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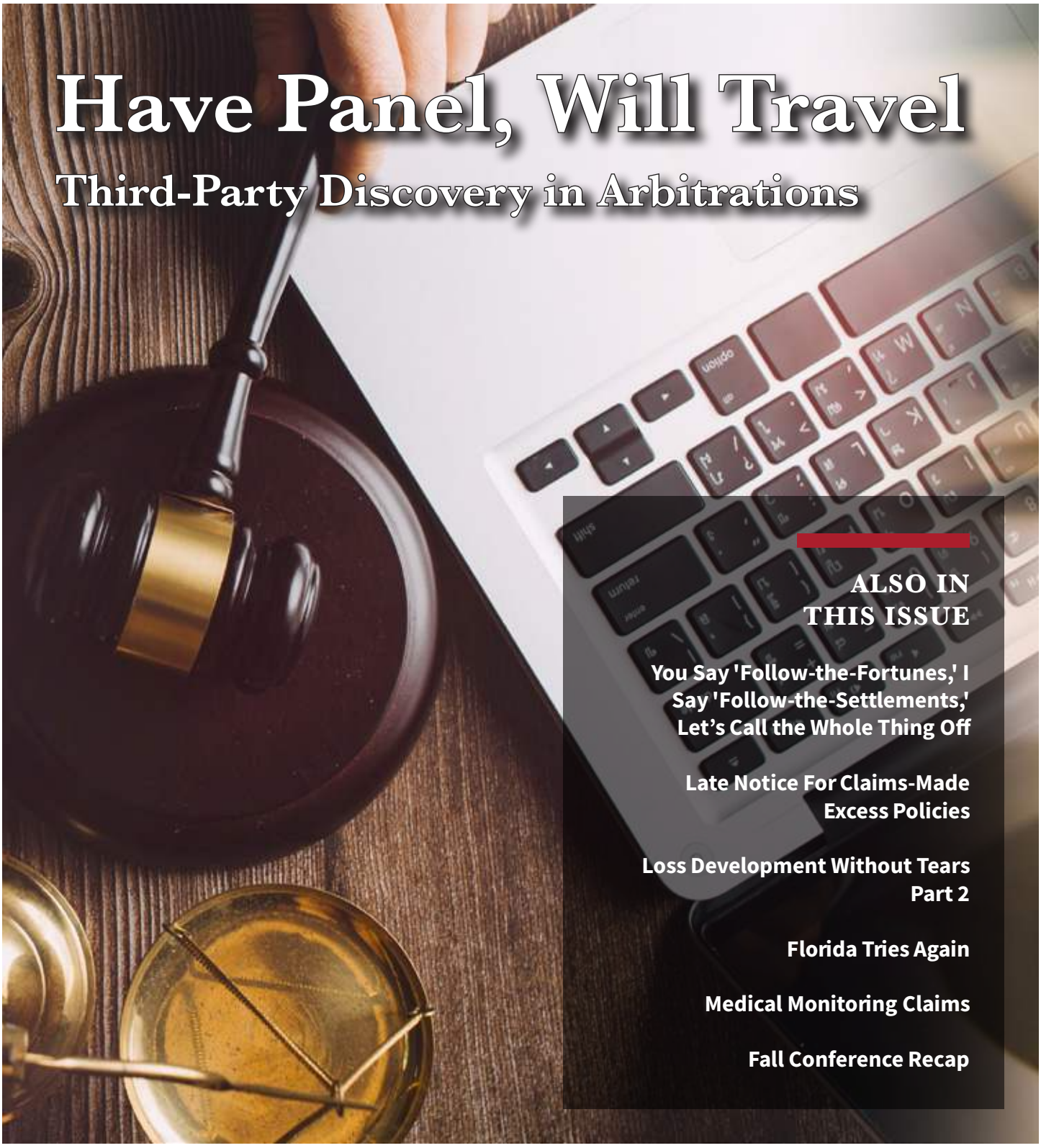

Have Panel, Will Travel

Third-Party Discovery in Arbitrations

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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.

Welcome to 2023 and the first issue of the ARIAS Quarterly for 2023. Hopefully, we will see you shortly in Amelia Island on May 17-19, 2023, for the Spring Conference.

This will be an exciting year for ARIAS. As you already heard, this is the Year of the Arbitrator. In coming issues, there will be spotlights and other articles celebrating our arbitrators. I hope to see you at some of the special events that are being planned.

In this issue we have six articles so I thank you for heeding my call for more articles. Keep 'em coming. First, we have "Have Panel, Will Travel: Third-Party Discovery in Arbitrations," by Jessica Snyder and Julian Buff from O'Melveny & Myers LLPP. In this article, Jessica and Julian explore the complication of obtaining third party discovery in arbitrations. This is an issue that arises periodically in insurance and reinsurance arbitrations and how the subpoena is issued and where the panel sits can be a big issue.

Our next article is "You Say "Follow-the-Fortunes," I Say "Follow-the-Settlements," Let's Call the Whole Thing Off," by Andrew L. Poplinger from Chaffetz Lindsey LLP. In his article, Andrew takes a contrary position on whether there is a difference between "follow-the-fortunes" and "follow-the-settlements" as was expressed in Bob Hall's article in the ARIAS Quarterly Q4 2022. The article examines how the courts have addressed the issue and the modern realities of how the concepts are being used. Anyone up for continuing the debate?

Speaking of Bob Hall, next we have "Late Notice For Claims-Made Excess

Policies: The Harvard v. Zurich Example," by Robert M. Hall of Hall Arbitrations and a member of the ARIAS Editorial Board. In this article, Bob discusses an important issue that arises in claims-made excess policies, which often results in disputes, some of which may be arbitrated. Good information if you have one of these disputes.

We promised you Part 2 from last issue's lead article and here it is. "Loss Development Without Tears: What Is Loss Development and How Do Actuaries Use It? Part 2," written by Gary Blumsohn, FCAS, Executive Director, Underwriting and Actuarial, Arch Reinsurance Company. Continuing with our series on how actuaries do things, Part 2 explains how actuaries calculate loss development patterns and then shows how those loss development patterns are used. Having spent several years on rate filing disputes and addressing loss development patterns, I can assure you that this article really helps explain how it all works.

We next turn to recent legislation in Florida relevant to reinsurance. In "Florida Tries Again - A Summary and Overview of 'Hurricane Insurance' Legislation In 2022," James F. Jorden of the Jorden Group narrates the ups and downs of the efforts in Florida to sort out its hurricane-related insurance and reinsurance issues. If you work on or work for companies that write property and property cat in Florida, you need this information.

Finally, we have a forward-thinking article on the issue of medical monitoring claims as they apply to PFAs. In "Medical Monitoring Claims: Trampling Tort and Insurance Principles in The Wake of PFAS," John E. DeLascio of Hinshaw & Culbertson LLP discusses his view on how medical monitoring claims involving forever chemicals (Per- and Polyfluoroalkyl Substances) are disrupting traditional tort and insurance concepts. Medical monitoring claims are a big issue, not only in PFAs but in other types of products and catastrophic injury losses (e.g., CTE from concussions – see the NFL).

We continue to need more of you to contribute to future issues. The deadlines and requirements are on the ARIAS website. We welcome committee reports, original articles and repurposed articles from ARIAS CLE programs or from company or firm publications. Leverage your thought leadership and publish an article in the Quarterly.

We hope you enjoy this issue of the Quarterly!

Larry P. Schiffer
Editor

Have Panel, Will Travel

Third-Party Discovery in Arbitrations

By Jessica Snyder and Julian Buff

Parties engaged in discovery before reinsurance arbitration panels have increasingly faced a question that borders on the metaphysical: When is a hearing a hearing? With the pandemic ushering in the age of video conferences and remote appearances, a related conundrum has also emerged: Where does an arbitration panel sit and what is the geographic reach of its subpoena power?

Gone are the days when third parties (often brokers) readily complied when arbitrators issued subpoenas to produce documents. As arbitrations proliferated and document discovery exploded, third parties started objecting. They argued that the Federal Arbitration Act ("FAA") does not permit pre-hearing discovery from third parties—that it authorizes arbitrators to subpoena third parties only for testimony at the hearing. In response, arbitrators started subpoenaing third parties to appear at a "hearing" scheduled solely for the purpose of obtaining testimony and documents from the third party. The subpoenaed parties again objected, arguing such a hearing is not really a hearing (i.e., on the merits). Some of those disputes ended up in court.

While early cases led to inconsistent results, a majority rule eventually emerged supporting arbitrators' authority to compel at least some pre-hearing discovery—so long as it was conducted at a "hearing." But even then, questions about the scope, timing, and procedure for this discovery have remained largely unresolved. Although a recent decision by the Sixth Circuit (*Symetra Life Ins. Co. v. Admin. Sys. Rsch. Corp., Int'l*)[1] brings further clarity to the issue—adopting a more flexible approach to geographic procedural limitations—it remains to be seen whether arbitration participants in other jurisdictions will continue to face obstacles in pursuing pre-hearing discovery from third par-

ties. This article examines the still uncertain landscape for third-party discovery.

I. Format for Compelling Third-Party Discovery

Section 7 of the FAA permits arbitrators "or a majority of them" to "summon in writing any person to attend before them or any of them as a witness and in a proper case to bring with . . . them any book, record, document, or paper which may be deemed material as evidence in the case."[2] The federal courts have adopted widely varying views on the exact contours of arbitral power to order discovery outside a final merits hearing.

An Expansive View. At the more expansive end of the spectrum, the Eighth Circuit has found that "implicit in an arbitration panel's power to subpoena relevant documents for production at a hearing is the power to order the production of relevant documents for review by a party prior to the hearing."[3] But the Eighth Circuit is unique in not requiring attendance at a hearing for third-party arbitral subpoenas to be enforced. Many courts in other circuits have expressly rejected the Eighth Circuit's "power-by-implication analysis," adhering instead to a stricter reading of Section 7's grant of power.[4]

A More Restrictive View. At the other end, the Second Circuit—along with the Third, Ninth, and Eleventh Circuits—has held that Section 7 does not authorize arbitrators to order nonparties to produce documents unless the nonparty, "is called as a witness at a hearing."[5]

In *Life Receivables*, for example, the Second Circuit held "[d]ocuments are only discoverable in arbitration when brought before arbitrators by a testifying witness."[6] The court based its decision on Section 7's "straightforward and unambiguous" language, which permits arbitrators to, "'summon in writing any person to attend before them or any of them as a witness . . .'"[7] In contrast to the Eighth Circuit, the Second Circuit cautions that, "[a] statute's clear language does not morph into something more just because courts think it makes sense for it to do so."[8] Many other courts have similarly held that non-party witnesses, "may only be compelled to bring documents to an arbitration proceeding but may not simply be subpoenaed to produce documents." *Hay Grp., Inc. v. E.B.S. Acquisition Corp.*, 360 F.3d 404, 406 (3d Cir. 2004); *see also CVS Health Corp. v. Vividus, LLC*, 878 F.3d 703, 706-07 (9th Cir. 2017) (finding that "an arbitrator's power to compel the production of documents is limited to production at an arbitration hearing" and noting that, "circuit courts that have addressed this question most recently have interpreted section 7 similarly").

Even so, arbitration panels still may issue enforceable subpoenas seeking testimony from third parties during preliminary hearings, not just final hearings. *Stolt-Nielsen SA v. Celanese AG*, 430 F.3d 567, 577-79 (2d Cir. 2005) (holding that arbitral Section 7 authority is not limited to witnesses at merits hearings, but extends to hearings covering a variety of preliminary matters); *see also Hay Grp.*, 360 F.3d at 407 (noting that while Section 7 does not permit a subpoena to compel production from a non-party in absence of a hearing, it does permit subpoenas in which "the non-party has been called to appear in the physical presence of the arbitrator and to hand over the documents at that time"). By allowing for discovery at preliminary hearings attended by the arbitrators, these courts strike a balance: ensuring that certain issues and evidence can be decided in advance of a merits hearing while also enforcing a presence requirement to fend off gratuitous subpoenas. *See Stolt-Nielsen*, 430 F.3d at 580; *see also Hay Grp.*, 360 F.3d at 414 (3d Cir. 2004) (Chertoff, J., concurring) (noting that Section 7's "procedure requires the arbitrators to decide that they are prepared to suffer some inconvenience of their own" when they subpoena third-party witnesses).

A Middle Ground. Staking out middle ground, the Fourth Circuit has adopted a third approach, one also used in some state courts. In *Comsat Corp. v. National Science Foundation*, 190 F.3d 269 (4th Cir. 1999), concerned that, "arbitral efficiency would be degraded if the parties are unable to review and digest relevant evidence prior to the arbitration hearing," the Fourth Circuit read into the FAA an exception allowing a party to petition the district court to compel discovery, "upon a showing of special need or hardship," such as when the party can show the information is otherwise unavailable.[9] In 2018, Judge Ruberman in the New York Supreme Court also enforced an arbitral subpoena seeking testimony from a non-party in part because of "special need or hardship." *Matter of Roche Molecular Sys. Inc. (Gutry)*, No. 53064/2018, 2018 WL 1938327 (N.Y. Sup. Ct. Apr. 24, 2018) (concluding that *Life Receivables* did not displace the earlier decision in *ImClone Sys., Inc. v. Waksal*, 22 A.D.3d 387 (N.Y. App. Div. 2005), which allowed for non-party depositions upon a showing of special need because *Im-*

Clone was predicated on a finding that "in the absence of a decision of the United States Supreme Court or unanimity among the lower federal courts, we are not precluded from exercising our own judgment in this matter"). The Third Circuit in *Hay Grp*. explicitly rejected the "special need" allowance for third-party discovery in certain circumstances, reasoning that "there is simply no textual basis for allowing any" such exception.[10]

II. Other Limitations on Third-Party Discovery Hearings

Assuming that most courts will follow the majority position—that discovery must be compelled at a preliminary hearing before the arbitrators—additional questions remain about the exact requirements for those hearings.

How many arbiters must attend? One important issue for compelling third-party discovery at a preliminary hearing is whether all or only some of the arbitration panel must be present. This issue is especially ripe in cases where the arbitration agreement requires evidence to be heard by the entire panel.

Some courts have found that Section 7 allows for the hearing to occur before a single arbitrator. E.g., Hay Grp., 360 F.3d at 413 (Tchertoff, J., concurring) ("Under Section 7 of the Federal Arbitration Act, arbitrators have the power to compel a third-party witness to appear with documents before a single arbitrator, who can then adjourn the hearings."). But the text of Section 7 appears to require a panel majority. See 9 U.S.C. § 7 ("The arbitrators . . . or a majority of them, may summon in writing any person to attend before them . . . . [I]f any person or persons so summoned to testify shall refuse or neglect to obey said summons, upon petition the United States district court for the district in which such arbitrators, or a majority of them, are sitting may compel the attendance of such person").

> "One important issue for compelling third-party discovery at a preliminary hearing is whether all or only some of the arbitration panel must be present."

Yet other arbitration rules require that all arbitrators be present for the taking of evidence. For example, AAA Commercial Arbitration Rules at R-35(a) provide in relevant part: "All evidence shall be taken in the presence of all the arbitrators and all the parties . . ."[11] Some state statutes may have similar requirements, such as N.Y. C.P.L.R. §7506(e): "The hearing shall be conducted by all the arbitrators, but a majority may determine any questions and render an award." How these rules might be applied and enforced in a preliminary discovery-focused hearing (as opposed to final merits hearing) remains to be seen.

Where (or how) can the hearing take place? Another key issue developing across different jurisdictions is the geographic limitation on where the hearings can be conducted, including whether they can be conducted virtually. Because only the courts have power to enforce subpoenas issued by arbitrators, the federal rules limit the reach of those subpoenas to "within 100 miles of where the person resides, is employed, or regularly transacts business in person."[12] With the COVID-19 pandemic having expanded opportunities for remote appearances, there is now some conflict between the courts and the rules over how this limitation applies.

For example, the AAA Commercial Arbitration Rules at R-33(c) state that the arbitrators "may also allow for some or all of the presentation of evidence by alternative means including video, audio or other electronic means other than an in-person presentation."[13] The ARIAS U.S. Rules at 14.6 also provide that the arbitrators "shall have the discretion to permit testimony by telephone, affidavit, or recorded by transcript, vid-

eotape, or other means, and may rely upon such evidence as [they] deem[] appropriate."[14]

Conversely, the Southern District of New York recently applied the federal rules' 100-mile limitation to subpoenas calling for testimony by videoconference.[15] In *Broumand v. Joseph*, Judge Rakoff found that subpoenas issued by a New York arbitration panel to witnesses in California and Virginia were unenforceable because they violated both (1) the 100-mile geographical limitation of Federal Rule of Civil Procedure 45(c) and (2) the presence requirement of Section 7 of the FAA.[16] The court disapprovingly cited several out-of-circuit decisions that held the federal rules' geographic limitations do not apply to teleconference testimony.[17] *See In re Newbrook Shipping Corp.*, 498 F. Supp. 3d 807, (D. Md. 2020) ("Given the modification of the deposition notice to provide for a remote deposition over Zoom or other teleconferencing platform, the deposition notice no longer requires [respondents] to travel more than 100 miles (or at all) to comply, so the Court declines to address [the] argument that the subpoena compels [respondents] to comply outside of the geographical bounds of Rule 45(c)."); *In re Xarelto (Rivaroxaban) Products Liability Litigation*, 2017 WL 2311719 (E.D. La. May 26, 2017) (refusing to quash a subpoena that required respondent to testify by videoconference at trial that would occur more than 100 miles away on the ground that the respondent would "attend the trial ... by remote transmission" at a place within 100 miles from where he resided). The court found those holdings inconsistent with FRCP 45(c), "which speaks, not of how far a person would have to travel, but simply the location of the proceeding at which a person would be required to attend."[18] In analyzing Section 7's provision that arbitrators may "summon before them" third parties, Judge Rakoff cited the Second Circuit's reasoning that the FAA's presence requirement, "forces 'the party seeking the non-party discovery—and the arbitrators authorizing it—to consider whether production is truly necessary.'"[19] And, "the Second Circuit has observed that arbitrators are less likely to abuse their power to utilize preliminary hearings as a discovery device to subpoena third-party witnesses gratuitously if 'the arbitrators themselves must attend any hearing at which such subpoenas are returnable.'"[20] Judge Rakoff rejected petitioner's bid to avoid the, "judicial consensus" that district courts cannot enforce arbitral summonses for a witness to appear via video conference by appealing to the extraordinary circumstances of the COVID-19 pandemic.[21]

Other courts, however, seem to be trending toward flexibility around geographic procedural limitations, making it possible for arbitration panels to, "sit" in different locations for preliminary hearings for the purpose of third-party discovery. The Sixth Circuit recently embraced that approach in *Symetra Life*.[22] In that case, Symetra Life petitioned the arbitration panel to issue a subpoena to compel Administrative Systems Research Corporation, International (ASR), a third-party administrator of employee benefits plans, to send a representative to appear at an arbitration hearing and to bring specified documents. After some dispute over location, the panel chose Houston, Texas, for the final hearing, but scheduled a hearing to receive the subpoenaed documents in Grand Rapids, Michigan.[23] ASR objected to the subpoena, and Symetra brought a petition to compel ASR's compliance in the Western District of Michigan, where ASR is located.[24] ASR argued that Symetra was not permitted to bring the action in the Western District of Michigan because, "the arbitration panel may 'sit' only in one location: where the final hearing is to be conducted"—i.e., Houston.[25] But the Sixth Circuit reasoned that, "the FAA's text contains no such restrictions," and "decline[d] ASR's invitation to read additional terms into the statute."[26] Because the arbitration panel declared itself to be sitting in Grand Rapids for the purpose of the subpoena-related hearing, the Sixth Circuit held that, "it was not improper for Symetra to bring this action in the Western District of Michigan."[27] ASR further argued that the FAA does not permit pre-hearing discovery subpoenas.[28] But the court was not persuaded, reasoning that "a straightforward reading of the statute's text" leads to the conclusion that "the subpoena was a proper exercise of the panel's Section 7 powers."[29]

The Sixth Circuit's decision involved a subpoena that called for an in-person hearing in the state in which the witness resided. Could geographic flexibility for where panels, "sit" be used in jurisdictions that allow for evidence to be taken virtually or telephonically to avoid the geographic limitations otherwise imposed by the federal rules for these preliminary hearings? While this is an open question in most jurisdictions, just the prospect of appearing virtually for a hearing may encourage many third parties to voluntarily agree to attend.

III. Takeaways

- While courts continue to disagree about the extent of arbitrators' power to compel third-party discovery, recent trends indicate that third-party discovery is permissible so long as it takes place in front of an arbitrator.

- If parties are successful in compelling pre-hearing testimony and documents, it is prudent to have at least a majority of arbitrators attend the hearing. Parties should consider whether the arbitration agreement or other applicable rules require all arbitrators to be present.

- While federal courts seem hesitant to bypass F.R.C.P. 45(c)'s geographical limitations and permit videoconference hearings more than 100 miles away from where a panel is sitting, some jurisdictions allow flexibility about where an arbitration panel may sit for purposes of preliminary hearings.

- Given the complexities and uncertainties in the enforceability of the arbitrators' third-party subpoenas, parties should be thoughtful about which witnesses are truly necessary to the parties' claims and defenses and work out agreements with those third parties whenever possible.

NOTES

1 *Symetra Life Ins. Co. v. Admin. Sys. Rsch. Corp., Int'l*, No. 31-2742, 2022 WL 16730542, at *1 (6th Cir. Nov. 7, 2022).

2 9 U.S.C. § 7.

3 *In re Sec. Life Ins. Co. of Am.*, 228 F.3d 865, 870-71 (8th Cir. 2000).

4 *See, e.g., Hay Grp., Inc. v. E.B.S. Acquisition Corp.*, 360 F.3d 404, 406-11 (3d Cir. 2004); *Life Receivables Trust v. Syndicate 102 at Lloyd's of London*, 549 F.3d 210, 217-18 (2d Cir. 2008).

5 *Broumand v. Joseph*, 522 F. Supp. 3d 8, 24 (S.D.N.Y. 2021) (citing *Life Receivables*, 549 F.3d at 218; *Hay Grp.*, 360 F.3d at 407; *CVS Health Corp. v. Vividus*, LLC, 878 F.3d 703, 708 (9th Cir. 2017); *Managed Care Advisory Grp., LLC v. CIGNA Healthcare, Inc.*, 939 F.3d 1145, 1160 (11th Cir. 2019)).

6 *Life Receivables*, 549 F.3d. at 216.

7 *Id.* at 214-16 (quoting 9 U.S.C. § 7) (emphasis removed).

8 *Id.* at 215-17.

9 *Comsat Corp.*, 190 F.3d at 275 (4th Cir. 1999).

10 360 F.3d 404 at 410.

11 AAA Commercial Arbitration Rules at R-35(a).

12 Fed. R. Civ. Proc. 45(c).

13 AAA Commercial Arbitration Rules at R-33(c).

14 ARIAS U.S. Rules at 14.6.

15 *See Broumand*, 522 F. Supp. 3d at 23.

16 *Id.* at 21.

17 *Id.* at 23.

18 *Id.* at 23-4.

19 *Id.* at 24 (*quoting Life Receivables*, 549 F.3d at 218).

20 *Id.* (quoting *Stolt-Nielsen*, 430 F.3d at 580).

21 *Id.* at 25.

22 *Symetra Life Ins. Co.*, 2022 WL 16730542, at *1.

23 *Id.* at *2.

24 *Id.*

25 *Id.* at *4.

26 *Id. See also Wash. Nat'l Ins. Co. v. Obex Grp. LLC*, No. 18-cv-9693 2019 WL 266681, at *5-6 (S.D.N.Y. Jan. 18, 2019) (granting petition to enforce nonparty summonses before an arbitration panel in multiple districts because "[n]othing in Section 7 requires an arbitration panel to sit in only one location").

27 *Symetra Life Ins. Co.*, 2022 WL 16730542,- at *4.

28 *Id.* at *5.

29 *Id.*

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You Say 'Follow-the-Fortunes,' I Say 'Follow-the-Settlements,' Let's Call the Whole Thing Off

By: Andrew L. Poplinger

Introduction

Reinsurance contracts commonly provide that the cedent's coverage determinations and claims settlements are binding on the reinsurer. These provisions, particularly in the United States, are generally referred to interchangeably as "follow-the-fortunes" or "follow-the-settlements" clauses.

As some commentators observe, however, the terms "follow-the-fortunes" and "follow-the-settlements" meant different things when originally adopted, with only the latter concerning the reinsurer's obligation to follow its cedent's loss settlement actions. This article explores the practical relevance of these historical distinctions in modern practice.

The Historical Origins of 'Follow-the-Fortunes' and 'Follow-the-Settlements'

The term "follow-the-fortunes" was first adopted in 18th century French marine reinsurance.[1] As originally used, the cedent's "fortunes" were "the broad aleatory 'underwriting fortunes' of the ceding company under the original policy."[2] Because "aleatory" means depending on chance, the "aleatory

underwriting fortunes" would not include the cedent's deliberate claims decisions. Thus, the reinsurer's obligation to "follow-the-fortunes" meant that it was "liable for exposure developing automatically out of an original covered risk without any action on the part of the insurer."[3]

"Follow-the-settlements" first appeared in 19th Century England. It replaced earlier loss-settlement terms, such as "pay as may be paid thereon," which English courts interpreted to require no deference to the cedent's loss settlements. Under these earlier wordings, the cedent had to prove its actual (as opposed to arguable) liability under the insurance policy to recover under its reinsurance.[4] Therefore, unless the cedent litigated its coverage with its policyholder to judgment, it faced the prospect of having to litigate the underlying coverage with its reinsurers. The "follow-the-settlements" clause addressed this conundrum by making the cedent's good faith and business-like settlements binding on the reinsurer.[5]

Use in Modern Practice

"Follow-the-fortunes" now has a broader meaning than when first adopted centuries ago. Today, it is a term of art—particularly as interpreted by U.S. courts—referring to the panoply of the cedent's actions that are binding on its reinsurers, including loss settlement decisions. A "follow-the-fortunes" clause:

> binds a reinsurer to accept the cedent's good faith decisions on all things concerning the underlying insurance terms and claims against the underlying insured: coverage, tactics, lawsuits, compromise, resistance or capitulation.… It is well-established that a follow-the-fortunes doctrine[6] applies to all outcomes, including settlements and judgments.[7]

Courts today use "follow-the-fortunes" to encompass, among other things, the same obligations imposed by the traditional "follow-the-settlements" clause.[8] And they frequently use the terms "follow-the-fortunes" and "follow-the-settlements" interchangeably to describe contractual terms requiring the reinsurer to accept the cedent's' loss settlement decisions,[9] even where they do not include the precise words "follow-the-fortunes" or "follow-the-settlements."[10] For example, courts have described the following as a "follow-the-fortunes" clause: "All claims involving this reinsurance, when settled by the company, shall be binding on the reinsurer."[11]

> "Courts today use 'follow-the-fortunes' to encompass, among other things, the same obligations imposed by the traditional 'follow-the-settlements' clause."

Likewise, those courts that hold reinsurers have an implied obligation to follow the cedent's claims settlements, even absent an express contractual provision, use "follow-the-fortunes" and "follow-the-settlements" interchangeably to describe these implied obligations.[12]

It is the rare modern decision that distinguishes between the terms "follow-the-fortunes" and "follow-the-settlements." To the extent courts differentiate between these terms or concepts, it is generally to note only that "follow-the-fortunes" is a broader concept, which subsumes "follow the settlements." A common refrain in judicial decisions is that "[t]he 'follow the settlements' doctrine is the application, in the settlement context, of the broader concept or doctrine of 'follow the fortunes.'"[13] That is, courts interpret the cedent's "underwriting fortunes" to include claim settlements, because the

cedent's good faith settlement reflects its aleatory loss developments.

Many commentators recognize that any historical distinction no longer persists, and today the labels "follow-the-fortunes" and "follow-the-settlements" both encompass the reinsurer's obligation to follow the cedent's claims decisions.

As Schwartz notes:

> Purists draw a distinction between "follow-the-settlements" and "follow-the-fortunes." In their view, "follow-the-fortunes" refers to the reinsurer's duty to follow its cedent's underwriting fortunes, while "follow-the-settlements" means that the reinsurer is bound by the cedent's settlements of underlying claims. *In practice, however, the two terms are often used interchangeably.*[14]

Hoffman, in tracing the origins of "follow-the-fortunes," explains:

> [T]oday the notion of following the "underwriting fortunes" that underlies that principle no longer provides the primary meaning of the phrase "follow-the-fortunes." Rather, the decisional law indicates that the so-called "follow-the-fortunes clause" today operates primarily as a loss settlement clause. In modern reinsurance parlance, *this means that the primary legal function of "follow the fortunes" in practice today is to give rise to the reinsurer's duty to follow the (settlement) actions of the reinsured.*[15]

Strain likewise recognizes that historical distinctions between "follow-the-fortunes" and "follow-the-settlements" do not persist in modern practice:

> There are those authorities within the industry who would not equate "follow-the-fortunes" with "follow-the-settlements." In this circle, the concept of "follow the fortunes" protects the reinsured company from the reinsurer's questioning the decision of the reinsured's underwriting staff… but the protection would not extend to claims settlement decisions…. This same school would therefore elect to limit the "follow-the-settlements" to the claims settlement process only. *This difference may have a historical basis. Nevertheless, the history of the jurisprudence on the subject treats these concepts as synonymous.*[16]

"Many commentators recognize that any historical distinction no longer persists..."

Ostrager and Vyskocil (both now on the Bench) describe loss settlements as an "underwriting fortune," because underwriting results include good faith claims payment decisions based on fortuitous loss developments:

> At its most basic level, the "follow-the-fortunes" doctrine requires a reinsurer to follow its cedent's underwriting fortunes. The follow-the-fortunes doctrine restricts the ability of reinsurers to question the validity of cedents' good faith claims payments. Under this doctrine, reinsurers must indemnify cedents for reasonable settlements and judgments and are precluded from obtaining a *de novo* review of the coverage determinations, which led to the payment of ceded claims.[17]

Although used interchangeably, there may still be room for distinction where "a contract includes both a follow-the-settlements clause and a follow-the-fortunes clause," in which case "the latter might be interpreted as applying to the cedent's underwriting fortunes."[18]

Take, for example, a treaty containing the following two clauses:

> <u>Follow the Fortunes</u>
> The Reinsurer's liability shall attach simultaneously with that of the Company and shall be subject in all respects to the same risks, terms, conditions, interpretations, waivers, modifications, alterations, and cancellations as the respective insurances (or reinsurances) of the Company, the true intent of this Agreement being that the Reinsurer shall, subject to the terms, conditions, and limits of this Agreement, follow the fortunes of the Company.

Loss Settlements
All of the Company's liability as determined by a court or arbitration panel or arising from a judgment, settlement, compromise or adjustment of claims or losses under the Policies reinsured, including payments involving coverage issues and/or the resolution of whether such claim is required by law, regulation, or regulatory authority to be covered (or not to be excluded), shall be binding on the Reinsurer.

Because the second clause appears limited to binding the reinsurer to the cedent's good faith loss settlements (or adverse judgments), one might conclude that the first clause must do something else. Although another might view the inclusion of both clauses as merely belt-and-suspenders. Regardless, the inclusion of both clauses makes any actual distinction irrelevant, as the reinsurer's obligation to follow the cedent's loss settlements is clear.

But were it necessary, it would be difficult to articulate a distinction between the two clauses, because the language of the "follow-the-fortunes" clause appears to already bind the reinsurer to the cedent's settlement decisions. In addition to including the phrase "follow the fortunes of the [cedent]"— itself recognized as engendering the obligation to follow the cedent's settlements —the clause further states that the reinsurer's liability attaches "simultaneously" with that of the cedent, and is "subject in all respects" to, among other things, the "same interpretations" of the cedent. The plain meaning of this language seems to bind the reinsurer to the cedent's interpretation of its coverage obligations. In this example, were the "Loss Settlements" clause not included, the "Follow-the-Fortunes" clause alone would likely bind the reinsurer to accept the cedent's loss settlement decisions.

> "In modern parlance, either term refers to the reinsurer's obligation to follow the cedent's good faith settlements."

Conclusions

There may have been a distinction between "follow-the-fortunes" and "follow-the-settlements" when these terms were first adopted in past centuries, but that distinction today is largely academic. "In many peoples' minds, following fortunes and following settlements are treated as one and the same, and U.S. court cases appear to reach that conclusion by referring to following settlements as 'following fortunes.'"[19] In modern parlance, either term refers to the reinsurer's obligation to follow the cedent's good faith settlements.

The key take away is a practical one. Today the terms "follow-the-fortunes" and "follow-the-settlements" are used interchangeably to refer to the reinsurer's obligation to follow the cedent's loss settlement decisions. Accordingly, if parties intend for the reinsurer to follow only the cedent's underwriting actions and decisions, but not its claim settlements, they should not rely on the shorthand "follow-the-fortunes." They should instead use language that clearly and unequivocally expresses that distinction. "If the contract includes only a follow-the-fortunes clause, … the clause may well be applied as a follow-the-settlements clause."[20]

NOTES

1 William C. Hoffman, Common Law of Reinsurance Loss Settlement Clauses: A Comparative Analysis of the Judicial Rule of Enforcing the Reinsurer's Contractual Obligation to Indemnify the Reinsured for Settlements, 28 Tort & Ins. L.J. 659 at 664 (1993).

2 *Id.*

3 Debra J. Hall, Robert M. Hall, Exploring the Skills and Knowledge You'll Need: Reinsurance Arbitrations in a Subprime Era, 53 No. 6 DRI For Def. 14 (2011).

4 Hoffman, *supra* at 673 (discussing *Chippendale v. Holt*, [1895] 1 Com. Cas. 197).

5 *Id.* at 675-76.

6 Courts often use the phrase "follow-the-fortunes doctrine" to describe the usual construction of follow-the-fortunes clauses, including the inherent limitations on the reinsurer obligations they impose. *See Brit. Int'l Ins. Co. v. Seguros La Republica, S.A.*, 342 F.3d 78, 85 (2d Cir. 2003). This includes

requiring the reinsurer to follow only the cedent's good faith settlements—not those that are the product of fraud, collusion, *ex gratia* payments, or the like—and only to the extent such settlements do not recognize a liability falling outside the terms of the reinsurance. *See Am. Employers' Ins. Co. v. Swiss Reinsurance Am. Corp.*, 413 F.3d 129, 136 (1st Cir. 2005) ("It is well settled that to trigger the deference due under a follow-the-fortunes clause the cedent's settlement must be made in good faith."); *Global Reins. Corp. of Am. v. Argonaut Ins. Co.*, 634 F. Supp. 2d 342, 350 (S.D.N.Y. 2009) (noting that a "follow the fortunes" clause "does not make a reinsurer liable for risks beyond what was agreed upon in the reinsurance certificate.").

7 *North River Ins. Co. v. Ace Am. Reinsurance Co.*, 361 F.3d 134, 139-140 (2d Cir. 2004).

8 *See, e.g., Curiale v DR Ins. Co.*, 593 N.Y.S.2d 157, 165 (N.Y. Sup. Ct. 1992) (explaining "follow the fortunes appears similar to a follow the settlements clause" and citing the House of Lords' decision in *Insurance Company of Africa v. Scor (UK) Reinsurance Co. Ltd.*, [1985] 1 Lloyd's Rep. 312, a seminal "follow the settlements" case); *Aetna Cas. & Sur. Co. v. Home Ins. Co.*, 882 F. Supp. 1328, 1348-49 (S.D.N.Y. 1995) (describing a "loss settlement" clause as a "follow the fortunes clause"); *Travelers Cas. and Sur. Co. v. Ins. Co. of N. Am.*, 609 F.3d 143, 149 (3d Cir. 2010) ("The follow-the-fortunes doctrine significantly restricts a reinsurer's ability to challenge the coverage decisions that led to its liability to the insurer.").

9 *See, e.g. Lexington Ins. Co. v. Clearwater Ins. Co.*, 2011 WL 3715546, at *3 n. 2 (Mass. Super. July 27, 2011) ("Although some commentators have drawn a distinction between 'follow the settlements' and 'follow the fortunes,' most courts have used the phrases interchangeably to describe the same doctrine."); *Employers Reinsurance Corp. v. Massachusetts Mut. Life Ins. Co.,* 2008 WL 3890358, at *5 (W.D. Mo., Aug. 19, 2008) ("The phrases 'follow-the-fortunes' and 'follow-the-settlements' are used interchangeably."); *Am. Employers' Ins. Co. v. Swiss Reinsurance Am. Corp.*, 413 F.3d 129, 132 (1st Cir. 2005) ("The certificates also contained 'follow-the-fortunes' provisions, often described as 'follow-the-settlements' provisions."); *Utica Mut. Ins. Co. v. Century Indem. Co.*, 419 F. Supp. 3d 449, 460 (N.D.N.Y., 2019) ("although the correct usage is context-dependent, courts often use the two terms interchangeably."); *Houston Cas. Co. v. Lexington Ins. Co.*, 2006 WL 7348102, at *3 n. 8 (S.D. Tex. June 15, 2006) ("The follow the settlements doctrine is also known as the follow the fortunes doctrine."), report and recommendation adopted sub nom. *Houston Cas. Co. v. Lexington Ins. Co.*, 2006 WL 8446160 (S.D. Tex. July 11, 2006); *Affiliated F.M. Ins. Co. v. Employers Reinsurance Co.*, 369 F. Supp. 2d 217, 221 n.7 (D.R.I. 2005) ("[T]he terms 'follow the settlements' and 'follow the fortunes' are essentially synonymous, and will be used interchangeably."); *Suter v. Gen. Acc. Ins. Co. of Am.*, 2004 WL 3751734, at *10 n.12 (D.N.J. Sept. 30, 2004) ("This Opinion will use the phrases 'follow the fortunes' and 'follow the settlements' interchangeably.").

10 *See* Steven C. Schwartz, Reinsurance Law: An Analytical Approach, §6.02[6] (2018).

11 *See, e.g., Am. Ins. Co. v. N. Am. Co. for Prop. & Cas. Inc.*, 697 F.2d 79, 81 (2d Cir. 1982); *Com. Union Ins. Co. v. Swiss Reinsurance Am. Corp.*, 413 F.3d 121, 124 (1st Cir. 2005).

12 *See, e.g., Int'l Surplus Lines Ins. Co. v. Certain Underwriters at Lloyd's of London*, 868 F. Supp. 917, 920 (S.D. Ohio 1994) ("It is commonly understood that reinsurers must 'follow the fortunes' of their insured. This fact may be formally expressed in an agreement of reinsurance. Even if it is not, the 'Follow the Fortunes' doctrine applied to all reinsurance contracts.").

13 *Okla. Ex rel. Holland v. Employers Reinsurance Corp.*, 2007 WL 2703157, at *4 (W.D. Okla. Sept. 13, 2007); *see also, e.g., Travelers Cas. & Sur. Co. v. Gerling Global Reins. Corp. of Am.*, 419 F.3d 181, 186 n.4 (2d Cir. 2005).("The follow the settlements doctrine ... is the follow-the-fortunes doctrine in the settlement context."); *Utica Mut. Ins. Co. v. Clearwater Ins. Co.*, 906 F.3d 12, 16 n.2 (2d Cir. 2018) ("A 'follow-the-settlements' obligation ... is a follow-the-fortunes obligation in the settlement context." (cleaned up)).

14 Schwartz, *supra* at §6.02[6], n.39 (emphasis added).

15 Hoffman, *supra* at 665 (emphasis added).

16 Robert W. Strain, Reinsurance, at 194 (Rev. Ed. 1997) (emphasis added).

17 Barry R. Ostrager & Mary Kay Vyskocil, Modern Reinsurance Law and Practice, § 9.01 (2d ed. 2000).

18 Schwartz, *supra* at §6.02[6].

19 Strain, *supra* at 27.

20 *Id.*

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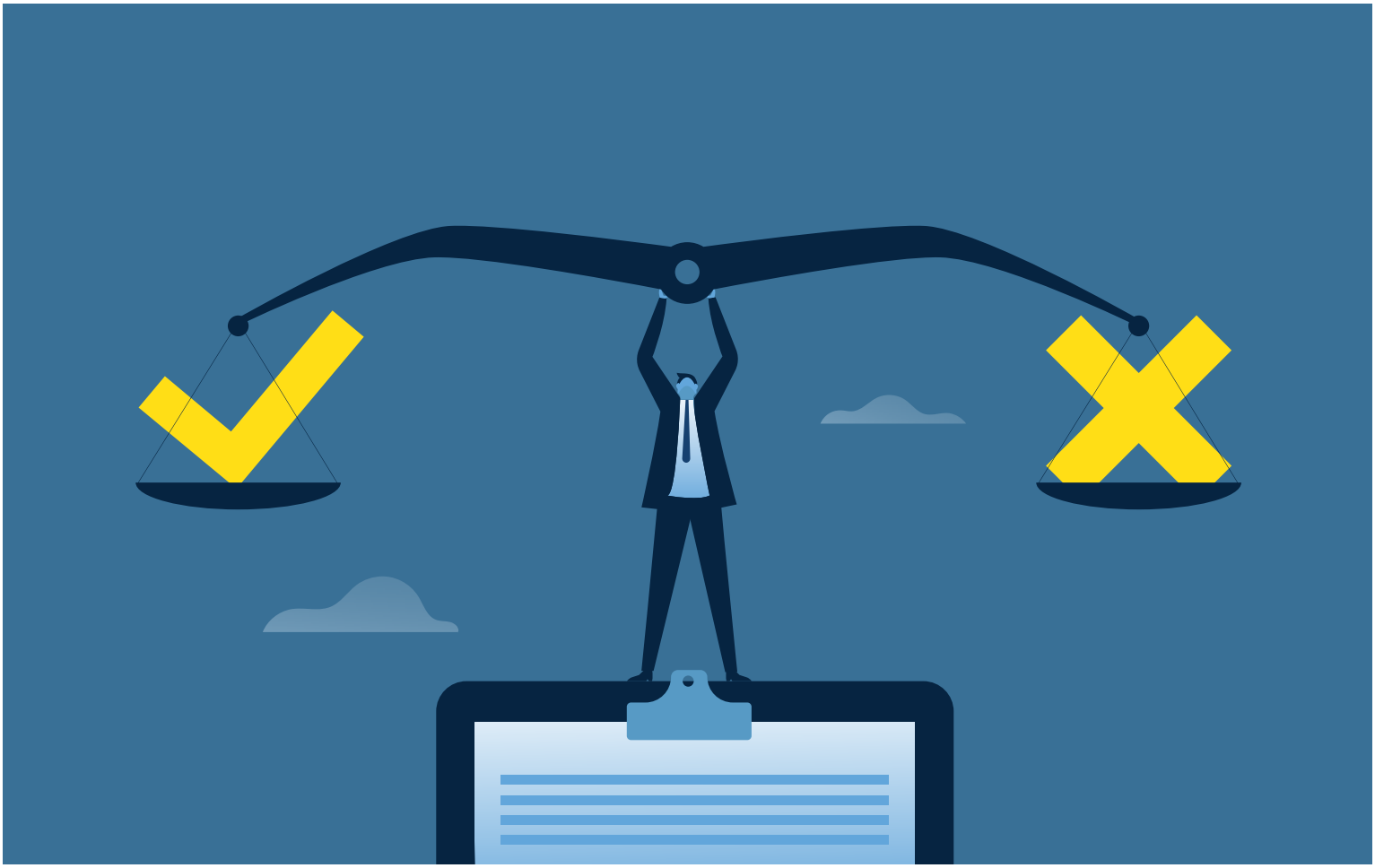

Late Notice For Claims-Made Excess Policies

The Harvard v. Zurich Example

By Robert M. Hall

I. Introduction

Claims-made policies can present insureds with challenges concerning the proper time to report a "claim" or an "incident" that might result in a claim. Claims-made excess policies can present additional challenges concerning the need to make another report to the excess insurer and the likelihood that the claim will penetrate the excess layer.

The purpose of this article is to present an in-depth examination of a case in point, that being proper notice to an excess insurer in relation to a suit alleging racial discrimination by Harvard concerning the admission of applicants of Asian descent. The racial discrimination case was argued before the United States Supreme Court in late 2022 and, as this is written, awaits a ruling by the high court. However, a summary judgment ruling on Harvard's late notice to its excess insurer in the coverage case was issued recently: *President & Fellows of Harvard College v. Zurich American Ins. Co.*, No. 21-cv-11530-ADB (D. Mass. Nov. 2, 2022) ("*Harvard v. Zurich*").

II. A Brief History of Claims-Made Coverage for Liability Insurance

A capacity shortage for professional liability and products liability in the 1970s jump started the use of claims-made policy forms for these and, eventually,

other types of liability risks. The need for claims-made forms resulted from classes of business with an extended reporting period or "tail." These long-tail liabilities made it difficult for actuaries to predict the timing of loss payments and ultimate payouts. This, in turn, made it difficult for underwriters to price the risks within these classes of business.

While the differences between occurrence-based and claims-made policy forms are well understood today in the insurance business and by most courts, this was not the case in the 1970s. Policy drafters, including the author, struggled to make policy language clear and effective and to avoid gaps in coverage (*e.g.* through use of common retroactive dates and extended periods to report claims after policy expiration). Early court decisions misinterpreted, ruled as ambiguous or simply rejected as unfair key provisions of claims-made policies. Over time, however, the sophisticated insureds who purchased claims-made policies, plus the courts, became comfortable with the strict loss reporting requirements of claims-made policies and the reasons behind them. Caselaw became supportive. Nonetheless, there remain aspects of claims-made coverage that can present problems for the inattentive.

III. The Claims-Made Excess Policy in Harvard v. Zurich

Zurich provided a one-year policy, effective November 1, 2014, with limits of $15 million in excess of $25 million provided by a claims-made policy issued by National Union, which was in excess of a $2.5 million self-insured retention. Defense costs were contained within limits in both policies. The Zurich excess policy followed the form of the underlying National Union policy, which required the policyholder to provide written notice of a claim as soon as practical but in no event later than 90 days after the end of the policy period on November 1, 2015. The Zurich policy stated that notice to the underlying insurer was not notice to Zurich.

> "Policy drafters, including the author, struggled to make policy language clear and effective and to avoid gaps in coverage."

The underlying discrimination suit was filed on November 17, 2014, and it was formally reported to National Union two days later. Formal notice was first provided to Zurich on May 23, 2017. On October 25, 2017, Zurich denied the claim for late notice.

IV. Arguments to the Court on Behalf of Harvard

It is not evident from the briefs or the district court decision why Harvard failed to give notice to Zurich until May 23, 2017. Perhaps it considered notice to Nation Union sufficient. However, Harvard argued that the lack of formal notice pursuant to the policy terms was irrelevant for several reasons.

First, Harvard argued that it gave notice when expenses were "tens of millions of dollars shy" of exceeding the underlying layer, but when it seemed to Harvard that expenses could possibly grow to enough to penetrate Zurich's layer. This is an argument commonly made on occurrence-based excess policies where the insured is allowed to use its judgment as when a claim is likely to impact an excess layer.

Second, Harvard argued that Zurich had actual notice of the claim through numerous media reports of the litigation within the period to report claims under the policy. Discovery of underwriting files indicated that Zurich was aware of the litigation and was following it.

Third, Harvard argued that given this actual notice received by Zurich, requiring formal notice pursuant to the policy terms was a technical requirement elevating form over substance. Harvard maintained that this violated equitable principles fundamental to Massachusetts contract law.

Finally, Harvard made an argument

that goes to the reason for using claims-made policies. Early notice of claims allows a claims-made insurer to adjust prices to reflect negative experience. Zurich had actual notice of the discrimination suit, Harvard argued, albeit not the "formal" notice required by the policy. But Zurich did not increase the premium based on this adverse experience and actually decreased the premium for 2016. Thus, formal notice would have had no impact on the purpose for which claims-made policies are used.

V. Arguments to the Court on Behalf of Zurich

Zurich pounded the terms of its contract as an excess claims-made insurance policy following the form of the underlying National Union policy. The latter policy required that the policyholder give notice of any claim under that policy not later than 90 days after policy expiration as a condition precedent to recovery. For there to be coverage under the Zurich policy, the claim had to be made against Harvard during the policy period and reported to Zurich not later than 90 days after the expiration of that policy. Zurich argued that Massachusetts case law supports strict compliance with these policy terms.

Zurich likewise argued that indirect, constructive notice was insufficient because the policy required the policyholder to report the claim. Zurich cited a number of cases in which courts, applying Massachusetts law, rejected indirect notice, including media reports, as being insufficient to trigger coverage by a claims-made policy.

VI. Ruling of the Court

The court firmly rejected Harvard's arguments and granted summary judgment to Zurich. *President & Fellows of Harvard College v. Zurich American Ins. Co.*, No. 21-cv-11530-ADB (D. Mass. Nov. 2, 2022). In so doing it observed:

> Massachusetts law is clear that (1) the unambiguous terms of an insurance policy must be strictly enforced and (2) an insured's failure to comply with the notice provision of a claims-made policy bars coverage. . . . Where a condition precedent is not fulfilled, "the contract, or the obligations attached to the condition, may not be enforced." . . . With regard to claims-made policies such as the one at issue here, notice within the policy period "is of the essence in determining whether coverage exists."[1]

The court went on to rule:

> It is thus clear that Zurich's lack of prejudice, or constructive or even actual knowledge would not change Harvard's obligation to provide notice in full compliance with the terms of the Policy. . . . Put simply, because an unambiguous policy must be applied as written; the notice provision in a claims-made policy must be strictly construed; and Harvard's failure to satisfy a condition precedent vitiates coverage, Zurich motion for summary judgment, . . ., is therefore GRANTED.[2]

VII. Commentary

On the surface, at least, this case is contest between an insurer with a well-crafted policy and an inattentive insured. But to those who were involved in early drafting of claims-made policies and the related court decisions, there is a historic resonance to Harvard's argument concerning notice to Zurich through the media and Zurich's failure to raise its premium as a result of the discrimination suit—this challenges the very theory behind claims-made policies, *i.e.* that early notice is necessary to adjust premium. This argument might have persuaded a court during the early days of the growing use of claims-made policies, but not after decades of business experience with claims-made policies and subsequent judicial decisions.

NOTES

1 *Slip op.* at 1 (internal citations omitted).

2 *Slip op.* at 2.

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Loss Development Without Tears

What Is Loss Development and How Do Actuaries Use It? Part 2

By Gary Blumsohn

Part 1 of this discussion (*See: ARIAS•U.S. Quarterly, Q4 2022*) explained how actuaries use loss development patterns. The examples in Part 1 just stipulated certain development patterns but didn't explain how actuaries calculate them. Part 2 will explain how actuaries calculate them and then show how they are used.

Loss Triangles

Loss triangles are tabulations of historical losses. Consider the example in Table 1 below:

Table 1

	Loss Development Age				
Year	**12**	**24**	**36**	**48**	**60**
2016	10	20	30	40	50
2017	15	30	45	60	
2018	17	34	51		
2019	20	40			
2020	25				

This table shows historical paid losses for years 2016 to 2020.[1] Start with the row that shows losses that occurred in 2016. The table shows that at the end of 2016 (at 12 months of age), the paid losses were $10. By convention, actuaries start counting from the beginning of the year, so that at the end of the year, the losses are labeled as being 12 months old. A year later, at the end of 2017, the losses that occurred in 2016 are 24 months old and the paid losses are $20. Similarly, at the end of 2018, 2019, and 2020, the losses that occurred in 2016 are $30, $40, and $50. Notice that the most recent evaluation of losses that occurred in 2016 is at 60 months, which is at the end of 2020.

Similarly, for losses that occurred in 2017, at 12 months, $15 have been paid; at 24 months, $30 have been paid; at 36 months, $45 have been paid; and at 48 months, $60 have been paid. For losses occurring in 2017, we have loss evaluations at the end of 2017, 2018, 2019, and 2020—in other words, four evaluations, rather than the five evaluations we had for the 2016 year.

The rest of the triangle is constructed similarly, ending with losses occurring in 2020, for which there is only one evaluation—$25 paid at 12 months.

Now consider the "link ratios" (also known as "age-to-age factors") that can be calculated from the above triangle. They are obtained by dividing the losses at one age by the losses at the previous age. For example, looking at losses from 2016, the "12-to-24 link ratio" is obtained by dividing the losses at age 24 ($20) by the losses at age 12 ($10): $20 ÷ $10 = 2.00. Table 2 shows all the link ratios that are calculated from the triangle in Table 1.

Table 2

	Link ratios			
Year	**12-24**	**24-36**	**36-48**	**48-60**
2016	2.00	1.50	1.33	1.25
2017	2.00	1.50	1.33	
2018	2.00	1.50		
2019	2.00			

Notice that the entire column of 12-24 factors is 2.00, which means that for each of the years in our data, the losses at 24 months were exactly double the losses at 12 months. Similarly, all the 24-36 factors are 1.50; and both 36-48 factors are 1.33. In practice, it never happens that all the factors down each column are the same—that would be too good to be true.

Actuaries generally assume, in the absence of a reason to assume otherwise, that future loss development will be the same as past loss development. (This is the chain ladder approach discussed in Part 1 of this paper.) In the example, all the history shows that at 24 months, the losses are double what they were at 12 months. Thus, in thinking about the 2020 year, the actuary will project that the losses will grow from $25 at 12 months to double that at 24 months, or $50. Similarly, at 36 months, the actuary will project that the 2020 losses at 36 months will be 1.50 times the value at 24 months, or $75. Proceeding in this way, each of the unfilled boxes in the bottom half of the triangle can be filled in, as shown below in Table 3. (Exercise for the reader: Confirm that you can match the actuary's numbers in the bottom half of Table 3.)

Table 3

	Loss Development Age				
Year	**12**	**24**	**36**	**48**	**60**
2016	10	20	30	40	50
2017	15	30	45	60	75
2018	17	34	51	*68*	*85*
2019	*20*	*40*	*60*	*80*	*100*
2020	*25*	*50*	*75*	*100*	*125*

Proceeding in this way provides us with a chain-ladder method of projecting the ultimate losses.

However, it would be wrong to assume that just because the data ends after five years that the loss development also ends after five years. Depending on the type of business, the development might continue for a few more years (e.g., private passenger auto liability) or it might continue for decades (e.g., workers' compensation). It is beyond the scope of this introduction to the subject to explain exactly how actuaries come up with the so-called "tail factor" that will develop the losses, in this example, from 60 months to ultimate. Suffice it to say that the tail factor is often the most speculative and judgmental part of the entire analysis, and two actuaries will often come up with significantly different estimates of the tail factor.

For sake of the example, assume that the actuary has estimated the tail factor to be 1.40. Table 4 is a repetition of Table 3, except that an additional column has been added to show the losses at ultimate.

Table 4

	Loss Development Age					
Year	**12**	**24**	**36**	**48**	**60**	Ultimate
2016	10	20	30	40	50	*70*
2017	15	30	45	60	*75*	*105*
2018	17	34	51	*68*	*85*	*119*
2019	20	40	*60*	*80*	*100*	*140*
2020	25	*50*	*75*	*100*	*125*	*175*

Table 5 shows the link ratios, also known as age-to-age (ATA) factors.

Row (1) shows the age-to-age factors from the triangle.

Row (2) shows the "age-to-ultimate" (ATU) factors. Just as age-to-age factors take the losses from one age (say, 24 months) to the next age (36 months), so the age-to-ultimate factors take the actuary from one age (say, 24 months) to ultimate. For example, this table shows that the 24-to-ultimate factor is 3.50. This means that if the losses at 24 months are $40, then we project the ultimate losses to be 3.50 x $40 = $140.

The age-to-ultimate factors are calculated by starting with the rightmost ATA factor (1.40). To get the 48-to-ultimate factor, multiply the 48-to-60 age-to-age factor (1.25) by the 60-to-ultimate factor (1.40), which gives 1.75. Next, calculate the 36-to-ultimate factor by multiplying the 36-to-48 factor (1.33) by the 48-to-ultimate factor (1.75), which is 2.33. Next, calculate the 24-to-ultimate factor by multiplying the 24-to-36 factor (1.50) by the 36-to-ultimate factor (2.33), which is 3.50. Finally, to get the 12-to-ultimate factor, multiply the 12-24 factor (2.00) by the 24-to-ultimate factor (3.50), which is 7.00.

Row (3) shows the percent of ultimate losses at each time period. For example, at 12 months, it says that 14.3% of the losses have been paid. The calculation of this is simple: The age-to-ultimate at 12 months is 7.00. This means that for every $1 paid at 12 months, we expect ultimately to pay $7. Thus, at 12 months, $1 ÷ $7 or 14.3% of the ultimate losses have been paid. More generally, we can say that the percent of ultimate is simply 1 ÷ ATU.

Table 5

	12	24	36	48	60
(1) Age-to-age (ATA)	2.00	1.50	1.33	1.25	1.40
(2) Age-to-ultimate (ATU)	7.00	3.50	2.33	1.75	1.40
(3) Percent of ultimate (1/ATU)	14.3%	28.6%	42.9%	57.1%	71.4%

The above example was overly simple, mainly because the age-to-age factors down each column were always identical. If this were always true, a lot of actuarial work could be replaced by computers. But consider a more realistic example in Table 6.

Table 6

	Loss Development Age				
Year	**12**	**24**	**36**	**48**	**60**
2016	10	20	30	40	50
2017	15	25	50	70	
2018	17	34	60		
2019	20	30			
2020	25				
	Link Ratios (ATA)				
Year	**12-24**	**24-36**	**36-48**	**48-60**	
2016	2.00	1.50	1.33	1.25	
2017	1.67	2.00	1.40		
2018	2.00	1.76			
2019	1.50				
Average ATA	1.79	1.75	1.37	1.25	
Age-to-Ultimate* (including tail factor)	7.52	4.20	2.39	1.75	1.40
Percent of ultimate (1/ATU)	13.3%	23.8%	41.8%	57.1%	71.4%

** Calculations are done to more decimal places than shown, so there might be rounding differences.*

In this example, the link ratios vary down the columns, so the actuary must use some average to get a selected link ratio at each age to use in the analysis. This is often highly judgmental. In Table 6, the actuary used the average of the numbers in each column. But actuaries will often use weighted averages rather than unweighted averages. Also, especially in larger triangles, it will often be observed that the link ratios trend up or down over time, so the actuary may give little weight to data that is more than, say, five years old. Triangles for some lines of business, especially excess casualty business, are often very volatile, with large variation in the link ratios in the triangle. This makes it difficult to come up with, "best estimate" link ratios and two different actuaries can come up with very significantly different numbers.[2]

Now, to complete the example, we show on Table 7 how an actuary would use these factors to calculate the loss reserves:

Table 7: Chain Ladder projection of ultimate

	(1)	(2)	(3)	(4) = (3) x (2)	(5) = (4) – (2)	(6) = (4) ÷ (1)
Year	Premium	Paid losses at 12/31/2020	ATU	Chain ladder projection of ultimate losses	Chain ladder projection of reserves	Projected ultimate loss ratio
2016	100	50	1.40	70.0	20.0	70%
2017	150	70	1.75	122.5	52.5	82%
2018	220	60	2.39	143.4	83.4	65%
2019	240	30	4.20	126.0	96.0	53%
2020	300	25	7.52	188.0	163.0	63%
Total	**1,010**	**235**		**649.9**	**414.9**	**64%**

Notes for the chain-ladder projection:

(2) The paid losses are taken from the diagonal of the triangle on Table 6.

(3) The age-to-ultimate factors are taken from Table 6. Since the 2016 year is the most developed, the last factor shown applies to the 2016 year, and the column successively works from right to left in the list of factors.

(4) The chain ladder projection of ultimate losses assumes that the ultimate losses are a multiplicative factor of the paid losses. As described in Part 1 if this paper, this projection of ultimate is the equivalent of saying that if the losses paid so far are, say, 20% more than would have been expected at this time, then the ultimate losses will also be 20% more than was expected at ultimate. (Remember the example of the time taken to commute home. If the first half of your commute took you double the usual time because it was snowing, you probably assume the second half will also take double the usual time.)

(5) The projected reserves, i.e., the projected unpaid losses, represent the difference between the projected ultimate losses and the losses paid already.

(6) The projected ultimate loss ratio is the projected ultimate losses divided by the premium.

Table 8: Bornhuetter-Ferguson projection of ultimate

	(1)	(2)	(3)	(4) = (3) x (1)	(5)	(6) = (4) x [1 – (5)]	(7) = (2) + (6)	(8) = (7) ÷ (1)
Year	Premium	Paid losses at 12/31/2020	Expected loss ratio	Expected losses	Expected % paid	B-F expected unpaid losses	B-F projection of ultimate losses	Projected ultimate loss ratio
2016	100	50	60%	60	71.4%	17.2	67.2	67%
2017	150	70	60%	90	57.1%	38.6	108.6	72%
2018	220	60	60%	132	41.8%	76.8	136.8	62%
2019	240	30	60%	144	23.8%	109.7	139.7	58%
2020	300	25	60%	180	13.3%	156.1	181.1	60%
Total	1,010	235		606		398.4	633.4	63%

Notes for the Bornhuetter-Ferguson projection:

(2) The paid losses are taken from the diagonal of the triangle on Table 6.

(3) The expected loss ratio will be what the actuary thought the loss ratio should be. It can come from the original pricing of the business, from a previous reserve review, from industry loss ratio information, or a variety of other sources.

(4) The expected losses are obtained by applying the expected loss ratio to the premium to get the dollars of expected losses.

(5) The expected percentage paid is from the last row of Table 6. This shows what percentage of the ultimate paid losses have historically been paid at each age of development.

(6) The expected unpaid losses represent the portion of the expected losses from column (4) that will be paid in the future. Since column (5) shows the percentage of losses that are expected to have been paid, the expected unpaid losses will be 1 – column (5). For example, for the losses in 2016, we expected 71.4% to have been paid, so 1 – 0.714 = 0.286, or 28.6% will be expected to be unpaid. With 2016 expected losses of $60 (col (4)), the expected unpaid losses will be 28.6% of $60, or $17.2. Note that column (6) in Table 8 represents the B-F projection of future losses. (As described in Part 1 of this paper, the B-F projection can be thought of as analogous to driving home and taking a long time to

travel the first half of the journey, but then finding that the reason for the delay is that there was an accident. Once one is past the accident, the delay on the first half is no longer predictive of a delay journey on the second half, so the estimated time to complete the second half of the journey is exactly the usual commuting time.) Column (6) can be compared to column (5) from Table 7, which is the chain ladder projection of future losses. In this example, the overall future losses projected using the B-F are $398.4, whereas the chain ladder projected future losses are $414.9. In this case the chain ladder is higher than the B-F, but in general it can be either higher or lower.

(7) B-F projection of ultimate reserves is the losses already paid (col. (2)) plus the losses projected to be paid in the future (col. (6)). This is comparable to column (4) in Table 7.

(8) The projected ultimate loss ratio is the projected ultimate losses divided by the premium.

Having done the chain ladder and Bornhuetter-Ferguson projections (and probably also doing them using incurred losses, as well as paid losses—and maybe using some additional approaches that are beyond the scope of this paper), the actuary needs to make some judgements about which of the numbers are more believable than others. How the actuary will think about this is beyond the scope of this paper.

NOTES

1 For convenience, this example shows paid losses. It could just as easily show case incurred losses and everything would be exactly as is described for the paid losses. In practice, an actuary would prefer to have both the paid loss triangle and the case incurred triangle so that the analysis can be done on both and the results can be compared.

2 A detailed discussion of how actuaries deal with these issues is beyond the scope of this paper. Interested readers might take a look at Blumsohn, Gary and Michael Laufer (2009), "Unstable Loss Development Factors" in E-Forum (Spring 2009), Casualty Actuarial Society, https://www.casact.org/sites/default/files/database/forum_09sp-forum_01blumsohn.pdf. The paper describes an experiment where several dozen actuaries were given a triangle for umbrella insurance losses and asked to select link ratios. The range of responses from different actuaries was disturbingly wide.

Gary Blumsohn has more than 30 years of experience as an actuary at insurance and reinsurance companies, including 16 years as the chief actuary at Arch Reinsurance Company. He is also an ARIAS-certified arbitrator.

Florida Tries Again

A Summary and Overview of 'Hurricane Insurance' Legislation In 2022

By James F. Jorden

In May 2022, Florida Governor DeSantis announced the signing of a new bill, which he characterized as embodying the "most significant reforms to Florida's homeowners insurance market in a generation." That was May. Six months later, Florida's legislature took a second go at addressing the substantial issues facing Florida's insurance/reinsurance market. Much printer ink has been and will continue to be spent analyzing both efforts. I thought it might be helpful for those not engulfed in the day-to-day drama of the Florida hurricane/insurance/reinsurance issues to provide a summary of what the experts consider the key components of these two significant bills—leaving to others the task of predicting the short and long-term results of these measures.

The First Try

On April 26, 2022, Governor DeSantis signed a proclamation calling on the Florida legislature to convene a special session addressing the property insurance market in Florida. The call was intended to address property insurance and reinsurance and potential changes to the Florida building code. The primary response was to adopt the Reinsurance to Assist Policyholders (RAR) program. The program established a $2-billion reimbursement layer of reinsurance for hurricane losses directly below the mandatory layer of the existing Florida Hurricane Catastrophe Fund and imposed mandatory participation of all eligible insurers. Under the RAP program, insurers were reimbursed 90% of all covered losses and 10% of loss adjustment expenses. All eligible insurers are required to participate for one year. RAP insurers that have private reinsurance equivalent to the RAP program must notify the Florida authorities.

During the session, Florida House

speaker Chris Sprowls introduced what became a companion bill intended to address numerous issues regarding condominium and home building protections and contractor limitations referred to as the My Safe Home Program. That program appropriates $150 million from the Florida general revenue funds to provide for cost of hurricane inspections, and necessary retrofitting of homes and condominiums having a value of $500,000 or less. On the issues of litigation and related expense issues, the bill also: (a) prohibits the assignment of the right to obtain attorney fees to other than the named insured or related persons; (b) prohibits assignment of the right to recover attorney fees; (c) creates a presumption that awarding of attorney fees based on Lodestar is sufficient and reasonable; and, (d) provides that insurer may be awarded attorney fees when claim is dismissed under certain circumstances.

The statute also includes numerous provisions eliminating other perceived improper conduct of contractors and lawyers in the context of soliciting homeowners to submit policy claims and assigning potential claim benefits.

The Second Try

The second legislative effort, adopted on December 15, 2022, was characterized by its sponsor, state senator Thomas Boyd, as a "*comprehensive bill intended to ensure policyholders in [Florida] have access to quality, affordable private market property insurance*." The bill contains three principal features. First, the foundation of the bill was the implementation of an optional hurricane reinsurance program for Florida property insurance companies, the Florida Optional Reinsurance Property Insurance Corporation ("FORA"). Second, the bill included a series of operational amendments of the law and procedures addressing various features of Florida's existing property insurance law. Third, the bill adopted a new Citizens Account to be offered by the existing Citizens Property Insurance Corporation for the issuance of new, presumed lower rate, property insurance policies by this state vehicle.

According to its authors, FORA was intended to address "anticipated shortages in the reinsurance market" by fashioning a program that would not only increase the availability of homeowner insurance, particularly as to hurricane damage protection, but also enable the

> "FORA was intended to address 'anticipated shortages in the reinsurance market' by fashioning a program that would not only increase the availability of homeowner insurance, particularly as to hurricane damage protection, but also enable the issuance of lower premium policies."

issuance of lower premium policies. The FORA program, as administered by the Florida State Board of Administration operating essentially as a separate entity of the state, is intended to enable insurers of property and residential premises to purchase reinsurance "through a new optional state reinsurance program…. at reasonable rates." As promulgated, the FORA Program will provide, commencing in 2023:

1. *Reinsurance that insurers can purchase at rates that would range from 50% to 65% below current on-line market rates, varying based on the tier level purchased.*
2. *Purchase tiers that begin at the Florida Hurricane Catastrophe Fund (FHCF) attachment point and cumulatively are limited to no more than $5 billion below that attachment point.*
3. *Allow insurers that purchase FORA coverage or receive free RAP coverage at each tier to have the option to purchase the next tier down.*
4. *Maintain the RAP program, thus allowing insurers and policyholders that could not participate during 2022-2023 to receive the benefits of RAP reinsurance.*
5. *Funding of FORA coverage with $1 billion in general revenue funds and FORA coverage premiums.*

In addition to establishing the FORA program, the bill also amends numerous provisions of the statutory provisions governing the Citizens Property Insurance Corporation in part to add a Citizens Account, primarily to provide multi-peril coverage on risks not located in areas eligible for coverage by the Florida Windstorm Underwriting Association.

The bill contains other provisions intended to eliminate practices deemed to be problematic (and costly) for both the insurers and insured: They include (in summary) the following:

a. Limiting requirements for insureds to participate in an appraisal to obtain full payment of claim and imposing other standards on use of appraisals.
b. Amending the "prompt pay" laws to require less time for decisions on payment of claims and other actions, such as claim communications and inspections.
c. Prohibiting the assignment of post-loss insurance benefits.
d. Prohibiting commencing "bad-faith" litigation against insurer until after a judicial finding against the insurer on an underlying contract claim.
e. Binding arbitration provisions may be included in policies if the policyholder is also offered an alternative contract without mandatory arbitration.

Substantial numerous additional provisions relating to the governance and regulatory obligations of property insurer are also provided for in the Bill, including among other conditions:

a. Additional market conduct examinations by the OIR under certain circumstances
b. New and additional grounds for the suspension or revocation of an insurer's license
c. Specifying annual rate increase limits for personal lines policies written by Citizens that do not cover a primary residence
d. Limiting rate increases for Citizens Account policies that do not cover primary residence
e. Requiring that Citizens Account impose a requirement for the securing and maintenance of flood insurance as a condition of personal lines residential insurance and imposing deadlines.
f. Specifying a "burden of proof" standard for corporate policyholders asserting water damage under Citizens Account policies.
g. Deleting a right to attorney fees to policyholders in suits arising

> "The bill contains other provisions intended to eliminate practices deemed to be problematic (and costly) for both the insurers and insured."

under residential or commercial property insurance

h. Authorizing insurers to use specified methods in investigating losses—and to void insurance policies under certain circumstances.
i. Authorizing surcharges on Citizens Account policyholders in the event of deficits.
j. Defining the term "factors beyond the control of the insurer"
k. Placing limits on commercial lines residential risk policies where the risk may be covered by an authorized insurer, unless the insurer's rate is more than 20% greater than the Citizens premium.
l. Deleting provisions authorizing payment of attorney fees.
m. Deleting the right to attorney fees under certain "sinkhole" claims
n. Prohibiting assignment of post-loss insurance benefits under residential or commercial policies
o. Specifying conditions for a provision that requires mandatory arbitration in property insurance contracts.

Details on Selected Provisions

Without attempting to cover the details on the provisions referenced in the outline above, (the FORA legislation encompasses 105 printed pages), I have chosen a few to provide a more specific description.

In an effort to place limits on what some have argued have been frivolous but expensive litigation against property insurers, the bill imposes standards for limiting extracontractual civil remedy actions as follows:

"In any claim for extracontractual damages …no action shall lie until a named insured or a named beneficiary has established through an adverse adjudication by a court of law that the property insurer breached the insurance contract and a final judgment or decree has been rendered against the insurer. Acceptance of an offer of judgment…. or payment of an appraisal award does not constitute an adverse judgment." (Civil Remedy Actions Against Property Insurers-S624.1551).

The bill also imposes limits on a property insurer's ability to delay or defer, otherwise properly made claims by insured. The bill provides that an insurer imposing the burden of obtaining an appraisal by the insured before payment of the claim will constitute grounds for suspension or revocation of the insurer's Certificate of Authority. (S624.418).

The bill authorizes a process for mandatory binding arbitration if the following conditions are met: (1) the requirements are contained in a separate endorsement attached to the insurance policy; (2) the premium charged for the policy reflects an "actuarially sound" discount (3) the policyholder signs a form accepting the process; (4) the insurer must agree to comply with the mediation provisions under the statute before initiating the arbitration and (5) the policyholder is also offered a policy that does not contain the mandatory arbitration clause. (S627.70154). The Bill also contains a provision that precludes a policyholder from assigning any post-loss property insurance benefits. (S627.7152(13)).

The full impact of the provisions in this bill will not likely be determined for several years—in part because most of the more significant provisions are not operative until 2023. However, more relevant is that only time will tell whether the actions designed to enhance the ability of insurers in writing property insurance, the provisions addressing premium costs and availability to homeowners and the efforts to limit litigation will be successful. In any event, it is clearly a massive bill that attempts to make Florida more attractive to property insurers and more successful in developing solutions for homeowners.

James F. Jorden is an ARIAS-qualified arbitrator/umpire, independent mediator, former General Counsel, officer and Board member of multinational insurance group, and founder of Jorden Burt Law Firm. For 30 years he has served the life and PC insurance industries on litigation, arbitration and corporate matters.

Medical Monitoring Claims

Trampling Tort and Insurance Principles in The Wake of PFAS

By John E. DeLascio

"Medical monitoring" claims continue to be controversial not only because they are often invoked in cases involving headline grabbing issues—such as opioids; PFAS; fracking; professional or student athlete concussions; HIV tainted blood—but, most fundamentally, because they dramatically depart from the traditional tenets of tort law. In the quest for larger recoveries, the plaintiffs' bar seeks awards not only on behalf of those claiming some actual injuries, but also it also seeks millions of dollars on behalf those who do not demonstrate any actual injury but who fear that, at some point the future, they may develop an injury because of some type of alleged toxic exposure.

By their very nature, these claims pose significant legal dilemmas as it has been recognized that "[f]or decades, a central tenet of tort law has been that a plaintiff may not recover damages for negligence absent physical injury."[1] Plaintiffs' lawyers can assert that they are purporting to pursue recoveries and expand legal remedies in response to an increasingly toxic world. Traditionally, defendants and most courts in the United States believed that these claims were at odds with traditional tort law principles.

Recently, medical monitoring claims have experienced a resurgence in a world grappling with impact of "social inflation" and the growing concern over alleged toxic exposures and other potential risks including exposure to certain chemicals broadly known as PFAS (Per- and Polyfluoroalkyl Substances), the so-called "forever chemicals." PFAS, as a category, comprises about 5,000 different compounds that contain bonds between carbon and fluorine atoms.[2] "The exceptional strength of those bonds leads PFAS to degrade slowly over time, and, as a result, to accumulate within the human body."[3] Though the long-term health effects of

PFAS are uncertain, many agree that "nearly all Americans have PFAS in their blood."[4]

Since Its Birth, the Medical Monitoring Claim Has Been Controversial

"Medical monitoring" claims were first awarded in the mid-1980s in *Friends for All Children, Inc. v. Lockheed Aircraft Corp.*[5] *Friends for All Children* is a case born out of a tragic story of an airplane engaged in a rescue mission, nicknamed "Operation Babylift," to evacuate Vietnamese orphan children from Saigon near the end of the Vietnam War. That plane crashed killing many of the orphan children; however, over a hundred infants survived. Some of the surviving orphans alleged that the crash's impact put them at an increased risk of incurring a neurological disorder. The United States Court of Appeals for the D.C. Circuit reasoned that allowing recovery for the expense of diagnostic exams "will, in theory, deter misconduct[.]" *Id.* at 825.

Advocates assert that "medical monitoring" is a remedy granted after exposure to a toxic substance that provides testing used for early detection of the signs of disease, which in turn allows for earlier and more effective treatment.[6]

Courts continue to wrestle with whether medical monitoring claims are even legally cognizable. Some commentators had warned that, "If not dead yet, the medical monitoring claim itself is hooked up to monitors and the prognosis is not good."[7] Yet, some courts have been receptive to these concepts.[8] Even in jurisdictions where "medical monitoring" claims have been squarely rejected, plaintiffs have asserted "phobia" claims (such as "cancerphobia") as a potential way around the legal restrictions of traditional tort law.[9]

Recently, legislative efforts are underway to erode the adherence to the traditional tenets of tort law and pave the way for more medical monitoring claims. Regardless of the claimed virtues and/or dangers of disregarding traditional tort law in allowing medical monitoring claims, there can be no real justification for also trampling on contract law. Indeed, medical monitoring claims raise a plethora of insurance coverage issues including, most fundamentally, they often do not allege actual "bodily injury" to even trigger coverage under a general liability policy. Moreover, the often cited justification for expanding the tort law, *i.e.*, to "punish polluters," would be rendered meaningless if the bill (the "punishment") is simply passed along to the insurer.

Given the expanding breadth of PFAS claims, there has been a renewed focus and scrutiny of medical monitoring claims. The proliferation of PFAS claims may be reviving the medical monitoring claim from its previously predicted deathbed. For example, on April 18, 2022, a federal judge approved a proposed $34 million settlement in a class action lawsuit involving manufacturer Saint-Gobain.[10] The lawsuit against Saint-Gobain alleged that the company produced fabrics coated with PFAS (specifically, Perfluorooctanoic Acid or "PFOA") from late 1960s to 2002. The discharge and effluent from the manufacturing process allegedly contaminated local drinking water sources. Notably, $6 million of that settlement amount was to be placed into a fund for a 15 year PFOA medical monitoring program. Nearby, the Supreme Court of New Hampshire entertained oral argument in November of 2022 in another PFAS case involving Saint-Gobain. *Kevin Brown, et al. v. Saint-Gobain Performance Plastics Corp., et al.*, No. 2022-0132. New Hampshire's Supreme Court is being asked to weigh in on whether the state recognizes claims for medical monitoring as a remedy for people who were exposed to toxic substances.

Courts remain divided as to whether medical monitoring costs are recoverable in a lawsuit (and if so, whether an actual injury must first be alleged) but "there are an increasing number of lawsuits nationwide that are pushing the envelope to try to get otherwise reluctant courts to award medical monitoring damages for PFAS cases." [11]

In April 2022, Vermont's governor signed into law a bill giving citizens "the right to file lawsuits against chemical companies for medical monitoring costs if the plaintiffs allege that they have been exposed to chemicals of concern, including PFAS."[12] The Vermont law, "the first of its kind in the nation, allows citizens to avoid the pitfalls of litigation and have an automatic ability to obtain medical monitoring relief."[13] Federal legislation has also been proposed and passed in the U.S. House of Representatives and introduced in the U.S. Senate.[14]

Other fairly recent claims activity appears to also be breathing some new life into the "medical monitoring" arena. For example, medical monitoring claims have been extended to concussion-injury cases. The United States District Court for the Northern District of Illinois, the court handling the

NCAA concussion Multi-District Litigation, granted final approval of the $75 million class action settlement between the NCAA and class plaintiffs, former collegiate athletes.[15]

Medical Monitoring Claims Not Only Trample Upon Traditional Tort Principles But Create Serious Insurance Coverage Issues

As much can be discussed regarding how medical monitoring claims may trample upon traditional tort tenets, policyholders have, in turn, also attempted to rewrite contract law and insurance coverage principles in an effort to obtain insurance coverage these claims. The critical question is whether claims for medical monitoring can constitute "bodily injury" under general liability policies. Medical monitoring claims raise numerous insurance coverage issues, most notably that they require funds be expended without any proof of injury or bodily injury.

CGL policies typically cover "Bodily Injury," which means "bodily injury, sickness or disease." By its very definition, medical monitoring claims require monitoring because they expect or fear some bodily injury in the future—but none actually exists presently. The traditional general liability policies typically do not state that they provide coverage for feared or anticipated bodily injury – they require actual "bodily injury."

Some courts have ruled that medical monitoring claims do not constitute claims of "bodily injury" covered under general liability policies. *See, e.g., HPF, LLC v. General Star Indem. Co.*, 338 Ill. App. 3d 912 (1st Dist. 2003) (finding no coverage for the medical monitoring claim for individuals who took the herbal dietary supplement Phen-Fen under the general liability policies). Other courts hold that medical monitoring claims can qualify as alleging bodily injury. *See, e.g., Baughman v. U.S. Liability Ins. Co.*, 662 F. Supp. 2d 386 (D.N.J. 2009) ("[C]onsistent with the New Jersey Supreme Court and other jurisdictions, the underlying complaints allegations that the plaintiffs were exposed to a toxic substance - mercury - and as a result have an increased risk of illness are allegations of 'bodily injury' under the CGL policy…."); *Burt Rigid Box Inc. v. Travelers Prop. Cas. Corp.*, 126 F. Supp. 2d 596, 638 (W.D.N.Y. 2001) (holding, "[i]t does not strain credulity to construe the plaintiffs' allegation that they are at a higher risk for developing certain cancers as a bodily injury as, if true, such allegation is predicated on the plaintiff's diminished physical ability to resist such illnesses.") *aff'd in part, rev'd in part on other grounds*, 302 F.3d 83 (2d Cir. 2002).

The medical monitoring insurance coverage cases to date appear to focus on the "temporal requirements of 'bodily injury' and 'occurrence' definitions" in a CGL policy.[16] "These cases generally allege an insured's obligation to conduct medical monitoring for claimants based on their previous exposure to an allegedly harmful substance."[17] The claimants concede they "have no present diagnosis or injury, instead alleging only an increased risk for future diagnosed injury."[18] "Some courts hold that alleged exposure to the substance creating the increased risk for injury during the policy period is, in itself, enough to establish 'bodily injury' for purposes of triggering CGL coverage."[19] "Other courts reason that, to give meaning to the policy's 'bodily injury' definition (which often requires "bodily injury" during the policy period), the court must find something more than mere exposure during the policy period."[20] "These courts hold that coverage cannot be triggered under the prior policy unless the claimant alleges a diagnosed injury that is retroactive to the prior policy period."[21]

Some may argue that the question whether so-called "medical monitoring" qualifies as "bodily injury" for purposes of triggering coverage under a liability policy remains largely unanswered. There are very few cases that have answered this specific question and the few reported decisions on the issue are generally very fact driven.

It should be argued that a threat of potential future harm does not constitute "bodily injury" within the meaning of that term in the policies. Although a person who suffers an increased risk for developing a disease can recover medical monitoring costs from the tortfeasor even when that person has not manifested injuries of that disease, the tortfeasor cannot then recover those medical monitoring costs from its insurer, as damages attributed to "bodily injury."[22] Although Arizona law allows for a tort recovery for medical monitoring costs, it did not allow recovery from insurance companies for those costs, because they are outside the definition of "bodily injury."[23] In *Transamerica Ins.*, the Arizona Court of Appeals held that insureds who were exposed to blood infected with human immunodeficiency virus (HIV), and suffered an increased risk of contracting AIDS, were not entitled to recover under the underinsured motorist provision of

their motor vehicle liability insurance policy for "bodily injury."[24] The court held that the plaintiffs had "suffered no physical injury, sickness, disease, or substantial pain as a direct result of the exposure to the virus."[25]

The court unequivocally held that the need for medical monitoring does not constitute bodily injury covered under an insurance policy.[26] In other words, although medical monitoring costs might be recoverable against a tortfeasor, they do not represent damages for bodily injury under the terms of a liability insurance policy.

Policyholders will argue, that exposure to toxins may be enough to constitute "bodily injury" in the form of cellular or subclinical injury. This issue may be a question for science to answer.

The potential resurgence of medical monitoring claims raises numerous coverage issues and defenses beyond the threshold issue of there being no "actual" bodily injury including trigger, and whether or not the claims allege an occurrence and/or seek "damages."

Conclusion

As the plaintiffs' theories of recovery continue to evolve and some courts have trampled on the traditional tenets of tort law to allow medical monitoring recoveries, the traditional contract rules should be preserved and protected. Contracts should not be rewritten years after being issued to fund these wild expansions of basic tort law. As doing so requires going far beyond the principles of traditional tort law and ignoring the actual contract or policy language.

NOTES

1 Adam P. Joffe, *The Medical Monitoring Remedy: Ongoing Controversy, and a Proposed Solution*, 84 Chi.-Kent L. Rev. 663 (2009) (citing W. Page Keeton, Prosser and Keeton on the Law of Torts 165 (5th ed. 1984)).

2 *In re E.I. Dupont de Nemours & Co. C-8 Pers. Injury Litig.*, No. 22-0305, 2022 U.S. App. LEXIS 25452, *2 (6th Cir. Sept. 9, 2022).

3 *Id* at *2-3.

4 *Id.* at *3.

5 746 F.2d 816 (D.C. Cir. 1984).

6 *See, e.g., Baker v. Saint-Gobain Performance Plastics Corp.*, 232 F. Supp. 3d 233 (N.D.N.Y. 2017); *Giovanni v. United States Dep't of the Navy*, 906 F.3d 94 (3d Cir. 2018); *O'Byrne v. Weyerhaeuser Co.*, No. 2:19-cv-2493, 2022 U.S. Dist. LEXIS 164637 (S.D. Ohio Sept. 12, 2022).

7 John Sullivan, *Monitoring the Death of Medical Monitoring*, Drug & Device Law (Aug. 17, 2017), https://www.druganddevicelawblog.com/2017/08/monitoring-the-death-of-medical-monitoring.html.

8 *See e.g., Hardwick v. 3M Co.*, No. 2:18-cv-1185, 2019 U.S. Dist. LEXIS 169322 (S.D. Ohio Sept. 30, 2019) (denying motions to dismiss PFAS claims despite lack of injury).

9 Carl J. Schaerf & Allison N. Fihma, *Phobia' Claims — NY's Backdoor To 'Medical Monitoring?*, Law360 (Jan 9, 2014, 6:22 PM EST), https://www.law360.com/articles/498519

10 *Sullivan v. Saint-Gobain Performance Plastics Corp.*, No. 5:16-cv-00125-GWC, 2022 U.S. Dist. LEXIS 72459 (D. Vt.).

11 John Gardella, *Medical Monitoring In Vermont Now a Legislated Right*, The National Law Review (Apr.. 26, 2022), https://www.natlawreview.com/article/medical-monitoring-vermont-now-legislated-right.

12 *Id.*

13 *Id.*

14 *See* PFAS Action Act of 2021, H.R. 2467, 117th Cong. (2021); PFAS Accountability Act of 2021, S. 1334, 117th Cong. (2021).

15 *In Re NCAA Student-Athlete Concussion Injury Litig.*, 332 F.R.D. 202 (N.D. Ill. Aug. 12, 2019).

16 4 Robyn L. Anderson, et al., New Appleman on Insurance Law Library Edition § 27.01 (2022).

17 *Id.*

18 *Id.*

19 *See, e.g., Plantronics, Inc. v. American Home Assur. Co.*, No. C 07-6038 PVT, 2008 U.S. Dist. LEXIS 88921 (N.D. Cal. Oct. 20, 2008). *But see, Flintkote Co. v. Gen. Accident Assur. Co.*, 480 F. Supp. 2d 1167, 1173 (N.D. Cal. 2007) ("[I]njury must mean something other than simply exposure to asbestos; injury is rather the result of asbestos exposure."); *Baughman v. United States Liab. Ins. Co.*, 662 F. Supp. 2d, 386 (D.N.J. 2009); *Owens-Illinois, Inc. v. United Ins. Co.*, 650 A.2d 974 (N.J. 1994)).

20 4 Robyn L. Anderson, et al., New Appleman on Insurance Law Library Edition § 27.01 (2022).

21 *Id.* (citations omitted).

22 *Transamerica Ins. Co. v. Doe*, 840 P.2d 288, 291 (Ariz. Ct. App. 1992).

23 *Id.*

24 *Id.*

25 *Id.*

26 *Id.* at 292.

John DeLascio is a Partner at Hinshaw & Culbertson LLP and practices in the area of complex insurance coverage and reinsurance matters.

Fall Conference facilitates engaging discussions on industry topics like catastrophe treaties, cyber risks and more

On November 3-4, 2022, the ARIAS US community gathered at the New York Hilton for a terrific fall conference!

More than 200 members attended the event, some of whom traveled from as far away as Bermuda, the Cayman Islands, Israel, and the United Kingdom to be there. More than 40 speakers from across the insurance and reinsurance industry presented on both emerging issues and more traditional reinsurance topics.

The conference kicked off with an engaging keynote speech from A.J. Jacobs, *New York Times* bestselling author and self-described "Human Guinea Pig." Jacobs shared his deep dive into the world of puzzles—everything from CIA ciphers to escape rooms to crosswords to jigsaws—and what he learned from his adventures with some of the most creative, smartest, and weirdest puzzle creators and solvers. Jacobs also discussed one of his secrets to solving life's puzzles: gratitude. He spoke about his experiences writing the book *Thanks a Thousand*, in which he thanked a thousand people who had anything to do with his morning cup of coffee. The conference participants were eager to ask Jacobs questions—including those about his less-than-favorable adventures as well as potential avenues he may explore in the future. Jacobs stayed for a short while after his speech and a number of lucky participants received copies of his latest book, *The Puzzler.*

Following the keynote, Ann Field moderated a panel on catastrophe treaties. The panel addressed the life of a property catastrophe treaty from start to finish, including all of the actuarial support, catastrophe modeling, and contract drafting. We then heard from two panels addressing cyber risks. That was followed by two rounds of breakout sessions, which featured a wide variety of topics, including: mediation; shareholder disputes in Bermuda and the Cayman Islands; political risk and credit insurance; as well as the differences between US and UK handling of claims related to COVID; the war in Ukraine; and Hurricane Ian.

In addition, the Member Services Committee hosted a networking session for new members during one of the breakout sessions, which facilitated introductions into the organization for our newest members. Day one capped off with the annual meeting in which Joy Langford was appointed to the Board of Directors, and Alysa Wakin assumed the role of Chairperson of ARIAS US. Then we gathered to network and catch up with old friends at the evening's cocktail party.

Day two started with some competition among newer members of the ARIAS community. Five members presented on what they viewed as the most important insurance and reinsurance case in recent memory, each vying for audience support for their case. That lively discussion was followed by a panel led by Jennifer Cavill on the Elon Musk/Twitter dispute in Delaware. The panel addressed important issues related to Delaware litigation and representations as well as warranties insurance and reinsurance. The conference wrapped up with presentations on the post-pandemic workplace and ethics. The ethics presentation focused on tools available in the community to ensure ethical behavior persists despite the absence of traditional judicial sanctions.

The conference concluded with closing remarks from Alysa Wakin.

Our Spring Conference is scheduled to be held May 17-19, 2023 at The Ritz-Carlton, Amerlia Island. We hope you'll join us!

Year of the Arbitrator

Dear ARIAS Membership,

In Chinese Culture, 2023 is The Year of the Rabbit. As a symbol of longevity, peace, and prosperity, the rabbit signifies that 2023 will be a year of hope. In our world, the ARIAS Board has decided to make 2023 The Year of the Arbitrator! While we have many important constituencies that contribute tremendously to the ARIAS community, The Year of the Arbitrator is intended simply to take a moment to express our appreciation for the objectivity, hard work, and good judgment that our ARIAS arbitrators bring to the dispute resolution process.

In the coming weeks, you will hear more about the initiatives the Board is developing in connection with The Year of the Arbitrator, but I'll mention a few here. On March 1, for a reception at Mintz Levin's new offices in New York City, we hosted the first of four quarterly networking events. This free event was be attended by the ARIAS Board, as well as company representatives and outside lawyers. In addition to general networking and cocktail merriment, arbitrators were invited to introduce themselves briefly to the group. We'll be holding more of these events in the future, so be sure to keep an eye on your inbox for future invitations.

Secondly, beginning with Q2, the ARIAS Quarterly will contain a Spotlight on a Newly Certified Arbitrator and an interview-style piece with a current arbitrator. Anyone interested in being considered to feature in either of these articles should reach out to an ARIAS Board member or email me directly at awakin@odysseygroup.com or Larry Schiffer at larry.schiffer@schiffer-lc.com.

Lastly, we intend to roll out an Arbitrator Benefits program in the coming months. This program is still in the development stage but will (hopefully) include group discounts in a variety of areas.

As many of you know or have experienced firsthand, the transition from MCI to our new management company has not been without challenges. The biggest challenge we currently face is ensuring adequate technical support for our Arbitrator Database. To that end, the Board recently convened a Task Force consisting of (in alphabetical order) Frank DeMento, Mike Kurtis, Mike Menapace, and Larry Schiffer. They have been very hard at work trying to get the Arbitrator Database updated and operating properly. We expect to report back on their extraordinary efforts in the coming weeks.

While the most recent few years have been challenging and unexpected for many of us, we are looking forward to a terrific 2023. Each of you—company representatives, outside counsel, consultants, and arbitrators—are critical to the success of ARIAS. Cheers to 2023!

All the best,

Alysa Wakin
Chairperson, ARIAS-US

UPCOMING EVENTS

Spring Conference

May 17-19, 2023

Ritz-Carlton on
Amelia Island, Florida

BOARD OF DIRECTORS

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The ARIAS•U.S. Quarterly (ISSN 7132-698X) is published 4 times a year by ARIAS•U.S.

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