RECENT DEVELOPMENTS IN EXCESS, SURPLUS LINES, AND REINSURANCE LAW

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I. DEVELOPMENTS IN EXCESS AND SURPLUS LINES INSURANCE LAW

Case law affecting the excess and surplus lines insurance industry addressed a number of issues in the last year, including the issue of exhaustion of underlying insurance and what a policyholder must establish in order to trigger coverage for excess insurance policies and the proper allocation of damages for insurance coverage. Key decisions in each area are discussed below.

A. *Exhaustion of Underlying Insurance*

This survey period saw significant developments in a number of different states with respect to the question of the exhaustion of underlying insurance and what a policyholder must establish in order to trigger coverage for excess insurance policies.

First and perhaps most significantly, in *Montrose Chemical Corp. v. Superior Court*,[1] the California Supreme Court addressed the issue of exhaustion among excess insurers on long-tail risks, and determined that the policies at issue allowed vertical—and did not require horizontal—exhaustion. This was the third decision by the California Supreme Court in environmental contamination coverage lawsuits involving Montrose Chemical Corporation, following *Montrose Chemical Corp. v. Superior Court*[2] and *Montrose Chemical Corp. v. Admiral Insurance Co.*[3]

As background, Montrose was sued for causing continuous environmental damage between 1947 and 1982 on account of its manufacturing of the pesticide dichloro-diphenyl-trichlorethane (DDT) at its facility in California. After Montrose was sued by the state and federal governments, it entered into partial consent decrees to resolve various claims and sought reimbursement from its liability insurers. For each policy year from 1961 to 1985, Montrose had purchased primary insurance and multiple layers of excess insurance.

The issue before the California Supreme Court was what Montrose had to establish in order to trigger each layer of excess insurance coverage.[4] Montrose proposed a rule of "vertical exhaustion" or "elective stacking," whereby the insured could "go up" its insurance tower in a given policy period without exhausting lower levels of insurance coverage available in other policy periods.[5] The insurers proposed a rule of "horizontal exhaustion," meaning that Montrose could access an excess policy only after it

1. 460 P.3d 1201 (Cal. 2020) (*Montrose III*).
2. 861 P.2d 1153 (Cal. 1993).
3. 897 P.2d 1 (Cal. 1995).
4. *Montrose III*, 460 P.3d at 1203.
5. *Id.* at 1205–06.

had exhausted other policies with lower attachment points for every year in which the environmental damage occurred.[6]

Ultimately, the California Supreme Court adopted what it articulated as a "vertical exhaustion" theory at the excess level.[7] Thus, an insurer on the risk whose policy is chosen to respond to a loss must pay the full loss up to policy limits and cannot limit its payment to its pro rata share. The carrier may seek reimbursement from other insurers under a contribution or subrogation theory.[8] This allows an insured to pick a second layer excess if the first layer excess underneath it in the same policy year (and other lower layers of coverage in the same policy year) is exhausted, even though first layer excess coverage in other policy years is not exhausted.[9] This also allows an insured to recover under all layers of coverage in one policy year, while shifting from the insured to the administrative burden of seeking reimbursement from other excess insurers.[10]

The court's analysis focused on "other insurance" clauses in the policies.[11] The court first noted that the "other insurance" clauses do not mention the effect of coverage in another policy period.[12] As such, while the other insurance language could reasonably be argued to refer to other insurance in other years of coverage, it could also be read as referring only to other insurance in the same policy year. In light of this, the court found that "the plain language of these clauses is not adequate to resolve this dispute in the insurers' favor."[13]

Looking outside the policies, the court found that the traditional use of other insurance clauses was to prevent multiple recoveries. Citing to both California precedent and a comment in the Restatement of the Law of Liability Insurance, the court noted that such clauses are generally used to address allocation between overlapping concurrent policies, not the allocation of liability amongst successive insurers.[14] Moreover, the court noted that courts in most other states have reached the same conclusion when

6. *Id.* at 1206.
7. *Id.*
8. *Id.* at 1208 & n.5.
9. *Id.* at 1206, 1214.
10. *Id.* at 1214.
11. *Id.* at 1205. The court construed the concept of "other insurance" clauses broadly to include definitions of ultimate net loss and retained limit as used in insuring agreements, loss payable provisions, and limits provisions in addition to clauses more traditionally viewed as "other insurance" clauses—namely, those that are titled "Other Insurance." This functional analysis of the policy language looks to see if it acts like an "other insurance" clause, even if it calls itself something else.
12. *Id.* at 1213.
13. *Id.* at 1210.
14. *Id.* at 1211.

considering successive insurers in long-tail injury claims and the sequence in which an insured can access its insurance across several policy periods.[15]

The court also found that while the "other insurance" clauses were not clear, other language in the policies "strongly suggests that the exhaustion requirements were meant to apply to directly underlying insurance."[16] Specifically, the court noted that each policy states an attachment point, which is the amount of directly underlying coverage, not the amount of coverage in other policy years. Many of the excess policies considered here included schedules which only list one or more directly underlying policies.

Lastly, the court found that any remaining ambiguities must be resolved "to protect the objectively reasonable expectations of the insured."[17] To that end the court found that "[c]onsideration of the parties' reasonable expectations favors a rule of vertical rather than horizontal exhaustion."[18]

This decision has significant practical consequences in a large exposure matter such as a suit seeking damages for remediation of environmental contamination,[19] where an excess insurer, or a tower of excess insurers, might be selected to pay a large environmental contamination loss and then seek contribution from other excess insurers. However, the practical consequences are not as significant in a matter involving an aggregate of comparatively smaller claims such as a large number of asbestos bodily injury claims. In those mass tort cases, there will be a continual pursuit of reimbursement by the insurer selected to obtain contribution as each claim is paid, so it would be unusual for a single loss to involve more than one layer of coverage in the year in question.

Similarly, in *Pfizer, Inc. v. U.S. Specialty Insurance Co.*,[20] a Delaware court considered whether, on account of an "Exhaustion Clause" in a Directors & Officers excess insurance policy, "a settlement between an insured and an insurer in satisfaction of a policy but for less than the policy limit affects attachment of excess insurers higher in a tower."[21] After reviewing the two general approaches, the court concluded:

> Delaware recognizes no business reason for an excess insurer to care whether the payment in satisfaction of a policy below was for the policy's full dollar value, so long as the protections afforded by all underlying insurance policies

15. *Id.* at 1211–12.
16. *Id.* at 1212.
17. *Id.* at 1213.
18. *Id.*
19. In *Montrose III* the loss was approximately $200,000,000 in expenditures and anticipated future liability. *Id.* at 1204.
20. C.A. No. N18C-01-310 PRW CCLD, 2020 WL 5088075 (Del. Super. Ct., Sept. 1, 2020).
21. *Id.* at *3. The "Exhaustion Clause" at issue required that the underlying policies be "exhausted by actual payment of claims." *Id.* at *4.

> are extinguished and the excess insurer's liability begins only at its own attachment point.[22]

Accordingly, the court held that "[a]n excess carrier cannot avoid coverage under an exhaustion clause due to a settlement below unless that settlement works some additional exposure or prejudice on the excess carrier above the attachment point."[23] As such, the policyholder's settlement with a lower level excess insurer for less than that insurer's policy limit did not create a "gap" relieving the upper layer excess insurer of its payment obligations.

B. *Allocation of Damages for Insurance*

This survey period also saw a number of notable cases from different states addressing the issue how damages should be allocated for purposes of determining triggered insurance coverage.

In *Lubrizol Advanced Materials, Inc. v. National Union Fire Insurance Co. of Pittsburgh, PA*,[24] the Supreme Court of Ohio considered the following certified question from the United States District Court for the Northern District of Ohio:

> Whether an insured is permitted to seek full and complete indemnity, under a single policy providing coverage for "those sums" the insured becomes legally obligated to pay because of property damage that takes place during the policy period, when the property damage occurred over multiple policy periods.[25]

The policyholder argued that court should apply an "all sums" allocation approach outlined in prior decisions relating to insurance coverage for environmental claims.[26] The insurance carrier argued that because the policy referred to "those sums" and the harm was discrete, the "all sums" allocation was not appropriate.[27] Instead, the carrier argued for use of an "actual" or "pro rata" allocation method.[28]

As an initial matter, the Supreme Court of Ohio "refuse[d] to engage in a hypertechnical grammar analysis to determine whether the phrase 'those sums' is always more limited than 'all sums' and would always lead to a different allocation[,]" and "decline[d] to set a bright-line rule based merely on a party's use of the word 'those' instead of 'all.'"[29] Instead, the court looked to the specific facts and circumstances. Because the court found that

22. *Id.*
23. *Id.*
24. 160 N.E.3d 701 (Ohio 2020).
25. *Id.* at 703.
26. *Id.*
27. *Id.* at 704.
28. *Id.*
29. *Id.*

"the time of damage is known or knowable," it concluded that "the operative contract language is not the reference to policy coverage for 'those sums' but rather to injury or damage 'that takes place during the Policy Period.'"[30] On that basis, the court concluded that "there is no reason to allocate liability across multiple insurers and policy periods if the injury or damage for which liability coverage is sought occurred at a discernible time" and that, instead, "the insurer who provided coverage for that time period should be liable, to the extent of its coverage, for the claim."[31]

Another significant decision came from Connecticut. In *R.T. Vanderbilt Company, Inc v. Hartford Accident & Indemnity Co.*,[32] the Connecticut Supreme Court affirmed the "unavailability of insurance" exception to time-on-the-risk pro rata allocation, holding that insureds should not be responsible for paying their pro-rata share of damages for periods of no insurance where insurance against that risk was unavailable in the marketplace.[33] The court also affirmed—in what it described as a case of first impression nationally—that an "occupational disease" exclusion is not limited to claims brought by the insured's own employees, but rather can apply to claims brought by individuals who used the insured's products while working for other employers.[34]

This dispute arose from a number of underlying tort claims alleging that exposure to contaminated talc and silica mined and sold by the insured caused asbestos-related disease and bodily injury.[35] The insured brought a declaratory judgment action against 30 insurers seeking to clarify its rights and obligations under various primary and excess insurance policies issued between 1948 and 2008.[36] The trial court found that Connecticut law called for a pro rata "time on the risk" approach to apportioning long-tail liability and adopted the "continuous trigger" exposure theory.[37] The trial court also adopted the "unavailability of insurance" exception to the "time on the risk" rule, under which insureds would not bear responsibility for periods of no insurance if they could establish that insurance coverage for the alleged loss was "unavailable" to them in the market.[38] Finally the trial court ruled that the pollution exclusions at issue were ambiguous regarding their applicability to asbestos-related claims, and that the occupational

30. *Id.* at 705–06.
31. *Id.* at 706.
32. 216 A.3d 629 (Conn. 2019).
33. *Id.* at 637.
34. *Id.* at 641.
35. *Id.* at 633.
36. *Id.*
37. *Id.* at 635.
38. *Id.*

disease exclusions at issue were unambiguous, but that they applied only to claims brought by the insured's own employees.[39]

On appeal, the intermediate appellate court upheld the trial court's adoption of the continuous trigger theory and the unavailability of insurance exception, and agreed with its conclusion that the pollution exclusions were ambiguous and did not bar coverage.[40] However, the court disagreed with the trial court's ruling on the occupational disease exclusions, concluding that those exclusions unambiguously barred coverage for occupational disease claims brought by both employees and nonemployees who developed an occupational disease while using the insured's product.[41]

The Connecticut Supreme Court affirmed all aspects of the intermediate appellate court's decision. With respect to the adoption of the "continuous trigger" theory and the "unavailability of insurance" exception, the court found that the lower appellate court's "well reasoned opinion more than sufficiently addresses these certified questions" and therefore adopted those parts of the lower court's opinion as its own statement of the law.[42] In doing so the court blessed the lower court's finding that damages and defense costs should not be allocated to any period where insurance was unavailable in the market, but that the insured bears the burden of proving that it was unable to obtain coverage at times when it was generally available in the marketplace.[43] The court also adopted the lower court's recognition of the potential for an "equitable exception" to the unavailability rule.[44] In the asbestos context presented by the *Vanderbilt* matter, such an exception could arise if the insured had continued to manufacture or distribute asbestos-containing products after it knew the products were hazardous, although notably the court did not find those facts in this case.

Lastly, in *Rossello v. Zurich American Insurance Co.*,[45] the Maryland Court of Appeals rejected "all sums" allocation and adopted a "pro rata" approach to allocating damages in a long-tail case.

Rossello was exposed to asbestos at his workplace in 1974 while the insured mechanical contractor was performing construction and renovations in the same building. Rossello inhaled asbestos originating from construction products used by the insured. The asbestos installer was insured under four general liability policies from 1974 to 1977 and not thereafter. The insured ceased operations in 1976. The insurer agreed that 1985 was the last practicable year that the insured could have purchased liability

39. *Id.* at 635–36.
40. *Id.* at 636.
41. *Id.*
42. *Id.* at 637.
43. *Id.*
44. *Id.*
45. 226 A.3d 444 (Md. 2020).

insurance covering asbestos injuries. Rossello was diagnosed with mesothelioma in 2013.

Rossello obtained a $2,682,847.26 net judgment against the insured asbestos installer. The trial court issued a writ of garnishment requiring the asbestos installer's insurer to satisfy the judgment. The court stayed the garnishment, and the parties filed cross-motions for summary judgment regarding how to allocate loss among various triggered insurance policies and periods of no insurance. Rossello argued that the insurer was liable for the entirety of the judgment on an "all sums" or joint-and-several liability theory. The insurer argued for a pro rata approach with allocation to the insured for uninsured periods, alternatively through 2013 (the year of manifestation and diagnosis) or 1985 (the last year that insurance covering this type of liability could have been purchased).

The trial court held that damages must be allocated on a pro rata, time-on-the-risk basis across all insured and insurable periods triggered by the injuries—1974 to 1985. Rossello appealed, and the court of appeals agreed with the insurer and adopted the "majority rule of pro rata allocation."[46]

In reaching this decision the court first determined that a policy is "triggered" when an actual injury occurs, and that a progressive injury can thus trigger multiple policies.[47] The court's analysis acknowledged and defined the four distinct approaches to determining when coverage is triggered: "manifestation," "exposure," "continuous," and "injury-in-fact."[48] The court noted that earlier Maryland cases had "disapproved of a trigger theory based exclusively on manifestation,"[49] and had adopted "injury in fact" as the appropriate trigger in asbestos-in-building cases. The court also acknowledged that it had previously held that a continuing injury triggers coverage under all applicable policy periods.[50] Notably, the court cautioned that although its decision "referred to various trigger theories by name, we must stress that courts and litigants should be careful when referring to such delineated theories. The nomenclature and reference of specific trigger models 'can be deceiving,' because a court must apply policy language to the factual context before it."[51]

The court's next concern was how to allocate loss among the triggered policies. The claimant argued that the policies' promise to pay "'all sums which the insured became legally obligated to pay'" required an "all sums" or joint-and-several liability on the part of the insurers. The insurer urged the court to follow prior authority that had relied on policy language that

46. *Id.* at 452.
47. *Id.* at 456.
48. *Id.* at 452–53.
49. *Id.* at 454.
50. *Id.* (citing Riley v. USAA, 899 A.2d 819 (Md. 2006)).
51. *Id.* at 456 (citation omitted).

referred to bodily injury "'which occurs during the policy period'" and the insuring agreement language which limited sums to be paid for loss "'to which this insurance applies . . . .'"[52]

The court began by noting that the Maryland Special Court of Appeals had previously held that indemnity was to be prorated among all carriers based on their time on the risk.[53] The court then adopted the reasoning of that precedent, and in doing so adopted the pro rata approach to allocation for bodily injury under the general liability policies.[54] The court also rejected the insurer's argument that this precedent was distinguishable, finding that there was no meaningful difference in the policy language as it applied to property damage versus bodily injury.[55] Likewise, the court rejected the argument that "pro rata" allocation was "unfair, unworkable and causes unnecessary complication," finding that proration was easy to administer, efficient and consistent with the reasonable expectations of the contracting parties.[56]

Finally the court addressed the unavailability of insurance argument. The parties here had agreed that general liability asbestos coverage was not commercially available after 1985. A question remained for the time period 1977 to 1985. The insured presented no evidence to rebut the assumption that general liability coverage was available during that time. The court found that the insured's decision not to buy insurance does not render coverage unavailable for purposes of pro rata allocation.[57] Therefore the relevant period for allocation of the judgment was twelve years, from 1974 (date of first exposure) to 1985 (the last year the insured could have purchased insurance for asbestos-related damages), and the insurer was liable for its pro rata share of damages in its four years of coverage.[58]

II. DEVELOPMENTS IN REINSURANCE LAW

In 2020, courts continued to affirm the strong federal public policy in favor of arbitration. The law concerning the relationship among the Federal Arbitration Act,[59] the Convention on the Recognition and Enforcement of Foreign Arbitral Awards,[60] and the McCarran-Ferguson Act[61] remains

52. *Id.* at 456–59.
53. *Id.* at 456–57.
54. *Id.* at 457.
55. *Id.* at 461.
56. *Id.* at 462.
57. *Id.* at 463.
58. *Id.*
59. 9 U.S.C. §§ 1–16.
60. Convention on the Recognition and Enforcement of Foreign Arbitral Awards, June 10, 1958, 21 U.S.T. 2517.
61. 15 U.S.C. §§ 1011–1015.

unsettled. Courts in the Second Circuit decided a pair of cases that appear to confirm that courts will continue to assess reinsurers' obligations to reimburse cedents for expenses in excess of limits and to follow their cedents' settlements consistent with the terms of the particular contracts at issue, rather than instituting a blanket rule of law concerning those issues. The courts also provided some further guidance concerning when vacatur of an arbitration award might be appropriate, affirming the arbitrator's discretion concerning the conduct of arbitration proceedings (such as the refusal to hear certain evidence) and providing further clarity on an arbitrator's disclosure obligations and the concept of "manifest disregard of the law." Finally, while 2019 heralded a potential trend toward the increased discoverability of reinsurance information, the decisions in 2020 affirmed that the scope of discoverability of reinsurance-related information by underlying policyholders remains limited.

A. *Arbitrability*

In *Nationwide Agribusiness Insurance Co. v. Hartford Steam Boiler Inspection & Insurance Co.*, the Central District of California granted the defendant's motion to compel arbitration, staying the litigation pending that arbitration.[62] The arbitration clause in the reinsurance agreement at issue contained an initial paragraph specifically directed toward disputes in which the parties agreed that reinsurance coverage existed but disagreed on the amount of that coverage and a second paragraph that provided that "all disputes or differences arising out of the interpretation" of the reinsurance agreement would be submitted to arbitration.[63] The ceding company argued that the first paragraph of the arbitration clause was a gatekeeping provision that set forth the types of claims that were arbitrable under the agreement and that the second paragraph further restricted the scope of the arbitration clause to disputes involving those claims that fell within the terms of the first paragraph *and* arose out of the interpretation of the reinsurance agreement.[64]

The court disagreed, noting that although the language of the agreement was unique, the plaintiff's interpretation would lead to an absurd result: that arbitrators would decide interpretation of law under the reinsurance agreement while the judiciary would determine issues of fact.[65] This absurdity, along with consideration of United States Supreme Court precedent

62. No. 5:19-cv-00531-JAK-KK, slip op. at 6 (C.D. Cal. Oct. 18, 2019).
63. *Id.* at 3–4.
64. *Id.* at 6–7.
65. *Id.* at 6.

that "arbitrable disputes should be determined in favor of arbitration," led the court to compel arbitration.[66] The court also stayed the litigation.[67]

PB Life & Annuity Co. v. Universal Life Insurance Co.[68] involved a dispute over whether assets in a reinsurance trust account complied with applicable insurance law. The federal district court for the Southern District of New York ordered the parties to arbitrate under the arbitration provision of the reinsurance agreement.[69]

The parties had entered into a coinsurance reinsurance agreement.[70] The credit for reinsurance article of the reinsurance agreement required that a reinsurance trust fund be established to ensure that the cedent received full credit for reinsurance. The trust fund had to comply with the laws of each party's domiciliary jurisdiction.[71] The parties entered into a reinsurance trust agreement as required by the reinsurance agreement.[72] A dispute arose over whether the assets the reinsurer placed in the trust agreement qualified under Puerto Rico law.[73] Allegedly, over sixty-five percent of the trust assets were loan obligations of the reinsurer's affiliated entities, which violated a ten percent limit on investing in assets of affiliated entities.[74]

The cedent demanded arbitration, and the reinsurer brought the court action.[75] The cedent moved to compel arbitration and the reinsurer sought an injunction precluding arbitration.[76] In granting the motion to compel and denying the injunction request, the court ultimately determined that the arbitration provision contained in the reinsurance agreement was broad enough to leave to the arbitrators the question whether disputes under the trust agreement came within its scope.[77] The arbitration provision in that agreement provided that:

> all disputes and differences between the Parties arising under or relating to this Reinsurance Agreement . . . shall be decided by arbitration . . . [and] the arbitration proceeding shall be conducted in accordance with the Commercial Arbitration Rules of the American Arbitration Association.[78]

66. *Id.* (citing Moses H. Cone Mem'l Hosp. v. Mercury Constr. Corp., 460 U.S. 1, 24, 25 (1983)).
67. *Id.*
68. No. 20-cv-2284 (LJL), 2020 WL 2476170 (S.D.N.Y. May 12, 2020).
69. *Id.* at *11.
70. *Id.* at *1.
71. *Id.* at *2.
72. *Id.* at *3.
73. *Id.*
74. *Id.*
75. *Id.*
76. *Id.* at *4.
77. *Id.* at *5.
78. *Id.* at *4–5.

The entire agreement clause in the reinsurance agreement clearly incorporated the trust agreement:

> This Reinsurance Agreement, the Reinsurance Trust Agreement and the Comfort Trust Agreement supersede all prior agreements, whether written or oral, between the Parties with respect to its subject matter and constitutes . . . a complete and exclusive statement of the terms of the agreement between the Parties with respect to its subject matter.[79]

The court found that the reinsurance agreement, which contained the binding arbitration clause, remained in effect and that the trust agreement did not amend or replace the reinsurance agreement.[80] The ruling noted that the agreements were meant to be read in conjunction with each other.[81] The decision rejected the notion that the trust agreement could replace the reinsurance agreement and its arbitration clause, and agreed with the cedent that such an argument would lead to an absurd result.[82]

The court then determined that the question of arbitrability should be left to the arbitrators.[83] The reinsurer argued that the dispute about the trust agreement assets did not fall within the scope of the reinsurance agreement's arbitration clause.[84] The court held that this was a question of arbitrability, which fell within the broad scope of the arbitration clause.[85] The court also commented that the American Arbitration Association rules, which were incorporated into the arbitration clause, vested the arbitrator with the power to determine questions of arbitrability.[86] Accordingly, the court granted the cedent's motion to compel arbitration and denied the reinsurer's motion to enjoin arbitration.[87]

In *Lomonico v. Foulke Management Corp.*,[88] the U.S. District Court for the District of New Jersey granted a motion to compel arbitration, denied a motion to dismiss, and stayed the case pending arbitration. *Lomonico* involved a situation where the plaintiff had signed a series of documents related to a deal whereby he would trade in his car to the defendant car dealership and buy or lease a car from that same dealership.[89] The plaintiff did not review the documents before he signed them, nor did the defendant advise the plaintiff of the terms of the documents.[90] When

79. *Id.* at *2.
80. *Id.* at *7.
81. *Id.* at *8.
82. *Id.*
83. *Id.* at *11.
84. *Id.*
85. *Id.*
86. *Id.*
87. *Id.*
88. Civil No. 18-11511 (RBK/AMD), 2020 WL 831134 (D.N.J. Feb. 20, 2020).
89. *Id.* at *1.
90. *Id.*

the plaintiff sought to avoid the deal, the car dealership alleged that the documents contained a valid arbitration provision and moved to compel arbitration of the dispute.[91] The plaintiff argued that he was unaware of the arbitration provision and that he was entitled to discovery "to resolve the dispute over whether [he] ever received copies of the documents he signed."[92] The court disagreed, stating that plaintiff would "need to come forward with 'reliable evidence that is more than a naked assertion . . . that [he] did not intend to be bound by the arbitration agreement,'" and finding that he had not done so.[93]

The plaintiff also challenged arbitrability on the ground that he was not provided signed copies of the documents, making the entire contract void under the New Jersey Consumer Fraud Act.[94] The court again disagreed because (1) the arbitration provision contained a delegation clause, and (2) the plaintiff challenged the validity of the entire agreement, rather than the arbitration provision itself.[95]

In *GE Energy Power Conversion France SAS, Corp. v. Outokumpu Stainless USA, LLC*,[96] the United States Supreme Court considered whether the United Nations Convention on the Recognition and Enforcement of Foreign Arbitral Awards (Convention) precluded the application of domestic equitable estoppel doctrines. ThyssenKrupp Stainless USA entered into three contracts with F.L. Industries for the construction of cold rolling mills at an Alabama steel mill.[97] All of the contracts contained identical arbitration clauses.[98] F.L. Industries entered into a subcontract with GE Energy to provide motors for the mills.[99] Soon after delivery of the motors, Outokumpu Stainless USA acquired the plant from the previous owners.

After the acquisition, the motors failed, and Outokumpu brought suit against GE for breach of contract.[100] GE moved to dismiss the suit and compel arbitration under the original contracts signed by ThyssenKrupp and F.L. Industries.[101] The lower court issued an order compelling arbitration, but the Eleventh Circuit vacated, holding that arbitration could not be compelled under the Convention between two parties unless those parties actually signed the agreement to arbitrate.[102] The court based its ruling

91. *Id.* at *3.
92. *Id.* at *4.
93. *Id.* citing Andre v. Dollar Tree Stores, Inc., No. 18-142, 2018 WL 3323825 (D. Del. July 6, 2018)).
94. *Id.* (citing N.J. Stat. Ann. § 56:8–2.22).
95. *Id.* at *6.
96. 140 S. Ct. 1637 (2020).
97. *Id.* at 1642.
98. *Id.*
99. *Id.*
100. *Id.*
101. *Id.*
102. *Id.* at 1642–43.

on the fact that the Convention explicitly mentioned compelling arbitration only between signatories to a written contract.[103] Thus, the Eleventh Circuit ruled that GE could not rely on the state doctrine of equitable estoppel to enforce the arbitration clause between two non-signatories because the Convention was silent on that issue.[104]

The Supreme Court reversed, holding that the Convention does not conflict with the enforcement of arbitration agreements by non-signatories under domestic-law equitable estoppel doctrines.[105] Because the Convention only specifically addresses enforcement by signatories, it relies on contracting states to turn to domestic law to enforce arbitration in situations where the Convention is silent.[106] The Court remanded the case for consideration of whether equitable estoppel would compel the non-signatories to arbitration.[107]

In *Certain Underwriters at Lloyd's, London v. Century Indemnity Co.*,[108] a dispute arose over the billing of molestation losses. After settling with its insured, the cedent allocated all of the molestation claim payments to the policy in effect at the time of the first act of molestation as agreed in the settlement agreement, and then accumulated the payments allocated to each policy period and billed them as a single loss occurrence.[109] An arbitration resolved the initial billing dispute in favor of the reinsurer, holding that the allocation under the settlement agreement was not the product of a reasonable and business-like investigation.[110] The ceding company then rebilled the same losses, but this time spread the loss payments across each of the policies in effect during the time of the abuse and then accumulated all the payments for each policy period and billed them as a single loss occurrence.[111]

After the first arbitration, the final award (and a clarification) was confirmed and a judgment was entered.[112] After the rebilling, the reinsurer refused to pay based on the judgment confirming the original arbitration award.[113] The cedent demanded arbitration and moved to compel arbitration.[114] The reinsurer moved to enforce the judgment, to enjoin the second arbitration demand, and to dismiss the petition to compel arbitration.[115]

103. *Id.*
104. *Id.* at 1643.
105. *Id.* at 1645.
106. *Id.*
107. *Id.* at 1647–48.
108. Nos. 18-cv-12041, 19-cv-11056, 2020 WL 1083360 (D. Mass. Mar. 6, 2020).
109. *Id.* at *2.
110. *Id.*
111. *Id.* at *3.
112. *Id.*
113. *Id.* at *2.
114. *Id.* at *3.
115. *Id.* at 6.

The court granted the reinsurer's motion to enforce the judgment in part, and denied the motion to enjoin the second arbitration and the motion to dismiss the petition to compel arbitration.[116] In so doing, the court addressed the preclusive nature of the first arbitration award (and judgment) and whether the second arbitration panel or the court should determine the preclusive effect of the first award.

The court held that the preclusive effect of a prior arbitration on a subsequent arbitration is an arbitrable dispute.[117] Here, said the court, the cedent was seeking to determine whether the preclusive scope of the prior arbitration decision encompassed the rebilling that was done without allocating the loss payments under the terms of the settlement agreement.[118] Thus, the court found that the issue was not whether the ceding company was attacking the first arbitration, but whether the original arbitration award precluded arbitration of the rebilling.

The court found that nothing in the arbitration award indicated that it was intended to have a prospective effect over new billings or that it foreclosed submitting the reinsurance billings in a new format.[119] The court stated that in concluding that the billings were improper, the arbitration award turned on the unreasonableness of the settlement agreement allocation and did not address all other issues.[120] Thus, the court held that the preclusive effect of the arbitration award was an issue for the subsequent arbitration panel to resolve.

The court applied the same principles to the reinsurer's motion to dismiss the petition to compel the second arbitration.[121] The court found that the cedent was an aggrieved party because there was no umpire appointed and there was an ongoing dispute between the parties regarding the appointment of the arbitrators.[122]

There was also an issue as to how many arbitration panels should be formed. The court declined to direct the formation of multiple panels because that issue was a procedural matter for the arbitrators to decide.[123] As the court concluded, "[i]t will be up to the arbitrator to determine whether multiple arbitration panels should be formed."[124]

116. *Id.*
117. *Id.* at *4.
118. *Id.*
119. *Id.* at *4.
120. *Id.*
121. *See id.* at *6.
122. *Id.* at *5.
123. *Id.* at *6.
124. *Id.*

B. *Consolidation*

In *Pennsylvania National Mutual Casualty Insurance Co. v. New England Reinsurance Corp.*,[125] the Third Circuit affirmed the decision of the United States District Court for the Middle District of Pennsylvania to convene a new arbitration panel to hear the parties' dispute, rather than sending the parties back to a prior panel.[126] Penn National entered into several treaties with multiple reinsurance companies, including Everest Reinsurance Company.[127] All of the treaties required arbitration of disputes.[128] In addition, the arbitration clauses provided that "[i]f more than one reinsurer is involved in the same dispute, all such Reinsurers shall constitute and act as one party . . . ."[129]

A dispute arose between Penn National and Everest, and Penn National demanded arbitration.[130] Everest refused to participate, claiming that the dispute should have been consolidated with an earlier arbitration.[131] Penn National brought suit to compel Everest to participate in the newly-demanded arbitration and Everest cross-moved to require referral to the prior panel it claimed should hear the dispute.[132]

The district court ruled that courts were only permitted to decide "gateway" matters where there was a valid arbitration clause, and noted that Everest could request the same relief—referral to the earlier panel—from the newly constituted panel.[133] Thus, the court granted Penn National's motion to compel the newer arbitration and denied Everest's motion to refer the matter to the previous panel.[134] The Third Circuit affirmed the district court's decision, finding that if it were to send the consolidation question to the earlier panel, it would be prejudging that question in contravention of the express terms of the arbitration agreement.[135]

C. *Discoverability of Reinsurance Information*

In *Mid-State Automotive, Inc. v. Harco National Insurance Co.*,[136] an insured brought suit in federal court against its insurer alleging breach of contract

125. 794 F. App'x 213 (3d Cir. 2019). Given the brevity of the Third Circuit's decision, some of the facts and elements of the district court's decision discussed herein have been obtained from the district court's opinion. *Pa. Nat'l Mut. Cas. Ins. Co. v. Everest Reinsurance Co.*, 2019 WL 1205297(M.D. Pa. Mar. 14, 2019).

126. *Pa. Nat'l Mut. Cas. Ins. Co.*, 2019 WL 1205297, at *1.

127. *Id.*

128. *Id.*

129. *Id.*

130. *Id.*

131. *Id.* at *2.

132. *See id.* at *3.

133. *Id.* at *2.

134. *Id.*

135. Pa. Nat'l Mut. Cas. Ins. Co. v. Everest Reins. Co., 794 F. App'x 213, 215 (3d Cir. 2019).

136. No. 2:19-cv-00407, 2020 WL 1488741 (S.D. W. Va. Mar. 25, 2020).

and bad faith after a fire loss at the insured's car dealership.[137] The parties were engaged in a discovery dispute centered on the insurer's redactions of reinsurance information included in documents that the insurer had produced.[138] The insured moved to compel full production of the reinsurance information, claiming that it was "highly relevant" to the insurer's allegedly unfair claims settlement practices.[139] The court agreed.[140]

Reinsurance information, the court reasoned, is relevant where it sheds lights on the insurer's state of mind in handling claims.[141] In particular, prior deposition testimony revealed that the insurer had been preparing ongoing "reinsurance reports" for its reinsurer's benefit that contained summaries of the status of the fire loss claim and the insurer's investigation.[142] Because those reports presumably contained the insurer's assessment of its claims handling, the court held that this type of reinsurance information was relevant to establishing whether the insurer acted unreasonably in denying coverage.[143]

The federal district court for the District of Idaho refused to permit discovery into communications between an insurer and its reinsurer in *Idahoan Foods, LLC v. Allied World Assurance Co. (US), Inc.*[144] In *Idahoan Foods*, an Idaho food processing company was a party to a contract with a potato company to produce potato flakes and slices.[145] The food processor suffered major losses when a fire at the potato company's facility destroyed nearly one million hundred-weight pounds of potatoes.[146] As a result, the food processor produced 16 million fewer pounds of refined potato products than it had forecasted for fiscal year 2017.[147] The food processor filed a claim under its policy with its insurer for business income and extra expense coverage due to the loss.[148]

After the insurer denied a majority of the food processor's claim, the food processor filed suit in Idaho federal court to recover the additional losses it believed to be covered under its insurance policy.[149] During discovery, the insured sought to compel production of the insurer's communications with its reinsurer.[150] The court held that the reinsurance contracts themselves

137. *Id.* at *1.
138. *Id.* at *8.
139. *Id.* at *7.
140. *Id.*
141. *Id.*
142. *Id.*
143. *Id.*
144. No. 4:18-cv-00273-DCN, 2020 WL 1948823 (D. Idaho Apr. 22, 2020).
145. *Id.* at *1.
146. *Id.*
147. *Id.*
148. *Id.*
149. *Id.*
150. *See Id.*

were discoverable, but any communications and discussions between the insurer and the reinsurer were "too far removed" for purposes of establishing breach of contract and bad faith by the insurer.[151] There is little reason, the court held, "to involve another party [the reinsurer] that had essentially an 'arms-length' transaction with [the insurer]."[152] The court ordered the insured to produce copies of its reinsurance contract, but denied the motion to compel production of communications and related information between the insurer and reinsurer.[153]

D. *Enforceability of Foreign Arbitral Awards*

In *Cvoro v. Carnival Corp.*,[154] plaintiff Cvoro developed carpal tunnel syndrome while working on a Carnival Cruise ship sailing under a Panamanian flag. Carnival sent her home to Serbia and arranged for follow-up care.[155] During the follow-up care, Cvoro was permanently injured, and sought arbitration in Monaco under the terms of the seafarer's employment agreement she had signed with Carnival.[156] The Monaco arbitration applied Panamanian law in accordance with the agreement, despite Cvoro arguing that U.S. federal law should apply.[157] Cvoro wanted U.S. federal law to apply because under the Jones Act in the United States, her remedies were more favorable than under the causes of action available under Panamanian law.[158] The arbitration panel did not make any award to Cvoro.[159] Cvoro then brought suit in the Southern District of Florida to have the arbitration decision set aside as against public policy in the United States.[160]

The Eleventh Circuit affirmed the district court's dismissal of the complaint, ruling that while U.S. federal law is protective of maritime employees, it is also respectful of international arbitration awards.[161] The court ruled that it could not set aside a foreign arbitration award under principles of public policy just because the remedies available under foreign law were less favorable than those available under U.S. federal law.[162] The court noted, but did not rely on, the fact that Cvoro did not actually pursue the claims available to her under Panamanian law.[163]

151. *Id.* at *2.
152. *Id.* at *3.
153. *Id.*
154. 941 F.3d 487 (11th Cir. 2019).
155. *Id.* at 491.
156. *Id.*
157. *Id.* at 492.
158. *Id.* at 499.
159. *Id.* at 492–93.
160. *Id.* at 493.
161. *Id.* at 498–99.
162. *Id.* at 499–500.
163. *Id.* at 500.

E. *Expenses in Excess of Limits*

The question of whether reinsurers are required to reimburse cedents for expenses in excess of the limits in facultative contracts has been the subject of litigation since the 1990 decision in *Bellefonte Reinsurance Co. v. Aetna Casualty & Surety Co.*,[164] in which the Second Circuit held that reinsurers were not obligated to pay any additional sums for defense costs over and above the limits on liability stated in the reinsurance certificates. In *Global Reinsurance Co. of America v. Century Indemnity Co.*,[165] Global, the reinsurer, sought a declaratory judgment that the limits stated in the certificates were the maximum that it must pay on each reinsurance contract. Century, the cedent, contended that the limits stated in the certificates capped indemnity payments but not Global's obligation to pay defense expenses, as the underlying primary policies required Century to pay defense costs in addition to the applicable limits of indemnity. The relevant provision of the reinsurance certificates provided:

> All loss settlements made by the Company, provided they are within the terms and conditions of the original policy(ies) and within the terms and conditions of the certificate of reinsurance, shall be binding on the Reinsurer. Upon receipt of a definitive statement of loss, the Reinsurer shall promptly pay its proportion of such loss as set forth in the Declarations. In addition thereto, the Reinsurer shall pay its proportion of expenses [agreed by the parties in this case to include defense costs] . . . incurred by the Company in the investigation and settlement of claims or suits and its proportion of court costs and interest on any judgment or award, in the ratio that the Reinsurer's loss payment bears to the Company's gross loss payment. If there is no loss payment, the Reinsurer shall pay its proportion of such expenses only in respect of business accepted on a contributing excess basis and then only in the percentage stated in Item 4 of the declarations in the first layer of participation.[166]

The certificates also contained a "following form" clause providing that Global's liability "'shall follow'" the liability of Century on the underlying primary policies, and "'shall be subject in all respects to all the terms and conditions of [Century's] policy except when otherwise specifically provided herein . . . .'"[167]

The trial court previously granted summary judgment in Global's favor, relying on *Bellefonte* to conclude that the reinsurer was not obligated to pay any sums for defense costs over and above the limits of liability in the reinsurance certificates. However, in an earlier appeal, the Second Circuit certified a question to the New York Court of Appeals, asking whether

164. 903 F.2d 910 (2d Cir. 1990).
165. 442 F. Supp. 3d 576 (S.D.N.Y. 2020).
166. *Id.* at 581.
167. *Id.*

New York contract law "'impose[s] either a rule of construction, or a strong presumption, that a per occurrence liability cap in a reinsurance contract limits the total reinsurance available under the contract to the amount of the cap regardless of whether the underlying policy is understood to cover expenses.'"[168] The Court of Appeals ruled that no such rule or presumption existed and that courts were bound to use "'traditional rules of contract interpretation'" in assessing reinsurance agreements.[169] The Second Circuit remanded the case, directing the trial court to interpret the terms "'solely in light of its language, and to the extent helpful, specific context.'"[170]

The trial court viewed the New York Court of Appeals' direction to "'use the traditional rules of contract interpretation'" as "casting doubt" on *Bellefonte* and cases following its reasoning, stating "even if those decisions have not been overturned, their continuing applicability may be scrutinized."[171] Heeding this direction, the trial court analyzed the language of the contract with the assistance of expert testimony from each party—the "specific context" ordered by the Second Circuit. However, the court found that "both parties overstate their argument" because both had ignored and misconstrued the explicit text of the contracts.[172] Instead, the court ruled that the "plain and unambiguous meaning" of the contracts was that the dollar limit stated in the reinsurance certificates "caps Global's obligation to pay losses and also caps Global's obligation to pay expenses when there are no losses, but does not cap Global's obligation to pay expenses when there are covered losses."[173] The express language of the contract, the court reasoned, directed Global to pay Century for expenses based on a proportionate share of losses, but did not expressly limit the expense costs owed by a limit or dollar amount in the certificate, "and the sentence should not be construed as 'impliedly stating' such a limit. Therefore, this clause must 'follow' the underlying insurance as to the payment of expenses, which means that these expenses must be paid in addition to, and are not capped by, the liability limit."[174]

168. *Id.* at 579 (quoting Global Reins. Corp. of Am. v. Century Indem. Co., 843 F.3d 120, 122 (2d Cir. 2016)).

169. *Id.* (quoting Global Reins. Corp. of Am. v. Century Indem. Co., 91 N.E.3d 1186, 1192–93 (N.Y. 2017)).

170. *Id.* (quoting Global Reins. Corp. of Am. v. Century Indem. Co., 890 F.3d 74, 77 (2d Cir. 2018)).

171. *Id.* at 590.

172. *Id.* at 587.

173. *Id.*

174. *Id.* (quoting Global Reins. Corp. of Am. v. Century Indem. Co., 91 N.E.3d at 1192–93).

F. *Follow the Settlements*

In *Utica Mutual Insurance Co. v. Fireman's Fund Insurance Co.*,[175] the United States Court of Appeals for the Second Circuit reversed a jury verdict in favor of cedent Utica against reinsurer Fireman's Fund. Utica insured Goulds Pumps under seven primary and umbrella policies; Fireman's Fund reinsured the umbrella policies. The central question in the litigation was whether the umbrella policies were excess to underlying *aggregate* (rather than per-occurrence) limits for bodily injury claims, which would allow Utica to combine all of the relatively small asbestos bodily injury claims from Goulds, which would in turn trigger the umbrella coverage and Fireman's reinsurance obligations. Although the primary policies were missing, the umbrella policies were located and contained schedules listing aggregate limits for property damage claims but not bodily injury claims.[176] Utica and Goulds litigated the question of whether the missing primary policies contained aggregate limits for bodily injury claims and then entered into a settlement in which the parties agreed that the primary policies did contain an aggregate limit for bodily injury claims that had been exhausted by Utica's prior claim payments and that Goulds had "available remaining insurance" in the amount of $325 million to pay claims from the umbrella policies.[177]

In light of the settlement agreement providing that the primary policies had been exhausted, Utica sought reimbursement from Fireman's under the reinsurance contracts, citing the "follow the settlements" clauses in those contracts, which stated that "'[a]ll claims involving this reinsurance, when settled by [Utica] shall be binding on [Fireman's Fund].'"[178] Fireman's denied liability on the basis that the umbrella policies had not been triggered because the bodily injury losses had not exceeded the stated limits in the schedules to the umbrella policies, relying on the "follow form" clause in the reinsurance contracts providing that its liability "'shall be subject in all respects to all the terms and conditions of [the umbrella policies].'"[179] After a jury verdict in the trial court for Utica, the Second Circuit ruled that the umbrella policies did not attach after exhaustion of any underlying aggregate limits for bodily injury claims. The court found that the "'applicable limits of liability'" in the umbrella policies referred specifically to the occurrence giving rise to Utica's liability. Because the umbrella policies included schedules explicitly setting forth aggregate limits for property damage claims, the lack of similar schedules relating to bodily injury

175. 957 F.3d 337 (2d Cir. 2020).
176. *Id.* at 340.
177. *Id.* at 342.
178. *Id.* at 341–42.
179. *Id.* at 341.

claims meant that the parties did not intend for the umbrella policies to apply after exhaustion of any underlying aggregate limits for those bodily injury claims.[180]

The Second Circuit also rejected Utica's contention that the "follow-the-settlements" clauses in the reinsurance contracts obligated Fireman's to accept Utica's interpretation of the umbrella policies as reflected in the settlement with Goulds. Citing New York law that a follow-the-settlements clause cannot "alter the terms or override the language of reinsurance policies,"[181] the court held that Utica's theory "directly contradicts the relevant language in the reinsurance contracts and umbrella policies." Because Fireman's reinsurance contracts "followed form," the controlling provisions were those in the umbrella policies, which "unambiguously" did not provide aggregate limits for bodily injury claims. Because the "follow-the-settlements" doctrine could not override that unambiguous language, Fireman's Fund was not obligated to pay for losses that did not trigger the per-occurrence limits in the schedules to the umbrella policies.[182]

In *Insurance Co. of the State of Pennsylvania v. Equitas Insurance Ltd.*, the federal district court for the Southern District of New York, applying English law, ruled that the ceding company was entitled to a presumption that it intended to purchase back-to-back reinsurance coverage for its underlying policy and that, therefore, the reinsurer was obligated to follow the ceding company's settlements.[183]

In that case, the parties cross-moved for summary judgment on a dispute over a large environmental pollution claim paid by the cedent under an umbrella policy.[184] The underlying policy was governed by Hawaii law and the settlement was allocated by the cedent under the "all sums" approach.[185] The cedent reinsured the umbrella policy under two facultative certificates.[186] The certificates were governed by English law and contained follow-the-settlements language.[187]

In granting summary judgment in favor of the cedent and denying summary judgment to the reinsurer, the court focused on the strong presumption of back-to-back coverage for facultative reinsurance.[188] The court provided a neat summary of English reinsurance law as it pertains to

180. *Id.* at 345.
181. *Id.* at 347 (citing U.S. Fid. & Guar. Co. v. Am. Re-Ins Co., 985 N.E.2d 876, 882 (N.Y. 2013)).
182. *Id.* at 347–48.
183. No. 17 CV 6850-LTS-SLC, 2020 WL 4016815, at *1, *5 (S.D.N.Y. July 16, 2020).
184. *Id.* at *1.
185. *Id.* at *4.
186. *Id.*
187. *Id.* at *5.
188. *Id.* at *3.

follow-the-settlements and back-to-back coverage.[189] Under English law, said the court, there is a presumption as a matter of law that the cedent's settlements are covered if the cedent can prove that it paid the settlement and the claims arguably fall within the insurance and reinsurance contracts.[190] A reinsurer can refuse to follow the settlement if it falls outside the legal scope of cover.[191]

The court noted that in determining the legal scope of cover under a reinsurance contract, English law provides a strong presumption of back-to-back coverage.[192] In other words, said the court, liability under a proportional facultative certificate is co-extensive with that of the reinsured policy.[193]

The main dispute here was whether the all-sums approach under Hawaii law flowed through to the facultative certificates or whether an exception to the back-to-back presumption under English law applied.[194] The reinsurer argued that under English law, the "all-sums" approach violated the temporal term of the contract and the back-to-back presumption could not expand coverage beyond what the parties intended.[195] In so arguing, the reinsurer relied on an exception to the back-to-back presumption under English law applicable in situations where the parties are unclear on the governing law.[196] The court rejected the reinsurer's argument, finding that the exception did not apply.[197] In this case, the parties knew that Hawaii law would apply and that Hawaii law concerning allocation could change.[198]

Finally, the court rejected the reinsurer's late notice defense, holding that the reinsurer did not meet its burden of presenting evidence that the cedent acted with extreme dishonesty that resulted in the reinsurer being extremely prejudiced by the notice.[199]

G. *Functus Officio*

In *Chicago Insurance Co. v. General Reinsurance Corp.*, the Southern District of New York denied a petition to compel arbitration, staying arbitration and granting a motion for declaratory relief.[200] The reinsurance agreement at issue provided for disputes between the parties to be arbitrated

189. *Id.*
190. *Id.* at *2.
191. *Id.*
192. *Id.* at *3.
193. *Id.*
194. *Id.* at *4.
195. *Id.* at *5.
196. *Id.*
197. *Id.*
198. *Id.*
199. *Id.*
200. No. 18-CV-10450 (JPO), 2019 WL 5387819 (S.D.N.Y. Oct. 22, 2019).

by a three-arbitrator panel.[201] In 2017, the parties arbitrated a dispute over whether the ceding company was entitled to bill its reinsurers on the basis that losses at each insured site of the underlying policyholder constituted a separate occurrence under the reinsurance agreement.[202] The arbitration panel rejected that argument, finding in favor of the reinsurers and retaining jurisdiction "'to resolve any dispute arising out of [the] Final Award.'"[203] Under the panel's decision, the plaintiff could submit only one billing per asbestos insured.[204]

In 2018, a dispute arose concerning new billings that the cedent issued to the reinsurers, purportedly "in accordance with the [Final Award's] protocols," as set forth by the 2017 arbitration panel.[205] The reinsurers claimed the original 2017 panel had retained jurisdiction over the dispute.[206] The ceding company claimed that the 2017 panel was *functus officio* and that it was entitled to a new arbitration with a different panel hearing the dispute over the 2018 billings.[207] The court rejected the ceding company's *functus officio* argument, finding that the new billing "arose from" the original panel's decision and that the original panel therefore retained jurisdiction over disputes arising out of the 2018 billing.[208]

H. *Insolvency—Offset and Mutuality*

In re Rehabilitation of Scottish Re (U.S.)[209] addressed a conflict between a triangular offset agreement and the requirement of "mutuality" of debts under Delaware's insurance liquidation statute. Scottish Re entered into approximately sixty reinsurance contracts with a group of life insurers referred to as the "Protective Entities." Beginning in February 2016, Scottish Re and the Protective Entities disputed Scottish Re's right to increase the premium rates on the contracts. At the same time, Scottish Re had fallen behind on reimbursements to the Protective Entities for claims paid. After negotiation, the parties entered into a settlement (the "Settlement Agreement") providing that premium and undisputed claims "may be offset on any reinsurance treaty between Protective and [Scottish Re], or on any treaties involving business coinsured with Protective . . . . "[210] A year later, Scottish Re was placed into Rehabilitation under the Delaware Uniform Insurers Liquidation Act (DUILA). During the rehabilitation proceedings,

201. *Id.* at *1.
202. *Id.* at *2.
203. *Id.* (citations omitted).
204. *Id.*
205. *Id.*
206. *Id.* at *2.
207. *Id.*
208. *Id.*
209. No. 2019-0175, 2020 WL 2549288 (Del. Ch. May 19, 2020).
210. *Id.* at *1.

the Protective Entities submitted "Asserted Offset Claims" to the Receiver, who objected to the claims on the basis that the calculations revealed the claims to be "triangular" or "cross-entity"—that is, premium due by one of the Protective Entities was offset by claims owed to a different Protective Entity.[211] The Protective Entities asked the court for an order directing the Receiver to enforce the provision of the pre-rehabilitation Settlement Agreement allowing offset between and among all the parties.

The Delaware Chancery Court rejected the Protective Entities' petition. It relied on the provision of DUILA allowing offsets in rehabilitation only for *mutual* debts between the insurer and another person.[212] The court ruled that the "triangular" offsets did not reflect "mutual" debts, which required that "'each party must own his claim in his own right severally, with the right to collect in his own name against the debtor in his own right and severally.'"[213] The Protective Entities, seemingly conceding the lack of mutuality in the proposed offsets, argued that the Settlement Agreement itself created the requisite mutuality to satisfy DUILA because it expressly allowed offsets among and between the various Protective Entities. The court rejected that argument as well, finding that the Settlement Agreement did not "create" mutuality because it "did not alter the Protective Entities' underlying legal relationships with respect to the amounts owed to and due from Scottish Re."[214] The court noted that an "absolute assignment" of one party's rights in a claim to another party would arguably create the requisite mutuality, but that the Settlement Agreement did not effect such an assignment.[215] Moreover, the court concluded, allowing the Settlement Agreement to create a "contractual exception" to the mutuality requirement would frustrate the statutory purpose to ensure that all similarly situated creditors were treated equally.[216]

The Protective Entities alternatively attempted to enforce their offset rights under the common law of "recoupment," which permits a defendant to assert a purely defensive claim to reduce the damages recoverable by a plaintiff where the recoupment claim arises out of the same transaction or occurrence as the plaintiff's suit. The court conceded that this "'equitable doctrine of recoupment has been recognized in insurance and other types of insolvency cases,'" and, when recognized, "'generally is not deemed to be subject to the setoff requirement of mutuality.'"[217] However, the court

211. *Id.*
212. Del. Code tit. 18, § 5927(a).
213. *Scottish Re*, 2020 WL 2549288 at *3 (quoting *In re* SemCrude, L.P., 399 B.R. 388, 393 (Bankr. D. Del. 2009)).
214. *Id.* at *4.
215. *Id.*
216. *Id.*
217. *Id.* at *5 (quoting Nat'l Ass'n of Ins. Comm'rs, Receiver's Handbook for Insurance Company Insolvencies 510 (2018)).

ruled that the Protective Entities had not demonstrated the elements of recoupment because the underlying reinsurance contracts, not the Settlement Agreement, were the controlling agreements that gave rise to the premium payments and claims for which offset was sought.[218]

Finally, the Protective Entities claimed that the Receiver was required to allow cross-entity offsets under the Settlement Agreement because the offset provision was part of an "executory contract" for which the Receiver is obligated to accept or reject all provisions. The court ruled this argument was premature because the Receiver had yet to file a plan for Scottish Re's emergence from rehabilitation. While the offset provision was "unenforceable during the course of these proceedings," the court allowed that the parties might need to resolve the dispute regarding the interpretation of the offset provision if the Settlement Agreement was included as an "accepted" executory contract as part of the eventual plan of rehabilitation.[219]

I. *Preemption*

The United States District Court for the Western District of Washington issued two recent decisions on motions to compel arbitration that leave the state of play on the enforceability of mandatory arbitration provisions in insurance and reinsurance contracts unsettled in that jurisdiction.

In *CLMS Management Services Ltd. Partnership v. Amwins Brokerage of Georgia, LLC*,[220] plaintiffs brought an insurance coverage action under a policy that contained a mandatory arbitration provision. Washington state law bars mandatory arbitration clauses in insurance contracts.[221] While the Federal Arbitration Act (FAA) would normally preempt a conflicting state law under the Supremacy Clause, the McCarran-Ferguson Act[222] creates a system of "reverse-preemption" for insurance law.[223] In *CLMS*, defendants argued that McCarran-Ferguson reverse-preemption applies only to an "Act of Congress," and that Article II, Section 3 of the Convention on the Recognition and Enforcement of Foreign Arbitral Awards (Convention)—which contains mandatory "shall" language instructing U.S. courts to refer cases to arbitration—does not require any separate act of Congress for its directive to apply.[224] To resolve the motion before it, the court undertook an analysis of the interplay between the Convention and

218. *Id.*
219. *Id.* at *6.
220. No. 19-cv-05785, 2019 WL 7185547 (W.D. Wash. Dec. 26, 2019).
221. *See* Wash. Rev. Code § 48.18.200; *see also* State Dep't of Transp. v. James River Ins. Co., 292 P.3d 118 (Wash. 2013).
222. 15 U.S.C. § 1012(b).
223. *See CLMS*, 2019 WL 7185547, at *2. In *James River*, for example, the Washington Supreme Court held "that under the McCarran-Ferguson Act, RCW 48.18.200 preempts Chapter 1 of the FAA." *Id.* (citing *James River*, 292 P.3d at 124).
224. *Id.* at *2–3.

the McCarran-Ferguson Act, citing a number of cases that had reached conflicting decisions on the issue of whether Article II, Section 3 of the Convention is "self-executing" such that the McCarran-Ferguson Act does not reverse-preempt the FAA in favor of state insurance law.[225] The court concluded that "Section 3 is self-executing . . . [and] is not an 'Act of Congress' that is subject to preemption under the McCarran-Ferguson Act."[226] Accordingly, "[t]he Convention controls and the Policy's arbitration clause is not barred by Washington law."[227] Finally, the court concluded that the parties' agreement to arbitrate fell within the scope of the Convention, and thus granted the motion to compel arbitration.[228] Plaintiffs have appealed this decision.[229]

In the other recent Washington district court case, *Washington Cities Insurance Authority v. Ironshore Indemnity Inc.*,[230] the court denied defendant's motion to compel arbitration, holding that the arbitration provision in the parties' reinsurance contract was void under Washington's statute prohibiting mandatory arbitration clauses in insurance contracts.[231] Whereas the central issue in *CLMS* was whether the Washington statute reverse-preempted the Convention, the court in *WCIA* did not mention the Convention at all. Rather, the *WCIA* court undertook a much more streamlined analysis, focusing principally on the question of whether the Washington statute—which by its terms applies to "'insurance contracts'"—also applies to reinsurance.[232] The court answered that question in the affirmative, finding that the statute applies to both insurance *and* reinsurance contracts. Thus, the court held that the mandatory arbitration provision in the parties' reinsurance agreement was void, and denied defendant's motion to compel arbitration.[233]

In a case before the Arkansas federal court, *J.B. Hunt Transport, Inc. v. Steadfast Insurance Co.*,[234] the court found that the McCarran-Ferguson Act does not supersede the Convention or Chapter II of the FAA. In *J.B. Hunt Transport*, the policyholder brought suit against two insurance companies

225. *See id.*
226. *Id.* at *5.
227. *Id.*
228. *Id.* at *6.
229. CLMS Mgmt. Servs. Ltd. P'Ship v. Amwins Brokerage of Ga. LLC, No. 20-35428 (9th Cir.).
230. 443 F. Supp. 3d 1218 (W.D. Wash. 2020).
231. Wash. Rev. Code § 48.18.200.
232. *WCIA*, 443 F. Supp. 3d at 1222 (quoting Wash. Rev. Code § 48.18.200(1)).
233. *Id.* at 1221–23. The court also rejected defendant's separate argument that other provisions of the Washington code—governing purchase of reinsurance coverage by local government joint insurance programs—carved the parties' reinsurance agreement out of Revised Code of Washington, section 48.18.200's bar on mandatory arbitration provisions in insurance contracts. *Id.* at 1223.
234. 470 F. Supp. 3d 936 (W.D. Ark. July 1, 2020).

for failing to defend and indemnify the policyholder for an underlying wrongful death action settlement.[235] One of the policies, written outside the United States, had an arbitration clause.[236] That insurer moved to compel arbitration.[237] The policyholder defended the motion by arguing that the arbitration clause in the policy was unenforceable because of a provision in Arkansas insurance law that precluded inclusion of arbitration provisions in insurance policies.[238]

In ruling that the Arkansas anti-arbitration statute did not reverse-preempt the Convention or Chapter II of the FAA, the court found that Congress did not intend McCarran-Ferguson to permit state law to vitiate international agreements entered into by the United States.[239] The court also agreed with those other courts that found Article II, Section 3 of the Convention to be self-executing.[240] Article II, Section 3 directs that the courts of a Contracting State "'when seized of an action in a matter in respect of which the parties have made an agreement within the meaning of this article, shall, at the request of one of the parties, refer the parties to arbitration.'"[241] Following the rationale of other courts, the federal district court in Arkansas focused on the word "shall" to conclude that Article II, Section 3 of the Convention is a self-executing provision of an international agreement and therefore is not preempted by the McCarran-Ferguson Act.[242] The court granted the motion to compel arbitration and stayed the action in its entirety until the arbitration is completed.[243]

J. *Right to Associate*

In *Barnes v. Security Life of Denver Insurance Co.*,[244] the United States Court of Appeals for the Tenth Circuit reversed the district court's denial of Jackson National Life Insurance Company's motion to intervene because the interests of Jackson and defendant Security Life of Denver Insurance Company (SLD) were not identical and SLD's counsel could not be expected to act in the best interests of both SLD and Jackson.[245] The court concluded that Jackson had established the requirements for intervention as of right and did not address Jackson's permissive intervention arguments.[246]

235. *Id.* at 939.
236. *Id.* at 941.
237. *Id.* at 939.
238. *Id.* at 941.
239. *Id.* at 943–45.
240. *Id.* at 943.
241. *Id.* at 944 (quoting Convention on the Recognition and Enforcement of Foreign Arbitral Awards art. II, § 3, June 10, 1958, 21 U.S.T. 2517).
242. *Id.* at *945.
243. *Id.* at *947.
244. 945 F.3d 1112 (10th Cir. 2019).
245. *Id.* at 1125.
246. *Id.* at 1121.

Barnes involved a situation where the plaintiff filed a putative class action against SLD alleging that, in the course of administering certain life insurance policies, SLD breached its contractual duties by imposing administrative costs that were not authorized under the terms of the policies.[247] SLD had entered into a reinsurance arrangement with Jackson and its predecessor pursuant to which SLD and Jackson independently administered groups of life insurance policies that were originally issued by SLD.[248] There was no indication that SLD and Jackson made the same decisions with respect to policy administration.[249]

Jackson moved for leave to intervene in the proceedings as of right on the grounds that it had an interest related to the property or transaction that was the subject of the plaintiff's action.[250] Jackson argued that as the entity that administered and reinsured the plaintiff's policy, it had a direct, substantial, and legally protectable interest in defending the manner in which it had administered the policy.[251] Jackson argued that SLD could not adequately represent Jackson's interests because Jackson administered only a portion of the policies, and, consequently, their interests and defense strategies may diverge in the litigation.[252]

In finding that Jackson had the right to intervene under Federal Rule of Civil Procedure 24(a)(2), the court noted that "the interest in the proceedings [must] be direct, substantial, and legally protectable," and that a "protectable interest is one that would be impeded by the disposition of the action."[253] The court agreed with Jackson that because it was solely responsible under the terms of the reinsurance agreement for paying or otherwise discharging all extracontractual obligations, and would thus bear the responsibility for paying any liability arising out of the misadministration of the policies, it had established an interest in the action that was direct, substantial, and legally protectable for the purposes of intervention under Rule 24(a)(2).[254] Further, the court concluded that Jackson established that its participation in the action would be "compatible with efficiency and due process."[255]

Next, the court concluded that Jackson easily satisfied the minimal burden of showing the potential for impairment of its interests, which only requires a showing that impairment of its substantial legal interest is possible, and need not be of a strictly legal nature but can also be of practical

247. *Id.* at 1115.
248. *Id.* at 1116–17.
249. *Id.* at 1117.
250. *Id.* at 1118.
251. *Id.*
252. *Id.* at 1118–19.
253. *Id.* at 1121–22 (citations omitted).
254. *Id.*
255. *Id.*

impact.[256] If the plaintiff prevailed, Jackson would be impacted both monetarily and practically, in terms of potentially having to modify the manner in which it carried out its administrative duties with respect to those policies.[257]

Finally, the court concluded that Jackson's interest would not be adequately represented by the existing parties to the litigation.[258] Here, the interests of Jackson and SLD were not identical given that SLD would likely defend against the plaintiff's claims, in part, by pointing to Jackson as the entity responsible for administering the policies. Given that the charges and expenses for the two distinct groups of policies had been managed by different insurers, there was no reason to assume that Jackson's and SLD's interests and defense strategies would align.[259] Moreover, SLD refused to allow Jackson to control the litigation because SLD's own unique interests were at stake.[260] Because Jackson satisfied each of the requirements for intervention as of right, the court concluded that the district court erred in denying Jackson's motion to intervene.[261]

K. *Vacatur*

In *Eaton Partners, LLC v. Azimuth Capital Management IV, Ltd.*,[262] the Southern District of New York denied Azimuth Capital Management IV, Ltd.'s motion to vacate the arbitrator's award in favor of Eaton Partners, LLC where the arbitrator did not commit misconduct by refusing to accept evidence from a party's witness.[263]

Prior to the first arbitration hearing, one of Azimuth's witnesses became unavailable due to a sudden death in the family.[264] Eaton expressed concerns about adjourning the hearing and suggested video testimony as an alternative.[265] The arbitrator agreed that suggestion might work.[266] After considering video testimony and speaking with the witness, Azimuth

256. *Id.* at 1123–24.
257. *Id.*
258. *Id.* at 1124–25.
259. *Id.* at 1125.
260. *Id.*
261. *Id.* at 1126. One judge dissented, disagreeing that Jackson had made a sufficient showing that SLD would not adequately represent Jackson's interests regarding claims on the policies. The dissent noted that the majority opinion ignored the impact of the law of judgments on the relationship between an indemnitor and an indemnitee and reasoned that in light of the law of judgments, it would be irrational of SLD not to represent Jackson's interests in the litigation because if SLD did not do so, a judgment against SLD in the litigation would have no preclusive effect if SLD sought indemnification from Jackson. *Id.* at 1126–35 (Hartz, J., dissenting).
262. No. 18 Civ. 11112 (ER), 2019 WL 4640008 (S.D.N.Y. Sept. 24, 2019).
263. *Id.* at *3.
264. *Id.* at *1.
265. *Id.*
266. *Id.*

withdrew the witness and proceeded with the case.[267] At a subsequent hearing, the arbitrator denied Azimuth's request to introduce a new rebuttal witness who was not on the witness list.[268]

While acknowledging the high burden of proof required to vacate an arbitration award, Azimuth argued that the arbitrator was guilty of misconduct for failing to postpone the hearing when its witness became unavailable and refusing to accept the additional rebuttal witness testimony.[269] The court noted that "[n]ot every failure of an arbitrator to receive relevant evidence, such as excluding witness testimony, constitutes misconduct requiring vacatur."[270] Instead, "[w]hen a party has had the opportunity to present all their evidence, and there is a wealth of evidence in the record to support the arbitration award, even an improper exclusion of testimony does not constitute a denial of a fundamentally fair hearing."[271] If, however, an arbitrator refuses to accept evidence from a key witness, the misconduct can rise to the level required for vacatur.[272] Accordingly, "excluding a key witness which causes the opposing party's crucial arguments to go unopposed is cause for vacating an arbitration award."[273] The court ultimately concluded that the exclusion of Azimuth's witness did not amount to the exclusion of a "key" witness.[274]

The court similarly rejected Azimuth's claims that the arbitrator improperly failed to postpone the hearing and that the arbitrator was guilty of misconduct in accepting Eaton's position regarding a video deposition given that the arbitrator had engaged the parties in a discussion on the best course of action.[275] The court held that "[e]ven if the Arbitrator had in fact refused to adjourn the hearing and only allowed [the witness] to appear by video, this would not have constituted a deprivation of Azimuth's right to a fundamentally fair hearing."[276] As a result, the court denied Azimuth's motion to vacate, confirmed the award, and awarded Eaton reasonable attorney's fees.[277]

In *Monster Energy Co. v. City Beverages, LLC*,[278] the Ninth Circuit held that an arbitrator's failure to disclose both his ownership interest in the organization administering the arbitration and the organization's

267. *Id.* at *1–2.
268. *Id.* at *1.
269. *Id.* at *3.
270. *Id.* (citing Areca, Inc. v. Oppenheimer & Co., 960 F. Supp. 52, 54–55 (S.D.N.Y. 1997)).
271. *Id.* (citing Pompano-Windy City Partners, Ltd. v. Bear Stearns & Co., 794 F. Supp. 1265, 1277–78 (S.D.N.Y. 1992)).
272. *Id.* (citing Tempo Shain Corp. v. Bertek, Inc., 120 F.3d 16, 20 (2d Cir. 1997)).
273. *Id.*
274. *Id.* at *4.
275. *Id.*
276. *Id.*
277. *Id.* at *6.
278. 940 F.3d 1130 (9th Cir. 2019), *cert. denied*, 141 S. Ct. 164 (June 29, 2020).

significant repeat business handling arbitrations for one of the parties justified vacatur of the arbitration award.[279] Monster and City Beverages, doing business as Olympic Eagle Distributing, entered an exclusive distribution agreement with an arbitration clause requiring the use of JAMS Orange County.[280] After Monster exercised its termination rights, to which Olympic Eagle objected for state law reasons, the district court compelled arbitration before JAMS.[281] JAMS provided a list of neutrals, from which the parties chose retired judge John W. Kennedy, Jr.[282] In his disclosure, Kennedy explained that each JAMS neutral "has an economic interest in the overall financial success of JAMS" and given "the nature and size of JAMS, the parties should assume that one or more of the other neutrals who practice with JAMS has participated in an arbitration, mediation or other dispute resolution proceeding with the parties, counsel or insurers in this case and may do so in the future."[283] He also disclosed that he had arbitrated and ruled against Monster in another dispute.[284] Kennedy ultimately ruled against Olympic Eagle, and Olympic Eagle moved to vacate "based on later-discovered information" showing Kennedy was a JAMS co-owner—along with roughly one-third of other JAMS neutrals.[285] After the district court confirmed the award, Olympic Eagle appealed.[286]

The Ninth Circuit reversed, explaining that under *Commonwealth Coatings Corp. v. Continental Casualty Co.*, vacatur is appropriate where an arbitrator "fails to 'disclose to the parties any dealings that might create an impression of possible bias.'"[287] To justify vacatur, an undisclosed interest in an organization "must be substantial" and the organization's "business dealings with a party to the arbitration must be nontrivial."[288] The court found that Kennedy's ownership interest in JAMS, with its right to a share of profits, greatly exceeded "the general economic interest" of other JAMS neutrals in the organization's success, making Kennedy's interest substantial.[289] The court further found that the ninety-seven arbitrations JAMS administered for Monster over the preceding five years represented a nontrivial rate of business dealings, justifying vacatur.[290] The court then established a rule: before conducting an arbitration, an arbitrator must disclose any ownership

279. *Id.* at 1138.
280. *Id.* at 1132–33, 1136.
281. *Id.* at 1132–33.
282. *Id.*
283. *Id.* at 1133.
284. *Id.* at 1136.
285. *Id.* at 1133, 1136 n.2.
286. *Id.* at 1133.
287. *Id.* at 1135–36 (quoting Commonwealth Coatings Corp. v. Cont'l Cas. Co., 393 U.S. 145, 149 (1968)).
288. *Id.* at 1136.
289. *Id.*
290. *Id.* at 1136, 1138.

interest in the organization "under whose auspices the arbitration is conducted" and the organization's "nontrivial business dealings with the parties to the arbitration."[291] One judge dissented, arguing that disclosure of the missing information would have made no difference, given what *was* disclosed, and that the rule would require vacatur in numerous JAMS cases.[292]

In *Metso Minerals Canada, Inc. v. ArcelorMittal Exploitation Miniére Canada*,[293] the Southern District of New York confirmed an arbitration award, rejecting an argument that vacatur was appropriate because the arbitrators had "manifestly disregarded the law."[294] ArcelorMittal entered a contract with Metso to purchase a new mill for use at ArcelorMittal's iron plant in Quebec.[295] The contract said that "its overarching objective was to expand the plant's iron production capacity by 8 million tons per year," but the mill never met this target.[296] ArcelorMittal initiated arbitration, asserting claims for breach of contract and breach of the duty to inform.[297] According to ArcelorMittal, Metso knew the design of its mill was defectively small, but failed to disclose that it "presented risks that could threaten output."[298] The arbitration panel split, with the majority rejecting ArcelorMittal's claims and finding that the mill was not defective because it matched the design, and therefore there was nothing Metso needed to disclose.[299] The dissent found Metso had breached its duty to inform by failing to communicate its concerns while designing the mill about whether the mill could meet the production target.[300] Metso petitioned to confirm the award, and ArcelorMittal cross-petitioned to vacate, arguing that the majority manifestly disregarded the law in dismissing the duty to inform claim.[301]

The court confirmed the award, finding that ArcelorMittal had failed to carry the heavy burden required for vacatur. In addition to the four narrow statutory grounds under the Federal Arbitration Act, a court in the Second Circuit may vacate where the arbitrators show a "manifest disregard of law."[302] The court found that ArcelorMittal had satisfied at most only one of the three prongs of the relevant test. First, the disregarded law must have been clear and applicable.[303] While the parties agreed that the

291. *Id.* at 1137–38.
292. *Id.* at 1139, 1142 (Friedland, J., dissenting).
293. No. 19 Civ. 3379 (LAP), 2019 WL 5693731 (S.D.N.Y. Nov. 1, 2019).
294. *Id.* at *1.
295. *Id.*
296. *Id.* at *4.
297. *Id.* at *1.
298. *Id.*
299. *Id.* at *2.
300. *Id.* at *5.
301. *Id.* at *3.
302. *Id.* at *2.
303. *Id.* at *3.

duty to disclose applied, they disagreed over whether the duty could be breached if the product was not defective.[304] The court, however, found that it was (largely) clear under Canadian Supreme Court precedent that a seller could breach the duty even if the product were not defective.[305] Second, the disregarded law must have been improperly applied.[306] Here, ArcelorMittal's claim faltered as it presumed the majority had dismissed the claim simply because the mill was not defective and refused to consider whether Metso had breached its duty by failing to disclose *design* risks.[307] The court found it plausible the majority had simply deemed those risks to be insufficiently important to require disclosure—so failing to disclose them did not breach Metso's duty to inform.[308] Third, the arbitrators must have intentionally disregarded the law, and on this point, ArcelorMittal fell "well short" of its burden.[309]

In *Adventure Motorsports Reinsurance v. Interstate National Dealer Services*,[310] a Georgia appellate court reversed a lower court's confirmation of an arbitration award, holding that the arbitrator manifestly disregarded the law by ignoring express contractual language.[311] Southern Mountain Adventures, a motorsports dealership, entered a contract with Interstate, a vehicle service contract administrator, in which Southern Mountain agreed to sell Interstate's service contracts to its customers.[312] Southern Mountain received as a commission the difference between its retail price for the service contract and the price on a "Rate Card," which listed the price dealers paid to Interstate.[313] The price paid to Interstate covered a variety of things, including reserves to pay service claims, and if any reserves remained when each service contract expired, Southern Mountain would share in those profits.[314] After two years under this arrangement, the parties restructured the deal so that the reserves would go to Adventure Motorsports Reinsurance instead of Interstate, with Interstate continuing to be reimbursed for claims from the reserves.[315] If any reserves remained when each service contract expired, Adventure Motorsports would keep the profit.[316] Eventually, Southern Mountain terminated the contract with Interstate and joined

304. *Id.* at *2.
305. *Id.* at *4.
306. *Id.* at *5
307. *Id.*
308. *Id.* at *6.
309. *Id.*
310. 846 S.E.2d 115 (Ga. Ct. App. 2020), *petitions for cert. filed*, Aug. 3, 2020 (Nos. S21C0008, S21C0015).
311. *Id.* at 117, 119.
312. *Id.* at 116–17.
313. *Id.*
314. *Id.* at 117.
315. *Id.*
316. *Id.*

with Adventure Motorsports to initiate arbitration, claiming that Interstate had improperly collected certain fees.[317] The arbitrator agreed, and the lower court confirmed the award.[318]

The appellate court reversed, holding that the arbitrator had ignored the terms of the contract.[319] Under the Georgia Arbitration Code, a court may vacate an arbitration award where the arbitrator manifestly disregarded the law.[320] An arbitration's outcome alone is insufficient to establish manifest disregard—there must be evidence in the record that the arbitrator "'knew the law and expressly disregarded it.'"[321] The rules of contract construction apply in arbitration, and an award should be consistent with the express terms of the parties' agreement.[322] The arbitrator had found that the agreement between Southern Mountain and Interstate did not authorize Interstate to collect fees for certain purposes—for example, Interstate could collect fees to cover claims but not fees to cover administrative costs.[323] Interstate argued, and the appellate court agreed, that all of the fees paid were based on the Rate Card prices.[324] That Interstate "used those payments to run its business, pay its costs, and retain a profit is not a ground for eliminating the . . . contractual liability" of Southern Mountain and Adventure Motorsports to pay Interstate "the prices listed on the Rate Card."[325] By ignoring the contracted-for prices on the Rate Card, the arbitrator manifestly disregarded the law.[326]

317. *Id.*
318. *Id.*
319. *Id.* at 119.
320. *Id.* at 118 (citing Ga. Code Ann. § 9–9–13(b)(5)).
321. *Id.* (quoting Airtab, Inc. v. Limbach Co., *LLC*, 673 S.E.2d 69, 72 (Ga. Ct. App. 2009)).
322. *Id.*
323. *Id.*
324. *Id.* at 118–19.
325. *Id.* at 119.
326. *Id.*