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

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## I. INTRODUCTION

In a year in which September 11 and asbestos reform dominated the headlines, the case law developments in the excess insurance and reinsurance arenas reflected the issues of the day. The inner workings of the excess insurance broker market were on display in several New York cases that addressed significant issues of insurance coverage for the destruction of the World Trade Center. At the same time, as federal legislators grappled with ways to fix the dysfunctional asbestos litigation system, courts continued to deal with its impact on insurers and reinsurers in complex cases addressing payment and allocation of asbestos losses and in insurer insolvency proceedings precipitated by asbestos exposures. Surplus carriers, meanwhile, continued their efforts to preserve and enhance the laws that define their role in the insurance marketplace.

## II. EXCESS INSURANCE

The most significant case of the past year in the excess insurance arena clarified the manner in which the "following the form" doctrine applies in the context of a loss that arises between the date coverage is bound and a policy is issued. The past year also saw several decisions by courts addressing the duties of the excess insurer in the event of primary insurer insolvency and the allocation of defense costs and post-judgment interest between primary and excess insurers. Another court applied the "other insurance" clause contained in a policy to determine whether an insurer was primary or excess.

### A. *Following Form*

Many excess policies are written on a "following the form" basis, meaning that the terms and conditions of the excess policy follow the form of the primary policy. Often in the case of large programs where it is understood that the insurance program will be comprised of many layers of insurance with multiple participants in each layer, the insured's broker provides a specimen policy to a market of primary and excess insurers. Insurers who agree to participate in the insured's program will issue a binder of insurance, which serves as a temporary or interim policy until a formal policy is issued. All of the terms of the insurance contract are not set forth in the binder. Rather, when the binders are issued, all of the terms and conditions of the policy may still be subject to negotiation. The terms and conditions of the policy are usually negotiated by the lead insurer on the primary layer, with the other primary insurers and the excess insurers ultimately issuing policies that are consistent with or uniform to the lead insurer's policy. Sometimes the negotiation process has not concluded by the policy inception date. When losses occur after the policy inception date but before formal policies have been issued by the primary and excess insurers, courts are called upon to determine what terms and conditions govern for each excess insurer who has not directly negotiated the terms and conditions with the insured.

This is precisely the issue addressed by the Second Circuit in *World Trade Center Properties, L.L.C. v. Hartford Fire Insurance Co.*,[1] a case arising out of the September 11 tragedy. At issue was whether the events that brought down the twin towers of the World Trade Center ("WTC") on September 11 constituted one or two occurrences. If the events were one occurrence, then up to $3.5 billion of coverage was available; if two separate occurrences, then up to $7 billion. Because only one of the many insurers that bound coverage on the WTC had issued a final policy before Septem-

1. 345 F.3d 154 (2d Cir. 2003).

ber 11, the court was required to conduct an "individualized inquiry to determine the terms of the insurance binders issued by each insurer."[2]

The dispute centered on whether the terms of the Travelers lead primary policy or the specimen form submitted by the insured's broker (the WilProp form) governed each excess insurer's liability to the insured. The WilProp form contained a definition of "occurrence" that treated as one occurrence all losses "attributable directly or indirectly to one cause or to one series of similar causes."[3] Both the district court and the Second Circuit held that, under this definition, "no finder of fact could reasonably fail to find that the intentional crashes into the WTC of two hijacked airplanes sixteen minutes apart as a result of a single, coordinated plan of attack was, at the least, a 'series of similar causes.'"[4] Conversely, the Travelers form did not define the term "occurrence." The insured contended that the excess insurers bound coverage under the Travelers form.[5]

In rejecting the insured's contention, the Second Circuit, applying New York law, first addressed the insured's "following the form" argument. The insured argued:

> Whether or not the broker includes a sample policy form with the submission, the industry practice in layered placements is for a lead insurer to act as the negotiator of policy terms on behalf of the participating insurers. In an effort to achieve concurrency (uniformity in coverage terms provided by the participating insurers), the other participating primary and excess insurers customarily agree to "follow the form" of the lead insurer, i.e., to accept the terms and conditions of the program policy.[6]

Because all of the participating insurers understood that Travelers was the lead primary insurer and Travelers expressly bound coverage on its own specimen form (a variation of which it issued three days after the loss as its policy) rather than on the WilProp form, the insured contended that the excess insurers followed the Travelers form. However, the Second Circuit concluded that even if the evidence showed a custom of following the form, "it appears that the form to be followed can as easily be the broker's policy form submitted with an underwriting submission as the form of one of the primary-layer insurers."[7] The issue was not whether the excess insurers were bound to follow the policy that the lead insurer issued on September 14 instead of the WilProp form; rather, the only question was

2. *Id.* at 158.
3. *Id.* at 160.
4. *Id.* at 180.
5. *Id.* at 160.
6. *Id.* at 167.
7. *Id.* at 167 n.9.

the applicable definition of "occurrence" under the specific binders issued by the excess insurers that were in force on September 11, 2001.[8]

The next step in the analysis sprung from the basic principle that the binder and the policy actually are two separate contracts of insurance, and may contain two separate sets of terms. When no formal policy has been issued as of the date of loss, the only relevant contract of insurance is the binder. Because binders themselves typically contain very little in the way of terms and conditions, a court may look to extrinsic evidence of the parties' prebinder negotiations for help in determining which terms are to be included in a binder.[9] According to the Second Circuit, "any policy form that was exchanged in the process of negotiating the binder, together with any express modifications to that form, is likely the most reliable manifestation of the terms by which the parties intended to be bound while the binder was in effect."[10]

Before addressing the prebinder negotiations of each of the excess insurers, the Second Circuit returned to the "following the form" doctrine. There was no evidence that the insurers had been provided with the Travelers form prior to issuing their binders. Therefore:

> In the absence of such evidence, we believe that the fact that an insurer agreed to follow the lead of Travelers and demonstrated an intention to be bound by the final policy form as ultimately negotiated by Travelers would be relevant only to the parties' post-binder relationship, which is of no import to this case. Such an agreement or understanding, whether explicit or derived from custom and usage, would not provide a basis for incorporating into the binder the terms contained in the Travelers form.[11]

Based on an exhaustive analysis of the evidence of three excess insurers' prebinder negotiations with the insurance broker, the Second Circuit concluded that the binders in question were issued based on negotiations involving the WilProp form, and incorporated the terms of that form.[12]

### B. *Duties of Excess Insurer to Insured in the Event of Primary Insurer Insolvency*

*Premcor USA Inc. v. American Home Assurance Co.*[13] is one of the latest in a line of cases addressing whether an excess insurer is required to "drop down" and provide coverage to the insured when the primary insurer cannot pay its limit of liability due to insolvency. The U.S. District Court for

8. *Id.* at 169.
9. *Id.* at 170.
10. *Id.*
11. *Id.*
12. *Id.*
13. No. 03 C 7377, 2004 WL 1152847, at *1 (N.D. Ill. May 21, 2004) (unpublished).

the Northern District of Illinois first articulated the law in Illinois that an excess insurer's duty to "drop down" to provide coverage is determined on a case-by-case approach and requires analysis of each policy's terms.[14] The court went on to state that the key question was whether the policy language required the excess insurer to assume liability "for any excess over the 'amount recoverable' under the underlying policy."[15] A policy including such language would obligate the excess insurer to "drop down" and provide primary coverage, while a policy that did not include this language would not.[16] Citing decisions from both Illinois and California, the court noted that the term "amount recoverable" was ambiguous "because it could be interpreted either to expose the excess insurer only for amounts over the dollar limits of the underlying insurance or to expose the excess insurer for amounts which the insured is not able to actually recover because of the underlying insurer's insolvency."[17]

Against this backdrop, the court analyzed the terms of the policy. The policy did contain the important "amount recoverable" language, but also contained a clause providing that coverage includes "that portion of the ultimate net loss in excess of the retained limit" and defined "ultimate net loss" as not including expenses "when such are covered by underlying policies of insurance whether collectible or not."[18] The policy also contained an endorsement providing that the "liability of the Company shall not be increased by the refusal or inability of the Insured to pay its Self-Insured Retention (or retained limit) or by the refusal or inability of any underlying insurer to pay, whether by Reasons of Insolvency, Bankruptcy or otherwise."[19] Because an endorsement to a policy supersedes conflicting policy provisions, the court held that the endorsement clearly prohibited any increase in the excess insurer's liability due to the insolvency of the underlying insurer.[20] Finally, the court held that the excess insurer had no duty to reimburse the insured for its expended defense costs.[21]

14. *Id.* at *6.
15. *Id.*
16. *Id.*
17. *Id.* (citing Donald B. MacNeal, Inc. v. Interstate Fire & Cas. Co., 477 N.E.2d 1322 (Ill. App. Ct. 1985); Reserve Ins. Co. v. Pisciotta, 640 P.2d 764 (Cal. 1982)).
18. *Id.* at *7.
19. *Id.*
20. *Id.*
21. *Id.* at *7–8. The insured had argued that the excess insurer was obligated to pay defense costs whether or not the underlying insurer actually paid its portion of those costs. The court disagreed based on Seventh Circuit precedent establishing that "exhaustion" of primary limits does not occur until the primary limits have been paid. *Id.* at *8 (citing New Process Baking Co. v. Fed. Ins. Co., 923 F.2d 62 (7th Cir. 1991); Zurich Ins. Co. v. Heil Co., 815 F.2d 1122 (7th Cir. 1987)).

### C. *Allocation of Defenses Costs and Post-Judgment Interest Between Primary and Excess Insurers*

In *Royal Insurance Co. of America v. Lexington Insurance Co.*,[22] the U.S. District Court for the Southern District of New York was called upon to determine whether the primary or the excess insurer was responsible for the defense costs incurred in the underlying action against their insured. The primary insurer's policy provided coverage in the amount of $1 million per occurrence. The excess insurer provided coverage in the amount of $5 million per occurrence above the primary coverage. The defense of the underlying tort action against their insured was first undertaken by the primary insurer and later taken over by the excess insurer. The excess insurer sued the primary insurer for reimbursement of the defense costs that it paid. The primary insurer's $1 million limit was exhausted by virtue of the $3.2 million settlement of the underlying tort action.[23]

The court first noted that under New York law, there are direct fiduciary duties between excess and primary insurance carriers that permit an excess insurer to seek reimbursement of legal fees that it pays in defense of the underlying tort action.[24] The court next addressed the terms of the primary policy, concluding that the primary insurer's obligation for defense costs was "in addition to, not part of, the policy limit" and that the duty to defend continued until the policy limit was exhausted through the payment of a judgment or settlement.[25] Thus, the primary insurer was obligated to reimburse the excess insurer for any defense costs that it incurred up to the time of the settlement of the underlying tort action.

The court reached this decision in spite of a provision in the excess insurance policy obligating the excess insurer to "pay, with respect to any claim we investigate or settle, or any 'suit' against an insured we defend: (I) All expenses we incur."[26] The court explained that this section merely defined "costs" under the policy; it did not indicate when the costs had to be paid. To hold otherwise "would eviscerate the ordering established in the respective policies, namely that [the excess insurer]'s obligation to defend is triggered only when [the primary insurer]'s applicable limits have been exhausted in the payment of settlement or judgment."[27]

A somewhat contrary result was reached in *Sentry Select Insurance Co. v. TIG Insurance Co.*,[28] where a trucking company's primary and excess insur-

22. No. 02 Civ. 2085 (RCC), 2004 WL 1620877 (S.D.N.Y. July 20, 2004) (unpublished).
23. *Id.* at *1.
24. *Id.* at *2.
25. *Id.* at *3.
26. *Id.*
27. *Id.*
28. No. 1:02-CV-1875-LJM-WTL, 2004 WL 1689391 (S.D. Ind. June 30, 2004) (unpublished).

ers filed cross-motions for summary judgment to determine which party owed the post-judgment interest that accrued during an unsuccessful appeal of a verdict entered against the trucking company. In the underlying case, a jury returned a verdict against the trucking company and awarded the decedent's estate $2.8 million in a wrongful death suit. Prior to the jury trial, the primary insurer offered its policy limits of $1 million to the plaintiff. Although the plaintiff rejected the offer, the primary insurer did not rescind it, and made the offer many more times before the jury entered its verdict of $2.8 million for the plaintiff.[29]

The excess insurer authorized an appeal of the judgment. After the appellate process was exhausted, the primary insurer paid the plaintiff the remaining limits of insurance available under its policy and the excess insurer paid the remaining principal balance. At the time of payment to the plaintiff, the post-judgment interest had grown to over $400,000. The primary and excess insurers paid the post-judgment interest in equal shares, and then brought a declaratory judgment action to determine which party owed the interest.

The court held that the primary insurer's duty to pay the resulting post-judgment interest terminated when it offered to pay its policy limits. The court relied on the primary insurer's policy, which provided:

> [W]e will pay for the "insured" . . . .
> 6. All interest on the full amount of any judgment that accrues after entry of the judgment in any "suit" against the "insured" we defend; but our duty to pay interest ends when we have paid, offered to pay or deposited in court the part of the judgment that is within our Limit of Insurance.[30]

It was also important that the excess insurer's policy language specifically authorized the excess insurer to appeal without increasing its limit of liability "except that [the excess insurer] will make the appeal at [the excess insurer's] cost and expense."[31]

The court reasoned that the post-judgment interest was a cost of the excess insurer's decision to appeal. The excess insurer made the decision to appeal and controlled the appeal. As such, the excess insurer's supplementary payment clause was triggered and the excess insurer was responsible for all post-judgment interest.

29. *Id.* at *2.

30. *Id.* at *4. The court also relied upon the Seventh Circuit's holding in *Overbeek v. Heimbecker*, 101 F.3d 1225 (7th Cir. 1996), for an analogous argument. In *Overbeek*, the insurer offered its policy limits prior to the trial and the plaintiff rejected the offer. The jury returned a lower verdict and the plaintiff appealed. The court held that the plaintiff could not, when its appeal was ultimately defeated, demand that the insurer pay the post-judgment interest that accrued during the appeal. The insurer had attempted to compensate the plaintiff in a timely fashion and would not be penalized for doing so. *Overbeek*, 101 F.3d at 1226–28.

31. *Sentry Select*, 2004 WL 1689391, at *6.

D. *Other Insurance*

In *Progressive Insurance Co. v. Universal Casualty Co.*,[32] an Illinois appellate court addressed the allocation of liability for an accident involving a pizza delivery driver who was driving a private vehicle on the job. The insurance dispute arose when one of Pizza Nova's delivery drivers caused a motor vehicle accident with a pedestrian. The vehicle was owned by the driver's father, but at the time of the accident was being driven by the son in the course of his employment for Pizza Nova.[33] The father carried liability insurance on the vehicle through Universal Casualty Company. The pedestrian filed suit and obtained service of process upon Pizza Nova, but was unable to serve the driver. Ultimately, Pizza Nova's liability insurer, Progressive Insurance Company, settled the lawsuit with the pedestrian for $57,500.[34] Progressive then sought reimbursement from Universal, the vehicle's liability insurer for the $20,000 limits available under the Universal policy.

Universal argued that its obligation to cover any loss was never triggered because its obligation was never "finally determined" and because Progressive's settlement with the pedestrian was an unauthorized voluntary payment.[35] In addition, Universal argued that it had not received notice of the underlying lawsuit and therefore its duty to defend never arose. Alternatively, Universal argued that it was, at most, a co-primary insurer with Progressive for the loss and that Progressive should have brought an action under the doctrine of equitable contribution, not equitable subrogation, to attempt any recovery.[36]

Generally, an excess insurer may only bring an action for reimbursement against an alleged primary insurer if both insurers have contracted with the same insured.[37] Progressive's policy undisputedly covered only Pizza Nova and not the driver or the vehicle owner. The driver, as an insured under only one policy, could not be the basis for Progressive's claim that it was an excess insurer. Instead, the appellate court ruled that both Progressive and Universal insured Pizza Nova. Pizza Nova was an additional insured of Universal because the parties did not dispute that Pizza Nova was legally responsible for the use of the vehicle. Universal's policy contained a provision providing for coverage of "any person or organization legally responsible for the use of" the insured automobile.[38]

32. 807 N.E.2d 577 (Ill. App. Ct. 2004).
33. *Id.* at 580.
34. *Id.* at 581.
35. *Id.*
36. *Id.* at 581–82.
37. *Id.* at 583.
38. *Id.* at 584.

The next issue was whether Universal and Progressive were primary and excess insurers, respectively, or whether they were co-primary insurers for the loss. Universal argued that they were co-primary insurers and that Progressive should have filed suit seeking equitable contribution. According to the court, equitable contribution is based on the relationship of multiple insurers who insure the same insured and cover the same risk, not the rights of the insured. Progressive argued that it was an excess insurer and entitled to equitable subrogation. The court explained that equitable subrogation is based upon the rights of the insured. It refers to a situation where an insurer has paid the principal debtor's obligation to the common underlying claimant and, by virtue of that payment on behalf of its insured, succeeds to the claimant's rights against the principal debtor.[39]

Progressive admitted that it was not a true excess insurer, but argued that it was an excess insurer for this loss according to the "other insurance" clause of its policy.[40] Thus, the issue became the effect of the "other insurance" clauses of both the Progressive and the Universal policies. If both were given effect, then they would cancel each other out and both would be co-primary insurers.[41]

The court first addressed Universal's "other insurance" clause, which provided that "the insurance with respect to a temporary substitute automobile or non-owned automobile shall be excess insurance over any other valid and collectible insurance."[42] The policy defined a "non-owned" automobile as "an automobile not owned by or furnished for the regular use of either the named insured or any relative."[43] The court ruled that Universal's "other insurance" clause did not apply because the vehicle at issue was owned by the named insured, the driver's father. The fact that the vehicle was not owned by Pizza Nova was irrelevant to application of Universal's "other insurance" clause.

In determining whether the Progressive policy's "other insurance" clause was applicable, the court considered the following policy language: "For any covered 'auto' you don't own, the insurance provided by this Coverage Form is excess over any collectible insurance."[44] The court scrutinized the term "collectible" and ultimately found a question of fact because it was unclear whether Universal received notice of the suit. Without such notice, Universal would have no obligation under its policy such that the insurance

39. *Id.* at 584–85. This distinction between equitable contribution and equitable subrogation was also discussed in *Reliance Ins. Co. v. Doctors Co.*, 299 F. Supp. 2d 1131, 1151–52 (D. Haw. 2003).

40. *Progressive*, 807 N.E.2d at 584–85.

41. *Id.* at 585.

42. *Id.*

43. *Id.* at 585–86.

44. *Id.*

could not be considered "collectible" and Progressive would not be considered the excess insurer under the terms of its own "other insurance" clause.[45]

The court remanded to the trial court to determine whether Universal had adequate notice of the suit. Only if Universal had adequate notice of the suit would Progressive be deemed the excess insurer and thus entitled to equitable subrogation. However, that right would be subject to the additional defense asserted by Universal that Progressive's settlement payment was voluntary, thereby precluding Progressive from recovering as a subrogee. While the court indicated that the payment made by Progressive would not be considered a voluntary payment because an excess insurer's payment on behalf of a primary insurer is presumptively involuntary, it remanded the case so that the trier of fact could make findings on the considerations affecting the voluntariness of a settlement, such as whether Progressive's anticipation of liability was reasonable and whether the settlement was arrived at in good faith.[46]

## III. SURPLUS LINES INSURANCE

During the past twelve months, courts have interpreted and legislatures have considered or enacted laws touching on various facets of operations in the surplus lines insurance industry. A combination of court decisions and legislative changes in Florida, West Virginia, and, most recently, Nevada has further eroded the preferred status of resident agents and brokers in those states. The courts and legislature of Texas have taken action to expand the premium tax obligation to surplus lines insurers and insureds if the statutory requirements for placement of surplus lines policies are not satisfied. The U.S. Treasury Department and the Internal Revenue Service have provided guidance concerning exemptions from federal premium excise taxation. Finally, state and federal courts have ruled on disputes concerning: (1) the nature and scope of a surplus lines agent's duty to investigate the solvency of the surplus lines insurer and the consequences of breach of that duty; (2) the appropriate domicile for resolution of disputed claims to the remainder in an insolvent surplus lines insurer's nondomiciliary security trust; and (3) whether the actions of a retail agent can bind a surplus lines insurer or surplus lines broker to coverage that the insurer did not write.

### A. *Case Law Developments*

#### 1. Resident/Nonresident Agents and Brokers

In Florida, the constitutionality and perceived inequity of recently enacted laws requiring nonresident Florida agents and brokers to obtain the coun-

45. *Id.* at 588.
46. *Id.* at 588–89.

tersignatures of, and share a significant part of their commissions with, resident Florida agents and brokers on Florida-based risks prompted the Council of Insurance Agents and Brokers ("CIAB")[47] to commence an action challenging such laws in the U.S. District Court for the Northern District of Florida. The CIAB also brought similar lawsuits challenging the laws of West Virginia, South Dakota, Nevada, Puerto Rico, and the U.S. Virgin Islands. On September 30, 2003, in *Council of Insurance Agents & Brokers v. Gallagher*,[48] the federal court invalidated as unconstitutional those provisions of Florida law barring Florida-licensed, nonresident property and casualty insurance agents from: (a) placing insurance coverage on risks located within the State of Florida without the countersignature of a Florida-licensed agent resident in the state; and (b) obtaining a license as a surplus lines agent.[49]

First, the district court held that CIAB did have standing to assert the challenge on behalf of its members and their employees, noting that "standing to assert constitutional *jus tertii* can be stacked."[50] Because the CIAB has associational standing to assert the rights of its members, and the members have standing to assert the rights of their employees and partners, CIAB thus has standing to assert the rights of the employees and partners.[51]

On the substantive issue before it, the court began by proclaiming: "This is one nation with one economy," and that "no state may build a fence at the border to keep out residents of other states or to keep them from competing for business within the state."[52] The court analogized this case to the facts of *Supreme Court of New Hampshire v. Piper*.[53] In *Piper*, the U.S. Supreme Court struck down a New Hampshire residency requirement for admission to the state bar based upon the Privileges and Immunities Clause, which guarantees to the citizens of one state that they will be allowed to do business in another state on substantially equivalent terms with those applicable to the citizens of that state.[54]

47. The CIAB is a trade association, members of which include many of the largest commercial property and casualty brokerage firms.

48. 287 F. Supp. 2d 1302 (N.D. Fla. 2003).

49. The court referenced and quoted from three Florida statutes in particular, although the decision presumably reaches every statute making the same unconstitutional distinction: (1) Fla. Stat. Ann. § 624.425 (West 2004) (requiring resident agent countersignatures for all property, casualty, and surety policies written in Florida); (2) Fla. Stat Ann. § 626.741 (West 2004) (which authorizes licensure of nonresident agents but provides that such agents "shall not directly or indirectly solicit, negotiate or effect insurance contracts in this state unless accompanied by a countersigning agent, resident in this state"; and (3) Fla. Stat. Ann. § 626.927(1) (West 2004) (which permits only resident agents to obtain surplus lines licenses).

50. *CIAB*, 287 F. Supp. 2d at 1307.

51. *Id.*

52. *Id.* at 1310.

53. 470 U.S. 274 (1985).

54. *See* U.S. Const. art. IV, § 2.

The Florida commissioner agreed that the rationale of *Piper* could be applied to insurance agents and conceded that any distinction between Florida-licensed resident agents and nonresident agents served no purpose. However, the commissioner took the position that the statutes at issue made no distinction between resident and nonresident agents. The court disagreed:

> [T]he statutes clearly *do* draw such a distinction. Nonresidents may become members of the Florida Bar with all the same rights and privileges as resident members of the Florida Bar. Nonresidents also may become Florida-licensed insurance agents, but under the statutes at issue, such nonresidents *do not* have the same rights and privileges as resident agents. Nonresidents cannot "solicit, negotiate, or effect insurance contracts" unless accompanied by resident agents, they cannot keep the entire commissions generated on the business they place, and they cannot apply for and become licensed as surplus lines agents.[55]

The court concluded that the Florida statute unconstitutionally discriminated against Florida-licensed, nonresident agents in violation of the Privileges and Immunities and Equal Protection Clauses of the U.S. Constitution. In so holding, it dismissed the commissioner's additional arguments, i.e., that a Florida-licensed agent may be required for placement of Florida risks[56] and that residency was required for local expertise and assistance.[57] The court granted the CIAB's motion for summary judgment and denied the commissioner's motion. The court further ordered that: (1) Sections 624.425, 626.741, and 626.927 of the Florida statutes violate the Privileges and Immunities Clause and the Equal Protection Clause of the U.S. Constitution; and (2) the Florida commissioner was enjoined from denying to nonresident Florida-licensed agents the same rights and privileges that Florida-licensed resident agents possess.

Following this case, other jurisdictions also took action on this issue. West Virginia repealed its residency requirements,[58] and CIAB dismissed its West Virginia lawsuit. On July 1, 2004, Governor Bush of Florida signed into law revisions to the provisions of Florida law deemed unconstitutional.[59] In October 2004, a Nevada district court issued an order that declared the Nevada statutes at issue in CIAB's Nevada action unconsti-

55. *CIAB*, 287 F. Supp. 2d at 1311–12.

56. The court agreed with the commissioner, but observed that there was no challenge to requiring Florida licensure, just Florida residency.

57. The court observed that an agent located in Mobile, Alabama, may be closer to and more familiar with a risk located in Pensacola, Florida, than an agent located in Miami, Florida. Moreover, Pensacola is closer to Indianapolis, Indiana, than it is to Key West, Florida.

58. W. VA. CODE § 33–12–11 (2003), as amended. The West Virginia code did not bar nonresident agents from obtaining surplus lines agents' licenses.

59. 2004 Fla. Laws ch. 2004–374. *See* discussion *infra* at section III.B.1. of this article.

tutional.[60] The Nevada Insurance Commissioner has appealed the decision to the Ninth Circuit.[61] As of this writing, the CIAB actions in South Dakota, Puerto Rico, and the U.S. Virgin Islands remain pending.

2. Surplus Lines Taxes

It is normally the responsibility of surplus lines brokers to collect surplus lines taxes from insureds and remit the taxes to the states. Traditionally, surplus lines insurers have not been held liable for unpaid premium taxes; rather, the surplus lines broker bears the obligation to the state to collect and remit the tax. It is therefore neither unreasonable nor unexpected that surplus lines insurers may assume that the state-licensed brokers with whom they deal will comply with all state law requirements, including the payment of taxes.

Driven by fiscal and budgetary concerns, certain states have sought to expand the obligation for unpaid taxes to insureds and to surplus lines insurers. This liability can run into the millions of dollars and may require surplus lines insurers, who have relied upon brokers for years, to develop systems to track and monitor the payment of taxes by the brokers in order to avoid the additional tax liability.

This issue is the subject of *Strayhorn v. Lexington Insurance Co.*,[62] a Texas case. The dispute initially arose when three AIG surplus lines insurers, Lexington Insurance Co., Landmark Insurance Co., and American International Specialty Lines Insurance Co., were assessed combined taxes in excess of $1 million by the Comptroller of the State of Texas. The three insurers had placed the insurance through Texas-licensed surplus lines brokers, but had also used out-of-state brokers who did not remit tax to Texas. The state took the position that the insurers' inability to prove payment of certain taxes through authorized surplus lines brokers made them "unauthorized" insurers, subject to a tax in the nature of a direct procurement tax. The insurers paid the taxes under protest but sued the Texas Comptroller, arguing that, as eligible surplus lines insurers, they were not subject to the statute requiring unauthorized insurers to pay a procurement tax.[63] The trial court agreed with the insurers, but the appellate court reversed, holding that surplus lines insurers who do not place surplus lines insurance through a licensed Texas surplus lines agent are engaging in unauthorized insurance. As such, they become "unauthorized insurers" who are liable for the premium tax.[64]

Currently, the case is pending before the Texas Supreme Court.

60. CIAB v. Molasky-Arman, No. CV-S-02–0813 (D. Nev. Oct. 2, 2004) (order granting plaintiff's motion for summary judgment).
61. CIAB v. Molasky-Arman, *appeal docketed*, No. 04–17271 (9th Cir. Nov. 18, 2004).
62. 128 S.W.3d 772 (Tex. App. 2004).
63. Tex. Ins. Code § 101.251 (2004), as amended.
64. *Strayhorn*, 128 S.W.3d at 775.

3. Insolvent Surplus Lines Insurer/Trust Remainder

In February 2004, a New York appellate court examined the interplay between principles of trust law and equity and those of state insurance insolvency law in *Levin v. National Colonial Insurance Co.*[65] The issue was whether competing claims to ownership of a trust remainder should be adjudicated in the domiciliary state of an insolvent surplus lines insurer or the state where the trust's ancillary receiver was appointed.

The facts of the case were as follows. National Colonial Insurance Company ("NCIC"), a Kansas-domiciled surplus lines insurer, established a trust with Chase Manhattan Bank as a requirement for writing excess and surplus lines business in New York State. NCIC was subsequently determined to be insolvent by the Kansas Insurance Department, and the Kansas Commissioner of Insurance was appointed liquidator. The New York Insurance Superintendent demanded that Chase explain or restore the funds drained from the trust fund. Chase ultimately replenished the trust with funds of its own and filed a proof of claim with the Kansas liquidator.

The superintendent then obtained an order in New York court authorizing him to take possession of the trust as conservator for the purpose of liquidating valid New York policy claims from the funds in the trust. Chase filed an affidavit in the proceeding claiming entitlement to any remainder in the trust after satisfaction of valid policyholder and beneficiary claims. The liquidator took the position that the remainder was the property of the estate, subject to disposition by the liquidation court.

In a special proceeding initiated by the superintendent seeking an order directing distribution of the trust remainder, a lower court found in favor of Chase. The appellate division reversed, finding in favor of the liquidator and the domiciliary state, and holding that the remainder was the property of the insolvent estate.[66]

The New York Court of Appeals affirmed, but took a different track in reaching its decision: it analyzed the issue as a question of which jurisdiction should determine rights to the remainder. The court discussed the relevant provisions of the Uniform Insurance Liquidation Act, adopted by New York in 1940,[67] and those of the National Association of Insurance Commissioners' Rehabilitation and Liquidation Model Act, adopted by Kansas in 1991,[68] observing that both schemes permit an ancillary receiver or conservator (like the New York superintendent) to liquidate proven, allowable claims from security within its jurisdiction such as the trust in issue. The court thus upheld the authority of the New York conservator

65. 806 N.E.2d 473 (N.Y. 2004).
66. *In re* Nat'l Colonial Ins. Co., 745 N.Y.S.2d 28 (App. Div. 2002).
67. *See* N.Y. Ins. Law §§ 7408–7415 (McKinney 2000).
68. *See* Kan. Stat. Ann. §§ 40–3605—40–3658 (2000).

to recover the assets of the trust and to liquidate from it any claims made under covered policies.[69] However, the court further held, affirming the order of the appellate division, that, while neither the Uniform Act nor the Model Act offered explicit guidance on the issue of which jurisdiction would be more appropriate to adjudicate competing claims to the remainder of the trust, it is most consistent with both schemes to conclude that the domiciliary state of the insolvent insurer is the proper forum in which to adjudicate such claims.[70]

4. Surplus Lines Agents/Brokers

Over the past year, courts in four jurisdictions have examined the role of the surplus lines broker.

*a. California*—A California appellate court affirmed the dismissal of an insured's suit for breach of contract, bad faith, negligent misrepresentation, and fraud allegedly arising from a denial of coverage under a policy covering her jewelry business in *Rios v. Scottsdale Insurance Co.*[71] The policy had been issued by Scottsdale through UCA, a licensed surplus lines broker. The insured obtained what she understood was a "special form" business and personal property coverage policy from her retail insurance agent, Whilt. Whilt had sought quotes for the special form policy from a number of markets, including UCA. UCA would not offer a quote for a "special form" policy because the business did not meet certain requirements, but did offer a quotation for a "basic form" policy. Although Whilt accepted the UCA counteroffer for the basic form policy, he mistakenly prepared and provided the plaintiff with a binder stating that the policy contained the special form coverage. When the jewelry business was burglarized, the insured submitted a claim for the loss, and Scottsdale denied coverage under its basic policy form. The lawsuit against Scottsdale and UCA ensued.[72]

The insured alleged that Whilt was the agent of Scottsdale and UCA, and that Scottsdale was bound by Whilt's representations on the policy binder that the policy provided "special form" coverage. The lower court disagreed, granting summary judgment for the defendants. The appellate court affirmed, finding that the Scottsdale policy did not, by its terms, provide coverage for the burglary, and that the binder issued by Whilt indicating that the policy provided "special form coverage" was superseded by issuance of a policy that did not provide the coverage.[73] Moreover, Whilt's misrepresentation of the nature of the coverage on the binder did

69. *Levin*, 806 N.E.2d at 478.
70. *Id.* at 478–79.
71. 15 Cal. Rptr. 3d 18 (Ct. App. 2004).
72. *Id.* at 21.
73. *Id.* at 21–22.

not bind Scottsdale and UCA, because Whilt was an agent for the insured, not the insurers.[74]

*b. West Virginia*—A West Virginia federal court held, in *American Equity Insurance Co. v. Lignetics, Inc.*,[75] that a retail agent was neither an actual nor an apparent agent of a surplus lines insurer. In this case, the insured told the agent, United Agencies, that it was relying on the agent to provide it with "all possible coverages for all possible contingencies."[76] United Agencies failed to obtain a "stop-gap" employers' liability policy, under a mistaken belief that the insured had purchased that coverage from its workers' compensation insurer. Instead, United Agencies obtained a commercial general liability policy containing an employers' liability exclusion from American Equity, a surplus lines insurer, through a surplus lines broker, Western Security Surplus. When American Equity subsequently denied coverage of Lignetics's employers' liability claim and commenced a declaratory judgment action to obtain an order confirming the lack of coverage, the insured asserted a third-party action against United Agencies and two individual brokers in the agency. One of the questions before the court was whether, in dealing with the insured, United Agencies was the agent of American Equities. Answering that question in the negative, the court wrote:

> United Agencies placed Lignetics' policy through a surplus lines broker serving as an intermediary between it and the insurer. United Agencies had no direct contact with American Equity; indeed, by law, it could not. In addition, . . . United Agencies' agents had no binding authority on behalf of American Equity. Moreover, there was no "manifestation of consent" by American Equity that United Agencies could act on its behalf, nor was there any suggestion that American Equity exercised control over United Agencies—both prerequisites for an agency relationship under West Virginia law.[77]

Since United Agencies did not have either apparent or actual authority to act for American Equity, any negligence on the part of United Agencies could not be imputed to American Equity.[78]

*c. Louisiana*—In *Deep South Towing, Inc. v. Sedgwick of New Orleans*,[79] a Louisiana appellate court clarified Louisiana's statutory requirement that surplus lines brokers are required to place surplus lines insurance with

74. *Id.* at 22–23.
75. 284 F. Supp. 2d 399 (N.D.W.Va. 2003).
76. *Id.* at 402.
77. *Id.* at 409.
78. *Id.* at 409–10. *See also* Kaselitz Family Ltd. P'ship v. Hudson & MUMA, Inc., No. 244382, 2004 WL 316176 (Mich. Ct. App. Feb. 19, 2004) (unpublished) (similarly finding no evidence of any "special" or "fiduciary" relationship between a retail agent and a surplus lines insurer with respect to fire insurance placed for the insured on its properties).
79. 876 So. 2d 102 (La. Ct. App. 2004), *rev'd on other grounds*, 887 So. 2d 458 (La. 2004).

insurers who appear on the Louisiana Commissioner of Insurance's "white list" of approved, nonadmitted insurers who meet certain requirements of financial soundness and stability. In this case, broker Sedgwick had placed surplus lines ocean marine liability insurance for Deep South Towing with HIH Casualty and Marine Insurance Co. of Australia, a company not on the white list. The HIH policy was renewed at least two times. The insured sustained a Jones Act loss in the last policy period, and was never paid by HIH. In fact, HIH was dismissed from the claimant's direct action for coverage after HIH had been placed in insolvency proceedings in Australia. The insured's lawsuit against Sedgwick and its corporate successor, Marsh USA, followed. The trial court found in favor of the surplus lines broker, finding that the risk of an unauthorized insurer becoming insolvent after two renewals does not fall within the scope of the duty of a surplus lines broker.

The appellate court reversed, finding for the insured, and remanded for determination of the plaintiff's damages. The appellate court analyzed the statutory requirements for placement of surplus lines insurance with an insurer on the white list. It acknowledged that the statutory purpose for the requirement was to protect insureds in Louisiana, to make sure that insurance is placed with solvent carriers, and to establish an orderly regulatory system for such placements.[80] The court rejected defendants' arguments that the white list requirement did not apply to ocean marine insurance.

The court also rejected defendants' arguments that a surplus line insurer need not be on the white list and that inclusion on the white list did not guarantee the solvency of the insurer. The court acknowledged that inclusion on the white list was not a guarantee of solvency, but nonetheless stressed that the law requires brokers to verify that unauthorized insurers are on the white list because inclusion is a safeguard that lessens the risk of insolvency. The court cited to its earlier decision in *Popich Brothers Water Transport, Inc. v. Gulf Coast Marine, Inc.*,[81] in which it held that a broker did not have the duty of investigating the financial soundness of an insurer, but that the broker need only verify that an unauthorized insurer is on the white list because that meant that the Commissioner of Insurance has verified the financial solvency of the unauthorized insurer.[82]

*d. Texas*—In *Greenwood Insurance Group, Inc. v. United States Liability Insurance Co.*,[83] a Texas appellate court affirmed a judgment in favor of the errors and omissions insurer of Greenwood Insurance Company, a surplus

80. *Id.* at 105–06 (construing, e.g., La. Rev. Stat. Ann. § 22:1262 (West 2004)).
81. 705 So. 2d 1267 (La. Ct. App. 1998).
82. *Deep South Towing*, 876 So. 2d at 106.
83. No. 01–03–00112-CV, 2004 WL 1351413 (Tex. App. June 17, 2004) (not yet released for publication).

lines broker, that placed the first layer of an insured's coverage (up to $1 million) with an A.M. Best "B"-rated surplus lines insurer that subsequently became insolvent and could not pay its share of a $1.3 million verdict against the insured. The errors and omissions policy contained an "insolvency exclusion" that bars coverage when the insured agent places insurance with an insurance company that is not rated "B+" or higher by A.M. Best at the time of the placement and that subsequently becomes insolvent.[84] The agent's argument that the insolvency exclusion was inapplicable was brushed aside by the court. The court found that the insolvent insurer did not pay because of the insolvency, and coverage for both defense and indemnity was therefore excluded by the policy.[85]

B. *Statutory and Legislative Developments*

1. Resident Agents and Brokers

As discussed above, the CIAB brought suits challenging as unconstitutional applicable laws in several jurisdictions that continue to require that resident agents countersign, and take a portion of the commission from, policies issued by nonresident agents.[86] Florida also barred nonresident agents from obtaining surplus lines licenses. Following the *Gallagher* decision in Florida, discussed above, the Florida and West Virginia legislatures both proposed statutory modifications addressing the Florida decision.

On July 1, 2004, Governor Bush of Florida signed into law Senate Bill 2588.[87] The legislation, enacted in response to *CIAB v. Gallagher*, deleted resident agent requirements in many sections of the Florida statutes. The bill is too lengthy to permit analysis here of all sections that were revised. However, the most relevant amendments to the Florida statute sections include: (1) Section 624.425, concerning the requirement of a resident agent countersignature; (2) Section 626.9272, licensing of nonresident surplus lines agents (which was added in its entirety); (3) Section 626.930, permitting a nonresident surplus lines agent to keep required records in its state of residence; (4) Section 626.933, regarding collection of taxes and service fees, which permits the Florida Surplus Lines Service Office to file suit on behalf of the Florida Insurance Department to recover taxes or statutory fees required to be paid by the surplus lines agent; and (5) Section 626.935, regarding suspension, revocation, or refusal of surplus lines agents' licenses.

2. Surplus Lines Taxes

As discussed above, the Texas legislature expanded the obligation to pay surplus lines taxes beyond the surplus lines agent or broker to the surplus

84. *Id.* at *3.
85. *Id.* at *5.
86. *See* discussion *supra* at section III.A.1 of this article.
87. *See* 2004 Fla. Laws. ch. 2004–374.

lines insurer and also to the insured. In *Strayhorn v. Lexington Insurance Co.*,[88] an intermediate appellate court upheld this expansion of the broker's traditional obligation by holding that an eligible surplus lines insurer is liable for premium taxes as an unauthorized insurer when it does not issue policies in Texas through an authorized surplus lines broker.

In response to the issues raised by that case, the Texas legislature amended Section 101.251 of the Texas Insurance Code to expand the premium tax obligation to all "insurers," including authorized, unauthorized, and surplus lines insurers, as set forth in the new definition included as subsection (k) to the code provision. Also revised were subsection (i), which provides that the tax, if not paid when due, "is a liability of the insurer, the insurer agent and the insured," and subsection (j), which clarifies the exemptions from the tax to include premiums on insurance procured by a licensed surplus agent from an eligible surplus lines insurer, and a licensed and authorized insurer in the state.[89]

3. Federal Excise Tax on Premiums

Section 4371 of the Internal Revenue Code imposes a federal excise tax on the premium paid for each policy of insurance or reinsurance involving U.S. risks issued by any foreign insurer or reinsurer.[90] Various treaties between the United States and other nations provide that foreign insurers or reinsurers may be exempt from the Section 4371 tax.[91] On October 10, 2003, the IRS issued Revenue Procedure 2003-78 to provide instructions for such exemption. The instructions require, among other things, that the taxpayer enter into a "Closing Agreement" with the IRS. The guidance includes forms of Closing Agreements for this purpose.[92]

C. *Summary*

In the wake of the CIAB litigation over residency and countersignature requirements for agents, it is likely that other states will follow Florida's lead in amending their statutory requirements. As of the time of this writing, CIAB litigation in several jurisdictions remains pending.

The Texas tax issue is sure to remain high on the list of concerns for surplus lines insurers. The potential tax issue just adds to the burden of surplus lines insurers who already face an increasingly soft insurance market and stagnant economy. Following the recent trend, it is likely that there

88. 128 S.W.3d 772 (Tex. App. 2004) (discussed *supra* at note 62 and accompanying text).
89. Tex. Ins. Code § 101.251 (Vernon 2004).
90. 26 U.S.C.A. § 4371 (West 2004).
91. 26 U.S.C.A. § 4373 (West 2004).
92. Rev. Proc. 2003-78, 2003 I.R.B. 45.

will be further regulation of surplus lines insurers by nondomiciliary states.[93]

## IV. REINSURANCE LAW

The past year saw a steady stream of court decisions addressing the subjects of substantive and procedural issues common to reinsurance law. Settlements of asbestos liabilities, particularly those involving nonproducts coverage, continued to spawn conflicting decisions regarding the ability of reinsurers to question the presentation and allocation of such losses under the "follow the fortunes" and "follow the settlements" doctrines. The viability of the defense of late notice, which reinsurers increasingly cite as a basis for nonpayment, was at issue in two opinions from the Southern District of New York. Courts in Illinois and New York examined the place and scope of the duty of utmost good faith in modern reinsuring agreements, with results that may foretell a growing reluctance among courts to recognize and impose the duty in situations where it is not expressly stated to exist. Reinsurers also saw a Pennsylvania court once again uphold the right of insureds to obtain direct access to reinsurance held by insolvent insurers under certain circumstances, this time in the context of the Reliance Insurance Company liquidation proceedings.

On the procedural front, the decisions from the past year reflected a trend among courts to enforce arbitration as the parties' chosen forum, following last year's rulings from the U.S. Supreme Court. Courts, for the most part, continue to defer to arbitration, and limit the bases upon which awards may be reviewed. At the same time, however, as parties struggle to adapt the arbitration process to their increasingly complex disputes, courts continue to decide issues regarding consolidation, panel composition, and enforcement of pretrial discovery subpoenas in arbitration proceedings, with conflicting results.

### A. *Coverage*

#### 1. Following Liability: Form, Settlements, and Fortunes

In *Travelers Casualty & Surety Co. v. Gerling Global Reinsurance Corp. of America*,[94] the U.S. District Court in Connecticut took an extremely narrow view of the "follow the settlements" doctrine's application to a cedent's

93. With this issue in mind, the National Association of Professional Surplus Lines Offices, Ltd. has published a survey summarizing state laws and regulations that impact the ability of surplus lines policies to be issued free from rates and forms regulation. *See* Nat'l Ass'n of Prof'l Surplus Lines Offices, Ltd., Laws Restricting Surplus Lines, *at* http://www.napslo.org/content/Legislation_Regulation/News/weirdlaw.htm.

94. 285 F. Supp. 2d 200 (D. Conn. 2003).

payment and allocation of an asbestos settlement with its insured.[95] The dispute centered around Travelers's settlement of claims by its insured, Owens Corning Fiberglass ("OCF"), for nonproducts coverage under primary and excess policies issued between 1952 and 1979.[96]

In 1993, OCF commenced arbitration against Travelers, seeking nonproducts coverage for its asbestos bodily injury claims. OCF moved for summary judgment in the proceeding on the basis that each of the claims of asbestos exposure (or, at a minimum, each of the hundreds of job sites at which OCF conducted its contracting operations) was a separate occurrence, each triggering a full set of occurrence limits.[97] Travelers opposed the motion, arguing that all of OCF's asbestos claims, whether for products or nonproducts coverage, arose from a single occurrence, and that because Travelers had already paid one set of occurrence limits in connection with OCF's product claims, OCF was not entitled to any further coverage.[98]

After nearly two years passed with no arbitration decision, Travelers came to believe that neither party would gain a complete victory in the proceeding and began to discuss settlement with OCF.[99] As is often the case in disputes of this magnitude, the negotiations focused on the amount and timing of payments by Travelers, with little discussion or agreement regarding the coverage assumptions underlying such payments.[100] Travelers eventually agreed to pay in settlement an amount roughly equal to the total per-occurrence limits available under its primary and excess policies. The settlement agreement did not specify the number of occurrences or allocate the settlement amount to specific policies and explicitly disclaimed any particular theory of coverage.[101]

Travelers allocated the settlement payments to its primary and excess policies by spreading the settlement amount evenly among all policy years on a single-occurrence basis. Travelers claimed that its allocation method was consistent with case precedent at the time and performed without regard for reinsurance recovery or substantive knowledge of Travelers's reinsurance program.[102]

When Travelers ceded the settlement payments to its facultative reinsurers, Gerling, which reinsured Travelers's excess policies between 1975 and 1977, objected to Travelers's use of a single-occurrence theory for allocating the settlement payments.[103] Travelers ultimately sued Gerling in

95. *Id.* at 201–02.
96. *Id.*
97. *Id.*
98. *Id.*
99. *Id.*
100. *Id.* at 205.
101. *Id.*
102. *Id.*
103. *Id.* at 206.

court, alleging breach of contract for Gerling's refusal to pay its allocated portion of the OCF loss settlements on the basis of Travelers's allocation.[104] Gerling moved for summary judgment, asking the court to find as a matter of law that the Travelers's settlement payments should have been allocated as multiple occurrences under the definition of "occurrence" in the original policies, and that Gerling was not obligated to follow Travelers's single-occurrence allocation under the "follow the fortunes" doctrine.[105] Travelers opposed the motion, contending that its allocation was consistent with the settlement that it reached with OCF, which was based on a reasonable interpretation of the primary and excess policies, and that Gerling must accept Travelers's interpretation and cannot relitigate coverage disputes resolved in the underlying settlement with its insured.[106] Gerling disputed these arguments, claiming that Travelers's allocation of the settlement was a unilateral decision made in the context of preparing its reinsurance submission in order to maximize the payments made under its excess policies.[107]

The court granted Gerling's motion, concluding that the "follow the fortunes"/"follow the settlements" doctrines did not apply.[108] The court explained its reasoning in part as follows:

> Travelers wanted to extract itself from the coverage dispute with OCF for as little dollar exposure as possible, however achieved, and OCF and Travelers came to a settlement without any agreement on the occurrence issue. Put simply, by refusing reinsurance coverage on the basis of Travelers' single occurrence allocation, Gerling is not punishing Travelers for not going to the mat with OCF on the single occurrence position it advanced—a situation which the follow the fortunes doctrine was promulgated to prevent.[109]

The court may have missed the point of the settlement, however, in concluding that "resolution of the number of occurrences issue was not necessary to end their dispute."[110] Settlement involves a decision by opposing parties to compromise their dispute in lieu of a formal resolution of their opposing positions. The "follow the settlements" doctrine would be constricted if its application were dependent upon the resolution of underlying disputed coverage positions. The court's analysis also failed to recognize that the amount of the settlement was inconsistent with the "multiple"-occurrence theory supported by Gerling, which would have resulted in virtually unlimited exposure to Travelers. Instead, the court found that requiring Gerling to follow Travelers's allocation did not promote the

104. *Id.*
105. *Id.* at 207.
106. *Id.* at 207–08.
107. *Id.* at 209.
108. *Id.* at 210.
109. *Id.*
110. *Id.* at 212.

goal of the "follow the settlements" doctrine "to incentivize settlement and reduce litigation" because Travelers was not being told that it should not have settled on any basis other than its single-occurrence position.[111] Thus, without finding that the settlement payments were fraudulent, collusive, or ex gratia, the court held that Gerling was not bound to follow Travelers's allocation of its settlement payments on a single-occurrence basis.[112]

In *North River Insurance Co. v. ACE American Reinsurance Co.*,[113] the Second Circuit addressed the nearly identical issue with respect to North River Insurance Co.'s settlement of OCF asbestos nonproduct claims, with the opposite result. In that case, North River had allocated one percent of the settlement to the value of its policy buy-back, which extinguished its liability for future nonasbestos-related claims.[114] It distributed this one percent among all of its policies and billed its reinsurers accordingly. Using the "rising bathtub" (i.e. horizontal exhaustion) approach, North River then allocated the remaining ninety-nine percent of the cost of the settlement ($332 million), which it designated as reimbursement for paid, nonproduct asbestos claims, to its second-layer policies. The insurer billed ACE $49 million, but did not seek indemnification from the reinsurers of its third, fourth, and fifth excess layers of coverage. ACE disputed North River's allocation method, contending that it should have sought coverage from other reinsurers. North River's presettlement analysis had identified risk of loss in higher layers, ACE noted. ACE argued that it owed North River only $23,847,000, which it had already paid.

The U.S. District Court for the Southern District of New York ruled that the "follow the fortunes" provision prevented ACE from disputing the allocation method.[115] On appeal, the Second Circuit found that the "follow the settlements" doctrine applied to the reinsured's post-settlement allocation decisions, regardless of whether inquiry would reveal inconsistency between allocation and the reinsured's presettlement assessments of risk, so long as the allocation met typical "follow the settlements" requirements: i.e., it was in good faith, reasonable, and within the scope of the applicable policies.[116] The court observed that requiring post-settlement allocation to match presettlement analyses would permit a reinsurer to intensely scrutinize the specific factual information informing settlement negotiations, require the courts to conduct a detailed review of underlying claims and settlements, and undermine the certainty that general application of the

111. *Id.*
112. *Id.*
113. 361 F.3d 134 (2d Cir. 2004).
114. *Id.* at 138.
115. *Id.* at 136.
116. *Id.* at 141.

doctrine to settlement decisions creates.[117] The court further held that the allocation was within the definition of "loss" contemplated by the insurance contracts.[118] In reaching its decision, the Second Circuit recognized a much broader rationale for the "follow the settlements" doctrine than that articulated by the court in *Travelers*: "[T]o foster the 'goals of maximum coverage and settlement' and to prevent courts, through 'de novo review of [the cedent's] decision-making process,' from undermining 'the foundation of the cedent-reinsurer relationship.'"[119]

An aspect of "follow the fortunes"/"follow the settlements" that courts continue to agree on is that the doctrine may not apply to abrogate the policy limits stated in a reinsurance contract. Thus, in *Excess Insurance Co., Ltd. v. Factory Mutual Insurance Co.*,[120] a New York court held that the reinsurance coverage limit was not superseded or overruled by policy language providing that the reinsurer agreed to follow the settlements of the insurer and bear a proportionate share of expenses, and the reinsurer was accordingly not liable for a proportionate share of litigation expenses in excess of its overall coverage limit.[121] Similarly, in *Travelers Casualty & Surety Co. v. Constitution Reinsurance Corp.*,[122] the U.S. District Court for the Eastern District of Michigan, on a motion to impose annualization of limits under multiyear reinsurance policies, ruled that the "follow the fortunes" clauses in those policies did not extend to Travelers's interpretation of the language in the reinsurance policies and did not grant to Travelers "unilateral authority to cede any amount it chooses to its various reinsurers (even if done in good faith)." Rather, Travelers must abide by the bargained-for limits in the reinsurance policies, which the court found to be unambiguous.[123]

### 2. Utmost Good Faith

The opinion of the U.S. District Court for the Northern District of Illinois in *PXRE Reinsurance Co. v. Lumbermens Mutual Casualty Co.*[124] is a good example of the unwillingness of some courts to embrace claims and arguments premised on traditional reinsurance principles and industry custom and practice. PXRE sought reconsideration of an order rejecting its requests for expansive discovery premised on the notion that Lumbermens, as a fiduciary, owed a special duty of disclosure to its reinsured. The judge

117. *Id.*
118. *Id.* at 143.
119. *Id.* at 140–41.
120. 769 N.Y.S.2d 487 (App. Div. 2003).
121. *Id.* at 490.
122. No. 01–71057, 2004 WL 2387313 (E.D. Mich. Aug. 2, 2004).
123. *Id.* at *6.
124. 330 F. Supp. 2d 981 (N.D. Ill. 2004).

rejected PXRE's claim that its reinsurance agreement with Lumbermens imposed a duty of utmost good faith ("uberrimae fidae") on its reinsurer under Illinois law. The court found that imposition of an additional "superfiduciary" duty on the reinsurer based solely on the parties' relationship as reinsurer and reinsured was not supported by the express terms of the parties' agreement and was contrary to the integration clause contained in that agreement.[125] The court reiterated the distinction that it had previously drawn between the reinsurance contract at issue and other cases in which courts had found such a duty to exist under Illinois law, noting that the contracts in those other cases contained express language imposing such a duty. The court also rejected PXRE's attempt to analogize its contract with Lumbermens to the historical relationships and dealings between cedents and underwriters in the London market from which the traditional notion of utmost good faith derives, observing that the transaction at issue involved a finite book of business and thus did not involve "the necessary type of future reliance that typically calls *uberrimae fidae* into play."[126]

A similar exception to the duty of utmost good faith founded on the nature of the business or obligations assumed under the contract was recognized by the U.S. District Court in Texas in *United Teacher Associates Insurance Co. v. Union Labor Life Insurance Co.*[127] The case involved a dispute between insurance companies with respect to the sale of several blocks of in-force Medicare Select and supplemental insurance. The purchaser, United Teacher, claimed that the seller, Union Labor, fraudulently concealed the existence of two consent orders signed by Union Labor and the Florida Department of Insurance, which greatly restricted potential rate increases on the policies.[128] The district court determined that when selling a block of policies, rather than reinsuring them, the duty of utmost good faith does not apply.[129] The court held that, as with any arm's length transaction between sophisticated parties, the seller need only avoid common law fraud.[130] Because the buyer did not ask about agreements with regulators, the seller had no obligation to disclose them and therefore committed no fraud.[131]

In *Folksamerica Reinsurance Co. v. Republic Insurance Co.*,[132] the U.S. District Court for the Southern District of New York gave an equally chilly response to a cedent's claim against its reinsurer for violation of the duty

125. *Id.* at 982.
126. *Id.* at 983.
127. 311 F. Supp. 2d 587 (W.D. Tex. 2004).
128. *Id.* at 590.
129. *Id.* at 596.
130. *Id.* at 598.
131. *Id.* at 598–99.
132. No. 03 Civ. 6608(VM), 2004 WL 1043086 (S.D.N.Y. May 6, 2004).

of utmost good faith and implied covenant of good faith and fair dealing in refusing to pay a claim. Although the issue came before the court on a housecleaning motion at a point when it had already resolved several major issues in the case and had turned its attention to remaining issues in hope of obviating the need for a trial, the court's statements in *Folksamerica* speak strongly against the ability of any party to establish a separate claim premised on breach of the duty of utmost good faith under New York law.[133] The court observed that New York has "consistently and repeatedly held that there is no right of action for 'bad faith' claims handling practices between the parties to an insurance contract."[134] Republic noted in response that such precedent speaks only to primary insurance, not reinsurance, and left open the possibility that New York law would recognize such a cause of action in the context of reinsurance.[135] The court was not persuaded, however, and found that Republic had failed to establish that the principles underlying reinsurance counseled in favor of recognizing an additional cause of action for bad faith failure to reinsure promptly.[136] The court refused to consider case law from other states recognizing such a duty, noting that the parties had established by their arguments on previous issues that "the law on reinsurance differs notably among the states."[137]

3. Aggregation and Annualization

In addition to the previous decisions addressing aggregation of losses in the context of a "follow the fortunes"/"follow the settlements" analysis,[138] several other courts in the past year have decided issues relating to the proper aggregation of losses and policy limits under reinsurance contracts.

In *Manhattan Re-Insurance Co. v. Safety National Casualty Corp.*,[139] the Ninth Circuit held, in an unpublished decision, that a cedent's aggregation of annual policy assessments was improper. The cedent, Manhattan Re-Insurance Co. ("MRC"), had appealed a California federal court ruling that certain U.S. Department of Labor ("DOL"), assessments that it paid over the course of many years were separate annual occurrences for the purpose of triggering reinsurance coverage. The U.S. District Court for the Central District of California had ruled that the amounts assessed annually against MRC by the DOL over a twenty-year period were covered under reinsurance policies issued to MRC by Safety National Casualty Corp. ("SNCC").

133. *Id.* at *1.
134. *Id.* at *6.
135. *Id.* at *7.
136. *Id.*
137. *Id.* at *6 n.12.
138. *See, e.g.*, N. River Ins. Co., et al. v. ACE Am. Reinsurance Co., 361 F.3d 134 (2d Cir. 2004).
139. 83 Fed. Appx. 861 (9th Cir. Nov. 13, 2003).

The district court further found, however, that the assessments could not be aggregated into a single claim in order to satisfy MRC's retention under the reinsurance policies.[140]

In its appeal to the Ninth Circuit, MRC argued that by ruling that the assessments must be treated as annual occurrences without aggregation, the district court rendered moot its holding that the assessments were covered by the certificates. The Ninth Circuit agreed with the district court and SNCC, finding that the assessments did not arise out of one single common cause and were not properly aggregated under the reinsurance contract. According to the court, MRC's duty to pay assessments each year was triggered by a different cause—the government's yearly calculation of the amount that an insurer must pay—rendering the resulting assessment in each year a separate event. The court found support for its ruling in the expectations of the parties, as reflected in MRC's historical handling of the assessments (specifically, its long-standing practice of passing on the annual assessments to its insured and first-layer reinsurer, which it abandoned only after the insured and reinsurer became insolvent). MRC's subsequent motion for reconsideration of the Ninth Circuit's decision was denied.[141]

Disputes regarding annualization often arise in the mass tort context where an insurer settles claims on the basis of annual per-occurrence limits and then expects its reinsurers to pay on the same basis. In the case of multiyear reinsurance policies, this approach may conflict with the reinsurance coverage limits of the multiyear reinsurance policy that generally do not apply "annually" or "each year." Rather, multiyear reinsurance contracts typically grant coverage up to a certain limit for each occurrence during the period of reinsurance coverage.

In *Travelers Casualty & Surety Co. v. Constitution Reinsurance Corp.*,[142] a Michigan federal court considered and rejected a reinsured's right to annualize the coverage limits available under multiyear reinsurance policies. The federal district court came to the same conclusion as most other courts that have addressed the issue, finding that Travelers's reinsurance contracts with Constitution Re, written for consecutive three-year periods, unambiguously granted coverage up to $1 million (not $3 million) for each occurrence during the period and that interpreting the limits to mean "each occurrence, each year" would require reading in a contract a term that is not there.[143]

### 4. Late Notice

The often raised but seldom decisive defense of late notice received thorough consideration from the U.S. District Court for the Southern District

140. *Id.* at 862.
141. *Id.* at 863.
142. No. 01–71057, 2004 WL 2387313 (E.D. Mich. Aug. 2, 2004).
143. *Id.* at *4.

of New York in *Folksamerica Reinsurance Co. v. Republic Insurance Co.*[144] In that case, the district court was called upon to determine the repercussions, if any, of a cedent's late notice of claims and occurrences under three facultative reinsurance certificates issued by Folksamerica.[145] The claims arose from personal injury lawsuits filed against two major insureds of Republic seeking damages for alleged asbestos- and silicosis-related injuries. Republic had in place several layers of reinsurance covering its losses on these accounts, with Folksamerica's coverage incepting at a higher layer typically reserved for "catastrophic" losses.[146] The reinsured losses in question "trickled in over the course of several years," eventually accumulating into an aggregate loss that triggered Folksamerica's coverage.[147]

The district court examined two different provisions in the reinsurance certificates that, according to Folksamerica, required "notice" in some form as a condition precedent to its duty to remit payment for losses covered under the certificates.[148] The first provision stated: "As a condition precedent, the Company shall promptly provide the Reinsurer with a definitive statement of loss on any claim or occurrence reported to the Company . . . which involves a death, serious injury or lawsuit."[149] The second provision, which immediately followed the first, provided that "[t]he Company shall also notify the Reinsurer promptly of any claim or occurrence where the Company has created a loss reserve equal to fifty (50) percent of the Company's retention [under the Certificate]," but did not expressly state that it was a condition precedent.[150] Republic's obligations to Folksamerica were further complicated by the involvement of a reinsurance intermediary charged with facilitating the transmission of claim documentation to reinsurers, that, unfortunately, failed to carry out these instructions as to Folksamerica because of a glitch in the broker's computer system.[151]

The district court rejected Folksamerica's argument that the second notice provision was intended as a condition precedent, observing that the drafters of the certificates were sophisticated, taking care to state when a provision operated as a condition precedent, and clearly omitted such language from the provision requiring prompt notice of a claim or occurrence upon reaching specified loss reserve levels.[152] The court noted the differences between the Folksamerica provision and the wording of an exemplary

144. No. 03 Civ. 0402 (HB), 2003 WL 22852737 (S.D.N.Y. Dec. 2, 2003).
145. *Id.* at *2.
146. *Id.*
147. *Id.* at *12.
148. *Id.* at *6.
149. *Id.* at *7.
150. *Id.*
151. *Id.* at *13 n.27.
152. *Id.* at *8.

clause recognized in one authoritative text as requiring prompt notice as a condition precedent to recovery.[153] The court observed:

> Unlike the provision utilized by Folksamerica (which Strain explains is not to be construed as a condition precedent), the above provision (1) specifies to what the condition precedent refers, (2) sets out the number of days that suffice for prompt notice, (3) expressly states that the Reinsurer need not establish prejudice, and (4) clearly provides that the Reinsurer will be relieved of liability should prompt notice not be provided.[154]

Unable to find any support for the interpretation of the provision urged by Folksamerica, the court concluded that the general policy disfavoring forfeiture of contractual undertakings weighed against treating the provision as a condition precedent.[155] In so holding, the court necessarily found that the New York law making compliance with contractual notice provisions a condition precedent to coverage under primary insurance, even when not explicitly designated as such in the contract, did not apply to reinsurance.[156] The court defended this distinction based on the differences in the contractual undertakings of reinsurers and primary insurers, concluding that "failure to give the required prompt notice is of substantially less significance for a reinsurer than for a primary insurer."[157]

The court then turned to examine the prejudice suffered by Folksamerica from Republic's delay in notice of the loss reserve increase.[158] In evaluating the proof offered by Folksamerica on this element, the court emphasized that in order to be actionable, the prejudice "must take the form of tangible economic injury," and that the loss of a reinsurer's right to associate in the claim would not suffice.[159] The court found that Folksamerica failed to meet its burden on this critical element of its defense.[160] The court rejected the potential prejudice outlined by Folksamerica's in-house counsel as having no basis in fact. In particular, the court found no credible evidence that Folksamerica would suffer tangible economic harm from its inability to provide prompt notice to its reinsurers. The court was equally dismissive of Folksamerica's claim that Republic's late notice caused it to post late reserves on these claims, which led to its being underreserved for a period of time, resulting in the loss of potential tax deductions. In

153. *Id.*
154. *Id.*
155. *Id.* at *7.
156. *Id.* at *9 ("New York law however drastically limits the availability of this remedy in the *reinsurance* context—only offering such relief when the provision clearly and expressly requires notice as a condition precedent.").
157. *Id.*
158. *Id.*
159. *Id.* (citing Unigard Sec. Ins. Co., Inc. v. N. River Ins. Co., 4 F.3d 1049, 1068–69 (2d Cir. 1992)).
160. *Id.* at *10.

rejecting that claim, the court noted that the additional missed reserves were inconsequential when compared to Folksamerica's overall reserves, and that any reserve shortfall would have been covered by the company's IBNR reserves for asbestos in any event.[161] The court found Folksamerica's other claims, including the alleged prejudice to its ability to raise premiums at renewal, unsupportable under the facts of that case.[162] Folksamerica did not raise, and the court did not address, other prejudice arguments available to reinsurers, including the potential prejudice to reinsurers that enter into commutations with their retrocessionaires based on imperfect information due to late notice of claims.

With respect to the provision requiring a definitive statement of loss ("DSOL"), which was expressly stated to be a condition precedent to coverage in the certificates, the court again agreed with Republic's interpretation of the provision, finding that the DSOL requirement was not a "second notice provision" triggered upon the reinsured's first notice of a qualifying claim or occurrence.[163] Rather, the "only viable reading of the DSOL mandates that it be read to require a detailed billing, promptly after submission of a summary invoice, as a condition precedent to Folksamerica's duty to remit its reinsurance payment."[164] In evaluating when Republic first acquired the duty to submit the DSOL, the court focused on the meaning of the word "promptly" in the provision.[165] The court found that the mandate of a "prompt" submission limits the amount of allowable time between Republic's billing to the reinsurer and its transmittal of the DSOL to a "reasonable time."[166] As to those losses that were billed at the time the action was commenced, the court found that the length of Republic's delay, if any, and whether such delay was reasonable involved material issues of fact that could not be resolved on a motion for summary judgment. The court also saved for another day the broader questions of (1) how the intermediary's role as an agent of Folksamerica or Republic might affect the operative date of notice to Folksamerica,[167] and (2) whether Folksamerica's receipt of information regarding the same claims as a treaty reinsurer constituted constructive notice of the claims sufficient to defeat any late notice defense.[168]

In 2004, the federal district court in New York revisited the provisions on motions for summary judgment on Folksamerica's remaining "notice"

161. *Id.*
162. *Id.* at *11.
163. *Id.* at *12.
164. *Id.*
165. *Id.* at *13.
166. *Id.*
167. *Id.* at *6.
168. *Id.* at *13.

defense relating to Republic's alleged failure to provide a DSOL (defined as documentation sufficient to allow the reinsurer to establish adequate loss reserves and determine the propensities of the loss) with respect to one of its reinsurance presentations, which was a condition precedent under the reinsurance certificates.[169] In evaluating the sufficiency of the information submitted by Republic, the court observed that upon receiving the information, Folksamerica was able to post "claim reserves" (not precautionary reserves) at an amount that exceeded the amount billed at that point and equaled the total amount that Republic would eventually bill Folksamerica on the loss.[170] At the same time, the court recognized that "Folksamerica was not obligated to accept, without sufficient documentation, Republic's assurances that coverage [under the original and reinsurance policies] was proper."[171] After wading through the extensive letter writing campaign between the parties concerning documentation of the claim (which only ended when Folksamerica accepted an offer to audit Republic's files), the court concluded that the cedent's responses to its reinsurer's inquiries "were always prompt, and were never indicative of evasion."[172] This was enough to satisfy the documentation requirements under the certificates.

5. Extracontractual Obligations

A reinsurer's obligation to reimburse its cedent for amounts paid to an insured in excess of policy limits was the subject of the opinion from the Tenth Circuit in *Employers Reinsurance Corp. v. Mid-Continent Casualty Co.*[173] The litigation arose from a dispute between Mid-Continent and its reinsurer, Employers Reinsurance Corp. ("ERC"), over the proper treatment of different categories of attorney fees that Mid-Continent was required to pay in declaratory judgment proceedings against its insureds. The fees at issue included (1) attorney fees incurred by the insureds in defending the underlying tort actions against them, and (2) attorney fees incurred by the insureds in the declaratory judgment action brought by Mid-Continent, both of which Mid-Continent was ordered to pay based on a finding that it wrongfully denied policy benefits to its insured.

Resolution of the dispute hinged on the proper classification of amounts paid as "losses" or "claim expenses" under the parties' excess of loss reinsurance agreement. The reinsuring agreement defined "loss" as including "punitive, exemplary, or compensatory damages" awarded to the insured

169. Folksamerica Reinsurance Co. v. Republic Ins. Co., No. 03 Civ. 6608 (VM), 2004 WL 1043086, at *2–3 (S.D.N.Y. May 6, 2004).
170. *Id.*
171. *Id.* at *6 n.10.
172. *Id.* at *4–6.
173. 358 F.3d 757 (10th Cir. 2004).

as a result of the conduct of Mid-Continent, with different percentages of reinsurance applying depending on whether ERC had counseled with Mid-Continent and concurred in the course of conduct in advance of any such conduct. The reinsuring agreement also obligated ERC to reimburse Mid-Continent for "claim expenses" if the amount of losses exceeded Mid-Continent's retention, at a rate equal to the fraction of the "loss" for which ERC was ultimately responsible. "Claim expenses" were defined in the reinsuring agreement as payments made by Mid-Continent under the supplementary payments provision in its underlying insurance agreements. In the case of the insured's coverage fees, the treatment of amounts paid as "losses" dictated whether the reinsured had exceeded its retention. With respect to attorney fees incurred by the insureds in defending the underlying tort actions, the classification of such payments controlled the percentage at which ERC would have to reimburse covered payments.

On the first issue, the Tenth Circuit reversed the district court and found that the meaning of the word "compensatory damages" was ambiguous as applied to attorney fees incurred by the insured in the coverage action. The appellate court relied on the fact that courts in different contexts had alternatively (and inconsistently) viewed "compensatory damages" as including or excluding attorney fees awarded to an insured in a coverage action. The Tenth Circuit remanded the issue to the district court for further proceedings to determine the meaning of the term "compensatory damages" in the reinsuring agreement. The court contemplated that such proceedings should include consideration of the circumstances surrounding the execution of the contract and "other relevant evidence," including custom and practice in the industry.

The Tenth Circuit found no ambiguity in the proper treatment of the insured's underlying defense costs, which the insurer was ordered to pay in the subsequent coverage action. As to those fees, the court noted that had they been properly paid by the insurer at the time they were incurred, they would have been classified as "claim expenses." The court was reluctant to classify such fees differently when awarded as part of a judgment in a subsequent declaratory judgment action, recognizing that such disparate treatment might violate public policy because it would create a potential financial incentive for the insurer to refuse to provide a defense to its insured.[174]

The last issue addressed was the interpretation of the provisions imposing different obligations on the reinsurer depending upon whether it had "counseled and concurred" in the conduct of the reinsured upon which the award of attorney fees was based. ERC contended that for the damages to be fully reinsured as a "loss" under the agreement, the counseling and

174. *Id.* at 770–71.

concurrence must have occurred before the first step in Mid-Continent's course of conduct, i.e. before Mid-Continent filed the declaratory judgment action against its insured. Mid-Continent, on the other hand, contended that it sufficed for the counseling and concurrence to occur before the last step in its course of conduct, i.e., when the declaratory judgment action concluded. The Tenth Circuit disagreed with both parties, finding that the percentage to be treated as a loss under the agreement "depends upon whether the damages arose from conduct predating ERC's concurrence in the course of conduct."[175] Under the circumstances, the court concluded that the attorney fees award might be properly allocated and paid at different rates based on the date of ERC's concurrence in the declaratory judgment action.

In *Home Insurance Co. v. Mississippi Insurance Guaranty Ass'n*,[176] the Mississippi Supreme Court rejected a primary insurer's attempt to recover extracontractual payments to its insured as a claim against the estate of an insolvent excess insurer. The payments at issue arose from the refusal of Home Insurance, a primary insurer, to settle a claim against its insured within its $500,000 policy limits. The subsequent trial against the insured resulted in a $2 million verdict against the insured. Unfortunately, by the time of the verdict, the insured's excess carrier, Mission National Insurance Co., had become insolvent, leaving the insured personally exposed for the excess judgment. In order to avoid a bad faith claim by its insured for failure to settle the lawsuit within policy limits, Home Insurance eventually agreed to pay the entire amount of the verdict and took an "assignment" of the insured's potential claims against Mission for amounts in excess of its policy limits.

Home Insurance subsequently pursued a claim against the Mississippi Insurance Guaranty Association ("MIGA"), as the guarantor of Mission's policies, for the statutory limit of $300,000 available to insureds of the insolvent carrier. MIGA sought dismissal of Home Insurance's claim on the grounds that the claim was really for amounts owed by Home Insurance as a result of its bad faith refusal to settle, and that Home Insurance was not an insured of Mission. The Mississippi trial court, appellate court, and supreme court all agreed with MIGA, refusing to recognize the claim as an assertion of the insured's assigned claims, and instead finding that the "assignment" was really a "a disguised subrogation attempt."[177] The supreme court observed that to be entitled to subrogation, Home Insurance must show that it paid for something that another party (in this case, Mission) is legally obligated to pay. The court concluded that because it refused

175. *Id.* at 773.
176. No. 2001-CA-01074-SCT, 2004 WL 63612 (Miss. Jan. 15, 2004).
177. *Id.* at *1.

to settle within its policy limits, Home Insurance was liable for the entire judgment, and therefore not entitled to subrogate against Mission.[178]

6. Privity and Cut-Through

Reprising its decision from a year ago in connection with the liquidation of Legion Insurance Company, in March 2004, the Pennsylvania Commonwealth Court in *Koken* v. *Reliance Insurance Co.*[179] adopted a referee's recommendation that certain insureds of Reliance Insurance Company be entitled to directly access facultative reinsurance contracts covering their businesses. The decision arose out of an arrangement in which Reliance Insurance Company issued fronting liability policies to two hospitals, with American Healthcare Indemnity Co. ("AHIC") reinsuring 100 percent of the risk. The reinsurance agreements with AHIC did not contain a cut-through clause providing for direct payment of reinsurance proceeds to an insured. They did, however, provide that if Reliance became insolvent, the reinsurance proceeds would be paid directly to Reliance, its liquidator or "other listed person."

On a motion by one of the hospitals, the referee had determined that the relationship between the insured and the reinsurer was such that allowing the insured to have direct access to the reinsurance was appropriate, even though the reinsurance contracts themselves did not contain cut-through provisions. In adopting the referee's recommendation, the judge relied on evidence establishing that the reinsurer had agreed to assume the direct liability of the original insured, that a familiar relationship existed between the insured and the reinsurer, and that the insureds had little or no contact with Reliance and seemingly exclusive contact with the reinsurer. The court found that such facts supported a novation of the reinsurance agreement, allowing the insured to stand in the shoes of the primary insurer and accept recovery under the reinsurance agreement as its exclusive remedy. Accordingly, any liability that Reliance may have owed to the hospitals was discharged and assumed by AHIC.[180]

7. Terrorism

The federal district court decision in *Combined Insurance Co. of America v. Certain Underwriters at Lloyd's, London* reported in last year's survey article was affirmed by the Second Circuit on August 22, 2003.[181] The Second Circuit held, in an unpublished decision, that the legislation that Congress passed in the wake of September 11 (the Air Transportation Safety and

178. *Id.* at *2.
179. 846 A.2d 167 (Pa. Commw. Ct. 2004).
180. *Id.* at 171.
181. 75 Fed. Appx. 799 (2d Cir. 2003).

System Stabilization Act and the Aviation and Transportation Security Act) did not give the Southern District of New York jurisdiction over disputes involving reinsurance of claims arising from the terrorist attacks.

### B. *Arbitration*

Court decisions from the last year tended to support the traditional preference for arbitration over litigation, both in the construction of arbitration clauses and in the deference afforded to arbitration awards. In other areas, however, including discovery and the confidentiality of awards, courts were somewhat less predictable. One state court refused to seal an arbitration award despite the parties' agreement to keep the award confidential, and courts continue to disagree regarding the arbitration panel's power to subpoena third-party witnesses and documents.

#### 1. Arbitrability

The scope and enforceability of arbitration provisions in reinsurance contracts is an issue that state and federal courts continued to face, with differing results, during the past year. Some courts interpreted arbitration clauses narrowly, despite the federal policy favoring arbitration of disputes. In *New Hampshire Insurance Co. v. Canali Reinsurance Co.*,[182] New Hampshire Insurance Company ("NHIC") insured expenses incurred by its insured for claims on certain vehicle service contracts. Canali reinsured NHIC's obligations to its insured. The reinsurance contract contained an arbitration clause that provided, in relevant part, that "[a]ll 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, and in the event of the arbitrators failing to agree, to the decision of an umpire to be chosen by the arbitrators."[183] NHIC and Canali also entered into a trust agreement pursuant to which NHIC made deposits in a trust account of money due to Canali under the reinsurance agreement. Canali claimed that NHIC underfunded the trust account and sought arbitration for breach of the reinsurance agreement.

The district court denied Canali's petition for arbitration, stating that "[n]arrow arbitration clauses such as the one upon which [Canali] relies cannot authorize compulsion of the arbitration disputes beyond their scope."[184] The court emphasized that the clause was restricted to disputes "arising out of the interpretation of this Agreement," and therefore could not be expanded to covered disputes regarding amounts due under the

182. No. 03 Civ. 8889 LTSDCF, 2004 WL 769775 (S.D.N.Y. Apr. 12, 2004).
183. *Id.* at *1.
184. *Id.* at *2.

agreement.[185] The court found that its interpretation was reinforced by the service of suit clause in the reinsurance agreement that stated that disputes regarding amounts due under the agreement will be submitted to the jurisdiction of a U.S. court.[186] On this latter point, the court did not appear to consider the fact that service of suit clauses are often incorporated in reinsurance agreements to comply with state "credit for reinsurance" laws, which generally provide that the service of suit language is not intended to override or limit the parties' agreement to arbitrate their disputes.[187]

Similarly, in *Farm Bureau Mutual Insurance Co. v. American International Group, Inc.*,[188] the court narrowly interpreted an arbitration clause in a reinsurance contract between Farm Bureau and American International Group ("AIG") and allowed the claim to proceed in court. Farm Bureau agreed to reinsure certain construction and business interruption risks insured by AIG. A dispute arose between the parties regarding representations made by AIG's agents, on which Farm Bureau relied in entering into the reinsurance contracts. AIG demanded arbitration. Farm Bureau opposed arbitration and filed suit, seeking rescission of the contracts on the basis of AIG's alleged misrepresentations.

The arbitration clause provided that "[a]ll disputes or differences arising out of the interpretation of this Agreement shall be submitted to the decision of two arbitrators."[189] The judge considered this to be a narrow clause, since it applied only to disputes over the interpretation of the contracts. The court rejected AIG's argument that the misrepresentation claims could not be decided without interpreting the reinsurance agreement, observing that the question was not how to interpret the contract, but whether a valid contract exists. The court also held, however, that if the contract is valid, the issue of what amount Farm Bureau owes AIG should be arbitrated because it would require interpretation of the terms of the contract.[190]

Other courts interpreted arbitration provisions more expansively, showing a willingness to expand the scope of arbitration provisions even to parties not explicitly named in the reinsurance agreement. In *Continental Casualty Co. v. Certain Underwriters at Lloyd's London*,[191] Lloyd's agreed to provide excess of loss reinsurance to Legion Insurance Company. The placement slip included a reference to an "arbitration clause" that incorporated by reference a standard clause providing for arbitration of all dis-

185. *Id.* at *3.
186. *Id.*
187. *Cf.* Sec. Life Ins. Co. of Am. v. Hannover Life Reassurance Co., 167 F. Supp. 2d 1086, 1089 (D. Minn. 2001) (finding that service of suit clause does not affect or limit a mandatory arbitration clause contained in a reinsurance agreement).
188. No. 4:03-CV-10050, 2003 WL 21976034 (S.D. Iowa May 28, 2003).
189. *Id.* at *1.
190. *Id.* at *3–4.
191. No. 02 Civ. 960 (TPG), 2004 WL 515532 (S.D.N.Y. Mar. 15, 2004).

putes arising from the slip. Legion ceded 100 percent of its risk to a group of quota share reinsurers, including Continental, which underwrote twenty percent of that risk. The slip's definition of "reinsured" included Legion and the quota share reinsurers.

Continental and the other quota share reinsurers paid Legion's losses to the extent that their $16.5 million in excess of loss reinsurance applied. Lloyd's refused to pay, claiming rescission on the ground of misrepresentation of the risk by Legion. The quota share reinsurers sought arbitration on the rescission issue. The court held that the quota share reinsurers, including Continental, were reinsureds who were entitled to seek arbitration under the excess of loss contract.[192]

In another case, the Tenth Circuit applied the arbitration clause in a reinsurance contract to disputes arising under other contracts between the parties, at least where the contracts are related. In *National American Insurance Co. v. SCOR Reinsurance Co.*,[193] a surety sued its reinsurer, contending that the reinsurer was liable for losses under two surety bonds on which it allegedly acted as co-surety. The reinsurer sought arbitration on the ground that the allegations fell within the scope of a separate reinsurance treaty between the parties. The arbitration clause in the treaty provided that "[a]ny irreconcilable dispute between the parties to this Agreement will be arbitrated in Chandler, Oklahoma, in accordance with the attached Arbitration Clause."[194] The attached clause provided that "as a condition precedent to any right of action hereunder, any irreconcilable dispute between the parties to this Agreement" will be arbitrated.[195]

The trial court held that the surety's claims were predicated on the reinsurer's independent commitment to act as co-surety on the bonds and, therefore, denied the reinsurer's motion to compel arbitration. On appeal the surety maintained that the use of the term "hereunder" in the attached clause limited the arbitration provision to those disputes arising under the treaty. The Tenth Circuit rejected this argument, holding that the treaty required "any irreconcilable dispute" to be arbitrated without limiting language.[196] The appellate court further held that any doubts concerning the scope of arbitrable issues should be resolved in favor of arbitration. The court was persuaded that the reinsurer's obligations under the treaty and its obligations as a co-surety were "closely related," because the reinsurer only agreed to act as co-surety as part of the underlying reinsurance transaction.[197]

192. *Id.* at *7.
193. 362 F.3d 1288 (10th Cir. 2004).
194. *Id.* at 1289–90.
195. *Id.* at 1291.
196. *Id.*
197. *Id.*

2. Stay of Litigation or Arbitration Proceedings

Generally, courts will refuse to allow litigation to proceed where the parties have agreed that arbitration is a condition precedent to any right of recovery under the contract. For example, in *Hartford Accident and Indemnity Co. v. Ace American Reinsurance Co.*,[198] the court refused a request by Hartford to stay the litigation rather than dismiss it, where the reinsurance contract between Hartford and one of its reinsurers, Chartwell, expressly provided that arbitration was a condition precedent to any right of action under the contract. The court held that a stay was not appropriate where the parties expressly agreed that as a condition precedent to any right of action, arbitration must first take place.[199]

A federal court in Connecticut decided an interesting and complicated case involving the interplay between state and federal law in the interpretation of reinsurance contracts, particularly with respect to arbitration procedures. In *Security Insurance Co. of Hartford v. Trustmark Insurance Co.*,[200] Security and Trustmark Insurance Company ("TIG") entered into a reinsurance agreement that contained both an arbitration clause and a choice-of-law clause that provided for the application of California law. Security filed a third-party suit against TIG, alleging fraud and negligent misrepresentation. Security moved to stay the proceedings pending arbitration on the basis of a California statute permitting stays under certain circumstances, notwithstanding the absence of such a provision in the Federal Arbitration Act ("FAA"). The court granted the stay, relying on *Volt Information Sciences v. Board of Trustees*,[201] which held, "[w]here . . . the parties have agreed to abide by state rules of arbitration, enforcing those rules according to the terms of the agreement is fully consistent with the goals of the FAA, even if the result is that arbitration is stayed where the Act would otherwise permit it to go forward."[202]

The court declined to follow the line of cases cited by TIG supporting the "strong default presumption" that the FAA, not state law, supplies the rules for arbitration.[203] According to the court, these cases "overlook[ ] the interpretative process inherent in carrying out the fundamental policy of the FAA of ensuring 'the enforceability, according to their terms, of private agreements to arbitrate.'"[204] The court added:

198. No. X02CV030178122S, 2003 WL 22245421 (Conn. Super. Ct. Sept. 23, 2003) (unpublished).

199. *Id.* at *7.

200. 283 F. Supp. 2d 602 (D. Conn. 2003), *aff'd*, 360 F.3d 322 (2d Cir. 2004).

201. 489 U.S. 468 (1989).

202. *Id.* at 479.

203. *Sec. Ins. Co.*, 283 F. Supp. 2d at 606 (quoting Sovak v. Chugai Pharm. Co., 280 F.3d 1266, 1269 (9th Cir. 2002)).

204. *Id.* (quoting *Volt*, 489 U.S. at 476).

> Although the FAA preempts state arbitration rules, absent the parties' intent to incorporate the same, state law provides the tools by which the intent of the parties is ascertained. If the parties so intend it, the otherwise preempted state arbitration law supersedes the FAA by the parties' choice. The resolution of the question lies in fundamental principles of contract interpretation under, in the present case[,] California state law.[205]

Relying on California principles of contract interpretation, the court concluded that the choice-of-law clause dictated the incorporation of state rules governing arbitration proceedings.

*Tonicstar Ltd. v. American Home Assurance Co.*[206] illustrates the point that courts in England may not look kindly on a party's attempt to use a stay to gain a purely tactical advantage. In *Tonicstar*, American Home had entered into a facultative excess of loss reinsurance contract with a Lloyd's syndicate. The syndicate later sought to rescind the policy for misrepresentation, and it filed suit in the English High Court on that basis. American Home sued the syndicate in federal court in New York. Shortly thereafter, American Home then moved the English court to stay the Lloyd's suit pending arbitration and petitioned the New York court to compel arbitration and restrain the English proceedings. The English High Court was piqued by American Home's actions, which it saw as an attempt to gain a tactical advantage in the litigation. The High Court concluded that England was the "natural forum" for the litigation because the treaty was drafted in England and placed through Lloyd's brokers, the terms and conditions were on a Lloyd's form on a slip policy containing standard Lloyd's terms, the premiums were payable in England, and the misrepresentations were allegedly made in England.[207]

### 3. Panel Composition

In *Continental Casualty Co. v. Hartford Steam Boiler Inspection & Insurance Co.*,[208] the federal court in Chicago ruled that Continental had the right to select both party-appointed arbitrators because its reinsurer failed to timely appoint its own arbitrator. The arbitration clause provided that if one party failed to timely select its arbitrator, the other party would be allowed to select a second arbitrator. Hartford Steam Boiler's mailroom inadvertently failed to deliver Continental's demand for arbitration to the proper person at Hartford Steam Boiler, allowing the appointment period to run.[209] The

205. *Id.* at 608.
206. 2004 Q.B. 118, 2004 WL 1174139 (Queen's Bench Div. May 26, 2004).
207. *Id.* at ¶ 11.
208. No. 03 C 1441, 2004 WL 725469 (N.D. Ill. Mar. 30, 2004) (unpublished).
209. *Id.* at *2.

judge was not impressed by the excuse and ruled that the provision was unambiguous and should be enforced according to its express terms.[210]

4. Consolidation

Consolidation is an issue in which one party pits considerations of efficiency and convenience against another party's right to separate arbitration of disputes arising under separate reinsurance contracts. In one recent case addressing the issue, the federal district court in Massachusetts rebuffed First State Insurance Group's repeated attempts to obtain a consolidated arbitration of its disputes with Employers Insurance of Wausau under multiple reinsurance contracts.[211] In a previous decision between the parties on the same issue, the district court had denied First State's request to consolidate, finding that consolidation, while preferable, could not be compelled.[212] Subsequently, the First Circuit held in a different case that the issue of consolidation is one for the arbitrator to decide.[213] In an odd twist, instead of asking the district court to reconsider its ruling based on this intervening precedent, First State asked the American Arbitration Association ("AAA") to appoint a single arbitration panel. In response, Wausau and Nationwide filed motions to enforce the district court's anticonsolidation ruling. The district court ordered First State to withdraw its request to the AAA, stating that it was the court's province, not the litigants', to correct errors of law.[214]

5. Confirmation/Vacation of Awards

Courts rarely vacate an arbitration award, even where the arbitration panel has clearly misapplied the law or facts of a case. The cases decided during the last year provided no exception to that general rule.

In *LDG Re v. Reliance Insurance Co.*,[215] LDG Re was the 100 percent reinsurer of workers' compensation business written by Reliance between 1997 and 1999. The reinsurance treaty provided that if the premiums exceeded losses for a particular month, Reliance would pay the difference to LDG, and if losses exceeded premiums, LDG would pay the difference to Reliance. The treaty was subsequently amended to provide that credits in favor of LDG would not include uncollected premiums. LDG allegedly failed to make payments to Reliance under the treaty, and Reliance sought arbitration. An arbitration panel awarded Reliance $50.8 million. LDG

210. *Id.* at *3–4.
211. Employers Ins. of Wausau v. First State Ins. Group, 324 F. Supp. 2d 333 (D. Mass. 2004).
212. *Id.* at 335.
213. Shaw's Supermarkets, Inc. v. UFCW, 321 F.3d 251 (1st Cir. 2003).
214. *Employers Ins. Of Wausau*, 324 F. Supp. 2d at 337–39.
215. No. Civ. A-04–1419, 2004 WL 1368826 (E.D. Pa. June 15, 2004) (unpublished).

contested the portion of the award that gave Reliance more than $6 million in uncollected premium credits, arguing that the issue of premium credits was not before the panel. The court disagreed, however, because Reliance's notice of arbitration stated that it was seeking "amounts past due and owing" under the treaty and that the issue to be arbitrated was whether LDG had "any legitimate or principled basis to withhold payment to Reliance."[216] The arbitration award was confirmed.

*Sphere Drake Insurance Co. v. All American Life Insurance Co.*[217] provides a good example of the extent to which a court will go to find a basis for confirming a flawed arbitration award. Sphere Drake sought to confirm an arbitration award that invalidated six reinsurance contracts with All American. One of the key issues in the dispute was the authority of All American's broker to enter into the reinsurance contracts. The arbitration panel had issued its award based on the parties' written submissions and a hearing on Sphere Drake's motion for judgment on the pleadings. The panel found that All American admitted in its position statement that its broker did not have authority to bind the six contracts. One of the arbitrators dissented vigorously on the ground that All American did not receive due process because it was not permitted to engage in discovery and present evidence.

All American cross-moved to vacate the award on several grounds, including the evident partiality of one of the panel members, leading to one of the most significant rulings on arbitrator partiality in recent years. Upon the case's return to district court, All American renewed its motion to vacate on three other grounds: (1) that it did not receive a fundamentally fair hearing; (2) that the panel members exceeded their authority in issuing the decision; and (3) that the panel exhibited a manifest disregard of the law.

The court denied All American's renewed motion to vacate. First, the court noted that All American had an opportunity to brief the issue and present oral argument to the panel, and its real complaint was that the panel erred in its interpretation of the evidence.[218] This was insufficient in the court's view because "factual or legal errors by arbitrators—even clear or gross errors—do not authorize courts to annul awards."[219] The court also rejected All American's argument that the agency issue went to contract formation, which is an issue for the judiciary, not arbitrators, to decide. The court held that All American had agreed to arbitrate the entire dispute with Sphere Drake, including the validity and existence of the reinsurance contracts. Consequently, All American could not now challenge

216. *Id.* at *5–6

217. No. 01 C 5226, 2004 WL 442640 (N.D. Ill. Mar. 8, 2004) (unpublished), *aff'd*, 103 Fed. Appx. 39 (7th Cir. 2004).

218. *Id.* at *5.

219. *Id.* (citations omitted).

the panel's authority to decide whether the parties entered into binding contracts.[220] Finally, the court held that the panel did not exhibit a "manifest disregard of the law" in issuing the award. According to the court, there must be more than an error in applying substantive law in order to vacate an arbitration award; the award must either require the parties to violate the law or exceed the arbitrators' authority. Neither of these two conditions was met in this case.[221]

6. Discovery

Although not a decision concerning reinsurance per se, *Hay Group, Inc. v. E.B.S. Acquisition Corp.*[222] addresses the thorny issue that arises frequently in the context of reinsurance arbitrations. There is a split of authority among the U.S. Courts of Appeals regarding the power of an arbitration panel to subpoena nonparties prior to the hearing.[223] In *Hay Group*, the Third Circuit weighed in on the issue, holding that under Section 7 of the FAA, arbitrators do not have the power to compel a nonparty witness to produce documents pursuant to a prehearing subpoena, unless the witness is summoned to produce the documents before the arbitrators in person.

In *Schlumbergersema, Inc. v. Xcel Energy, Inc.*,[224] the federal district court in Minnesota was faced with a similar thorny question posed by a conflict between the FAA and the Federal Rules of Civil Procedure with respect to the enforcement of an arbitration deposition subpoena directed to a nonparty. Notably, the Eighth Circuit had previously granted district courts the authority to enforce an arbitration panel subpoena requiring production of documents beyond the 100-mile territorial limit provided for in Rule 45(b)(2) of the Federal Rules of Civil Procedure.[225] In *Schlumbergersema*, the district court refused to extend that authority to a subpoena requiring a nonparty to produce a corporate witness for deposition in another state.[226] The court justified the different approach on the basis that a production of documents is less onerous and imposes a lesser burden on the nonparty than does a witness deposition.

In *Gulf Insurance Co. v. Transatlantic Reinsurance Co.*,[227] a New York appellate court held that a clause that gave reinsurers access to "all records of [the cedent] that pertain in any way" to the treaty did not function as a

220. *Id.* at *11–12.
221. *Id.* at *12–13.
222. 360 F.3d 404 (3d Cir. 2004).
223. *See* Louis J. Aurichio, *Circuit Split Deepens Over Scope of FAA Pre-Hearing Subpoena Authority*, 15–1 Mealey's Litig. Rep.: Reinsurance, May 13, 2004.
224. No. Civ. 02–4304 PAMJSM, 2004 WL 67647 (D. Minn. Jan. 9, 2004).
225. In the Matter of Arbitration Between Sec. Life Ins. Co. of Am. & Duncanson & Holt, 228 F.3d 865, 870–71 (8th Cir. 2000).
226. *Schlumbergersema*, 2004 WL 67647, at *2.
227. 788 N.Y.S.2d 44 (App. Div. 2004).

per se waiver of the attorney-client or product privilege.[228] The court held that the reinsurers were free to challenge any privilege claim, but that the inspection clause was not a "blanket waiver of those privileges under all circumstances."[229]

7. Confidentiality of Award

Courts have become increasingly reticent to confer blanket confidentiality in the context of litigation and settlement of litigation. That wariness is apparently spreading to arbitration awards, despite the tradition of keeping arbitrations confidential. Most notably, in *Travelers Insurance Co. v. Connecticut General Life Insurance Co.*,[230] a Connecticut court refused to seal an arbitration award, despite the fact that both parties to the award agreed to its confidentiality. In that case, the arbitration panel issued an award that did not include specific language concerning confidentiality, but the parties agreed to keep confidential all documents and communications concerning the arbitration. When the parties sought to confirm the award, they asked the court to seal the accompanying documents and the court agreed to do so.[231] Travelers later moved to enforce the confirmation order and again the parties agreed that the documents should be filed under seal. This time, however, the court refused to seal the documents, stating that the parties must show that they would suffer a specific injury if the documents were not sealed. In May 2003, which was between the date of the confirmation of the award and the ruling on the motion to enforce the confirmation order, the Connecticut courts had adopted new rules concerning the filing of documents under seal.[232] These new rules included a presumption that all documents filed with the court are available to the public. Under the new rules, courts must articulate an "overriding interest" in protection to justify sealing a court filing. The court found no such interest present in the *Travelers* case.[233]

C. *Litigation*

Jurisdictional issues, particularly subject matter jurisdiction, seemed to dominate the reinsurance decisions issued in litigated cases over the past year. Courts generally appeared to interpret issues of subject matter jurisdiction more narrowly than issues of in personam jurisdiction. Courts also

228. *Id.* at 45.
229. *Id.* at 46.
230. No. CV030822323, 2003 WL 22413681 (Conn. Super. Ct. Oct. 14, 2003) (unpublished).
231. *Id.* at *1.
232. *Id.* at *2.
233. *Id.* at *3–4.

issued decisions reaffirming the broad scope of permissible discovery in litigation.

1. In Personam Jurisdiction and Indispensable Parties

*Dion Durrell & Associates, Inc. v. S. J. Camp & Co.*[234] applied typical due process principles to a reinsurance dispute. As is the case in most states, the Texas long-arm statute grants jurisdiction to courts where the defendant has established minimum contacts with the forum state and jurisdiction meets traditional notions of fair play and substantial justice. NHIC, a Texas corporation, contracted with Camp to assist in obtaining a reinsurer for NHIC. Camp then contacted Dion, an insurance intermediary, to structure a proposal for submission to a potential reinsurer. NHIC eventually entered into a reinsurance agreement with Allianz Bermuda. Camp sued NHIC, Dion, and Allianz, alleging that they breached an agreement that Camp would be the reinsurance intermediary for NHIC. In particular, Camp accused Dion of trying to deprive Camp of its commission. Dion representatives traveled to Texas, made calls, and sent faxes and e-mails to Texas in facilitating the reinsurance contract between NHIC and Allianz Bermuda. These actions constituted sufficient minimum contacts to establish jurisdiction in the Texas courts.[235]

In *Tribune Co. v. Swiss Reinsurance America Corp.*,[236] a federal court refused to dismiss a suit involving an assumption agreement between Reliance National Insurance Company and Swiss Re, ruling that Reliance's liquidator was not a necessary party to the action. Tribune sought direct payment from Swiss Re for workers' compensation claims originally assumed by Reliance and reinsured with Swiss Re. The court found that complete relief could be awarded in the liquidator's absence and would not expose Swiss Re to a substantial risk of multiple or inconsistent obligations.[237]

2. Subject Matter Jurisdiction

Several cases decided during the past year involved issues of subject matter jurisdiction, particularly with respect to foreign sovereigns. In *Elixir Shipping, Ltd. v. Perusahaan Pertambangan Minyak Dan Gas Bumi Negara*,[238] a federal court held that U.S. courts do not have jurisdiction over an Indonesian shipping company merely because its insurer is reinsured by U.S. companies. The Indonesian shipping company was held to be an agency or instrumentality of a foreign state and therefore was immune from U.S.

234. 138 S.W.3d 460 (Tex. App. 2004).
235. *Id.* at 465–66.
236. No. 02 C 4772, 2003 WL 22282465 (N.D. Ill. Sept. 30, 2003) (unpublished).
237. *Id.* at *7.
238. 267 F. Supp. 2d 659 (S.D. Tex. 2003).

jurisdiction under the Foreign Sovereign Immunities Act ("FSIA").[239] The FSIA contains an exception to sovereign immunity where the foreign entity engages in commercial activity in the United States or engages in commercial activity that causes a direct effect in the United States.[240] The court held that the procurement of reinsurance in the United States did not fall within this "commercial activity" exception.[241] Although the reinsurers could have potential liability as a result of the shipping company's commercial activity in Indonesia, that effect was not sufficiently direct or immediate to fall within the exception.

In a similar case, *Allstate Insurance Co. v. Banco Do Estado Do Rio Grande Do Sul, S.A.*,[242] a federal court held that the defendant Banco Do Estado Do Rio Grande Do Sul, S.A ("Banrisul"), a state-owned Brazilian company, was immune from suit under the FISA, even though its former subsidiary entered into reinsurance contracts in the United States. Uniao was a member of a pool of Brazilian insurance companies that entered into a series of reinsurance contracts, including five with Allstate. Each of the contracts contained an arbitration clause whereby the parties agreed to resolve any disputes by arbitration in Illinois. Uniao was later sold by its parent corporation, Banrisul, a state-owed Brazilian corporation. The documents governing the auction of Banrisul's shares in Uniao provided that Brazilian law would govern any dispute. As part of the sale, Banrisul agreed to be responsible to Uniao's new owner for Uniao's obligations.

In 2000, after Uniao failed to pay amounts that it owed to Allstate under the reinsurance contracts, Allstate commenced five arbitration proceedings against Uniao in Illinois and ultimately obtained judgments that were judicially confirmed in the U.S. District Court. After being informed by Uniao that Banrisul was responsible for payments of the judgments, Allstate filed a petition against Banrisul in Illinois. Banrisul moved to dismiss the petition for lack of subject matter jurisdiction, claiming that it was immune to suit in the United States because it was a "foreign state" under the FSIA.[243]

The court granted Banrisul's motion to dismiss, rejecting Allstate's argument that Banrisul had waived its sovereign immunity by allowing Uniao to enter into the reinsurance contracts. Although Banrisul owned eighty-eight percent of Uniao's voting shares and admitted that it possessed "almost absolute power to control" Uniao, the court found that Uniao was not acting as an agent of Banrisul when it entered into the reinsurance contracts.[244]

239. 28 U.S.C. § 1610(c) (2000).
240. *Elixir Shipping*, 267 F. Supp. 2d at 663.
241. *Id.* at 665.
242. No. 04 Civ. 1550 (DLC), 2004 WL 1398437 (S.D.N.Y. June 23, 2004) (unpublished).
243. *Id.* at *1–2.
244. *Id.* at *4.

The court stated, "Allstate has not shown that Banrisul exercised day-to-day control over Uniao's operations, that Uniao was required to obtain Banrisul's prior approval before entering into the contracts with Allstate, or that Banrisul abused the corporate form."[245] The court concluded that the lawsuit was, in essence, an attempt to avoid litigating the Uniao judgments in Brazil.[246]

Finally, as previously noted, in *Combined Insurance Co. of America v. Certain Underwriters at Lloyd's, London*,[247] the Second Circuit affirmed a lower court ruling stating that the Air Transportation Safety and System Stabilization Act of 2001[248] does not vest the Southern District of New York with jurisdiction over reinsurance disputes arising from the events of September 11. Specifically, the court held that the issue of whether Lloyd's breached the reinsurance contract turns on interpretation of the contract, and did not require the court to refer to or choose among competing descriptions of the events of September 11.[249]

### 3. Forum Non Conveniens/Improper Forum

A long delay in filing a motion to dismiss for improper venue does not necessarily defeat such a motion, according to the Seventh Circuit in *American Patriot Insurance Agency, Inc. v. Mutual Risk Management, Ltd.*[250] Nine months after American Patriot filed suit for fraud and breach of contract against its reinsurers, the reinsurers filed a motion to dismiss the suit on improper venue grounds based on a forum selection clause contained in a contract between the plaintiff and one of the reinsurers' affiliates. The motion was granted. The Seventh Circuit held that the delay was not improper. Improper venue could be waived, however, if the defendant said that he was content with the venue of the suit, or if he stalled to see "which way the wind is blowing."[251]

In *Transatlantic Reinsurance Co. v. Continental Insurance Co.*,[252] a New York court transferred a reinsurance contract dispute to a California federal court, where an action concerning the same issues and parties was pending. In granting the transfer, the court relied not only on the "first to file" rule, but also looked to the convenience of the parties and witnesses, particularly nonparty witnesses, many of whom were located in California.

245. *Id.* at *5.
246. *Id.* at *6.
247. 75 Fed. Appx. 799 (2d Cir. 2003).
248. Pub. L. No. 107–42, 115 Stat. 230 (2001), *codified at* 49 U.S.C. § 40101 (2004).
249. *Combined Ins. Co. of Am.*, 75 Fed. Appx. at 801.
250. 364 F.3d 884 (7th Cir. 2004).
251. *Id.* at 888.
252. No. 03 Civ. 3227 (CBM), 2003 WL 22743829 (S.D.N.Y. Nov. 20, 2003) (unpublished).

4. Discovery

At least one case decided in the last year permitted discovery of reinsurance information in the context of a direct insurance action. For example, in *PECO Energy Co. v. Insurance Co. of North America*,[253] PECO filed a motion to compel its insurers to produce information concerning their reinsurance, reserves, and other policyholders' claims files. The insurers argued against production of the reinsurance information on the grounds of relevancy and attorney-client, work product, and trade secret privileges, claiming that the disclosure would "threaten the very foundation of the reinsurance market."[254] The court noted that reinsurance information can be relevant to rebut an affirmative defense, such as late notice.[255] The court also noted that while reinsurance information may raise confidentiality concerns, there is no absolute exclusion to discovery of reinsurance information and, in fact, such discovery has been permitted by other courts.[256] Furthermore, the court observed that confidentiality and commercial sensitivity concerns can be alleviated by a stipulated confidentiality agreement by the parties.[257] The court found the policy argument regarding the dangers associated with producing reinsurance information equally unpersuasive, observing that "the fact that the reinsurance industry has endured despite the widespread discovery of such information belies their ominous warning."[258]

D. *Insolvency*

In *Commercial Risk Re-Insurance Co. v. Superintendent of Insurance of the State of New York*,[259] Commercial Risk Re-Insurance Company sued the rehabilitator of Frontier Insurance Company for the return of sums deposited in a trust account pursuant to a 1996 reinsurance agreement between Commercial Risk and Frontier. As a foreign reinsurer, Commercial Risk was required under New York law to establish a trust account to secure its liabilities. The trust agreement gave Frontier the right to withdraw assets from the trust account at any time without notice. Eleven days before it was placed into rehabilitation, Frontier withdrew $1.7 million from the trust account (which had been funded by premiums ceded to Commercial Risk) even though Frontier was owed only $68,000 at the time. The rehabilitator admitted that these sums were improperly withdrawn from the

253. 852 A.2d 1230 (Pa. Super. Ct. 2004). *See also* Eric Rothschild, Louis J. Schwartzberg, & Christopher J. Lowe, *Discoverability of Reinsurance Information: PECO Energy Company v. Insurance Company of North America*, 15–7 Mealey's Litig. Rep.: Reinsurance, p. 12, Aug. 5, 2004.

254. *PECO*, 852 A.2d at 1233.

255. *Id.*

256. *Id.* at 1234.

257. *Id.*

258. *Id.* at 1234 n.6.

259. 769 N.Y.S.2d 530 (App. Div. 2003).

trust account and used to pay expenses not provided for in the trust agreement.[260]

Auditors eventually determined that over $1.2 million of the converted trust funds remained in Frontier's money market account at the time of the liquidation. Commercial Risk sought the immediate return of these funds, contending that they were not properly treated as general funds of the estate and that to allow them to remain as part of the estate would give the liquidator greater rights over the funds than those possessed by Frontier. As to the trust funds that were dissipated, the reinsurer requested an order directing the rehabilitator to set aside an amount equivalent to those funds in a separate account for the benefit of the reinsurer.

The trial court in New York County denied Commercial Risk's request for immediate return of the funds, but did order segregation of the entire converted amount in a separate account. On appeal, the court held that Commercial Risk was entitled to immediate return of the over $1.2 million converted from the trust account and still in the possession of the rehabilitator, finding that such funds "never became property of Frontier, but rather became subject to a constructive trust in Commercial Risk's favor."[261] As to the funds that had been dissipated, the appellate court found that the reinsurer was merely a common creditor of the estate, and was thus not entitled to have funds segregated in a separate account.

Finally, in *Koken v. Reliance Insurance Co.*,[262] the Pennsylvania Commonwealth Court refused to compel the liquidator of Reliance Insurance Company to arbitrate a setoff dispute under two reinsurance treaties, despite the existence of arbitration provisions in the treaties. Although the treaties contained arbitration clauses, the court held that the liquidation order prohibited the arbitration of disputes without the liquidator's consent.[263] As one commentator noted, the decision "raises more questions than it answers," because it failed to clearly distinguish prior Pennsylvania cases enforcing arbitration provisions against receivers of insolvent insurers.[264]

260. *Id.* at 531.
261. *Id.* (citation omitted).
262. 846 A.2d 778 (Pa. Commw. Ct. 2004).
263. *Id.* at 781.
264. *See* Daryn Rush, *The Right to Arbitrate Against Receivers: Koken v. Reliance Decision Raises Questions*, 15–2 Mealey's Litig. Rep.: Reinsurance, p. 10, May 27, 2004.