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The Challenges for Secured Creditors in Insurance Insolvency: When Having a Secured Claim May Not Guarantee Payment

There is often misunderstanding and frustration, and occasionally anger, when worlds collide. In the case of banking institutions dealing with the unique world of insurance insolvency, the results may not be as dramatic as in other cultural clashes, but they can be equally confused. This is because insurance insolvency operates in its own separate world, where the usual rules of bankruptcy do not apply and where, without appropriate safeguards, having a secured claim may not guarantee repayment. For banks and other secured creditors, lending to insurance companies is governed by a separate set of rules to which careful attention must be paid.

Unlike other corporate entities, licensed insurance companies that become insolvent do not go through the usual federal bankruptcy process. Rather, every state has its own separate insurance insolvency system with its own rules that govern the process. As a result, everything that a creditor thinks he or she knows about collecting secured debts under the bankruptcy code does not necessarily apply. In this separate world, if care is not taken, regulators may attempt to subrogate the rights of secured creditors in order to carry out the strong public policy preference under the insurance laws of most states for the protection of policy holders over other creditors.

The reason for all of this is rooted in a basic truth: Insurance is just different from other businesses. An insurance company's customers are deeply dependent on the long-term reliability of the product, insurance coverage, to make them whole and thus avoid financial ruin. Moreover, customers may be depending upon the product years, or decades, after they have paid for it with their premiums. As a result, the government regulates insurance companies closely to make sure they remain solvent, and where they do not, has an elaborate system to wind down these companies

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in a way that protects the insureds. The result is a process different from traditional bankruptcy, with a unique set of goals and biases.

While every state has its own regulatory structure, the basic process is similar in many jurisdictions, including New York. When the state

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By Mark G. Peters
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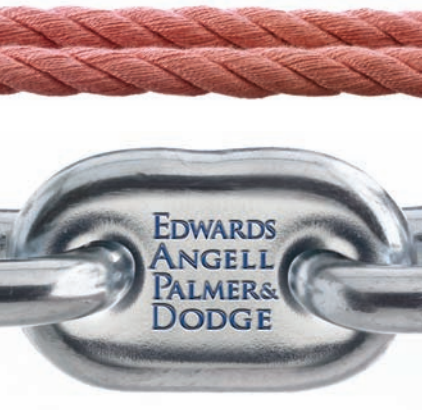

Mark G. Peters is a new partner in the Insurance & Reinsurance Department's New York office
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insurance regulator determines that an insurance company is insolvent or otherwise poses a danger to consumers, he or she will seek a court order placing the company in receivership with that state's statutory receiver. In New York, for example, the Insurance Superintendent would be named as the receiver and the process would be managed by his agent, the Special Deputy Superintendent in Charge of the New York Liquidation Bureau (the NYLB).

Generally, at the same time that the Insurance Commissioner is taking charge of an insolvent company's operations, a state-run security fund or guarantee association will evaluate and, as appropriate, pay claims of the company's policy holders from a fund created by annual assessments of solvent insurers. That fund will then step into the shoes of the insureds and become a creditor of the insolvent insurance company. As a general rule, the managers of the various security funds and guarantee associations take their role as creditors quite seriously, viewing collections as an important part of keeping their funds solvent for the next crisis. They will work closely with the receiver – in New York they are all part of the NYLB – to ensure the maximum collection from the insolvent company.

The actual insolvency goes through a two-step process. The first step is for the receiver to take control of all of the insolvent company's assets. This is typically a very broad mandate, which would very likely include taking control of any assets held by an insurance company but pledged as security for a loan made by a bank or other entity. Typically, once the assets have been marshaled, the receiver will conduct an audit or other review to determine the full scope of the insolvent company's assets and liabilities and report back to the receivership court when this is completed.

While this is only the first step in the process, there is a practical point to be noted here. It is unlikely that the receiver would agree to release any assets (even those held as security against secured claims if held by the insolvent company) until after this initial accounting and report to the court, and until a court has approved any particular claim. Indeed, in many instances, such a distribution is prohibited outright. While the time for this step is difficult to predict and will vary widely depending on many factors, it is not unreasonable to assume that it will take at least a year if not more. Thus, even a secured claim will not likely be paid without some considerable wait.

As a general rule, after paying the receiver's own costs and certain other claims, the first priority on an insolvent company's assets belongs to the various insureds, who must all be made whole before other creditors. In many states, including New York, the priority statute does not expressly distinguish between secured and unsecured creditors, simply lumping all creditors together to be paid only after the insureds (including security funds) have been made whole.

This is not the end of the story, however. The liquidation statutes of most states, despite the poorly drafted priority provisions, should be read to require that secured claims, to the extent of their security, receive a priority above both insureds and other creditors. For example, New York's code provides:

> The owner of a secured claim against an insurer for which a receiver has been appointed in this or any other state may surrender his security and file his claim as a general creditor, or the claim may be discharged by resort to the security, in which case the deficiency, if any, shall be treated as a claim against the general assets of the insurer on the same basis as claims of unsecured creditors. If the amount of the deficiency has been adjudicated in ancillary proceedings as provided in this act, or if it has been adjudicated by a court of competent jurisdiction in proceedings in which the domiciliary receiver has had notice and opportunity to be heard, such amount shall be conclusive; otherwise the amount shall be determined in the delinquency proceeding in the domiciliary state.

N.Y. Ins. Law § 7413(d). New York law further provides that secured assets when properly segregated should not be considered part of the estate's general assets available to pay policy-holders. N.Y. Ins. Law § 74089(a)(7).

A plain reading of the statute would suggest that it protects secured creditors. Indeed, at least one New York court has expressly held that the statute gives secured creditors a preference. *In re Allcity Insurance Company,* 66 A.D.2d 531, 536 (1st Dep't 1979); *see also G.H. Murphy Co. v. Reserve Insurance Co.*, 54 N.Y.2d 69, 80 (1981) (noting the need to distinguish between secured and

"It is unlikely that the receiver would agree to release any assets (even those held as security against secured claims if held by the insolvent company) until after this initial accounting and report to the court, and until a court has approved any particular claim."

unsecured creditors). *See also* OGS Opinion No. 08-12-08. A number of other states have similar provisions. Seen this way, the statute appears to require that once the receiver has completed his/her review of the estate, a secured creditor should be entitled to be paid the secured assets as against its loss on the loan.

Again, however, practical considerations intervene. To begin with, in the event of an insolvency, the regulator's first concern is to make sure that individual policyholders are made whole. While the security funds will cover much of this, those funds have a variety of limits. Moreover, the security fund administrators themselves become creditors and, as noted above, will be forceful in demanding payment. All of this places considerable pressure upon the receiver to find alternate ways to fund such obligations. One way to do so would be to employ the imprecise drafting in many state statutes and take the position that, even if the statute does say that a secured claim "may be discharged by resort to the security", the section of the statute listing the order of priority of claims simply refers to creditors generally and relegates them all to a priority below insureds.

There are numerous and compelling arguments to be made against such a reading of the law, including the legal arguments noted above and public policy arguments to the effect that such a stance would make it virtually impossible for insurance companies to obtain secured loans and financing in the future. Indeed, if litigated, it would be difficult for a receiver to prevail, but such a proceeding could be time consuming and costly. The real concern, of course, is that an activist receiver would use what uncertainty does exist as the basis for trying to negotiate a partial payment that would allow some of the security to be used to pay insureds.

In conclusion, while there could be a considerable delay in payment, as a legal matter a secured creditor should be able to collect on its debt to the extent of the security posted. However, in the event of an economic event large enough to cause the insolvency of a significant insurance company, the possibility exists that pressure to make policyholders whole will force a receiver to attempt to negotiate a reduction in the payment on such a claim, and the insurance insolvency laws in many states provide room to maneuver. Finally, the unique state-by-state status of insurance insolvency means that the usual assumptions applicable to federal bankruptcy may not be made. This is a different world and should be seen as such.

EAPD's New Attorneys

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Patrick J. Gennardo has joined the firm as a Partner in the Insurance and Reinsurance Department. He will spearhead the department's new "Complex Commercial Litigation – Insurance and Reinsurance Industry" practice group, which will represent insurance and reinsurance companies in complex commercial, corporate and regulatory disputes. Patrick brings more than 15 years of experience in handling complex, multi-jurisdictional litigation, in addition to compliance, regulatory, and other insurance matters. He has successfully represented clients in a variety of class actions, as well as major financial institutions that were under investigation by insurance regulators and state attorneys general, and he has defended insurance carriers in complex insurance-coverage disputes.

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Joining Patrick is **Franklin G. Monsour**, Counsel in the New York office of the Complex Commercial Litigation – Insurance and Reinsurance Industry practice group. His practice focuses on representing financial institutions and insurance and reinsurance entities in complex, multi-jurisdictional litigation, government investigations, and coverage disputes.

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Mark G. Peters has joined the firm as a Partner in the Regulatory & Transactional Services practice group, in the Insurance & Reinsurance Department. Previously, Mark was the special deputy superintendent in charge of the New York Liquidation Bureau, the agency that manages insolvent insurance companies on behalf of the state. "With his background running the Liquidation Bureau, Mark offers an invaluable perspective to our clients who are confronting regulatory and enforcement issues," said **Alan Levin**, the head of EAPD's Insurance & Reinsurance Department. "His insider's knowledge puts him in a strong position to help our clients navigate the changing state and federal regulatory landscape. In addition, Mark has strong experience in dealing with complex financial restructuring." Mark's public service also includes seven years at the Office of the Attorney General in New York. He began his legal career serving as a clerk to US District Judge Charles P. Sifton.

By Chris Sage
London

Climbing the Twin Peaks: First Glimpses of the UK's New Regulatory Structure

On 26 July 2010 Her Majesty's Treasury (the Treasury) launched its consultation (the Consultation) on the implementation of financial regulation reforms, originally announced by the Chancellor of the Exchequer on 16 June 2010. The Consultation closed on 18 October 2010 and the Treasury's findings are awaited. In the meantime, the Consultation has given us an insight into the future shape of financial services regulation as envisaged by the UK's coalition government.

The Current System: Tripartite Regulation

The current regulatory system is known as a "tripartite system", under which the Treasury sets the overall scope of policy, the Bank of England (the Bank) is responsible for monetary and financial stability and acts as a lender of last resort, and the Financial Services Authority (FSA) implements Treasury policy and is responsible for (among other things) prudential regulation, consumer protection and prevention of market abuse.

In addition to the three bodies referred to above, the FSA also has responsibility for the Financial Ombudsman Service (the Ombudsman) and the Financial Services Compensation Scheme (FSCS) and established the Consumer Financial Education Body (CFEB), although each is run independently.

The Proposal: "Twin Peaks"

Although the name would suggest that the number of regulatory entities is to be reduced from three to two, in fact, "twin peaks" refers to two limbs of regulation – prudential regulation and conduct regulation (or consumer protection). Prudential regulation is, itself, broken down into macro-prudential (focused on systemic risk and financial stability) and micro-prudential (focused on each individual authorised firm).

Prudential regulation will fall into the hands of the Bank, through the creation of a Financial Policy Committee (FPC) which will be responsible for macro-prudential regulation, and a newly-established subsidiary of the Treasury, whose working title is the Prudential Regulatory Authority (PRA), which will be responsible for micro-prudential regulation. Conduct regulation will be the responsibility of another newly-established independent agency, the Consumer Protection and Markets Authority (CPMA).

The FPC will have the power, in support of macro-prudential policy, to require the PRA to take regulatory action with respect to the firms that it regulates. For example, if the FPC considers that a general increase in capital held by banks is required as a result of an upswing in the credit cycle, then it will instruct the PRA to amend its rules accordingly. The FPC will also have similar macro-prudential controls over the CPMA if necessary.

The PRA will have operational responsibility for the prudential regulation and supervision of individual firms. The Consultation specifically notes that the PRA's responsibilities will include minimising the disruption caused by any firms that fail. The PRA will have responsibility to:

- make rules governing the performance of regulated activities classified as "prudential"
- supervise firms and enforce compliance with those rules
- authorise firms to engage in regulated activities classified as "prudential"

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Industry Presence

EAPD ARTICLES

EAPD's article-writing is not limited to the IRD Review. The following list is a selection of recently published articles by our professionals:

- **Mark Peters** (New York) The Challenges for Secured Creditors in Insurance Insolvency -- When Having a Secured Claim May Not Guarantee Payment, to be published in *Bankruptcy Law360* and *Insurance Law360*.
- **Eric Hermanson** (Boston) *Tomlinson v. Landers*: How One Insurer's Attempt To Protect Itself From Medicare Secondary Payor Obligations Led To The Prospect Of Extracontractual Liability, to be published in *Bloomberg Insurance Law Report*.
- **David Kendall** (London), **Vincent Vitkowsky** (New York), **James Shanman** (Stamford), **Peter Fidler** (London) and Peter Scarpato's articles to be published by The Review in December 2010.

For further details on any of the above contact Jennifer Topper at: JTopper@eapdlaw.com.

- approve individuals carrying out certain functions within those firms.

Hector Sants, currently the Chief Executive of the FSA, who was due to step down in the summer of 2010, has agreed to stay on with the FSA to oversee the transformation. Mr Sants will then become the first Chief Executive of the PRA and, *ex officio*, a deputy governor of the Bank. The CPMA will:

- assume the core regulatory function of making rules governing the conduct of firms, in both retail and wholesale spheres, and supervise compliance with those rules
- grant permissions for all regulated activities classified as "non-prudential"
- approve individuals carrying out conduct-related controlled functions within firms regulated by the PRA and all controlled functions within firms that it regulates alone
- assume responsibility for market conduct and market infrastructure including investment exchanges.

Divided but Coordinated?

Given the Consultation's observation that *"no single institution [currently] has the responsibility, authority or powers to monitor the system as a whole... and respond"* it is unsurprising that coordination between the newly divided PRA and CPMA is addressed in some detail. A number of formal arrangements will be legislated for, including:

- an obligation on each authority to have regard to the objectives of the other
- a seat on the CPMA board for the CEO of the PRA, and vice versa
- memoranda of understanding between the PRA and CPMA will be required by statute
- the establishment of "colleges" to support joint working on the supervision of firms falling under the remit of both the PRA and the CPMA
- requirements for each of the PRA and CPMA to consult the other, and the FPC, when making new rules.

New Regulators, Old Regulator?

Under the proposals, the PRA and the CPMA will effectively divide the current FSA role between them. The FSA has submitted a memorandum to the Treasury discussing implementation of that division. The memorandum discusses the high level processes put in place to achieve the transition to the new structure, and the risks associated with it. It also identifies the long term issues and opportunities associated with the new regime. Among the risks identified are people retention issues, "personnel stretch" as management of the transition occupies staff who would otherwise be focused on regulatory activities and a requirement for redesign of supervisory procedures including authorisation and ARROW which currently deal with prudential and consumer protection issues in a fully integrated manner.

"Under the proposals, the PRA and the CPMA will effectively divide the current FSA role between them."

It seems likely that much of the present FSA Handbook of Rules and Guidance will also be divided and re-used. It remains to be seen whether more fundamental changes will be made to the rules and whether the two regulators will be able to maintain sufficient consistency between their respective rules to ensure that firms are not required, in circumstances where an activity has both prudential and consumer protection implications, to deal with at least two regulators and at least two different sets of rules regulating the same activities.

Other Agencies

The Ombudsman, FSCS and CFEB will remain independent of the regulators. It is proposed that the CPMA will assume responsibility for all three, although they will maintain their independence, but the Consultation acknowledges that the FSCS will also have to work closely with the PRA and calls for comments on whether the FSCS fits better within the remit of the PRA or the CPMA.

The Treasury also intends to consult on transferring responsibility for consumer credit regulation from the Office of Fair Trading (OFT) to the CPMA.

Implications for the Insurance Industry

The proposals have left those in the insurance industry with little guidance as to how they will be regulated from 2012. The Consultation, reflecting the majority of the post credit-crunch calls for reform, is almost exclusively focused on banking and capital markets, with insurers appearing little more than an afterthought (with just seven mentions in a 76 page document) and insurance intermediaries failing to register at all. Consequently, although it appears from the document that insurers will be regulated by both the PRA and the CPMA and it appears to follow that insurance intermediaries will be regulated by the CPMA alone, the position remains far from clear. In particular, there will inevitably be an element of prudential regulation carried out by the CPMA if it is the sole regulator of intermediaries. The CPMA's role will clearly extend beyond protection of retail customers to encompass wholesale markets activities and it is essential that its rules, systems and processes reflect the differing natures of those functions.

Sean McGovern, Director, North America and General Counsel of Lloyd's notes that: *"The PRA is the right place to regulate insurer solvency but it should have a separate insurance division headed by a senior and respected person with insurance expertise who would sit on the board..."*. He also expresses concern that the CPMA's primary role is as a consumer champion: *"It is dangerous for a regulator to be an advocate for one side of the financial contract rather than to simply formulate clear rules of engagement..."*.

Insurers at Lloyd's, in particular, have voiced concern at the prospect of having to deal with three separate regulators, while the brokers who bring the business to them, and who handle many millions of pounds and dollars of premiums and claims money on a daily basis, fall to be regulated only by the CPMA.

Insurance intermediaries will be aware of the current review of the Insurance Mediation Directive, with a public hearing to be held in Brussels on 10 December 2010, and a revised text to be presented to the Council and European Parliament in early 2011. With Solvency II still expected to be implemented on 31 December 2012, that year is set to be a regulatory watershed for insurers in particular, but also for intermediaries. What they, and the individuals with responsibility for implementing the new regulations, need least of all in the run up to such fundamental regulatory changes is a root and branch reshaping of the UK regulatory authority that is to apply it.

Product liability: Looking Beyond the Terms of a Judgment

By Mark Everiss and
William Slaiding
London

In a recent case, the Commercial Court has held that an underlying judgment against an insured did not conclusively determine the basis of liability for the purposes of that insured's claim under its product liability insurance. It was open to the insured to contend that it was liable on other grounds or indeed to argue that the decision in the underlying judgment was incorrect.

"Product liability policies often exclude contractual liability unless the liability would have attached in the absence of a contract."

Product liability policies often exclude contractual liability unless the liability would have attached in the absence of a contract. In the case of *Omega Proteins Limited v Aspen Insurance UK Ltd* (2010) EWHC 220 (Comm), the court considered whether a finding of contractual liability in an underlying judgment prevented a later finding of tortious liability within the same policy cover.

Background

The claimant, Omega Proteins Ltd (Omega), was in the business of processing by-products from animal carcasses used in the meat industry which it supplied to customers. Omega was supplied with animal carcasses by Northern Counties Meat Ltd (NCM). In breach of the contract with Omega, NCM supplied Omega with meat materials which were fit only for disposal within the meaning of *EC Regulation 1774/2002* (a statutory regulation introduced following the BSE crisis). Omega proceeded to mix this material with other material, thereby contaminating the whole resulting mixture, which it then supplied to its customers. The State Veterinary Service discovered the contravention and ordered that the mixture be destroyed.

The Underlying Judgment

A company which had purchased some of the contaminated material began an action for damages for breach of contract against one of Omega's customers. Omega was joined to the proceedings as a third party and, in turn, joined NCM as a fourth. In the underlying case the Commercial Court held that Omega was liable to pay damages for breach of contract to its customer and that NCM was liable to indemnify Omega in respect of this liability.

Unfortunately, NCM was in liquidation and unable to satisfy the judgment. Omega therefore brought the present claim against NCM's insurers, Aspen, under the Third Parties (Rights against Insurers) Act 1930.

Whether or not there was a liability in tort was not something that was considered by the court in the underlying case.

The Policy

The insurance policy provided an indemnity in respect of *"all sums which the Insured becomes legally liable to pay"* for loss or damage to property caused by any product. This was subject to an exclusion clause for liability arising *"under any contract or agreement unless such liability would have attached in the absence of such contract or agreement."*

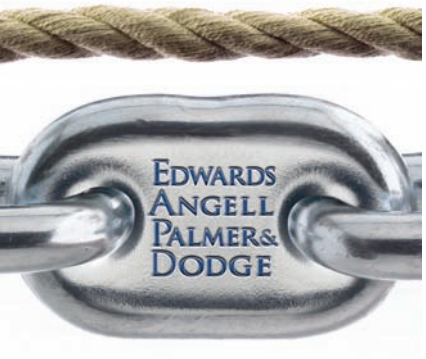
Aspen contended that Omega's claim fell within the exclusion. They argued that the court in the underlying case had conclusively determined that NCM's liability to Omega was in contract and that it was not possible to look beyond the terms of this judgment to find grounds for an alternative claim in negligence.

In support of this contention, Aspen relied upon the observations of Mr Justice Tomlinson in *London Borough of Redbridge v Municipal Mutual Insurance Ltd* [2001] Lloyd's Rep IR 545 at 550 when he commented, in respect of liability insurance, that the enquiry of whether insurers are liable should *"begin and end with the question on what basis had liability been established"* and that, in his judgment, it was *"normally neither permissible nor possible to look beyond or outside the four corners of the determination itself for the basis of liability to which the insured becomes subject"*.

Omega accepted that the liability arose under the contract, but contended that the question of whether there was cover depended on whether such liability would have attached in the absence of the contract.

Omega submitted that it could not be right that the question of whether the insured was entitled to cover under the policy should be determined by the choice of grounds (whether contractual or tortious) upon which a third party elected to rely when bringing a claim against the insured.

Omega argued that Aspen's proposition that it was not possible to look beyond the terms of the underlying judgment would mean re-writing the exclusion clause so as to read *"unless the judge in the trial which established liability had expressed the view that liability would arise in the absence*



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of contract", or something to that effect. As the question posed by the exclusion clause was hypothetical, on which the judge in the underlying case could not have reached a binding decision, Omega submitted that the parties could not have intended that his failure to make such a decision should conclusively determine whether or not Omega could recover.

The Court's Decision

Mr Justice Clarke ruled in favour of Omega, agreeing that the correct question for the court to ask was what liability would have attached, on the same facts, in the absence of a contract. Omega was not prevented from making recovery because of the terms of the underlying judgment.

As a first instance decision, Tomlinson J's judgment was not binding on Clarke J and he concluded that even if it was, it was distinguishable because Tomlinson J referred only to what would 'normally' be the position and each case depended on its own facts. In any event, the judge disagreed with Tomlinson J's conclusion and reasoning.

Clarke J instead agreed with and drew support from the judgments in the cases of *West Wake Price v Ching* [1957] 1 WLR 45 and *MDIS v Swinbank* [1999] 2 All ER (Comm) 722 CA. On the basis of these judgments, the judge set out a series of propositions as to the position in liability insurance generally.

Significantly, while agreeing that a judgment, award or agreement may settle the question as to whether a loss is covered by one of the perils insured against, Clarke J stated that it would not be determinative of that question. Unless the insurer was a party to the proceedings, or had agreed to be bound by the outcome, it was open to it to dispute that the insured was liable, or to challenge the basis of that liability. Similarly, the insured could argue that it was in fact liable or contend that it was liable on other grounds. The earlier judgment was conclusive that NCM had to pay Omega the judgment sum, but it was not evidence that NCM had no tortious liability.

Turning to the question of whether liability would have attached in the absence of the contract, Clarke J concluded that it would. He held that NCM would have been liable in negligence for supplying the wrong meat materials to Omega without warning that they were fit only for disposal. This was an action which would foreseeably cause and did cause actual physical damage to Omega's property (the uncontaminated material with which the supplied meat materials were mixed).

The judge held that Omega was entitled to be indemnified by Aspen for all sums which NCM would have been liable towards Omega had there been no contract between NCM and Omega. Omega was not entitled to recover that which it could recover from NCM only in contract, as this would be covered by the exclusion clause.

The Burden of Proof

Clarke J considered obiter the question of the incidence of the burden of proof, concluding that in order for Aspen, as insurer, to bring itself within the exclusion, it needed to demonstrate that the liability arose under a contract and that the exception did not apply. In the present case, the judge said this would have involved showing that: *"in the absence of a contract, there would have been no liability in negligence."* Aspen was unable to discharge this burden of proof on the facts.

Impact of the Case

The meaning of contractual liability exclusions in relation to liability insurance has been clarified by Clarke J's decision. Such an exclusion will not apply in circumstances where the insured would also have had a liability in tort.

The decision makes it clear that both insureds and insurers may look beyond the terms of an underlying judgment, award or agreement in determining whether the insured's liability falls within the scope of the policy cover. This decision may be of assistance to insureds where a judgment, settlement or award fails to evidence an insured liability. Conversely, it may also be of assistance to insurers who wish to challenge the basis or amount of any liability determined in such a way.

Guest Article

Class Actions Come to Poland: A New Risk for the Insurance Industry

By Ludomir Biedecki and
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In July 2010, the Act on Pursuing Claims in Group Proceedings dated December 17, 2009 (Journal of Laws from 2010, No. 7, item 44) (the Act), went into force, introducing class actions into the Polish legal system. Although it is perceived as a step towards improving the efficiency of court proceedings and facilitating access to courts for people who cannot afford to start a lawsuit by themselves, the effects of the Act (in particular whether it will be the trigger of a revolution in the Polish judicial system and cause a flood of class action suits) remain to be seen. However, what is certain today is that new risks are faced by sectors susceptible to damages caused by hazardous products (eg the tobacco and pharmaceutical industries) or where relations with consumers are standardized on a mass scale (eg banks, developers, tourism). In both cases, insurers and reinsurers could be at risk either indirectly or directly.

"Unlike under American regulations Polish class actions are based on an "opt-in" model of participation..."

With respect to liability regarding mass consumer services, the Polish judiciary has already developed quite extensive experience, and it does not seem that the Act's effect in this area will be great. However, unprecedented exposure for insurers and reinsurers may be connected with liability related to hazardous substances (which under Polish law are movables, animals and electric energy). Polish regulations are more restrictive for producers and importers than provided by EU regulations. The claimant does not have to prove either the dangerous feature of a specific product or the causal link between such property and the damage. The burden of proof is limited to the fact of incurring damage.

It is therefore worthwhile to examine the general features of class actions, as adopted in Polish law.

Pursuant to the Act, only a group of at least 10 people (there is no maximum limit of claimants) has the right to pursue claims under the regime of class actions. Unlike under American regulations Polish class actions are based on an "opt-in" model of participation, which requires (i) the claimants to be defined (not anonymous) and (ii) the claimants' unambiguous declaration of willingness to participate in the class action (made in front of the court). Once a suit is filed, it is announced in the press to enable all those interested to join the class. It should be noted that a class action does not exclude individual claims brought under the general regime of liability in force in Poland.

It is important to point out that class actions are not possible in all legal cases. The catalogue of claims covered by the Act is strictly limited to those that can be brought in connection with consumer protection and responsibility for damage caused by dangerous products and tortious acts (but excluding protection of personal rights). Additionally, the claims brought by the class must be of the same type, and the circumstances on which they are based have to be the same. Although employment-related issues were included in first drafts of the Act, the Polish legislature has ultimately excluded them.

As a measure of protection against the risk of "blackmailing" potential defendants by using the threat of instigating a class action, the Act provides for a guaranty deposit to secure the costs of the proceeding. At the request of the defendant, the court may oblige the claimants to deposit a sum equivalent to the estimated amount of costs to be incurred by the defendant, although it cannot be higher than 20% of the value of the damages claimed. However, in the course of the litigation the defendant may request an increase of the deposit. If the claimant does not satisfy the obligation of securing costs, the statement of claim will be dismissed.

Class actions are conducted by a representative appointed by the claimants. The representative may be a member of the claiming group or a municipal consumer ombudsman. It is important to note from the procedural point of view that the representative has to be represented by an attorney at law. The representative's obligations include: (i) agreeing on the rules for participation in the group and the remuneration of the attorney; and (ii) handling

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the proceedings under his/her own name but on behalf of all group members. Thus, members of the group are not party to the class action and do not take an active part in the proceedings.

One of the most important features of class actions in Poland is that all the group's members agree on the unified amount per person being claimed. Such an agreement may also diversify the amounts being claimed, provided that they are settled within subgroups of at least two persons.

The court fee in cases of property rights asserted in a group proceeding amounts to 2% of the value of the subject of litigation, but cannot be less than PLN 30 or more than PLN 100,000. (PLN 100,000 currently equals approximately USD 34,500 or GBP 22,000.) All members of the group initiating a class action contribute to this fee, which makes this kind of proceeding much cheaper than individual cases, where fees amount to 5% of the value of damages claimed and have to be borne by the claimant individually. However, contrary to individual claims, the Act does not provide for the possibility of being exempted from court charges (which is quite frequently applied in cases initiated by persons with low income).

Given the relatively short period of time since the Act became effective, it is difficult to estimate its effects. However the following difficulties regarding its application may be pointed out: (i) no mechanism has been developed so far relating to the gathering of future claimants having similar claims against an entity; (ii) the judiciary lacks experience in handling class actions, which may cause inefficiency in court proceedings; and (iii) unavoidable costs of court fees and attorneys' remuneration may discourage certain groups of potential claimants from joining a class action.

In practice, the first class actions have been filed by recent flood victims in Poland and by victims of medical malpractice. The damages claimed are respectively PLN 9.3 million (approximately USD 3.2 million/GBP 2 million). and PLN 75 million (approxi-mately USD 26.1 million/GBP 16.5 million). Other class actions are being considered, although the obligation of the guaranty to secure costs seems to be an obstacle.

It is too soon to gauge the magnitude of exposure from class actions brought under the Act on insurers and reinsurers of Polish risks, but whatever the risk, it is one that has never before existed.

Update:

The Cigarette Rule: Still Smokin'

By Julia Karen Ulrich
New York

In a June 2010 *Insurance & Reinsurance Review* article entitled "The Cigarette Rule – Up in Smoke?", we reported on a then-recent jury verdict in *Artie's Auto Body v. The Hartford Fire Insurance Company*,[1] in which a Connecticut jury awarded nearly $15 million to a class of automotive body shop plaintiffs based on the jury's finding that the insurance company defendant violated the Connecticut Unfair Trade Practices Act (CUTPA).[2]

The authors also opined that the *Artie's* lawsuit could potentially result in a seismic shift in the law, ultimately restricting potential plaintiffs' ability to bring similar actions in the future, if this became the case that finally forced the issue of whether the so-called "cigarette rule" -- used to determine whether an act or practice is "unfair" within the meaning of CUTPA -- has been superseded by a newer, narrower federal standard. Although the Superior Court presiding over the *Artie's* matter denied, on October 14, 2010, the defendant's post-trial motions on this issue, our prediction may still be correct -- the Superior Court served up the issue nicely for appeal, noting the Supreme Court's prior position that it will take up the issue in a proper case when "presented to us,"[3] and further opining that "[i]t may be that this case will prove to be the appropriate case to frame the issue for review, but that review must occur at the Supreme Court."

As a brief refresher, the insurance company defendant in *Artie's* challenged the Superior Court's charging of the jury on all three prongs of the now FTC-abandoned cigarette rule, which provided that a plaintiff alleging unfairness within the meaning of CUTPA must prove that: (1) the act or practice offends public policy as it has been established by statutes, the common law or other established concept of unfairness; (2) the act or practice is immoral, unethical, oppressive or unscrupulous; or (3) the act or practice causes substantial injury to consumers, competitors or other business persons. In 1984, the FTC narrowed the rule to concentrate on the third "substantial injury" prong, although Connecticut has not yet abandoned the three-prong rule.

We will continue to monitor this case and report on pertinent developments, particularly at the appellate level.

Footnotes

1. *Artie's Auto Body et al. v. Hartford Fire Ins. Co.*, FST-CV03-0196141-S, 2009 WL 3737931 (Conn. Super., Sept. 22, 2009).
2. Conn. Gen. Stat. §42-110a et seq.
3. *Votto v. American Car Rental, Inc.*, 273 Conn. 478, 484, n. 3 (2005).

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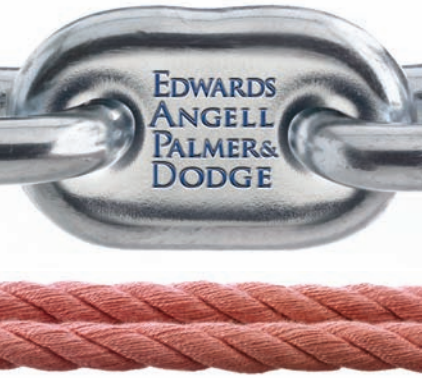
By Richard Hopley
London

Court of Appeal Overturns EL Insurance "Trigger" Decision

The Court of Appeal has handed down its long-awaited decision in the appeal of the Employers' Liability Insurance "Trigger" Litigation. In a long and complex judgment, the Court of Appeal has overturned the main finding of the first instance decision (the judgment of Mr Justice Burton in November 2008). At the heart of the Court of Appeal's ruling is the view that employers' liability (EL) policies are relatively straightforward contracts sold in a number of standard forms. The vast majority of claims to which the policies have for decades responded (over 99%) arise out of accidents causing immediate injury. The latency of industrial diseases is not a reason to depart from the ordinary meaning of the words used by the contracting parties.



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Background

The Court of Appeal was considering, by reference to six lead cases, how EL policies should respond to the claims of UK mesothelioma victims. The cost to insurers of the UK's mesothelioma liability problem has been estimated to be at least £10 billion. As much as 90% of the cost is in the future. Mesothelioma is an invariably fatal cancer. For all practical purposes, its only known cause is exposure to asbestos. Although caused during exposure, the onset of mesothelioma (a point called the date of the tumour by the Court) is not until decades later. It is this latency that gives rise to the dispute. The most recent period of severe occupational exposure in the UK was during the 1960s. The latency of the disease means that we are still several years from the peak fatality rate of around 2,000 deaths per year.

The Issue

The Court was construing EL policies to determine what "triggers" an EL insurer's liability to indemnify an insured employer; or, as one appeal judge preferred to characterise it, what is the "temporal hook" that attaches the ultimate liability to the policy year in question.

The Various Forms of EL Wording

It is accepted that mesothelioma is caused by the inhalation of asbestos fibres during exposure. EL wordings that are expressed to indemnify for injury or disease "caused" during the period of cover (causation wording) have presented no difficulty and it has not been disputed that such policies respond (are "triggered") on an exposure (also called date of inhalation) basis. In other words,

Industry Presence

EVENTS

- The Firm is a co-sponsor of International Law Weekend, in New York on October 21-23. **Vincent Vitkowsky** (New York), co-chaired the event featuring more than 30 panels on public and private international law.
- We hosted a webinar examining the recent Attorneys General investigations into lenders' foreclosure practices, specifically related to the use of "robo-signers." **Kathleen Furey** (New York), **Steve Huggard** (Boston), **Matthew Martel** (Boston) and **Mark Peters** (New York) were the featured speakers.
- IRD partners **Laurie Kamaiko** (New York), **Elaine James** (West Palm Beach) and **Mary-Pat Cormier** (Boston) performed a mock trial at the Annual Litigation Management Conference at XL in Bermuda.

The firm participated in and/or underwrote portions of the following conferences during the Autumn:

- American Bankers Insurance Assn. (ABIA) Annual Conference
- IACP Annual Conference
- Association of Insurance Compliance Professionals Annual Conference (AICP)
- International Bar Association Conference
- New England Council
- American Council of Life Insurers (ACLI) Annual Conference
- AIRROC /Cavell Networking Event
- NAIC
- ARIAS
- ACI's 16th Annual D&O Liability Conference
- National Association of Professional Surplus Lines Offices (NAPSLO).

For further details on any of the above contact Jennifer Topper at JTopper@eapdlaw.com

where EL policies contain causation wording, it is the policy (or, more likely, policies) in force during the period of occupational exposure that should respond to the claim.

As well as causation wording, two other forms of wording have appeared in EL policies issued over the last few decades. The EL trigger litigation focuses on these other forms. A significant proportion of policies were expressed to indemnify in respect of injury or disease "sustained" during the period of cover, while others were expressed to indemnify where disease was "contracted" during the period. In some policies, both expressions appeared. For decades, EL insurers responded to mesothelioma claims consistently on an exposure basis, no matter which of the forms of wording was in the policy. This changed with the Court of Appeal's decision in Bolton *MBC v Municipal Mutual Insurance* [2006] 1 WLR 1492. In that case, which concerned public liability (PL) insurance, the Court ruled that injury (for the purposes of construing the PL policy) does not "occur" during exposure; it first occurs *at the earliest* when a victim's tumour develops; and that this point is about 10 years before the onset of symptoms, usually decades after the exposure. A number of insurers decided that "sustained" or "contracted" wording in EL policies should be construed in the same way and the EL trigger lead cases were selected to resolve this market issue. The judge at first instance ruled that EL policies containing "sustained" or "contracted" wording should be interpreted to mean the same as those containing causation wording.

Court of Appeal's Decision

The Court of Appeal overturned Burton J's judgment in relation to the construction of "sustained", but upheld the construction of "contracted" (but by different reasoning).

There was almost no unanimity among the three Court of Appeal judges. The main questions were decided by a majority (Lord Justices Rix and Burnton), but largely on different grounds and for different reasons. The leading judgment was given by Lord Justice Rix, but he was in a minority on several of the issues. The three judges each had a different view on the commercial purpose of EL insurance. In approaching the questions of construction, the majority emphasised that EL policies were insurance contracts issued on a variety of standard forms entered into year after year. Rix LJ said the Court was concerned with "*... the most basic question of the period for which cover is granted and the loss which must occur during that period for the cover to be effective and...different triggers or temporal hooks are well recognised, that is to say, causation wording, sustained wording, and occurring wording...*". There were no grounds to believe that something has "gone wrong" with the wording and therefore no justification for manipulating the terms. The words should be given their ordinary meaning. The Court made clear that the evidence that insurers had for decades paid claims exclusively on an exposure basis, without regard to the differences in wording, was irrelevant to the interpretation of the policies. The "factual matrix" of knowledge within which the parties entered into these contracts, notably the lack of understanding of the aetiology of mesothelioma (and, indeed, of other industrial diseases with periods of latency) until the latter part of the twentieth century (long after the policies in issue had been entered into) was also irrelevant.

"There was almost no unanimity among the three Court of Appeal judges. The main questions were decided by a majority (Lord Justices Rix and Burnton), but largely on different grounds and for different reasons."

The Court of Appeal ruled that mesothelioma is not "sustained" during exposure; it is "sustained" when the injury occurs (otherwise described as "suffered", "incurred" or "inflicted") decades after exposure. The decision of the Court of Appeal in *Bolton* was binding in relation to this issue. In *Bolton*, the Court of Appeal had ruled that injury occurred *at the earliest* 10 years before symptoms. In the first instance decision of the EL trigger litigation, Burton J had concluded (although it is technically not part of his ruling) that, in light of the more advanced medical evidence he had heard, mesothelioma starts to occur five years before the point of "diagnosability" (the disease being diagnosable when symptoms manifest themselves). The Court of Appeal acknowledged the different views (the "10-year rule" and the "five year rule"), but was not asked to choose between them. The effect of this judgment is that an EL policy containing "sustained" wording, in force during the period of exposure, does not provide cover for any resulting mesothelioma claim.

The Court of Appeal found that "contracted" (usually appearing in the expression "disease contracted") could bear a variety of ordinary meanings; it is capable of referring to disease either in its origin or its onset or even its progress. As a matter of construction, therefore, it could refer to the time of exposure or the disease's "causal origins". On this basis, a policy expressed to indemnify in respect "disease contracted" (including where this appears alongside "injury sustained" wording) during the period of insurance will respond on the same basis as causation wording.

The three judges each came to different conclusions as to the effect of the Employers' Liability (Compulsory Insurance) Act 1969. It is arguable (but with considerable doubt) that the view of the majority was that "sustained" wording in EL policies issued after 1972 (when EL insurance became compulsory pursuant to this Act) should be construed as responding on a caused basis. This issue probably requires clarification by a further ruling; in any event, it would be relevant only in relatively unusual circumstances.

The Consequences

As a result of the Court of Appeal's ruling, the precise terms of the EL cover in force when the tumour develops as well as that in force during the period of exposure will have to be identified to establish which (if any) policy or policies should respond. A victim will be able to obtain compensation from the culpable employer where that employer remains in existence and solvent. Where that is not the case, the victim is reliant upon finding an EL policy that will indemnify his employer's liability. Whether that policy is liable to respond will have to be determined by applying the various principles (many of which are contradictory or unclear) set out by the Court of Appeal.

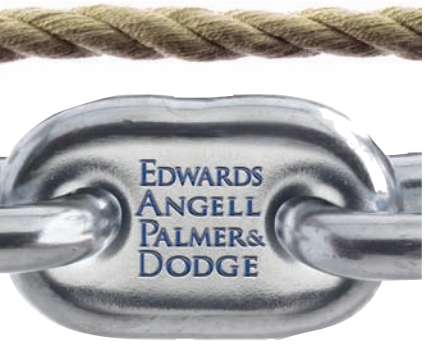
As for the past, EL insurers who underwrote policies on a sustained basis have for decades indemnified mesothelioma claims on an exposure basis when they were under no liability; their policy was not triggered. Given the sums involved, that is an issue that may well be investigated among insurers and their reinsurers.

The parties have been given permission to appeal to the Supreme Court on all the main issues and therefore a final determination of these issues is still some way off.

By Eric B. Hermanson
Boston

The Medicare Secondary Payor Act and Insurance Bad Faith Liability

Over the past few years, liability insurers settling claims on behalf of policyholders have increasingly found themselves grappling with Medicare Secondary Payor obligations. These Medicare requirements are technical and complex, and noncompliance may carry significant penalties: an insurer that settles directly with a tort claimant, without taking account of Medicare's right to recover conditional payments under the Secondary Payor Act, may be liable to Medicare for up to twice the lien amount, plus interest and attorneys' fees.



"...an insurer, attempting to protect itself from Medicare Secondary Payor liabilities, may provide plaintiffs with the basis to allege bad faith claim handling under state law."

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A recent decision of the U.S. District Court for the Middle District of Florida highlights another potential problem: that an insurer, attempting to protect itself from Medicare Secondary Payor liabilities, may provide plaintiffs with the basis to allege bad faith claim handling under state law. Although this issue is just beginning to emerge, it has the potential to become a real concern for insurers, particularly in jurisdictions like Florida, where plaintiffs' lawyers are adept in the art of the "bad faith setup."

Background

The Medicare Secondary Payor Act

Medicare is a federal program that provides medical benefits for approximately 47 million people in the United States. Initially established in 1965 to provide medical care for individuals age 65 and over, it has since expanded to encompass various other diseases, and now covers approximately 8 million individuals under the age of 65.

In the mid-1970s, concerns began to emerge about the Medicare program's long-term fiscal stability. In 1980, as a response to those concerns, Congress enacted the Medicare Secondary Payor (MSP) Act (42 USC 1395y(b)(2)). The purpose of the Act was to ensure that the federal Medicare Program was a "secondary payor," which was not called upon to make payments for individuals' medical expenses when a "primary plan" – defined as a liability insurance policy, workers compensation policy, auto insurance policy, or group health plan – was available to cover the same expenses. 42 U.S.C. § 1395y(b)(2)(A)(ii).

Medicare Modernization Act of 2003

For some years after enactment of the Medicare Secondary Payor Act, enforcement of these provisions was lax. The Centers for Medicare and Medicaid Services (CMS), which administer the Medicare Program, did not consistently seek recovery of Medicare expenditures after settlements of bodily injury claims. And when CMS did try to recoup Medicare expenditures from settling parties, courts often rejected those efforts on various grounds.

For example, in *Thompson v. Goetzmann,* 315 F. 3d 457 (5th Cir. 2002), *amended and modified en banc*, 337 F.3d 459 (2003), the plaintiff, a Medicare beneficiary, was injured by an allegedly defective prosthesis. After a lawsuit, she settled with the manufacturer for $256,000. Medicare learned of the settlement and filed suit to recover a portion of the settlement amount. The Fifth Circuit denied Medicare's right of recovery on grounds that: [1] the Medicare Secondary Payor Act, as then drafted, only permitted recovery from primary payors who paid "promptly at the time medical services were provided" -- not from third parties who settled after medical services were complete; and [2] a self-insured defendant was not a "primary plan" within the meaning of the Act. The court also noted in passing that the Medicare Secondary Payor Act had no provision requiring payback by the claimant or the claimant's attorney.

In 2003, in response to *Goetzman* and similar cases, Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, H.R. 1, Title III, § 301(b)(2)A. The Act expanded the definition of "primary plan" to include self-insured entities (as well as insurers and group health plans), and it changed the way Medicare reimbursement rights were treated in litigation settlements. Among other things, the Act gave Medicare what some have described as a "super-lien," with priority rights over other parties in tort settlements.

After the 2003 amendments, the Secondary Payor Act read as follows:

> [a] primary plan, and an entity that receives payment from a primary plan, *shall reimburse* [Medicare] for any payment made by [Medicare]

...with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service (emphasis added)...

A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise waiver or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan's insured, or by other means...

In order to recover payment made under this subchapter for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan's payment to any entity.

Medicare's Rights As Secondary Payor

After the 2003 Act, it was clear that all payments made by the Government under the Medicare program were "conditional," and were subject to recoupment out of a tort settlement if a self-insured defendant, or a defendant's insurer, later agreed to pay for the recipient's medical care. In such cases, the Government was given a "direct right of recovery for the entire amount conditionally paid," plus interest. *Cox v. Shalala*, 112 F.3d 151, 154 (4th Cir. 1997).

Moreover, it became clear that the Government could pursue recovery from a primary payor even if the primary payor had already paid the settlement amount to the plaintiff as part of the settlement. As HHS stated, in its implementing regulations:

> In the case of liability insurance settlements and disputed claims under employer group health plans, workers compensation insurance or plan, and no-fault insurance, the following rule applies: If Medicare is not reimbursed as required by paragraph (h) of this section, *the primary payor must reimburse Medicare even though it has already reimbursed the beneficiary or other party.*

In effect, then, an insurer that settles a contested tort action without taking appropriate steps to protect Medicare's interests risks having to pay twice for the plaintiff's medical care – once to the plaintiff and a second time to the Government. To the extent the Government is required to initiate litigation to recover these amounts, the insurer risks having to pay double the amount, plus interest, under 42 U.S.C. § 1395y(b)(2)(B)(iii). The insurer cannot escape its reimbursement obligation simply by paying the plaintiff, on behalf of its insured, and assuming that the plaintiff (or his counsel) will repay the Government from those proceeds.

"In most cases, insurers rely on plaintiffs' counsel to resolve these issues with Medicare. Generally, in the settlement documents, an insurer will make the plaintiff's satisfaction of the lien a condition precedent to any settlement payment."

Risks to Settling Insurers

The risks are real to settling insurers who fail to comply with these Medicare provisions. Over the last several years, the Government has displayed an increasing willingness to prosecute claims and seek penalties from settling parties.

For example, in the recent (and highly publicized) case of *U.S. v. Stricker,* No. 09-KOB-2423-E (N.D. Ala.), the defendants included a group of insurance companies – Travelers, AIG, National Union, Lexington, American Home, the Insurance Company of the State of Pennsylvania; a group of self-insured defendants; and a group of plaintiffs' law firms that collectively negotiated a $300 million settlement of a class action liability lawsuit (the "Abernathy Settlement"). The settlement was allegedly entered into without any party determining whether any of the class members were Medicare beneficiaries, or notifying the Government under 42 CFR §411.25, or taking steps to reimburse Medicare conditional payments.

Some years later, the Government sued for repayment from the settling insurers and other parties. It alleged that the Abernathy Settlement included 907 Medicare beneficiaries, who received conditional Medicare payments totaling $67.1 million. It demanded that the settling parties reimburse the $67.1 million directly, plus double damages and interest: a total of roughly $150 million.

The District Court ultimately dismissed the Government's case in *Stricker* on statute of limitations grounds. But the message was clear. *Stricker* was clearly intended as a warning to insurers (and others) to exercise caution when settling claims involving Medicare beneficiaries. Given the penalties associated with the statute, it is not the kind of warning an insurer can easily ignore.

Measures to Avoid Medicare Statutory Liability

Unfortunately, in practice, the protection of Medicare's statutory interests is easier said than done. The calculation of what the Government has spent on a particular plaintiff's care, and which aspects of that care were related to a particular incident, may be difficult. The process is even more complicated in cases where a plaintiff has ongoing medical expenses – meaning that Medicare may face expenses in the future arising out of the plaintiff's injury. In some cases, the process of resolving a Medicare lien can take six months or longer.

In most cases, insurers rely on plaintiffs' counsel to resolve these issues with Medicare. Generally, in the settlement documents, an insurer will make the plaintiff's satisfaction of the lien a condition precedent to any settlement payment. While the plaintiff's counsel is negotiating the lien, the insurer will either withhold payment, or will issue a check with Medicare as a payee, so that the plaintiff cannot cash the check and access the funds without Medicare's express approval.

Some insurers -- though not all -- will agree to make a partial payment to the plaintiff while the lien remains outstanding, so long as the plaintiff's law firm agrees to indemnify the insurer for any Medicare liability that could arise if liens are not satisfactorily resolved. On the other hand, this practice bears some risks, and some state court ethics rulings have suggested that it is problematic. *See, e.g.,* Tennessee Formal Op. 2010-F-154 (2010); *see also* Wisconsin Formal Opinion E-87-11 (barring defense lawyers from proposing, demanding, or entering into an indemnification agreement for medical liens).

Continued on page 14

The Bad Faith Setup

Finally, what if a plaintiff's law firm is unwilling to await the outcome of this complex process and demands payment from an insurer up front without satisfactorily addressing Medicare's conditional payments? This was the situation in a recent decision from the Middle District of Florida, *Tomlinson v. Landers*, No. 07-CV-1180-J-TEM (April 27, 2009). The holding of that case is somewhat troubling from an insurer's perspective.

Tomlinson, a Medicare recipient, was seriously injured in a head-on auto accident with another individual (Landers). On June 20, 2007, his counsel wrote to Landers' insurance carrier, Millers Classified Insurance Co. ("MCIC"), demanding that the insurer tender policy limits of $100,000 to settle Tomlinson's bodily injury claim. Discussions between Tomlinson and MCIC did not succeed in resolving the claim.

On November 14, 2007, Tomlinson's counsel again wrote MCIC, stating that Tomlinson "will consider MCIC to be in bad faith unless your limits of $100,000 are paid within ten (10) days of the date of this letter." On November 20, 2007, MCIC accepted the plaintiffs' demand and tendered a check in the amount of $100,000, made payable to Tomlinson, his attorney, *and to Medicare*, which had a lien against the settlement proceeds.

On November 29, 2007, Tomlinson's counsel returned the check to MCIC, with the demand that MCIC tender a check that did not include Medicare as a payee. Tomlinson's counsel indicated that he intended to "resolve the lien directly with Medicare, and hold [MCIC] harmless." It insisted that the insurer accept this offer as part of the settlement, under Florida's "mirror image rule." *See Montgomery v. English*, 902 So. 2d 836, 837 (Fla. 5th DCA 2005) (no contract is formed unless the acceptance of an offer is "absolute, unconditional and identical with the terms of the offer").

On December 7, 2007, MCIC advised Tomlinson's counsel that the Medicare Secondary Payor Act required the insurer to take responsibility for satisfying Medicare's lien in order to avoid a potential liability for twice the lien amount and attorneys' fees. "We simply cannot rely on a promise from the claimant to satisfy the lien because the statute and regulations provide that a settling party like [MCIC] would remain liable even after paying the money to your client … A Secondary Payor can be subject to liability for double the amount of the lien plus attorneys' fees."

MCIC then offered two alternative ways of proceeding, to accommodate Medicare's interests. The first method (which MCIC had previously offered) was to issue a check made payable jointly to Tomlinson, his law firm and Medicare. The second method was to wait until plaintiffs' counsel had secured written documentation from Medicare, stating the amount of the conditional payments for which Medicare was seeking reimbursement. MCIC would then issue separate checks to Medicare for the amount of their lien, and to Tomlinson for the remainder.

Tomlinson declined both of these options, and proceeded with a suit against MCIC's insured. One year later, on January 29, 2009, MCIC moved to enforce the settlement, arguing that there had been a valid offer and acceptance, because all essential terms of the settlement demand were accepted when MCIC agreed to pay its policy limits.

"…the insurer might have valid preemption defenses to any state law claim of liability for bad faith claim handling based on the insurer's attempt to protect Medicare's statutory rights. … these defenses have not yet been tested in the federal appellate courts."

The court denied MCIC's motion. It held that no settlement had been consummated between the parties because no meeting of the minds had occurred on the steps that must be taken to resolve the Medicare lien at issue. Specifically, the court noted plaintiffs' "objection to MCIC's insistence on the inclusion of Medicare as a payee on the settlement check," and plaintiffs' desire "to resolve any Medicare liens on their own accord," subject to an agreement to hold MCIC harmless.

Based on this offer, which MCIC had rejected, the court found that "the parties were engaged in ongoing negotiations regarding the inclusion, or lack thereof, of Medicare as a payee on the settlement check, and that no meeting of the minds ever occurred regarding this point of contention between the parties."

The *Tomlinson* Dilema

The insurer in *Tomlinson* faced a dilemma. On the one hand, the insurer could have simply complied with Tomlinson's counsel's time-limited demand for immediate payment of policy limits. This would have cut off the possibility of a claim for bad faith by Tomlinson under Florida law. But in so doing, the insurer would have left itself liable to Medicare for failing to protect Medicare's secondary-payor lien. If Medicare had then moved to seek reimbursement from the insurer directly – as in *Stricker* – the insurer might have found itself liable to pay its policy limits twice: once to Tomlinson in settlement, and once to Medicare, as reimbursement for Medicare conditional payments made on Tomlinson's behalf. (In fact, if Medicare found it necessary to initiate litigation to recover the conditional medical payments, the insurer might have become liable to pay its policy limits three times: once to Tomlinson in settlement, and twice more to the Government under 42 U.S.C. § 1395y(b)(2)(B)).

On the other hand, the insurer could have refused to comply with Tomlinson's time-limited demand – as in fact it did – unless Tomlinson also included provisions that adequately protected the insurer from Medicare liability. This option would have cut off the possibility of double-payment and penalties under the Medicare Secondary Payor Act. However, under Florida's version of the "mirror-image rule," the refusal would have left the insurer exposed – as in fact it did – to a potential claim of bad faith under Florida law.

Finally, of course, the insurer might have valid preemption defenses to any state law claim of liability for bad faith claim handling based on the insurer's attempt to protect Medicare's statutory rights. However, these defenses have not yet been tested in the federal appellate courts.

Conclusion

The question of how to approach the *Tomlinson* dilemma will implicate difficult and subtle considerations, which may vary depending on the facts of the case, the jurisdiction, and the still-emerging law in this area. For the moment, the most that can comfortably be said is that insurers must remain sensitive to the potentially conflicting obligations imposed by the Medicare Secondary Payor Act and state common law.

Reinsurance in the Lloyd's Market: Governing Law and Jurisdiction

By Antony Woodhouse and Martin Henshall
London

In *Stonebridge Underwriting Ltd v Ontario Municipal Insurance Exchange* [2010] EWHC 2279 the Commercial Court ruled that the parties to a reinsurance contract placed at Lloyd's using a typical London market slip policy form had impliedly chosen English law as the governing law of the contract. As a result, England would be the proper place to hear a dispute under the contract as there was a distinct advantage in having issues of its construction decided by the Commercial Court.

Background

Ontario Municipal Insurance Exchange (OMEX) was a not-for-profit reciprocal insurance exchange owned and governed by Ontario municipalities.

Two of the insurance programs run by OMEX were reinsured under an excess of loss policy placed on the London market by a London broker, JLT Risk Solutions, with a Lloyd's underwriter, Stonebridge Underwriting Limited, on behalf of the members of Lloyd's Syndicate 990. The syndicate was managed by XL London Market Ltd (XL).

The Issues

The dispute arose when XL refused to pay claims made by OMEX under the policy. The parties disagreed on two issues:

- The proper construction of the policy's excess provisions. The parties contested whether the policy's annual aggregate deductible (AAD) must have been exhausted before any claim could be made.
- Whether OMEX had complied with a claims co-operation clause, which was worded as a condition precedent, requiring it to notify XL within 30 days of becoming aware of any loss which could give rise to a claim. XL contended that OMEX had breached the clause as it was significantly late in notifying XL in respect of several very large claims and had not provided notice of exhaustion of the AAD.

The policy was silent on the matters of governing law and the jurisdiction in which any disputes were to be resolved. As a result, OMEX issued proceedings before the Ontario Superior Court of Justice on 18 January 2010 for payment of the claims. In response, XL issued proceedings in London on 17 February 2010 for a declaration that it was not liable to pay the sums claimed.

The Application

Pursuant to CPR r.6.37(3), a court will not grant permission to serve a claim form out of jurisdiction unless the claimant can show that England is the *forum conveniens* (the proper place in which to bring the claim). OMEX made an application on 6 May 2010 for an order that service of XL's claim form in Ontario be set aside on the ground that England was not the proper place for the dispute between the parties. The application was heard before Mr Justice Clarke.

In his judgment Clarke J set out the factors that a court would take into account when determining the question of *forum conveniens*. These were the applicable law, the nature of the dispute, the location of the parties and any considerations as to costs.

Applicable Law

The parties agreed, albeit on different grounds, that the governing law of the contract under the Rome Convention was English law.

XL argued that Article 3(1) of the Rome Convention applied as it could be *"demonstrated with reasonable certainty by the terms of the contract or the circumstances of the case"* that the parties had made an implied choice of English law. It emphasised that the policy incorporated a number of standard London market clauses and was placed in London by a London broker with a London underwriter.

OMEX argued that there was no implied choice of English law, but accepted that an English court would apply English law under Article 4(1) of the Rome Convention as the characteristic performer of the contract, the party providing an indemnity, was XL and XL was domiciled in England.

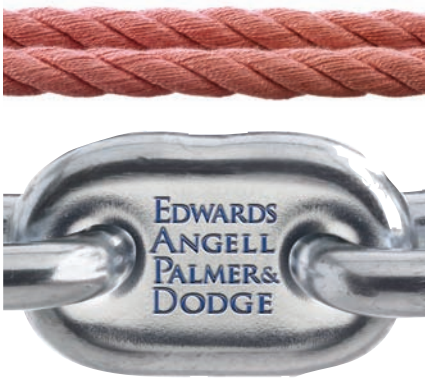
Clarke J agreed with XL's argument, ruling that there would be *"something surprising about a policy on a Lloyd's slip, broked through a Lloyd's broker with a Lloyd's underwriter on behalf of a Lloyd's syndicate, being governed by a law other than that of England."*

English Law, English Jurisdiction?

XL submitted that once the Commercial Court had accepted that the contract was governed by English law, it was of the utmost importance that the case was heard in England. There were two reasons for this.

First, there was a real risk that an Ontario court

"The policy was silent on the matters of governing law and the jurisdiction in which any disputes were to be resolved."



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would apply Ontario law. Section 123 of the Insurance (Ontario) Act 1990 stated that where the policy was *"to be delivered or handed over to the insured ... in Ontario [it] shall be deemed to evidence a contract made therein, and the contract shall be construed according to the law thereof."*

The court heard how the application of Ontario law would have a significant impact on the case. Section 129 of the 1990 Act allowed an Ontario court to block avoidance for non-compliance with a condition if it regarded it as being just to do so. Under English law XL would be able to avoid the contract, and therefore not be liable to pay the claim, if it could show that OMEX had breached the claims co-operation clause. Therefore, one consequence of applying Ontario law might have been to prevent XL from relying on a defence open to it under English law.

Clarke J agreed that this carried a significant risk to XL which was not alleviated by the fact that it would have the opportunity to persuade an Ontario court not to exercise its powers under section 129.

The second reason advanced by XL was that the expertise of the Commercial Court would be required to interpret the relevant policy provisions in their context and with an appreciation of the manner in which this kind of reinsurance operated.

Clarke J agreed that there was a *"distinct advantage"* in having the issue of construction of this policy determined by the English Commercial Court which is the court *"(a) whose law applies (b) which has power to determine what are the relevant principles ... (c) which regularly applies them and (d) which has a particular degree of experience and expertise in reinsurance matters, particularly those concerning Lloyd's."*

He added that any evidence was likely to be located in London where the underwriters and placing brokers were located and where any expert as to London, and, in particular, Lloyd's, market practice was likely to be found. Moreover, any Canadian witnesses would be able to give their evidence by video-link in accordance with standard Commercial Court practice.

Ontario Arguments

Clarke J went on to dismiss a number of submissions by OMEX that Ontario was the proper forum for the dispute:

- The existence of the Ontario proceedings was not a reason for the Commercial Court to decline jurisdiction. While the Ontario proceedings were indeed commenced first in time, the proceedings in England were at a more developed stage.
- The possibility of a third party claim by OMEX against its Canadian broker was not a ground for declining jurisdiction as OMEX would be able to join the broker to the English proceedings.
- There was nothing sufficiently special in the circumstance that the reassured was a Canadian mutual to mandate Canadian jurisdiction as a great deal of London reinsurance was of an international nature.

Commentary

The decision provides an insight into the approach that the Commercial Court will adopt when determining the governing law and jurisdiction of a reinsurance contract which is silent on these points.

It confirms that the parties to a reinsurance contract placed at Lloyd's are likely to be regarded as having made an implied choice of English law. This implied choice will then be significant in determining whether the Commercial Court in England is the proper place for any dispute to be heard. Clearly, the parties to a contract should not, however, rely on this approach being taken by the Courts. The preferable course is for the parties to make their choice of law and the relevant jurisdiction explicit in the contract.

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