RECENT DEVELOPMENTS IN EXCESS, SURPLUS LINES, AND REINSURANCE

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I. INTRODUCTION

This survey reviews developments in excess insurance, surplus lines insurance, and reinsurance law from September 2007 through September 2008, with the goal of assisting practitioners in observing trends in these areas.

II. EXCESS INSURANCE

A. *Exhaustion*

In 2008, a California appellate court examined whether an insured who settles with its primary insurers for less than policy limits can collect on an excess insurance policy. In another significant case, a court considered whether refusal to consent to settlement under strict time constraints amounts to bad faith. Courts also reviewed the duties excess insurers owe to one another.

In *Qualcomm, Inc. v. Certain Underwriters at Lloyd's, London*,[1] the California Court of Appeals held that the language in an excess directors and officers liability insurance policy meant that when a company settled an insurance dispute with its primary insurer and the primary insurer paid less than the full limits of its policy, the company effectively forfeited all coverage from the excess carrier.

The suit arose after Qualcomm incurred approximately $30 million in defense and settlement expenses related to a series of stock-option lawsuits and the company settled its coverage disputes with its primary insurer. The settlement provided that the primary insurer would pay $16 million of the $20 million primary insurance policy in exchange for a full release of any further claims under that policy.[2]

Qualcomm turned to its excess insurer, Certain Underwriters at Lloyd's of London (Lloyd's), for coverage. Qualcomm asserted that even though it settled for less than the full amount of the primary policy, the company had

1. 73 Cal. Rptr. 3d 770 (Ct. App. 2008), *rev. denied*, No. S163293, 2008 Cal. LEXIS 6969 (Cal. June 11, 2008).
2. *Id.* at 774.

paid an additional $4 million of loss exceeding the amount of the primary policy, entitling it to excess coverage. Therefore, Qualcomm argued, $20 million had been paid out by a combination of Qualcomm and the primary insurer before Lloyd's was asked to contribute.[3]

Lloyd's refused coverage and Qualcomm brought suit. Lloyd's argued that the primary policy was not exhausted because the primary insurer is required to pay the policy limit in order to trigger excess coverage. On grounds that excess coverage had not been triggered, the appellate court sustained Lloyd's demurrer to Qualcomm's complaint.[4]

The court referenced the language of the policy, which read: "Underwriters shall be liable only after the insurers under each of the Underlying policies have paid or have been held liable to pay the full amount of the Underlying Limit of Liability."[5] The court held that interpretation of an insurance contract is controlled by the "clear and explicit meaning" of the contract's written provisions, which must be "interpreted in their ordinary and popular sense."[6]

Accordingly, the court found that because the primary insurer actually had to have paid the entire $20 million in order for excess coverage to be triggered, Lloyd's was not obligated to reimburse Qualcomm for loss incurred.[7]

Following this decision, a superior court in Delaware declined to apply the reasoning in *Qualcomm* to a case interpreting Delaware and New Jersey law because it was "contrary to the established case law of New Jersey and Delaware."[8] The court explained that the established case law in New Jersey and Delaware provided that an excess insurer's liability is triggered even if the plaintiffs have not actually received all of the payments exhausting the underlying policy limits.[9]

B. *Excess Insurer Duties*

In *Central Illinois Public Service Co. v. Agricultural Insurance Co.*,[10] the intermediate Appellate Court of Illinois considered the issues of whether a lower-tiered excess insurer owed any duty to a higher-tiered excess in-

3. *Id.*
4. *Id.* at 774–75.
5. *Id.* at 778–79.
6. *Id.* at 775.
7. *Id.* at 783–85.
8. HLTH Corp. v. Agricultural Excess & Surplus Ins. Co., No. 07C-09-102 RRC, 2008 WL 3413327, at *15 (Del. Super. July 31, 2008).
9. *Id.* (citing Stargatt v. Fid. & Cas. Co. of N.Y., 67 F.R.D. 689 (D. Del. 1975), *aff'd*, 578 F.2d 1375 (3d Cir. 1978); Westinghouse Elec. Corp. v. Am. Home Assurance Co., Nos. A-6706-01T5, A-6720-01T5, 2004 WL 1878764 (N.J. Super. Ct. July 8, 2004); Zeig v. Massachusetts Bonding & Ins. Co., 23 F.2d 665 (2d Cir. 1928)).
10. 880 N.E.2d 1172 (Ill. App. Ct. 2008).

surer to engage in meaningful settlement negotiations and whether an underlying insurer still owed that duty if it could not settle the matter within its own policy limits.

The case arose out of an accident where an elevator at the Central Illinois Public Service Company (CIPS) power plant in Newton, Illinois, dropped fifteen floors, injuring twenty-three people inside. The Dover Elevator Company (Dover) and CIPS were named as defendants. CIPS had several layers of insurance. Pertinent to the dispute were Great American Assurance Company, formerly known as Agricultural Insurance Company (Great American), the second-level excess carrier, and American International Specialty Lines Insurance Company (AISLIC), the third-level excess carrier.[11]

Dover and CIPS settled with ten of the plaintiffs, exhausting CIPS' primary and first-level excess coverage. CIPS requested that Great American and AISLIC fund an additional $29 million payment to settle with the remaining thirteen plaintiffs. Great American and AISLIC agreed and decided that liability for the $29 million settlement would be determined in an allocation trial between Dover and CIPS. The trial court ultimately determined that Great American was responsible for its policy limit of $15 million and AISLIC was responsible for $10.325 million.[12]

CIPS filed an action for declaratory judgment regarding coverage for the accident. AISLIC filed a counterclaim against Great American alleging negligence and bad faith in the settlement process. AISLIC alleged that Great American ignored its demands to enter into good faith settlement efforts or tender its policy limits so that AISLIC could resolve the matter.[13]

The Illinois Appellate Court first considered what duties, if any, one excess insurer owes to another. The court agreed with a federal case, *Liberty Mutual Insurance Co. v. American Home Assurance Co.*,[14] and held that the decisions of Illinois courts regarding the duties of primary carriers also describe the responsibilities of excess carriers.[15]

However, the court disagreed with the federal court's assessment that Illinois law established no duty running from excess insurer to excess insurer. While the federal court determined that an underlying excess insurer lacked substantial control over the litigation that precluded any duty to the secondary excess insurer, the Illinois Appellate Court held that this reasoning "fails to address the circumstance that complex litigation often progresses through stages in which the involvement, or control, an

11. *Id.* at 1174.
12. *Id.*
13. *Id.* at 1175.
14. 348 F. Supp. 2d 940 (N.D. Ill. 2004).
15. *Cent. Illinois Pub. Serv. Co.*, 880 N.E.2d at 1176.

insurer has in the litigation and settlement changes."[16] The court held that dismissal was inappropriate because the issue of whether Great American controlled the settlement process was a factual question. The case was reversed and remanded.

Recently, the Seventh Circuit Court of Appeals held that an excess insurer assumed an insured's defense within the meaning of a policy provision requiring payment of post-judgment interest upon assumption of the defense. In *Rockwell Automation, Inc. v. National Union Fire Insurance Co. of Pittsburgh, Pa.*,[17] the excess insurer's policy provided as follows: "whenever [the excess insurer] assumes the defense of any claim or suit, it will pay . . . all interest that accrues after entry of judgment and before we have paid, offered to pay or deposited in court the part of the judgment that is within our applicable Limits of Insurance."[18] There were a judgment and post-judgment interest in the underlying case and the excess insurer argued that the interest was not covered.

The court noted that the excess insurer solicited and received input from the insured and its other insurers on identifying appellate counsel and that the excess insurer's claims handler stated that he was going to make the decision regardless of what input he received.[19] The court explained that the facts showed that the excess insurer took the lead in selecting appellate counsel and also supervised and paid counsel.

Therefore, it was clear that the excess insurer assumed the insured's defense within the meaning of a policy provision that required payment of post-judgment interest upon assumption of the insured's defense. The excess insurer's policy bound it to pay post-judgment interest not included in any of the underlying policies or other insurance when it assumed the defense of any claim or suit against its insured. Therefore, whether the excess insurer voluntarily assumed the insured's defense or did so out of contractual obligation was irrelevant.[20]

Finally, the Second Circuit Court of Appeals examined excess insurer duties in the bad faith context.[21] It held that two excess carriers breached the duty of good faith and fair dealing when they refused to consent to a settlement in the middle of trial.

In the underlying suit, the insured sought the excess insurers' consent to settle for $20 million. The insured only gave the insurers eleven hours to discuss the settlement. The court approved the settlement. The insurers refused to consent to the settlement, so the insured paid it out of his own

16. *Id.* at 1178.
17. 544 F.3d 752 (7th Cir. 2008).
18. *Id.* at 754.
19. *Id.* at 757.
20. *Id.*
21. Schwartz v. Liberty Mut. Ins. Co., 539 F.3d 135 (2d Cir. 2008).

pocket. The insured filed suit against his insurers, the insurers lost at trial, and the appellate court reviewed the findings of the jury.[22]

The excess insurers argued that the insured forfeited his rights to coverage for the settlement by only giving the insurers eleven hours overnight to consent to the settlement. However, the court noted that the insurers attended mediations and settlement conferences, sent correspondence to the other insurers regarding the trial and settlement, and monitored the trial in the courtroom. The court stated: "The record certainly does not require a finding that [the excess insurers] were blindsided by [the insured's] request for consent to the $20 million settlement."[23]

C. *Excess Insurer Rights*

In *Federal Insurance Co. v. North American Specialty Insurance Co.*,[24] the New York Appellate Division considered whether an excess insurer has standing to assert a malpractice claim against a law firm appointed by the primary insurer to defend an insured.

An employee of a subcontractor that was injured on the job had filed a personal injury action against the site's owners and the contractor. Commercial Underwriters Insurance Co. (CUIC), which issued the contractor's $1 million CGL policy, appointed the law firm Rivkin Radler, LLP (Rivkin) to defend.[25]

After the underlying court granted summary judgment for the owners on their indemnification claims, a settlement was reached where Commercial paid its $1 million policy limit and Federal Insurance Co. (Federal) paid $2 million of its $10 million excess liability policy.[26]

Federal then sued CUIC and Rivkin for malpractice, alleging negligence. The appellate court determined that because an attorney is not liable to a third party for negligence in performing services on behalf of a client, an excess insurer does not have standing to assert a malpractice claim against a law firm appointed by the primary insurer to defend an insured. The court noted that New York courts enforce a strict privity requirement in legal malpractice matters. Rivkin's duty in the action was to its client, the insured, and not to its client's insurer. The court reasoned that this result aims to prevent situations in which attorneys must weigh the competing interests of other interested parties against those of their client. Therefore, no privity existed between Federal and Rivkin that would permit Federal to maintain a malpractice action.[27]

22. *Id.* at 140.
23. *Id.* at 146.
24. 847 N.Y.S.2d 7 (N.Y. App. Div. 2007).
25. *Id.* at 9.
26. *Id.* at 12.
27. *Id.* at 13–14.

The court also rejected Federal's claim that the exception for "near privity" applied based upon negligent misrepresentation by Rivkin. Federal essentially argued that an attorney may be held liable to third parties for submitting an erroneous opinion letter relied upon by a third party. However, the court found that there was no allegation of any negligent misrepresentation by Rivkin. The court also found that Federal's decision to settle the action was not based on its reliance on representations made by Rivkin. Federal settled because the settlement was reasonable and Federal was advised by its own separate counsel.[28]

III. SURPLUS LINES

At the federal level, there are two significant pieces of legislation pending in congressional committee. One piece of proposed legislation strengthens the state's regulation over nonadmitted insurers. Another proposed bill would create a federal Office of Insurance Information that would increase federal regulation over nonadmitted insurers. The courts also are reviewing whether state statutory regulations apply to surplus lines insurers.

A. *Statutory and Legislative Developments*

1. Federal Legislation

The major piece of federal legislation is the Nonadmitted and Reinsurance Reform Act (NRRA) of 2007,[29] now pending before the Senate Committee on Banking, Housing, and Urban Affairs. This bill would significantly change the regulatory regime. Currently, multistate surplus lines transactions must abide by the regulations of each state in which an exposure exists. That creates differing requirements for surplus lines brokers in a multistate transaction. This practice is in sharp contrast to admitted insurance transactions, where policies that have multistate exposures are governed by the rules of one state only.

The NRRA subjects nonadmitted insurance to the regulatory requirements of the insured's home state only and prohibits any state other than the home state of an insured from requiring a premium tax payment for nonadmitted insurance. It also allows an insured's home state to require surplus lines brokers to file annual tax allocation reports detailing the portion of the nonadmitted insurance premiums attributable to properties, risks, or exposures located in each state.[30]

The NRRA also states that only an insured's home state may require licensing of a surplus lines broker in order to conduct nonadmitted insurance

28. *Id*. at 13.
29. S. 929, 110th Cong. (2008) (passed in the House as H.R. 1065 on June 25, 2007).
30. *Id*.

business with an insured. A state would not be able to collect fees derived from licensure of a surplus lines broker unless it has a regulatory mechanism for participation in a uniform national insurance producer database.[31]

Also of note, the bill urges states to "adopt a nationwide or uniform procedure, such as an interstate compact, that provides for the reporting, payment, collection and allocation of premium taxes for [surplus lines insurance]."[32]

Another important piece of legislation is the Insurance Information Act of 2008 (IIA),[33] introduced in the House of Representatives on April 17, 2008, to create the Office of Insurance Information (OII) within the Department of Treasury. The OII would receive, analyze, collect, and disseminate publicly available data and information and issue reports regarding all lines of insurance except health insurance, as well as establish federal policy on international insurance matters, and ensure that state insurance laws are consistent with agreements between the United States and a foreign regulatory entity. The OII also would advise the secretary of the Treasury on major domestic and international insurance policy issues. IIA would preempt any inconsistent state law.

2. State Legislation

In California, upon passage of Assembly Bill 1699 in June 2008, §§ 1750 and 1765 of the state's insurance code relating to surplus lines broker licenses and license fees were amended.[34]

Surplus lines brokers must now pay a fee of $250 when the broker is an individual transacting only on behalf of a surplus lines broker organization.[35] The filing fee for a license to act as a surplus lines broker will now be $1,000 every two years or for any initial fractional license year.[36]

In addition, for each surplus lines office maintained by the licensee from which the licensee transacts business with California residents, the code now requires each natural person or persons located at these offices who are responsible for the discharge of duties placed upon the licensee acting as a surplus lines broker at the office to also be licensed as a surplus lines broker.[37] Also, entities licensed as a surplus lines broker must now provide two hours of appropriate training every five years to its employees who solicit, negotiate, or effect insurance coverage placed by a nonadmitted insurer.[38]

31. *Id.*
32. *Id.*
33. H.R. 5840, 110th Cong. (2008).
34. Cal. Ins. Code §§ 1750, 1765 (West 2008).
35. *Id.* § 1750(e).
36. *Id.* § 1765(d).
37. *Id.* § 1765.2(a).
38. *Id.* § 1765(f).

B. *Case Law Developments*

1. Application of State Insurance Code in Florida

In *Essex Insurance Co. v. Zota*,[39] the Florida Supreme Court ruled that delivery of a policy by a surplus lines company to the broker is delivery to the insured. The court also ruled that all but one section of Chapter 627 of the Florida Insurance Code applies to surplus lines, possibly expanding the rules applying to surplus lines.

Mercedes Zota was injured when she fell from scaffolding while painting a mural on the second-story ceiling of a home. Zota's employers had contracted with Lighthouse Intracoastal, Inc., the owner of the home, to paint the ceiling of that residence. Lighthouse had secured various types of insurance, including a surplus lines policy from Essex Insurance.[40]

The surplus lines policy was delivered by MacDuff Underwriters, Inc. to Lighthouse's producing agent. When securing insurance policies for Lighthouse, the agent received policies and then provided them to Lighthouse. The agent received a copy of the Essex policy, but no one provided a copy of the policy to Lighthouse.

At trial, the defendants (the Zotas and Lighthouse, among others) argued that Essex had violated Florida Statutes §§ 626.922 and 627.421 by not delivering the policy to Lighthouse, preventing Essex from denying coverage.[41] The court granted summary judgment for the defendants based upon this argument.[42]

The case came before the Florida Supreme Court for review of several questions of Florida law certified by the U.S. Court of Appeals for the Eleventh Circuit.[43] Essex contested whether Florida Statutes § 626.922 or § 627.421 requires delivery of evidence of insurance directly to the insured and not to the insured's agent.[44] The court found that "neither statute has altered the common-law presumption that an insurance representative, serving as an independent insurance broker, acts on behalf of the insured for purposes of procuring insurance coverage."[45]

39. 985 So. 2d 1036 (Fla. 2008).

40. *Id.* at 1040.

41. Essex Ins. Co. v. Zota, No. 04-60619-CIV-COHN, 2005 WL 2456860 (S.D. Fla. Apr. 13, 2005), *final summary judgment granted*, 2005 WL 2456081 (S.D. Fla. June 2, 2005).

42. *Essex Ins. Co.*, 2005 WL 2456081, at *5. *See also* CNL Hotels & Resorts, Inc. v. Twin City Fire Ins. Co., 291 F. App'x 220, 225 (11th Cir. 2008) (excess insurer can be punished for a primary insurer's failure to file the correct forms with the Florida Department of Insurance, pursuant to Florida's surplus lines law and citing *Zota*.)

43. Essex Ins. Co. v. Zota, 466 F.3d 981, 990 (11th Cir. 2006).

44. *Essex Ins. Co.*, 985 So. 2d at 1041–42. *See also* Fla. Stat. §§ 627.421(1), 626.922 (2008).

45. *Essex Ins. Co.*, 985 So. 2d at 1045.

The court stated that Part 1 of Chapter 627 dealing with rates and rating organizations did not apply to surplus lines but that all other parts of Chapter 627 do apply to surplus lines. The court said that due to scrivener error, the term "chapter" in § 627.021(2)e (stating that "this chapter does not apply . . . to surplus lines") meant "part," referring to Part I, Rates and Rating Organization, and was never intended to mean "chapter."[46]

Under this ruling, surplus lines insurers could potentially be subjected to all the state's rules in Chapter 627 relating to insurance contracts.

2. Statutory Notice Requirements Apply to Surplus Lines Insurer in New Hampshire

Surplus lines insurers' unregulated status has been called into question. In *Grand China, Inc. v. United National Insurance Co.*,[47] the Supreme Court of New Hampshire held that cancellation was governed by the statutory notice requirements even though the insurer was a surplus lines insurer.

In New Hampshire, statutory requirements call for sixty days' notice prior to cancellation of a commercial policy.[48] The court noted that the statute specifically exempts "workers' compensation policies or any policies provided and controlled by RSA 417-A or RSA 417-B."[49] Then court also stated that neither party claimed that the surplus lines insurance at issue was for workers' compensation or that it was governed by any of those subchapters.

The insurer argued that surplus lines insurers are only governed by the statutes that state they can offer policies through licensed and properly appointed producers who must satisfy the insurance commissioner that the needed coverage is unavailable through an admitted insurer.[50] The insurer further argued that the stamp on surplus lines policies illustrates that they are unregulated. The stamp reads as follows:

> The company issuing this policy has not been licensed by the state of New Hampshire and the rates charged have not been approved by the commissioner of insurance. If the company issuing this policy becomes insolvent, the New Hampshire guaranty fund shall not be liable for any claims made against the policy.[51]

However, the court explained that this language did not state that surplus line insurers were entirely unregulated, but, rather, it only referred to the rate-filing process and the guaranty fund.[52]

46. *Id.* at 1043.
47. 938 A.2d 905 (N.H. 2007).
48. N.H. Rev. Stat. § 417-C:2 (2008).
49. *Grand China, Inc.*, 938 A.2d at 907 (citing N.H. Rev. Stat. § 417-C:6).
50. *See* N.H. Rev. Stat. §§ 405:1–:12, 405:17-b, 405:24, 406-B:16.
51. *Id.* § 405:24.
52. *Grand China, Inc.*, 938 A.2d at 908.

The court also considered that the statutory language requiring the cancellation notice requirement stated that it applied to liability policies, and the policy at issue was a liability policy. It rejected the insurer's argument that the statute should have expressly stated that the cancellation notice requirements applied to surplus lines insurance. The court also rejected the insurer's argument that requiring it to follow the statute would have a chilling effect on the surplus lines market, stating that the market was already tilted in favor of the insurers.[53]

The most surprising part of the opinion detailed why the court ignored a New Hampshire Insurance Department Bulletin issued after the trial court's ruling that the statutory notice requirement applied to surplus lines insurers. The Bulletin stated that surplus lines insurers were not governed by the statutory notice requirements. However, the court explained that it only deferred to administrative agencies given a statute of doubtful meaning, then stated, "[b]ecause we hold that surplus lines policies are clearly governed by RSA 417-C:2, we do not defer to the administrative agency in this case."[54] Most important to the court was the fact that the legislature could have exempted surplus lines insurers from the statute, but it did not.

3. State Regulations Apply to Surplus Lines Insurer in New Jersey

New Jersey also recently insisted that a surplus lines insurer follow state regulations. In *Piermount Iron Works, Inc. v. Evanston Insurance Co.*,[55] the Appellate Division of the New Jersey Superior Court ruled that a surplus lines insurer was bound by otherwise nonapplicable regulations when it included a clause in a policy that mirrored the clause in an Insurance Services Office (ISO) policy form required by regulations.

The insured maintained an excess liability policy with Evanston Insurance Company (Evanston), a surplus lines insurer. The policy contained the standard ISO clause on nonrenewal that required notice of nonrenewal. The policy expired on March 13, 2002. Evanston never mailed a nonrenewal notice. Evanston was contacted by a surplus lines wholesale broker on March 14, 2002, and refused to renew without a new application and other requirements.[56] Additionally, Evanston quoted a significantly larger premium amount. The insured obtained replacement coverage in April 2002.

However, the underlying claim against the insured for personal injury arising from a construction site accident occurred on March 28, 2002.[57]

53. *Id.* at 908–09.
54. *Id.* at 909.
55. 938 A.2d 134 (N.J. Super. Ct. App. Div. 2007).
56. *Id.* at 136–37.
57. *Id.* at 137.

Therefore, the court was presented with the issue of whether the Evanston policy had been properly renewed.

The court began its analysis by explaining that "the Commissioner of Banking and Insurance has adopted regulations designed to prevent lapses in insurance coverage by requiring insurers to give their insureds at least thirty days notice before canceling or non-renewing a policy."[58] Then the court observed that the regulations did not apply to surplus lines insurers such as Evanston, citing New Jersey Administrative Code § 11:1-20.1(a).[59] However, the court noted that "there is no dispute that the nonrenewal clause in the Evanston policy is exactly the same as the clause included in the standard policy (standard ISO policy) issued by insurers that are subject to the regulations."[60]

The court concluded:

> [W]hen an insurer voluntarily includes in its policy a clause that mirrors one included in a standard ISO policy required by insurance regulations, both the insurer and the insured can reasonably expect that the clause in the insurer's policy will be construed consistently with the clause in the ISO policy and with the regulations requiring that clause. In so concluding, we are not applying the regulation to Evanston, rather we are construing the notice clause in the Evanston policy.[61]

IV. REINSURANCE

A. *Regulatory and Legislative Update*

While the merits of an Optional Federal Charter[62] for insurance companies or an Office of Insurance Information within the Treasury Department[63] remain a topic of debate in Congress and the insurance industry,[64] a less divisive area of reform addresses certain global, multinational insurance issues, such as those involving reinsurance markets and surplus lines.[65] In the United States,

58. *Id.* at 138–39; *see also* N.J. Admin. Code § 11:1-5.2(a).
59. *Piermount Iron Works*, 932 A.2d at 139.
60. *Id.*
61. *Id.* at 140–41.
62. *See, e.g.*, National Insurance Act of 2007, H.R. 3200, 110th Cong. (2007); National Insurance Act of 2007, S. 40, 110th Cong. (2007).
63. *See, e.g.*, Insurance Information Act of 2008, H.R. 5840, 110th Cong. (2008) (proposed in the House of Representatives on Apr. 17, 2008, "To establish an Office of Insurance Information in the Department of the Treasury").
64. *See* Erin McNeill, *Industry Groups Divided over Proposal for Federal Insurance Information Office*, CQ Today, July 8, 2008, at 9 ("Proponents say the lack of federal coordination of insurance regulations hinders entry of foreign firms, which must contend with more than 50 regulators at the state level, and impedes U.S.-based firms from competing abroad . . . . Others worry that such a central office could lead to pre-emption of state regulations and the consumer protections they afford."), *available at* 2008 WLNR 13131527.
65. Thecla Fabian, *Optional Federal Charter Not Likely Soon, But Dodd Holds Out Hope for*

"multiple regulatory regimes have caused tension with foreign officials and put the U.S. insurance industry at a disadvantage, said Sen. Tim Johnson (D-S.D.),"[66] and the introduction of legislation addressing some of the global segments of the insurance industry "may be the best option available."[67]

State regulations that currently require foreign reinsurers to post 100% collateral in a U.S. bank for the risks they absorb may be ripe for such change, although the current unstable financial markets may delay any developments in this area. Foreign, nonadmitted reinsurers have often complained of these requirements, "pointing out, among other arguments, that U.S. reinsurers do not have any collateral requirements in many foreign countries and that the current regulations do not recognize when an alien reinsurer cedes some of the risk back to a U.S. reinsurer."[68] The National Association of Insurance Commissioners (NAIC) has recently proposed an easing of these requirements, "tying them to the financial strength of alien reinsurers,"[69] and creating a NAIC Reinsurance Supervision Review Department (RSRD).[70] Under the proposed plan, the RSRD would be responsible for setting certification standards for individual states to meet in order to become supervisors of two new classes of reinsurers: national reinsurers and port of entry reinsurers.[71] The RSRD also would "serve as the repository for relevant data concerning reinsurers (U.S. and non-U.S.) and the reinsurance markets,"[72] and it would "evaluate the reinsurance supervisory regimes of other countries and establish standards for a state to be certified to regulate reinsurance on a cross-border basis,"[73] among other responsibilities. While this type of centralized effort at regulating reinsurance is likely still welcome, it is uncertain in light of the current financial

Limited Fixes, Daily Rep. for Executives, July 30, 2008, at A-21, *available at* 146 DER A-21 (2008).

66. *Id*.

67. *Id*. (noting that "[i]nsurance industry representatives said they would prefer legislation establishing an industry-wide OFC, but would support a more limited fix that would allow increased U.S. access to surplus lines[,]" and quoting Franklin Nutter, president of the Reinsurance Association of America, as stating that legislation addressing reinsurance markets and surplus lines " 'would go a long way' ").

68. Baird Webel, Congressional Research Service, No. RL32789, Insurance Regulation: Issues, Background, and Current Legislation 6 (2008).

69. *Id*.

70. *See* Framework Memorandum from Ryan Couch, Nat'l Ass'n of Ins. Comm'rs Staff, to Reinsurance (E) Task Force Members, Interested Regulators and Interested Parties regarding Reinsurance (E) Task Force Activities 6 (Sept. 12, 2008), *available at* http://www.naic.org/documents/committees_e_reinsurance_080912_rtf_mod_prop.pdf.

71. *Id*.

72. *Id*. at 3.

73. News Release, Nat'l Ass'n of Ins. Comm'rs, NAIC Reinsurance Proposal Advances Toward Full Adoption: State Insurance Regulators Carefully Consider Steps to Strengthen Reinsurance Regulation (Sept. 25, 2008), *available at* http://www.naic.org/Releases/2008_docs/reinsurance_advances2.htm.

market whether an easing of the requirements to post 100% collateral is as palatable as it may have been a few months ago.

Another attempt to simplify reinsurance regulation involves recently proposed federal legislation designed to reduce the frequently overlapping authority of multiple states over reinsurance transactions. The Nonadmitted and Reinsurance Reform Act of 2007[74] would "invest the home state of the insurer purchasing the reinsurance with the authority over the transaction while investing the home state of the reinsurer with the sole authority to regulate the solvency of the reinsurer."[75]

B. *Case Law Developments*

As this is written, the world financial system is in turmoil. With the crisis have come calls for increased regulation on Wall Street and the insurance markets. How these profound and still-developing circumstances will affect the regulation of the reinsurance industry is not yet clear, but it does seem likely to spawn litigation. We are likely to see policyholders increase their efforts to obtain access to reinsurance information during discovery or to reinsurance assets during their insurers' liquidation proceedings. We also can expect further efforts to entangle any and all possible parties in a reinsurance dispute, including efforts to litigate a broker's liability for losses. And we can expect a continued lively debate over the limits to the follow-the-fortunes doctrine. All of these themes, and others, have been foreshadowed by the case law over the last year, which is discussed in detail below.

1. Discovery of Reinsurance Information

Courts have continued to address the discoverability of reinsurance-related information in nonreinsurance disputes. Typically, policyholders seek access to an insurance company's reinsurance information in the hope that it will reveal the company's internal valuation or understanding of the risk, will provide extrinsic evidence on the meaning of policy terms, or will help establish time of notice. In recent cases, courts remain divided over whether to allow such discovery.

In an action between an insurer and its policyholder, the U.S. District Court for the Western District of Louisiana resolved various motions to compel the production of certain documents after conducting an *in camera* review of the withheld materials.[76] Among other things, the policyholder sought production of documents related to its insurer's reinsurance

74. H.R. 1065, 110th Cong. (2007); S. 929, 110th Cong. (2007).
75. *Id.* at 9.
76. Cameron Parish Sch. Bd. v. RSU Indem. Co., No. 2:06-cv-1970, 2008 U.S. Dist. LEXIS 56069 (W.D. La. July 23, 2008).

coverage,[77] arguing that "the information sought is relevant to [the insurer's] assessment of the value and, hence, the disputed preexisting condition of Plaintiff's covered property. Plaintiff also contends that reinsurance information is relevant to [the insurer's] own assessment of its exposure as insurer, which in turn is relevant to its handling of the claim and whether the claim was adjusted in bad faith, as alleged."[78]

While the court held that the reinsurance information was not relevant to the plaintiff's breach of contract claim, it agreed with the plaintiff and found that such information "may be probative of bad faith."[79] Accordingly, the court found that "absent assertion of a valid privilege, . . . information on the nature and scope of [the insurer's] reinsurance strategy as to Plaintiff's policy is discoverable."[80]

Similarly, the Southern District of Florida, in a policyholder's bad faith action against his insurer, ordered the insurer to reveal to the plaintiff the names of its reinsurers.[81] The plaintiff policyholder intended "to issue subpoenas to these entities (once identified) 'so that he may seek discoverable information pertaining to [Defendant's] evaluation of the claim and its communication with . . . (the reinsurer or bad faith insurer) regarding its decision to proceed in a course of conduct that injured its insured.' "[82] The court found the requested information to be "relevant or . . . likely to lead to the discovery of admissible evidence."[83]

In another case, the U.S. District Court for the Northern District of Illinois also allowed the discovery of reinsurance policies and communications between an insurer and its reinsurer.[84] The plaintiff policyholders had alleged that the terms of the insurance policies at issue were ambiguous, thereby necessitating extrinsic evidence to aid in their interpretation.[85] The

77. Although not expressly stated in the opinion, it appears that certain of the reinsurance information sought by the plaintiff may have included communications between the defendant and its reinsurer. *See id*. at *6 (noting that "Defendant contends that the identity of and communications with its reinsurance carriers are irrelevant and not reasonably calculated to lead to the discovery of admissible evidence").

78. *Id*. at *5–6.

79. *Id*. at *6.

80. *Id*. at *7.

81. Simon v. Pronational Ins. Co., Case No. 07-60757-CIV, 2007 WL 4893477, at *2–3 (S.D. Fla. Nov. 1, 2007) (issuing orders in response to plaintiff's motion to compel various documents).

82. *Id*. at *2 (quoting the underlying Reply Brief) (alteration in original).

83. *Id*. The U.S. District Court for the Southern District of California similarly compelled the production of "non-privileged communications with reinsurers" in the context of a bad faith claim where the information could be relevant to the insurer's "state of mind for the potential for coverage and therefore [its] duty to defend . . . ." Ins. Co. of Penn. v. City of San Diego, Civ. No. 02cv693 BEN (CAB), 2008 WL 926560, at *1 (S.D. Cal. Apr. 4, 2008).

84. Mach. Movers v. Fid. & Deposit Co., No. 06 C 2539, 2007 WL 3120029, at *3–4 (N.D. Ill. Oct. 19, 2007).

85. *Id*. at *3.

court found that the insurers' "communications with reinsurers regarding the policy could be probative evidence of [the insurers'] subsequent conduct that could be used to give meaning to the disputed terms."[86] Additionally, following Seventh Circuit precedent, the court held that reinsurance agreements are discoverable pursuant to Federal Rule of Civil Procedure 26(a)(1)(D), as part of a party's initial disclosures.[87]

Similarly, the Superior Court of Massachusetts granted a plaintiff policyholder's motion to compel its insurer's reinsurance agreements, where the plaintiff sought the agreements in part because of the insurer's possible likelihood of insolvency and where "[t]he areas of dispute in this case relate directly to the language of the policies and the time of notice."[88] Accordingly, the court found that "[r]elevant evidence may be gathered from reinsurance agreements that may resolve these disputes."[89] In so finding, the court also noted that reinsurance agreements are insurance agreements for disclosure purposes under Massachusetts Rule of Civil Procedure 26(b)(2)[90] and that any concerns regarding safeguarding the confidential or proprietary nature of reinsurance agreements can be addressed by issuing a protective order.[91]

Not all courts require production of reinsurance materials, however. The U.S. District Court for the Western District of Washington declined to compel production of reinsurance communications in the context of a bad faith claim.[92] The court found that "[r]einsurance involves an insurance company's effort to spread the burden of indemnification. It is a decision based on business decisions and not questions of policy interpretation."[93] Noting that this was particularly true in the context of treaty reinsurance, the court found no connection to the claims asserted against the ceding company and its reinsurance program.[94]

Reinsurers have similarly pursued discovery about the scope of their cedents' reinsurance coverage, particularly where they contend that cedents have made allocation decisions based on which of their underlying policies

86. *Id.*
87. *Id.* at *4.
88. Neles-Jamesbury, Inc. v. Liberty Mut. Ins. Co., No. 02-0982A, 2007 WL 4099341, at *1, *2 (Mass. Super. Ct. Oct. 15, 2007).
89. *Id.* at *2.
90. *Id.*
91. *Id.*
92. Heights at Issaquah Ridge Owners Ass'n v. Steadfast Ins. Co., No. C07-1045RSM, 2007 WL 4410260, at *4–5 (W.D. Wash. Dec. 13, 2007). Although the court declined to compel production of communications with reinsurers, it did compel production of the reinsurance agreements themselves, pursuant to Fed. R. Civ. P. 26(a)(1)(D), noting that this "rule is absolute, and does not require a showing of relevance." *Id.* at *4.
93. *Id.*
94. *Id.*

were protected by reinsurance. In a short opinion, the U.S. District Court for the District of Connecticut affirmed the denial of Argonaut's motion to compel information regarding its cedents' reinsurance coverage for the underlying direct policies and how its cedents allocated settlements among those policies as "not a proper subject of inquiry."[95] In so holding, the court noted: "[i]f all the policies involved in the underlying insurance dispute were turned over to the reinsurers, the entire follow-the-fortunes doctrine would be undermined. The protections afforded insurers would be illusory, settlements would be discouraged and the door would be wide open for reinsurers to relitigate and seek judicial review of every settlement."[96]

In a different type of discovery dispute involving a pool, the plaintiff, National Council on Compensation Insurance, Inc. (NCCI), acting "solely as attorney-in-fact for the participating companies of the National Workers Compensation Reinsurance Pool," sought to prevent discovery from the individual participating pool members on whose behalf it had brought suit.[97] Defendant AIG argued that the individual pool member companies were each plaintiffs in the action and therefore party discovery from each of them should be permitted.[98] Alternatively, AIG argued that NCCI at least had custody or control over documents within the files of the individual pool members, even if the pool members were not themselves party to the suit.[99]

The court agreed with AIG, finding that the pool itself (but not each individual member) was a party plaintiff, despite bringing suit through an agent, NCCI:[100]

> [Additionally, b]y authorizing this litigation on behalf of the participating members of the Pool, the Board of Governors [of the Pool] has exhibited that it has "practical and actual managerial control" over the Pool. We conclude that the control necessarily extends to obtaining from the participating members documents relevant to the litigation, whether they are documents and information that the Pool would affirmatively use and thus voluntarily disclose, *see* Fed. R. Civ. P. 26(a)(1), or instead is information that defendants seek through Rule 34 document requests.[101]

In reaching its decision, the court rejected NCCI's argument that the pool and its participating members are akin to a corporation and its

95. Hartford Accident & Indem. Co. v. Argonaut Ins. Co., No. 3:06CV1813(WWE), 2008 WL 2559440, at *1 (D. Conn. June 23, 2008).

96. *Id*. (citations omitted).

97. Nat'l Council on Comp. Ins., Inc. v. Am. Int'l Group, Inc., No. 07-C 2898, 2007 WL 4365371, at *1 (N.D. Ill. Dec. 11, 2007).

98. *Id*.

99. *Id*.

100. *Id*. at *2.

101. *Id*. at *4 (citation omitted).

shareholders.[102] Unlike a corporation, "[a] non-incorporated association [such as the Pool] has 'no legal existence separate' from its members. Moreover, while shareholders do not manage or control the operations of the corporation, under the Articles of Agreement, the Board of Governors are the ones who manage and control the activities of the Pool."[103] Thus, the court found that a pool's discovery obligations are not analogous to those of a corporation, which is not required to produce documents that may be in its shareholders' possession.[104]

2. Policyholder Access to Reinsurance Proceeds

An insured's ability to sue a reinsurer directly continues to arise only under very limited circumstances, as addressed in recent decisions from the Western District of Louisiana, the Eastern District of Pennsylvania, and the Commonwealth of Pennsylvania.

In *LaSalle Parish School Board v. Allianz Global Risks U.S. Insurance Co.*,[105] LaSalle Parish School Board brought suit against Allianz for failure to pay outstanding amounts owed on an insurance claim that arose from the destruction of LaSalle High School during a tornado. LaSalle was the named insured on a policy issued by the Property Casualty Alliance of Louisiana (PCAL), and PCAL in turn reinsured its interest through an agreement with Allianz.[106] The U.S. District Court for the Western District of Louisiana noted that "LaSalle, at least in part, is attempting to bring a claim *under the reinsurance contract* itself."[107] The court further noted that "[t]he Louisiana Supreme Court has held that an insured generally may not sue its insurer's reinsurer directly," subject to a few exceptions.[108] Those exceptions include where the reinsurance contract "is for liability rather than for loss";[109] where the reinsurance contract meets a statutory exception under Louisiana law by clearly assuming the ceding insurer's duties owed to the policyholder;[110] or where the reinsurance agreement creates a third-party beneficiary contract.[111] In finding none of these exceptions to the general rule applied, the court held that LaSalle lacked standing to sue Allianz under its reinsurance contract with PCAL.[112]

102. *Id.* at *5.
103. *Id.*
104. *Id.*
105. No. 07-0399, 2008 WL 1859847 (W.D. La. Apr. 24, 2008).
106. *Id.* at *2.
107. *Id.* *4 (emphasis in original).
108. *Id.* at *6.
109. *Id.*
110. *Id.*
111. *Id.* at *7.
112. *Id.* at *8.

The court also addressed two Louisiana statutes, Louisiana Revised Statutes §§ 22:658 and 1220, "that establish additional and differing causes of action not only for insureds, but also—potentially—for 'claimants.'"[113] The court held that where the reinsurance agreement only covers its cedent's loss and does not allow another claimant to bring a claim under the policy, "a cognizable third party claim based on § 658 or § 1220" does not arise.[114] Accordingly, the court dismissed "LaSalle's claims for liability pursuant to the reinsurance contract issued by Allianz and under La. R.S. §§ 22:658 and 1220."[115]

Finally, the court examined LaSalle's noncontract claims of detrimental reliance and negligent misrepresentation arising largely from the alleged statements of an employee of defendant Eagle, the claims adjustor retained by Allianz.[116] Because of a number of unanswered factual questions, including a general uncertainty as to the nature of the relationship between Allianz and Eagle, the court denied the motion to dismiss as to those claims.[117]

The Eastern District of Pennsylvania also addressed a similar attempt by a policyholder to bring suit against its insurer, its insurer's reinsurer, and the third-party administrator, alleging claims of breach of contract and bad faith related to the handling of his claim for total disability benefits.[118] As alleged in the complaint, the insurer had ceded 100% of its risk on the policy to a reinsurer and had delegated its claims-handling duties to a third-party administrator who was owned by a corporate affiliate of the reinsurer.[119] This opinion addressed the reinsurer and third-party administrator's motion to dismiss for failure to state a claim.

The reinsurer and third-party administrator argued that the policyholder could not state a breach of contract claim against them under Pennsylvania law where they were not in privity of contract with him.[120] Facing lack of privity, the policyholder sought relief by alleging third-party beneficiary status to the contracts among his insurer, the reinsurer, and the third-party administrator.[121] The court rejected this argument, noting that the cedent did not contract with the reinsurer for the "benefit" of the policyholder and that the policyholder could only recover funds directly from the insurer and not from the reinsurer or the third-party administrator.[122] Moreover, the court found

113. *Id.*
114. *Id.*
115. *Id.*
116. *Id.* at *9–10.
117. *Id.* at *10–11.
118. Brand v. AXA Equitable Life Ins. Co., No. 08-2859, 2008 WL 4279863, at *1–2 (E.D. Pa. Sept. 16, 2008).
119. *Id.* at *1 (discussing the facts alleged in the complaint).
120. *Id.* at *2.
121. *Id.*
122. *Id.* at *3–4.

that the policyholder had failed to allege a "compelling" reason for the court to grant third-party beneficiary status such as the insolvency of his insurer.[123]

The policyholder's bad faith claims also failed because neither the reinsurer nor the third-party administrator acted as the "insurer" under the relevant Pennsylvania statute that "permits relief only for bad faith conduct 'toward the insured' by 'the insurer.' "[124] Notably, the reinsurer's acceptance of 100% of the risk for this policy did not alter the fact that its contractual obligations were owed solely to the cedent and not to the policyholder.[125]

In a separate case, the Eastern District of Pennsylvania again addressed a situation where the policyholder brought suit against the reinsurer, alleging third-party beneficiary status under the reinsurance agreement.[126] In that case, the plaintiff (Doeff) had malpractice insurance with Legion Insurance Company, which served as a fronting company for Transatlantic Reinsurance Company.[127] Upon Legion's insolvency, Doeff brought suit against Transatlantic directly seeking access to the proceeds of the reinsurance agreement between Transatlantic and Legion. Transatlantic moved to compel arbitration based on the terms of its agreement with Legion, arguing that Doeff could not claim "the benefits of [that] agreement" while "disavowing the arbitration provision . . . ."[128] Doeff argued that, as a third party to the reinsurance contract, he could not be bound by its arbitration provision, but the court noted that a prior decision by the Commonwealth Court had declared Doeff to be a "third-party beneficiar[y] of the reinsurance agreement."[129] Accordingly, "as a third-party beneficiary who has brought claims directly against [Transatlantic] pursuant to the reinsurance agreement, Doeff is bound by the terms of that agreement, including the arbitration provision, and he cannot avoid arbitration so long as his claims fall within the scope of the arbitration requirement."[130] The court further noted that the doctrine of equitable estoppel would prevent Doeff from seeking the "benefits of a contract and, at the same time, disavow[ing] portions that impose an obligation."[131]

In a case involving the impact of a liquidation proceeding on this issue, a Pennsylvania state court examined a policyholder's ability to directly access reinsurance proceeds during Reliance Insurance Company's liquidation

123. *Id*. at *4.
124. *Id*. (citations omitted).
125. *Id*.
126. Doeff v. Transatl. Reins. Co., No. 07-2110, 2007 WL 4373041, at *1 (E.D. Pa. Dec. 13, 2007).
127. *Id*.
128. *Id*.
129. *Id*. at *2.
130. *Id*. at *3.
131. *Id*. at *4.

proceedings.[132] On behalf of Reliance, the liquidator brought an action against both the reinsurer and the insured seeking a declaration that the insured could not obtain direct access to the reinsurance proceeds as a result of Reliance's insolvency. In reviewing the underlying determinations by the referee below, the court noted that "the general rule is that the liability of the reinsurer is intended to run to the estate of the insolvent insurer for the eventual benefit of the insureds, and not directly to the policyholders of the insurer. Where, however, an insolvent insurance company acts as a mere pass-through and does not act as a true insurer, direct access to reinsurance may be allowed."[133] For example, "[w]here there is a fronting reinsurance arrangement equity suggests that direct access be permitted."[134]

The court identified several factors to evaluate when determining whether to allow direct access by a policyholder to reinsurance proceeds, including whether the insurer held any risk in the transaction; whether "the insurer enter[ed] into the transaction in order to generate fees, and not premium"; whether the reinsurer effectively functioned as a "'direct insurer' for the policyholder" (holding claims handling responsibilities, etc.); whether "the policyholder facilitate[ed] the reinsurer's involvement" in some way; and whether "the equities favor the policyholder's claim to direct access."[135] Applying those factors, the court upheld the referee's finding that the policyholder was entitled to direct access to the reinsurance proceeds under the Loss Portfolio Transfer agreement, where "Reliance acted as a fronting agent, was not exposed to liability, and all funds were paid directly to the reinsurer."[136] As such, the Loss Portfolio Transfer was "not an asset of the Estate."[137] The court also upheld the referee's finding that the policyholder was *not* entitled to any reinsurance proceeds under the Gross Compensation Program, where Reliance, as the insurer, had actually retained a portion of the underwriting risk and where the payment Reliance received for its role in the transaction was based on prospective insurance policies with unknown claims (i.e., where the insurer's involvement was not merely as a fronting agent).[138]

3. Follow the Fortunes

The follow-the-fortunes and follow-the-settlements clauses continue to produce litigation and case law. Cases have involved both unambiguous

132. Ario v. Swiss Re Am. Corp., 940 A.2d 552 (Pa. Commw. Ct. 2007).
133. *Id*. at 557.
134. *Id*.
135. *Id*. at 558 (identifying five factors to consider) (internal citations omitted).
136. *Id*. at 560.
137. *Id*.
138. *Id*. at 558.

treaty language as well as the lack of treaty language and have addressed questions regarding exceptions to the follow-the-fortunes doctrine, related burden-of-proof issues, and the timing of when follow-the-fortunes obligations are triggered.

In a recent decision granting partial summary judgment to the cedent company, the U.S. District Court for the Western District of Missouri concluded that the treaty at issue contained an unambiguous "follow-the-settlements" provision.[139] Specifically, the court noted: "This is an unambiguous automatic reinsurance Treaty which explicitly laid out the obligations of the parties. Article IX clearly states that 'The Corporation [ERC] shall reimburse the Reinsured or its legal representative promptly for loss against which indemnity is herein provided.' "[140] Moreover, the court noted that "[n]owhere in the Treaty does it state that ERC may question claims once those losses are incurred and paid. ERC's right of joint participation [in the investigation, adjustment or defense of any claim] under the Treaty does not negate ERC's obligation to promptly pay claims."[141]

Although the court found the treaty language to be unambiguous on its face, it also noted that the reinsurer, ERC, was both the drafter of the treaty and a sophisticated party.[142] Accordingly, it could have incorporated language into the treaty that would have preserved its ability to question claims if it had desired this right.[143] Additionally, the court noted that the parties' course of conduct over thirteen years demonstrated that ERC had consistently paid claims submitted by its cedent, thereby "confirm[ing] the conclusion that ERC followed the settlements of [its cedent,] Mass Mutual."[144]

As a result of these findings, the court took a strong stance against allowing ERC, as the reinsurer, to question any of its cedent's claims-handling practices.[145] Rather, the court found that "ERC may only now question those claims that are not covered under the Treaty or that were made in bad faith."[146] It further held that "the application of the follow-the-settlements [doctrine]" in this instance "serves to bar many or all of ERC's claims" against its cedent.[147]

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139. Employers Reins. Corp. v. Mass. Mut. Life Ins. Co., No. 06-0188-CV-W-FJG, 2008 WL 3890358, at *7 (W.D. Mo. Aug. 19, 2008).

140. *Id.* (quoting the reinsurance treaty at issue).

141. *Id.*

142. *Id.* at *8.

143. *Id.*

144. *Id.* Because the court determined that the treaty contained express language, it did not reach the question of whether industry custom and practice also requires a reinsurer to follow the settlements in the absence of clear treaty language.

145. *Id.* at *9.

146. *Id.*

147. *Id.* The court also found against Employers Reinsurance Corporation regarding its practice of offsetting amounts owed under the treaty, despite there being an express

In another analysis of the follow-the-fortunes doctrine, the New York appellate division affirmed the denial of a reinsurer's motion for summary judgment where an issue of fact remained as to whether "the bad faith and the *ex gratia* payment exceptions to the 'follow the fortunes' doctrine" applied.[148] The plaintiffs (all of whom were various subsidiaries of AIG) had issued several excess umbrella liability policies to Castle & Cooke, Inc., only one of which was reinsured by ACE American on a facultative basis. After denying coverage to Castle & Cooke under the policy that ACE reinsured, AIG entered into a future cost agreement (FCA) with its policyholder that delineated which of the remaining policies would cover claims on an ongoing basis. Despite not initially including the reinsured policy in the FCA, AIG later submitted a notice of loss to its reinsurer alleging that claims were now being allocated to it. The appellate division noted that

> where there is a concurrency of coverage between the ceding company's policy and the policy of reinsurance, *the [follow-the-fortunes or follow-the-settlements] doctrine imposes a contractual obligation* upon the reinsurer to indemnify the ceding company for payments it makes pursuant to a loss settlement under its own policy, provided that such settlement is not fraudulent, collusive or otherwise made in bad faith, and provided further that the settlement is not an ex gratia payment, i.e., one made by a party that recognizes no legal obligation to pay, but makes payment to avoid greater expense, as in the case of a settlement by an insurance company to avoid the cost of a suit.[149]

In so finding, the court concluded that questions of fact remained and affirmed the denial of the reinsurer's cross-motion for summary judgment.[150]

Another recent decision addressed which party bears the burden of proving that a claim fell within the scope of the cedent's policy and was thus subject to reimbursement under the reinsurance agreement, in the absence of a follow-the-settlements provision.[151] The defendant reinsurer had issued a 100% facultative reinsurance certificate to the plaintiff cedent company.[152] In an underlying decision, the court had previously held that the reinsurance agreement did not include a follow-the-settlements provision.[153] After the cedent reached a settlement with its policyholder, it

provision in the treaty allowing the parties to engage in offsetting. The court found that this provision did not apply to amounts in dispute between the parties and could only be invoked where the parties agreed upon the losses or damages being offset. *Id.* at *10.

148. Granite State Ins. Co. v. ACE Am. Reins. Co., 849 N.Y.S.2d 201, 204 (N.Y. App. Div. 2007).

149. *Id.* at 203 (emphasis added).

150. *Id.*

151. Am. Motorists Ins. Co. v. Am. Re-Ins. Co., No. C 05-5202 CW, 2007 WL 4197427 (N.D. Cal. Nov. 21, 2007).

152. *Id.* at *1.

153. *Id.* at *4.

attempted to cede its losses to the reinsurer, "arguing that it is entitled to settle cases under the contract, there is no evidence that it settled the . . . claim in bad faith and, therefore, Defendant is obliged to reimburse it for the settlement . . . ."[154]

The court noted that the plaintiff's right to settle claims was still subject to the terms of the reinsurance agreement that provided indemnity to the plaintiff only "against losses or damages which [plaintiff] is legally obligated to pay."[155] Thus, the plaintiff would bear the ultimate burden at trial of proving that the underlying claim was in fact covered by its policy, and the defendant did not bear the burden of proving the inverse—that the claim fell outside the scope of coverage. Accordingly, the court denied cross-motions for summary judgment and remanded the case for trial.[156]

In another matter before the Northern District of California, the court addressed a situation where the plaintiff prematurely sought a declaratory judgment mandating that its reinsurer follow its fortunes before any such duty had arisen.[157] The plaintiff, Tall Tree Insurance Company, sought a declaratory judgment that it owed its policyholder, Hewlett-Packard Company, reimbursement for incurred defense costs and that defendant reinsurer, Munich Reinsurance America, was obligated to reimburse Tall Tree for those expenses under their reinsurance agreement.[158] The court held that there was no actual controversy between Tall Tree and Hewlett-Packard that would warrant a declaratory judgment because Tall Tree was conceding the availability of coverage and could simply pay its policyholder.[159] Moreover, the court held that there was no actual controversy between Tall Tree and Munich where Tall Tree had yet to pay Hewlett-Packard and, therefore, Munich was not yet in a position to "decide if plaintiff has paid a claim in good faith."[160] The follow-the-fortunes obligation had not yet arisen where "there is no act for defendant to assess and 'follow.'"[161] The court therefore dismissed the complaint without prejudice.[162]

In a case that granted summary judgment to the defendant reinsurer, Lexington Insurance Company, the U.S. District Court for the Western District of Washington found that the cedent company, Washington Cities Insurance Authority (WCIA), had paid a claim that fell outside the scope of

154. *Id*. at *3, *5
155. *Id*. at *5 n.3 (quoting an exhibit to the record).
156. *Id*. at *6.
157. Tall Tree Ins. Co. v. Munich Reins. Am., Inc., No. C-08-1060 MMC, 2008 WL 2950098 (N.D. Cal. July 29, 2008).
158. *Id*. at *1.
159. *Id*.
160. *Id*. at *2.
161. *Id*.
162. *Id*.

its policy.[163] Although the court recognized that "'the follow the fortunes' doctrine creates an exception to the general rule that the decision-making process is subject to de novo review," it also noted that "the reinsurer is not bound to pay where the primary insurer paid on a claim that was completely outside the scope of the policy, and not in good faith."[164] Moreover, the court gave greater weight to the "distinction between insured and uninsured risks" in this case because the reinsurance at issue was facultative where "the reinsurer accepts only specific risks, as set forth in the underlying policy."[165]

Guided by these principles, the court interpreted the scope of the underlying insurance policy to determine whether it covered the design defect that caused a Renton city bridge to require extensive repairs.[166] After finding the defect to be excluded under the policy, the court further held that WCIA's payment of the claim was also not in good faith, having been paid "late in this action, after discovery had closed, and without further notice to or consultation with defendants, knowing that defendants had already declined to cover the claim under the 'inherent vice' exclusion."[167] As such, the reinsurer had "no obligation . . . to follow the settlement and reimburse WCIA for the payment to the City."[168]

4. Fiduciary Duty

The U.S. District Court for the District of Connecticut allowed for the possibility that a fiduciary duty may arise in the context of a rent-a-captive reinsurance program.[169] Plaintiff WEB Management brought suit against defendant Arrowood for the failure to return a letter of credit WEB had posted for Arrowood's benefit in connection with a rent-a-captive reinsurance program.[170] Arrowood moved to dismiss two of WEB's claims, namely WEB's claims for breach of fiduciary duty and violation of the Connecticut Unfair Trade Practices Act (CUTPA). The court held that while subsequent discovery may show otherwise, upon "[a]ccepting all factual allegations in the complaint as true and drawing all reasonable inferences in favor of WEB . . . [t]he [rent-a-captive] program placed Arrowood in a uniquely dominant position over WEB's property sufficient to create a fiduciary relationship between the parties" such that the motion to dismiss

163. City of Renton v. Lexington Ins. Co., No. C06-203RSM, 2007 WL 2751356 (W.D. Wash. Sept. 19, 2007).
164. *Id*. at *6.
165. *Id*.
166. *Id*. at *7–8.
167. *Id*. at *8.
168. *Id*. at *9.
169. WEB Mgmt. LLC v. Arrowood Indem. Co., No. 3:07-cv-424 (VLB), 2008 WL 619310, at *1 (D. Conn. Mar. 5, 2008).
170. *Id*. at *1.

this claim must be denied.[171] Moreover, because WEB sufficiently alleged that "Arrowood acted unethically and oppressively in violation of public policy by breaching its fiduciary duty under the [rent-a-captive] program," WEB also stated a claim under the CUTPA.[172]

5. Broker Liability

Two recent cases addressed alleged reinsurance broker misrepresentation of the scope of the risk during the placement process. In both cases, the cedent, who had been denied reinsurance protection based on the broker's misconduct, sought reimbursement for those damages from the broker.[173]

The Fifth Circuit affirmed the grant of summary judgment for Aon Re, a reinsurance broker, and denied any relief to TIG, a cedent who had used Aon in placing reinsurance with U.S. Life.[174] TIG and U.S. Life had previously arbitrated a dispute over outstanding amounts owed by U.S. Life. The arbitration panel granted partial rescission of the treaty, to the benefit of U.S. Life, on the grounds that Aon, as TIG's agent, had omitted information about part of the risk during the placement process.[175] TIG subsequently brought this suit against Aon for reimbursement of the "unreinsured liability," claiming "negligence, negligent misrepresentation, breach of fiduciary duty, and seeking common-law indemnity."[176]

Applying Texas law, the Fifth Circuit first addressed Aon's allegation that TIG's claims were time-barred and found that TIG's legal injury initially occurred upon the signing of the reinsurance treaty between TIG and U.S. Life.[177] The court then assessed whether the "discovery rule" should postpone the accrual of TIG's claims against Aon:

> The injury in this case, the consummation of an agreement between TIG and U.S. Life that was based on incomplete underwriting data, is not inherently undiscoverable because it is the type of injury that could have been discovered by the exercise of reasonable diligence. An entity in TIG's circumstances has numerous sources from which it could determine whether accurate information was sent to one with whom it was negotiating a contract. A starting point is the company's own files. Another source is the party with whom it is about

171. *Id*. at *2.
172. *Id*. at *3.
173. In contrast, another case found that a reinsurer's agent was improperly joined in the dispute where it did not have "a material interest as to the disputed coverage under the [re]insurance contract to which it [wa]s not contractually privy." First Auto. Serv. Corp., N.M. v. First Colonial Ins. Co., No. 3:07-cv-682-J-32TEM, 2008 WL 816973, at *5 (M.D. Fla. Mar. 25, 2008).
174. TIG Ins. Co. v. Aon Re, Inc., 521 F.3d 351, 352–53 (5th Cir. 2008).
175. *Id*. at 354.
176. *Id*.
177. *Id*. at 355–56.

> to contract. Inquiry could be made to determine or confirm the facts and assumptions on which the bargain was to be based.[178]

The court also noted that certain evidence pointed to TIG's suspicion that U.S. Life might not have received complete information during the placement process, which demonstrated that "TIG's injury is not, categorically, the type of injury that is inherently undiscoverable."[179] It further noted that TIG was not "relying on Aon Re for expertise that TIG did not possess."[180] As a result, even if Aon owed a fiduciary duty to TIG, the court found that TIG's injury was still "not inherently undiscoverable" and, thus, the discovery rule would not extend the accrual of TIG's claims, which were therefore time-barred.[181]

Finally, the court rejected TIG's claim for common law indemnity. Under Texas law, common law indemnity is limited to situations involving vicarious liability.[182] Because the arbitration panel granted U.S. Life the equitable remedy of rescission, TIG was not required to pay damages to U.S. Life resulting from Aon's allegedly tortious conduct.[183] Thus, vicarious liability did not apply and common law indemnity was not available.[184]

In another matter addressing a reinsurance broker's liability to its cedent, the U.S. District Court for the Eastern District of Pennsylvania addressed a number of issues related to claims that losses allegedly arose out of the broker's failure to provide complete information to a reinsurer.[185] As in the TIG case, a prior arbitration decision awarded the reinsurer partial rescission of its contract with the cedent, United National, and the cedent then sought a determination of whether it was liable to the reinsurer "only vicariously through Aon, and, if not, . . . the degree of fault, if any, for [the reinsurer's] injuries that is attributable to Aon."[186]

In one of several motions addressed by the court, Aon sought to preclude evidence of a variety of its omissions in the placement materials that had been provided to the reinsurer.[187] The motion was based on *Restatement (Second) of Torts* § 551 regarding a party's duty to disclose information in the context of a business transaction.[188] The court noted that "the

178. *Id.* at 358.
179. *Id.* at 359.
180. *Id.*
181. *Id.*
182. *Id.* at 360.
183. *Id.*
184. *Id.* at 361.
185. United Nat'l Ins. Co. v. Aon Ltd., No. 04-539, 2008 WL 3819865 (E.D. Pa. Aug. 8, 2008).
186. *Id.* at *6.
187. *Id.* at *1.
188. *Id.*

thrust of Aon's argument is that the loss ratios [which Aon had provided to the reinsurer] required no additional disclosures because they were complete in themselves."[189] The court disagreed, finding that "all of the alleged omissions are things that could, arguably at least, render Aon's disclosures misleadingly incomplete."[190] Specifically, the court noted that the placement packages "disclosed various favorable loss ratios, but allegedly omitted information from which one could project that the loss ratios provided were on the verge of becoming unfavorable."[191]

After addressing the possible importance of various types of omitted information, the court also recognized the role of industry custom under § 551(2)(3), and found that whether Aon's omissions constituted information that was "basic to the transaction" depended "heavily on contested descriptions of industry custom."[192] As a result, the court found that the issue must be presented to a jury and denied Aon's request to exclude evidence of its omissions.[193]

The court also addressed whether the underlying arbitration record between United National and its reinsurer could be admitted as evidence.[194] Because the arbitrators were not bound to follow the law and their award did not make any findings of fact or conclusions of law, the court held that it could not draw any conclusions regarding liability from the award itself.[195] It also found that while portions of the arbitration record might be relevant to Aon's disclosure of information to the reinsurer, they might constitute hearsay.[196] Accordingly, the court declined "to offer a blanket ruling on the admissibility of the arbitration record," preferring instead "to rule separately on each piece of the record sought to be admitted."[197]

6. Contract Interpretation

Cases involving contract interpretation also have surfaced over the last year involving both ambiguous and unambiguous language, as well as the interplay between reinsurance agreements, placement slips, and the need to interpret language in light of the parties' agreement as a whole.

The Supreme Court of Connecticut reversed a grant of summary judgment that had been decided in favor of the defendant reinsurers by finding

189. *Id*. at *4.
190. *Id*. at *5.
191. *Id*.
192. *Id*. at *6.
193. *Id*.
194. *Id*.
195. *Id*.
196. *Id*. at *7.
197. *Id*. at *8. Additional issues were also the subject of this motion proceeding, including the admissibility of evidence that was not presented to the arbitration panel, expert reports and testimony, and case law from the United Kingdom. *Id*. at *8, *12–14.

certain phrases in a reinsurance treaty to be ambiguous.[198] The cedent company, Hartford, and its affiliates (Hartford) brought a declaratory judgment action against their reinsurers, who then cross-moved for summary judgment. Hartford attempted to cede losses to the reinsurers arising from a $1.15 billion settlement with its insured, a former manufacturer of asbestos products.[199] In so doing, Hartford aggregated its losses in a manner contested by the reinsurers under the terms of their treaty.[200] The Supreme Court of Connecticut interpreted the reinsurance treaty "to effectuate the intent of the parties as expressed by their words and purposes," noting that "[i]f the treaty is ambiguous, extrinsic evidence may be introduced to support a particular interpretation."[201] The court further noted that the *contra proferentem* rule does not apply in the context of reinsurance agreements.[202] Applying these principles, the court interpreted the disputed language (involving the broad definition and application of the treaty's "common cause" provision) to be ambiguous, reversed summary judgment, and remanded the case to the trial court.[203]

The Court of Appeals of Texas reversed a summary judgment determination by the trial court on a contract interpretation issue.[204] Both parties in the action had cross-moved for partial summary judgment based on their interpretations of the contract language used in an administrative services agreement and a reinsurance agreement.[205] After concluding that the contract language was "unambiguous,"[206] the court of appeals held that a "claims start-up fee" that was paid by a reinsurer pursuant to an administrative services agreement constituted a "loss adjustment expense" within the meaning of the reinsurance agreement.[207] As a result, the "claims start-up fee" should properly be "included in calculating 'losses incurred' under the Reinsurance Agreement."[208]

In another summary judgment determination based on reinsurance contract language, the U.S. District Court for the District of New Jersey

198. Hartford Accident & Indem. Co. v. Ace Am. Reins. Co., 936 A.2d 224 (Conn. 2007).
199. *Id*. at 228.
200. *Id*.
201. *Id*. at 231 (quoting Metro. Life Ins. Co. v. Aetna Cas. & Sur. Co., 765 A.2d 891, 896, 897 (Conn. 2001)).
202. *Id*.
203. *Id*. at 235, 239.
204. Employers Reins. Corp. v. Am. Sw. Ins. Managers, Inc., 261 S.W.3d 432 (Tex. Ct. App. 2008), *rev. denied* (Nov. 21, 2008).
205. *Id*. at 434.
206. *Id*. at 436.
207. *Id*. at 438.
208. *Id*.

interpreted a reinsurance treaty under New Jersey law.[209] The reinsurer alleged that the warranty provision, which limited the amount of coverage to be issued in certain underlying policies, also operated to limit the amount of loss that could be ceded to the treaty.[210] The court found this interpretation to be "unreasonable" given that the warranty provision in the treaty was separate and apart from the ultimate net loss provision in the treaty, the latter of which did control the amount of loss that could be ceded.[211] Construing the plain and unambiguous language of the warranty provision in light of the contract as a whole, the court granted the cedent plaintiff's motion for summary judgment.[212]

The Court of Appeals of Texas also addressed questions of contract interpretation in the context of a lawsuit brought by a reinsurer and its cedent against the agent "responsible for binding and adjusting the [underlying] policies."[213] Under the terms of the reinsurance treaty, the agent earned a "percentage of the premiums it produced and a sliding scale commission based on the loss ratio."[214] Under the terms of the agency agreement, the cedent (and fronting company) was "responsible for and shall promptly pay all expenses attributable to the actions of [itself] as a result of business produced under this Agreement . . . These expenses include, but are not limited to: losses and loss adjustment expenses incurred at the direction of [the cedent]."[215]

After the agency agreement was terminated and the claims were in run-off, the agent attempted to claim that its sliding-scale commission should not be impacted by run-off claims and therefore it should not be required to refund any premium to the cedent. Specifically, the agent argued that the cedent was responsible for paying all losses itself, in accordance with the terms of the agency agreement quoted above. The court noted, however, that the "agency agreement expressly incorporates the reinsurance treaty and amendments," and that the "commission adjustment provision appears in the reinsurance treaty and provides for the inclusion of 'all losses' in the commission adjustment calculation."[216] Additionally, "[t]he treaty . . . clearly contemplates that all losses, including run-off, are to be funded from the premiums."[217] Moreover, the agent's interpretation of the two

209. Princeton Ins. Co. v. Converium Reins. (N. Am.) Inc., No. 06-599 (MLC), 2008 WL 834403 (D.N.J. Mar. 27, 2008).
210. *Id*. at *1.
211. *Id*. at *8–9.
212. *Id*. at *9.
213. Gamma Group, Inc. v. Transatl. Reins. Co., 242 S.W.3d 203, 205 (Tex. App. 2007).
214. *Id*. at 208.
215. *Id*. at 209 (quoting the agency agreement).
216. *Id*. at 209–10.
217. *Id*. at 211.

agreements together was unreasonable, as it would result in a "windfall" for the agent.[218]

The court also addressed the trial court's finding that run-off payments must be "reasonable," despite the lack of such a provision in the party's agreements.[219] Noting that the parties were "sophisticated businesses" who could have included such terms in their agreements had they so desired, the court reversed the finding of the trial court and declined to rewrite the parties' contracts for them.[220] Interestingly, the court in part also relied on the "follow-the-settlements" provision of the reinsurance treaty, noting that while it did not apply to the agent's responsibilities (but rather to those of the reinsurer), it was still "illustrative of the parties' overall intent to insulate all claims payments from post-payment scrutiny."[221]

Issues regarding contract interpretation and mandatory arbitration also have arisen over the last year in the context of placement slips. Northbrook Indemnity brought an action to compel arbitration of its dispute with First Automotive, pursuant to an arbitration clause contained in a reinsurance agreement between the parties.[222] The reinsurance agreement at issue was "born out of an initial placement slip," which contained the words "arbitration clause" but not the express terms of the provision.[223] Subsequent placement slips were also agreed between the parties. The court focused its inquiry on whether the dispute in the case, which arose under several of the placement slips, fell within the scope of the reinsurance agreement or was independent of it, in order to determine whether it must be arbitrated.[224]

In reaching its decision to compel arbitration, the court noted that "the agreements here all govern the same ongoing relationship between the same parties concerning the same subject matter and for overlapping time periods."[225] Moreover, "[t]he broad terms of the arbitration provision do not limit those 'differences' which are arbitrable only to claims brought directly under the Reinsurance Agreement."[226] Finally, any doubts must be resolved in favor of arbitration.[227]

218. *Id.*
219. *Id.* at 212.
220. *Id.* at 213.
221. *Id.* at 214.
222. Northbrook Indem. Co. v. First Automotive Serv. Corp., No. 3:07-cv-683-J-32JRK, 2008 WL 3009899, at *1, *4 (M.D. Fla. Aug. 1, 2008).
223. *Id.* at *2.
224. *Id.* at *5.
225. *Id.* at *8.
226. *Id.* at *9.
227. *Id.*

7. No Tort Liability in the Context of Reinsurance

The U.S. District Court for the Central District of California addressed whether claims for the tort of breach of the covenant of good faith and fair dealing are appropriate in a reinsurance setting. The court answered no, and so it granted a reinsurer's motion to dismiss the complaint brought against it by its cedent, California Joint Powers Insurance Authority.[228] Among other claims, the cedent alleged that its reinsurer, Munich Reinsurance America, had tortiously breached the implied covenant of good faith and fair dealing by denying reinsurance coverage and disputing whether the claims were covered by the underlying insurance policy.[229] After finding California courts have not addressed whether an insurer may recover in tort for breach of the covenant of good faith and fair dealing, the court determined that a California court "would not impose tort liability in the reinsurance context."[230] The court reasoned that the parties to a reinsurance contract are sophisticated entities that possess similar bargaining power. Accordingly, the social policy reasons that justify tort recovery in the insured-insurer context are absent in the insurer-reinsurer context.[231]

8. Fraudulent Inducement

The U.S. District Court for the Southern District of New York addressed a post-trial motion by an insurer arguing that the jury verdict finding it guilty of fraudulently inducing the reinsurer's predecessor to enter two reinsurance contracts was flawed for several reasons.[232] The cedent argued that the "(1) the Court improperly instructed the jury as to the appropriate standard for imposing punitive damages, and [the reinsurer] did not offer sufficient proof to meet the correct standard; (2) there was insufficient evidence to support an award of punitive damages even under the standard stated by the Court; and (3) [there] was no legally sufficient evidentiary basis for the jury's finding that the statute of limitations did not bar [the reinsurer's] suit."[233]

In denying the cedent's motion, the court found no error in the jury instruction, noting that the "public harm" element of a fraud claim was inapplicable here.[234] It further noted that there was ample evidence of the

228. Cal. Joint Powers Ins. Auth. v. Munich Reins. Am., Inc., No. CV 08-956 DSF (RZx), 2008 WL 1885754 (C.D. Cal. Apr. 21, 2008).
229. *Id*. at *1.
230. *Id*. at *2.
231. *Id*. at *3–4.
232. AXA Versicherung AG v. N.H. Ins. Co., No. 05 Civ. 10180(JSR), 2008 WL 1849312 (S.D.N.Y. Apr. 22, 2008).
233. *Id*. at *1.
234. *Id*. at *4.

cedent's egregious conduct that would justify the jury's award of punitive damages, including the fact that the cedent conceived of the "Primary Facility as a means of writing unprofitable risks in a soft insurance market" and misleading the reinsurer into thinking that the facility was facultative-obligatory, when in fact, the reinsurer held the authority to refuse any risks.[235] Finally, the court rejected the cedent's allegation that the reinsurer's claim was time-barred, finding that the jury had adequate evidence to find that a "'reasonable reinsurer . . .' would not have been put on notice that it had been defrauded until documents in another litigation came to its attention, causing what one witness described as a 'thunderbolt.'"[236]

9. Insolvency Matters

Insolvency and liquidation proceedings are unfortunately likely to increase in frequency given the current economic conditions. Two recent decisions illustrate the role that legislatures will likely have in determining how these cases are decided.

In a New York case, Everest Reinsurance Company brought a motion to lift a permanent injunction barring suits against its cedent company, Midland Insurance Company, which was in the midst of liquidation.[237] Everest sought to bring suit against the liquidator for allegedly faulty claims-handling practices during the liquidation proceeding that it believed violated the terms of several reinsurance agreements between Everest and Midland. Specifically, Everest alleged that the liquidator failed to provide "timely notice of claims that would trigger Everest's reinsurance obligations," did not allow Everest the "opportunity to participate in the defense and settlement of claims," and failed to provide requested information or allow access to records.[238]

The opinion addressed several motions of interest. Everest moved to vacate the court's interim decision allowing Midland's policyholders to opine on Everest's claims against the liquidator, arguing that it was a contractual dispute between Everest and the liquidator regarding reinsurance contracts to which the policyholders were not a party.[239] The court denied Everest's

235. *Id*. at *3.

236. *Id*. at *4. For example, the court noted that although the cedent provided its reinsurer with a bordereau listing thirty-six previously unidentified losses in September 2000, the jury could have reasonably found that the reinsurer would not have been placed on notice of any fraudulent conduct by the cedent where the bordereau did not indicate the date on which the cedent had learned of the loss. To the contrary, the reinsurer could have reasonably assumed that the cedent also only recently learned of the losses itself—not that it "had deliberately concealed them." *Id*.

237. *In re* Liquidation of Midland Ins. Co., No. 41294/1986, 2008 WL 151786, at *1 (N.Y. Sup. Ct. Jan. 14, 2008).

238. *Id*. at *3.

239. *Id*. at *4.

motion as "meritless," noting that the policyholders' lack of privity with the reinsurers was not akin to a lack of standing in a liquidation proceeding.[240] If Everest were to prevail in its claims against the liquidator, which criticize its claims settlement procedures, the policyholders' rights could be affected. Accordingly, policyholders were allowed to present arguments out of "fairness."[241] The court further noted that

> [its] decision to solicit the input of the policyholders and reinsurers is in keeping with the purpose of Article 74 of the Insurance Law, which adopted the Uniform Insurers' Liquidation Act (UILA) . . . . "The overall purpose of the Uniform Act, like liquidation proceedings generally, is not only to preserve available assets for the benefit of creditors, but to protect the interest of persons who purchased insurance policies from a company which has become insolvent."[242]

The participation of policyholders added an interesting aspect to the case. One policyholder, Baxter International, wished to present evidence of settlements by Everest as a direct insurer in other contexts that would contradict its complaints about the settlement practices followed by the liquidator. While the court accepted the evidence, it noted that the real issue was whether the liquidator violated the claims-handling procedures of the reinsurance contracts between Midland and Everest, and this type of evidence would not address that question.[243]

In order to lift the permanent injunction barring suits against the insolvent insurer, Everest had to demonstrate a likelihood of success on the merits of its proposed action against Midland. The court required additional briefing as to the claims practices of the liquidator and how they were purportedly flawed.[244] While Everest presented several possible claims against the liquidator, it sought a level of involvement in the claims-handling, decision-making process that appeared to overstep the nature of its "discrete rights that neither give rise to, nor should be confused with, an all-encompassing right to be involved in the Liquidator's internal process of adjusting claims."[245]

The court weighed Everest's rights to participate in the liquidation proceedings in light of the reinsurance contracts at issue and the provisions of Article 74 of the New York Insurance Law governing liquidation proceedings. In evaluating the evidence of the liquidator's claims-handling

240. *Id*. at *5–6.
241. *Id*. at *5.
242. *Id*. at *6 (citation omitted) (quoting Matter of Transit Cas. Co., 588 N.E.2d 38, 42 (N.Y. 1992)).
243. *Id*. at *7–8.
244. *Id*. at *6.
245. *Id*. at *17.

processes, the court held that Everest failed to satisfy its burden of demonstrating a likelihood of success on the merits of its claims regarding access to Midland's records,[246] timely notice,[247] its right to associate in the defense of claims or the investigation of claims,[248] or its right to interpose defenses to claims.[249] Importantly, however, it also noted that Everest sought only declaratory relief, and that its proposed action related only to policyholder claims the liquidator might allow in the future. Thus, "at worst," Everest was only "speculating as to its injury."[250]

Additionally, the court noted that "Everest has not overcome the strong public interest and well-established policy that the injunction barring lawsuits against insolvent insurers is designed to protect. If Everest and the other reinsurers were permitted to litigate as Everest wishes, the Midland estate and the Liquidator—and with them the public interest—would be irreparably harmed."[251] Moreover, the court opined that to the extent Everest believed that the liquidator's claims-handling practices violated the contractual obligations under the reinsurance treaties, Everest had the option of withholding reinsurance payments. The liquidator could then elect to bring suit against Everest for nonpayment of claims and Everest could allege its various breach-of-contract defenses.[252]

In evaluating Everest's arguments regarding its right to interpose defenses to claims, the court sought to harmonize the reinsurer's contractual and statutory rights (pursuant to New York Insurance Law § 1308) with those of the superintendent of Insurance, within whom the legislature has vested "exclusive fiduciary powers over handling claims."[253] The court held that new procedures should be developed to allow reinsurers the ability to interpose defenses *after* the liquidator has determined that a claim should be allowed but *prior to* the court's approval of the claim.[254] In this manner, the liquidator's decision-making authority would not be usurped by the reinsurer, but the reinsurer could meaningfully exercise its right to interpose defenses before a court finally approved a claim.

Interestingly, the court also "call[ed] upon the Legislature to consider whether amendment of the UILA is advisable, to harmonize and modernize the insurance liquidation scheme as it relates to the rights of reinsurers."[255]

246. *Id.* at *12–13.
247. *Id.* at *11–12.
248. *Id.* at *13–14.
249. *Id.* at *14–15.
250. *Id.* at *22.
251. *Id.* at *23.
252. *Id.*
253. *Id.* at *20.
254. *Id.* at *21.
255. *Id.* at *26.

Finally, in a different matter involving a liquidation proceeding, the Court of Appeals of Ohio held that under the McCarran-Ferguson Act (the federal statute that provides for state statutes to "supersede conflicting applicable federal statutes when regulating the insurance industry"), the Ohio Liquidation Act "reverse-preempted" the Federal Arbitration Act.[256] The court noted that "[t]he Ohio Liquidation Act expressly provides that claims involving liquidation of an insolvent insurer will be asserted in the liquidation court."[257] Accordingly, John Hancock's efforts to compel arbitration under federal law were denied in the context of a liquidation proceeding that sought to litigate reinsurance agreements irrespective of those agreements' mandatory arbitration provisions.

256. Hudson v. John Hancock Fin. Servs., Inc., No. 06AP-1284, 2007 WL 4532704, at *4 (Ohio Ct. App. Dec. 27, 2007).

257. *Id*. at *5.