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EDITORIAL POLICY — ARIAS • U.S. welcomes manuscripts of original articles, book reviews, comments, and case notes from our members dealing with current and emerging issues in the field of insurance and reinsurance arbitration and dispute resolution. All contributions must be double-spaced electronic files in Microsoft Word or rich text format, with all references and footnotes numbered consecutively. The text supplied must contain all editorial revisions. Please include a brief biographical statement and a portrait style photograph in electronic form. The page limit for submissions is 5 single-spaced or 10 double-spaced pages. In the case of authors wishing to submit more lengthy articles, the Quarterly may require either a summary or an abridged version, which will be published in our hardcopy edition, with the entire article available online. Alternatively, the Quarterly may elect to publish as much of the article as can be contained in 5 printed pages, in which case the entire article will also be available on line. Manuscripts should be submitted as email attachments. Material accepted for publication becomes the property of ARIAS • U.S. No compensation is paid for published articles. Opinions and views expressed by the authors are not those of ARIAS•U.S., its Board of Directors, or its Editorial Board, nor should publication be deemed an endorsement of any views or positions contained therein.

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While it might be just a little bit late now, I still want to welcome all of you to the new decade. The 2020s will bring new challenges and new opportunities for ARIAS•U.S. and its members. The *Quarterly* is ready to embrace these challenges and opportunities with insightful and thoughtful articles from you, our members.

In our first *Quarterly* of the new decade, we have some terrific articles that I hope you will find interesting and useful. Our lead article is a deep analytical dive into the 2013 decision by the New York Court of Appeals in *United States Fidelity & Guaranty Co. v. American Re-Insurance Co.* You may recall that this case formulated an "objective reasonableness" test for a cedent's post-settlement allocation decisions.

The authors of this article, Jason Eson and Crystal Monahan from Rubin, Fiorella, Friedman & Mercante, LLP, review the cases since *USF&G* to determine whether the courts are even using the "objective reasonableness" test. "Assessing *USF&G's* Objective Reasonableness Standard" is a must-read for outside and in-house counsel involved in allocation decisions or in allocation disputes.

This year will also likely bring about more activity because of the growing regulatory trend supporting insurance business transfers. To explain why these new regulations and statutes provide for more flexibility for legacy business deals, Luann Petrellis, a runoff and restructuring professional, has written an article, "U.S. Regulation Is Generating More Flexibility for Legacy Deals," that provides historical and runoff industry perspectives on these

new rules and procedures. Luann also explains how these regulations potentially will change the landscape of runoff this decade.

We also are happy to have an article by Peter A. Halprin of Pasich LLP, who explains how umpire challenges will work under the new ARIAS•U.S. Panel Rules for the Resolution of Insurance and Contract Disputes, which took effect in September 2019. The article, "Umpire Challenges under the New ARIAS•U.S. Panel Rules for the Resolution of Insurance and Contract Disputes," helps us understand the purpose of the challenge procedure in policyholder and other direct arbitrations and why it may encourage insureds to use ARIAS arbitration for their policy disputes. Those of you interested in direct arbitrations should read this article.

Finally, I have taken my presentation materials from the 2019 Fall Conference breakout session and turned them into an article about social media for arbitrators. "Arbitrators and Social Media: Do They Mix?" discusses how and whether arbitrators should use social media. It also provides a step-by-step guide to using LinkedIn for business marketing purposes and briefly discusses other social media platforms. I hope you find it useful.

Although it is mentioned elsewhere in this issue of the *Quarterly*, I want to acknowledge that Ann Field, a past ARIAS Board member and still very active in ARIAS as chair of the Women's Networking Committee (recently renamed the Women's Resource Committee), was profiled as a 2019 "Notable Woman in Reinsurance" by Porter Wright's Women in Reinsurance.

As you read this issue of the *Quarterly*, our Spring Conference is just around the corner. If you are on a Spring Conference panel, please turn your hard work into an article like I did. If you lead an ARIAS committee, please write about what your committee is doing. If you've written a blog post or client alert, please turn it into an article for the *Quarterly*. We welcome your submissions for 2020.

Larry P. Schiffer
Editor

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Assessing *USF&G's* 'Objective Reasonableness' Standard

By Jason Eson and Crystal Monahan

It has been seven years since the New York Court of Appeals handed down *United States Fidelity & Guaranty Co. v. American Re-Insurance Co.*, 985 N.E.2d 876 (N.Y. 2013), a decision ("*USF&G*") that many industry insiders believed would be a watershed opinion. As we enter a new decade, it seems appropriate to look back at one of the reinsurance industry's most talked about and scrutinized cases of the 2010s.

In announcing the "objective reasonableness" test to the reinsurance world, it seems reasonably clear that New York's highest court was attempting to simplify and standardize judicial review of the often-complex reinsurance allocation process. It is hard to disagree with such a practical, sensible goal. So far, however, we are no closer to the Court of Appeals' apparent objective.

Even compared to other judicially formulated tests, "objective reasonableness" seems to be a vague standard. And, to date, other courts have been hesitant to apply it. In fact, no subsequent court has issued an opinion applying *USF&G* and squarely addressing whether the allocation at bar was objectively reasonable. As discussed below, the New York Court of Appeals has given the reinsurance industry a standard that is so open-ended that it can arguably be satisfied by unsupported claims of objectivity, thus permitting the analysis to become completely disassociated from the facts of the disputed allocation. We submit that this is not what the court intended to provide.

The *USF&G* Decision

In *USF&G,* the reinsurers challenged the cedent's allocation decisions in a number of respects. The case came before the New York Court of Appeals on the reinsurers' appeal from an Appellate Division order affirming

the trial court's granting of summary judgment in favor of the cedent (*USF&G*). While other courts had considered the "reasonableness" of a cedent's allocation decisions, *USF&G* is only the second time that the Court of Appeals had analyzed an allocation in a reinsurance matter.[1]

After reviewing and mostly agreeing with prevailing federal law in the Second and Third Circuits, the *USF&G* court took the opportunity to articulate its own "objective reasonableness" standard for assessing the propriety of a post-settlement allocation. According to the Court of Appeals, the "objective reasonableness" standard boils down to whether the allocation is "one that the parties to the settlement of the underlying insurance claims might reasonably have arrived at in arm's length negotiations if the reinsurance did not exist." 985 N.E.2d at 882-83.

In the litigation between USF&G and its reinsurers, the reinsurers challenged USF&G's decision to allocate all of the settlement to claims covered by reinsurance and nothing to the bad-faith claims, which were not covered by reinsurance. USF&G and its insured, asbestos distributor MacArthur, had been engaged in a hard-fought coverage litigation that proceeded to trial but ultimately was settled before a jury verdict. In its discussion of this challenge to USF&G's allocation, the court focused on the very real possibility of a jury verdict on MacArthur's bad-faith claims—specifically, USF&G's failure to defend the underlying asbestos claims asserted against MacArthur. Moreover, the court took interest in the fact that, immediately before the settlement, MacArthur's counsel made a demand that apportioned a sizeable percentage of the overall settlement amount to the bad-faith claims. Considering these and other facts, the court reversed the Appellate Division and denied summary judgment to USF&G, finding that it was "impossible to conclude, as a matter of law, that parties bargaining at arm's length, in a situation where reinsurance was absent, could reasonably have given no value to the bad-faith claims." *Id*. at 883-86.

The reinsurers also challenged USF&G's decision to assign a $200,000 value to each of the lung cancer claims asserted by claimants against USF&G.[2] Pointing out that $200,000 exceeded the insured's settlement demand for lung cancer claims, the court concluded that an inference could be drawn that other claims (asbestosis, pleural thickening and other cancers) falling below the $100,000 retention amount were undervalued so that lung cancer claims could be given a higher value. The court therefore found the existence of a triable issue of fact and remanded to the lower court on this issue. *Id*. at 885.

Finally, the reinsurers challenged USF&G's decision to allocate all of the losses encompassed in the settlement to a single insurance policy, instead of spreading the loss over the policy block. If the claims had been pro-rated over the many triggered policy years, few if any of the losses would have exceeded the $100,000 retention. On this point, the court disagreed with the reinsurers' challenge and affirmed summary judgment in USF&G's favor. According to the court, because the asbestos claimants could have chosen any one of the policies to cover the loss under California law (the all sums approach), there was no evidence "from which a factfinder could infer that this aspect of USF&G's allocation was unreasonable." *Id*. at 887-88.

Accordingly, the court remanded the case for trial on the reasonableness of the first two aspects of the allocation challenged by the reinsurers. The parties settled prior to a verdict.

Cases Applying the 'Objective Reasonableness' Standard

Since the *USF&G* decision, New York state and federal courts have cited and relied on the "objective reasonableness" standard for discovery and summary judgment motions. Further, although juries have recently confronted allocation issues under the *USF&G* paradigm, no judge has ruled that a cedent or reinsurer is entitled to judgment based on its own application of the objective reasonableness standard. Thus, the better part of a decade has passed without any judicial decision issued in which the nuances of objective reasonableness are explored head-on and applied to another allocation. Some cases, however, have shed light on the procedural ramifications of *USF&G*.

1. Scope of discovery. *USF&G* and the cases in its wake have broadened the scope of discovery and expanded the scope of inquiry, giving the reinsurer license to explore whether a cedent's pre-settlement conduct sheds light on the unreasonableness of its post-settlement allocation decisions. This can be viewed as a significant victory for reinsurers because, prior to *USF&G,* cases such as *North River Insurance Co. v. ACE American Reinsurance Co.*, 361 F.3d 134 (2d Cir. 2004), arguably prohibited a reinsurer from scrutinizing a cedent's pre-settlement conduct.

In *North River*, the cedent recognized during the course of a coverage dispute with its insured that its higher-layer excess insurance policies were exposed and may have to pay. The parties subsequently settled their dispute. The cedent allocated the settlement to the layer of insurance policies reinsured by ACE, but did not allocate to the higher-layer excess insurance policies. ACE contended that "in deciding to settle, North River considered the risk of loss in layers above ACE, and that as a result, ACE is not liable for the portion of the settlement paid to release risks attributable to upper layers." *Id*. at 142. The Second Circuit rejected ACE's attempt to scrutinize North River's pre-settlement conduct, stating, "An insurer may engage in all manner of analyses to inform its decision as to whether, and at what amount, to settle, but those analyses are irrelevant to the contractual obligation of the reinsurer to indemnify the reinsured for loss under the reinsurance policy."[3] *Id*. at 142-43.

The court's analysis in *USF&G*, however, does not accord the same degree of deference to a cedent as the *North River* court did. By thoroughly reviewing and analyzing USF&G's conduct and representations leading up to its allocation, the Court of Appeals has implicitly confirmed that, at least in New York, reinsurers have the right to discovery regarding a cedent's pre-settlement and pre-allocation conduct.

The scope of discovery permitted under *USF&G* was addressed in a colorful opinion in the case of *Travelers Indemnity Co. v. Excalibur Reinsurance Corp.*, 2013 U.S. Dist. LEXIS 50134 (D. Conn. Apr. 8, 2013) (applying New York law). Just weeks after the *USF&G* decision was handed down, a Connecticut federal district court provided a comprehensive overview of the dynamics of the allocation process in that case, ruling that the reinsurer was entitled to discovery that would permit it to properly challenge the reasonableness of the cedent's post-settlement allocation decision.

Specifically, the reinsurer challenged the cedent's allocation of claims settlement amounts to the second of the four policy years during which Excalibur was the reinsurer, rather than to the first policy year, when Excalibur was not a reinsurer. *Id*. at *12. Excalibur argued that because it reinsured claims-made policies, a claim triggering coverage in year one would not trigger coverage in the following policy years, which Excalibur reinsured.[4] *Id*. at 24. While it granted Excalibur's motion to compel, the court was quick to point out that it was not ruling on the merits, stating "[t]his Ruling does no more than to decide that Excalibur is entitled to discovery on the facts relevant to the issues." *Id*. at *30.

The reinsurer in L*exington Insurance Co. v. Sirius American Insurance Co.* also successfully relied on *USF&G* to gain access to additional discovery, which the cedent had attempted to shield based on the follow-the-settlements provision in the reinsurance certificates. 2014 N.Y. Misc. LEXIS 4138, at *25 (N.Y. Sup. Ct. Sept. 15, 2014) ("Under these [follow–the-settlement] doctrines, Sirius is entitled to discovery regarding [the cedents'] settlement and allocation decisions, to the extent that it has not already been provided.")

2. Dispositive motions. It logically follows that broadening the scope of discovery and expanding the scope of inquiry into a cedent's pre-settlement conduct has also made it more difficult for courts to rule as a matter of law that a cedent's allocation is objectively reasonable. A reinsurer is more likely to have access to sufficient discovery to establish that there are triable issues of fact.

For instance, although discovery was in its infancy in *New Hampshire Insurance Co. v. Clearwater Insurance Co.*, 2013 N.Y. Misc. LEXIS 5117, *14-15 (N.Y. Sup. Ct. Oct. 31, 2013), Clearwater's relatively slight submission in opposition to New Hampshire's motion for summary judgment was nonetheless sufficient to create a triable issue of fact on whether the cedent's allocation was proper. To support its opposition, Clearwater argued that AIG member companies (including New Hampshire) unreasonably assigned the entire settlement amount to asbestos products claims reinsured by Clearwater and nothing to premises claims and defense costs under policies issued by other AIG carriers not reinsured by Clearwater. In particular, Clearwater submitted a New Hampshire "request for authority" memorandum that reflected New Hampshire's recognition that a global AIG settlement would eliminate non-products exposure through operations and/or premises claims and payment under "certain" policies of defense costs in addition to policy limits. *Id*. In denying New Hampshire's summary judgment motion, the court held that the "settlement agreement, giving the AIG member companies carte blanche to allocate the gross settlement amount, coupled with the memorandum requesting authority to-settle, are evidence from which a factfinder could conclude that the

allocation of the settlement to Clearwater was unreasonable."[5] *Id.* at *16.

Voluminous document production also played a significant role in thwarting efforts by cedent Utica Mutual Insurance Company ("Utica") to obtain summary judgment against its umbrella policy reinsurer in *Utica Mutual Insurance Co. v. Century Indemnity Co.*, 2018 U.S. Dist. LEXIS 165110 (N.D.N.Y. Sept. 26, 2018). In that case, the court denied Utica's summary judgment motion that its allocation was objectively reasonable because Century presented evidence suggesting that Utica acted in bad faith by "inflate[ing] its reinsurance recovery by billing its reinsurer under a different set of rules than it had agreed to with its policyholder [Goulds]." *Id.* at *17. Century also contended that Utica granted Goulds an additional $140 million in coverage in exchange for Goulds's agreement that the primary policies issued to Goulds contained aggregate limits, but unreasonably allocated that payment to the reinsured umbrella policies. The court concluded that "neither party has established, as a matter of law, the propriety (or impropriety) of the allocation decisions at issue here,"[6] although it also noted that a reinsurer challenging an allocation will ultimately bear a heavy burden. *Id.* at *19.

3. Trial. While a reinsurer may point to *USF&G* as a victory in broadening the scope of discovery and thwarting a cedent's efforts to obtain summary judgment, the decision has also made trying an allocation dispute an even more challenging proposition for a reinsurer—especially where a jury is the trier of fact.

The *Utica v. Century* action discussed above proceeded to a jury trial in late 2019. The reasonableness of Utica's allocation was among many issues addressed at trial. At the close of trial, the jury instructions included a recitation of the "objective reasonableness" standard from *USF&G*.[7] The jury charges, however, were posed as very general questions not expressly related to allocation, e.g.,:

- Did plaintiff Utica Mutual Insurance Company prove by a preponderance of the evidence that Century Indemnity Company failed to do what it was obligated to do under the 1973 Certificate?
- Did defendant Century Indemnity Company prove by a preponderance of the evidence that plaintiff Utica Mutual Insurance Company failed to act with utmost good faith in settling with Goulds or in billing Century Indemnity Company after its settlement with Goulds?[8]

The jury returned a verdict for Utica after only brief deliberations. Following the verdict, Century renewed its motion for judgment as a matter of law on the basis that Utica's allocation was objectively unreasonable or, in the alternative, requested a new trial. A post-trial motion for judgment as a matter of law is subject to the same demanding standard applied to a summary judgment motion;[9] that is, now with an even more expansive trial record, Century had to complete a "Hail Mary pass" to sustain its burden.

> "A reinsurer is more likely to have access to sufficient discovery to establish that there are triable issues of fact."

The court denied Century's motion and, in the process, rejected Century's contention that Utica's allocation was unreasonable as a matter of law because Utica billed Century inconsistently with the terms of the settlement agreement entered between Utica and its insured. First, the judge rejected Century's characterization of the trial record. Pointing to the extensive trial record, the court ruled that "there is plenty of trial testimony from Utica witnesses establishing that Utica's conduct remained reasonably consistent, if not exactly perfect, before, during, and after its settlement with Goulds."[10]

Second, the court rejected Century's argument that, pursuant to the holding in *USF&G*, an inconsistent allocation was per se unreasonable. In its order, amidst a fairly lengthy and straightforward recounting of *USF&G*, the court made the surprising observation that the *USF&G* decision "recognizes that

the follow-the-settlements doctrine sweeps broadly enough to permit the resolution of most reinsurance disputes at summary judgment while acknowledging that some edge cases will still require a trial." *Id*. at *33. Not only is this reading of *USF&G* unsupported empirically by decisions resolving allocation disputes as a matter of law,[11] it is arguably contradicted by the court's own earlier acknowledgement that motions for a judgment must, as a matter of law, "measure up" to a "demanding standard." And while the court characterized the Utica-Century case as an "edge" case warranting a jury trial, the unsupported observation tends to reveal a biased (pro-cedent) reading of *USF&G* and portends the difficulties a reinsurer may have convincing a judge presiding over a bench trial that a cedent's allocation was unreasonable as a matter of fact.

4. Other tribunals. While *USF&G* has clearly influenced the landscape of New York state and federal jurisprudence, courts outside the state have yet to cite or rely on the decision as part of an allocation analysis.[12] We will have to wait until the 2020s before learning whether a court in another jurisdiction decides to apply the "objective reasonableness" standard to an allocation.

For the (mostly) confidential world of arbitration, it is obviously difficult to assess whether (and the extent to which) panels have relied on or been influenced by *USF&G* and the "objective reasonableness" standard in its analysis of a disputed allocation. At least one panel appears to have applied the standard, however. In the process of addressing whether the alleged impartiality of an umpire warranted vacatur of an arbitration award, the court in *National Indemnity. Co. v. IRB Brasil Resseguros S.A.*, 164 F.Supp.3d 457 (S.D.N.Y. 2016) revealed a portion of the panel's award, including a conclusion concerning an allocation issue: "After thoroughly reviewing the record, the Panel by majority concluded that [retrocedent] IRB failed to carry its (minimal) burden of demonstrating by a preponderance of the evidence that is allocation was objectively reasonable." *Id*. at 471.

Issues Facing a Reinsurer Attempting to Show an Allocation is Unreasonable

There are a number of issues confronting a reinsurer attempting to demonstrate that the cedent's allocation was objectively unreasonable. While neither the cedent nor the reinsurer can predict how a court may apply the standard to unique facts, reinsurers are particularly at a disadvantage for the following reasons.

As a threshold matter, a reinsurer is tasked with convincing a court that *USF&G's* "objective reasonableness" standard does not subsume or replace a follow-the-settlement analysis—rather, it is derivative and secondary. Although *USF&G* focused on an allocation, it occurred in the context of a settlement and does not reject, modify or even implicitly cast doubt on existing authorities regarding the follow-the-settlement standard. An allocation is subject to analysis after a court first determines that the settlement was reasonable and entered into in good faith. Thus, if the settlement is not reasonable, then the allocation must be rejected as well.

In addition, a cedent may argue that the "objective reasonableness" test stands alone and urge a court to apply the standard to an allocation flowing from a simple coverage determination, perhaps in an attempt to avoid an examination of its good faith. The facts of *USF&G* do not support this argument. In addition, at least one federal district court has acknowledged that "objective reasonableness" is linked to follow-the-settlements. Such authority should pose a barrier to a cedent's attempt to expand "objective reasonableness" to an allocation outside the context of a settlement. See, e.g., *Utica Mutual Ins. Co. v. Munich Reinsurance Am., Inc.*, 2018 U.S. Dist. LEXIS 106970, *2, fn. 4 (N.D.N.Y. June 27, 2018)("The follow-the-settlements doctrine binds the reinsurer ... to the cedent's reasonable post-settlement allocation decisions")(citing *USF&G*).

Other, more practical issues confront a reinsurer. First, there is an apparent inconsistency in the way in which motive and/or intent is incorporated into the "objective reasonableness" analysis. Under a pro-cedent view of *USF&G*, a reinsurer either would be prohibited or severely restricted in its ability to examine the cedent's motives for settling and allocating (e.g., allegations that the cedent targeted reinsurance proceeds). This difficulty arises from the *USF&G* court's finding that a "cedent's motive should generally be unimportant." 985 N.E.2d at 883 (emphasis supplied).

While arguing that motive and/or subjective intent is irrelevant to establishing lack of reasonableness, the cedent is not likewise restricted from turning around and using its own alleged pre-settlement intent as evidence that its allocation was reasonable. For example, a cedent would not be restrict-

ed from arguing that a reinsurer must follow its alleged interpretation of its underlying policies at issue, regardless of whether that interpretation is consistent with industry practice or law.

Second, although cedents would argue that the reinsurer is restricted in examining the cedent's pre-settlement motive, the "objective reasonableness" test does not seem to likewise prohibit the cedent from manufacturing evidence after the allocation has been made to support its conduct. *USF&G* clearly permits the cedent to choose the allocation most favorable to it, so long as the allocation was one the cedent and insured "might reasonably have arrived at in arm's length negotiations if the reinsurance did not exist."

One does not even have to maintain a cynical outlook on allocation dynamics to be skeptical of a cedent's post-allocation representations that of course it would have settled and allocated the same way even if reinsurance did not exist. In another Utica litigation involving a different reinsurer but before the same judge, the court credited exactly this type of self-serving testimony from a Utica claims attorney, who asserted that "she would not have done anything differently even if there were no reinsurance coverage…" *Utica Mutual Ins. Co. v. Fireman's Fund Ins. Co.*, 287 F. Supp. 3d 163, 171 (N.D.N.Y. 2018).[13]

Similarly, the standard incentivizes the cedent to retain an expert to testify at trial concerning allocation dynamics, using industry-speak such as "whipsawing" and opining that the allocation selected was not only reasonable but the most reasonable among the options (including hypothetical and speculative ones) available to the cedent. Essentially, the cedent retains a hired gun to bless its allocation, thereby arguably invading the province of the fact finder. Such testimony may not be very damaging during a bench trial before a discerning judge, but it may be extremely prejudicial in a jury trial.

Finally, *USF&G* follows other jurisdictions in holding that "[c]edents are not the fiduciaries of reinsurers and are not required to put the interests of reinsurers ahead of their own." 985 N.E.2d at 882. Although this holding does not directly address utmost good faith, it implicitly incorporates into the decision the existing industry uncertainty regarding the parameters of that doctrine.[14] Aggressive cedents will continue to use this as a license to attempt to gut or even eliminate the bad-faith exception to follow-the-settlements. Combined with *USF&G's* guidance to tread very carefully when scrutinizing the cedent's intent and motives, the cedent can build an ironclad defense to the bad-faith exception.[15]

Confronted with these issues, reinsurers must be proactive in arguing the more pro-reinsurer aspects of the *USF&G* decision. As noted at the beginning of this subsection, a reinsurer must convincingly assert that *USF&G* contemplates a two-step analysis: first of the settlement and, if that is reasonable, then of the allocation. The *USF&G* decision does not restrict the reinsurer's ability to raise limitations to follow-the-settlements (e.g., that the cedent settled in bad faith). So, even if the decision arguably permits a cedent to allocate damages to the detriment of the reinsurer, the issue of utmost good faith is not written out of the equation because it is (as it has been) addressed in the context of a challenge to the settlement.[16] In other words, a reinsurer may separately challenge the settlement and the allocation and argue that the cedent must (still) demonstrate that its settlement was reasonable and made in good faith before the court even considers whether the allocation flowing from the settlement was objectively reasonable.

There are other strategic considerations. For example, reinsurers should be sure to obtain as much evidence as possible concerning the cedent's pre-settlement conduct. Specifically, reinsurers need to be able to demonstrate how the cedent's conduct affected the allocation and increased the reinsurance billings.

Moreover, the reinsurer must give great consideration and care to retaining the right expert to counteract and rebut the cedent's allocation expert. A cedent may attempt to use its expert to draw legal conclusions about the merits of the allocation—for example, that it was objectively reasonable. Armed with additional discovery concerning the cedent's conduct and pre-settlement motivations, reinsurer's counsel can effectively cross-examine the cedent's expert and use its own expert to highlight any evidence that the cedent's allocation decisions were driven by the maximization of reinsurance recovery.

Possible Limits on 'Reasonableness'

Notwithstanding the amorphous nature of the "objective reasonableness" standard, and even if the bad-faith exception is curtailed, some clear limitations or red flags may still be identified and/or predicted, based on pre-existing authorities and comments by the Court of Appeals within the *USF&G* decision.

First, as discussed above, a reinsurer's successful challenge to the propriety of a settlement should pre-empt any consideration of the subsequent allocation. The reinsurer in *USF&G* was not challenging USF&G's decision to settle or the amount of the settlement. 985 N.E.2d at 881. Thus, the court's decision is necessarily based upon the assumption that the settlement was valid. A dispute over the validity of a settlement—on grounds of bad faith, ex gratia payments, fraud or collusion—would supersede any analysis of the validity of a subsequent allocation. Only if the settlement itself was valid would the post-settlement allocation need to be evaluated under the "objective reasonableness" standard.

Second, an allocation that assigns to a reinsurer amounts that are not covered by the reinsurance contract is unreasonable. Although the *USF&G* court was ruling in the context of a summary judgment motion, that court had previously held that a reinsurer is only required to pay amounts covered by the reinsurance contract in the context of a post-settlement allocation. See *Travelers Cas. & Sur. Co. v. Lloyd's of London, 760 N.E.*2d 319, 328-29 (N.Y. 2001). The *USF&G* court cites favorably to its prior decision, stating that the holding of *Travelers* "is consistent" with its position that a cedent's allocation decisions are not "immune from scrutiny." 985 N.E.2d at 882.

Third, an allocation that is inconsistent with the law of the case is likely not objectively reasonable. The New York Appellate Division First Department held in 2007 that an allocation that did not follow a prior judgment regarding the number of occurrences was unreasonable. See *Allstate Ins. Co. v. Am. Home Assur. Co.*, 43 A.D.3d 113, 122 (1st Dep't 2007), leave to appeal den. 890 N.E.2d 246 (2008). *USF&G* does not directly address the issue of whether a prior judgment directly affecting the allocation must be followed. The decision, however, does indicate that orders of other courts—and the cedent's representations to a court—could be considered in analyzing whether an allocation is objectively reasonable. 985 N.E.2d at 885-86.

Fourth, an allocation that is inconsistent with the demands and compromises of the settlement negotiations may not be objectively reasonable. As discussed above, some courts have been reluctant, under the guise of deference to a cedent's decisions, to review settlement negotiations in the context of a challenge to an allocation. The *USF&G* court, however, was not deferential in its review. It carefully analyzed the settlement negotiations between *USF&G* and its insured, including the specific terms of demands and when the settlement was reached. 985 N.E.2d at 885-86. In part, this lack of deference may be attributed to the fact that the court's task was to identify material disputes of fact, not to make findings of fact. However, the fact that the allocation was inconsistent with the demands was sufficient to create a question of fact—which also means that such inconsistencies could be used to demonstrate that an allocation is not objectively reasonable.

Conclusion

USF&G provided a vague standard for assessing whether a post-settlement allocation must be followed by a reinsurer. The parameters of this standard have not yet been thoroughly analyzed or discussed by subsequent courts in the context of specific facts. In *USF&G*, the Court of Appeals confirmed that, if a settlement is reasonable, deference to post-settlement allocations applies in New York, as it does elsewhere. The court also made clear that, although deference may ultimately be given, reinsurers and judges are, nevertheless, entitled to carefully scrutinize the cedent's conduct.

The court, however, gave only a minimal explanation of what "objective reasonableness" means: "The reinsured's allocation must be one that the parties to the settlement of the underlying insurance claims might reasonably have arrived at in arm's length negotiations if the reinsurance did not exist." Furthermore, it offered no guidance as to how that standard might practically be applied. This lack of guidance creates both benefits and difficulties for reinsurers. Taking advantage of the benefits and minimizing the difficulties will require diligence throughout the litigation or arbitration of disputes.

Finally, although the "objective reasonableness" standard is vague, some clarity can be gained by harmonizing it with other cases. We have identified some pre-*USF&G* decisions that, when viewed through the "objective reasonableness" filter, provide at least some indications of what objectively unreasonable conduct should be.

NOTES

1. The first time was in 2001, in *Travelers Casualty & Surety Co. v. Certain Underwriters at Lloyd's of London ("Travelers v. Lloyds")*, 760 N.E.2d 319 (N.Y. 2001). In *Travelers*, the Court of Appeals found in favor of the reinsurer based on the meaning of the reinsurance contract language, and also held that follow-the-settlements would not be applied to override the reinsurance contract language.

2. Pursuant to the treaty, the reinsurers agreed to pay to USF&G the amount over the $100,000 retention, to be capped at $100,000 per loss. By assigning a $200,000 value to the lung cancer claims, USF&G maximized its reinsurance recovery for each lung cancer claim. 985 N.E.2d at 885.

3. The Second Circuit, in *Travelers Casualty & Surety Co. v. Gerling Global Reinsurance Corp. of America,* further limited the scope of reinsurer scrutiny by refusing to examine a cedent's post-settlement allocation if "the settlement itself was in good faith, reasonable, and within the terms of the policies." 419 F.3d 181, 189 (2d Cir. 2005). The court stated, "[W]ere we to undertake such an analysis, we would be engaging in precisely the kind of 'intrusive factual inquiry' that the follow-the-fortunes doctrine is meant to avoid." Id. (citing *North River*, 361 F.3d at 141).

4. The reinsured claims-made policies provided that "this Policy is limited to indemnity for only those CLAIMS THAT ARE FIRST MADE AGAINST THE INSURED DURING THE POLICY PERIOD." (emphasis in original). 2013 U.S. Dist. LEXIS 50134 at *24.

5. The New York Appellate Division affirmed the denial of New Hampshire's motion for summary judgment. See New *Hampshire Ins. Co. v. Clearwater Ins. Co.*, 129 A.D.3d 99, 114-115 (N.Y. App. Div. 2015).

6 The court also denied Century's cross-motion for partial summary judgment on the basis of Utica's unreasonable allocation.

7. *Utica Mut. Ins. Co. v. Century Indem. Co.*, 2019 U.S. Dist. LEXIS 207547, *33-34 (N.D.N.Y. Dec. 3, 2019).

8. 6:13-cv-0995 (DNH/ATB), Dkt. 628.

9. As the court noted, Century's post-trial motion "may only be granted if there exists such a complete absence of evidence supporting the verdict that the jury's finding could only have been the result of sheer surmise and conjecture, or the evidence in favor of the movant is so overwhelming that reasonable and fair minded [persons] could not arrive at a verdict against [it]." *Utica v. Century*, 2019 U.S. Dist. at *19 (citing to Fed. R. Civ. P. 56).

10. *Utica Mut. Ins. Co. v. Century Indem. Co.,* 2019 U.S. Dist. LEXIS 207547 at *20-22.

11. In fact, both before and after *USF&G,* courts have routinely denied summary judgment to cedents on the propriety of their allocations. The post-*USF&G* denials of summary judgment in the New Hampshire and Utica v. Century cases are discussed above. Pre-*USF&G* denials of summary judgment include: *Emp'r Reinsurance Corp. v. Laurier Indem. Co.*, Case No. 03-cv-1650-T-17MSS, 2007 U.S. Dist. LEXIS 45670, at *11-12 (M.D. Fla. June 25, 2007) (adopting magistrate judge's order denying cedent's motion for summary judgment on allocation); *Affiliated FM Ins. Co. v. Emp'rs Reinsurance Corp.,* CA 02-419S, 2004 U.S. Dist. LEXIS 27961, at *37-46 (D. R.I. Sept. 3, 2004) (denying cedent's motion for summary judgment because defendant had demonstrated a question of material fact as to whether a substantial portion of the settlement paid by the plaintiff and billed to the reinsurer was attributable to an unreinsured loss); and *Hartford Acc. & Indem. Co. v. Columbia Cas. Co.*, 98 F. Supp. 2d 251, 259 (D. Conn. 2000) ("Columbia has demonstrated the existence of a material factual dispute as to whether Columbia is bound by the 'follow the settlements' provision in light of the inferences of unreasonableness or self-service which could be drawn from Hartford's allocation …").

12. The United States District Court for the District of Connecticut applied New York law in *Travelers v. Excalibur*.

13. Similar to the procedural posture in the Utica-Century case, Utica obtained a jury verdict in its favor, prompting Fireman's to renew its motion for judgment as a matter of law. The jury charges, similar to those in Utica-Century, were posed as very general questions not expressly related to allocation. Nonetheless, the court ruled that "[a]lthough there was not a specific jury question asking such, by answering in the affirmative that Utica did what it was obligated to do under those policies, the jury made an implicit finding that Utica's settlement decisions regarding the Goulds settlement were objectively reasonable, or stated another way, that FFIC did not prove that Utica's settlement decisions were objectively unreasonable." 287 F. Supp. 3d at 169. It bears noting that the court appears to be applying "objective reasonableness" beyond its intended scope (i.e., allocation) to include the cedent's "settlement decisions."

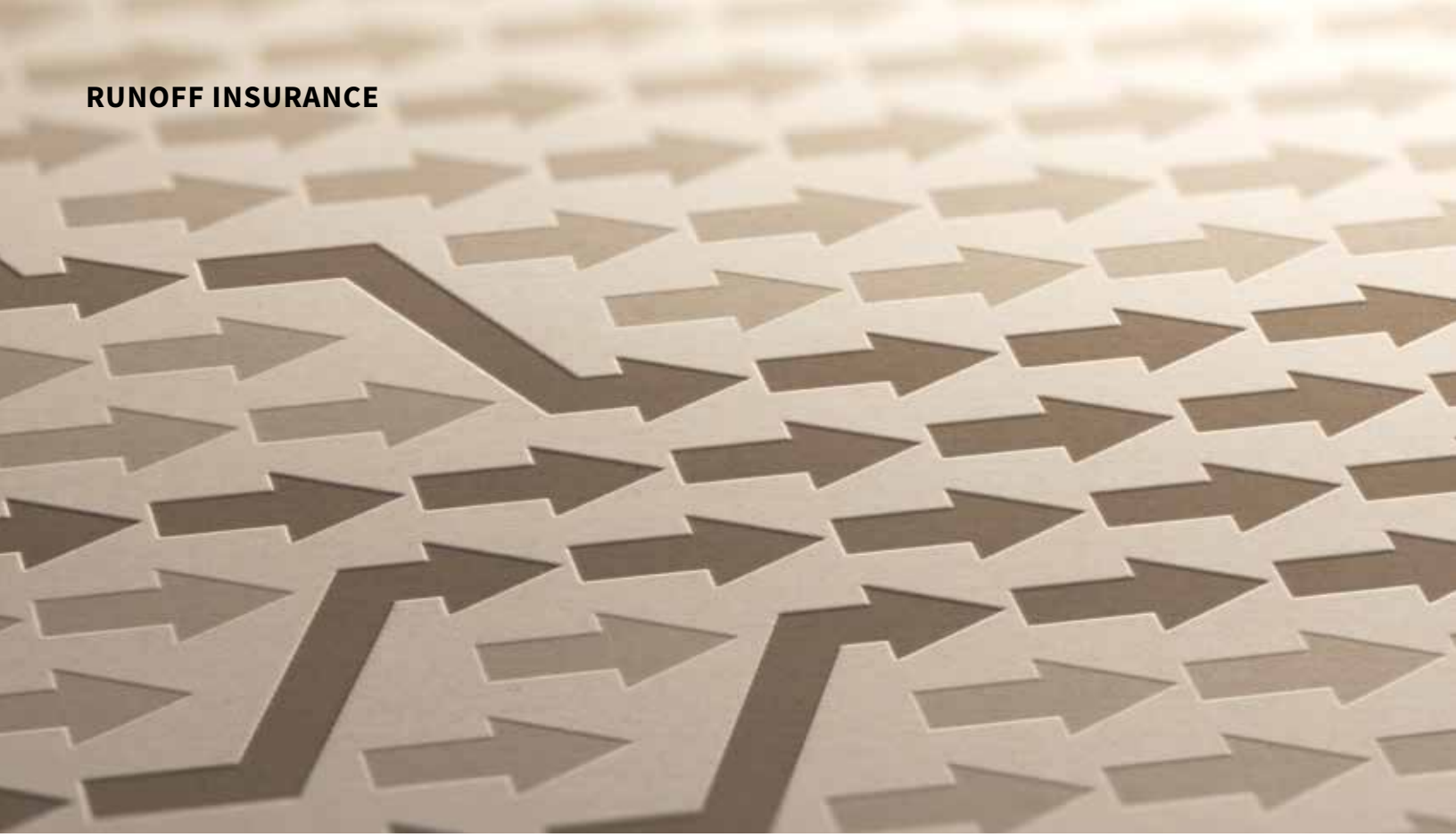
14. Hall, Robert M. 2014. "Utmost Good Faith in the Reinsurance Relationship." *Reinsurance*, 6(10): 4.

15. At least one court, however, has not permitted the *USF&G* finding to bleed into and weaken the duty of utmost good faith owed by the cedent to the reinsurer. See *Granite State Ins. Co. v. Transatlantic Reins. Co.*, 2013 N.Y. Misc. LEXIS 6142, *20 (N.Y. Sup. Ct. Dec. 23, 2013) ("Despite the fact that, [c]edents are not the fiduciaries of reinsurers, and are not required to put the interests of reinsurers ahead of their own, a cedent must disclose anything material affecting the risk to the reinsurer.") (internal citations omitted). Nonetheless, this reading of *USF&G* is in the underwriting context and does not limit the cedent from taking advantage of the allocation process.

16. The court's statement that "motive should generally be unimportant" may suggest that it does not believe that good faith or utmost good faith should be considered when analyzing an allocation. However, this would be prejudicial to the reinsurer, because it may prevent a court from considering evidence that an allocation was in bad faith, even if the settlement was not.

Jason B. Eson is a partner at Rubin, Fiorella, Friedman & Mercante LLP. Jason attended law school at American University.

Crystal Monahan is a partner at Rubin, Fiorella, Friedman & Mercante LLP. Crystal attended the University of Michigan Law School.



U.S. Regulation Is Generating More Flexibility for Legacy Deals

By Luann Petrellis, Esq.

According to PwC's latest Global Insurance Run-off Survey, the size of the U.S. runoff market is estimated at $348 billion. Respondents to PwC's survey noted that interest in transactions, capital efficiency and potential finality solutions for runoff management in the United States continues to grow. The significant levels of U.S. runoff liability are drawing increasing attention from owners and acquirers of legacy liabilities.

This interest is borne out by the level of deal activity in the United States last year. During 2018, $5 billion of legacy liabilities were transacted, more than the rest of the world put together.

It is rare that run-off business is fully contained within a single subsidiary legal entity. More frequently, the business is intermingled with other core business that the company does not wish to dispose of. If only there was a way of carving out a specific subset of liabilities for disposal!

Fortunately, the regulatory tools that enable such carve-outs have arrived. As a result, more and more (re)insurers are now considering how restructuring tools could benefit their businesses, from a carve-out transaction in which a seller divests part of its business to consolidating related business written across the group into a single entity.

There are other companies looking to build market share by acquiring and consolidating active and legacy businesses within their existing operations. The seller typically benefits from exiting non-strategic or unprofitable lines, while the acquirer can increase scale, diversification or geographic reach.

Two recent U.S. regulatory developments, in particular, have moved the landscape forward:

IMAGE CREDIT: OLIVIER LE MOAL/GETTY IMAGES

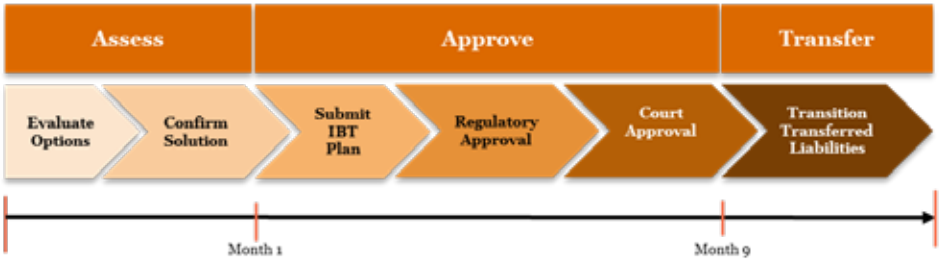
- The enabling of insurance business transfers (IBTs) in Oklahoma; and
- Division legislation in Connecticut, Illinois, Iowa, Georgia and Michigan.

These restructuring mechanisms build on pioneering developments in Rhode Island and Vermont and have the potential to simplify and expedite the separation of core from non-core business lines, thereby encouraging restructuring transactions.

The Insurance Business Transfer (IBT)

The Oklahoma IBT closely follows the format and processes of the U.K.'s much-used "Part VII" transfer. Governed by state legislation and regulatory approval and supervised by the courts, it enables insurance policies of all classes, retail or wholesale, to be novated to an Oklahoma-domiciled insurer from an insurer in any other jurisdiction without the individual consent of policyholders. Sellers can establish an insurer in Oklahoma and transfer non-core business lines to the entity in preparation for a sale, or the buyer can establish an insurer in Oklahoma and receive the non-core business at closing.

Figure 1: The IBT Approval Process Typically Takes Approximately 9 Months



The IBT approval process requires regulatory and judicial review and approval and results in a court-sanctioned novation (without the need for policyholder consent) of the transferred policies, including the attaching reinsurance. The process also requires review by an independent expert who evaluates the impact of the transfer on affected policyholders, both transferred and assumed, to ensure that all policyholders are protected. The IBT brings the transferring company complete finality for the transferred policies and is more cost-effective than traditional novation, which requires consent from each policyholder individually.

Transfers must be planned carefully, with due consideration for implementation actions and the position of the companies after the transfer, to avoid potential pitfalls. The key elements of an IBT are shown in Figure 2. It is important to consider all key areas in the planning process and follow an overall transition approach and structure that enhances potential benefits and meets corporate objectives. With many inter-related work streams, careful project management becomes central to the success of the transfer, not only in terms of meeting important deadlines but also in ensuring that all work streams operate to deliver the required result.

Figure 2: Key Elements of the IBT Process

Key Elements of IBT Process		
	Strategy	• Options review and impact assessment • Understanding of process / requirements
	Design	• Determination of capital structure • Modelling of assets / liabilities
	Project Management	• Detailed project planning • Resources / progress monitoring / reporting
	Tax	• Impact on group / policyholder • Group structuring and tax optimization
	Regulatory	• Capital requirements / extraction • Consultation with regulators
	Policyholder Contact	• Identification / notification • Promotion
	Independent Expert	• Selection and briefing • Preparation of support materials
	Legal	• Drafting transfer documentation • Preparation and support for court hearings
	Ongoing Administration	• Migration / rationalization post transfer • Accounting treatment

State Division Legislation

In 2017, Connecticut passed division legislation that allows a domestic insurer to divide into two or more "resulting insurers" and allocate assets and obligations, including insurance policies, to the new companies. Since then, Illinois, Iowa, Georgia and Michigan have passed similar legislation.

Essentially, division legislation is a de-merger, requiring only regulatory approval of the plan of division. It is

> "Transparency, optionality, and speed of execution are critical to maximizing deal value."

Case Studies of U.K. Insurance Business Transfers

Lloyd's of London and Equitas: Finality for Names
A U.K. insurance business transfer was a crucial final component of the reconstruction and renewal plan that saved the Lloyd's of London insurance market in the 1990s from financial peril due to asbestos exposures. In the first stage, all 1992 and prior liabilities, including extensive U.S. asbestos and environmental losses, were reinsured to the newly created vehicle, Equitas. It was not until Berkshire Hathaway became involved and a U.K. IBT legally removed the liabilities from the original names that they at last achieved finality.

A Group Reorganization
One of the largest insurers in the U.K. wanted to rationalize its general insurance business. Over time, it had accumulated 12 insurance entities, each requiring separate governance, report and accounts, and capital. The group used a U.K. IBT to consolidate into a much simpler structure with three entities—one primary entity for general insurance underwriting, an entity for legacy liabilities, and a white-label carrier.

A Sale of Legacy Liabilities
A large U.S. insurer wished to dispose of legacy operations in the U.K., but these operations were split across four different entities, one of which was not even part of the group. Using a U.K. business transfer, it was able to package all the liabilities for sale into a single entity, creating a simpler proposition for a share sale and thereby maximizing value.

An Accelerated Transaction
A large U.K. insurer sought to transfer a portfolio of legacy liabilities, and timing was a primary consideration. The company was able to arrange reinsurance protection from a legacy consolidator, providing the economic transfer in the required time frames. It then followed up with a U.K. business transfer to ensure legal finality, completing the deal and giving the buyer full control.

expected that any new entity created by a division will need to be merged with an entity holding the necessary state licenses or merged into a shell company. The receiving company could be another group company (in the case of an intra-group restructuring), a shell company to be sold, or an existing company owned by a buyer.

The legislation may enable a company to restructure its business and operations into separate insurers, either to promote operational efficiencies or to position for sale to a third party. The legislation applies to any type of business and is not limited to closed blocks. Each resulting insurer is responsible individually for policies and other liabilities allocated to it under the division plan. The plan of division cannot become effective unless it is approved by the chief insurance regulator after reasonable notice and a hearing (if the regulator determines notice and hearing are in the public interest; a hearing is required in some states).

Although division legislation allows a company to segregate its business, it must be combined with a subsequent sale or an IBT to achieve legal finality.

Planning and Organization

Transparency, optionality, and speed of execution are critical to maximizing deal value. The flexibility to execute deals via alternative structures, such as the IBT and division legislation, helps maintain optionality.

Transactions must be structured to ensure policyholders are protected. Regulators will focus on the successor company being adequately capitalized, with appropriate management, governance and oversight.

In the initial stages, regulators can rely on existing statutory and regulatory guidelines to review capital and solvency requirements, with the discretion to require additional capital or reinsurance protections to receive regulatory approval. But as experience with these tools grows, a modus operandi for U.S. transactions will develop, and U.S. regulators may develop additional guidelines for capital and solvency requirements as more transactions are affected and experience is gained. For any transfer of business, state licensing requirements and guarantee fund issues must be considered to ensure regulatory compliance in all states where policies have been issued.

To facilitate speed of execution, executives need to focus simultaneously on multiple priorities, including deal execution, separation planning, and negotiation of transitional service agreements. Leading practices include having a transaction committee that can rapidly make decisions, a project office that guides the planning effort, and the use of external advisors with deep expertise in insurance transactions to support and guide the in-house transaction team.

Conclusion

Following a recent succession of P&C and reinsurance megadeals, many are predicting that insurance industry transactional activity will continue. Multi-line insurers have divested themselves of numerous franchises over the last three to four years, and this trend seems likely to continue.

Legislation emerging in several states can provide more efficient restructuring tools for companies to achieve operational and capital efficiencies as well as legal finality, and will catalyze further activity in this area. However, transactions using these new regulatory tools are complex and depend on many internal and external factors. Working with an experienced adviser to help your organization through the process will pay dividends and ensure success.

RESOURCES

PwC. 2019. Global Insurance Run-Off Survey.

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To obtain your own copy contact BAlbert@demotech.com.

Luann Petrellis is an insurance professional who specializes in developing runoff and restructuring strategies for discontinued (re) insurance businesses.

Umpire Challenges under the New Panel Rules for the Resolution of Insurance and Contract Disputes

By Peter A. Halprin, Esq.

On September 16, 2019, the new ARIAS•U.S. Panel Rules for the Resolution of Insurance and Contract Disputes went into effect (the "Insurance Rules").[1] The impetus behind the Insurance Rules was to create arbitration rules for use in non-reinsurance disputes, including direct insurance disputes and those involving captives.

The Insurance Rules contain a protocol, unique among ARIAS rules, to manage umpire challenges. This article highlights three key aspects of the challenge protocol—the timing of challenges, grounds for challenges, and the potential results of challenges.

Umpires as Neutrals

The starting point for the Insurance Rules is the ARIAS•U.S. Neutral Panel Rules for the Resolution of U.S. Insurance and Reinsurance Disputes (the "Neutral Rules").

Under Article 6.1, the Neutral Rules require that the arbitration panel consist of three neutral arbitrators who qualify under the ARIAS•U.S. Neutral Arbitration Panel Criteria (the

IMAGE CREDIT: PINKOMELET/GETTY IMAGES

> The Insurance Rules contain a protocol, unique among ARIAS rules, to manage umpire challenges.

"Neutral Criteria"). The Neutral Criteria, per Article 6.3, cover the following:

- prior service as a party-appointed arbitrator;
- prior service as an umpire or neutral arbitrator;
- prior expert or consultant service; and
- prior service as counsel for or employment by one of the parties.

If, in the five years prior to the date of nomination, an arbitrator candidate has served in excess of the enumerated threshold amount associated with any area of conflict, the arbitrator shall fail to meet the Neutral Criteria.

Under Rule 6.1 of the Insurance Rules, only the umpire is required to meet the Neutral Criteria. As such, the challenge procedure discussed below is focused on umpires and not party-appointed arbitrators. This approach was designed to limit challenges to those involving the umpire and not waste the parties' time and resources on whether the party-appointed arbitrators have a truly neutral background.

The Timing of Challenges

Under Rule 16.9(a) of the Insurance Rules, challenges must take place within the following parameters:

A Party that intends to challenge the umpire shall send notice of its challenge within fifteen (15) days after it has been notified of the appointment of the umpire, or within fifteen (15) days after the grounds upon which it intends to challenge have become known to that Party, but no later than 90 days after the Organizational Meeting.

Rule 16.9(a) modifies Article 13(1) of the UNCITRAL Arbitration Rules by barring challenges lodged more than 90 days after the organizational meeting. The intent of this modification was to put the onus on parties to promptly investigate the grounds for challenge and to expeditiously lodge complaints. This prevents gamesmanship, for example, on the eve of a hearing.

The Grounds for Challenge

The grounds for challenge are enumerated in Rule 16.9(d), as follows:

If, within fifteen (15) days from the date of the notice of challenge, all Parties do not agree to the challenge or the challenged umpire does not withdraw, the Party making the challenge may elect to pursue it if the challenge is based on: (1) the failure of the umpire to meet the requirements for umpire set forth in the relevant contract(s); (2) the failure of the umpire to meet the Neutral Criteria listed in 6.3(a) – 6.3(d) above; (3) a violation of the standards set forth in Comment 3 to Canon 1 of the ARIAS•U.S. Code of Conduct; or (4) the alleged failure to make adequate disclosures as required by Canon IV of the ARIAS•U.S. Code of Conduct. In that case, within fifteen (15) days of the notice of challenge, the Party making the challenge shall seek a decision on the challenge from a neutral three-member sub-committee made up exclusively of members of the ARIAS Ethics Committee and the Board of Directors (the "Sub-Committee"). The Party seeking such a decision shall do so by notifying the Executive Director, in writing, of its intention to seek a decision on the challenge from the Sub-Committee.

Under Article 12 of the UNCITRAL Arbitration Rules, "any arbitrator may be challenged if circumstances exist which give rise to justifiable doubts as to the arbitrator's impartiality or independence." Here, the grounds for challenging an umpire through the protocol are limited to those enumerated in Rule 16.9(d).

The first two grounds involve the failure of the umpire to meet the requirements set forth in the relevant contract or under the Neutral Criteria. The third ground requires reference to Comment 3 to Canon 1 of the ARIAS•U.S. Code of Conduct. As set forth in Comment 3, "The parties' confidence in the arbitrator's ability to render a just decision is influenced by many factors, which arbitrators must consider prior to their service. There

are certain circumstances where a candidate for appointment as an arbitrator must refuse to serve ..." An example of such a circumstance, per Comment 3(a), is "where the candidate has a material financial interest in a party that could be substantially affected by the outcome of the proceedings."

The fourth ground is the failure to make adequate disclosures as required by Canon IV of the ARIAS•U.S. Code of Conduct. Per Canon IV, "Candidates for appointment as arbitrators should disclose any interest or relationship likely to affect their judgment. Any doubt should be resolved in favor of disclosure." Per Comment 2 to Canon IV, required disclosures include, but are not limited to, relevant positions taken in published works or in expert testimony, the extent of previous appointments as an arbitrator by either party, and any past or present involvement with the contracts or claims at issue.

The Potential Results of a Challenge

There are three likely outcomes that will result from a challenge: (1) the challenging party will prevail, resulting in the replacement of the umpire; (2) the challenging party's challenge will not be accepted; or (3) the umpire will withdraw.

In terms of the mechanics of the challenge, Rule 16.9(e) of the Insurance Rules provides that a three-person subcommittee will be chosen at random by the ARIAS•U.S. executive director exclusively from the members of the ARIAS•U.S. Ethics Committee and Board of Directors.

For a hearing on the papers, the associated fee is $5,000, payable to ARIAS. If an in-person hearing is determined to be required, the associated fee is a daily rate of $2,400, plus reasonable costs and expenses (e.g., court reporter, room fees, etc.).

The subcommittee has discretion in how it decides the challenge. But it is charged with rendering a decision on the challenge within 30 days of receiving the papers or completing a hearing on the merits.

Rules 16.9(i) and 16.9(j) of the Insurance Rules suggest that the three scenarios set forth above will be resolved as follows:

- Where the challenger prevails, the challenging party shall be awarded its fees and costs, and the second-highest ranked umpire candidate will serve as the replacement umpire.
- Where the challenger fails, the party opposing the challenge shall be awarded its fees and costs, and the umpire will remain in place.
- Where the umpire withdraws, the second-highest ranked umpire candidate will serve as the replacement arbitrator.[2]

The Challenge of Challenges

The drafting of the challenge provision was an attempt to provide parties acting in good faith with a fair and efficient challenge process, while at the same time deterring mischievous parties from using frivolous challenges as a tool for obstruction and delay. While actual challenges under the Insurance Rules will no doubt test the procedure, its mere presence advances the Insurance Rules as a valuable tool for the resolution of direct insurance and insurance-related contract disputes.

This article originally appeared on the Kluwer Arbitration Blog and has been reprinted, with slight modifications, with permission from http://arbitrationblog.kluwerarbitration.com/2019/10/05/umpire-challenges-under-the-new-arias-us-panel-rules-for-the-resolution-of-insurance-and-contract-disputes/.

NOTES

1. See Halprin, Peter A., David W. Ichel, and Peter K. Rosen. 2019. "Introducing the ARIAS•U.S.Panel Rules for the Resolution of Insurance and Contract Disputes." *ARIAS Quarterly*, (4):14-17.

2. Although the answer likely depends upon the timing of the withdrawal, it seems unlikely that related fees and costs incurred may be awarded to the challenger in the event of a withdrawal, as the pertinent portion of the Insurance Rules refers to a "decision" of the subcommittee. Absent a "decision," it is unclear how such fees and costs could be awarded under the procedure.

Peter A. Halprin is a partner in Pasich LLP's New York office.

Arbitrators and Social Media: Do They Mix?

By Larry P. Schiffer

With the advent of the internet and the proliferation of social media, many organizations—be they Fortune 500 Companies or solo service providers—have moved some or all of their business development and marketing efforts to cyberspace. This article introduces social media and gives some examples of how service providers, including arbitrators, are using social media to generate business.

Defining Social Media

By *social media*, I mean Internet or application-based platforms that allow users to share information, pictures and other content, either directly with each other or through groups or chats or blogs or posts. Facebook is a prime example of social media. A Facebook user can post all sorts of information on his/her "wall" or can create a group or a page to promote personal interests or activities.

LinkedIn is another example of social media. LinkedIn is primarily for business (rather than personal) interaction, but it also allows for the posting

IMAGE CREDIT: SESAME/GETTY IMAGES

of information or collective communication through groups. Users connect with each other to see relevant posts. YouTube, Instagram, Twitter and many other platforms also are available for users to post content.

Today, a substantial amount of social media use takes place through applications (apps) on smartphones rather than on computers. Every social media platform has a downloadable app for smartphones. These apps are optimized for the smaller screen of the phone, allowing users to keep up with their social media content wherever they are without having to worry about a computer. Facebook, LinkedIn, Twitter, YouTube, and Instagram all have mobile apps.

Although we use the term *social media,* these platforms have become business platforms. Nearly every business webpage has icons that link to their sites on Twitter, Facebook, and other social media. When you visit a website and see the image below, that means you can reach that business via Facebook, Instagram, LinkedIn and Twitter (in the order presented) just by clicking on those icons.

In fact, many businesses scan social media posts to find people they want to work with and ask them to become influencers for them. For example, let's say you have a cute baby and you post pictures of your baby wearing a manufacturer's product. If you "tag" that manufacturer in your post, it's possible that the manufacturer's social media team will reach out and ask you to work with them to promote their brand. Social media influencers can make or break start-up companies trying to reach millennials and younger audiences.

So, how active is social media? The statistics in the far right column from Gary Hayes (2018) give you some examples of the activity that takes place on social media within just a few seconds. And the numbers have only increased since this survey was taken.

Social Media Platforms for Business

There are many social media platforms out there, but only a handful are relevant to business development by arbitrators. Others may disagree with this assessment, and new platforms arrive with frequency. Who your audience is has a lot to do with the social media platform that makes sense for you to use.

In the context of ARIAS, the audience is lawyers, law firms, insurance companies, reinsurance companies, brokers, third-party administrators, and others within the insurance and legal community. What that means is some of the social media platforms being used by your children or grandchildren are not relevant to an arbitrator marketing arbitration services (e.g., Snapchat, Reddit, and WhatsApp).

The most useful social media platforms with widespread use and acceptability for business are the following:

- LinkedIn (www.linkedin.com)
- Twitter (www.twitter.com)
- Instagram (www.instagram.com)
- Facebook (www.facebook.com)
- YouTube (www.youtube.com)

Social Media Counts

In the last 24 seconds, there have been—

284,622 mobile views of YouTube

27,060 photos uploaded to Instagram

2,847,204 likes on Facebook

$3,383 made from YouTube

569,444 videos watched on YouTube

33,210 hours streamed on Netflix

2,847,204 videos viewed on Snapchat

$116,973 from sales of iPhones

284 new mobile social users

1,423,602 plus 1s on Google Plus

740 started using PokemonGo globally

17,083,224 messages on FB messenger and WhatsApp

1,195,806 likes on Instagram

7,134 profiles viewed on LinkedIn

113,898 photos uploaded to Facebook

147,600 tweets tweeted

949,068 Google searches

2,277,837 videos viewed on Facebook

49 users joining LinkedIn

123 hours uploaded to YouTube

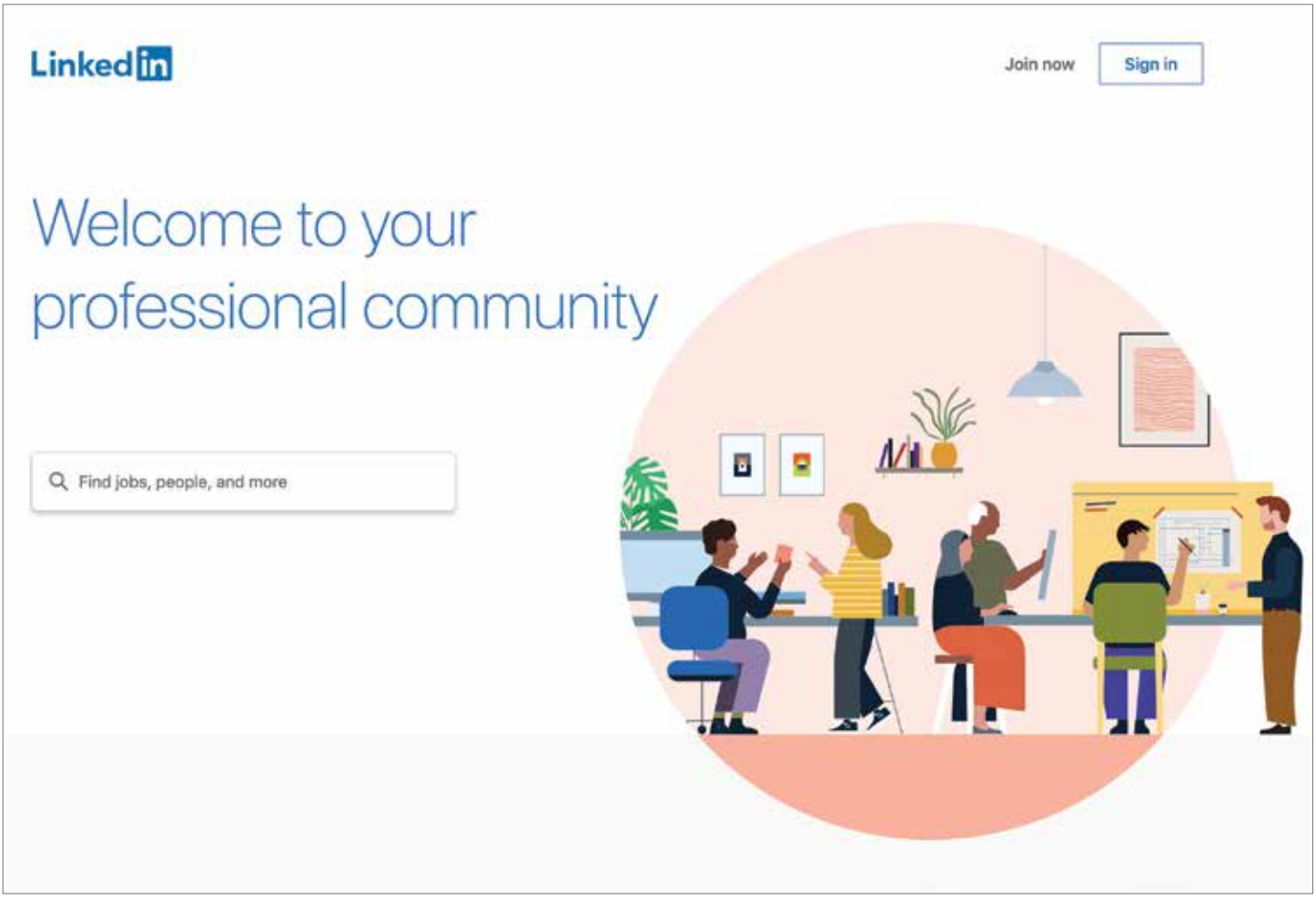
221,400 photos shared on SnapChat

This list does not include the various blogging platforms that exist, including WordPress, Blogger, and Tumblr, that are also useful for business development through thought leadership. There are also subscription services like Lexology that allow organizations to build blogs. What's good about blogging is that blog posts are often picked up by others and reposted and recirculated to a wider audience. An example of an arbitrator with a blog is international arbitrator Marc Goldstein, who has a blog called Arbitration Commentaries at http://arbblog.lexmarc.us/.

There are also content aggregators that gather and repurpose content from across the web. Organizations subscribe to these aggregators, which repost the organizations' blog posts or other web-based content on the aggregator's platform and recirculate it to a much broader, subscription-based audience. Examples of these aggregators include JD Supra and The National Law Review.

LinkedIn. Of the social media platforms listed above, the most useful professional social media platform for our purposes is LinkedIn. LinkedIn is a business social media platform that requires a user to join in order to use its services. Members of LinkedIn can post content, write articles, apply for jobs and form groups.

If you are not a member of LinkedIn already, the image below is what you will see when you go to the LinkedIn site (https://www.linkedin.com/). Just click on "Join now" at the top to start your membership; there is no cost for the basic membership. Once you become a LinkedIn member, you will need to create your profile. You will generate a home page that looks like the image on page 22 (also known as your LinkedIn feed).



> Filling out the profile in a professional way that highlights your skills and experience is imperative.

On this page you will see posts from people or businesses you follow, groups you have joined, hashtags you follow, your profile information in short form, and various menus and options to search—create a post, check a group, and many other things. As you connect with more people, join more groups, and create more posts, more information will appear on your feed.

For a professional, it is key to have a good headshot (taken by a professional, not your spouse) and a headline about you or your business. (As you can see, my headline is "How Can I Help You Resolve Your Insurance and Reinsurance Issues and Disputes?"). These items are part of your profile. An example of a headline used by an arbitrator on LinkedIn is "Arbitrator and Insurance/Reinsurance Consultant."

I would recommend that you add arbitrator certification to that headline so it reads more like this: "ARIAS•U.S.-Certified Arbitrator and Insurance/Reinsurance Consultant." ARIAS-certified arbitrators should add that certification statement because the headline appears on every post they make.

Adding the headline gives every reader a quick snapshot of who you are and why they may want to get to know you. For an arbitrator, this is a simple way of telling a wide audience that you are available to serve on insurance and reinsurance arbitrations.

Filling out the profile in a professional way that highlights your skills and experience is imperative. It is critical not to neglect the profile, especially the headline, the "about" section (where you can expand on your headline and summarize your experience), and, of course, your work history and accomplishments. There is a drop-down menu showing the categories of items you can add to your profile.

The "About" section is often neglected, but it gives you an opportunity to summarize your skills and experience. Think of it as an elevator speech. Here's what my "About" section says:

I am a lawyer concentrating on insurance and reinsurance arbitration, litigation, and mediation. I collaborate with my clients in a responsive and cost-effective manner. I understand the industry and focus on the overall client big picture in helping to win or resolve disputes. I regularly chair, speak, and write on insurance and reinsurance issues for industry and bar association programs and publications, and moderate several LinkedIn groups and blogs.

I have substantial experience in trying reinsurance arbitrations for cedents and reinsurers in both property/casualty and life. I also have significant experience in handling a wide range of insurance and reinsurance coverage, claims, insolvency, runoff, and related issues and disputes in both court or before arbitration panels. I also have significant experience in advising on insurance and reinsurance contract wording for both insurance and reinsurance companies and non-insurance clients. I am involved in the intersection between insurance and technology, especially with cybersecurity and cyber insurance issues.

After joining LinkedIn, it is important to start connecting with other users (but be careful about who you connect with, to minimize conflict and ethical issues) and to join groups that are relevant to your interests and practice. For arbitrators, joining the various insurance and reinsurance and arbitration groups is important. You don't necessarily have to post, but you may find the information posted in these groups helpful in your practice.

There are quite a few relevant groups with different levels of activity and information. There are 192 groups

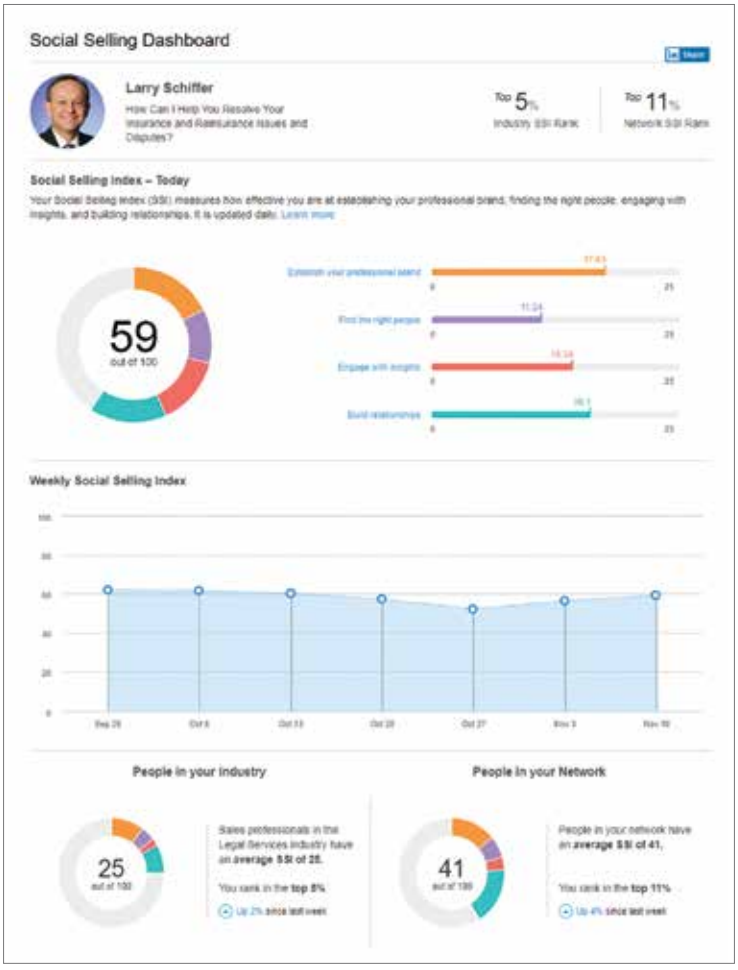
involving some aspects of reinsurance (searching just the word *arbitration* yields 325 group results). Here are some examples:

- **Reinsurance Insurance Professionals Worldwide Group (38,477 members):** The purpose of this group is to bring reinsurance and insurance professionals together on LinkedIn.
- **Insurance & Reinsurance Professionals Group (13,212 members):** A professional discussion and networking group for those involved in the insurance and reinsurance industry.
- **Reinsurance Professionals Group (9,772 members):** This is a group for global reinsurance professionals.
- **Life Reinsurance Group (2,024 members):** The life reinsurance group is a networking group for all practitioners and professionals engaged in, or with an interest in, the life reinsurance industry.
- **Global P&C Reinsurance & Insurance Network Group (1,940 members):** This is a global network of non-life re/insurance professionals. Provides a forum to discuss, debate, suggest and comment on key themes impacting the re/insurance market.
- **Reinsurance Claims Group (1,339 members):** This group is a forum for the open discussion of issues and sharing of information concerning ceded and assumed reinsurance claims in the U.S. and overseas markets.
- **Reinsurance Disputes Group (1,333 members):** This group is for a broad-based discussion of trends, issues, concerns, developments, ideas, and other items about reinsurance disputes, including how to solve them, how to mediate them, how to litigate them, and how to avoid them.
- **Insurance and Reinsurance Arbitration and Mediation Group (964 members):** This group is intended for insurance and legal professionals to come together and address issues germane to resolving complex insurance and reinsurance coverage disputes through alternative dispute resolution.

Joining a group and connecting with other LinkedIn members is nice, but if you want to develop business, you have to do more. Keeping in mind the Code of Conduct, Canon IX ("Arbitrators shall be truthful in advertising their services and availability to accept arbitration appointments"), arbitrators are free to post articles, comments, links to blog posts and other materials relevant to their practice. Just remember that you may have to disclose any articles relevant to a dispute's subject matter, and your social media profile may become relevant in the arbitrator selection process.

LinkedIn also has something called a Social Selling Index, which is a tool that allows you to see how your LinkedIn presence ranks compared to other members. Here's how LinkedIn describes it:

By checking out your SSI, you'll see how you stack up against your industry peers and your network on LinkedIn. Further, you can see how you are performing on each of the four elements of social selling—establishing your professional



brand, finding the right people, engaging with insights, and building relationships—and track your progress over time to help you understand how you're improving. Each color on the dashboard represents a different element of social selling, so you can see where you are strong and where you might need improvement.

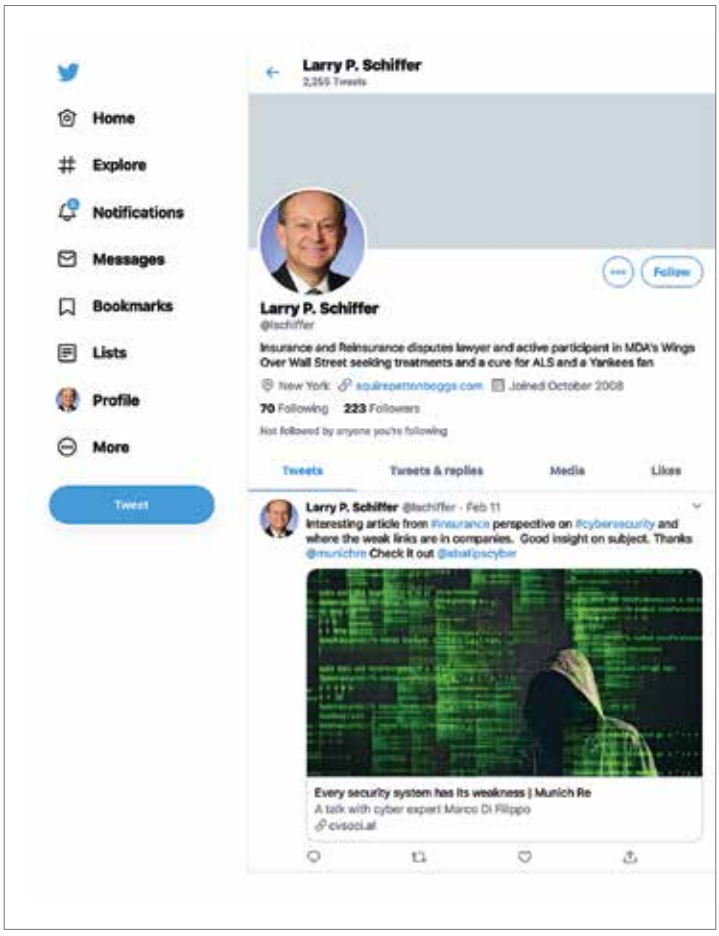
If you type *social selling index* into any search engine, like Google, it will take you to the LinkedIn page that allows you to access your SSI dashboard. It provides very interesting insights into how well you are doing in marketing your "brand" on LinkedIn.

Twitter. Whether you, as an arbitrator, want to participate professionally on other social media channels is a personal choice. Twitter provides the opportunity to interact with others using 280-character messages. Nearly all insurance and reinsurance companies have Twitter "handles," or user names; nearly all government officials have Twitter accounts. Twitter is a good way to circulate articles and blog posts beyond LinkedIn or a personal e-mail list. The image below is a snapshot of my Twitter profile page showing how I leverage my blog posts.

Other Social Media Platforms

While many consumer businesses, including most law firms, are using Facebook, Instagram and YouTube, the utility of these platforms for arbitrators is limited unless an arbitrator plans to post with frequency. For example, if you want to market yourself by posting short videos discussing insurance, reinsurance or arbitration issues, YouTube would be the place to do so.

Nevertheless, given the nature of these social media, it is less likely that buyers of arbitration services will be looking to these platforms to learn about arbitration services. A search for *arbitrator* or *reinsurance* on these platforms yields some results, but certainly not active participation by insurance and reinsurance arbitrators seeking to use those platforms for marketing. Keep in mind, however, that if you have a personal or professional presence on Facebook, Instagram or YouTube, you can bet that counsel will be looking at your profile.



Conclusion

Social media is another tool in the arbitrator toolbox for generating arbitration business. The more tech-savvy your company or law firm, the more likely you will be expected to be present on social media. Think it through and do what is comfortable for you, but don't discount the potential economic value of using social media to help enhance your arbitration practice.

This article is based on the course materials submitted for the ARIAS Fall Conference 2019 Breakout Session, "Round Pegs in Round Holes: Effectively (and Ethically) Marketing, Evaluating, and Selecting Arbitrators in a Changing World."

Larry Schiffer is editor of the *ARIAS Quarterly* and a senior partner at Squire Patton Boggs (US) in New York.

Prior Disputes: The *Functus Officio* Doctrine

Since March 2006, the Law Committee has been publishing summaries of recent U.S. cases addressing arbitration- and insurance-related issues. Individual ARIAS•U.S. members are also invited to submit summaries of cases.

Case: *Chicago Ins. Co. v. General Reinsurance Corp., et al.*, No. 18-cv-10450, 2019 WL 5287819 (S.D.N.Y. Oct. 22, 2019)

Court: U.S. District Court for the Southern District of New York

Date decided: October 21, 2019

Issue decided: Whether the *functus officio* doctrine bars an arbitration panel from deciding a dispute between parties that arises from a prior dispute adjudicated by that panel.

Submitted by: Robert W. DiUbaldo

General Reinsurance Corporation and SCOR Reinsurance Company (collectively, "Reinsurers") reinsured Chicago Insurance Company under a second layer casualty excess reinsurance agreement (the "Agreement"). The Agreement provided that disputes between the parties would be arbitrated before three arbitrators.

Chicago and an affiliated company insured Thorpe, which was an asbestos distributor and installer. After Thorpe filed for bankruptcy, Chicago and its affiliate reached an agreement with Thorpe to settle all liability under the relevant insurance policies. Chicago then billed the reinsurers for a portion of the settlement payment. When the reinsurers disputed the billing as presented, the matter was submitted to arbitration (the "2017 Arbitration").

The panel in the 2017 Arbitration ultimately rejected Chicago's billing methodology for its settlement payment and issued a final award in favor of the reinsurers. The 2017 final award also stated that the 2017 Arbitration panel "retain[ed] jurisdiction to resolve any dispute arising out of [the] final award." Chicago did not move in court or otherwise to challenge the final award, including the portion in which the panel retained jurisdiction to address future disputes arising therefrom.

In September 2018, Chicago submitted a new billing to the reinsurers related to the same billing at issue in the 2017 Arbitration, asserting that the new billing was prepared in accordance with certain claims protocols contained in the 2017 final award. Reinsurers rejected the new billing and alerted the 2017 Arbitration panel. The umpire advised the parties that the majority of the panel found that the panel had, and would exercise, jurisdiction to resolve any dispute concerning the new billing since it arose out of the final award. Chicago's party-arbitrator did not participate in the panel's decision based on his view that there was no jurisdictional basis to do so.

Thereafter, Chicago commenced a separate arbitration to resolve the dispute concerning the new billing. Reinsurers declined to proceed with the new arbitration based on the position that the 2017 Arbitration panel retained jurisdiction over the dispute. Chicago then filed a petition to compel the reinsurers to arbitration before a new panel and to stay the arbitration before the 2017 Arbitration panel. The reinsurers filed a cross-petition to stay the new arbitration and for declaratory relief providing that the 2017 Arbitration panel had jurisdiction to resolve the dispute.

Chicago argued that the 2017 Arbitration panel was *functus officio* and, therefore, a new arbitration must take place under the Agreement to resolve the dispute concerning the new billing. The court, however, found (1) that *functus officio* did not apply because the 2017 Arbitration panel explicitly retained jurisdiction to resolve any dispute arising out of the final award, and (2) that Chicago consented to this retention of jurisdiction when it chose not to dispute or seek to vacate the final award.

Because *functus officio* "is applicable only once the arbitrator's assigned duties have come to an end," the court found that the 2017 Arbitration

panel's duties "definitionally" had not ceased because the dispute on the new billing arose out of the 2017 Final Award, as acknowledged by Chicago when submitting that billing. Accordingly, the court held that the 2017 Arbitration panel retained jurisdiction to adjudicate whether Chicago's new billing comports with the panel's final award. The court also denied Chicago's petition to compel arbitration and stay the arbitration before the 2017 panel, and it granted reinsurers' cross-petition in full.

Robert DiUbaldo is a shareholder of Carlton Fields, P.A.

Is a Notice-Prejudice Rule Public Policy?

In *Pitzer College v. Indian Harbor Insurance Co.,* the California Supreme Court held that (1) California's notice-prejudice rule is a fundamental public policy of the state and, therefore, in coverage disputes in California regarding late notice, the choice-of-law provision in an insurance contract may be disregarded to ensure the rule is applied, and (2) the notice-prejudice rule generally applies to consent provisions in the context of first-party liability coverage, but not to consent provisions in third-party liability insurance contracts.

Effective July 23, 2010, Indian Harbor Insurance Company ("Indian Harbor") issued an insurance policy (the "policy") that provided coverage to Pitzer College ("Pitzer") for, inter alia, legal and remediation expenses resulting from pollution. Among the terms and conditions in the policy was a notice provision requiring Pitzer to provide Indian Harbor with oral or written notice of any pollution condition and, in the event of oral notice, "to furnish ... a written report as soon as practicable."

The policy also contained a consent provision requiring Pitzer to obtain Indian Harbor's written consent before incurring expenses, making payments, assuming obligations and/or commencing remediation due to pollution. The policy, however, also included an "emergency exception" to the consent provision that authorized Pitzer to incur costs if a delay would cause injury to persons or damage to property or significantly increase the cost of responding to a pollution condition, without first obtaining Indian Harbor's written consent. The policy's emergency exception required Pitzer to notify Indian Harbor "immediately" after incurring any such cost. *Pitzer College*, 8 Cal.5th at 98.

In March 2011, Pitzer incurred approximately $2 million in costs remediating darkened soil at a construction site for a new dormitory on its campus. Pitzer did not notify Indian Harbor about the remediation until July 11, 2011, approximately three months after performing the work and six months after discovering the darkened soil. *Id.* at 99.

On March 16, 2012, Indian Harbor denied coverage based on Pitzer's failure to comply with the policy's notice and consent provisions. Pitzer thereafter sued Indian Harbor in Los Angeles County Superior Court for declaratory relief and breach of contract. Indian Harbor removed the case to federal court and moved for summary judgment on the grounds that it lacked a contractual obligation to indemnify Pitzer for the remediation costs based on Pitzer's failure to provide timely notice and obtain consent before remediating. *Id.*

The U.S. District Court for the Central District of California granted Indian Harbor's summary judgment motion.

Case: *Pitzer College v. Indian Harbor Insurance Co.,* 8 Cal.5th 93 (Cal. Sup. Ct. 2019)

Court: Supreme Court of California

Date decided: August 29, 2019

Issue decided: Is California's common law notice-prejudice rule a fundamental public policy of the state of California such that a choice-of-law provision in an insurance policy that does not conform to that rule may be overridden? If so, does the notice-prejudice rule apply to the consent provision of the insurance policy at issue?

Submitted by: Michele L. Jacobson, Esq., and Beth K. Clark, Esq.

In so doing, the district court held that New York law applied pursuant to the policy's choice-of-law provision and, although fundamental public policy of the state can override a choice-of-law provision, Pitzer had not established that California's notice-prejudice rule was such a policy. Applying New York law—which imposes a strict no-prejudice rule on policies delivered outside of New York—the district court ruled in Indian Harbor's favor, holding that Pitzer had failed to provide the contractually required notice. The district court noted that, had New York law been different, Indian Harbor would have lost its motion because it could not establish prejudice.

The district court also held that Pitzer had failed to comply with the policy's consent provision, rejecting Pitzer's attempt to invoke the emergency exception to that provision. Notably, while Pitzer had separately argued that the notice-prejudice rule should apply to the consent provision, the district court did not address this argument. *Id*. at 99-100.

Pitzer appealed the district court's decision to the U.S. Court of Appeals for the Ninth Circuit. After oral argument, the Ninth Circuit certified questions of California law to the California Supreme Court, stating that "[r]esolution of this appeal turns on whether California's notice-prejudice rule is a fundamental public policy for the purpose of choice-of-law analysis. If the California Supreme Court determines that the notice-prejudice rule is fundamental, the appeal then turns on whether, in a first-party policy like Pitzer's, a consent provision operates as a notice requirement subject to the notice-prejudice rule." *Id*. at 100.

The California Supreme Court held that the "crux of this case lies in the choice-of-law provision designating that New York law should govern all matters arising under the policy." Id. The court explained that, under California law, the parties' choice of law governs unless (1) it conflicts with the state's fundamental public policy and (2) the state has a materially greater interest in the determination of the issue than the contractually chosen state. Here, the California Supreme Court held that the notice-prejudice rule is a fundamental public policy of the state of California. The court arrived at this conclusion because the notice-prejudice rule (1) cannot be contractually waived and therefore restricts the freedom of contract, (2) protects insureds against inequitable results caused by an insurer's superior bargaining power, and (3) increases the likelihood that an insurer, rather than the public, will pay costs of harm, which is in the general public interest. *Id*. at 100-105.

After holding that the notice-prejudice rule was fundamental public policy in California, the California Supreme Court stated that it would not decide whether California has a materially greater interest than New York in determining coverage. That issue would be left to the Ninth Circuit. *Id*. at 105.

The court then turned to whether the policy's consent provision was subject to the notice-prejudice rule. The court ruled that the purposes of the consent provision—preventing an insured from making unnecessary expenditures, allowing the insurer to approve and control costs, and protecting an insurer's subrogation rights—were akin to the purposes of a notice provision. Both provisions were included in insurance contracts to assist the insurer in performing its primary contractual obligations, but they did not constitute primary contractual obligations. Therefore, the court held, "the notice-prejudice rule makes good sense for consent provisions in the first-party policies just as it does for notice provisions." The court, however, ruled that a consent provision or "no voluntary payment provision" in a third-party policy serves a different purpose (i.e., protection of the insurer's right to control the defense and settlement of claims, which is fundamental to the insurer's primary contractual obligations) and, therefore, is not subject to the notice-prejudice rule. Moreover, the court held that the notice-prejudice rule would only apply in the first-party context where coverage does not depend on the existence of a third-party claim or potential claim. *Id*. at 106-109.

Finally, vis-à-vis the policy, the court held that it could not decide whether the notice-prejudice rule applied to the policy's consent provision because a dispute existed as to whether the policy provided first- or third-party coverage. The court concluded that deciding that dispute was beyond the scope of the Ninth Circuit's certified questions. Therefore, it left that decision to the Ninth Circuit. *Id*. at 109-110.

Michele L. Jacobson is a partner in the litigation department and member of the Executive Committee of Stroock & Stroock & Lavan, L.L.P.

Beth K. Clark is special counsel in the Litigation Department of Stroock & Stroock & Lavan, L.L.P.

Newly Certified Arbitrators

Lori Lovgren is an independent arbitrator and seasoned regulatory attorney with more than 25 years of property and casualty insurance experience. She has had experience as a neutral arbitrator for AAA, FINRA, and the Florida Attorney General's Office and is also a Florida Supreme Court-trained and certified mediator. She has mediated more than 35 disputes between domestic insurers and policyholders. She has also served in a leadership role in a membership organization of insurers and practiced law in a group focused on insurance matters. Her professional designations include Chartered Property and Casualty Underwriter (CPCU) and Associate in Insurance Data Analytics (AIDA).

Newly Certified Neutral Arbitrators

Peter Bickford is an independent arbitrator and counselor to the insurance and reinsurance markets with 40-plus years of industry experience. He has been an executive officer of both a life insurance company and a property/casualty insurance and reinsurance facility (the New York Insurance Exchange), for which he had line responsibility for the contract and claims operations. He was also the founder of a small boutique insurance and reinsurance law firm and subsequently was the co-chair of the insurance corporate and regulatory group of a nationally recognized law firm. He has been an ARIAS-certified arbitrator since 1997 and a certified umpire since 2009. He has written and spoken on many insurance and reinsurance topics, primarily relating to insolvency and regulatory issues.

David C. McLauchlan became an ARIAS-certified neutral arbitrator in December 2019, having been certified by ARIAS since 2009 as an arbitrator and mediator. He was a partner in the law firms of Lord Bissell & Brook and Locke Lord LLP before starting his own practice, the McLauchlan Law Group LLC. He has practiced law for 30-plus years and concentrates his practice in resolving complex business disputes through mediation, arbitration and, when necessary, business litigation. David has mediated, arbitrated and tried cases before state and federal courts and in private arbitrations, serving as lead trial counsel and appellate counsel. Throughout his career he has successfully managed large litigation teams and served as a mentor and leader to numerous young litigators who are now successful partners, managing partners, and corporate law department executives.

Kevin J. Tierney has been approved as an ARIAS-certified neutral arbitrator. He has more than 40 years of experience as a lawyer and senior executive in the life, health and disability insurance and reinsurance industry. He served as senior vice president and general counsel of UNUM Corp. and a number of its life insurance subsidiaries and as general counsel of Disability Reinsurance Management Services, Inc., a reinsurance intermediary manager and TPA. He is a former independent trustee of a Merrill Lynch mutual fund that was available to life insurance companies as a funding vehicle for their variable annuity contracts, and he also served as a director of a publicly traded P&C insurance group.

CHAFFETZ LINDSEY PROMOTES FIVE TO NEW ROLES

Chaffetz Lindsey, a leading New York-based arbitration and litigation boutique, has promoted five team members to new roles in the firm: Andrew (Drew) Poplinger to partner, Rainbow Willard to counsel, and Joshua (J.D.) Anders, Karen Baswell, and Ted DeBonis to senior attorney.

Poplinger joined the firm in September 2012 and was promoted to counsel in 2017. He represents clients in commercial disputes before state and federal courts and before all major arbitral institutions and in ad hoc disputes in a variety of industries, including insurance and reinsurance, oil and gas, construction and financial services. Legal 500 USA named him one of six "Next Generation Attorneys" nationwide for Advice to Insurers.

Willard, who joined Chaffetz Lindsey in 2017, is fluent in English and Spanish and regularly appears in front of international arbitration tribunals and U.S. courts. She has helped several clients navigate parallel proceedings in international arbitration and national courts in a host of foreign jurisdictions.

Since joining Chaffetz Lindsey in 2013, Anders has represented individual and corporate clients in disputes in state and federal court and in arbitration proceedings. His strong research and analytical skills have made him a key team member in a succession of complex disputes.

Baswell was one of the original seven attorneys when Chaffetz Lindsey opened for business in 2009. She has been a mainstay of the firm's insurance and reinsurance practice, and has experience in international arbitration, with a focus on construction disputes.

Since joining Chaffetz Lindsay in 2011, DeBonis has represented clients in a wide range of complex litigation and arbitration matters, including representing insurers, reinsurers, corporations, and individuals in commercial litigation, arbitration, and mediation.

SARAH ANDERSON JOINS FREEBORN'S TAMPA OFFICE

Sarah M. Anderson has joined the Tampa office of Freeborn & Peters LLP as an associate in the Litigation Practice Group and as a member of the Insurance and Reinsurance Industry Team.

Prior to joining Freeborn, Anderson served as a law clerk to Judge James D. Whittemore and Judge Timothy J. Corrigan in the U.S. District Court for the Middle District of Florida. She also served as the tobacco judicial law clerk in the Middle District of Florida and was responsible for the district's docket of Engle progeny cases against the Big Tobacco companies over injuries suffered related to the health effects of smoking.

ANN FIELD PROFILED IN NOTABLE WOMEN IN REINSURANCE

Ann Field, an attorney and vice president at Zurich in North America, has been profiled in Notable Women in Reinsurance. Field is the director of the Reinsurance Claims and Legal Department, which is dedicated to the handling of all reinsurance claims and all disputed reinsurance recoveries for Zurich within North America. Accordingly, she oversees all reinsurance arbitrations and litigation of the in-house and external attorneys for Zurich in North America and directs and manages a staff of attorneys and reinsurance claim specialists who are responsible for the largest and most complex claims of the company, as well as the reinsurance issues related to those claims. She also directs and manages attorneys and reinsurance claim specialists who are responsible for the reinsurance issues and disputes surrounding "non-complex" claims.

In Memoriam: Terry Kelaher

Terry Kelaher, a longtime member of ARIAS•U.S., died recently after battling cancer and kidney disease. Kelaher joined Allstate Insurance in 1988 and served as a vice president and general manager of the Specialty Operations Division, where he oversaw the management of Allstate's discontinued businesses. Prior to assuming responsibility for Allstate's domestic and international reinsurance businesses, he was chairman and chief executive officer of Allstate Insurance Company of Canada and Allstate Life Insurance Company of Canada. He was also a co-founder and vice chairman of AIRROC.

In Memoriam: Robert J. Federman

Robert J. Federman, who worked in the insurance industry for 18 years and was an active arbitrator and mediator for more than 40 years, died on February 9. He served as claims vice president of Transit Casualty before entering private law practice as the founding managing partner of Federman, Gridley & Gradwohl in Los Angeles, where he was responsible for the defense of insurance-related litigation. In 1998, he relocated to San Luis Obispo, California, where he continued his law practice, of counsel to Ward and Federman. He presented alternative dispute resolution programs and seminars through several organizations, including the American Bar Association and the Association of Defense Trial Attorneys.

BOARD OF DIRECTORS

ARIAS•U.S.
7918 Jones Branch Drive, Suite 300
McLean, VA 22102
Phone: 703-574-4087
Fax: 703-506-3266
info@arias-us.org
www.arias-us.org

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7918 Jones Branch Drive,
Suite 300, McLean, VA 22102.

AIDA Reinsurance & Insurance Arbitration Society
7918 Jones Branch Dr.
Suite 300 • McLean, VA 22102
Phone: 703-506-3260 • Fax: 703-506-3266
Email: info@arias-us.org