News & Views

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LEGAL NEWS AND DEVELOPMENTS IN EXECUTIVE, EMPLOYMENT, FIDUCIARY, CRIME, AND CYBER LIABILITY

MANDATORY ARBITRATION PROVISIONS IN ERISA CLASS ACTIONS

Class action waiver and mandatory arbitration provisions have garnered substantial attention in the context of employment litigation, with the Supreme Court upholding their enforceability in a 5-4 decision last year in *Epic Systems Corp., Inc. v. Lewis*. The resulting controversy led state and federal legislatures to propose laws seeking to restrict their use.

The use of such provisions as a means of fighting against ERISA class actions has received less attention. The Supreme Court is currently hearing arguments in *Retirement Plans Committee of IBM et al. v. Jander et al.* that may, depending on the outcome, reopen the floodgates to more ERISA class actions. It begs the question: should companies include class action waiver and mandatory arbitration provisions in their plan documents?

We are pleased to offer the following expert viewpoint[1] from Mayer Brown's ERISA Litigation Practice Group:

MANDATORY ARBITRATION: THE NEXT FRONTIER FOR ERISA RETIREMENT PLANS?

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Richard E. Nowak, Partner

Background: On August 20, 2019, a Ninth Circuit panel in *Dorman v. Schwab*, No. 18-15281, reversed the district court's denial of Schwab's motion to compel arbitration and held that Schwab could force the plaintiff to individually arbitrate his fiduciary duty claims challenging the administration of Schwab's 401(k) plan. In 2017, plaintiff Michael Dorman filed a putative class action in federal court alleging that Schwab had breached its fiduciary duties under ERISA by adding allegedly poorly performing in-house investment funds to its 401(k) plan investment lineup. In 2015 – two years before the lawsuit was filed – Schwab had amended its 401(k) plan document to include an arbitration clause stating that "[a]ny claim, dispute, or breach arising out of or in any way related to the Plan" had to be resolved by individual, rather than class or collective, arbitration. Based on this 2015 plan amendment, Schwab filed a motion in the district court to compel individual arbitration. The district court denied the motion because it concluded that the plan's arbitration provision was unenforceable with respect to the plaintiff's fiduciary duty claims.

In a surprise ruling, the Ninth Circuit reversed and held that the plan's arbitration provision was enforceable and that Schwab could compel the individual arbitration of the plaintiff's fiduciary duty claims. In so holding, the Court overturned its decades-old precedent in *Amaro v. Continental Can Co.*, 724 F.3d

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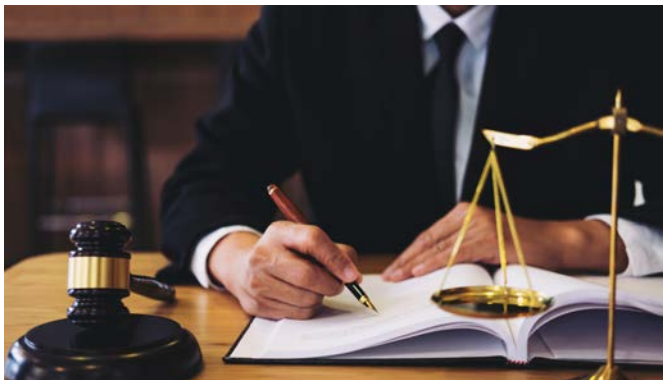
747 (9th Cir. 1984), that ERISA claims are not arbitrable in light of recent Supreme Court decisions affirming the arbitrability of federal statutory claims.[2] Turning to the Schwab plan's arbitration provision, the Court held that, even though the plaintiff's fiduciary duty claims belonged to the plan under ERISA § 502(a)(2), the claims were arbitrable because the plan had "expressly agreed in the Plan document that all ERISA claims should be arbitrated."

In addition to being groundbreaking, the *Schwab* decision is noteworthy because, just last year, the Ninth Circuit refused to compel arbitration in *Munro v. Univ. of Southern Calif.*, 896 F.3d 1092 (9th Cir. 2018). In *Munro*, the plaintiffs filed a similar suit against USC alleging that USC breached its fiduciary duties with respect to the administration of its retirement plan. Like *Schwab*, USC moved to compel arbitration but did so on the grounds that the plaintiffs had signed individual employment agreements containing arbitration agreements; the USC plan did not include an arbitration provision. This distinction proved dispositive because *Munro* and *Schwab* both reiterate the principle that fiduciary duty claims under ERISA § 502(a)(2)belong to the plan (as opposed to an individual participant) and cannot be signed away by a participant in an employment agreement or a release agreement.

Analysis: Although decisions affirming the enforcement of arbitration agreements are routinely lauded by employers, the *Schwa*b decision does not, standing alone, provide a panacea for plan fiduciaries seeking to reduce their liability with respect to fiduciary duty claims. As an initial matter, it remains to be seen whether the full Ninth Circuit will review the decision *en banc*, and whether courts in other jurisdictions will enforce arbitration provisions in plan documents with respect to fiduciary duty claims. In addition, plan sponsors should keep in mind that the arbitration of ERISA claims may have its own drawbacks. Among other considerations, arbitrators have a tendency to split the difference rather than ruling in favor of one party.

"... a plan fiduciary facing individual arbitration demands from multiple participants relating to the same fiduciary conduct may find itself on the receiving end of inconsistent and contradictory rulings."

In addition, unlike courts, arbitrators are neither bound by precedent nor are their decisions precedential. Consequently, a plan fiduciary facing individual arbitration demands from multiple participants relating to the same fiduciary conduct may find itself on the receiving end of inconsistent and contradictory rulings. Such rulings could cause problems with respect to the future administration of the plan, particularly given that arbitration decisions generally cannot be appealed.



For plan sponsors considering amending their plans to include arbitration provisions, they should be prepared for participants to challenge the enforceability of such provisions. Plan sponsors should also evaluate the advantages and disadvantages of including an arbitration provision with respect to each of their plans, including whether to include a class action waiver. While most plan sponsors would prefer to avoid the uncertainty and potential damages associated with an arbitration class action, a class waiver can potentially backfire if a large number of participants are motivated enough to file individual arbitration demands.[3] This is because the cost of litigating individual arbitration demands *en masse* could exceed the cost of litigating a class action in federal court without the potential benefit of a binding judgment or class-wide release in case of a settlement.

Notwithstanding Schwab's big win in the Ninth Circuit, we are still in the early rounds of the fight over the enforceability of arbitration provisions with respect to ERISA fiduciary duty claims. It remains to be seen whether other courts will enforce similar plan arbitration provisions and if there will be industry-wide movement to include such provisions in plan documents. Ultimately, the issue may wind its way to the Supreme Court. Until then, plan sponsors should carefully vet with their ERISA counsel the advantages and disadvantages of including a mandatory arbitration provision for fiduciary claims in their employee benefit plans.

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[2] The Court specifically referenced, among others, the Supreme Court's recent decisions in *Lamps Plus, Inc. v. Varela*, No. 17-988 (Apr. 24, 2019) and *Epic Systems Corp. v. Lewis*, 138 S. Ct. 1612 (2018).

[3] For example, after rideshare service Uber prevailed on a motion to compel individual arbitration in a wage-and-hour class action, more than 12,500 drivers served individual arbitration demands.

DELAWARE SUPREME COURT: WHAT IS A "SECURITIES CLAIM?"

Although defined in public company D&O policies, insureds and insurers sometimes disagree on the meaning of "Securities Claim." Thanks to the Delaware Supreme Court's October 31, 2019 reversal in *In Re Verizon Insurance Coverage*, we may now have greater clarity. Wording can differ among policies, however, and as is typically the case, the precise policy language mattered here.

WHAT YOU SHOULD KNOW

When a parent company spins off a subsidiary and the subsidiary later fails, litigation often ensues. The typical fact pattern is one where the parent is alleged to have saddled the spun off subsidiary ("SpinCo") with too much debt, leading to its inevitable failure. A bankruptcy trustee or creditor then brings claims for fraudulent transfers under the bankruptcy code as well as common law claims for breach of fiduciary duty or aiding and abetting breaches that allegedly caused or led to the bankruptcy. In the *Verizon* case described below, the litigation trustee representing creditors of the failed SpinCo sued Verizon to recover losses from the failed spin-off.

The coverage issue was whether or not the claims constituted "Securities Claims" so as to trigger coverage under the D&O policy. The lower court said they did. The Delaware Supreme Court said no and reversed. The policy defined "Securities Claim" as a Claim "alleging a violation of any federal, state, local or foreign regulation, rule or statute regulating securities (including, but not limited to, the purchase or sale or offer or solicitation of an offer to purchase or sell securities)."

Applying a plain meaning interpretation, the Delaware Supreme Court found that the common law claims asserted here were not regulations, rules or statutes regulating securities under the policy's definition. As an aside, courts have also grappled with whether a spin transaction in and of itself constitutes a purchase or sale of securities within the meaning of D&O policies. See *Federal Ins. Co. v. Campbell Soup Co.*, 885 A.2d 465 (N.J. App. 2005).

If your company is contemplating a spin transaction or is a bankruptcy risk, you should proactively seek broader coverage around these issues. While such enhancements may be difficult to achieve in the current marketplace, you will not obtain broader coverage if you fail to request it.

THE COURT'S RULING

The coverage dispute at issue in *Verizon* arose following the company's 2006 spin-off of its print and electronic directories business to Idearc (a company created by Verizon as part of the transaction) in exchange for 146 million shares of Idearc stock, $7.1 billion in Idearc debt, and $2.5 billion cash. After Verizon distributed the common stock to its shareholders and transferred the debt to its banks in exchange for Verizon debt owned by the banks, Idearc operated as a separate, publicly-traded company until 2009 when it filed for bankruptcy.

U.S. Bank N.A., appointed as trustee to pursue claims on behalf of creditors against Verizon, two related entities, and Idearc's director, filed suit in 2010 in Texas federal court seeking $14 billion in damages for alleged violations of fraudulent transfers under the U.S. Bankruptcy Code; payment of unlawful dividends in violation of the Delaware Code; and common law claims for breach of fiduciary duty, aiding and abetting a breach of fiduciary duty, promoter liability, unjust enrichment, and alter ego liability.

Verizon submitted notice of the litigation to its insurers under a six-year run-off D&O program purchased in connection with the Idearc spin-off. The primary insurer, AIG, acknowledged coverage for the director's defense costs, but denied coverage for Verizon's, finding the litigation did not constitute a "Securities Claim." The litigation was ultimately dismissed, but not before Verizon and Idearc's director incurred more than $48 million in defense costs.

Following the dismissal, Verizon filed suit against its insurers in the Superior Court of Delaware seeking coverage for its defense costs in the *U.S. Bank* action. Verizon and the insurers filed cross motions for summary judgment, each arguing that its interpretation of "Securities Claim" was supported by unambiguous terms in the policy.

In their motion, the insurers argued that the "regulations, rules or statutes regulating securities" in the policy definition refer to federal and state securities laws, not to common laws. In its motion, Verizon asserted that the word "rule" in the definition includes common law rules, looking first at the dictionary definition of "rule" (which includes judicial orders and rulings) and second at the word "any" used to modify "rule" to support its argument. The word "any," Verizon argued, includes common law rules and claims that do not "specifically" or "principally" regulate securities. Finding that each side presented reasonable interpretations of the definition of

"Securities Claim," the lower court resolved the conflicting interpretations in favor of the insureds, broadly interpreting "any…regulation, rule or statute regulating securities" to mean "pertaining to laws one must follow when engaging in securities transactions." Nothing in the policy's definition of "Securities Claim," the lower court found, expressly excluded common law claims or limited coverage only to claims alleging violations of federal or state securities laws. If insurers had intended to place such limitations in the policy, the lower court added, the policy should have included limiting language.

On appeal, the Delaware Supreme Court agreed with insurers' "plain meaning interpretation of a Securities Claim." Verizon's interpretation, the court noted, would render the definition's "regulating securities" condition meaningless. Finding that the "regulations, rules or statutes" referenced in the definition are those that specifically regulate securities, not common or statutory laws like those at issue in U.S. Bank, the Supreme Court reversed and directed the lower court to enter summary judgment in favor of insurers.

CALIFORNIA SUPREME COURT: NOTICE-PREJUDICE RULE OVERRIDES CHOICE-OF-LAW PROVISION

Courts have wrestled with the applicability and scope of late notice provisions for decades. In a significant ruling for policyholders, the California Supreme Court recently found its state's notice-prejudice rule is a fundamental public policy that takes precedence over choice-of-law provisions in first-party insurance policies. While we strongly encourage insureds to timely notify their insurers of all new claims and seek consent prior to incurring any costs, this ruling may provide some relief under first-party policies' stringent notice and consent requirements.

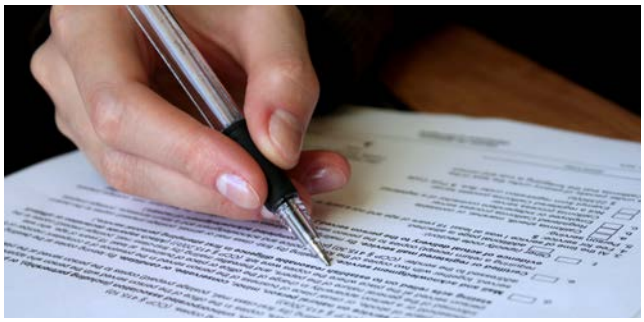
THE COURT'S RULING

After Pitzer College uncovered soil contamination while developing a new dormitory, it proceeded to remediate the area prior to notifying its pollution and remediation insurance carrier. Unsurprisingly, the claim was denied for late notice, as well as Pitzer's failure to obtain its insurer's written consent to incur expenses, assume obligations, and/or commence remediation due to a pollution condition.

Coverage litigation ensued in *Pitzer College v. Indian Harbor Ins. Co.*, and although Pitzer's policy required that all disputes "be determined in accordance with the law and practice of the State of New York," Pitzer pursued coverage litigation in California due to the state's policyholder-friendly late notice rule. Unlike New York's minority view that insurers can invoke late notice to deny coverage to out-of-state policyholders without having to show prejudice, California requires an insurer demonstrate it was prejudiced as a result of the late notice.

The district court found that New York law applied because Pitzer failed to timely submit the claim and "failed to establish" that California's notice-prejudice rule is a fundamental policy that overrides a choice of law provision. Further, the district court rejected Pitzer's argument that its remediation costs were incurred on an emergency basis and therefore subject to an emergency exception to the consent provision, finding that even if such exception was applicable, Pitzer had failed to notify its insurer "immediately" after it incurred its costs.

Pitzer appealed to the Ninth Circuit Court of Appeals, which in turn certified questions to the California Supreme Court, observing that "[r]esolution of this appeal turns on whether California's notice-prejudice rule is a fundamental public policy for the purpose of choice-of-law analysis," and "[if] the California Supreme Court determines that the notice-prejudice rule is fundamental, the appeal then turns on whether, in a first party policy like Pitzer's, a consent provision operates as a notice requirement subject to the notice-prejudice rule."



The California Supreme Court focused its analysis on its earlier decision in *Nedlloyd Lines B.V. v. Superior Court* (1992), in which it had previously articulated California's multi-step choice of law analysis that the "parties' choice of law generally governs unless (1) it conflicts with a state's fundamental public policy, and (2) that state has a materially greater interest in the determination of the issue than the contractually chosen state."

Tasked with determining whether California's notice-prejudice rule is, in fact, a fundamental public policy, the

court noted "the difference between a 'strong' public policy and a 'fundamental' one is essentially semantic when our goal is to protect those with inferior bargaining power in the insurance context. A policy such as the notice-prejudice rule may be considered fundamental because it is connected to concerns of fundamental fairness in the negotiation process." Further, "rules have been found to be fundamental public policies when (1) they cannot be contractually waived; (2) they protect against otherwise inequitable results; and (3) they promote the public interest."

Ultimately, the California Supreme Court rejected the insurer's argument that the notice-prejudice rule is not a fundamental policy "delineated in constitutional or statutory provisions" or a rule of unconscionability, finding that "California's notice-prejudice rule is a fundamental public policy of California" and is "based on the rationale that the essential part of the contract is insurance coverage, not the procedure for determining liability, and 'the notice requirement serves to protect insurers from prejudice, ... not ... to shield them from their contractual obligations' through 'a technical escape-hatch.'"

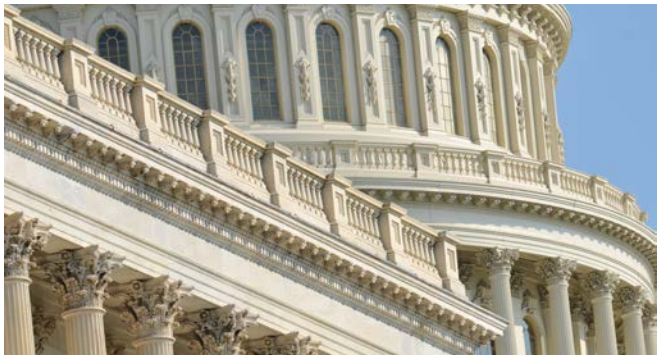
"... the notice requirement serves to protect insurers from prejudice, ... not ... to shield them from their contractual obligations' through 'a technical escape-hatch.'"

Importantly, the court further noted that its notice-prejudice rule "cannot be contractually waived" and "overrides the parties' express intentions for a defined notice term, preventing a technical forfeiture of insurance benefits unless the insurer can show it was prejudiced by the insured's late notice."

The court then turned to coverage for Pitzer's remediation costs incurred without the insurer's knowledge and express consent. Although the insurer argued that its consent provision "guards against the insured making unnecessary expenditures, allows the insurer to approve and control costs, and protects the insurer's subrogation rights," the court found the purposes of the consent provision "are much the same as those pertaining to notice provisions." Consequently, because the consent provisions "facilitate the insurer's primary duties under the contract and speak to minimizing prejudice in performing those duties, … the notice-prejudice rule makes good sense for consent provisions in first party policies just as it does for notice provisions."

Because the California Supreme Court's review was limited to answering the Ninth Circuit's query, the Ninth Circuit is now tasked with deciding "whether California has a materially greater interest than New York in determining the coverage issue, such that the contract's choice of law would be unenforceable because it is contrary to [the state's] fundamental public policy."

CAC Specialty will continue to monitor this case and report further developments.



10 WAYS TO SCREW UP YOUR INSURANCE RECOVERY

John Tanner

Three years ago, I wrote an article[1] describing the top ten ways insureds screw up insurance recoveries. It was essentially a highlight list of what you should *not* do if you want your claims to go smoothly. If, in some bizarre world, you were actually seeking to manage insurance claims poorly, you would do these ten things. In our experience, claim friction only increases in a hard market.

As we face firming market conditions, we thought it would be timely to again emphasize this list to our readers. Here is our top ten list of things insureds sometimes do that make claims difficult:

1 EMPHASIZE PRICE OVER VALUE AND COST OVER COVERAGE

If you treat your insurance like a commodity on the front end, your claim may be treated like one on the back end. Price matters, of course, but are you prioritizing price over breadth of coverage, carrier relationships and, ultimately, payment of claims? As the saying goes, cheap insurance can be the most expensive. But, what about when all of the available insurance is expensive? Make sure you are getting what you are paying for. In such circumstances, a commodity-based shotgun marketing approach may be ill-advised. Rather, now is the time that having experienced and knowledgeable brokers pays off to deliver greatest value.

2 MEET YOUR INSURANCE PARTNERS ONLY AFTER THE CLAIM ARRIVES

This point is a natural extension of the first. To your insurers, relationships may not matter if you are perceived as a price buyer. Make sure your brokers have strong relationships with your carriers, but more importantly, make sure you do as well. Is your insurance purchase business or personal? In a hard market or difficult claim, it is both. Do you know the top decision-makers, from both underwriting and claims, on whether a claim gets paid? Do they know you well enough to feel good about helping you through a difficult claim? Do they know that you value the relationship as a partnership of mutual respect and trust?

3 PROVIDE NOTICE OF ONLY LARGE OR SIGNIFICANT CLAIMS

Most insurance policies contain a notice provision whereby if you fail to notify an insurer of a claim in a timely manner, the insurer does not have to pay. You should never lose coverage by failing to provide notice. When in doubt, notify. Do not assume that a frivolous claim under your retention will stay that way, or that it will not lead to other more significant claims later.

4 DELEGATE, BUT DO NOT COMMUNICATE

Claims go more smoothly with effective communication between all key parties. In many companies, finance and procurement control the insurance budget, risk management negotiates the purchase, and legal handles the claims. Internal priorities may not always align, and when there is poor communication flow, bad claims often result. Legal should include risk management in the claim process and work with finance to properly evaluate and weigh contract terms—and the potential cost of obtaining more favorable terms—in the insurance buying process. Likewise, while finance and legal should build direct relationships with the insurers, risk management is typically closest to the key parties and can often play an integral role in navigating a claim through to a successful resolution.

5 KEEP YOUR INSURERS IN THE DARK

Claims will not go well if you and your lawyers ignore insurance until you are on your way to mediation. Make sure to keep your carrier partners informed at every step in the process with no surprises. If your initial claim evaluation indicated that the claim lacked merit, and the carrier has no information to suggest otherwise when called upon to settle a large claim, you can expect healthy skepticism or, worse yet, an assumption that you desire settlement for reasons not covered by the policy.

6 RETAIN LEGAL COUNSEL WITHOUT INSURER INPUT

Whether you or your insurer have the duty to defend, it is in your best interest to effectively manage your defense expenses rather than engage multiple firms in multiple jurisdictions without telling your insurers. Your insurance carriers may be able to offer negotiated rates with law firms and may have insight from specific experience with law firms in your area—sometimes including specific experience with the very firm suing you. Counsel selection and rates should be a part of your insurance underwriting process. Even in a non-duty to defend world, the insurers only cover reasonable expenses. Better to define reasonable upfront.

7 IGNORE CONSENT REQUIREMENTS

If you want your claim to go poorly, settle your claim using insurer dollars without running it by them first. Most policies require some level of insurer consent prior to incurring defense expenses or agreeing to settle.

8 FAIL TO CONSIDER ALL POTENTIALLY AVAILABLE INSURANCE

Most of the time, a D&O claim will only be covered by D&O insurance, a GL claim will only be covered by GL insurance, and a cyber claim will only be covered by cyber insurance. But, in a bad claim, you will need coverage wherever you can find it. If your search for excess insurance or other potential lines of coverage begins years after the loss event, a bad claim experience is the likely result. Instead, consider all potentially applicable insurance at the time you learn of the claim or loss.

9 DO NOT RESPOND TO INSURER REQUESTS FOR INFORMATION

It may be tempting to table a response to a long reservation of rights letter with overly broad requests for detail and information (when you have a very large retention and do not anticipate that the claim will ever exceed it, for example). Nevertheless, “file it and forget it” is a direct path to a bad claim experience. Most policies include express cooperation clauses that may be implicated here. Review reservation of rights letters carefully with your broker and legal defense team both in terms of defense obligations and current or future positions for potential impact on indemnity for any future settlement or judgment.

10 BE GREEDY AND OVERESTIMATE YOUR POSITION

If you want to screw up your insurance recovery, listen only to your version of reasonable, ignore insurer coverage defenses, take an overly aggressive stance on coverage, and

go for broke! Sometimes bad claims are just plain bad: bad facts, bad actors, bad law and valid—or at least potentially valid—coverage defenses. Be practical when it makes sense to be practical. While reasonable minds can disagree, the most reasonable minds will find common ground. Always be quick to listen, slow to speak, and slow to anger. If the carriers have good defenses, acknowledge that fact and reach a compromise. In a difficult claim, compromise can make really bad look pretty good.

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