the excess insurers, Insurance Co. of the State of Pennsylvania (ICSOP), sought reimbursement from the primary insurers, St. Paul Fire & Marine Insurance Co. and Travelers Property Casualty Co. of America (collectively, Travelers) and Zurich American Insurance Co. Travelers filed a declaratory judgment and ICSOP counterclaimed, asserting three causes of action against each primary insurer, including equitable subrogation and unjust enrichment.[107]

Zurich filed a motion to dismiss the unjust enrichment claim arguing that (1) California permits excess insurers to assert equitable subrogation claims only against primary insurers, (2) unjust enrichment claims must fail because primary insurers do not owe a direct duty to excess insurers, and (3) unjust enrichment is not a viable claim under California law.[108] The court quickly dismissed Zurich's second and third arguments because California permits reimbursement for unjust enrichment in insurance cases[109] and an unjust enrichment claim is not dependent on the existence of a direct duty owed by a primary to an excess insurer.[110] In addressing Zurich's first argument, the court recognized that there was no California precedent directly on point.

Zurich relied on several cases for the proposition that the sole recourse for an excess insurer against a primary insurer is equitable subrogation.[111] In *Commercial Union Assurance Co. v. Safeway Stores, Inc.*,[112] the California Supreme Court found that an excess insurer could bring an equitable subrogation claim for breach of the primary insurer's duty of good faith and fair dealing.[113] In this circumstance, the excess insurer stands in the shoes of the insured and asserts through equitable subrogation the insured's claim against the primary insurer for breach of the duty of good faith.[114] The California Court of Appeal in *Fireman's Fund Insurance Co. v. Maryland Casualty Co.*[115] further held that an excess insurer can only bring a breach of the implied duty of good faith and fair dealing through equitable subrogation.[116]

106. 2016 WL 1191808 (N.D. Cal. Mar. 28, 2016).
107. *Id.* at *2.
108. *Id.* at *4.
109. *Id. See* Hartford Cas. Ins. Co. v. J.R. Mktg., L.L.C., 190 Cal. Rptr. 3d 599, 607–08 (2015) (recognizing unjust enrichment claims in the insurance context).
110. *ICSOP*, 2016 WL 1191808, at *4.
111. St. Paul Fire & Marine Ins. Co. v. Ins. Co. of Pa., 2016 WL 1191808, at *4 (N.D. Cal. Mar. 28, 2016).
112. 26 Cal. 3d 912 (1980).
113. *ICSOP*, 2016 WL 1191808, at *5.
114. *Id.*
115. 26 Cal. Rptr. 2d 762 (1994) (*Fireman's Fund I*).
116. St. Paul Fire & Marine Ins. Co. v. Ins. Co. of Pa., 2016 WL 1191808, at *5 (N.D. Cal. Mar. 28, 2016).

ICSOP countered that these decisions merely stand for the proposition that "the only *contract law* claim that may be brought by an excess insurer against a primary insurer is a claim for equitable subrogation."[117] Here, ICSOP's unjust enrichment claims were not dependent on any actual or implied contractual duties.[118] Instead, ICSOP relied on two federal decisions allowing excess insurers to bring equitable indemnity claims and arguing that the unjust enrichment claim is analogous.[119] The district court agreed with Zurich that the equitable indemnity cases were not on point, but found them instructive because equitable indemnity is itself based on unjust enrichment principles.[120]

ICSOP relied on *Continental Casualty Co. v. St. Paul Surplus Lines Insurance Co.*[121] and *Lexington Insurance Co. v. Sentry Select Insurance Co.*,[122] which held that excess insurers could bring equitable indemnity claims against primary insurers,[123] as compared to equitable contribution claims, which are restricted to insurers on the same level of the risk and the same insured.[124] Both district courts agreed that there was no case law preventing an insurer from bringing an equitable indemnity claim, "which requires only that one insurer pay a liability that another insurer should have discharged."[125] They also agreed that equitable indemnity was a restitution-based claim, similar to unjust enrichment. Drawing analogies from these decisions, the district court denied Zurich's motion to dismiss the unjust enrichment claims, finding no California law prohibited such a claim and that there was precedent for restitutionary claims in insurance cases.[126]

The Ninth Circuit in *RSUI Indemnity Co. v. Discover P & C Insurance Co.* addressed whether an excess insurer could pursue an equitable subrogation claim against a primary insurer where the primary insurer had previously rejected a policy limits settlement offer and the parties entered into a settlement that exceeded the primary policy's limits.[127] Discovery P & C had successfully dismissed the equitable subrogation claim on

117. *Id.*
118. *Id.*
119. *Id.*
120. *Id.* at *6.
121. No. 2:07-CV-01744, 2014 WL 4661087 (E.D. Cal. Sept. 17, 2014).
122. No. CV F 08-1539, 2009 WL 1586938 (E.D. Cal. June 5, 2009).
123. St. Paul Fire & Marine Ins. Co. v. Ins. Co. of Pa., 2016 WL 1191808, at *6–7 (N.D. Cal. Mar. 28, 2016).
124. In California, an excess insurer cannot bring an equitable contribution claim against a primary insurer. *See* Fireman's Fund Ins. Co. v. Commerce & Indus. Ins. Co., No. C-98-1060, 2000 WL 1721080 (N.D. Cal. Nov. 7, 2000).
125. *ICSOP*, 2016 WL 1191808, at *7.
126. *Id.* at *4 (citing Hartford Cas. Ins. Co. v. J.R. Mktg., L.L.C., 190 Cal. Rptr. 3d 599, 607–08 (2015).
127. 649 F. App'x 534 (9th Cir. 2016).

grounds that California law required an excess judgment, not a settlement, as the predicate, and RSUI appealed. The Ninth Circuit analyzed several appellate decisions to reach its conclusion.

First, the Ninth Circuit reviewed *Hamilton v. Maryland Casualty Co.*,[128] in which the California Supreme Court required a litigated excess judgment for an assignee of the insured to pursue a claim for a breach of the duty to settle. The court imposed the litigated judgment requirement to counter the risk of a collusive settlement between the insured and the claimant where the insured enters a stipulated judgment in excess of the insurance limits, the claimant executes a covenant not to execute against the insured, and the insured assigns its breach of contract claim against the insurer to the claimant.[129] Next, the court noted that in *Isaacson v. California Insurance Guarantee Ass'n*,[130] the California Supreme Court allowed an insured to pursue a claim against its insurer for a breach of the duty to settle where the parties entered into a settlement in excess of the policy limits and the insured funded part of the settlement.[131] The insured's contribution to the settlement amount negated the possibility of collusion.

The Ninth Circuit also identified two intermediate appellate decisions more directly on point. In *Fortman v. Safeco Insurance Co.*,[132] the California Court of Appeal allowed an excess insurer to pursue an equitable subrogation claim without requiring an excess judgment. The appellate court in *RLI Insurance Co. v. CNA Casualty of California*,[133] however, expressly rejected *Fortman*.[134] Faced with contradictory intermediate appellate decisions on point, the Ninth Circuit determined that the California Supreme Court was most likely to follow the rule established in *Fortman*.[135] The critical distinction for the court was that the excess insurer in *Fortman* contributed to a settlement where the primary insurer unreasonably refused to settle a claim within its policy limits. In *RLI Insurance*, by contrast, the court focused on *Hamilton* and its concern about collusion to deny the excess insurer's claim without regard to the excess insurer's participation in the settlement. Reversing and remanding the case to the district court, the Ninth Circuit concluded that the California Supreme Court would likely not require an excess judgment before an excess insurer pursues an equitable subrogation claim against a primary insurer where the excess insurer contributed to the settlement.

128. 41 P.3d 128 (Cal. 2002).
129. *RSUI Indem. Co.*, 649 F. App'x 534.
130. 750 P.2d 297, 308–09 (Cal. 1988).
131. *RSUI Indem. Co.*, 649 F. App'x at 535.
132. 271 Cal. Rptr. 117 (1990).
133. 45 Cal. Rptr. 3d 667 (2006).
134. RSUI Indem. Co. v. Discover P & C Ins. Co., 649 F. App'x 534, 536 (9th Cir. 2016).
135. *Id.*

II. REINSURANCE

A. *Discoverability of Reinsurance Information*

This survey period saw several courts address whether reinsurance communications and information are discoverable.

In a coverage dispute in North Carolina, a federal court ordered an insurer to produce communications regarding reinsurance.[136] There, the policyholder requested that the insurer produce all communications it had with any reinsurer or regulatory agency regarding the underlying claim.[137] In response, the insurer moved for a protective order.[138] The insurer argued that the reinsurance communications were not relevant to the issue of whether the policyholder was entitled to coverage, nor likely to lead to the discovery of admissible evidence, because there were no allegations that the insurer was insolvent or otherwise incapable of satisfying a judgment or settlement.[139] The court stated that the insurer's interpretation of discovery was "too limited."[140] The court added that the "timing and content of the communications" could lead to the discovery of admissible evidence regarding the insurer's handling and investigation of the underlying claim, which may bear on the policyholder's bad faith claim.[141]

A federal court in Nevada came to the opposite conclusion.[142] There, the policyholder sought communications between the insurer and its reinsurer and, after the insurer refused to produce the communications on the grounds that they were protected by the attorney-client privilege and/or work-product doctrine, moved to compel production.[143] The insurer claimed that sharing of information with its reinsurer did not waive any privilege protection because of the common interest doctrine.[144] The policyholder did not contest that issue. Rather, the policyholder claimed that the insurer failed to show the communications were "for the purpose of obtaining or providing legal services."[145] The court disagreed. The court noted that the requested e-mails discussed the liability lawsuit, coverage issues, reserves, and budget from outside counsel

136. PCS Phosphate Co v. Am. Home Assur. Co., 2015 WL 8490976 (E.D.N.C. Dec. 10, 2015).
137. *Id.* at *3.
138. *Id.*
139. *Id.*
140. *Id.*
141. *Id. PCS Phosphate* was decided under the version of Rule 26 of the Federal Rules of Civil Procedure in effect prior to the 2015 amendments.
142. Ooida Risk Retention Grp., Inc. v. Bordeaux, 2016 WL 427066 (D. Nev. Feb. 3, 2016).
143. *Id.* at *9.
144. *Id.*
145. *Id.* at *10.

and, thus, were privileged.[146] However, the insurer was ordered to produce a communication it failed to list on its privilege log.[147]

Similarly, a New York federal court denied a policyholder's request for reinsurance communications.[148] The policyholder argued in its motion to compel that the communications were relevant to identify policies and policy terms.[149] The insurer argued that the policyholder did not provide any basis for its assertion that policy terms were difficult to locate or that the reinsurance evidence would assist with that search.[150] The court agreed with the insurer, denied the motion, and stated that the policyholder "offered no explanation" for its alleged need of the reinsurance information in order to identify policies or policy terms.[151] The court also refused to consider an argument raised by the policyholder for the first time during oral argument: that the reinsurance information would be relevant to the issue of notice or to the interpretation of the policy.[152]

That same court, however, ordered the insurers to produce reinsurance contracts as part of their initial disclosures under Rule 26.[153] The insurers argued that the terms "reinsurance" and "insurance" are not interchangeable, that reinsurance does not affect an insurer's ability to pay a judgment, and that producing the agreements would be unduly burdensome.[154] However, the court stated that "the plain language and policy of Rule 26(a)(1)(A)(iv) [of the Federal Rules of Civil Procedure] support the conclusion that reinsurance agreements fall within its contours."[155] The court also rejected the burden argument.[156] Thus, it ordered the insurer to produce its reinsurance agreements, but limited the production to those agreements related to policies for which the policyholder was seeking damages, with excess policies attaching at amounts excess of the claims at issue not having to produce the discovery.[157] The court reasoned that limiting the production in that way was consistent with Rule 26's focus on the satisfaction of judgments.[158]

146. *Id.*
147. *Id.*
148. Certain Underwriters at Lloyd's v. Amtrak, 2016 WL 2858815 (E.D.N.Y. May 16, 2016).
149. *Id.* at *4.
150. *Id.*
151. *Id.*
152. *Id.*
153. Certain Underwriters at Lloyd's v. Amtrak, 2016 WL 2858815, at *14 (E.D.N.Y. May 16, 2016).
154. *Id.*
155. *Id.* at *16.
156. *Id.* at *17.
157. *Id.* at *18.
158. *Id.*

Finally, in another case before a New York federal court, the court denied a reinsurer's request to obtain material from a cedent's auditor.[159] The reinsurer claimed that it was entitled to the auditor's work in connection with a billing dispute.[160] The cedent argued that the auditor's work was protected work-product and, hence, not discoverable.[161] The reinsurer counter-argued that there was no evidence that counsel was involved in the retention of the auditor and, thus, the information was discoverable.[162] Based on evidence that the auditor was hired because of the prospect of litigation, the court held that the auditor's work was work-product.[163] Further, the court held that the reinsurer did not establish a "substantial need" for the auditor's work because the reinsurer was provided with the same source data that was provided to the auditor.[164] Accordingly, the reinsurer's motion to compel was denied.[165]

B. *Follow the Fortunes/Follow the Settlements*

This survey period saw several courts address the follow the fortunes/follow the settlements doctrines.

A New York federal court granted a cedent's motion for summary judgment on the grounds that the follow the settlements doctrine barred the reinsurer from contesting the cedent's allocation of underlying settlements.[166] The dispute involved billings under certain reinsurance agreements covering policies issued between 1978 and 1981 to a seller, distributor, and manufacturer of pump products.[167] The cedent alleged that the reinsurer breached its contract by not paying unpaid billings arising out of numerous underlying asbestos cases.[168] The reinsurer alleged that it was not liable for any of the costs the cedent incurred in the underlying cases and sought reimbursement of amounts paid under the cedent's first billing.[169] In its motion for summary judgment, the cedent argued that the reinsurer was bound by its settlements in the underlying cases under the follow the settlements doctrine.[170] The reinsurer argued that

159. Amtrust N. Am., Inc. v. Safebuilt Ins. Servs., 2016 WL 3260370 (S.D.N.Y. June 10, 2016).
160. *Id.* at *3–4.
161. *Id.*
162. *Id.*
163. *Id.* at *4.
164. *Id.* at *5.
165. *Id.*
166. Utica Mut. Ins. Co. v. Clearwater Ins. Co., 2016 U.S. Dist. LEXIS 6219 (N.D.N.Y. Jan. 20, 2016).
167. *Id.* at *2.
168. *Id.* at *8
169. *Id.*
170. *Id.* at *10.

the doctrine did not apply because the cedent "settled unreasonably or in bad faith."[171] It asserted that the settlements were in bad faith because the cedent allegedly "intentionally shifted liability from its primary policies, which did not have reinsurance coverage, to its umbrella policies, which had such coverage" and, therefore, put its own interest ahead of the reinsurers.[172] The court found that the reinsurer produced no evidence that the settlement allocations were made in bad faith and stated that a cedent is not obligated to strictly align its interests with the reinsurers.[173] On the other hand, the court found that the cedent produced evidence that its settlement decisions were reasonable.[174] Accordingly, the court held that the follow the settlements doctrine applied and ruled in favor of the cedent.[175]

In contrast, the New York Supreme Court denied a cedent's summary judgment motion, which argued that its allocation of insurance proceeds to various underlying claims was protected by the follow the settlements doctrine.[176] There, the court found that defendant was not collaterally estopped on the issue based upon two prior cases involving it.[177] Thus, it focused on the language of the facultative certificate at issue.[178] The certificate stated that the reinsurer's liability "shall follow [the cedent's] liability in accordance with the terms and conditions of the policy reinsured hereunder."[179] The cedent argued that the clause was a follow the settlements clause, whereas the reinsurer argued that the clause was a following form clause.[180] The court held that the clause was a following form clause.[181] It stated that "one would expect follow the settlement clauses to 'employ language referring in some way to the cedent's claims handling decisions,' such as the use of the terms 'settlement,' 'compromise,' 'payment,' 'allowance' or 'adjustment.'"[182] Thus, the reinsurer was allowed to challenge the cedent's allocation of insurance proceeds to the underlying claims on a theory that the losses allocated to the certificate were "ac-

171. *Id.*
172. *Id.* at *11.
173. *Id.* at *12.
174. *Id.* at *14.
175. *Id.* at *16.
176. Granite State Ins. Co. v. Clearwater Ins. Co., 2016 N.Y. Misc. LEXIS 2314 (N.Y. Sup. Ct. June 17, 2016).
177. *Id.* at *25.
178. *Id.*
179. *Id.*
180. *Id.*
181. Granite State Ins. Co. v. Clearwater Ins. Co., 2016 N.Y. Misc. LEXIS 2314, at *26 (N.Y. Sup. Ct. June 17, 2016).
182. *Id.* (quoting N.H. Ins. Co. v. Clearwater Ins. Co., 129 A.D.3d 99, 111 (N.Y. App. Div. 2015).

tually covered" by the certificate.[183] The propriety of the allocations was a question of fact to be resolved at trial.[184]

Finally, another New York federal court held that the follow the fortunes doctrine did not bar a third-party complaint against a claims administrator.[185] There, an insurer sued two individuals who allegedly were alter egos of reinsurance companies and who fraudulently induced the insurer to engage in a complicated reinsurance program that ultimately failed.[186] In turn, the individual defendants filed a third-party complaint against the claims administrator alleging that, inter alia, the claims administrator negligently performed its duties and breached a contract that called for it to perform administrative services for various insurance policies that were part of the reinsurance program.[187] The claims administrator filed a motion to dismiss the third-party complaint, in part on the grounds that it was barred by the follow the fortunes doctrine.[188] The claims administrator argued that the follow the fortunes doctrine applied by virtue of the individual defendants' alleged "control" of the reinsurance companies and that the defendants had no standing to assert claims because "that would be tantamount to second-guessing good faith determinations" made by the cedents.[189] The court disagreed, stating that the follow the fortunes doctrine did not apply because the reinsurance companies that were allegedly "controlled" were not parties to the case and that the individual defendants did not come within the ambit of the follow the fortunes doctrine.[190] Ultimately, however, the court dismissed the third-party complaint on other grounds.[191]

C. *Challenges to Arbitrator Disclosures, Conduct, or Qualifications in Reinsurance Arbitrations*

This survey period saw multiple courts address challenges to arbitrator disclosures, arbitrator conduct, or arbitrator qualifications in reinsurance arbitrations.

A New York federal court granted a reinsurer's petition to confirm a number of arbitration awards and rejected the cedent's argument that the arbitration umpire was biased in favor of the reinsurer.[192] The case

183. *Id.* at *27.
184. *Id.*
185. Amtrust N. Am., Inc. v. Safebuilt Ins. Servs., 2015 U.S. Dist. LEXIS 147628 (S.D.N.Y. Oct. 28, 2015).
186. *Id.* at *3–5.
187. *Id.* at *7–9.
188. *Id.* at *10.
189. *Id.*
190. *Id.* at *11–12.
191. *Id.*
192. Nat'l Indem. Co. v. IRB Brasil Resseguros S.A., 164 F. Supp. 3d 457 (S.D.N.Y. 2016).

stemmed from a series of arbitrations over a seven-year period between the cedent and reinsurer relating to the reinsurer's alleged obligation to reinsure losses suffered by a Brazilian company in Brazil.[193] The arbitration panel, which included two party-appointed arbitrators and the umpire, issued three awards in the reinsurer's favor in 2015.[194] When the reinsurer petitioned to confirm the arbitration awards, the cedent cross-petitioned to vacate the awards. The cedent argued that the umpire's untimely disclosure of his role as party-arbitrator on behalf of an alleged affiliate of the reinsurer, concurrent service as both umpire and party-arbitrator for the reinsurer's affiliate in another arbitration, and his refusal to withdraw as umpire constituted "evident partiality" under the Federal Arbitration Act.[195]

Ultimately, the court disagreed that the standard of partiality was not met.[196] The court first noted that a district court's review of an arbitration award is narrow and that arbitration panel determinations are "accorded great deference" under the Federal Arbitration Act.[197] Next, the court explained that the umpire's disclosure of the appointment on behalf of the reinsurer's affiliate was not untimely, noting that his initial disclosure in 2009 was accurate and his supplemental disclosure came two days after learning of his 2012 selection as umpire.[198] Finally, the court held that the umpire's concurrent assignments and non-withdrawal did not demonstrate partiality.[199] In doing so, the court found that "it cannot be that selection and payment for a person's services as party-arbitrator or umpire, without more, produces a material or commercial financial relationship sufficient to constitute disqualifying partiality."[200] Likewise, the court also found that "payment as an arbitrator in a past matter is . . . insufficient to produce a conflict in a later matter," particularly since "specialized arbitrators are likely to know one another, and repeated or overlapping service by the same arbitrators in different arbitrations is bound to occur."[201] Finally, the court noted that there was "no evidence" that the umpire "even knew which party nominated him as an umpire candidate" prior to the cedent's accusations of bias.[202] Thus, the court concluded

193. *Id.* at 460.
194. *Id.*
195. *Id.* at 474, 478.
196. *Id.* at 484.
197. Nat'l Indem. Co. v. IRB Brasil Resseguros S.A., 164 F. Supp. 3d 457, 474 (S.D.N.Y. 2016) (quoting Tempo Shain Corp. v. Bertek, Inc., 120 F.3d 16, 19 (2d Cir. 1997)).
198. *Id.* at 477.
199. *Id.* at 478–84.
200. *Id.* at 479–80 (internal quotation marks omitted).
201. *Id.* at 480.
202. *Id.* at 483.

that the concurrent assignments "do not approach the standard of partiality that a reasonable person would have to conclude that [the umpire] was partial to" the reinsurer.[203]

On the other hand, the Sixth Circuit held that an arbitrator's ex parte communications with outside counsel, which violated the terms of the parties' arbitration agreement, was grounds for vacating an arbitration award.[204] The arbitration, commenced in 2011, involved a reinsurance dispute regarding billings under a treaty covering the cedent's workers compensation insurance programs.[205] Pursuant to two scheduling orders issued by the arbitration panel, ex parte communications with members of the panel were to cease with the filing of the parties' initial pre-hearing briefs.[206] Neither order specified when or whether ex parte communications could resume.[207] Following the submission of the parties' pre-hearing briefs and an arbitration hearing, the arbitration panel issued an "interim final award" in favor of the reinsurer.[208] The day the interim award was issued, counsel for the reinsurer and the reinsurer's party-arbitrator communicated ex parte about the arbitration.[209] After the cedent filed a supplemental brief disputing certain aspects of the interim award, counsel for the reinsurer and the reinsurer's party-arbitrator spoke two more times as the panel considered the ceding company's brief.[210] The arbitration panel, without consulting with the cedent's arbitrator (who was out of the country), ultimately issued two orders, striking both the cedent's supplemental brief and its motion for clarification of the interim award.[211]

About one year later, following various in-court disputes, the arbitration panel issued its final award, granting the reinsurer significant relief.[212] The cedent moved to vacate the award and the reinsurer moved to confirm it.[213] The federal district court confirmed it.[214] Following an appeal, the Sixth Circuit reversed, ruling that the arbitrator's ex parte contacts with the reinsurer's counsel "voided both" the interim and final awards.[215] Applying

203. *Id.* at 484.
204. Star Ins. Co. v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA, 2016 U.S. App. LEXIS 15306 (6th Cir. Aug. 18, 2016).
205. *Id.* at *4–5.
206. *Id.* at *8.
207. *Id.*
208. *Id.* at *12.
209. Star Ins. Co. v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA, 2016 U.S. App. LEXIS 15306, at *13 (6th Cir. Aug. 18, 2016).
210. *Id.* at *13–19.
211. *Id.* at *18–19.
212. *Id.* at *25–26.
213. *Id.* at *28.
214. *Id.* at *29–30.
215. *Id.* at *32.

Michigan Court Rule 3.602(J), the appellate court held that "ex parte communications between a party and an arbitrator void an arbitration award if those communications violate the parties' arbitration agreement" under Michigan law.[216] The appellate court also held that the prejudicial effect of the ex parte communications was "irrelevant" to the analysis.[217] Thus, because the court found the ex parte contacts between the reinsurer's counsel and the reinsurer's arbitrator "clearly violated both scheduling orders," it ruled that both the interim and final awards must be vacated.[218]

Another federal court in Massachusetts declined to intervene in a reinsurance arbitration to remove the reinsurer's party-appointed arbitrator, despite the cedent's claim that the arbitrator did not meet the qualifications under the arbitration agreement.[219] The parties' arbitration agreement required that arbitrators be officers of life insurance or reinsurance companies "excluding . . . officers of the two parties . . . their affiliates or subsidiaries or past employees of any of these entities."[220] After the reinsurer named its party-arbitrator, the cedent filed a motion in federal court to remove the arbitrator on the basis that he did not meet the arbitration agreement's qualifications because he was a former employee of an affiliate of the ceding company.[221] The reinsurer disagreed, asserting that the arbitrator ceased working for the company before it became affiliated with the cedent and that the company was in fact no longer affiliated with the cedent.[222] Ultimately, the court held that it did not have jurisdiction to remove an arbitrator prior to the arbitration award, even where a party challenges the arbitrator's qualifications under the arbitration agreement.[223] In the court's view, "neither [the] statutory language [of the Federal Arbitration Act] nor policy supports pre-award judicial intervention" to resolve a challenge to an arbitrator's qualifications under an arbitration agreement.[224] Thus, because any such challenge would have to wait until after the conclusion of the arbitration, the court directed the parties to arbitration.[225]

216. *Id.* at *35.
217. *Id.* at *43.
218. *Id.* at *38.
219. John Hancock Life Ins. Co. (U.S.A.) v. Emp'rs Reassurance Corp., 2016 U.S. Dist. LEXIS 80592 (D. Mass. June 21, 2016).
220. *Id.* at *3.
221. *Id.* at *5.
222. *Id.* at *5–6.
223. *Id.* at *22.
224. *Id.* at *18.
225. *Id.* at *22.