RECENT DEVELOPMENTS IN EXCESS INSURANCE, SURPLUS LINES INSURANCE, AND REINSURANCE LAW

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The period from 2009 to 2010 witnessed many important developments in excess insurance, surplus lines insurance, and reinsurance law and regulation. Most notably, the Dodd-Frank Wall Street Reform Bill included a series of new regulations aimed at establishing uniformity for significant features of nonadmitted and surplus lines regulation. In excess insurance, courts in New York and Illinois continued to clarify how allocation rules impact whether coverage by excess insurers will be triggered for long-tail claims. In reinsurance law, a series of important decisions included *Travelers Casualty & Surety Co. v. Insurance Co. of North America*, in which the Third Circuit affirmed a district court's ruling that the follow-the-fortunes doctrine obligated a reinsurer to pay its portion of a $137 million settlement, but only as to that portion of the settlement within the limits of the policies the reinsurer agreed to cover.[1]

I. EXCESS INSURANCE

A. *Regulatory Developments*

On April 12, 2010, the Florida Office of Insurance Regulation issued Information Memorandum OIR-10–01M. The memorandum provides guidance to Florida property insurers regarding their coverage of catastrophe risk. Specifically, it asks that property insurers evaluate their catastrophe risks for the 2010 hurricane season and assess whether their amount of reinsurance, including excess of loss, is adequate. It also recommends that property insurers consider employing other risk transfer mechanisms in combination with traditional reinsurance to adequately limit exposure.

Additionally, the Washington legislature enacted Chapter 48.164 of the Washington Insurance Code, which will be effective March 29, 2010, through December 31, 2016.[2] The new chapter allows the Washington State Office of the Commissioner to establish a temporary joint underwriting association for excess flood insurance if either: (1) excess flood insurance of a particular class or type is not available from the voluntary

1. 609 F.3d 143, 158, 165 (3d Cir. 2010).
2. Wash. Rev. Code § 48.164 (2010).

market; or (2) there are so few insurers selling excess flood insurance that a competitive market does not exist.[3] The association is funded primarily through premiums paid by insureds; however, the association may assess member insurers to the extent necessary to meet its financial obligations.

B. *Case Law Developments*

1. Excess Insurer Rights

Several courts issued opinions this year that affect excess and umbrella insurers' right to obtain reimbursement of defense costs. In *Cargill, Inc. v. Ace American Insurance Co.*,[4] the Supreme Court of Minnesota reversed a prior decision and ruled that a defending insurer has an equitable right to recoup defense costs from other insurers with at least a co-equal duty to defend. There, government and private entities had sued the insured in connection with alleged environmental contamination. The insured submitted the costs of defense of the lawsuits to several insurers, including Liberty Mutual.

The supreme court adopted the majority view that "where more than one primary insurer covers the same risk and an insurer discharges a common obligation also belonging to another insurer . . . a right to equitable contribution should exist."[5] The court noted that Liberty Mutual's policy covered only harm occurring "during the policy period," and "although Liberty Mutual may have an obligation to defend Cargill, there is a common liability among all of the primary insurers that have a duty to defend."[6] The court observed that the *Iowa National* rule[7] encouraged insurers to deny a defense "and, essentially, play the odds that, among all the insurers on the risk, it will not be selected by the insured to defend."[8]

The Minnesota Supreme Court did not address contribution claims by excess insurers. However, if a policyholder sought defense costs under one tower of insurance (i.e., the excess policies in a single year), an excess carrier in that tower would be only *secondarily* liable for defense costs versus primary insurers in other triggered years. Therefore, it stands to reason that under *Cargill*, an excess insurer would have grounds to seek contribution from those other primary insurers.

3. *Id.*
4. 784 N.W.2d 341, 343 (Minn. 2010).
5. *Id.* at 353.
6. *Id.* at 351 (emphasis omitted).
7. The *Iowa National* rule was the rule in place prior to this decision and was ultimately overruled by the court. *See* Iowa Nat'l Mut. Ins. Co. v. Univ. Underwriters Ins. Co., 150 N.W.2d 233 (Minn. 1967).
8. 784 N.W.2d at 352.

2. Excess Insurer Duties

A few courts examined coverage defenses asserted by excess insurers, independent of the coverage obligations of the primary insurers. In *Metropolitan Property & Casualty Insurance Co. v. Marshall*,[9] the insured was sued by the family of a woman who was murdered by the insured's son. The son was on a weekend pass from a rehabilitation facility at the time of the murder. While the insured's primary carrier was providing a defense, the insured learned of another insurer that provided excess homeowners coverage. The excess insurer denied coverage based on late notice and the contention that there was no "occurrence" as defined by the policy. The excess insurer denied coverage for the insured's son, meanwhile, because he was not an insured.[10]

The court agreed that the son was not an insured because he was only visiting for the weekend and was not a resident of the insured's home.[11] The court found, however, that from the mother's perspective, the murder was an accident, and therefore, constituted an occurrence.[12] Furthermore, the court found that the insured's notice was timely. Both her attorney and the primary insurer had advised her that she was not liable, and even her excess insurer assessed her exposure as "zero."[13] Accordingly, she had no reason to believe that her primary insurance would be exhausted.

In *Cincinnati Insurance Co. v. Oblates of St. Francis De Sales, Inc.*,[14] the Archdiocese of Oklahoma sought coverage for a lawsuit arising from allegations of child molestation by a priest. The claim was settled for $5,000,000. Although it initially denied coverage, the primary general liability insurer paid its $1,000,000 policy limit toward the settlement. The Archdiocese then sought coverage from the excess insurer. The excess insurer, however, maintained that the allegations did not constitute an "occurrence" under the policy and filed a declaratory judgment action on those grounds. The Ohio Court of Appeals upheld the grant of summary judgment to the excess insurer. Evidence in the lawsuit revealed that before the priest in question was assigned to the Oklahoma church, the Archdiocese knew of repeated past acts of sexual abuse and had been advised that the priest's "disorder" was not curable. Because the Archdiocese failed to warn the Oklahoma church regarding the priest's history, the priest was allowed access to children. The court found that the victim's injuries were thus "expected" and not a covered "occurrence."[15]

9. No. 020058/2008, 2010 WL 2651638, *1 (N.Y. Sup. Ct. July 6, 2010).
10. *Id.* at *2.
11. *Id.*
12. *Id.* at *3.
13. *Id.*
14. No. L-09–1146, 2010 WL 3610451, *1 (Ohio Ct. App. Sept. 17, 2010).
15. *Id.* at *4.

The question of the number of "occurrences" also often affects whether excess insurance is triggered. In *Bausch & Lomb Inc. v. Lexington Insurance Co.*,[16] the insured manufacturer of contact lens solution was sued in various products liability suits for injuries allegedly sustained by thousands of users. The insurer had issued three successive umbrella policies that were excess of large retained limits, or self-insured retentions. Two of these policies required exhaustion of a $2 million retention for each occurrenceuntil an aggregate $4 million. retention was exhausted.[17] The insured argued that the suits all arose out of a single occurrence, i.e., the design or manufacture of the solution. Therefore, the insured said, it only needed to exhaust $2 million total in each policy year to trigger the insurer's defense obligation. On the other hand, the insurer maintained that each claimant's injury constituted a distinct occurrence. Since no individual claimant alleged damages approaching $2 million, the insurer argued that coverage in each year was not triggered until judgments or settlements exceeded the aggregate retention of $4 million.

The court applied New York's "unfortunate events" test and determined that each claim of injury constituted a separate occurrence. The unfortunate events test provides that "[a]n accident is an event of an unfortunate character that takes place without one's foresight or expectation."[18] The court noted that "a product that is intentionally formulated, and intentionally manufactured as formulated, as were the solutions in this case, is not itself the 'accident.'"[19] In the underlying lawsuits, there was no allegation or evidence that the solutions were accidentally tainted in the course of manufacture or that the solutions were not manufactured as intended. Therefore, the court stated that "it is the individual exposure to the product" that constituted the accident or occurrence.[20] "Because the incident that gave rise to liability was the exposure to the product itself, there was no need to look to some point further back in the causal chain such as the manufacture, sale, or distribution of the product."[21] Consequently, exhaustion of the $4 million aggregate retentions for the applicable policy years was required as a condition precedent to coverage.

Courts also ruled on cases involving application of prior notice exclusions. In *Executive Risk Indemnity Inc. v. Pepper Hamilton LLP*,[22] the insured law firm assisted a client in the securitization of student loans. Later, se-

16. 679 F. Supp. 2d 345 (W.D.N.Y. 2009).
17. The third policy contained retentions of $2 million both per occurrence and in the aggregate; therefore, the issue of number of occurrences was irrelevant for that year.
18. *Id*. at 351 (citing Arthur A. Johnson Corp. v. Indemnity Ins. Co., 164 N.E.2d 704, 707 (N.Y. 1959) (internal quotations omitted)).
19. *Id*. at 352.
20. *Id*.
21. *Id*. at 353 (internal quotations omitted).
22. 891 N.Y.S.2d 1, 1 (N.Y. 2009).

curities fraud claims were brought against the client in connection with the student loan securities. The client then went bankrupt. The bankrupt estate brought malpractice claims against the law firm. After the securities fraud claims were brought, but before the law firm was sued, the law firm submitted its application for the insurance policy for the year in question. The law firm's general counsel issued a memorandum to the law firm regarding pending litigation against the firm. In response, the attorney working for the student loan securitizer stated that two lawsuits had been filed in connection with the client, but "to date," the law firm had not been sued. He said, "I am not certain as to whether we will be joined in the future."[23] The law firm, however, did not disclose this information in its insurance application.

The primary policy excluded "any act, error, omission, circumstance or personal injury" occurring before its effective date if "any insured at the effective date knew or could have reasonably foreseen that such act, error, [or] omission . . . might be the basis of a claim."[24] The primary insurer accepted the defense of the malpractice claims against the law firm, but the follow-form excess carriers denied coverage based on this exclusion.

The New York Court of Appeals held that the claims were excluded. The court found that the law firm both "subjectively" and "reasonably" believed that it could be subject to a lawsuit arising from that particular client but did not provide that information to the insurers.[25] The court noted that the terms of the exclusion did not require awareness of wrongful conduct on the part of the insured, only *some* act or omission that could form the basis of a claim against the insured.

In *Murphy v. Allied World Assurance Co*,[26] directors of a bankrupt brokerage firm sought coverage under their directors' and officers' liability policies. The excess insurers denied coverage under their prior notice exclusion. The directors argued that the exclusion did not apply to them because they had no personal knowledge of the possible claim; only others at the company did. As discussed in last year's survey, the U.S. District Court of the Southern District of New York previously held that the exclusion applied.[27] This year, the Second Circuit affirmed. The Second Circuit agreed that the exclusion applied if *any insured* had knowledge of the facts giving rise to a possible claim, not just the particular insureds seeking coverage. Although the primary policy contained a severability provision, it could

23. *Id*. at 4.
24. *Id*. at 3.
25. *Id*. at 5.
26. 370 Fed. App'x 193 (2d Cir. 2010).
27. Murphy v. Allied World Assur. Co., No. 08 Civ. 3821, 2009 WL 1528527, *1 (S.D.N.Y. May 29, 2009).

not be reconciled with the language of the exclusion in the excess policies; therefore, the latter language controlled. The court also agreed that the claims "arose out of" the fraudulent concealment scheme of which certain insureds were aware, as the phrase "arising out of" is interpreted broadly by New York courts.[28]

3. Exhaustion

A number of courts addressed the question of whether there was proper exhaustion of underlying insurance or self-insurance such that an excess or umbrella liability insurance policy was required to respond to a claim. In *Great American Insurance Co. v. Bally Total Fitness Holding Corp.*,[29] the defendant-insureds sought a declaration that they were entitled to coverage under excess directors' and officers' liability insurance policies issued by ACE American Insurance Company and Fireman's Fund Insurance Company. ACE and Fireman's Fund opposed the defendants' motion and sought a declaration that defendants' settlement with certain underlying excess insurers did not satisfy the conditions precedent to coverage under the ACE and Fireman's Fund policies.[30]

The ACE excess policy provided that its liability for a covered loss attached only after the underlying insurers paid their limits for a loss and the insureds paid any self-insured retention.[31] The Fireman's Fund excess policy also required, as a condition precedent to coverage, that all underlying insurance be exhausted by actual loss payment before the limits of that policy could be reached.[32]

The settlement between the insureds and their first and second layer excess insurers was for an amount less than the total amount of coverage limits provided by those policies ($30 million).[33] Although the underlying insurers had not paid their full policy limits, the insureds asserted that the ACE and Fireman's Fund excess policies were implicated because the insureds incurred defense costs that exceeded the limits of those policies.[34]

Applying Illinois law, the U.S. District Court for the Northern District of Illinois ruled that the ACE and Fireman's Fund policies clearly and unambiguously required the underlying excess insurers to pay the full amount of their policy limit before ACE and Fireman's Fund had any obligation to provide coverage.[35]

28. *Murphy*, 370 Fed. App'x at 195.
29. No. 06-C-4554, 2010 WL 2542191, *1 (N.D. Ill. June 22, 2010).
30. *Id.* at *1.
31. *Id.*
32. *Id.*
33. *Id.* at *2.
34. *Id.*
35. *Id.* at *5.

Rosciti v. Liberty Mutual Insurance Co. arose out of negligence and product liability claims that plaintiffs brought against a bankrupt corporation named Monaco Coach.[36] Pursuant to Rhode Island's "direct action" statute, plaintiffs sought to recover directly from an excess insurance policy issued to Monaco by the Insurance Company of the State of Pennsylvania (ICSOP).[37] ICSOP contended that Monaco was required to exhaust its $500,000 retained limit under the excess policy before plaintiffs could access the coverage limits. There was no dispute that the retained limit was not (and would not be) reached as a result of Monaco's insolvency.[38]

The issue before the court was whether the Rhode Island statute nullified the retained limit exhaustion requirement in ICSOP's excess policy.[39] The U.S. District Court for the District of Rhode Island held that it did not, and that the ICSOP policy had no obligation to respond to plaintiffs' claims as a result of Monaco's failure to pay its retained limit.[40] Applying Rhode Island law, the court noted that the ICSOP excess policy clearly and unambiguously required exhaustion of Monaco's retained limit by payments for "judgments, settlements, or defense costs," regardless of whether plaintiffs' claims exceeded that amount.[41] Further, the ICSOP policy provided that "under no circumstances, shall the bankruptcy, insolvency, or inability of [Monaco] to pay require [ICSOP] to drop down or in any way replace [Monaco's] retained limit or assume any obligation associated with [Monaco's] retained limit."[42]

In *Furnace & Tube Service, Inc. v. Westchester Surplus Lines Insurance Co.*, the plaintiff settled a claim brought against it by Mississippi Phosphates Corp. for $4.2 million.[43] Furnace was insured by three policies issued by Gray Insurance Company: (1) a primary policy, with a policy period from October 1, 2006, to October 1, 2009, and a $1 million annual limit of liability; (2) an excess policy, with a policy period of October 1, 2006, to October 1, 2007, and a $4 million per occurrence limit; and (3) an excess policy effective from October 1, 2007, to October 1, 2008, which also had a per occurrence limit of liability of $4 million.[44] Westchester provided umbrella coverage above the Gray policies for the relevant policy periods.[45]

36. No. C.A. 09–338 S, 2010 WL 3432305, *1 (D.R.I. Aug. 30, 2010).
37. *Id.* at *1 (citing R.I. Gen. Laws 1956 § 27–7-2.4 (2010)).
38. *Id.* at *1–2.
39. *Id.* at *1.
40. *Id.* at *3–8.
41. *Id.* at *3–5.
42. *Id.* at *4.
43. 1:09CV374 LG-RHW, 2010 WL 1427590, *1 (S.D. Miss. Apr. 8, 2010).
44. *Id.* at *2.
45. *Id.*

As part of the settlement, plaintiff contributed $100,000 and Gray paid $4.1 million.[46] While Mississippi Phosphates released Gray from any further liability, it sought additional damages from Furnace, which tendered the claim to Westchester.[47] Westchester disclaimed any duty to defend or indemnify under the umbrella policy, arguing that plaintiff's settlement failed to exhaust the underlying coverage provided by Gray. According to Westchester, the Mississippi Phosphates claim constituted an occurrence in two policy periods during which Gray provided coverage, requiring it to pay two limits (or $10 million) before the Westchester umbrella policy could be reached.[48] Furnace then commenced a declaratory judgment action.[49]

Applying Louisiana law, the court found in Westchester's favor and held that the Mississippi Phosphates claim constituted a separate occurrence under each of the Gray policies in effect during the 2006–2007 and 2007–2008 policy periods.[50] Therefore, two Gray policy periods were implicated by the claim, each with its own $5 million limit that had to be exhausted before coverage under the Westchester umbrella policy attached.[51] As such, the court held that Westchester's obligations to Furnace began after $10 million in underlying insurance was exceeded.[52]

4. Allocation

Several courts also addressed allocation disputes between insureds and excess/umbrella insurers. In *Foster Wheeler LLC v. Affiliated FM Insurance Co.*,[53] plaintiff sought a declaration that certain primary and first-layer excess insurers were obligated to provide defense and indemnity coverage with respect to asbestos-related bodily injury claims. Foster Wheeler contended that the allocation period for any covered asbestos claim should end no later than October 1, 1982.[54] The insurers, on the other hand, argued that the allocation period should extend until at least October 1, 1985, because Foster Wheeler's excess policies in effect from October 1, 1982, to October 1, 1985, were triggered by the asbestos claims.[55]

Because New Jersey law governed the parties' dispute, the court applied the New Jersey Supreme Court's holding in *Owens-Illinois, Inc. v. United*

46. *Id.* at *1.
47. *Id.*
48. *Id.* at *2–3.
49. *Id.* at *1.
50. *Id.* at *2–3.
51. *Id.*
52. *Id.* at *3.
53. No. 60777/01, 2010 WL 1945774, *1 (Sup. Ct., N.Y. Mar. 16, 2010).
54. *Id.* at *1–3.
55. *Id.*

Insurance Co.[56] to determine the proper method of allocation.[57] The court noted that, under the *Owens-Illinois* test, where multiple policies provide coverage for an insured's loss, an insurer's obligations are determined by length of time in which the insurer provided coverage and that policy's limit of liability.[58] Moreover, the insured is responsible for its portion of loss attributable to a period in which it was self-insured or chose not to purchase coverage that was available in the marketplace.[59]

Foster Wheeler admitted that it chose not to pursue coverage for the asbestos claims from certain umbrella and higher-layer excess policies that provided coverage for the October 1, 1982, through October 1, 1985, policy period, because it believed that those insurers would deny coverage on the ground that a material concealment had occurred during the application process (and have a reasonable chance of prevailing on this defense).[60] Specifically, Foster Wheeler had represented to the umbrella policies' brokers that certain primary policies issued for that period covered asbestos claims when, in fact, those policies contained an asbestos exclusion.[61] The defendant-insurers argued that costs associated with the asbestos claims against Foster Wheeler should nonetheless be allocated to the October 1, 1982, through October 1, 1985, period and that whether Foster Wheeler could collect from other insurance policies was immaterial to the insurers' proposed allocation.[62]

The court agreed with the defendant-excess insurers, noting that, under New Jersey law,[63] Foster Wheeler was required to pay its share of both defense costs and indemnity for policy years implicated by a loss in which it was self-insured or uninsured, as well as for years in which coverage was (or might be) precluded.[64] The court held that the umbrella policies in effect from October 1, 1982, through October 1, 1985, were triggered, and thus, had to be included for purposes of allocating liability for the asbestos claims at issue regardless of whether Foster Wheeler could potentially collect on those policies.[65]

In *Crucible Materials Corp. v. Certain Underwriters at Lloyd's London & London Market Cos*.,[66] plaintiff sought coverage under a second-layer excess

56. 138 N.J. 437, 450 (1994).
57. *Foster-Wheeler*, 2010 WL 1945774, at *4 (citations omitted).
58. *Id*.
59. *Id*.
60. *Id*. at *3.
61. *Id*.
62. *Id*. at *4.
63. *Id*. (citing Benjamin Moore & Co. v. Aetna Cas. & Sur. Co.,179 N.J. 87, 99 (2004)).
64. *Id*. at *5.
65. *Id*.
66. 681 F. Supp. 2d 216, 220 (N.D.N.Y. 2010).

liability insurance policy issued by defendants. Lloyd's argued that Crucible's loss did not exceed the limits of the underlying primary and first-layer excess policies, and thus there was no coverage.[67]

The parties disagreed as to whether New York or Pennsylvania law governed their dispute.[68] Lloyd's asserted that New York law applied, and under the allocation principles set forth in *Consolidated Edison Co. of N.Y., Inc. v. Allstate Insurance Co.*,[69] Crucible's loss should be prorated evenly across all implicated policy periods with each insurer bearing responsibility based upon their "time on the risk."[70] Crucible argued that Pennsylvania law, which rejected the time on the risk allocation formula, should be applied.[71]

The court held that New York law applied, and under the allocation methodology set forth in *Consolidated Edison*, the plaintiff's loss did not trigger the coverage provided by Lloyd's excess policy.[72] Specifically, the court noted that even the most "conservative" interpretation of Crucible's liabilities resulted in thirteen policy periods being triggered, and that after dividing Crucible's highest projection of damages across this period, the attachment point of the Lloyd's policy would not be reached.[73]

Likewise, in *Boston Gas Co. v. Century Indemnity Co.*,[74] the First Circuit certified the following allocation questions to the Supreme Judicial Court of Massachusetts:

1. Where an insured covered by standard CGL policy language incurs loss as a result of ongoing environmental contamination occurring over more than one policy period, and the insurer provided coverage for less than the full period of years in which contamination occurred, should the insured's loss be prorated in some manner among all insurers on the risk?

2. If some form of pro rata method is called for under such circumstances, what allocation formula should be employed?[75]

The insured, Boston Gas Company, was covered by certain CGL policies for the policy periods of December 1, 1951, through December 1, 1969, as well as three different first-layer excess policies issued by Century Indemnity Company.[76] The policies provided coverage for property

67. *Id.* at 231–32.
68. *Id.* at 224–26.
69. 98 N.Y.2d 208 (2002).
70. *Crucible*, 681 F. Supp. 2d at 226.
71. *Id.*
72. *Id.* at 230–32.
73. *Id.* at 231–32.
74. 910 N.E.2d 290, 292 (Mass. 2009).
75. *Id.* at 292–93 (paraphrasing).
76. *Id.* at 294–95.

damage caused by an occurrence, subject to the exhaustion of certain self-insured retentions.[77] Occurrence was further defined as an "accident" that happened during the policy period or resulted in property damage during the policy period.[78] Moreover, the policies provided that "all damages arising out of such exposure to substantially the same general conditions shall be considered as arising out of one occurrence."[79]

Boston Gas sought indemnification from Century for costs associated with the investigation and cleanup of contaminated soils and groundwater at facilities operated by Boston Gas.[80] After it filed a declaratory judgment action, Century counterclaimed and brought third-party claims against other Boston Gas insurers that provided coverage during the relevant periods.[81] The jury found that Century was obligated to indemnify Boston Gas for certain amounts incurred in the investigation and cleanup of the environmental contamination.[82]

The parties disagreed as to how the amounts owed to Boston Gas should be allocated among the various insurers whose policies had been triggered.[83] Boston Gas argued that a "joint and several" allocation methodology should be applied under Massachusetts law, such that Boston Gas could recover the entire damages award from Century; Century would then be entitled to seek contribution from other insurers that provided coverage during the relevant periods.[84] By contrast, Century argued that a pro rata allocation based on each insurer's time on the risk should be applied.[85]

The court agreed with Century, holding that a pro rata allocation based upon each insurer's "time on the risk" was required by the language of the policies at issue, since those policies only provided coverage for property damage that occurred "during the policy period," not before or after a relevant period.[86] The court noted that the phrase "during the policy" period was a limiting one, both with respect to trigger of coverage and Century's indemnity obligations.[87] Because Boston Gas did not present any evidence illustrating that property damage occurred any more or less in a specific policy year, the court found that the time-on-the-risk method of apportionment was appropriate.[88] However, the court stated that a differ-

77. *Id.* at 295–96.
78. *Id.*
79. *Id.* at 295.
80. *Id.* at 296.
81. *Id.*
82. *Id.* at 297.
83. *Id.*
84. *Id.*
85. *Id.*
86. *Id.* at 306–07.
87. *Id.* at 307.
88. *Id.* at 314.

ent method of pro rata allocation may be applied in cases where a party can establish a more accurate loss allocation.[89]

Moreover, the court found that Boston Gas was required to satisfy "only a prorated amount of its per occurrence self-insured retention for each triggered policy period, to be prorated on the same basis as Century's liability."[90] The court characterized this portion of its holding as an "equitable result," since the policy language at issue did not clearly or unambiguously provide how the self-insured retentions should be calculated where multiple policy periods were implicated by a claim.[91] Notably, in certain jurisdictions, such as New York and New Jersey, courts examining similar policy language have held that an insured cannot prorate its deductible or self-insured retention obligations.[92]

II. SURPLUS LINES INSURANCE

On July 21, 2010, President Barack Obama signed the Dodd-Frank Wall Street Reform and Consumer Protection Act.[93] This new law will bring numerous changes to the regulation of financial services in the United States. Within this 2,319 page bill, eight pages—entitled the Nonadmitted and Reinsurance Reform Act (NRRA)—affect excess and surplus lines insurance and reinsurance. The provisions of the NRRA are designed to bring about efficiencies in the manner in which excess and surplus lines insurance transactions are taxed and regulated. They also define which state has regulatory authority to oversee the solvency of a reinsurer and to recognize the credit for reinsurance of a ceding company.

The common concept embedded in the surplus lines/nonadmitted insurance and reinsurance provisions of the bill is that of *one state* regulation. Under the NRRA, the home state of the insured is the only state that can regulate and tax surplus lines/nonadmitted insurance transactions.[94] Additionally, only *one state*, the reinsurer's state of domicile, can regulate a reinsurer for solvency.[95] And if an insurer's state of domicile has recognized credit for reinsurance, no other state can deny the insurer the credit for

89. *Id*. at 315–16.
90. *Id*.
91. *Id*. at 316.
92. *See, e.g.*, Olin Corp. v. Ins. Co. of N. Am., 221 F.3d 307, 328 (2d Cir. 2000) (applying New York law); Long Island Lighting Co. v. Allianz Underwriters Ins. Co., No. 604715/97, at *8 (Sup. Ct., N.Y. Cty Dec. 30, 2003), *modified on other grounds*, 1006A 6 Misc. 3d (Jan. 11, 2005) (same); Benjamin Moore & Co. v. Aetna Cas. & Surety Co., 179 N.J. 87 (2004).
93. H.R. 4173, 111th Cong. (2010), Pub. L. No. 111–203, 124 Stat. 1376 (2010) (codified at 12 U.S.C.A. § 5301, *et. seq*.).
94. 15 U.S.C.A. § 8201(a); 8202(a) (Home State Authority).
95. 15 U.S.C.A. § 8222(a) (Domiciliary State Regulation).

the reinsurance.[96] This one state approach seeks to eliminate the current overlapping, multiplicative, inconsistent, and sometimes conflicting rules among the states in regard to surplus lines/nonadmitted placements and regulation of reinsurers and reinsurance transactions.

Through the NRRA, the U.S. Congress created a new regulatory framework for the excess and surplus lines insurance and the reinsurance businesses. In regard to excess and surplus lines insurance transactions, the NRRA:

(1) Gives sole regulatory and enforcement authority to the home state of the insured for the placement[97] and taxation[98] of surplus lines/nonadmitted insurance. The bill defines the home state of the insured as the state of the insured's principal place of business, or, if it is an individual, the state where the individual's principal residence is located;[99]
(2) Provides a structure for creating a uniform system to collect, allocate, and distribute a surplus lines/nonadmitted premium tax among the states;[100]
(3) Establishes uniform eligibility requirements for U.S.-based (domestic) surplus lines insurers by applying two provisions of the National Association of Insurance Commissioners' (NAIC) Model Nonadmitted Insurance Act;[101]
(4) Prohibits states from preventing surplus lines licensees from placing or procuring insurance from an alien insurer that is listed on the NAIC International Insurance Department's *Quarterly Listing of Alien Insurers*;[102]
(5) Allows a large, sophisticated commercial buyer of insurance or an "exempt commercial purchaser"[103] to have its insurance placed directly in the surplus lines market without a "diligent search" of the licensed market being performed;[104]
(6) Expresses a congressional intent that the states establish uniformity in the payment, collection and remittance of surplus lines premium tax through the establishment of an interstate compact or other similar procedure; and[105]

96. 15 U.S.C.A. § 8221(a) (Credit for Reinsurance).
97. 15 U.S.C.A. § 8202(a) (Home State Authority).
98. 15 U.S.C.A. § 8201(a) (Home State's Exclusive Authority).
99. 15 U.S.C.A. § 8206(6((A)(i) (Home State).
100. 15 U.S.C.A. § 8201(b) (Allocation of Nonadmitted Premium Taxes).
101. 15 U.S.C.A. § 8204 (Uniform Standards for Surplus Lines Eligibility).
102. *Id.*
103. 15 U.S.C.A. § 8206(5) (Exempt Commercial Purchaser).
104. 15 U.S.C.A. § 8205 (Streamlined Application for Commercial Purchasers).
105. 15 U.S.C.A. § 8201(b) (Allocation of Nonadmitted Premium Taxes).

(7) Encourages each state to participate in the NAIC national producer database or another national database in the licensing of excess and surplus lines brokers. The NRRA fosters this participation by prohibiting the states from collecting any licensing fee in the licensing of an excess or surplus lines broker or in renewing an excess or surplus lines broker's license after July 21, 2012, unless the state participates in a national producer database.[106]

The surplus lines reforms are a direct result of an industry effort to simplify and rationalize the surplus lines premium tax allocation and payment procedures. For years, the surplus lines industry was plagued with conflicting, inconsistent, and confusing tax allocation formulas and payment procedures in and among the various states. Except for the last requirement, which becomes effective on July 21, 2012,[107] the provisions of the Act take effect on July 21, 2011, one year from the day the bill was signed by the president.[108]

The NRRA gave the states one year from the date of enactment to change their surplus lines laws to bring them into conformance with its provisions. To do this by July 21, 2011, states must amend their surplus lines laws to:

(1) Require a tax payment on the surplus lines premium[109] that may either be on the "gross" premium or on the portion of the premium representing the surplus lines exposure in the state;
(2) Apply the required surplus lines premium tax only when the state is the home state of the insured as defined in the Act;[110]
(3) Allow the state, if it is the home state of the insured, to license surplus lines brokers to sell, solicit, or negotiate surplus lines insurance with respect to such insureds;[111]
(4) Establish eligibility requirements for U.S.-based surplus lines insurers that are consistent with two provisions, §§ 5A(2) and 5C(2)(a), of the NAIC Nonadmitted Model Act.[112] These provisions require that: (1) each insurer is authorized to write the type of insurance (it wishes to write on a surplus lines basis) in its domiciliary jurisdiction; and (2) meet capitalization requirements consisting of the greater of: (a) $15 million in capital and surplus; (b) the state's own capitalization requirements for surplus lines insurers; or (c) other stated

106. 15 U.S.C.A. § 8203 (Participation in National Producer Database).
107. *Id.*
108. 15 U.S.C.A. § 8201. note: Effective date upon expiration of the 12-month period beginning on 7/21/10 (Effective Date).
109. 15 U.S.C.A. § 8201(a) (Home State's Exclusive Authority).
110. *Id.*
111. 15 U.S.C.A. § 8202(b) (Broker Licensing).
112. 15 U.S.C.A. § 8204(1) (Uniform Standards for Surplus Lines Eligibility).

levels of capitalization.[113] Two states, California and New York, have recently moved to increase in their capitalization requirement for surplus lines insurer eligibility to $45 million;

(5) Prohibit the state from preventing a licensed surplus lines broker from placing insurance with an alien insurer listed on the NAIC International Insurance Division's *Quarterly Listing of Alien Insurers*.

(6) Incorporate the definitions of an "Exempt Commercial Purchaser"[114] and "Qualified Risk Manager"[115] as set forth in the NRRA in the state surplus lines code to enable surplus lines brokers to place insurance for "Exempt Commercial Purchasers" in the surplus lines market without having to fulfill a "diligent search" requirement;[116]

(7) Either participate in an interstate compact or establish procedures of a similar nature to allocate and distribute the surplus lines tax to other states when appropriate.[117] Congress expressed its intent in the NRRA for "each state to establish nationwide uniform requirements, forms and procedures, such as an interstate compact, that provide for the reporting, payment, allocation and collection" of surplus lines premium taxes; and[118]

(8) Have the state participate in the NAIC producer database or some other national insurer producer database for the licensure and renewal of surplus lines broker licenses or forego collection of any licensing fees for the licensing of surplus lines brokers.[119] The effective date of this provision is two years from the enactment of the bill.[120] Thus, each state must participate in a national producer database by July 21, 2012, or will be preempted from charging surplus lines licensing and licensing renewal fees.

Although the NRRA requirements are mandatory for the states, one provision of the NRRA reflects Congress's "intention" that each state adopt "nationwide uniform requirements, forms and procedures such as an interstate compact that provides for reporting, payment, collection and allocation of premium taxes for nonadmitted/surplus lines insurance."[121] Since the passage of the NRRA, the fulfillment of congressional intention has been the focus of most of the post-NRRA enactment activity. In fact, even before the NRRA was passed, efforts to create an interstate compact

113. Model Act § 5C(2)(a) (Uniform Standards for Surplus Lines Eligibility).
114. 15 U.S.C.A. § 8206(5) (Exempt Commercial Purchaser).
115. 15 U.S.C.A. § 8206(13) (Qualified Risk Manager).
116. 15 U.S.C.A. § 8205 (Streamlined Application for Commercial Purchasers).
117. 15 U.S.C.A. § 8201(b) (Allocation of Nonadmitted Premium Taxes).
118. 15 U.S.C.A. § 8201(b)(4) (Nationwide System).
119. 15 U.S.C.A. § 8203 (Participation in National Producer Database).
120. *Id.*
121. *Id.*

for surplus lines tax allocation and distribution had received a great deal of attention.[122]

Whether the states can amend their laws to become compliant with the NRRA and implement a compact or agreement to share revenue on multistate surplus lines transactions by July 21, 2011, is questionable, as it is seemingly a herculean task. The first half of 2011 will be very interesting as the states wrestle with becoming NRRA compliant. In any event, things will change in the taxation and regulation of surplus lines and reinsurance as a result of NRRA's passage.

III. RECENT DEVELOPMENTS IN REINSURANCE LAW

A. *Regulatory Developments*

The Dodd-Frank Wall Street Reform and Consumer Protection Act[123] launched a variety of initiatives in response to the nation's financial crisis, but it did not reshape the insurance industry as dramatically as some may have initially predicted. Rather, it created a foundation from which increased regulation could later emerge, should the political and economic climate support such change. The provisions of interest to the reinsurance industry are discussed briefly below.

Title V of the Dodd-Frank Act created a Federal Insurance Office (FIO) within the Department of the Treasury. The Act expressly reserves the regulation of the insurance industry to the states,[124] but it vests the FIO with multiple monitoring and consultation functions.[125] Those functions are aimed at monitoring risks that could pose a "systemic crisis in the insurance industry or the United States financial system,"[126] monitoring the pricing and accessibility of insurance products,[127] and consulting with state regulators,[128] among other activities. In performing these functions, the FIO is permitted to require insurers and reinsurers[129] to submit "data or information as the Office may reasonably require."[130] To that end, the FIO is vested with subpoena power to enforce its data collection efforts.[131]

122. Arthur D. Postal, *Surplus Lines Compact Drafted*, PropertyCasualty360.com, Oct. 1, 2007, *available at* http://www.property-casualty.com/News/2007/10/Pages/Surplus-Lines-Compact-Drafted.aspx.

123. Pub. L. No. 111–203, 124 Stat. 1376 (2010) (codified at 12 U.S.C.A. § 530 *et. seq*.).

124. 31 U.S.C.A. § 313(k) (Retention of Existing State Regulatory Authority).

125. 31 U.S.C.A. § 313(c) (Functions).

126. 31 U.S.C.A. § 313(c)(1)(A).

127. *Id*.

128. 31 U.S.C.A. § 313(c)(1)(G).

129. 31 U.S.C.A. § 313(c)(1)(E)(2) (defining "insurers" to include "reinsurers" for purposes of this provision).

130. 31 U.S.C.A. § 313(e)(2).

131. 31 U.S.C.A. § 313(e)(6) (Subpoenas and Enforcement). Part of the FIO's directive involves generating certain reports on the insurance industry to be provided to Congress.

The provisions defining the role of the FIO also touch on the longstanding issue of the differential treatment often accorded foreign insurers and reinsurers doing business in the United States. For example, certain limited preemption provisions are triggered where a state insurance measure results in "less favorable treatment of a non-U.S. insurer domiciled in a foreign jurisdiction that is subject to a covered agreement than a U.S. insurer domiciled, licensed, or otherwise admitted in that State" and where such measure is "inconsistent with a covered agreement."[132] Additionally, although a "savings clause" seeks to guard against federal preemption of many state insurance measures, those measures governing the capital or solvency of an insurer that result in less favorable treatment of a non-U.S. insurer than a U.S. insurer are specifically *not* protected from preemption.[133]

Section 511 of the Dodd-Frank Act contains the much-anticipated Nonadmitted and Reinsurance Reform Act of 2010. The reinsurance provisions are not extensive, but they do address issues regarding credit for reinsurance and reinsurer solvency concerns. Specifically, if a ceding insurer is domiciled in an NAIC-accredited state or a state that has "financial solvency requirements substantially similar to the requirements necessary for NAIC accreditation, and recognizes credit for reinsurance for the insurer's ceded risk, then no other State may deny such credit for reinsurance."[134] Additionally, certain key preemption provisions apply as follows:

> (b) ADDITIONAL PREEMPTION OF EXTRATERRITORIAL APPLICATION OF STATE LAW.—In addition to the application of subsection (a) all laws, regulations, provisions, or other actions of a State that is not the domiciliary State of the ceding insurer, except those with respect to taxes and assessments on insurance companies or insurance income, are preempted to the extent that they—
>
> (1) restrict or eliminate the rights of the ceding insurer or the assuming insurer to resolve disputes pursuant to contractual arbitration to the extent such contractual provision is not inconsistent with the provisions of title 9, U.S. Code;

Of particular interest will be the forthcoming report, due no later than September 30, 2012, on the "breadth and scope of the global reinsurance market and the critical role such market plays in supporting insurance in the United States." *Id.* § 313(k). Additionally, the Act requires a report no later than January 1, 2013, regarding "the impact of part II of the Nonadmitted and Reinsurance Reform Act of 2010 on the ability of state regulators to access reinsurance information for regulated companies in their jurisdictions." *Id.*

132. 31 U.S.C. § 313(f) (Preemption of State Insurance Measures). Generally speaking, a "covered agreement" is defined as a treaty between the United States and a foreign government regarding the business of insurance or reinsurance "that achieves a level of protection for insurance or reinsurance consumers that is substantially equivalent to the level of protection achieved under State insurance or reinsurance regulation." 124 Stat. 1587.

133. 31 U.S.C. § 313(j).

134. 15 U.S.C.S. § 8221(a) (Credit for Reinsurance).

(2) require that a certain State's law shall govern the reinsurance contract, disputes arising from the reinsurance contract, or requirements of the reinsurance contract;

(3) attempt to enforce a reinsurance contract on terms different than those set forth in the reinsurance contract, to the extent that the terms are not inconsistent with this part; or

(4) otherwise apply the laws of the State to reinsurance agreements of ceding insurers not domiciled in that State.[135]

Although the cedent's domicile governs credit for reinsurance, a reinsurer's domicile is "solely responsible for regulating the financial solvency of the reinsurer."[136] As with the credit for reinsurance framework, the Act preempts the application of laws of other nondomiciliary states laws with respect to the disclosure of financial information, mandating only that the reinsurer be in compliance with the requirements of its own domicile.[137]

B. *Case Law Developments*

In addition to witnessing the landmark federal legislation discussed above, last year saw the continued development of reinsurance case law addressing a variety of issues, including the follow-the-fortunes/follow-the-settlements doctrine, the ability of a policyholder to bring a direct action against a reinsurer, the duties and potential liability of reinsurance intermediaries, the ability of a policyholder to seek access to its insurer's reinsurance information, and general contract analysis of reinsurance-specific terms.[138] It also witnessed numerous arbitration decisions of particular importance to the reinsurance industry. The following summary highlights key decisions in many of these areas.

1. Follow-the-Fortunes/Follow-the-Settlements Doctrine

The limits of the follow-the-fortunes/follow-the-settlements doctrine continued to be tested over the last year, as reflected in case law across multiple jurisdictions. Although courts generally did not allow a reinsurer

135. *Id.*

136. 15 U.S.C.S. § 8222(a) (Domiciliary State Regulation).

137. 15 U.S.C.S. § 8222(b) (Limitation on Financial Information Requirements).

138. *See, e.g.*, Pac. Emp'rs Ins. Co. v. Global Reins. Corp., No. 09–6055, 2010 WL 1659760, *1 (E.D. Pa. Apr. 23, 2010) (analyzing language in a facultative certificate purportedly capping reinsurer's exposure); Ohio Ins. Co. v. Emp'rs Reins. Corp., 694 F. Supp. 2d 794, 800–01 (S.D. Ohio 2010) (interpreting agreements to determine whether a cedent's payments of prejudgment and post-judgment interest and legal expenses were covered by a reinsurance agreement); Gulf Ins. Co. v. Transatl. Reins. Co., 886 N.Y.S.2d 133, 137–38 (N.Y. App. Div. 2009) (interpreting the phrases, "net retained insurance liability" and "policies attaching during the term," and analyzing a variety of extrinsic evidence offered by the parties regarding same).

to second guess good faith, reasonable settlement decisions of a cedent, they did not universally hold in favor of cedents. Rather, courts limited the application of follow-the-settlements clauses to those settlements that were clearly covered by reinsurance agreements. Where settlements were inconsistent with the terms of the cedent's underlying policy, courts generally did not enforce follow-the-settlements provisions. Several significant decisions are discussed below.

In *Travelers Casualty & Surety Co. v. Insurance Co. of North America*, the Third Circuit affirmed a district court's ruling that the follow-the-fortunes doctrine obligated a reinsurer to pay its portion of a $137 million settlement, but only as to that portion of the settlement within the limits of the policies the reinsurer agreed to cover.[139] At issue were allegations that Travelers had allocated settlement amounts in order to maximize its reinsurance coverage.[140] Specifically, Insurance Company of North America (INA), the reinsurer, argued that Travelers: (1) manipulated its allocation of a settlement to reach the layer of insurance that INA reinsured; and (2) improperly treated a three-year policy as subject to three separate per occurrence limits, as opposed to a single per occurrence limit.[141] The Third Circuit explained that it would apply the majority rule that the follow-the-fortunes doctrine applies to post-settlement allocations.[142] It further explained that, for a reinsurer to prevail in contesting those allocations, it "must either provide direct evidence that the insurer was motivated primarily by reinsurance considerations, or show that the after-the-fact rationales offered by the insurer are not credible."[143]

On the first issue, whether Travelers had improperly manipulated its allocation to reach the excess layer, INA argued that Travelers' allocation decisions were motivated solely by reinsurance considerations and therefore were made in bad faith. Specifically, INA argued that Travelers: (1) improperly bypassed certain policies in allocating the settlement; (2) failed to conduct a detailed analysis of a certain category of claims; (3) improperly allocated to indemnity only, not defense; and (4) utilized a legal memorandum that addressed the reinsurance implications of certain coverage deci-

139. 609 F.3d 143, 148 (3d Cir. 2010). The court also addressed the district court's conclusion that prejudgment interest on the award should be calculated according to the Pennsylvania rate. *Id.* The Third Circuit disagreed, stating "[h]owever, because we believe that Travelers' award of prejudgment interest should be calculated according to the higher New York rate, we remand on that issue only so that the prejudgment interest can be recalculated." *Id.*

140. *Id.*

141. *Id.* at 155–56.

142. *Id.* at 158.

143. *Id.* at 159.

sions.[144] The Third Circuit disagreed and held that INA failed to "meet its burden at trial of showing that the allocation decisions it was challenging were driven primarily by reinsurance considerations."[145] The court concluded that Travelers' decisions were reasonable in light of the net nature of the settlement and the other evidence presented at trial.[146]

As to the second issue, whether Travelers improperly applied per occurrence limits on each year of multiyear policies, the Third Circuit agreed with INA. INA argued that the follow-the-fortunes doctrine was inapplicable because Travelers' allocation decision with regard to multiyear policies improperly "enlarged the limits of those policies beyond what INA agreed to reinsure."[147] The district court concluded that "'under Michigan law the three-year XN policies clearly and unambiguously have a single per-occurrence limit for the entire policy period.'"[148] On appeal, Travelers did not challenge the district court's interpretation of the policies.[149] Rather, Travelers argued that, regardless of the current state of Michigan law, INA could be bound because the Michigan courts had not unequivocally addressed the issue of per occurrence limits when the allocation was made. Therefore, Travelers' approach was arguably authorized by the underlying policies.[150] The Third Circuit rejected this argument, finding it unsupported by Third Circuit precedent.[151] Further, the court found no evidence in the record indicating that it was reasonable for Travelers to expect that, had the coverage dispute been litigated, the insured would have successfully pressed the annualization issue.[152]

In another analysis of the follow-the-settlements doctrine, a New York trial court granted summary judgment to a cedent because it found no evidence that the cedent acted in bad faith, and any further inquiry would de-

144. *Id*. INA also argued that the district court's order should be vacated because the court based its ruling on evidence that should have been excluded. *Id*. at 164 ("INA's argument is that, because Travelers invoked the attorney-client and work-product privileges to shield the substance of [lawyer] consultations, it should not have been allowed to defend its conduct with reference to those consultations."). The Third Circuit rejected this argument because the district court's ruling did not depend on the inferences. *Id*. Therefore, it was unnecessary for the Third Circuit to reach the merits on this issue. *Id*.

145. *Id*. at 165.

146. *Id*. at 161–64.

147. *Id*. at 165.

148. *Id*. at 166–67 (quoting J.A. at 95 (unpublished district court opinion)).

149. *Id*. at 167.

150. *Id*.

151. *Id*. at 168–69.

152. *Id*. ("In sum, Travelers has pointed to nothing in the policy language, its prior assessments of its potential liability, or its interactions with Acme to indicate that, when it performed its allocation, it was reasonable to expect that, had the coverage dispute been litigated, Acme could have successfully pressed the annualization issue against it, or even that it would have had any reason to do so.").

feat the purpose of the follow-the-settlements doctrine.[153] The treaties at issue covered a large group of asbestos risks that U.S. Fidelity & Guaranty Company (USF&G) insured and settled in a coverage action.[154] American Re-Insurance Company, among other reinsurers, declined to indemnify USF&G for the settlements in the amounts required by its treaty language.

Specifically, American Re sought a declaratory judgment that its reinsurance liability was limited to: "(i) amounts over $100,000 and up to $200,000 of USF&G's money paid to each claimant; (ii) who USF&G [could] prove was exposed to asbestos before July 1960; and (iii) who USF&G [could] prove was exposed to the asbestos products or operations of its insured."[155] Further, American Re sought to avoid payments of attorneys fees as well as the administrative expenses associated with the trust that ensured proper payments to the claimants.[156] The court rejected American Re's claims because it found no evidence that USF&G settled in bad faith, and therefore, the follow-the-settlements doctrine prohibited American Re from relitigating coverage issues.[157]

Additionally, other reinsurers challenged USF&G's settlements on several grounds.[158] They contended that USF&G improperly allocated reinsurance amounts to them based on a continuous occurrence trigger when USF&G had received the benefit of an accident trigger from its insured.[159] The court disagreed, concluding that USF&G's allocation was entirely proper, and nothing in the follow-the-settlements rule dictated a different result.[160] The other reinsurers also asserted that the asbestos claims should be treated as one loss under the treaty, but the court rejected that claim as inconsistent with the underlying settlement and governing law.[161]

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153. U.S. Fid. & Guar. Co. v. Am. Re-Ins. Co., No. 604517/02, 2010 WL 3536828 (N.Y. Sup. Ct. Aug. 20, 2010).

154. *Id*. at 1–3.

155. *Id*. at 9.

156. *Id*. at 10.

157. *Id*. at 11–13. The court also rejected similar claims from other reinsurers, stating:

> Here, again, while the . . . defendants may challenge USF&G's good faith in settling the underlying action, and whether the settlement payments made by USF&G were ex gratia, or outside the scope of the underlying policy, the follow-the-fortunes doctrine prevents them from challenging the actual disbursement of funds to various claimants.

Id. at 23–24.

158. In addition to the issues noted above, the other reinsurers argued that their coverage should be limited because the parties had agreed to amend the reinsurance amendments to include a greater retention for USF&G. *Id*. at 16–21. The court rejected this contention. *Id*. Finally, the reinsurers attempted to avoid liability on a portion of the settlement amount they alleged was attributable to a bad faith claim. *Id*. at 21–22. The court also rejected this contention, stating "[n]or have the . . . defendants presented any further evidence that a portion of the settlement amount was attributable to . . . [a] bad faith claim." *Id*. at 22.

159. *Id*. at 13.

160. *Id*. at 13–16.

161. *Id*. at 25. The court explained:

In a different matter, another New York trial court declined to apply a follow-the-settlements provision upon finding that the cedent had settled claims outside the bounds of the policy.[162] There, the cedent entered into a settlement agreement with its insured regarding certain third-party claims arising from environmental contamination.[163] The reinsurer declined to cover the claims because the settlement included monies paid for items that were well outside the policy terms.[164] The court found that, in evaluating the claims at issue, the cedent improperly focused on the terms of a prior settlement agreement with its insured, as opposed to the terms of the policies.[165] Accordingly, the court held that the reinsurer was not bound to follow-the-settlements.[166]

Similarly, a federal district court in Connecticut declined to allow a cedent to use a follow-the-fortunes clause to recover from the reinsurer because the losses occurred beyond the time frame of the reinsurance agreement.[167] In that case, however, the court focused on whether the claim was within the coverage of the reinsurance agreement, as opposed to the underlying agreement.[168] The cedent argued that the settlement should be covered pursuant to the following follow-the-fortunes provision: "all reinsurance under this agreement shall be subject to . . . the same modifications, alterations and interpretations the respective policies of the REINSURED . . . and the liability of the [reinsurer] shall follow that of the REINSURED in every case."[169] The cedent argued that this provision

> This manner of allocating the loss is, as already noted, contrary to the manner in which the Underlying Coverage Action was settled because each asbestos claimant therein was considered a separate accident or occurrence. Further, under both New York and California law, each asbestos-related injury is considered a separate 'occurrence' or 'accident' since each claimant is separately exposed to asbestos at different points in time.

Id. (citations omitted).

162. Am. Home Assurance Co. v. Am. Re-Ins. Co., No. 602485/06, slip op. at 7 (N.Y. Sup. Ct. May 24, 2010) ("[T]he reinsurers have demonstrated that the 2004 Billings call for payments beyond the scope of coverage provided by the Policies, and thus, they are not bound to AIG's settlement of the Anniston Site claims under the follow the settlements doctrine.").

163. *Id*. at 1–5.

164. The settlement amounts covered punitive damages, environmental damage that would have been excluded by the pollution exclusion, losses outside the policy periods, and losses paid before the insured exhausted its self-insured retention. *Id*. at 9–14.

165. *Id*. at 11–12.

166. *Id*. at 14 ("[T]he Reinsurers have demonstrated that the 2004 Billings, that stem from the settlement of the Anniston Site claims, are not payments made within the scope of the Policies, and that AIG failed to conduct a reasonable investigation as to coverage, to which AIG fails to raise a triable issue in opposition. Therefore, the Court determines that the Reinsurers are not bound to follow AIG's settlement of the Anniston Site claims.").

167. Arrowood Surplus Lines Ins. Co. v. Westport Ins. Corp., No. 3:08CV01393 (AWT), 2010 WL 56108, at *4 (D. Conn. Jan. 5, 2010).

168. *Id*. at *3. The losses occurred between December 15, 2000, and December 15, 2002, but the reinsurance agreement only covered policies in effect between February 1999 and August 2000. *Id*. at *1–3.

169. *Id*. at *3. (alterations omitted).

should apply because "its settlement with the insured was based on the risk that the court hearing [the insured's] claims against it would 'modify' the policies [the cedent] issued to be three-year policies."[170] The court rejected this argument because, even if the policy was modified to a three-year term, it would not have come under the terms of the reinsurance agreement, as the agreement was terminated in August 2000 and multiyear policies "'became effective'" at each anniversary date of the policy.[171] The second anniversary date of the policy would have postdated the terms of the reinsurance agreement, and therefore, could not have been covered.[172]

2. Direct Actions and Third-Party Rights

Courts also addressed another common reinsurance topic this year: direct actions and third-party rights. In what appears to be a growing trend, many of these claims arose where one of the parties was in liquidation or receivership. Even in cases of insolvency, however, most courts declined to permit direct actions against reinsurers. Outside the context of insolvency, one federal district court permitted a direct action where the company's status as a reinsurer was ambiguous. Cases of particular interest are addressed below.

The Third Circuit addressed an interesting direct action issue in *G-I Holdings, Inc. v. Reliance Insurance Co*.[173] There, G-I Holdings, Inc. obtained from Reliance Insurance Co. a liability policy covering claims made against G-I directors and officers between July 1, 1999, and July 1, 2002.[174] Reliance, however, experienced financial difficulties and terminated the directors and officers policy as of July 15, 2000, with Hartford covering the remainder of Reliance's original policy period.[175] Additionally, Hartford and Reliance entered into a series of reinsurance agreements, among other agreements, pertaining to the risks covered during the remaining Reliance policy period.[176]

Director and officer claims later arose, which related back to January 3, 2000, a date within Reliance's shortened policy period.[177] Nonetheless, G-I sought coverage from Hartford for the suits, asserting, among other reasons, that the reinsurance relationship between Hartford and Reliance was sufficiently close to allow G-I to bring a direct action against Hartford.[178]

170. *Id*.
171. *Id*. at *4.
172. *Id*.
173. 586 F.3d 247, 251 (3d Cir. 2009).
174. *Id*.
175. *Id*. at 251–52.
176. *Id*. at 250–52.
177. *Id*.
178. *Id*. at 253, 258–60.

The Third Circuit rejected G-I's arguments.[179] The court reasoned that Hartford's reinsurance relationship with Reliance did not entitle G-I to bring a direct action against it because Hartford did not exercise a significant level of control over Reliance, nor were there any allegations that the Reliance agreement was a fronting policy.[180]

A Missouri appellate court also addressed direct action issues with insolvency.[181] In *J.C. Penney Life Insurance Co. v. Transit Casualty Co.*, the reinsurer had entered into receivership, and the cedent sought to obtain higher priority in the dissolution proceedings, as claim payments receive higher priority under Missouri law.[182] The cedent, therefore, attempted to categorize the agreement between the parties as permitting a direct right of action by the policyholders against the reinsurer.[183] The cedent argued that a direct action right existed because the reinsurer had accepted 100 percent liability on the policies as well as responsibility for investigating, defending, and adjusting claims.[184]

The court rejected the cedent's contentions on multiple grounds. First, the court reasoned that policyholders were not third-party beneficiaries of the reinsurance agreement at issue because the reinsurer had not agreed to deal directly with the policyholders.[185] Second, the reinsurer had not agreed to service and handle the reinsured policies.[186] Third, the agreement at issue did not contain any reference to direct actions.[187] In short, the agreement at issue did not contain sufficient evidence to demonstrate that it was anything other than an indemnity reinsurance agreement, which could not be prioritized.[188]

A Pennsylvania trial court also addressed a case this year regarding third-party rights with respect to reinsurance agreements and insolvency.[189] At issue in *General Reinsurance Corp. v. American Bankers Insurance Co. of Flor-*

179. *Id.* at 258 ("Contrary to what G-I argues, however, none of those agreements creates direct liability of Hartford for the amended Reliance policy.").

180. *Id.* at 259–60.

181. J.C. Penney Life Ins. Co. v. Transit Cas. Co., 299 S.W.3d 668, 670 (Mo. Ct. App. 2009).

182. *Id.* at 670–71.

183. *Id.* at 673–76.

184. *Id.* at 674.

185. *Id.* at 674–75.

186. *Id.* In contrast, in *O'Hare v. Pursell*, 329, S.W.2d 614, 621–22 (Mo. 1959), a case relied upon by the court, the reinsurer had agreed to service and handle all policies and to deal directly with the original insureds in good faith. *Transit Cas. Co.*, 299 S.W.3d at 675.

187. *Id.* at 674–75.

188. *Id.* at 676 ("[W]e agree with the special master's finding that it is a contract for reinsurance, and not an insurance contract, because it does not directly and clearly create third-party liability.").

189. Gen. Reins. Corp. v. Am. Bankers Ins. Co., 996 A.2d 26, 28 (Pa. Commw. Ct. 2010).

ida was whether an insolvent cedent's liquidator or a governmental third party, the Mississippi Insurance Guaranty Association (MIGA), was entitled to certain reinsurance proceeds from a terminated reinsurance agreement.[190] The court held that the liquidator was entitled to the reinsurance proceeds.[191]

The liquidator asserted that MIGA was not entitled to the reinsurance proceeds because, among other reasons,[192] MIGA was not entitled to assert third-party beneficiary rights as to the proceeds of the reinsurance agreements.[193] MIGA argued that the Mississippi Code authorized it to act as a policyholder with respect to the reinsurance agreement, which, in turn, permitted it to assert third-party beneficiary rights to the reinsurance agreements.[194] The court rejected this argument at the threshold because no statute assigned MIGA rights with regard to reinsurance agreements.[195] Nonetheless, the court addressed the substance of MIGA's third-party beneficiary argument.[196]

The court recognized "[t]he general rule that reinsurance recoveries are general assets of the estate,"[197] but that, "where a policyholder can assert third-party beneficiary rights to reinsurance proceeds, the effect is to find those reinsurance proceeds not to be assets of the insolvent insurer estate."[198] This type of recovery, however, is limited to those situations where the reinsurance agreement or other compelling circumstances clearly demonstrate the third-party's right to reinsurance proceeds.[199] Not only were such circumstances not present in this case, but the reinsurance agreement contained explicit language prohibiting third-party beneficiary

190. *Id*.
191. *Id*. at 39.
192. The liquidator also asserted that MIGA was not entitled to recover because: (1) collateral estoppel barred the claim; and (2) no statute entitled MIGA to claim that it was the "insurer" as to the claims. *Id*. at 30. The court rejected the collateral estoppel argument, but agreed with the liquidator on the statutory argument. *Id*. at 32 (concluding that a Mississippi decision did not preclude the court from considering MIGA's claim); *id*. at 36. ("A guaranty fund is the 'insurer' for purposes of claims administration but not for purposes of estate administration, including the pursuit of proceeds to a reinsurance agreement to which the 'insurer' had been a party.").
193. *Id*. at 30; *see also id*. at 36 ("MIGA asserts . . . that it is the statutory successor to every Legion policyholder, or insured, whose . . . claims have been paid by MIGA. As such, MIGA is entitled to assert any third-party beneficiary rights enjoyed by Legion policyholders to the . . . Reinsurance Agreement. Further, MIGA contends that . . . it should be found a third-party beneficiary of the Gen Re Agreements.") (internal citations omitted).
194. *Id*. at 36.
195. *Id*. at 36–37. MIGA only had rights with respect to policies, and, in fact, those rights were limited in scope.
196. *Id*. at 37.
197. *Id*.
198. *Id*. at 38 (citation omitted).
199. *Id*. (citation omitted).

recovery in the event of insolvency.[200] The court concluded that this case did not present unusual circumstances that would warrant departing from the general insolvency procedures or the plain language of the reinsurance agreements.[201] The court focused on the following facts: this arrangement did not involve a fronting agreement; the reinsurance agreement was not facultative; the reinsurer did not assume 100 percent of the risk; and the policyholders were unaware of the reinsurer.[202] Thus, the court concluded that MIGA could not assert third-party beneficiary rights to the reinsurance proceeds.[203]

At least one court, however, permitted an insured to proceed directly against a party asserting to be a reinsurer based on a finding that the insurance contract was ambiguous as to the reinsurer's role under the policy.[204] In *Felman Production v. Industrial Risk Insurers*, Industrial Risk Insurers (IRI), an unincorporated association, issued a policy to Felman Production, Inc. that covered property damage and business interruption losses associated with a metals plant.[205] Felman suffered a loss and sought insurance coverage from IRI as well as two of its member companies.[206]

One of IRI's member companies moved to dismiss, arguing that it could not be held directly liable to Felman because it was a reinsurer, not an insurer, under the contract.[207] In support of this argument, the company pointed to a portion of the policy where it was identified as the reinsurer.[208] Felman, in turn, pointed to the following evidence demonstrating that the company was an insurer: (1) the policy contained signature lines for each of the member companies of IRI; (2) the insurer was referred to as "the Companies" throughout the policy; (3) "the Companies" were defined as the members of IRI applicable to the policy; and (4) the insurer was defined simply as IRI.[209] The court recognized that a reinsurer typically cannot be

200. *Id*. The agreements provided: "[i]n no instance shall any insured of the Company or any claimant against an insured of the Company have any rights under this Agreement," and "[i]n the event of the insolvency of [the cedent], the reinsurance proceeds will be paid to [the cedent] or the liquidator . . ." *Id*. (alteration in original omitted).

201. *Id*. at 38–39.

202. *Id*. at 39.

203. *Id*. ("In short, MIGA has not identified any compelling circumstances of the type identified in *Legion* that would allow the court to find Legion policyholders in Mississippi to be the intended third-party beneficiaries of the 1993 Reinsurance Agreement.").

204. Felman Prod. v. Indus. Risk Insurers, No. 3:09–0481, 2009 WL 3380345, at *2 (S.D.W. Va. Oct. 19, 2009) ("[T]he Court finds that the terms of the original insurance contract are ambiguous as to [the company's] role under the Policy and, thus, that it was reasonable for Felman to expect [the company] to act as a direct insurer and to join [the company] as a defendant in the instant suit.").

205. *Id*. at *1.

206. *Id*.

207. *Id*. at *2.

208. *Id*. at *3.

209. *Id*.

held directly liable to a policyholder.[210] Nonetheless, it found in favor of Felman, because the contract was, "at a minimum, ambiguous as to [the member company's] role" and, therefore, "must . . . be construed against [the member company] and liberally in favor of Felman."[211] Thus, the district court never reached the question of whether an insured could proceed directly against its reinsurer because the contract was unclear as to whether the company was, in fact, a reinsurer.

3. Intermediary Liability

Parties continue to litigate a broker's liability for damages arising out of a breach of its duties in connection with a reinsurance transaction.[212] One opinion from an intermediate New York appellate court is of particular interest. In *American Home Assurance Co. v. Nausch, Hogan & Murray, Inc.*, the court allowed an insurer to proceed against its broker with a contribution claim because the insurer was subject to liability for damages, not purely economic loss, as a result of the broker's actions.[213] More particularly, an arbitration panel had previously adjudicated the rights of the insurer and reinsurer and rescinded a reinsurance contract between the parties because the insurer's broker violated the duty of utmost good faith.[214] The panel had found that the broker breached the duty by trying to "slip one by the reinsurer" regarding a fundamental contract change as well as by failing to disclose a problem about the insurer's data.[215]

The insurer then sued the broker in New York state court seeking indemnity from the broker for the entire repayment to the reinsurers.[216] In the alternative, the insurer sought pro rata contribution from the broker

210. *Id.* at *2 ("Generally, an insured party cannot maintain a direct action against a reinsurer because the insured is neither a party to the reinsurance policy nor in privity therewith.") (citation omitted). The court also recognized two exceptions to the general rule: (1) "A reinsurer may become directly liable to the insured based on the terms of the reinsurance contract[;]" and (2) "A reinsurer may also become directly liable to the insured via conduct; generally by directly handling an insured's claim." *Id.* (citations omitted). The court, however, did not need to address these specific issues as the terms of the insurance contract were ambiguous as to whether the company was, in fact, a reinsurer under the policy.

211. *Id.* at *3.

212. *See, e.g.*, Aldrich v. Marsh & McLennan Co., Inc., 901 N.Y.S.2d 897 (N.Y. Sup. Ct. 2009) (granting, in part, a motion to dismiss as to certain brokers who had previously been released from liability for losses in connection with asbestos claim and failure to disclose critical information regarding reinsurance policies covering same).

213. 897 N.Y.S.2d 413, 413 (N.Y. App. Div. 2010).

214. *Id.* at 415. Surprisingly, few cases addressed the duty of utmost good faith this past year. Another decision of interest is Guarantee Trust Life v. Ins. Admin. Corp., No. 09 C 5129, 2010 WL 3834026, at *3 (N.D. Ill. Sept. 24, 2010) (dismissing claim because Illinois does not recognize a separate cause of action for breach of the duty of utmost good faith).

215. *Aldrich*, 897 N.Y.S.2d at 415 (quotations omitted).

216. *Id.*

to the extent the insurer may have participated in the misrepresentation.[217] The broker moved to dismiss on both causes of action.[218] The court denied the motion on both counts.

The court permitted the indemnity claim to proceed because the record supported a theory that the insurer's liability was vicarious only.[219] As to the contribution claim, the broker argued that it should be dismissed because the rescission claim lay in contract, and a party may not proceed with a contribution claim for purely economic loss.[220] The court disagreed, stating that the broker "ignore[d] the realities of how insurance operates and therefore overlook[ed] that plaintiffs have been subject to liability for damages."[221] The court concluded that the insurer was "not merely deprived of the benefit of their bargain, but have actually had to cover far more of the underlying losses than they would have but for defendants' tortious conduct."[222]

4. Discovery of Reinsurance Information

In the last year, policyholders have continued their quest to gain access to their insurers' reinsurance information, even where the reinsurers have no involvement in the dispute. Although federal courts have often required the disclosure of reinsurance agreements as part of Rule 26(a) initial disclosures,[223] it is the compelled disclosure of communications between cedents and reinsurers that often sparks the most controversy.

The Supreme Court of New York addressed such a case in the context of a declaratory judgment action where a policyholder sought access not only to its insurer's reinsurance agreements, but also to communications between the plaintiff insurers and their reinsurers, which were not parties to the dispute.[224] The policyholder argued that the communications would reveal the insurers' analysis of the risks they were insuring at the time they

217. *Id*.
218. *Id*. at 415–16.
219. *Id*. at 416.
220. *Id*.
221. *Id*.
222. *Id*. at 417 (citations omitted).
223. *See, e.g.*, Hartman v. Am. Red Cross, No. 09–1302, 2010 WL 1882002, *1 (C.D. Ill. May 11, 2010) (recognizing that many federal courts have required the disclosure of reinsurance agreements as part of Rule 26 initial disclosures and mandating their disclosure); Sunnen Prods. Co. v. Travelers Cas. & Sur. Co., No. 4:09CV00889 JCH, 2010 WL 743633, *1 (E.D. Mo. Feb. 25, 2010) (in the context of a discovery hearing addressing a variety of categories of documents on a motion to compel, court ordered production of any reinsurance agreement that would be applicable to the underlying insurance policy at issue in the dispute).
224. Mt. McKinley Ins. Co. v. Corning Inc., No. 602454/2002, slip op. (N.Y. Sup. Ct. Feb. 25, 2010).

issued the underlying policies and their understanding of the policy language at issue. The policyholder further argued it was entitled to know whether the insurers had taken inconsistent positions in communications with their reinsurers.[225]

In rejecting the policyholder's arguments, the New York Supreme Court declined to adopt a per se rule that reinsurance agreements are always relevant. Instead, it found that the policyholder failed "to assert the relevance between reinsurance information and a material issue in this action,"[226] and that its "assertion of relevance [wa]s purely conclusory and without authority from the cases it cites."[227] Accordingly, the court declined to grant the requested discovery of reinsurance information.

5. Arbitration

Arbitration continues as the usual method for resolving reinsurance disputes, but courts are increasingly called to resolve disputes arising out of those arbitrations. Over the last year, courts addressed disputes arising out of every phase of reinsurance arbitrations—from the initial arbitrability of the dispute, to intersections of state and federal law, allegations of arbitrator misconduct, arbitrator resignation,[228] and the limits of a panel's authority in rendering an award.[229] Detailing each of these cases is beyond the scope of the present article, but cases of particular interest to reinsurance practitioners are discussed below.

225. *Id*. at 21.
226. *Id*. at 23.
227. *Id*. at 24.
228. In *Insurance Co. of North America v. Public Service Mutual Insurance Co*., the Second Circuit declined to extend the rule it articulated in *Marine Products Export Corp. v. M.T. Globe Galaxy*, 977 F.2d 66 (2d Cir. 1992), regarding how to fill a panel vacancy arising from the death of an arbitrator. 609 F.3d 122, 122 (2d Cir. 2010). The *Marine Products* rule requires that " 'absent special circumstances,' if a vacancy arises on an arbitral panel due to the death of an arbitrator prior to the rendering of an award, a new panel should be convened." *Id*. at 123–24. In *Public Service Mutual*, the panel vacancy arose from an arbitrator's resignation, as opposed to death. The court concluded that requiring an entirely new panel to be convened whenever an arbitrator resigns would carry the risk of manipulation by parties who were unhappy with how their arbitration was proceeding—and who may then encourage their party-appointed arbitrator to resign for the purpose of forcing the creation of a new panel. Accordingly, the court held that "in dealing with vacancies resulting from resignations, the *Marine Products* rule does not apply, and district courts should use their power pursuant to 9 U.S.C. § 5 in deciding how to proceed." *Id*. at 130.
229. *See*, *e.g.*, Amerisure Mut. Ins. Co. v. Global Reins. Corp., 927 N.E.2d 740 (Ill. Ct. App. 2010) (finding that panel had exceeded its authority by awarding attorney fees where panel had relied on Illinois law as the source of its authority for granting such fees); Nat'l Union Fire Ins. Co. v. Odyssey Am. Reins. Corp., No. 05 Cv. 7539 (DAB), 2009 WL 4059183 (S.D.N.Y. Nov. 18, 2009) (denying motion to vacate a supplemental arbitral award of attorney fees upon finding that none of the statutory bases for vacatur applied and that the award was not in manifest disregard of the law).

a. Arbitrability of a Dispute

In a case that has migrated between federal district and appellate courts for a number of years, the Second Circuit issued a significant decision in *Axa Verischerung AG v. New Hampshire Insurance Co*.[230] The underlying dispute involved claims by AXA that various AIG subsidiaries fraudulently induced it to participate in two reinsurance facilities. After a jury rendered a judgment in AXA's favor for approximately $34 million, AIG appealed on several grounds. Among the arguments made were that AXA's claims were subject to mandatory arbitration and should not have been tried before a jury, and that AXA's claims were time-barred.

The Second Circuit remanded the question of arbitrability to the district court, which examined the following narrow language of the arbitration clause at issue: "All disputes or differences arising out of the interpretation of this Agreement shall be submitted to the decision of two arbitrators, one to be chosen by each party. . . ."[231] The district court adopted the premise that, if the claims sounded in fraud, they were not subject to arbitration, and further noted that the narrow language of this clause limited arbitration to disputes "arising out of the '*interpretation*' of the contracts."[232] The court concluded that AXA's allegations were grounded in alleged misrepresentations of "collateral aspects of how the arrangements between the parties would operate" as opposed to compliance with contractual provisions.[233] The claims, therefore, were not subject to arbitration. The court further held that, even if AXA's claims had been arbitrable, AIG waived any right to arbitration.[234] The Second Circuit subsequently adopted the district court's finding that AXA's claims sounded in fraud, and thus, were not subject to arbitration. As a result, the court decided that there was no need to reach the issue of whether AIG had waived its right to arbitrate.

Notably, however, the court then turned to AIG's statute of limitations defense and effectively rendered all prior rulings moot—it held that AXA's

230. No. 08–2521-cv, 2010 WL 3292927, *1 (2d Cir. Aug. 23, 2010).

231. AXA Verischerung AG v. N.H. Ins. Co., 708 F. Supp. 2d 423, 426 (S.D.N.Y. 2010) (citing the arbitration clause language) (emphasis in original).

232. *Id*. at 428 (citation omitted). It explained, "arbitration clauses limited to interpretive disputes are widely understood to cover only those disputes that can be resolved by reference to the terms of the contract."

233. *Id*. at 430.

234. *Id*. at 438. The court found that AIG was untimely in raising its arbitration demand during the litigation with AXA. Interestingly, however, in reaching this determination, the court also analyzed positions AIG had taken in a separate matter involving a different reinsurer, Farm Bureau, which had participated in the same reinsurance facilities. The court identified allegations raised by Farm Bureau in that litigation that the court felt were similar to those raised by AXA and noted that AIG had not asserted that such claims were subject to arbitration. The court noted that "[t]his alone may well constitute waiver, not just for the Farm Bureau action but for the instant action as well." *Id*. at 433.

claims of fraudulent inducement were in fact time-barred and vacated the $34 million jury award. In analyzing this affirmative defense, the court focused on AXA's duty of inquiry in the context of its allegations that it was misled into believing that the reinsurance facilities were facultative obligatory as opposed to purely facultative.[235] The court held that:

> AXA was confronted with a clear 'storm warning' in August 1998, as well as additional facts through 2000, 'such as to suggest . . . the probability that it had been defrauded,' thereby triggering a duty of inquiry. AXA's failure to engage in that inquiry imputed to it knowledge of the alleged fraud and renders its fraudulent inducement claims time-barred.[236]

Accordingly, the court found that the statute of limitations barred AXA's claims of fraudulent inducement.

In a different matter, the Third Circuit addressed several important questions regarding the reach and scope of arbitration in a reinsurance dispute in which the parties' own contract did not contain an arbitration clause. In *Century Indemnity Co. v. Certain Underwriters at Lloyd's, London*,[237] Lloyd's had served as Century Indemnity's retrocessionaire[238] and declined to reimburse Century for amounts Century claimed it was due under their treaties. Century brought suit against Lloyd's, and Lloyd's responded by seeking to compel arbitration. The retrocessional agreements between Lloyd's and Century did not contain arbitration clauses, but they referred to and incorporated all of the underlying reinsurance treaties, which did contain mandatory arbitration provisions.[239] The district court compelled arbitration.[240]

The parties proceeded to arbitrate their dispute, and after an award was rendered in favor of Lloyd's, Century moved to vacate the award in part on the ground that it should not have been compelled to arbitrate.[241] The district court declined to vacate the award, and Century appealed.

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235. 2010 WL 3292927, at *3.

236. *Id*. (citations omitted) (alteration in original). The court further identified other alleged "storm warnings" related to AXA's percentage mix of business and increasing losses that, when "[t]aken together . . . contributed to the duty to inquire under which AXA already operated as a result of its receipt of the 1998 wordings." *Id*. at *4 (citation omitted).

237. 584 F.3d 513, 519–20 (3d Cir. 2009).

238. By way of background, the court explained the term "retrocessionaires" as follows:

> Reinsurance agreements covering classes or lines of business, rather than a particular policy, are called reinsurance treaties. Subsequently, reinsurers may seek to spread their exposure to risk through further reinsurance. The reinsurance of reinsurance is called a retrocession, and the reinsurers of reinsurers-that is, reinsurers who assume retrocession risk through retrocessional agreements-are called retrocessionaires.

Id. at 519 (citing Black's Law Dictionary 1432 (9th ed. 2009)).

239. *Id*. at 520.

240. *Id*. at 520–21.

241. *Id*. Century also moved to vacate the award on substantive and procedural grounds under 9 U.S.C. § 10. *Id*. at 522.

On appeal, the Third Circuit analyzed the retrocession agreement's language and structure and found that the federal policy favoring arbitration "probably does not apply" to the threshold question of whether an agreement to arbitrate exists.[242] In examining the reinsurance treaties and retrocession agreements, the court applied ordinary state-law based contract rules and noted the contracts' *lack of* any limiting or exclusionary language narrowing the application of the arbitration clause.[243] Century argued that arbitration was improper because: (1) the "incorporation-by-reference language" could not overcome the terms of the arbitration clause in the underlying reinsurance treaties, whose language specifically identified Century and its cedent as the parties subjecting their disputes to arbitration; and (2) the retrocession contained a service of suit clause, demonstrating that disputes were not arbitrable.[244] The Third Circuit disagreed, holding that "the retrocessional agreements incorporated the arbitration clause of the reinsurance treaties and thus formed an agreement between Century and Lloyd's to arbitrate disputes."[245] The court further held that the dispute at issue fell within the scope of the arbitration clause *without* applying the presumption favoring arbitration.[246] Accordingly, it upheld the district court's order compelling the parties to arbitrate.

b. Allegations of Evident Partiality and Arbitrator Misconduct

In the highly specialized reinsurance industry, the pool of potential arbitrator candidates is smaller than in other industries, and the likelihood of encountering the same individuals serving as arbitrators is correspondingly greater.[247] This situation naturally breeds debate over the types of relationships among parties, arbitrators, and counsel that could lead to "evident partiality" on the part of an arbitrator sufficient to overturn an award. Over the last year, multiple cases related to reinsurance have addressed these types of allegations with a wide range of outcomes.

In *Arrowood Indemnity Co. v. Trustmark Insurance Co.*,[248] the U.S. District Court for the District of Connecticut addressed the issue of whether an umpire's work as a party-appointed "advocate" for one party in unre-

242. *Id.* at 526 (citation omitted).

243. *Id.* at 551 (" 'Subject to the percentage allocation in the preceding paragraph, *all terms and provisions of the Policy shall be applied to this agreement as if contained herein*, . . .' ") (quoting the retrocession agreement) (emphasis in original).

244. *Id.* at 554.

245. *Id.* at 555.

246. *Id.* at 556.

247. *See, e.g.*, Ario v. Cologne Reins. (Barbados), Ltd., No. 1:CV-98–0678, 2009 WL 3818626, at *10 (M.D. Pa. Nov. 13, 2009) ("Reinsurance is a field sufficiently specialized that those with expertise can be expected to serve on multiple arbitration panels.").

248. Order on Pending Motions, No. 3:03-CV-1000 (PCD) (D. Conn. Feb. 2, 2010), ECF No. 100.

lated matters constituted bias such that the umpire could no longer serve as a neutral arbitrator in an arbitration involving the same party. Specifically, after the umpire was appointed in the arbitration at issue, the plaintiff selected him to serve as its party-appointed arbitrator in six unrelated matters. The defendant argued that the umpire's service as plaintiff's party-appointed arbitrator had led to a "'significant financial relationship'" that precluded his ability to remain neutral.[249] The court disagreed, stating "[s]ervice as a party-appointed arbitrator is not in and of itself evidence of partiality."[250] As a result, the court found no "evident partiality" within the meaning of the Federal Arbitration Act.[251]

In a matter involving arguably less potential partiality, the U.S. District Court for the Middle District of Pennsylvania addressed similar allegations and declined to vacate an arbitral award. In *Ario v. Cologne Reinsurance (Barbados), Ltd.*,[252] the umpire had been selected in the fairly traditional manner of being chosen by the two party-appointed arbitrators. After this appointment, the same umpire was selected to serve in a separate, unrelated dispute in which Cologne's party-appointed arbitrator was again involved in the umpire's selection. In seeking to vacate the arbitral award, Ario argued, among other points, that the umpire's service in the second arbitration, after having been selected (in part) by Cologne's party-appointed arbitrator, gave the umpire an improper pecuniary interest that was akin to having accepted business from a party itself.[253] Ario further alleged fault with his own party-appointed arbitrator for accepting a different and unrelated appointment as umpire in an arbitration with a Cologne affiliate while this dispute was pending.

In rejecting Ario's claims, the court concluded that the disclosures had been timely made while the proceedings were still pending before the panel. The court noted that:

> [T]here is no evident partiality from an arbitrator's accepting a position as an umpire in another, unrelated arbitration while the current arbitration is still ongoing, even if that position was partially obtained by the action of a party-appointed arbitrator, or is a position in an arbitration where one of the parties is an affiliate of a party to the current arbitration.[254]

249. *Id.* at 2.

250. *Id.* Indeed, the court noted that "[e]xperienced arbitrators often have professional relationships with the parties." *Id.* at 3.

251. *Id.* (citing 9 U.S.C. § 10).

252. *Ario*, 2009 WL 3818626, at *10 (holding that there was no evidence that either the umpire or Ario's party-appointed arbitrator "received any compensation directly either from a party or from a law firm for a party, or was compensated for any business services rendered for that entity. Instead, they acted only as arbitrators and any compensation received was for their roles as arbitrators").

253. *Id.* at *9.

254. *Id.* at *10.

In contrast, in *Scandinavian Reinsurance Company Ltd. v. St. Paul Fire & Marine Insurance Company*, the U.S. District Court for the Southern District of New York vacated an arbitral award.[255] In doing so, the court recognized that all three panel members were certified by the AIDA Reinsurance and Insurance Arbitration Society (ARIAS), and thus required to abide by the ARIAS guidelines for arbitrator conduct. Specifically, the court noted that "[t]he guidelines require arbitrators to 'disclose any interest or relationship likely to affect their judgment' and resolve all doubts in favor of disclosure."[256] It then concluded that two of the arbitrators failed to disclose the fact that they simultaneously presided over another arbitration involving what the court considered to be similar issues, related parties, and a common witness.[257] Although St. Paul urged that the arbitrators' involvement in the other arbitration was immaterial, the court found that the arbitrators:

> [P]laced themselves in a position where they could receive *ex parte* information about the kind of reinsurance business at issue in [the arbitration], be influenced by recent credibility determinations they made as a result of [the common witness'] testimony in the [other] arbitration, and influence each other's thinking on issues relevant to the [arbitration].[258]

Accordingly, the court found a "material conflict of interest" in the arbitrators' simultaneous service in the two arbitrations[259] and vacated the arbitral award.[260]

The U.S. District Court for the Northern District of Illinois also decided a pair of cases regarding whether an arbitrator was adequately "disinterested."[261] Although both cases addressed the same issue, whether a party could appoint the same arbitrator in a subsequent arbitration involving identical parties, the court reached different conclusions in each case. The cases are procedurally interesting in that the party opposing the appointment of the common arbitrator filed motions for preliminary injunctions to prevent the arbitrations from proceeding.

255. No. 09 Civ. 9531 (SAS), 2010 WL 653481, *1 (S.D.N.Y. Feb. 23, 2010).
256. *Id*. at *2.
257. *Id*. at *8.
258. *Id*.
259. *Id*. at *9.
260. *Id*. Notably, the court did not reach the question of whether the arbitrators acted purposefully to conceal their involvement in the other arbitration, because the arbitrators' good faith in failing to disclose a conflict of interest would not have changed the outcome. *Id*. at *8–9.
261. Trustmark Ins. Co. v. John Hancock Life Ins. Co., 680 F. Supp. 2d 944 (N.D. Ill. 2010); Memorandum Opinion & Order, Trustmark Ins. Co. v. Clarendon Nat'l Ins. Co., No.09-C-1673, (N.D. Ill. Feb. 1, 2010), *available at* http://02ec4c5.netsolhost.com/blog/wp-content/uploads/2010/02/Trustmark-Clarendon-2.1.10.pdf.

In *Trustmark Insurance Co. v. John Hancock Life Insurance Co.*, plaintiff alleged breach of contract based on the confidentiality agreement governing the first arbitration and the underwriting agreement's requirement that the arbitrators be "disinterested."[262] The court enjoined the arbitration after finding breaches of both agreements. First, the court reasoned that the common arbitrator allegedly participated in deliberations regarding extending the confidentiality agreement covering the first arbitration to cover the second.[263] Second, the common arbitrator referenced information learned during the first arbitration while serving in the second arbitration.[264] The Seventh Circuit Court of Appeals, however, reversed the court on all grounds.[265] The court held that Trustmark had failed to demonstrate the touchstone requirement of the injunctive relief it sought—irreparable injury.[266] Moreover, the court held that Hancock's party-appointed arbitrator's service in the prior arbitration did not vest him with a disqualifying interest in the outcome of the present proceeding.[267] Rather, the requirement that an arbitrator be "disinterested" refers to "lacking a financial or other personal stake in the outcome," not to lacking financial knowledge of the dispute.[268]

In *Trustmark Insurance Co. v. Clarendon National Insurance Co.*, on the other hand, the court denied the preliminary injunction as premature,[269] noting that the requirement that an "arbitrator be disinterested is an issue of bias or qualification available for challenge only after an arbitration award issues."[270] The court further noted that the plaintiff "cannot avoid this outcome by merely restating the qualification challenge as a breach of contact claim."[271]

In a case involving a different type of allegation of arbitrator misconduct, after more than a decade of litigation regarding the reinsurance of certain workers' compensation policies, the Ninth Circuit affirmed an arbitration award against a reinsurer for more than $400 million, plus interest.[272] At issue was whether the arbitrators violated the Federal Arbitration Act by

262. 680 F. Supp. 2d 944, 947 (N.D. Ill. 2010).
263. *Id.* at 948–49.
264. *Id.*
265. Trustmark Ins. Co. v. John Hancock Ins. Co., 631 F.3d 869 (7th Cir. 2011).
266. *Id.* at 872.
267. *Id.* at 872–74.
268. *Id.* at 873.
269. *Clarendon Nat'l Ins. Co.*, No.09-C-1673, at 4. The plaintiff also filed a complaint against the defendant as part of its efforts to disqualify the common arbitrator and find a breach of the first arbitration's confidentiality agreement by virtue of having appointed the common arbitrator. The court dismissed plaintiff's claims in their entirety.
270. *Id.* at 6.
271. *Id.*
272. U.S. Life Ins. Co. v. Superior Nat'l Ins. Co., 591 F.3d 1167, 1170 (9th Cir. 2010).

holding an ex parte meeting with panel-retained expert witnesses to assess whether the insurers engaged in improper claim handling. The court held:

> The process employed by the arbitration panel, which included an ex parte meeting with panel-retained workers' compensation experts was unusual; however, after deferentially reviewing the panel's award, we determine that the arbitration process provided the parties with a fundamentally fair arbitration and that the arbitration award rested on a plausible interpretation of the governing arbitration documents.[273]

These cases suggest that, although opinions regarding "evident partiality" run strong, there is no clear consensus among courts or practitioners as to precisely what qualifies as "evident partiality." Until a consensus is reached, it is an issue likely to plague reinsurance practitioners for some time.

c. Intersection of State and Federal Law

Arbitration issues often provoke a complex intersection of state and federal law, and this past year was no exception. As discussed below, complicated questions of federal preemption and the application of the New York Convention and the McCarran-Ferguson Act have all arisen in the context of disputes involving arbitration.

In *Ario v. The Underwriting Members of Syndicate 53 at Lloyd's for the 1998 Year of Account*,[274] the Third Circuit analyzed the intersection of the Convention on Foreign and Arbitral Awards (the New York Convention),[275] the Federal Arbitration Act (FAA),[276] and the Pennsylvania Uniform Arbitration Act (PUAA).[277] The parties agreed that the arbitral award fell under the New York Convention, but they disagreed as to whether federal court jurisdiction applied to the proceeding seek-

273. *Id*. U.S. Life moved to stay the mandate pending a petition for a writ of certiorari in the Supreme Court of the United States, arguing in part that the decision was in conflict with "the decisions of the Fifth Circuit and the New York Court of Appeals on the important question whether arbitrators' ex parte receipt of evidence on the key issue in dispute constitutes prejudicial 'misbehavior,' and thus is grounds for vacatur of an arbitration award under Section 10(a)(3) of the Federal Arbitration Act. . . ." U.S. Life Ins. Co. v. Superior Nat'l Ins. Co., No. 07–55938, Appellant's Mot. to Stay the Mandate, at 1 (9th Cir. Mar. 25, 2010), ECF No. 56. Further, U.S. Life argued that the Ninth Circuit's decision was "in tension with Supreme Court decisions holding that reliance on secret evidence in the analogous context of administrative tribunals violates due process." *Id*. at 2. The Ninth Circuit granted the motion on March 26, 2010, but did not give its reasoning. U.S. Life Ins. Co. v. Superior Nat'l Ins. Co., No. 07–55938, Order (9th Cir. Mar. 26, 2010), ECF No. 57.

274. 617 F.3d 277, 283 (3d Cir. 2010).

275. The Convention on the Recognition & Enforcement of Foreign Arbitral Awards, June 10, 1958, 21 U.S.T. 2517.

276. Codified as amended in scattered sections of 9 U.S.C.

277. 42 Pa. Cons. Stat. § 7301 *et seq*. (2007).

ing to confirm or vacate the award. They further disagreed as to whether the FAA or the PUAA's vacatur standards should be applied to their dispute.

Ario contended that, because the reinsurance treaties indicated that "the arbitration shall be in accordance with the rules and procedures established by the Uniform Arbitration Act as enacted in Pennsylvania,"[278] the parties had affirmatively opted out of the FAA, including the provision allowing removal[279] to federal court of any disputes involving awards under the New York Convention.[280] On appeal, the Third Circuit held that it is not possible for parties to opt out of the FAA entirely, as it is the FAA itself that enables parties to incorporate state law standards to govern their arbitrations. Although parties can waive their right of removal under 9 U.S.C. § 205, this requires "clear and unambiguous language requiring such a waiver."[281] Opting to apply the PUAA is insufficient to affect this waiver.[282] Moreover, in this case, the reinsurance agreement's service of suit clause specifically preserved the right to remove an action to federal court, thereby undermining any contention that a right of removal had been clearly waived.[283]

The court also held that FAA vacatur standards would control in lieu of the New York Convention's vacatur standards.[284] For the FAA standards to be supplanted by those of the PUAA, the parties must express a "clear intent" to do so. Here, the court held that the arbitration clause's designation of the PUAA's "rules and procedures" did not evince a "clear intent" by the parties to invoke the PUAA's vacatur standards. Nor did the service of suit clause language show such intent where it did not affirmatively elect to apply the PUAA vacatur standards.[285]

In another decision involving the New York Convention and the application of state law, the Fifth Circuit considered the viability of a Loui-

278. *Ario*, 617 F.3d at 284.
279. 9 U.S.C. § 205.
280. *Ario*, 617 F.3d at 286–88.
281. *Id*. at 289 (quotations and citations omitted).
282. *Id*. at 290.
283. *Id*.
284. *Id*. at 290–91. In addressing the vacatur standards for an award under the New York Convention, where both the arbitration and the enforcement action occurred in the United States, the Third Circuit adopted the Second Circuit's reasoning in *Yusuf Ahmed Alghanim & Sons v. Toys 'R' Us, Inc*., 126 F.3d 15, 16 (2d Cir. 1997), and held that the New York Convention "specifically contemplates that the [country] in which, or under the law of which, the award is made, will be free to set aside or modify an award in accordance with its domestic arbitral law and its full panoply of express and implied grounds for relief." *Id*. at 292 (alteration in original) (quotations omitted).
285. *Id*. at 293.

siana law prohibiting arbitration clauses in insurance policies.[286] At issue was whether a Louisiana law preempted the New York Convention governing arbitrations where one party moved to compel arbitration pursuant to applicable reinsurance agreements and the other party moved to quash arbitration as being unenforceable under Louisiana law.[287] The court held that the McCarran-Ferguson Act did not apply to bar arbitration because it was the New York Convention that superseded state law and not its implementing legislation, the Convention Act.[288] The court found that "[t]he text of the McCarran-Ferguson Act does not support the inclusion by implication of 'a treaty implemented by an Act of Congress.' "[289] Thus, the court concluded that "implemented treaty provisions, self-executing or not, are not reverse-preempted by state law pursuant to the McCarran-Ferguson Act."[290]

286. Safety Nat'l Cas. Corp. v. Certain Underwriters at Lloyd's, London, 587 F.3d 714, 717 (5th Cir. 2009).

287. *Id*. at 717.

288. *Id*. at 724–25.

289. *Id*. at 731. In other words, a treaty that was implemented by an Act of Congress, such as the New York Convention, was not itself an "Act of Congress" within the meaning of the McCarran-Ferguson Act.

290. *Id*. The Fifth Circuit noted that its holding in *Safety National* puts it in direct conflict with a Second Circuit decision, which held that, because the New York Convention was not a self-executing treaty and depended on acts of Congress for its implementation, it was an "Act of Congress" for purposes of the McCarran-Ferguson Act. *See* Stephens v. Am. Int'l Ins. Co., 66 F.3d 41, 42 (2d Cir. 1995). The conflict between the circuits may position this issue as one for Supreme Court consideration.