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Increasing Use of Bad Faith and Extracontractual Claims in Multi-National Disputes

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I. INTRODUCTION

In disputes between policyholders and insurers, policyholders frequently include causes of action for bad faith and extracontractual claims. The utilization of these types of claims by policyholders is on the rise in the United States in both litigated and non-litigated matters. Bad faith and extracontractual claims are claims outside of the contract with your policyholder and can expose the insurer/reinsurer to punitive, statutory or treble damages as well as the possibility of attorneys' fees and costs.

We provide an overview of how United States courts interpret the most common bad faith causes of action and extracontractual claims asserted by policyholders. In addition, we discuss the ever increasing use of bad faith claims between primary and excess insurers as well as between insurers and reinsurers. Bad faith and extracontractual claims raise many varied and difficult issues for insurers and reinsurers including potential damages well beyond the applicable policy limits, the possibility of joint and several liability, evaluating, defending and then settling covered and non-covered claims, as well as heightened reporting requirements. Further, several of the most commonly utilized extracontractual claims statutorily provide jurisdiction in the United States providing policyholders a necessary "hook" to bring their claims in a more favorable jurisdiction than would otherwise be the case.

II. OVERVIEW OF BAD FAITH CLAIMS BY POLICYHOLDERS

As a general matter, United States courts recognize that insurers owe a duty of good faith to policyholders arising out of the special relationship between the insurer and the policyholder stemming from the perceived unequal bargaining power in the negotiation of policies of insurance and the resolution of claims. In order to bridge this gap between insurer and

policyholder, courts have acknowledged that a breach of the insurer's duty of good faith yields a remedy in tort, not contract, and can lead to an award of damages that are not tied to policy limits. The idea of a “bad faith” cause of action by a policyholder against its insurer is now well-established throughout the United States.

The tort of bad faith has been accurately described as a "hybrid cause of action" in that it shares elements of both a traditional negligence action and an intentional tort. Steven Plitt, *The Elastic Contours of Attorney-Client Privilege and Waiver in the Context of Insurance Company Bad Faith: There's a Chill in the Air*, 34 *Seton Hall L. Rev.* 513, 519 (2004) (hereinafter "Plitt"). The first element, whether the insurer acted reasonably toward its policyholder, is a negligence-based standard. Thus, the "threshold test" in a bad faith action is whether "the insurance company act[ed] in a manner consistent with the way a reasonable insurer would be expected to act under the circumstances." *Trus Joist Corp. v. Safeco Ins. Co.*, 735 *P.2d* 125, 134 (Ariz. 1986). Conversely, courts have uniformly held that "[w]here an insurer acts reasonably, there can be no bad faith." *Id.*

The second element, whether the insurance company acted knowingly, is subjective and elevates the bad faith cause of action to a quasi-intentional tort. Plitt, *supra*, at 520-21. This second element, which is recognized in a majority of states, *see id*., *supra*, at n.19, requires a showing of a "dishonest purpose, . . . conscious wrongdoing, breach of a known duty through some ulterior motive or ill-will partaking of the nature of the fraud." *Centennial Ins. Co. v. Liberty Mut. Ins. Co.*, 404 *N.E.2d* 759, 762 (Ohio 1980); *see also Freidline v. Shelby Ins. Co.*, 774 *N.E.2d* 37, 40 (Ind. 2002).

Regardless of what factors a court applies to evaluate such claims, it is generally recognized to be inappropriate to review the insurer's conduct using "20-20 hindsight." *Commercial Union Ins. Co. v. Liberty Mut. Ins. Co.*, 393 *N.W.2d* 161, 166 (Mich. 1986). Rather,

> [t]he conduct under scrutiny must be considered in light of the circumstances existing at the time. A microscopic examination, years after the fact, made with the luxury of actually knowing the outcome of the original proceeding is not appropriate. It must be remembered that if bad faith exists in a given situation, it arose upon the occurrence of the acts in question; bad faith does not arise at some later date as a result of an unsuccessful day in court.
>
> [*Id.*]

There remains a divergence of opinion in the United States regarding whether an insurer can still be liable for bad faith even if it turns out that the claim is not covered by the policy. Ostrager & Newman, *Handbook on Insurance Coverage Disputes* § 12.01 (12th ed. 2004) (hereinafter "Ostrager"). We believe the more reasoned analysis holds that absent coverage there should not be any bad faith.

A. <u>Wrongful Denial of Defense</u>

One of the most common situations involving policyholder claims of bad faith arises out of an insurer's alleged wrongful denial of a defense. Often, such a claim is included as part of a declaratory judgment action filed by a policyholder in response to an insurer’s refusal to defend. As between a request for coverage and a claim for bad faith, the allegation of bad faith refusal to defend raises the greater exposure to the insurer as it opens the door to damages above and beyond the applicable policy limits.

As discussed above, courts recognize that the duty to defend creates a special relationship between the insurer and the policyholder. This duty is triggered once a claim is made. Because p;e duty to defend is generally so broadly construed, such that the mere *possibility* that the claim is covered triggers the duty, the insurer must give careful consideration before deciding to deny the policyholder a defense.

One leading case addressing the applicable standard for evaluating an insurer's alleged bad faith concluded that an insurer cannot be liable for bad faith in denying an insured's claim unless it had no "fairly debatable" reason for denying the claim. *Pickett v. Lloyd's*, 621 *A.2d* 445, 453-54 (N.J. 1993). In *Pickett*, the court articulated the "fairly debatable" standard for establishing bad faith conduct of an insurer in the context of a first-party automobile accident claim. In adopting what it perceived to be the "most balanced approach" to an analysis of bad faith claims, the *Pickett* court, accepting the Rhode Island Supreme Court's holding in *Bibeault v. Hanover Ins. Co.*, 417 *A.2d* 313 (R.I. 1980), reiterated:

> [t]o show a claim for bad faith, a plaintiff must show the absence of a reasonable basis for denying benefits of the policy and the defendant's knowledge or reckless disregard of the lack of a reasonable basis for denying the claim. It is apparent, then, that the tort of bad faith is an intentional one . . . implicit in that test is our conclusion that the knowledge of the lack of a reasonable basis may be inferred and imputed to an insurance company where there is a reckless . . . indifference to facts or to proofs submitted by the insured.
>
> [*Pickett*, *supra*, 621 *A.2d* at 454.]

In further defining the "fairly debatable" standard, the *Pickett* court explained: "[a] claimant who could not have established as a matter of law a right to summary judgment on the substantive claim would not be entitled to assert a claim for an insurer's bad faith refusal to pay the claim." *Id.*

Courts have employed similar reasoning to bad faith claims involving third-party claims. *See*, *e.g*., *Universal Rundle Corp. v. Commercial Union Ins. Co*., 725 A.2d 76 (N.J. App. Div. 1999); *Hudson Universal, Ltd. v. Aetna Ins. Co.*, 987 *F. Supp*. 337 (D.N.J. 1997) (if there are genuine issues of material fact regarding coverage which would preclude summary judgment in favor of the insured, then the insurer cannot be held liable in bad faith for consequential damages). Other United States jurisdictions have adopted similar standards. *See*, *e.g*., *Duir v. John Alden Life Ins. Co*., 754 *F.2d* 245, 249 (7th Cir. 1985) (under Wisconsin law the policyholder must demonstrate "(1) the absence of a reasonable basis by the insurer for denying the benefits of the policy to the insured; and (2) the insurer's knowledge or reckless disregard of the lack of a reasonable basis for denying the claim"); *Voccio v. Reliance Ins. Cos.*, 703 *F.2d* 1, 2 (1st Cir. 1983) (under Rhode Island law bad faith requires a reckless indifference to the facts or lack of a reasonable basis for the insurer's actions); *Delgado v. Heritage Life Ins. Co.*, 157 *Cal. App. 3d* 262 (Cal. Ct. App. 1984) ("In order to justify an award of punitive damages the plaintiff must establish that beyond the insurer's bad faith breach of an insurance contract, it acted 'with the intent to vex, injure or annoy, or with a conscious disregard of the plaintiff's rights.'"); *McCormick v. Sentinel Life Ins. Co.*, 153 *Cal. App. 3d* 1030 (Cal. Ct. App. 1984) ("We note at the outset an insurer may breach the duty of good faith without acting maliciously or immorally. Such a breach may occur merely by *unreasonably* denying a claim for benefits."); *Pavia v. State Farm Mut. Auto. Ins. Co.*, 82 *N.Y.2d* 445 (1993) ("[I]n order to establish a prima facie case of bad faith, the plaintiff must establish that the insurer's conduct constituted a 'gross disregard' of the insured's interests--that is, a deliberate or reckless failure to place on equal footing the interests of its insured with its own interests when considering a settlement offer. In other words,

a bad-faith plaintiff must establish that the defendant insurer engaged in a pattern of behavior evincing a conscious or knowing indifference to the probability that an insured would be held personally accountable for a large judgment if a settlement offer within the policy limits were not accepted.”).

B. Breach of Duty to Settle

Other conduct giving rise to claims of bad faith is the alleged failure or refusal to settle within policy limits. Some courts in the United States have recognized a separate "duty to settle" under liability policies. *Jordan v. United States Fidelity & Guar. Co.*, 843 *F. Supp*. 164, 171 (S.D. Miss. 1993); *Continental Cas. Co. v. Kinsey*, 513 *N.W.2d* 66, 69 (N.D. 1994); *Am. Physicians Ins. Exch. v. Garcia*, 876 *S.W.2d* 842, 848 (Tex. 1994). The following are some of the factors courts routinely review in the context of evaluating a claim of bad faith arising out of a duty to settle:

1. Strength of the insured's case in the underlying action;
2. Failure of the insurer to adequately investigate the circumstances surrounding the claim;
3. The insurer's treatment of its attorney's advice;
4. Failure of the insurer to keep the insured informed;
5. The relative financial risk to the insured and insurer; and
6. The relative fault of the insured.

Brown v. Guarantee Ins. Co., 319 *P.2d* 69, 75 (Cal. Ct. App. 1958). However, courts almost uniformly hold that this separate duty is not implicated where there is no settlement offer on the table or where the offer exceeds policy limits. *See*, *e.g.*, *McLaughlin v. Nat'l Union Fire Ins. Co.*, 29 *Cal. Rptr. 2d* 559, 566 (Ct. App. 1994); *State Farm Fire & Cas. Co. v. Metcalf*, 861 *S.W.2d* 751, 756 (Mo. Ct. App. 1993). In order to incur extracontractual liability, the insurer must decide arbitrarily or in bad faith to refuse to settle a claim within policy limits. *See Ganaway v. Shelter Mut. Ins. Co.*, 795 *S.W.2d* 554 (Mo. Ct. App. 1990).

Some courts have insinuated that an insurer is obligated to accept *any* settlement offer within policy limits, thus implying a strict liability standard. *Crisci v. Security Ins. Co.*, 426 *P.2d* 173, 177 (Cal. 1967) ("The duty of the insurer to consider the insured's interest in settlement offers within the policy limits arises from an implied covenant in the contract, and ordinarily contract duties are strictly enforced and not subject to a standard of reasonableness."); *Rova Farms Resort, Inc. v. Investors Ins. Co. of Am.*, 323 *A.2d* 495, 509 (N.J. 1974). However, this strict liability approach has not explicitly been adopted by any court, and claims for breach of the duty to settle continue to require a showing of unreasonableness or arbitrariness. *See*, *e.g.*, *Rawlings v. Apodaca*, 726 *P.2d* 565, 573 (Ariz. 1986); *Glenn v. Fleming*, 799 *P.2d* 79, 85-86 (Kan. 1990).

C. <u>Dilatory or Inadequate Claims Handling Practices</u>

Policyholders frequently argue that an insurer's failure to expeditiously respond to a claim constitutes bad faith, including, for example, a delayed response to a tender, failure to investigate the evidence against the policyholder, failure to respond to settlement demands or failure to promptly assign defense counsel. *See*, *e.g.*, *Lissmann v. Hartford Fire Ins. Co.*, 848 *F.2d* 50 (4th Cir. 1988); *Pavia v. State Farm Mut. Auto. Ins. Co.*, 589 *N.Y.S.2d* 510 (N.Y. App. Div.), *rev'd*, 626 *N.E.2d* 24 (N.Y. 1993). For the most part, courts are reluctant to find in favor of policyholders in such situations absent appreciable prejudice to the policyholder. *See, e.g., Pavia*, *supra*, 626 *N.E.2d* at 28-29. One set of circumstances where courts have found bad faith, however, is when the insurer refuses to defend or settle a claim without thoroughly investigating the claim. *See, e.g., Shade Foods, Inc. v. Innovative Prods. Sales & Mktg., Inc.*, 93 *Cal. Rptr. 2d* 364, 386-87 (Cal. Ct. App. 2000); *Republic Ins. Co. v. Stoker*, 867 *S.W.2d* 74, 79 (Tex. Ct. App. 1993), *rev'd on other grounds*, 902 *S.W.2d* 338 (Tex. 1995).

D. <u>Bad Faith Statutes</u>

Some states have enacted statutes that govern bad faith claims. Pennsylvania has enacted one such a statue, which reads:

> In an action arising under an insurance policy, if the court finds that the insurer has acted in bad faith toward the insured, the court may take all of the following actions:
> (1) Award interest on the amount of the claim from the date the claim was made by the insured in an amount equal to the prime rate of interest plus 3%.
> (2) Award punitive damages against the insurer.
> (3) Assess court costs and attorney fees against the insurer.
>
> [42 *Pa. C.S.A.* § 8371.]

This statute creates an "independent cause of action, separate and distinct from the underlying contractual insurance claims arising from the express terms of the contract of insurance." *Benevento v. Life USA Holding, Inc.*, 61 *F. Supp.* 2d 407 (1999). The statute does not define the standard for bad faith, and Pennsylvania courts have enunciated a standard similar to that found in other jurisdictions. *Terletsky v. Prudential Property & Casualty Ins. Co.*, 649 *A.*2d 680, 688 (Pa. Super. 1995) (finding that the policyholder must prove "(1) that the [insurer] did not have a reasonable basis for denying benefits under the policy; and (2) that the [insurer] knew or recklessly disregarded its lack of reasonable basis in denying the claim.").

One important aspect of the Pennsylvania statute is that the policyholder need not prove aggravating circumstances to justify an award of punitive damages. Instead, punitive damages are mandated under the statute. As the Pennsylvania Superior Court recently ruled:

> Section 8371 . . . specifically empowers the trial court to award punitive damages "if the court finds that the insurer has acted in bad faith toward the insured." The statute provides no other language suggesting a pre-condition for the award of punitive damages. Thus, by statutory mandate, a finding of bad faith is the

> only prerequisite to a punitive damages award under section 8371. Moreover, this Court has suggested that the elements of proof necessary to establish a claim for punitive damages under this section are co-extensive with those that establish the bad faith claim itself.
>
> [*Hollock v. Erie Ins. Exchange*, 842 *A.*2d 409, 418 (Pa. Super. Ct. 2004).]

III. OVERVIEW OF BAD FAITH CLAIMS BETWEEN INSURERS AND REINSURERS

In recent years there has also been an increase in bad faith claims filed between primary and excess insurers as well as between insurers and reinsurers in the United States. These bad faith claims present different challenges for an insurer than do the more commonly experienced bad faith claims by a policyholder.

A. Bad Faith Claims Between Primary and Excess Insurers

Most courts have found that an excess insurer only has rights against a primary insurer derivative to the rights of the insured. Under this theory, if the primary insurer breaches its duty to the insured to, for example, defend in good faith or settle within policy limits, the excess insurer may recover against the primary insurer through equitable subrogation. *See*, *e.g. Twin City Fire Ins. Co. v. Country Mut. Ins. Co.*, 23 *F.3d* 1175, 1178-79 (7th Cir. 1994) (Illinois law); *Continental Cas. Co. v. Pullman, Comley, Bradley & Reeves*, 929 *F.2d* 103, 106-07 (2d Cir. 1991) (Connecticut law). For example, in *Certain Underwriter's of Lloyd's v. Gen. Accident. Ins. Co*., 909 *F.2d* 228 (7th Cir. 1990), Lloyd's, the excess insurer, brought a bad faith claim against General Accident, the primary insurer, for refusing to settle within its policy limits. General Accident had limits of $300,000, and, on the eve of trial, defense counsel believed the

case could be settled for these policy limits. General Accident, however, only offered $75,000, which plaintiffs rejected, and the jury returned a verdict for over $800,000. The case then settled for $650,000, exposing Lloyd's to $350,000. In the bad faith action, the jury found in favor of Lloyd's and awarded Lloyd's the entire amount it contributed towards the settlement.

Some courts have held that a primary insurer owes a direct duty to the excess insurer. *Gen. Star Nat'l Ins. Co. v. Liberty Mut. Ins. Co.*, 960 *F.2d* 377, 380 (3rd Cir. 1992) (applying New York law); *W. World Ins. Co. v. Allstate Ins. Co.*, 376 *A.2d* 177, 180 (N.J. App. Div. 1977) (finding that a primary insurer has "the same positive duty to [the excess carrier] to take the initiative and attempt to negotiate a settlement within its policy limit as it owed to its assured").

The New York Court of Appeals has held that:

> [The primary carrier] owed a primary obligation to its assured and to the excess insurer to exercise good faith in handling the defense and to safeguard the rights and interest of the excess carrier. As primary insurer, it acts as a fiduciary and is held to an exacting standard of utmost good faith. Any such right of action arises as a result of the independent and direct duty to the excess insurer and is not dependent upon equitable principles of subrogation.
>
> [*Hartford Accident & Indem. Co. v. Michigan Mut. Ins. Co.*, 462 *N.Y.S.2d* 175, 178-79 (App. Div. 1983).]

Also, another trial court has observed that:

> [t]he primary insurer has certain duties and obligations that it owes to the excess insurer as a result of the distinctive relationship between the two carriers. The unique relationship results because the excess insurer relies upon the primary carrier to act in good faith in processing claims. This includes reliance upon a primary carrier to act reasonably in: (1) discharging its claims handling obligations; (2) discharging its defense obligations; (3) properly disclosing and apprising the excess carrier of events which are likely to effect that carrier's coverage; and (4) safeguarding the

> rights and interests of the excess carrier by not placing the primary carrier's own interests above that of the excess insurer. The actions of the primary carrier can affect the rights of the excess carrier. This duty then is protected by industry custom and the common law.
>
> [*Am. Centennial Ins. Co. v. Warner-Lambert Co.*, 681 *A.2d* 1241, 1246 (N.J. Law Div. 1995)]

In *Hartford Accident & Indem. Co., supra*, Hartford, the excess insurer, brought a bad faith action against Michigan Mutual, the primary insurer, based on the litigation strategy of the defense counsel retained by Michigan Mutual. Hartford repeatedly requested that defense counsel implead the injured plaintiff's employer, who was allegedly partially liable, however, Michigan Mutual resisted these requests because, Hartford contended, it provided employer's liability coverage to the employer, which would have been impacted if the employer was brought into the case. The New York Appellate Division found that Hartford's contentions "raise serious issues involving ethical considerations, in terms of the fiduciary obligations of the parties" and allowed the case to proceed. Thus, in several jurisdictions in the United States, the primary insurer has been found to owe fiduciary duties to the excess insurer.

Earlier this year, a major food service provider at sporting events was found liable in the amount of $110 million for serving a visibly intoxicated man at a football game who then left the game in his car and caused an accident with a family, which resulted in a two year old girl being paralyzed from the neck down. The primary insurer retained counsel for the insured, and the excess insurer assigned counsel to supervise the case. There were several opportunities for the primary insurer to settle the case within policy limits or for an amount significantly less than the ultimate verdict, however, the primary insurer did not do so. Counsel for the excess insurer

stated on the record towards the end of the trial that the primary insurer was acting in bad faith by refusing to settle the case. The verdict is on appeal. The excess insurer has taken the position that the primary insurer acted in bad faith by refusing to settle the case and for refusing to tender its policy limits to the excess insurer so that the excess insurer could negotiate a settlement.

In California, an excess insurer's rights against the primary insurer are derivative of the rights of the insured and may only be premised on the theory of equitable subrogation. *Fireman's Fund Ins. Co. v. Maryland Cas. Co.*, 21 *Cal. App. 4th* 1586, 1600 (Cal. Ct. App. 1994); *Diamond Heights Homeowners Ass'n v. Nat'l Am. Ins. Co.*, 227 *Cal. App. 3d* 906 (Cal. Ct. App.1991). The tying of the excess insurer's rights to equitable subrogation causes excess insurers problems because equitable subrogation has elements that are distinct from a general bad faith claim. In *Fireman's Fund Ins. Co. v. Maryland Cas. Co.*, *supra*, 21 *Cal. App.* 4th at 1586, the excess insurer brought a bad faith claim against the primary insurer based on the primary insurer's allocation of indemnity to only four out of its six policy years. The trial court granted the primary insurer summary judgment, and the appellate court affirmed, reasoning that the excess insurer did not prove the elements of equitable subrogation, namely that the insured released the primary insurer for bad faith liability and the excess insurer had no greater rights against the primary insurer than did the insured.

B. <u>Bad Faith Claims Arising out of the Insurer/Reinsurer Relationship</u>

Bad faith actions are also becoming more prevalent in the reinsurance context. The Second Circuit, expressing the majority view, has stated that the duty of good faith is essential to the reinsurance relationship because "[r]einsurers depend on ceding insurers to provide information concerning potential liability on the underlying policies" and because reinsurers generally do not independently evaluate risks or process claims. *Travelers Indem. Co. v. Scor*

Reinsurance Co., 62 *F.3d* 74, 76 (2d Cir. 1995). This relationship is also premised upon the "follow the fortunes" doctrine, which posits that if the cedent has acted in good faith, the reinsurer may not second guess the coverage decisions of the cedent. *North River Ins. Co. v. Cigna Reinsurance Co.*, 52 *F.3d* 1194, 1205 (3d Cir. 1995).

The majority of bad faith cases in the reinsurance context arise out of the cedent's failure to notify the reinsurer of coverage changes or keep the reinsurer apprised of claims. *Unigard Sec. Ins. Co. v. North River Ins. Co.*, 4 *F.3d* 1049, 1054 (2d Cir. 1993). One extreme example of such a case is *Certain Underwriters at Lloyd's London v. Home Insurance Co.*, 783 *A.2d* 238 (N.H. 2001), where the cedent did not provide notice to the reinsurer until eleven years after it received the claim. In such cases, the reinsurer is generally required to prove prejudice resulting from the lack of notice in order to prevail. *Unigard*, *supra*, 4 *F.3d* at 1069.

One of the earlier examples of a bad faith case in the reinsurance context is *Central National Insurance Co. v. Prudential Reinsurance Co.*, 241 *Cal. Rptr.* 773 (Cal. Ct. App. 1987). In that case, Central National, the cedent, sought indemnification from three of its facultative reinsurers, including PruRe (who assumed 50% of the risk), for Central National's $1.2 million contribution to the post-verdict settlement of a case arising out of a fight between players during a basketball game between the Houston Rockets and the Los Angeles Lakers. PruRe did not receive notice of the claims until after the verdict was returned. PruRe denied any liability under the reinsurance contract based on Central National's late notice as well as mishandling of the claim by Central National in paying indemnity for claims not covered under Central National's policy. Central National filed suit against PruRe for breach of contract and bad faith. At trial, the Court refused to instruct the jury that Central National's payment of excluded claims was a defense under the reinsurance contract. The jury found PruRe liable for breach of contract and

bad faith. This verdict, however, was reversed on appeal. In its opinion, the appellate court found that PruRe lacked standing to challenge Central National's handling of the claims on the theory that Central National violated the implied covenant of good faith and fair dealing. On the other hand, the appellate court found that Central National violated its duty to provide prompt notice to PruRe. The appellate court remanded the case to the trial court for further proceedings.

Another interesting example of a bad faith claim in the reinsurance context is *Travelers Casualty & Surety Co. v. Gerling Global Reinsurance Corp.*, 419 *F.3d* 181 (2d Cir. 2005). In that case, Travelers, the cedent, brought suit against Gerling, its reinsurer, for payment under several facultative reinsurance certificates. Travelers paid to Owens-Corning $273.5 million in settlement of asbestos related claims and sought reimbursement of $44 million from Gerling. Gerling objected on the basis that Travelers submitted its reinsurance claims in bad faith because its allocation methodology allocated less indemnity to Travelers's primary policies, which were allegedly not reinsured, than to its excess policies, which were reinsured. Travelers used the "rising bathtub" allocation methodology, which allocated the settlement evenly over each policy year, and used a single occurrence trigger theory. Gerling, on the other hand, insisted on the use of a multiple occurrence trigger theory, which, because the Travelers primary policy did not have an aggregate limit for non-products coverage, would allocate a larger portion of the settlement amount to the primary policies. In particular, Gerling objected on the basis that Travelers used a multiple occurrence theory when settling with Owen-Corning but used a single occurrence theory when seeking reimbursement from its reinsurers.

The District Court granted Gerling's motion for summary judgment, finding that the follow the fortunes doctrine did not apply. The Second Circuit reversed, reasoning that "[r]einsurers raising such claims will generally face a very heavy burden; a cedent choosing

among several reasonable allocation possibilities is surely not required to choose the allocation that *minimizes* its reinsurance recovery to avoid a finding of bad faith." *Id.* at 193. Further, the Second Circuit found that Travelers did not take a position on the occurrence issue during its negotiations with Owens Corning and "decline[d] to authorize an inquiry into the propriety of a cedent's method of allocating a settlement if the settlement itself was in good faith, reasonable, and within the terms of the policies." *Id.* at 189. The Second Circuit held that Gerling's allegations of bad faith were "too insubstantial" and failed to demonstrate the requisite intent on the part of Travelers.

IV. OVERVIEW OF ANTITRUST CLAIMS

One of the more common extracontractual claims asserted on behalf of policyholders involves claims that the actions by an insurer or insurers violate the United States Sherman Act. These claims are attractive to policyholders because they are statutory and provide a basis for federal jurisdiction. Further, the Sherman Act permits an award of treble damages and statutory attorneys' fees and costs as well as joint and several liability.

Under Section 1 of the Sherman Act, "[e]very contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States . . . is illegal." 15 *U.S.C.* §1. "The usual [Sherman Act] claim requires monopoly or near monopoly power in some market, and a wrongful exclusionary act designed to enhance such power in that market or to achieve an improper advantage in another market." *Town of Norwood v. New England Power Co*., 202 *F.3d* 408, 420-21 (1st Cir. 2000). The insurance industry as a whole, however, receives special treatment under the antitrust laws by virtue of the McCarran-Ferguson Act:

> No Act of Congress shall be construed to invalidate, impair or supercede any law enacted by any State for the purpose of regulating the business of insurance . . . unless such Act specifically relates to the business of insurance; Provided, that [the antitrust laws] shall be applicable to the business of insurance to the extent that such business is not regulated by State law.
>
> [15 *U.S.C.* §1012(b)]

The McCarran-Ferguson Act further carves out an exception to the "business of insurance" exemption from antitrust liability: "Nothing contained in this chapter shall render the said Sherman Act inapplicable to any agreement to boycott, coerce, or intimidate, or act of boycott, coercion or intimidation." 15 *U.S.C.* §1013(b)

Thus, the Act exempts from the antitrust law all conduct that is part of the "business of insurance," "regulated by State law" and not in the form of "boycott, coercion or intimidation." *Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of R.I.*, 883 *F.2d* 1101, 1107 (1st Cir. 1989). The United States Supreme Court in *Union Labor Life Ins. Co. v. Pierno*, 458 *U.S.* 119, 129 (1982), articulated three criteria to test whether a particular practice is the "business of insurance" exempted from the antitrust laws by the McCarran-Ferguson Act: "(1) whether the practice has the effect of transferring or spreading a policyholder's risk"; (2) "whether the practice is an integral part of the policy relationship between the insurer and insured"; and (3) "whether the practice is limited to entities within the insurance industry."

In *Hartford Fire Ins. Co. v. California*, 509 *U.S.* 764 (1993), the Supreme Court emphasized that it is crucial "to distinguish between a conditional boycott and a concerted agreement to seek particular terms in particular transactions." 509 *U.S.* at 801-02. "It is this expansion of the refusal to deal beyond the targeted transaction that gives great coercive force to a commercial boycott: unrelated transactions are used as leverage to achieve the desired result."

Hartford, 509 *U.S.* at 802-03. In *Hartford*, the court found that it was not a boycott for reinsurers to collectively refuse to reinsure certain types of commercial general liability insurance policies ("CGL") because the refusal was limited to the CGL reinsurance transaction itself. *Hartford*, 509 *U.S.* at 806. The Court in *Hartford*, however, did hold that an allegation that defendant insurers and reinsurers told "groups of insurance brokers and agents . . . that a reinsurance boycott, and thus loss of income to the agents and brokers who would be unable to find available markets for their customers, would ensue" if the terms desired by defendants in CGL insurance were not approved, was a boycott under the McCarran-Ferguson Act. *Hartford*, 509 *U.S.* at 810-11.

One of the significant issues facing foreign insurers is whether they can gain the protection of the exemption from the Sherman Act as afforded by the McCarran-Ferguson Act. As noted above, the premise of the McCarron-Ferguson Act is that if the insurer is in the "business of insurance" meaning they are regulated by the relevant insurance authorities they can gain the protection of the exemption. For foreign insurers that presents two quite different scenarios. First, if the foreign insurer is authorized to write business in the State of New York, for example, it properly would be viewed as being able to avail itself of the McCarran-Ferguson Act exemption from antitrust claims. However, to the extent that a foreign insurer or reinsurer is not authorized to write business in the United States or the claim by the policyholder involves claims of a boycott, the protection of the exemption should not be available.

One example of the latter situation is *CSR v. Federal Ins. Co., et al.*, 40 *F.Supp.2d* 559 (D.N.J. 1998), a major Australian conglomerate brought suit against numerous general liability and product insurers alleging that the insurers engaged in a group boycott by refusing to renew the policyholder's insurance program unless it agreed to withdraw millions of dollars of asbestos

claims. The majority of insurer defendants were not licensed in the United States and therefore did not qualify for the McCarron-Ferguson Act exemption. Moreover, the Complaint alleged a boycott which on its face takes the claim outside of the McCarron-Ferguson Act. The insurers moved to dismiss the antitrust claims for failure to state a claim. The court declined to decide whether it would apply a *per se* or rule of reason analysis. Further, the court denied the motion to dismiss noting that discovery was required to further evaluate the insurers' conduct and that under the generally lenient standard of a motion to dismiss, the policyholder had alleged conduct which could not be found to be reasonable under the circumstances.

In *Arroyo-Melecio v. Puerto Rico American Ins. Co.*, 398 *F.3d* 56 (1st Cir. 2005), consumers of compulsory automobile insurance in Puerto Rico brought an antitrust action against private automobile insurers and the Puerto Rico Joint Underwriting Association ("JUA") claiming that the defendants created a monopoly in the JUA as to all forms of low-cost compulsory insurance as well as boycotted and coerced one broker to maintain the monopoly. The monopoly was allegedly created by the private insurers agreeing not to sell the compulsory insurance forcing consumers to purchase from the JUA and placing it in a monopoly position. Plaintiffs also complained about the practice by the JUA of not permitting repairs using original equipment manufacturers' parts. The court rejected plaintiff's claim that the horizontal non-competition agreement, even if it created a monopoly in the JUA, was a boycott. Under *Group Life & Health Ins. Co. v. Royal Drug Co*., 440 *U.S.* 205, 220 (1979), the McCarran-Ferguson Act protects wholly intra-industry horizontal arrangements, even as to price, as part of the business of insurance. 440 *U.S.* at 221. "Even if the alleged horizontal agreement between the defendant insurers [in writing estimates at the same rate] did exist, it would be immune from antitrust

scrutiny under the McCarran-Ferguson Act." *Quality Auto Body, Inc. v. Allstate Ins. Co*., 660 *F.2d* 1195, 1201 (7th Cir. 1981); *Uniforce Temp. Pers., Inc. v. Nat'l Council on Comp. Ins., Inc*., 87 *F.3d* 1296, 1299-1300 (11th Cir. 1996) (insurers' collective rate-making activities to make workers' compensation insurance available to temporary employee provider only in the assigned risk or residual market is within the "business of insurance"); *Owens v. Aetna Life & Cas. Co*., 654 *F.2d* 218, 225-26 (3d Cir. 1981) (holding that "business of insurance" includes "authorizing agents to solicit individual or group policies").

In *Gilchrist v. State Farm Mutual Automobile Ins. Co*., 390 *F.3d* 1327 (11th Cir. 2004), insured motorists brought an antitrust class action against automobile insurers alleging a conspiracy to improperly limit coverage for auto body repairs by use of inferior non original parts. The heart of the complaint was that the insurers lowered the quality and cost of repairs by specifying the use of non-OEM parts and not passing along the savings to their policyholders through reduced premiums. The court, in dismissing the claim, concluded that the claim directly involved the insurance contract and went to the heart of the "relationship between insurer and insured" as well as the "reliability, interpretation, and enforcement of the insurance policy itself." *Gilchrist*, 390 *F.3d* at 1333 (citations omitted).

V. OVERVIEW OF CONSUMER FRAUD CLAIMS

Policyholders frequently assert claims against insurers arising under a particular state's Consumer Fraud statue. A typical statute provides as follows:

> The act, use or employment by any person of any unconscionable commercial practice, deception, fraud, false pretense, false promise, misrepresentation, or the knowing, concealment, suppression, or omission of any material fact with intent that others rely upon such concealment, suppression or omission, in

> connection with the sale or advertisement of any merchandise or real estate, or with the subsequent performance of such person as aforesaid, whether or not any person has in fact been misled, deceived or damaged thereby, is declared to be an unlawful practice.
>
> [*N.J.S.A*. 56:8-2]

A finding of liability under United States Consumer Fraud statutes typically permits the policyholder to recover in addition to any other appropriate legal or equitable relief, treble damages as well as attorneys' fees, filing fees and reasonable costs of suit. *See*, *e.g*., *N.J.S.A*. 56:8-19. In *Lemelledo v. Beneficial Mgmt. Co*., 696 A.2d 546 (N.J. 1997), the New Jersey Supreme Court concluded that the Consumer Fraud Act applies to "encompass the sale of insurance policies as goods and services that are marketed to consumers."

In *NN&R, Inc. v. One Beacon Ins. Group*, 362 *F. Supp. 2d* 514 (D.N.J. 2005), the plaintiff claimed that purported misrepresentations by the insurer's putative agent to the effect that the incremental increases in plaintiff's insurance premium would be accompanied by increases in coverage constituted a violation of the Consumer Fraud Act. Plaintiff claimed that the defendants violated the Consumer Fraud Act by failing to make certain payments for "replacement cost" under a property policy. The court rejected this claim concluding that the alleged conduct did not amount to unconscionable conduct. *NN&R*, *supra*, 362 *F. Supp. 2d* at 523. In *Van Holt v. Liberty Mutual*, 163 *F.3d* 161 (3d 1998), homeowners sued their flood insurer claiming violation of the Consumer Fraud Act in the insurer's investigation and adjustment of claims. More specifically, the plaintiff alleged that the flood insurer committed an unconscionable commercial practice by failing to address their damage claims promptly and ultimately denying them. An "unconscionable commercial practice necessarily entails a lack of good faith, fair dealing, and honesty. The capacity to mislead is the prime ingredient in all types

of consumer fraud. Mere customer dissatisfaction does not constitute consumer fraud." *Van Holt*, *supra*, 163 *F.3d* at 168. Indeed, "[t]he mere denial of insurance benefits to which . . . plaintiffs believe[ ] they are entitled does not comprise an unconscionable commercial practice." *Id*. The court also rejected a claim that a violation of regulations promulgated under the New Jersey Unfair Claims Act constituted a fraudulent or misleading commercial practice.

VI. OVERVIEW OF STATUTES GOVERNING CLAIMS HANDLING PRACTICES AND PROCEDURES

Most states have enacted unfair claims practices statutes. These statutes generally prohibit "vexatious conduct" on the part of the insurer, which is measured by a reasonableness standard that differs little from the common-law bad faith standard. Some of these statutes explicitly allow or preempt bad faith causes of action. In the absence of such clarification, there is a divergence of opinion regarding whether breach of such statutes creates a private cause of action. Ostrager & Newman, *Handbook on Insurance Coverage Disputes* § 12.03 (12th ed. 2004). We believe that the more reasoned conclusion is that such statutes do not create any private cause of action. The majority of the applicable statutes provide authority to the state, typically the attorney general's office, to seek redress for harm to the public. Further, it is often an open question whether the violation of an unfair claims practices statute is determinative of the bad faith issue or merely a factor for the court to consider.

Regardless of the foregoing, these statutes often create problems for insurers because, unlike the standard for common law bad faith, the standards and procedures included in these statutes can vary widely by state. An insurer must therefore be conscious of the requirements of such statutes in jurisdictions in which it issues policies. Further, unlike common law bad faith actions, unfair claims practices statutes often provide for the shifting of attorney's fees.

New York Insurance Law § 2601 states that "[n]o insurer doing business in this state shall engage in unfair claim settlement practices." The statute then lists the following acts as violations if "committed without just cause and performed with such frequency as to indicate a general business practice":

> (1) knowingly misrepresenting to claimants pertinent facts or policy provisions relating to coverages at issue;
>
> (2) failing to acknowledge with reasonable promptness pertinent communications as to claims arising under its policies;
>
> (3) failing to adopt and implement reasonable standards for the prompt investigation of claims arising under its policies;
>
> (4) not attempting in good faith to effectuate prompt, fair and equitable settlements of claims submitted in which liability has become reasonably clear, except where there is a reasonable basis supported by specific information available for review by the department that the claimant has caused the loss to occur by arson. After receiving a properly executed proof of loss, the insurer shall advise the claimant of acceptance or denial of the claim within thirty working days;
>
> (5) compelling policyholders to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them; or
>
> (6) failing to promptly disclose coverage . . . .

Insurance Law § 2601 does not provide a private cause of action. *New York Univ. v. Continental Ins. Co.*, 87 *N.Y.2d* 308 (1995). Further, this statute does not impose a tort duty running from the insurer to the insured separate and apart from the insurance contract. *Id.* Each violation of this section is a felony and punishable by a fine not to exceed $500. Insurance Law

§ 109(c)(1). The superintendent of insurance may bring a civil cause of action to recover any penalty imposed under the statute. Insurance Law § 109(d). Other states provide for similar penalties. *See, e.g*., *N.J.S.A*. 17:18-18 ($200 per offense).

In *Universal-Rundle Corp. v. Commercial Union Ins. Co*., 725 *A.2d* 76 (N.J. App. Div. 1999), a policyholder argued that pursuant to the New Jersey unfair claims statute his insurer's conduct was improper because one of the unfair practices included in *N.J.S.A*. 17:29B-4 is "not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear." The Appellate Division held that "nothing indicates that the statutes establish a different or additional standard [for bad faith] apart from the one articulated in *Pickett*." *Id.* at 250. In *Pierzga v. Ohio Cas. Group of Ins. Cos*., 504 *A.2d* 1200, 1204 (N.J. App. Div. 1986), the court concluded that because the unfair claims practices statute applied to wrongs to the public rather than any individual violations of the statute it did not create an individual or private causes of action in favor of the policyholder.

Not all jurisdictions in the United States, however, have reached the same conclusion. Pennsylvania's Unfair Trade Practices and Consumer Protection Law (the "CPL") prohibits a seller of goods and services from engaging in any "fraudulent conduct which creates the likelihood of confusion or misunderstanding." 73 Pa. Stat. Ann. §201-2(4)(xvii) (Purdon Supp. 1992). Pennsylvania courts have interpreted that section broadly to cover a wide variety of fraudulent acts including acts committed by insurers. *See*, *e.g*., *Wright v. North American Life Assur. Co*., 539 A.2d 434 (Pa. Super. 1988); *Schroeder v. Acceleration Life Ins. Co. of Pennsylvania*, 972 *F.2d* 41 (3d Cir. 1992) (court concluded that insured's allegation against credit disability insurer of fraud by promising benefits it never intended to pay stated a claim under the Pennsylvania CPL).

VII. OVERVIEW OF RICO AND CONSPIRACY CLAIMS

The Racketeering Influence and Corrupt Organizations ("RICO") statute provides a private civil cause of action for "[a]ny person injured in his business or property by reason of a violation of [18 U.S.C. § 1962]." 18 *U.S.C.* § 1964(c). Modeled after the criminal statute, the civil statute provides in relevant part:

> (a) It shall be unlawful for any person who has received any income derived, directly or indirectly, from a pattern of racketeering activity or through collection of an unlawful debt . . . to use or invest, directly or indirectly, any part of such income, or the proceeds of such income, in acquisition of any interest in . . . any enterprise which is engaged in . . . interstate or foreign commerce . . .
> (b) It shall be unlawful for any person through a pattern of racketeering activity or through collection of an unlawful debt to acquire or maintain, directly or indirectly, any interest in . . . any enterprise which is engaged in . . . interstate or foreign commerce.
> (c) It shall be unlawful for any person employed by or associated with any enterprise engaged in . . . interstate or foreign commerce, to conduct or participate, directly or indirectly, in the conduct of such enterprise's affairs through a pattern of racketeering activity or collection of unlawful debt.

Section 1962 provides three substantive sections that prohibit separate, but similar, conduct. Under each of these sections, the plaintiff must prove (1) the commission of two or more predicate acts (*e.g*., mail fraud, wire fraud, embezzlement, extortion); (2) of an "enterprise" (a group of individuals associated by law or fact); (3) constituting a pattern; (4) of racketeering activity. A successful plaintiff in a RICO civil action is entitled to treble damages and attorney's fees. RICO provides for joint and several liability for RICO defendants. *United States v. Garcia-Guizar*, 160 *F.3d* 511, 527 (9th Cir. 1998).

A policyholder must prove both that the insurer violated one of the provisions of 18 *U.S.C*. § 1962 and that the plaintiff was injured in his "business or property by reason of" the

violation. Thus, under § 1962(a), a plaintiff would have to prove that they were harmed by reason of the defendant's use or investment of income derived from a pattern of racketeering activity in some enterprise engaged in interstate or foreign commerce. 18 *U.S.C.* § 1962(a). Under § 1962(b), a plaintiff has to show that they were harmed by reason of the defendant's acquisition or maintenance of control of an enterprise through a pattern of racketeering activity. As to § 1962(c), the statute requires that the "person" (the defendants) engaged in racketeering be distinct from the "enterprise" whose activities he or she seeks to conduct through racketeering.

In certain circumstances, RICO claims against insurance companies are barred by the McCarron-Ferguson Act, 15 *U.S.C*. § 1011, et seq ("McCarron Act"), which provides: "No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . unless such Act specifically relates to the business of insurance." 15 *U.S.C*. § 1012(b). Again, however, questions arise where the claims are lodged against foreign insurers who are not regulated by state insurance regulations.

Courts employ a four-part test in determining whether the McCarron Act precludes application of a Federal statute such as the RICO Act: (1) does the Federal statute "specifically relate" to the business of insurance; (2) do the acts challenged under the Federal statute constitute the "business of insurance"; (3) has the State enacted laws regulating the challenged acts; and (4) would the State laws be "invalidated, impaired, or superseded" by the application of the Federal statute. *Dornberger v. Metropolitan Life Ins. Co.*, 961 *F. Supp.* 506, 516 (S.D.N.Y. 1997).

In the case of the RICO statute, the courts' determination generally hinges on elements (2) and (4). With respect to element (2), the Supreme Court has enunciated a broad definition of

"business of insurance": "The relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement – these were the core of the 'business of insurance.'" *SEC v. National Secs., Inc.*, 393 *U.S.* 453, 460 (1969). Thus, most claims that arise out of the relationship between the insurer and the insured fall within this definition. Whether element (4) is satisfied, however, depends upon the relationship between RICO and the State's enforcement scheme. If the State only provides administrative remedies for the claims at issue, the Court will be likely to find that RICO does not supersede but instead supplements the administrative scheme. *Dornberger*, *supra*, 961 *F. Supp*. at 519-20; *Forsyth v. Humana, Inc.*, 114 *F.3d* 1467, 1480 (9th Cir. 1997). On the other hand, if State law prohibits a recovery under the circumstances at issue, the Court is likely to find that State law preempts the application of RICO. *Kentucky v. Bank One, N.A.*, 92 *F.3d* 384, 392 (6th Cir. 1996).

Most RICO claims against insurers are predicated upon actions that are almost "per se" criminal acts, such as overcharging premiums or collecting premiums on policies that were never issued. In such instances, RICO claims are generally permitted to proceed if the plaintiff can prove the necessary predicate acts. RICO claims tied to an insurance company's claims handling procedures, however, are not favored by the courts. For example, in *Asbeka Indus. v. Travelers Indemnity Co.*, 831 *F. Supp.* 74 (E.D.N.Y. 1993), the insured, a defendant in several asbestos-related lawsuits, brought a RICO claim against its insurers after the insurers disclaimed any duty to defend and indemnify, alleging that the insurers misrepresented the scope of coverage under the policies and failed to handle the claims in a professional manner. The insured alleged that the insurers committed mail fraud through its letters denying coverage and requesting information. The Court dismissed these claims, reasoning as follows:

> It is inconceivable to this Court how those business letters can serve as predicate acts of mail fraud. The innocuous business communications contained in those letters do not even remotely disclose a "scheme to defraud" [the insured], nor do they even remotely give rise to a strong inference of intent to defraud. The cases are legion that a RICO complaint cannot be sustained on innocuous business communications, absent some factual basis for inferring the sender's intent to defraud the recipient via a scheme to defraud.
>
> [*Id.* at 89.]

The *Asbeka* Court then held the insured liable for sanctions under *Fed. R. Civ. P.* 11 and ordered that the insured pay the insurer's attorney's fees associated with the motion to dismiss the RICO claim.

Recently, multiple complaints have been filed against AIG and its subsidiaries alleging antitrust and conspiracy allegations that AIG conspired with insurance brokers with regard to the bidding on insurance policies. The plaintiffs allege that certain insurance brokers conspired with AIG and other insurers to steer potential insureds to these insurers in exchange for undisclosed fees, commissions and other kickbacks. Instead of creating a competitive market for insurance, plaintiffs allege that the insurer and broker defendants conspired to create an artificial market based on collusion, which resulted in undisclosed kickbacks to the brokers and increased premiums for the insurers. The complaints also include RICO allegations. Plaintiffs allege that the defendants engaged in three "broker-centered" enterprises, wherein the decision-making regarding the scheme was consensual and the purpose was uniform. The predicate acts alleged by plaintiffs include mail fraud (using the Postal Service to carry materials containing false and fraudulent misrepresentations) and wire fraud.

Plaintiffs have also brought civil conspiracy claims against insurance companies based on the insurance industry's collective effort to have new policy forms or endorsements approved by

the State regulatory authorities. For example, in *Continental Casualty Co. v. Diversified Indus., Inc.*, 884 *F. Supp.* 937 (E.D. Pa. 1995), the Court permitted an insured's conspiracy claim to go forward, which was based upon the insurance industry's approval of the "sudden and accidental" pollution exclusion while allegedly representing that the scope of coverage provided by the general liability form would not change. The conspiracy claim in this case was not part of a RICO claim. It was an independent claim for conspiracy to misrepresent the scope of coverage. Some Courts have also permitted conspiracy claims to proceed that are based upon allegations that insurers conspired to boycott the sale of insurance polices to the plaintiff. *Monarch Life Ins. Co. v. Loyal Protective Life Ins. Co.*, 326 *F.2d* 841 (2d Cir. 1963).

In *Weiss v. La Suisse*, 69 *F. Supp .2d* 449 (S.D.N.Y. 1999), policyholders brought suit against a Swiss insurer and its parent alleging, among other things, RICO claims arising out of alleged failure to pay out on policies on children which provided for payment not only on death, but also at end of policy term and in the event the child married the before end of the contract. The court concluded that the policyholders did not state claims for conspiracy or RICO violations but did for breach of contract. Plaintiffs alleged that the defendants maintained a pattern of racketeering activity through mail and wire fraud to deceive and defraud plaintiffs in the purchase of life insurance policies. The court rejected that claim given the requirement that the RICO "person" be distinct from the RICO "enterprise." In *Weiss*, however, plaintiffs alleged that the Swiss insurer and its parent were both the "persons" and the "enterprise." The court did not address the applicability of McCarron-Ferguson. Instead, it dismissed the policyholders' RICO claims for failure to state a claim.

RICO claims have also been asserted in the reinsurance context. In *Compagnie de Reassuarance D'Ile de France v. New England Reinsurance Corp.*, 57 *F.3d* 56 (1st Cir. 1999),

retrocessionaires brought an action against retrocedent, primary insurer and underwriter to recover for, among other claims, violations of the RICO Act. The First Circuit concluded that the defendants' promise to cede facultative reinsurance was not shown to be fraudulent although the underwriter used automatic and semiautomatic facilities and the retrocessionaries failed to show a right to recover under the RICO Act. The RICO claim failed because the court concluded that although the "enterprise" and defendant were "facially distinct," they were "in reality no different from each other."

VIII. BAD FAITH AND EXTRACONTRACUAL CLAIMS ARE SUBJECT TO ARBITRATION

The increase in bad faith and extracontractual claims asserted by policyholders has been met by an increase in the efforts by insurers and reinsurers to compel arbitration of those claims. The ability on the part of an insurer or reinsurer to compel arbitration of these extracontractual claims is a significant advantage. First, the cost and expense associated with an arbitration is usually far less than what would be encountered in litigating the dispute in a United States court. Second, compelling arbitration permits the insurer or reinsurer to remove from the equation a United States jury and court and substitute in their place experienced industry professionals. In other words, your cost is reduced and your ability to accurately predict within a reasonable range the expected outcome of the dispute increases. As a general matter, an arbitration clause should apply to extracontractual claims if it is broadly-worded and because of the presumption of arbitrability.

The Arbitration Act, 9 *U.S.C.* § 2, "is a congressional declaration of a liberal federal policy favoring arbitration agreements." *Moses H. Cone Memorial Hospital v. Mercury Construction Corp.*, 460 *U.S.* 1, 24 (1983). Section 201 of Title 9 contains the Convention on

the Recognition and Enforcement of Foreign Arbitral Awards, which applies to "the recognition and enforcement of arbitral awards made in the territory of a State other than the State where the recognition and enforcement of such awards are sought." Pursuant to 9 *U.S.C.* § 201, "[e]ach Contracting State shall recognize an agreement in writing under which the parties undertake to submit to arbitration all or any differences which have arisen . . . whether contractual or not, concerning a subject matter capable of settlement by arbitration." The phrase "agreement in writing" includes "an arbitral clause in a contract or an arbitration agreement, signed by the parties."

Article II, subsection 3 of § 201 states that:

> The court of a Contracting State, when seized of an action in a matter in respect to 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, unless it finds that the said agreement is null and void, inoperative or incapable of being performed.

Article III provides that "[e]ach Contracting State shall recognize arbitral awards as binding and enforce them in accordance with the rules of procedure of the territory where the award is relied upon." In determining whether to compel arbitration under the Convention, courts ask the following four preliminary questions:

> (1) Is there an agreement in writing to arbitrate the subject of the dispute?
> (2) Does the agreement provide for arbitration in the territory of a signatory country?
> (3) Does the agreement arise out of a legal relationship, whether contractual or not, which is considered as commercial?
> (4) Is a party to the contract not an American citizen, or does the commercial relationship have some reasonable relation with one or more foreign states?

Filanto, S.P.A. v. Chilewich International Corp., 789 *F. Supp.* 1229, 1236 (S.D.N.Y. 1992) (*citing Ledee v. Ceramiche Ragno*, 684 *F.2d* 184, 186-87 (1st Cir. 1983)). Before compelling arbitration of bad faith or extracontractual claims, a court must be satisfied that all four of these elements are met. *Corcoran v. Ardra Ins. Co., Ltd.*, 657 *F. Supp.* 1223, 1227 (S.D.N.Y. 1987).

In many cases, the relevant reinsurance contract between the parties mandates arbitration. In typical cases, the arbitration clause of the agreement will read as follows: "In case of disputes under this Agreement, the Insurer and the Policy Holder shall each name an arbitrator. The arbitrators shall name the third arbitrator. A majority decision reached by the arbitration tribunal shall be binding." Thus, the first requirement for the court to compel arbitration is clearly satisfied. With regards to the second preliminary question, although the agreement mandates arbitration, it frequently does not specifically state where the arbitration shall take place. As long as the anticipated jurisdiction is a signatory country, the second requirement should be fulfilled. The third preliminary question should also be answered affirmatively because the agreement is an insurance contract, which would be considered a commercial agreement. Finally, with regards to the fourth inquiry, the insurance agreement requires a reasonable relationship with the anticipated jurisdiction.

Once a court is satisfied that all four elements are met, it "must order arbitration." *Chloe Z Fishing Co., Inc. v. Odyssey Re (London) Limited*, 109 *F. Supp. 2d* 1236, 1241 (S.D. Cal. 2000) (*citing Ministry of Defense of Islamic Republic of Iran v. Gould, Inc*., 969 *F.2d* 764, 770 (9th Cir. 1992)). The Arbitration Act, 9 *U.S.C* § 3, provides that if a party is sued "upon any issue referable to arbitration under an agreement in writing for such arbitration, the court. . . shall on application of one of the parties stay the trial of the action until such arbitration has been had in accordance with the terms of the agreement." "There is a strong federal policy favoring

arbitration as an alternative means of dispute resolution." *Hartford Accident & Indem. Co. v. Swiss Reinsurance Am. Corp.*, 246 *F.3d* 219, 226 (2d Cir. 2001).

Where "the existence of an arbitration agreement is undisputed, doubts as to whether a claims falls within the scope of that agreement should be resolved in favor of arbitrability." *Ace Capital Re Overseas Ltd. v. Central United Life Ins. Co.*, 307 *F.3d* 24 (2d Cir. 2002). In *Ace Capital Re Overseas Ltd.*, *supra*, a reinsurer argued that a retrocession agreement was fraudulently induced and subject to rescission. The reinsurance agreement contained the following arbitration clause:

> As a condition precedent to any right of action hereunder, if any dispute shall arise between the parties hereto with reference to the interpretation of this Agreement or their rights with respect to any transaction involved, whether such dispute arises before or after termination of this Agreement, such dispute, upon the written request of either party, shall be submitted to three arbitrators, one to be chosen by each party, and the third by the two arbitrators so chosen.
>
> [*Id*. at 27.]

In considering whether or not a claim for fraudulent inducement was covered under the arbitration clause, the Second Circuit employed a two-part test: "whether the parties agreed to arbitrate disputes at all; and whether the dispute at issue comes within the scope of the arbitration agreement." *Id.* at 28. The Second Circuit determined that the parties agreed to arbitrate and that the arbitration clause was broad enough to encompass the fraudulent inducement claim. *Id*. at

30. After a court determines that an arbitration clause is broad, "there arises a presumption of arbitrability and arbitration of even a collateral matter will be ordered if the claim alleged implicates issues of contract construction or the party's rights and obligations under it." *Id.* at 34.

In a case concerning whether a claim was outside the scope of an arbitration clause, the Southern District of New York explained that "[a]rbitration clauses fall into two groups: 'narrow' clauses, which limit arbitration to specific types of disputes and 'broad' clauses that cover any and all dispute, controversy or claim under an agreement." *Calamia v. Riversoft, Inc.*, 2002 *WL* 31779991 (S.D.N.Y. 2002) (*citing Oldroyd v. Elmira Savings Bank,* 134 *F.3d* 72 (2d Cir. 1998)). The Southern District of New York has also made clear that: "An arbitration clause is broad if the language of the clause, taken as a whole, evidences the parties' intent to have arbitration serve as the primary recourse for disputes connected to the agreement containing the clause," whereas a narrow arbitration clause "is designed to play a more limited role in any future dispute." *Alemec Ins. Services, Inc. v. Risk Transfer Inc*., 2003 *WL* 22024070 (S.D.N.Y. 2003) (*citing Collins & Aikman Prods. v. Bldg. Systems, Inc.,* 58 *F.3d* 16, 25 (2d Cir. 1995)).

The language of arbitration clauses, taken as a whole, frequently suggests that the parties intended to have arbitration serve as the primary recourse for all disputes connected to the agreement. Under those circumstances, a court would most likely determine that the arbitration clause is broad, and that extracontractual claims should be arbitrated. In other instances, the parties can agree, because of the strong policy in favor of arbitration, that all of the bad faith claims will be arbitrated along with the underlying coverage issues.

IX. ISSUES ARISING OUT OF BAD FAITH AND EXTRACONTRACTUAL CLAIMS

As should be obvious from our discussion of the significance and potential magnitude of the extracontractual claims discussed above, these extracontractual claims implicate numerous other additional issues. We discuss some of these additional issues below.

A. Threat Of Joint and Several Liability

One troubling aspect of certain of the extracontractual claims asserted by policyholders is that they present the threat of joint and several liability against an insurer. Typically, in the United States, an insurer is only legally responsible for that amount of liability allocated to it by a court or jury. Generally that allocation of liability is conducted pursuant to established case law directing how a policyholder's loss will be spread amongst several insurers and differing years and limits. Further, generally a defendant is entitled to seek contribution and indemnity from other responsible parties.

The concept of joint and several liability (present, for example, in antitrust cases) turns these principles on their heads and opens the door to one insurer – at the whim of the policyholder – being held jointly and severally liable for the entire judgment entered on an extracontractual claim. This situation sometimes arises when one prominent insurer is impecunious or under funded and cannot satisfy the extracontractual judgment awarded again it. Under those circumstances, the policyholder will look for a "deep-pocket" to be responsible for most of if not the entire judgment. The difficulty with joint and several liability is that the very factor driving the policyholder to seek the entire judgment from one insurer (the lack of assets of other insurers) will also serve to thwart any effort to obtain contribution and indemnity for any

portion of the judgment over and above the share properly allocated to that insurer. In short, the tort concept of joint and several liability is at odds with the more straightforward breach of contract damages insurers typically face.

B. Jurisdictional Issues

Not only do these extracontractual claims result in the need to evaluate the possibility of whether they can be arbitrated, extracontractual claims are frequently utilized by policyholders as a means to retain jurisdiction in the United States rather than the having claims dismissed in favor of a foreign and (for the policyholder) not as favorable jurisdiction.

C. Pressure Points

Policyholders and their attorneys believe that the use of bad faith and extracontractual claims present them with a "big stick" that will be effective in forcing a resolution of the underlying coverage disputes. Courts have almost uniformly recognized that allowing bad faith claims to be litigated before the adjudication of a threshold coverage issue prejudices the insurer as it causes unnecessary discovery, trial preparation and confusion. Not surprisingly, as a result, courts routinely sever and stay bad faith claims to protect parties from wasting valuable resources attending to claims that would necessarily be rendered moot by a coverage determination in the insurer's favor. Severance of bad faith claims furthers the convenience of the parties, as well as judicial economy, because it permits the parties and the court to avoid unnecessary trial preparation and a trial itself on issues that may never need to be resolved. The claims for bad faith and extracontractual damages that a policyholder typically asserts will, for the most part, be moot unless they can prove coverage under the relevant policy.

Multiple decisions in different jurisdictions have made consistent rulings on this issue. *See*, *e.g.*, *O'Malley v. United States Fidelity and Guaranty Co.*, 776 *F.2d* 494, 500-01 (5th Cir.

1985) (district court properly declined to hear bad faith claim after concluding that insurer was not liable under policy; bifurcation of bad faith and coverage claims appropriate); *Providence Journal Co. v. The Travelers Indemnity Co.*, 938 *F. Supp*. 1066, 1070 & n.3 (D.R.I. 1996) (claim against insurer for refusal to perform under policy in bad faith severed); *Bartlett v. John Hancock Mutual Life Insurance Co.*, 538 *A.2d* 997, 1001-02 (R.I. 1989), *abrogated on other grounds*, *Skaling v. Aetna Ins. Co*., 799 *A.2d* 997 (R.I. 2002) (bad faith claim severed and discovery stayed). Other courts have also severed bad faith claims to avoid prejudice to insurers. *See*, *e.g.*, *American National Red Cross v. The Travelers Indemnity Co.*, 924 *F. Supp.* 304, 308 (D.D.C. 1996) (severance of bad faith claims appropriate to avoid "undue prejudice"); *see also O'Malley*, *supra*, 776 *F.2d* at 501 (severance of bad faith claims appropriate to avoid prejudice and expedite trial); *Aetna Casualty & Surety Co. v. Nationwide Mutual Insurance Co.,* 734 *F. Supp.* 204, 208 (W.D. Pa. 1989) (motion to sever bad faith claims granted to avoid "substantial risk of prejudice").

D. <u>Defense Issues Raised by Extracontractual Claims</u>

Extracontractual claims also present some unique difficulties in terms of defending your policyholder against such claims. As a general matter, many types of extracontractual claims (RICO, bad faith and antitrust) could be viewed as falling outside the scope of coverage available to your policyholder. As a result, it is quite common for situations to arise where a policyholder is facing such extracontractual claims as well as more run-of-the-mill (and covered) breach of contract or negligence claims. A decision may be made by the insurer to agree to defend the policyholder under a reservation of rights for non-covered claims (frequently these types of extracontractual claims are not covered) with an accompanying non-waiver agreement. In those

situations, an insurer may well face a situation where not only do they have to deal with personal counsel for the policyholder but non-covered claims well in excess of available policy limits. These situations require careful attention to avoid exposing the company to bad faith claims.

E. Settlement Issues

Attempting to resolve disputes involving extracontractual claims can also present significant difficulties. First, if you are defending a policyholder against such extracontractual claims under a reservation of rights, a conflict can easily arise with your policyholder as to the demand by the underlying plaintiff and how that proposed settlement is allocated between covered and non-covered claims. For example, for purposes of allocating a settlement, how do you assign value to these types of extracontractual claims given the uncertainty presented? Further, keeping in mind a possible bad faith claim for failing to settle within policy limits, an insurer must be careful not to aggressively allocate the majority of the settlement to non-covered claims to the detriment of its insured.

Similarly, it is difficult to evaluate extracontractual claims asserted by policyholders for purposes of reaching a settlement of both coverage and extracontractual issues. Because of the hybrid nature of the claims, a settlement of a case involving both coverage claims and extracontractual claims should be and will be carefully scrutinized by reinsurers.

F. Damages – Statutory, Treble, Punitive, Fees and Costs

Another difficulty presented by bad faith and extracontractual claims is the threat of an award of statutory, treble or punitive damages as well as attorneys fees and costs (all outside the policy limits). This poses a concern on two fronts. First, to the extent that you are defending against such claims by a policyholder, statutory, treble and punitive damages pose the risk of damages far and above whatever the applicable policy limits available to the policyholder.

Further, an award of attorneys fees and costs, as permitted, for example, on an antitrust claim, further increase the exposure and are contrary to the otherwise well-established rule in the United States that each side is responsible for its own attorneys fees and costs.

Similarly, to the extent that you have agreed to defend your policyholder under a reservation of rights, these non-covered claims raise the possibility of punitive and other types of statutory or exemplary damages not generally covered. Furthermore, as a reinsurer certain portions of a settlement may not be covered – *i.e.*, fines, penalties or damages punitive in nature.

X. CONCLUSION & RECOMMENDATIONS

The use of bad faith and extracontractual claims by policyholders continues to rise. Bad faith and extracontractual claims require careful handling and consideration as discussed herein. Although these claims present many difficult and unique issues for insurers, the risks attendant to such claims can be managed by appropriate planning, management and documentation of the file.