RECENT DEVELOPMENTS IN EXCESS, SURPLUS LINES, AND REINSURANCE

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I. REINSURANCE

Case law developments affecting the reinsurance industry addressed a number of issues in the last year, from a reinsurer's liability in excess of the "Reinsurance Accepted" amount in a facultative certificate, to the power of arbitration panels, to the discovery of reinsurance and claims information. Key decisions in each area are discussed below.

A. *Liability Beyond the "Reinsurance Accepted" Amount in Facultative Certificates*

In this survey period, the Second Circuit asked the New York Court of Appeal to address a significant issue of New York law relating to the Second Circuit's *Bellefonte* opinion.[1] In the well-known *Bellefonte* case, the court held that the "Reinsurance Accepted" section in a facultative certificate unambiguously caps the amount a reinsurer is obligated to pay for both loss and defense expenses incurred by the ceding company.[2] As covered in past surveys, this issue has been disputed in the courts for years.

In December 2016, faced with another case in which the cedent disputed the court's conclusion in *Bellefonte*,[3] the Second Circuit expressed a potential openness to reconsider the *Bellefonte* decision, stating:

> [W]e find it difficult to understand the *Bellefonte* court's conclusion that the reinsurance certificate in that case unambiguously capped the reinsurer's liability for both loss and expenses. Looking only at the language of the certificate, we think it is not entirely clear what exactly the 'Reinsurance Accepted' provision in *Bellefonte* meant. Evidence of industry custom and practice might have shed light on this question, but the *Bellefonte* court did not consider any such evidence in its decision.[4]

Because the proper interpretation of the facultative certificate was an issue of New York law, the Second Circuit certified a question to the New York Court of Appeals asking:

> Does the decision of the New York Court of Appeals in *Excess Insurance Co. v. Factory Mutual Insurance Co.* . . . impose either a rule of construction, or a strong presumption, that a per occurrence liability cap in a reinsurance contract limits the total reinsurance available under the contract to the amount of the cap regardless of whether the underlying policy is understood to cover expenses such as, for instance, defense costs?[5]

1. Bellefonte Reins. Co. v. Aetna Cas. & Sur. Co., 903 F.2d 910 (2d Cir. 1990).
2. *Id.* at 914.
3. Global Reins. Corp. of Am. v. Century Indem. Co., 843 F.3d 120, 128 (2d Cir. 2016).
4. *Id.* at 126.
5. *Id.* at 128.

On January 10, 2017, the New York Court of Appeals agreed to accept the certified question regarding the *Bellefonte* decision.[6] Oral argument before the New York Court of Appeals was held shortly after this survey period ended, on November 15, 2017. On December 14, 2017, the court issued its decision, answering the certified question in the negative.[7] The decision will be analyzed in more detail in the next survey.

B. *Power of Arbitration Panels*

In this survey period, several cases analyzed the powers of arbitration panels. In *Mountain Valley Property, Inc. v. Applied Risk Services, Inc.*, the First Circuit affirmed a ruling that an arbitrator did not manifestly disregard the law or exceed its powers in ruling a dispute was not arbitrable.[8] At issue was whether Mountain Valley had to arbitrate its claims against Applied Risk under a Reinsurance Participation Agreement (RPA) between the parties.[9] After a prior federal court referred the dispute to arbitration to determine the arbitrability of the claims, the appointed arbitrator ruled that the case had to be adjudicated in court. In particular, the arbitrator concluded that under the McCarran-Ferguson Act, the Nebraska Uniform Arbitration Act (NUAA), which banned enforcement of arbitration clauses in "insurance-related cases" regardless of the intent of the parties, reverse-preempted the Federal Arbitration Act (FAA) and required in-court adjudication of the RPA dispute.[10] The arbitrator also distinguished case law cited by Applied Risk on the grounds that it did not involve the issue of whether a dispute could be arbitrated as a matter of law.[11]

After the Maine federal court denied Applied Risk's motion to vacate the arbitrator's decision, Applied Risk appealed to the First Circuit. On appeal, Applied Risk argued that the arbitrator failed to properly consider case law that mandated the dispute be arbitrated based on the intent of the parties.[12] Noting that it was not deciding "whether the arbitrator's decision was correct," the First Circuit ultimately affirmed the arbitrator's power to determine that the dispute was not arbitrable.[13]

The appellate court first noted that under Section 10 of the FAA, courts have limited powers to review arbitration awards.[14] It then described how the arbitrator "carefully distinguished" the case law cited

6. Global Reins. Corp. of Am. v. Century Indem. Co., 68 N.E.3d 98 (N.Y. 2017).
7. Global Reins. Corp. of Am. v. Century Indem. Co., — N.E.3d —, No. 124, 2017 WL 6374281, at *2 (N.Y. Ct. App. Dec. 14, 2017).
8. Mountain Valley Prop. v. Applied Risk Servs., 863 F.3d 90, 91 (1st Cir. 2017).
9. *Id.*
10. *Id.*
11. *Id.* at 92–93.
12. *Id.* at 95.
13. *Id.*
14. *Id.* at 94–95.

by Applied Risk and "carefully applied the framework" for determining if the McCarran-Ferguson Act applied and the NUAA reverse-preempted the FAA.[15] Because the "arbitrator's reasoning and conclusions [were] at the very least colorable" the First Circuit concluded that it could not vacate the arbitrator's award.[16] It also found that the arbitrator did not exceed his powers, explaining that the arbitrator in fact decided "precisely the question the district court . . . authorized him to decide . . . whether the dispute was arbitrable."[17]

At the other end of the spectrum, in *Minnieland Private Day School, Inc. v. Applied Underwriters Captive Risk Assurance Company, Inc.*, the Fourth Circuit held that only a court, and not an arbitration panel, had the authority to determine whether a dispute under an RPA was arbitrable under the McCarran-Ferguson Act and Virginia law.[18] There, Minnieland argued the RPA was an "insurance contract," not a "reinsurance" agreement, and, under the McCarran-Ferguson Act, Virginia Code § 38.2-312 reverse-preempted the FAA and rendered the arbitration provision void.[19] In response, Applied moved to compel arbitration of the issue, arguing that the RPA arbitration clause contained a provision delegating the issue of arbitrability to the arbitrator (the "Delegation Provision"), including the exclusive authority to decide whether the RPA was an insurance contract subject to Virginia Code § 38.2-312.[20]

After the Virginia federal court held that the question of arbitrability was to be decided by a court and not an arbitrator, Applied appealed to the Fourth Circuit. On appeal, Applied argued that the lower court wrongly determined that the Delegation Provision was not enforceable and that the RPA was an insurance contract. The Fourth Circuit disagreed, holding that because the Delegation Provision "constitute[d] 'an additional antecedent agreement' to arbitrate," the court was required to consider Minnieland's challenge to it before ordering compliance with it.[21] This meant that "the court, not an arbitrator, should determine whether the RPA constitutes an insurance contract" for purposes of Virginia law.[22]

Ultimately, because the Fourth Circuit found that Virginia Code § 38.2-312 "renders void delegation provisions in putative insurance contracts—at least to the extent such provisions authorize an arbitrator to resolve

15. *Id.* at 95.
16. *Id.* (citations omitted).
17. *Id.*
18. Minnieland Private Day Sch., Inc. v. Applied Underwriters Captive Risk Assurance Co., 867 F.3d 449, 459 (4th Cir. 2017), *appeal filed* (Nov. 14, 2017).
19. *Id.* at 452–53.
20. *Id.* at 452.
21. *Id.* at 455 (citing Rent-A-Center, West, Inc. v. Jackson, 561 U.S. 63 (2010)).
22. *Id.* at 457.

whether the contract at issue constitutes an 'insurance contract,'" it affirmed the lower court's denial of the motion to compel.[23] It also directed the parties to brief the issue of whether the RPA is an insurance contract under Virginia law and remanded the case to the district court for that determination.[24]

Finally, in *General Re Life Corporation v. Lincoln National Life Insurance Co.*, a Connecticut federal court held that an arbitration panel had the authority to issue a "clarified" arbitration award months after the arbitration panel's initial issuance of the award, finding that the *functus officio* doctrine did not preclude such "clarification" where the initial award was ambiguous and the clarified award did not alter the purpose or substance of the original award.[25]

The case involved a yearly renewable term reinsurance agreement between the parties (Treaty) under which Gen Re had the authority to increase the reinsurance premiums as long as the increase was based on a change in anticipated mortality.[26] Significantly, if Gen Re exercised that authority, the Treaty granted Lincoln a corresponding right to recapture the reinsured life insurance policies.[27] In 2014, after Gen Re increased the Treaty's reinsurance premiums, Lincoln asserted the increase was improper and demanded arbitration.[28]

In July 2015, the arbitration panel issued an award in favor of Gen Re's right to raise rates and outlined an approach for implementing a recapture if Lincoln chose that option (Final Award).[29] Lincoln did decide to recapture, but the parties disagreed about how to interpret the Final Award, prompting Lincoln to ask the arbitration panel to resolve the recapture dispute.[30] Gen Re objected, claiming that the panel was not empowered to reconsider and change the Final Award.[31] Nevertheless, the arbitration panel issued a "Clarification" detailing the proper method for implementing a recapture under the Final Award and Treaty.[32]

Gen Re petitioned the Connecticut federal court to confirm the Final Award and Lincoln cross-petitioned to confirm the Clarification.[33] The court considered whether the panel had the power to issue the Clarifica-

23. *Id.*
24. *Id.* at 459.
25. General Re Life Corp. v. Lincoln Nat'l Life Ins. Co., — F. Supp. 3d ——, No. 15-cv-1860, 2017 WL 1230844, at *1 (D. Conn. Mar. 31, 2017), *appeal filed* (Aug. 14, 2017).
26. *Id.*
27. *Id.*
28. *Id.*
29. *Id.* at *1–2.
30. *Id.* at *3.
31. *Id.* at *4.
32. *Id.*
33. *Id.* at *5.

tion under an exception to the *functus officio* doctrine.[34] The court explained that "for the arbitrators to have had the authority to issue" the Clarification, the Final Award "must be found to have been ambiguous" and the Clarification "must merely clarify the ambiguity and not substantively change the Final Award."[35]

Ultimately, the court concluded that the Final Award was ambiguous and that the panel had the authority to issue the Clarification.[36] In the court's view, the fact that both parties and the arbitration panel each interpreted the recapture aspect of the Final Award differently supported a finding of ambiguity.[37] The court also held that the Final Award was ambiguous in the context of the Treaty "because of the potential contradiction" between the Final Award and the Treaty.[38] Lastly, the court emphasized that because of the "strong deference" courts give to the arbitral process, it was important to defer to the arbitration panel's own conclusion that there was an ambiguity in the Final Award requiring issuance of the Clarification.[39]

The court found the Clarification was consistent with the Final Award and merely clarified the ambiguity therein, noting the Clarification focused on the relief, not the substance of the Final Award.[40] It further explained the Clarification did not modify the "spirit and basic effect" of the Final Award.[41] Accordingly, the court confirmed the clarified arbitration award.

C. *Discovery of Reinsurance and Claim Information in Reinsurance Disputes*

In this survey period, a number of courts addressed whether reinsurance and claim information was discoverable in reinsurance disputes. The cases are discussed below.

In a lawsuit brought by a cedent against its reinsurer under two facultative reinsurance contracts, a Pennsylvania federal court granted a reinsurer's motion to compel further discovery responses from the cedent and denied the cedent's motion to compel.[42] In connection with a late notice defense, the reinsurer sought the cedent's historical loss reserves regarding underlying asbestos-related claims. The court stated that the

34. *Id.* at *7.
35. *Id.* at *9.
36. *Id.* at *10.
37. *Id.* at *11–12.
38. *Id.* at *12.
39. *Id.*
40. *Id.* at *12–14.
41. *Id.* at *15.
42. R&Q Reins. Co. v. St. Paul Fire & Marine Ins. Co., Civ. No. 16-1473, 2017 WL 3272016 (E.D. Pa. Aug. 1, 2017).

loss reserves were relevant to whether the cedent provided "prompt notice of loss" because the information could demonstrate when the cedent "had notice of potential losses" from the policyholder.[43] The court added that the reserve information was not protected by the attorney-client privilege or work-product doctrine because the information was created by claims adjustors, not attorneys, in the ordinary course of business.[44] The court also ordered the cedent to produce information related to other reinsurance contracts covering policies issued to the policyholder because the information was potentially relevant to the late notice defense.[45]

In another reinsurance dispute, a Massachusetts federal court allowed in part and denied in part a request for documents regarding a cedent's allocation of asbestos losses to its reinsurers.[46] Most notably, the court ordered the cedent to produce facultative certificates for reinsurers that were similarly situated in the same block as the defendant reinsurer.[47] On the other hand, the court denied the reinsurer's request for reinsurance agreements outside the block, finding that even if such information was relevant (which the reinsurer could not articulate), it did not outweigh the burden of locating and producing these agreements.[48]

Finally, a Utah federal court ordered that various reinsurance information of insolvent carrier Western Insurance Company was relevant and discoverable in a dispute between Western's Special Deputy Liquidator and several former directors/officers of Western.[49] The Liquidator sued the directors/officers and alleged that they negligently caused the insolvency of Western. Thereafter, the directors/officers filed a motion to compel deposition testimony from the Liquidator regarding Western's reinsurance agreements, reinsurance payments, and settlements with reinsurers.[50] In granting the motion, the court pointed out that the Liquidator essentially admitted the "relevance" of the reinsurance information by arguing that the directors/officers should have submitted reinsurance claims prior to liquidation.[51] The court further noted that, to the extent the Liquidator asserted that it has not received any reinsurance, the discovery requested by the directors/officers would be relevant for purposes

43. *Id.* at *3.
44. *Id.*
45. *Id.*
46. Lamorak Ins. Co. v. Everest Reins. Co., No. 15-cv-13425, 2017 WL 4876219, at *1 (D. Mass. May 26, 2017).
47. *Id.*
48. *Id.*
49. Western Ins. Co. v. Rottman, Civ. No. 13-cv-436, 2016 WL 7480361 (D. Utah Dec. 29, 2016).
50. *Id.* at *2.
51. *Id.* at *3.

of verification.[52] Finally, the court noted that "if Western had received payment for [reinsurance] claims, depending on the policy and the claims, that payment may provide evidence of the claims' value on the day of liquidation."[53]

II. EXCESS INSURANCE

This reporting period saw several important decisions addressing the intertwined and overlapping issues of exhaustion, allocation, "elective stacking," non-cumulation, and prior insurance clauses. Four of the more significant cases of the year addressing these issues are discussed below.

A. *Exhaustion, Allocation, and "Elective Stacking"*

Two courts addressed underlying exhaustion and allocation among multiple secondary policies in the context of progressive injury cases. In one of the cases, the court applied horizontal exhaustion; in the other case, the court held that the specific language of each excess policy must be examined to determine whether horizontal or vertical exhaustion applies with respect to that policy.

In *Nooter Corp. v. Allianz Underwriters Insurance Co.*, the Missouri Court of Appeals addressed whether horizontal or vertical exhaustion applied where multiple excess policies contained different policy language relating to underlying exhaustion.[54] Horizontal exhaustion requires all lower-level policies to exhaust their limits of liability before any excess insurer's obligations are triggered, and vertical exhaustion requires only that the policy directly underlying the excess policy exhaust its limits.[55] Nooter, a defendant in approximately 20,000 asbestos bodily injury lawsuits, filed suit seeking defense and indemnity coverage from multiple primary and excess insurers and certain primary policies claim exhaustion.[56]

Nooter and eight umbrella and excess insurers filed appeals from the trial court's order granting in part and denying part various parties' summary judgment motions.[57] Before addressing methods of exhaustion, the court first reaffirmed its prior decision *Doe Run Resources Corp. v. Certain Underwriters at Lloyd's, London*,[58] requiring joint and several liability among insurers and applying "all sums" allocation.[59] The court next addressed the challenge to the trial court's ruling that the vertical exhaustion

52. *Id.*
53. *Id.*
54. — S.W.3d ——, 2017 WL 4365168 (Mo. Ct. App. Oct. 3, 2017).
55. *Id.* at *9.
56. *Id.* at *1.
57. *Id.* at *3–4.
58. 400 S.W.3d 463, 475 (Mo. Ct. App. 2013).
59. *Nooter Corp.*, 2017 WL 4365168, at *8.

method applied to determine the order in which excess insurers must respond to claims.[60]

The court first evaluated the substantially similar "Other Insurance" clauses in certain of the excess insurance policies.[61] The clauses generally provide that if "other valid and collectible insurance . . . is available . . . covering a loss also covered by this Policy," this insurance shall "be excess of and shall not contribute with such other insurance. . . ."[62] The court noted that the "Other Insurance" clauses, in isolation, require Nooter to exhaust all other insurance first, but after surveying other jurisdictions and Missouri precedent finding such clauses applicable only where policies provide concurrent (as opposed to consecutive) coverage, the court determined that at a minimum the "Other Insurance" clauses were ambiguous under the circumstances and construed the policies in favor of Nooter and vertical exhaustion.[63]

The court next analyzed "older" policies issued by Certain Underwriters at Lloyd's, London and Certain London Market Insurance Companies (London Policies) that did not contain "Other Insurance" clauses. The London Insurers argued that the definition of "Ultimate Net Loss" required horizontal exhaustion because the London Policies' liability was limited to sums paid in settlement or losses "after making deductions for all recoveries, salvages and other insurance . . . whether recoverable or not. . . ."[64] Nooter argued that the Attachment of Liability provision required the Policies to attach upon exhaustion of the underlying primary insurance.[65] The court agreed with Nooter and concluded that the Ultimate Net Loss provision was only relevant for determining how liability under the London Policies would be calculated, not when the policies would be triggered.[66]

The court turned next to the North Star excess policy, which was identical to the London policies but lacked London's Attachment of Liability provision.[67] North Star argued that without language that specifically identified underlying coverage, all underlying policies must exhaust before its

60. *Id.* at *9.
61. *Id.* at *10.
62. *Id.* at *11.
63. *Id.* at *12.
64. *Id.* at *13.
65. *Id.* The London Policies contained the following provision:

ATTACHMENT OF LIABILITY.

Liability under this Policy shall not attach unless and until the Primary Insurers shall have admitted liability for the Primary Limit or Limits, or unless and until [Nooter] has by final judgment been adjudged to pay a sum which exceeds such Primary Limit or Limits.

66. *Id.*
67. *Id.* at *14.

policy was triggered.[68] The court disagreed. It found that the absence of a provision requiring horizontal exhaustion did not alter the "implied exhaustion" requirement of excess policies, which mandates that only the underlying policy must exhaust before attaching.[69]

Finally, the court addressed Evanston Insurance Company's excess policies, which contained language in the insuring agreement requiring Evanston to pay on behalf of its insured "the *ultimate net loss* in excess of the *applicable underlying limits*," which was defined to mean the underlying policy limits *or* "any other available insurance" *or* the retained limit if underlying insurance is applicable.[70] Evanston argued this language overcame the "implied [vertical] exhaustion" and required horizontal exhaustion.[71] The court, however, focused on the disjunctive 'or' and found Evanston's construction unreasonable because "it would be possible for the policy to only require the exhaustion of *any* applicable insurance *not* identified in the schedule of underlying insurance."[72] Instead, the court concluded vertical exhaustion was the proper method, finding the cited language relevant only to the calculation of Evanston's liability.[73] Therefore, each excess policy was triggered upon the exhaustion of its underlying policy(ies) in the same policy period.

In *Montrose Chemical Corp. of California v. Superior Court*, the California Court of Appeal took a different approach to exhaustion analysis.[74] The questions before the court included: (1) whether the trial court correctly concluded that Montrose must horizontally exhaust policies as it seeks indemnification for its over-$100 million liability for environmental contamination associated with its production and manufacturing of dangerous chemicals, including DDT; and (2) whether the over 115 excess policies constituted an "uber-policy" under which Montrose could "electively stack" the policies and "select which policy(ies) to access for indemnification in the manner [it] deem[s] most efficient and advantageous."[75]

The court first rejected Montrose's argument that *State of California v. Continental Insurance Co.*[76] mandates that Montrose's excess policies were one "uber-policy" requiring "all sums with stacking" under which Montrose can seek indemnification from higher-level excess policies before exhausting lower-level excess policies in different policy periods.[77] The

68. *Id.*
69. *Id.*
70. *Id.* at *15.
71. *Id.*
72. *Id.*
73. *Id.*
74. 222 Cal. Rptr. 3d 748 (Cal. Ct. App. 2017), *review granted* (Nov. 29, 2017).
75. *Id.* at 751–52.
76. 281 P.3d 1000 (Cal. 2012).
77. *Montrose*, 222 Cal. Rptr. 3d at 761.

court distinguished *Continental* as a decision regarding whether an insured could access more than one policy in effect during multiple triggered policy periods, not a decision regarding the "order and sequence in which an insured must do so."[78] Moreover, policies must be "interpreted *according to their terms* even if alternative allocation schemes might be more desirable."[79]

The court found the plain language of some policies at issue required the exhaustion of lower-level policies in the same policy period and all other insurance.[80] The American Centennial Policies, for example, agreed to indemnify Montrose for the ultimate net loss in excess of the "'retained limit,'" which was defined as "'the greater of: . . . the total of the applicable limits of the underlying policies listed in [the Declarations] hereof, *and the applicable limits of any other underlying insurance collectible by the insured*.'"[81] This language requires horizontal exhaustion, contrary to Montrose "elective stacking" argument.

In addition, at least some of the excess policies contained "Other Insurance" clauses stating that "if other collectible insurance . . . is available to the insured covering a loss also covered hereunder . . . the insurance hereunder shall be in excess of, and not contribute with, such other insurance." [82] The court dismissed Montrose's argument that Other Insurance clauses concern only how insurers share liability, noting that *Community Redevelopment Agency v. Aetna Casualty & Surety Co.*[83] concluded that similar "other insurance" policy language required exhaustion of all applicable underlying insurance before the insurer's excess policy was obligated to provide indemnity coverage.[84] Therefore, at least some of the policies were inconsistent with elective stacking and the court affirmed the denial of Montrose's summary judgment on this issue.

The court reversed the trial court's ruling granting the excess insurers summary judgment that universal horizontal exhaustion applied to all 115 excess policies, finding this conclusion inconsistent with the language in at least some of the excess policies.[85] The appellate record contained some policies with insuring agreements promising indemnity in excess of scheduled underlying insurance and other policies promising indemnity in excess of scheduled underlying insurance *and* any other valid and collectible insurance.[86] This difference in policy language was evaluated

78. *Id.* at 762.
79. *Id.*
80. *Id.* at 763.
81. *Id.* at 764 (emphasis added by court).
82. *Id.*
83. 57 Cal. Rptr. 2d 755 (Cal. Ct. App. 1996).
84. *Montrose*, 222 Cal. Rptr. 3d at 766–67.
85. *Id.* at 771.
86. *Id.*

in *Carmel Development Co. v. RLI Insurance Co.*,[87] where one policy was excess specific underlying insurance and the other policy was excess all underlying applicable insurance whether scheduled or not.[88] In *Carmel Development*, the court concluded that the policies were not at the same level because the policy that was excess only specific underlying policies would respond prior to the policy that was excess all underlying insurance.[89] Therefore, to determine the order of exhaustion of the excess insurers, it is necessary to evaluate each policy's language.[90] Because the record was incomplete, the court remanded the case to the trial court to determine the order of exhaustion consistent with the plain language of all of the policies.[91]

B. *Exhaustion, Allocation and Non-Cumulation, and Prior Insurance Clauses*

In *Olin Corp. v. OneBeacon America Insurance Company* (*Olin IV*),[92] the Second Circuit addressed the issue of how a prior insurance clause in certain excess policies impacts the method of exhaustion for primary policies and the allocation methodology for sharing among numerous insurers for environmental cleanup of five sites. OneBeacon appealed the trial court's summary judgment ruling and certain issues decided by jury trial.[93] This article addresses only that part of the Second Circuit's decision addressing the trial court's denial of OneBeacon's summary judgment motion seeking application of the OneBeacon policies' prior insurance clause and the Second Circuit's review of the trial court's determination of exhaustion and allocation in light of the New York Court of Appeals' *In re Viking Pump* decision.[94]

OneBeacon issued three excess insurance policies for the policy year 1970–1971.[95] INA provided primary coverage under policies in effect during the period of contamination.[96] London Market Insurers issued certain excess policies that were in effect during the contamination period and prior to the inception of the 1970–1971 OneBeacon policies.[97]

The OneBeacon policies each contain a "prior insurance" provision and a "continuing coverage" clause in Condition C whereby the policy limits

87. 24 Cal. Rptr. 3d 588 (Cal. Ct. App. 2005).
88. *Montrose*, 222 Cal. Rptr. 3d at 768–69.
89. *Id.* at 769 (citing *Carmel Dev.*, 24 Cal. Rptr. 3d at 516–17).
90. *Id.* at 765.
91. *Id.* at 771.
92. 864 F.3d 130 (2d Cir. 2017).
93. *Id.* at 140.
94. 52 N.E.3d 1144 (N.Y. 2016).
95. *Olin IV*, 864 F.3d at 137.
96. *Id.* at 140–41.
97. *Id.*

could be reduced by the amount any prior policy owes Olin for the same loss or where the policy could be called on to pay for loss that takes place after the policy expires.[98] The trial court ruled as a matter of law that Condition C was inapplicable to the present action because the prior insurance provision applied only if the previous policy was issued by the same insurer, and the prior policies were issued by London Market Insurers.[99] Relying on Second Circuit's analysis in *Olin Corp v. American Home Assurance Co.* (*Olin III*),[100] the trial court ruled that each policy in effect during the period of contamination would share in the loss on a pro rata basis.[101]

To evaluate the appeal, the Second Circuit first reviewed the New York Court of Appeals' decision *In re Viking Pump*.[102] The Second Circuit noted that the court of appeals has never adopted a strict mandate for either pro rata or "all sums" allocation, but instead made clear that insurance coverage disputes are to be resolved by looking at the plain language of the policy.[103] The policies at issue in *Viking Pump* included prior insurance provisions which, based on their plain meaning, contemplated a single loss triggering more than one policy.[104] The court concluded that where a policy covers loss or damage that is continuing into other policy periods, joint and several ("all sums") allocation of the loss is warranted and, therefore, vertical rather than horizontal exhaustion was appropriate.[105]

With this understanding of *Viking Pump*, the Second Circuit addressed the issue of exhaustion first. Following the *Viking Pump* decision, OneBeacon argued for the application of a hybrid exhaustion and allocation whereby liability would first be allocated on a pro rata basis until the primary policies horizontally exhaust, and then the excess policies would be jointly and severally liable.[106] OneBeacon argued that based on this methodology, Olin did not prove that all of the triggered primary policies are exhausted and, therefore, Olin cannot meet its burden of proving the OneBeacon policies are triggered and obligated to respond to its losses.[107]

The Second Circuit rejected this argument, finding that *Viking Pump* dictates that all sums and vertical exhaustion apply where policies with prior insurance clauses are among the triggered policies during the con-

98. *Id.* at 137.
99. *Id.* at 138, 140.
100. 704 F.3d 89 (2d Cir. 2012).
101. *Olin IV*, 864 F.3d at 147.
102. *Id.* at 142 (citing *In re* Viking Pump, Inc., 52 N.E.3d 1144 (N.Y. 2016).
103. *Id.*
104. *Id.* at 143.
105. *Id.*
106. *Id.*
107. *Id.*

tamination period.[108] The court found additional support in other provisions of the OneBeacon policies, including the loss payable provision, which demonstrated that the policies were triggered upon the exhaustion of only the underlying policy and not other underlying policies in other policy periods.[109] The court concluded that because the undisputed damages at each site were far in excess of the underlying primary policy, that primary policy was exhausted and the OneBeacon policies were triggered and obligated to respond to Olin's losses.[110] The court therefore vacated and remanded the case to the trial court to enter a new damages amount consistent with all sums allocation and vertical exhaustion.[111]

The court next addressed OneBeacon's argument that the trial court failed to give effect to the policies' prior insurance provision when it concluded the provision did not apply unless the prior insurance was issued by the same insurer. The court agreed. The court acknowledged that the purpose of prior insurance and continuing coverage clauses is to prevent insureds from stacking policy limits to obtain cumulative coverage.[112] The court denied the provisions were ambiguous and concluded that the plain reading of OneBeacon's policies shows no intent to limit the application of the provisions only to circumstances where OneBeacon issued the previous or subsequent policies.[113] The court reasoned that any other reading of the provision would "strip the prior insurance provision of its bargained-for-effect, as evinced by its plain language, and permit Olin to recover multiple times for a single loss by pursuing multiple insurers within the same layer of coverage."[114]

OneBeacon then argued that because Olin could recover from prior insurers in the same layers that its policy limits should be reduced, but the court rejected this out-of-hand.[115] The court concluded that anti-stacking provisions like Condition C are intended to protect against double recovery, which necessarily means that the prior policy has already paid for that specific loss.[116] Therefore, the effect of the prior insurance clause on whether OneBeacon's policy limits are reduced depends on what prior insurers in the same layer paid for the same losses.[117]

108. *Id.* at 144.
109. *Id.*
110. *Id.*
111. *Id.* at 147.
112. *Id.*
113. *Id.*
114. *Id.* (citing Stonewall Ins. Co. v. E.I. du Pont de Nemours & Co., 996 A.2d 1254, 1260 (Del. 2010)).
115. *Id.* at 150.
116. *Id.*
117. *Id.*

The Second Circuit could not resolve this question on the record. The prior policies in the relevant layers were issued by the London Market Insurers, which entered into a global settlement agreement with Olin releasing liability for multiple environmental sites beyond the sites at issue in the litigation.[118] The court was unable to identify a particular amount paid by the London Market Insurers for each of the sites at issue in the litigation. Therefore, the court remanded for the trial court to develop the record and determine the effect of Condition C on OneBeacon's liability, with instructions that it was OneBeacon's burden to show what amount London Market Insurers paid under the relevant policies for each loss in order to reduce policy limits for those losses.[119] The court concluded that if OneBeacon can meet its burden of proof after discovery, it will be entitled to have its limits of liability "reduced accordingly."[120]

In *Travelers Property Casualty Company of America v. Continental Casualty Company*,[121] the primary insurer, Travelers, filed suit against its insured, C.K.S. Packaging, Inc. and the excess insurer, Continental, seeking a declaration that multiple bodily injury claims over the course of five years were caused by one occurrence and that a non-cumulation clause in each of Travelers' five primary policies reduced its total liability to one policy limit.[122]

Travelers accepted CKS's tender of the lawsuits over the course of several years and provided CKS with a defense.[123] Thereafter, Travelers advised CKS that it was taking a "one occurrence" position and that because of the policies' non-cumulation provision Travelers' liability was limited to a single $1 million policy limit, less a single $50,000 retention.[124] Travelers handled the claims and settled a number of lawsuits before it exhausted its single policy limit.[125] Travelers then notified Continental that it exhausted its policy limits and owed no further obligation to CKS.[126] Before it exhausted its applicable policy limits, Travelers filed this declaratory judgment action.[127]

The Travelers policies define "occurrence" as "'an accident, including continuous or repeated exposure to substantially the same general harmful conditions.'"[128] The policies also all contained a non-cumulation amendment that provided:

118. *Id.*
119. *Id.*
120. *Id.* at 151.
121. 226 F. Supp. 3d 1359 (N.D. Ga. 2017).
122. *Id.* at 1365.
123. *Id.* at 1364.
124. *Id.*
125. *Id.*
126. *Id.* at 1364–65.
127. *Id.* at 1365.
128. *Id.* at 1362.

> Non-cumulation of Each Occurrence Limit–If one "occurrence" causes "bodily injury" and/or "property damage" during the policy period and during the policy period of one or more prior and/or future policies that include a Self-Insured Excess Commercial General Liability Coverage Form for the insured issued by us or any affiliated insurance company, the amount we will indemnify the insured for in excess of the "retained limit" is limited. This policy's Each Occurrence limit will be reduced by the amount of each payment made by us and any affiliated insurance company under the other policies because of such "occurrence."[129]

Travelers moved for summary judgment on the "one occurrence" and the application of the non-cumulation clause.[130] The court first addressed the "one occurrence" argument, acknowledging that Georgia employs the cause theory to determine the number of occurrences.[131] Travelers argued that all of the claims constituted a single "occurrence" because the injuries "all involve 'exposure to substantially the same general harmful condition'" because all of the claimed injuries were caused by the bottle used to package the gel fuel.[132] Therefore, Travelers argued that the "harmful condition" was "substantially the same."[133]

The court agreed. The court explained that the "cause theory" focuses on the proximate cause of the injury, not the "but for" cause.[134] The court held that the decision to use the CKS bottle to package gel fuel for use with firepots was the "constant, uninterrupted cause" that led to the bodily injury claims, and thus there was a single occurrence.[135]

The court next addressed whether the non-cumulation provisions apply to limit Travelers' liability to one policy limit.[136] The plain language provides that the non-cumulation provision reduces the policy limits of each policy by payments made by other Travelers policies for damages caused by the same "occurrence."[137] Continental argued that evidence of Travelers' claims handling demonstrates that Travelers itself did not treat the claims as one occurrence.[138] Continental pointed out that Travelers set up different claim numbers and claim notes for each policy year; Travelers set reserves and paid claims from policies based on the date of the bodily injury; and that Travelers initially charged CKS more than one retained limit.[139]

129. *Id.* at 1363.
130. *Id.* at 1365.
131. *Id.* at 1368.
132. *Id.*
133. *Id.*
134. *Id.* at 1369.
135. *Id.* at 1369–70.
136. *Id* at 1370.
137. *Id.*
138. *Id.* at 1372–73.
139. *Id.*

The court rejected Continental's argument because it was based on extrinsic evidence and neither party argued that the policy language was ambiguous.[140] Instead, the court evaluated the plain language and relied on Georgia precedent,[141] as well as additional decisions outside of the jurisdiction affirming the application of the non-cumulation clause where the damages taking place over multiple policy periods were all caused by one occurrence.[142] Therefore, the court granted Travelers' motion for summary judgment finding the injuries were all caused by one occurrence and that the policies' non-cumulation clauses were effective and reduced Travelers' total liability for all injuries caused by the same occurrence to one policy limit.[143]

III. SURPLUS LINES

Courts during this past year addressed issues affecting surplus lines carriers and the interpretation and application of surplus lines policies. Recent developments clarified the applicability of insurance laws to surplus lines policies given the specialized risks being insured, the requirements applicable to such surplus line policies in order to fall outside of generally applicable insurance law, and the validity of arbitration provisions in surplus lines policies. Finally, there were some regulatory changes as well, including the right of surplus lines carriers domiciled in Texas to write domestic risks.

A. *Interpretation of Surplus Lines Policies As Specialized Risks*

The court in *Palmer Park, Square, LLC v. Scottsdale Insurance Company* considered whether an insured's claim for penalty interest is considered a claim "on the policy" and, if so, whether Michigan's tolling provision applies to a surplus line insurer.[144] The insured owned a vacant apartment complex that was broken into and vandalized. Eighteen months later, it submitted a property loss notice to Scottsdale, which acknowledged receipt of the notice and noted a number of coverage restrictions under the policy, in particular a two-year limitations period following the date of the loss.[145] The insured then invoked its right to an appraisal for a damages assessment and the parties agreed that the total loss was $1,642,796. Scottsdale conceded policy limits.[146]

140. *Id.* at 1373.
141. Plantation Pipeline Co. v. Cont'l Cas. Co., No. 03-CV-2811, 2008 WL 10884027 (N.D. Ga. July 9, 2008).
142. *Travelers*, 226 F. Supp. 3d at 1371.
143. *Id.* at 1373–74.
144. Palmer Park, Square, LLC v. Scottsdale Ins. Co., C.A. 16-11536, 2017 WL 227958 (E.D. Mich. Jan. 19, 2017), *appeal filed* (Feb. 10, 2017).
145. *Id.* at *1.
146. *Id.*

Shortly after receiving final payment, the insured demanded $125,754 in "penalty interest" for the first time, stemming from Scottsdale's purported failure to satisfy the claim in a timely manner. Nearly four years after the loss, the insured filed suit claiming that Scottsdale failed to remit payment within sixty days of receiving the notice of loss, entitling it to twelve percent interest.[147] Scottsdale moved for summary judgment on the basis that the insured's claim was brought outside of the policy's two-year limitations period.

The court rejected the plaintiff's argument that a claim for penalty interest constitutes an "independent cause of action" under the Michigan Insurance Code.[148] Rather, the court held that the penalty interest was inseparable from a claim "on the Policy" and therefore was subject to the two-year period of limitations contained in the policy at issue.[149] Nonetheless, the insured argued that the limitations period was a "red herring" because the insurance code's mandatory tolling should be applied to the policy, precluding enforcement of a limitations period absent a formal denial of liability.[150] The court rejected this argument too, reasoning that while the code requires every *standard* policy to include a tolling provision, "surplus line insurance contracts are not subject to the general provisions of the Insurance Code."[151] Under the insurance code, "surplus line insurers are free to include policy 'language' that is otherwise inconsistent with the 'code' so long as it does not 'misrepresent the true nature of the policy.'"[152]

The court reasoned that "the ability to offer individualized insurance coverage enables such insurers, through the use of non-standard forms, to tailor their policies to the exact needs of the insured, and also to perform a valuable service in writing deductibles."[153] Because surplus line carriers are permitted to insure only those risks that a traditional authorized carrier will not, they serve a critical function in the marketplace.[154] However, this "symbiotic relationship" contains risks for both sides—an insured must be aware that the carrier is willing to insure against higher risks, and the policy will be tailored to enable it to take those higher risks.[155]

147. *Id.* at *2.
148. *Id.* (citing MICH. COMP. LAWS § 500.2006)).
149. *Id.* at *3.
150. *Id.* (citing MICH. COMP. LAWS § 500.2833(1)(q)).
151. *Id.* (quoting Gulf Underwriters Ins. Co. v. McClain Indus., Inc., 765 N.W.2d 16 (Mich. 2009)) (emphasis in original).
152. *Id.* at *4 (citing MICH. COMP. LAWS § 500.1904(2)).
153. *Id.* (quoting Royal Prop. Grp., LLC v. Prime Ins. Syndicate, Inc., 706 N.W.2d 426, 437 (Mich. Ct. App. 2005)).
154. *Id.* (citing MICH. COMP. LAWS § 500.1910(1)).
155. *Id.*

Thus, the court held that Scottsdale was "not subject to the general provisions of the Insurance Code," because the risk associated with insuring the vacant property "was much higher than the traditional market was willing to bear."[156] Therefore, the insured "should have known to pay particular attention to the policy because it was obtained through a surplus lines insurance carrier."[157] The limitations period under the policy was clear and Scottsdale was entitled to judgment as a matter of law dismissing the insured's claim for penalty interest.[158]

The court in *Berenato v. Seneca Specialty Insurance Company* addressed surplus lines law in the context a warehouse fire that occurred after the insured turned off its sprinkler system.[159] The defendants—the insurer, broker, and surplus lines licensee—responded that the unambiguous language of the policy barred coverage.[160] The court granted the defendants' motion for summary judgment.[161]

The plaintiff owned a vacant building in Philadelphia for which he purchased a policy from Seneca containing a "protective safeguards endorsement" stating that as a condition of his coverage, the insured was required to maintain certain "protective devices or services" on the property, including an "automatic sprinkler system."[162] The insured turned off the sprinkler system, but did not notify the insurer.[163] The property then caught fire and the insurer refused to cover the loss because the insured had violated the protective safeguards endorsement by disabling the sprinkler system.[164]

When the insured purchased the policy, he informed the broker that there was a functioning sprinkler system on the property.[165] The proposal the broker obtained from the insurer, which the insured admitted he accepted, outlined the scope of coverage and the relevant exclusions, including the protective safeguards endorsement and its sprinkler system requirement.[166] The insurer then issued the policy, but the insured never received it due to a transmission error involving the surplus lines licensee and the broker.[167]

The court first held that the protective safeguards endorsement was unambiguous and that the insured violated it when he turned off the

156. *Id.*
157. *Id.* (citing *Royal Prop. Grp.*, 706 N.W.2d at 439).
158. *Id.*
159. 240 F. Supp. 3d 351, 353 (E.D. Pa. 2017).
160. *Id.*
161. *Id.*
162. *Id.* at 353–54.
163. *Id.* at 354.
164. *Id.*
165. *Id.* at 355.
166. *Id.*
167. *Id.*

sprinkler system.[168] Next, it rejected the plaintiff's argument that the insurer could not rely on the endorsement because he never received the insurance policy.[169] Importantly, the court held that the surplus lines insurer had no duty under Pennsylvania law to deliver the policy, and the plaintiff did not have a reasonable expectation of coverage for fire-related losses in the absence of a working sprinkler system.[170]

Addressing the issue of whether the surplus lines insurer had a duty to deliver the policy, the court held that the duty fell on the surplus lines licensee. Pennsylvania's surplus lines statute provides that "[u]pon placing surplus lines insurance, the surplus lines licensee shall deliver to the insured or the writing producer the contract of insurance."[171] This is consistent with the statute's purpose of "[p]rotecting persons seeking insurance" by requiring non-admitted insurers to issue policies through regulated surplus lines licensees, rather than interacting directly with customers.[172] As a result, surplus lines insurers are "not permitted to have direct contact with the insured" and must instead "rely upon intermediaries to deliver the policy to the insured."[173] Thus, Seneca was only required to deliver the policy to the licensee, which it did.[174]

The plaintiff further argued that Seneca could not invoke the protective safeguards endorsement because, having never received the policy, the plaintiff had no reason to believe that a working sprinkler system was a precondition to coverage.[175] The court rejected application of the "reasonable expectations" doctrine, which holds that "the proper focus for determining issues of insurance coverage is the reasonable expectations of the insured."[176] Undisputedly, the plaintiff knew he needed to maintain a working sprinkler system. He acknowledged such to the broker and the plaintiff's own expert opined that the plaintiff "*believed that he could not shut the sprinkler system down as the Seneca insurance policy required it*."[177] Thus, there was no genuine dispute that the plaintiff was aware that he could not turn his sprinkler system off without risking a loss of insurance coverage. Summary judgment was granted in favor of the insurer.[178]

168. *Id.* at 356.
169. *Id.* at 358.
170. *Id.*
171. *Id.* at 358–59 (citing 40 PA. CONS. STAT. § 991.1612(a)).
172. *Id.* at 359 (citing 40 PA. CONS. STAT. § 991.1601); *see also* Al's Cafe, Inc. v. Sanders Ins. Agency, 820 A.2d 745 (Pa. Super. Ct. 2003) (discussing legislative purpose).
173. *Berenato*, 240 F. Supp. 3d at 359 (citing Tudor Ins. Co. v. Twp. of Stowe, 697 A.2d 1010, 1018 (Pa. Super. Ct. 1997)).
174. *Id.*
175. *Id.*
176. *Id.* (citing Reliance Ins. Co. v. Moessner, 121 F.3d 895, 903 (3d Cir. 1997)).
177. *Id.* (emphasis in original).
178. *Id.* at 359–60.

Likewise, the plaintiff's claims against the broker and surplus lines licensee also failed as a matter of law. There was no evidence that the broker agreed to do anything other than procure insurance for the plaintiff, which it did, satisfying any contractual obligations it had.[179] There was also no evidence that the broker's alleged breach caused the plaintiff's damages, because there was no evidence that the plaintiff would have acted differently had he received the policy.[180] For this reason, summary judgment was also appropriate in favor the surplus lines licensee.[181]

B. *Qualification as a Surplus Lines Policy Under Florida Law*

In *Houston Specialty Insurance Company v. Vaughn*, the U.S. District Court for the Middle District of Florida addressed competing allegations regarding breach of the duty to defend and breach of a cooperation clause, the latter of which hinged upon whether the policy qualified as a surplus lines policy.[182] The court held that there were triable issues of fact as to whether the policy qualified as a surplus lines policy because the copy submitted to the court lacked statutorily mandated language that is required for all surplus lines policies in Florida.[183]

Houston Specialty Insurance Company (HSIC) argued that the insureds failed to cooperate by rejecting its defense and settling the underlying action without its knowledge.[184] The insureds argued that HSIC failed to comply with Florida statutes, thus waving its right to enforce the cooperation clause.[185] Under Florida insurance law, in order for an insurer to deny coverage based on a coverage defense, the insurer must comply with the claims administration process set forth in Section 627.426(2) of the Florida Statutes, which requires the insurer to comply with certain written notice requirements, obtain a non-waiver agreement from the insured, and retain independent counsel mutually agreeable to the parties.[186] In particular, an insurer's claim that an insured has not complied with a cooperation provision is a "coverage defense" subject to the requirements of the statute.[187]

It was undisputed that HSIC did not send a reservation of rights letter within the statute's specific time period after learning that the insureds

179. *Id.* at 361.
180. *Id.*
181. *Id.* at 364.
182. 8:15-cv-2165-T-17AAS, 2017 WL 990581 (M.D. Fla. Mar. 14, 2017), *appeal filed* (Oct. 10, 2017).
183. *Id.* at *6.
184. The underlying state court claim involved a roofer falling through the roof of a mobile home, resulting in personal injuries. *See* Houston Specialty Ins. Co. v. Vaughn, 8:15-cv-2165-T-17AAS (M.D. Fla. July 14, 2015).
185. *Houston Specialty*, 2017 WL 990581, at *6.
186. *Id.* at *5 (citing FLA. STAT. § 627.426(2)).
187. *Id.* (citing Mid-Continent Cas. Co. v. Basdeo, 742 F. Supp. 2d 1293, 1332 (S.D. Fla. 2010)).

would be rejecting its defense.[188] HSIC argued, however, that it was a surplus lines insurer and was not required to comply with the claims administration procedure set forth in Section 627.426(2).[189] Under Florida law, "'the provisions of chapter 627 do not apply to surplus lines insurance.'"[190]

In Florida, to constitute a surplus lines policy, the following must be stamped or written on first page of the policy, certificate, cover note, or confirmation of insurance: "'THIS INSURANCE IS ISSUED PURSUANT TO THE FLORIDA SURPLUS LINES LAW. PERSONS INSURED BY SURPLUS LINES CARRIERS DO NOT HAVE THE PROTECTION OF THE FLORIDA INSURANCE GUARANTY ACT TO THE EXTENT OF ANY RIGHT OF RECOVERY FOR THE OBLIGATION OF AN INSOLVENT UNLICENSED INSURER.'"[191] In addition, surplus lines policies "'shall have stamped or printed on the face of the policy in at least 14-point, boldface type, the following statement: SURPLUS LINES INSURERS' POLICY RATES AND FORMS ARE NOT APPROVED BY ANY FLORIDA REGULATORY AGENCY.'"[192]

HSIC had attached to its complaint a copy of the policy that did not contain the foregoing language required under the relevant statutes. Although it attempted to cure this deficiency by submitting an affidavit from the producer with an alternative version of the policy that contained the required language required, the court noted that copy attached to the complaint was stamped "CERTIFIED ORIGINAL COPY." Because the copy of the policy with the required language apparently was not a certified original copy, genuine issues of material fact existed as to whether the policy qualified as a surplus lines policy under Florida law.[193]

C. *Validity of Arbitration Provisions in Surplus Lines Policies*

In *Lexington Insurance Company v. Exxon Mobil Corporation*, the court addressed whether an additional insured to a surplus lines policy was compelled to arbitrate its coverage claim pursuant to the policy's dispute resolution clause.[194] The claim arose from a fire at an Exxon refinery. Three individuals injured were employees of Brock Services, which was performing work at Exxon under an agreement that required Brock to name Exxon as an additional insured on its applicable liability policies.[195] Exxon demanded that Brock's insurer, Lexington, recognize that the umbrella policy that Lex-

188. *Id.* at *6.
189. *Id.*
190. *Id.* (quoting FLA. STAT. § 626.913(4)).
191. *Id.* (quoting FLA. STAT. § 626.924(1)).
192. *Id.* (quoting FLA. STAT. § 626.924(2)).
193. *Id.*
194. 2017 WL 1532271, at *1 (Tex. App. Apr. 27, 2017).
195. *Id.*

ington issued provided insurance coverage to Exxon for claims arising from the casualty. When Lexington failed to respond to Exxon's demand, Exxon sued. Lexington responded by filing a motion to compel arbitration.[196]

Exxon argued that it was not bound by the arbitration clause in the policy because Brock had acquired the policy and Exxon did not negotiate to have a policy that contained an arbitration clause.[197] The court rejected this argument, holding that Exxon essentially could not seek to recover under the policy, while at the same time avoid provisions it disfavored.[198] The court reasoned that "[u]nder the doctrine of direct benefits estoppel, non-signatories to arbitration agreements may be bound to the arbitration clause of a contract when the plaintiff is suing seeking to enforce all of the other terms of a written agreement."[199]

The court further rejected Exxon's arguments that application of the arbitration clause against an additional insured was "unconscionable."[200] Arbitration agreements in surplus lines policies are not presumptively unconscionable under Texas law.[201] Furthermore, Chapter 981 of the Texas Insurance Code, regulating surplus lines insurers, does not prohibit surplus lines carriers from including arbitration provisions in their policies.[202] Finally, Section 981.005 provides that policies obtained from surplus lines insurers are "'(1) valid and enforceable as to all parties; and (2) recognized in the same manner as a comparable contract issued by an authorized insurer.'"[203]

Exxon made two arguments with respect to Lexington's status as a surplus lines carrier. First, Exxon argued that enforcing the arbitration clause would frustrate the requirements in article 21.42 of the Texas Insurance Code, which allows Texas courts to exercise jurisdiction over surplus lines carriers that sell insurance policies to Texas residents. The court disagreed, holding that a court's decision to enforce an arbitration clause does not divest the trial court of jurisdiction over the dispute.[204] Second, Exxon argued that Lexington failed to meet its burden to show that it was an authorized insurer in Texas entitled to enforce the terms of the umbrella policy.[205] Lexington filed an affidavit for the agency that issued the umbrella policy, stating that when Lexington issued the umbrella pol-

196. *Id.*
197. *Id.* at *2.
198. *Id.*
199. *Id.* (citing *In re* Kellogg Brown & Root, Inc., 166 S.W.3d 732, 739–40 (Tex. 2005) (original proceeding)).
200. *Id.* at *2–3.
201. *Id.* at *3 (citing TEX. CIV. PRAC. & REM. CODE ANN. § 171.001 (West 2011)).
202. *Id.* (citing TEX. INS. CODE ANN. §§ 981.001-.222 (West 2009 & Supp. 2016)).
203. *Id.* (quoting TEX. INS. CODE ANN. § 981.005).
204. *Id.* at *6.
205. *Id.* at *7.

icy at issue, "Lexington was an eligible surplus lines insurer."[206] This satisfied Lexington's burden in the face of no competing evidence from Exxon.[207]

The court held that once the parties "disagreed about whether the policy covered the casualty, and Lexington established that the umbrella policy contained a valid arbitration agreement that required disputes over coverage to be arbitrated, the trial court was required to submit the matter to arbitration regardless of the merits of the respective parties' arguments."[208]

D. *Texas Legislation Enabling Domestic Surplus Lines Insurers To Write Domestic Risks*

The Texas Legislature has passed House Bill 2492, which will enable surplus lines insurers domiciled in Texas to be authorized to conduct business in the state.[209] The legislation was signed into law on June 15, 2017.[210] It amends Chapter 981 of the Texas Insurance Code and becomes effective as of January 1, 2018. However, those domiciled surplus lines insurers must still meet the requirements of the Texas Insurance Code pertaining to capital requirements.[211] In addition, domiciled surplus lines insurers are subject to a premium tax imposed by Chapter 225 of the Texas Insurance Code and a maintenance tax, as if the domestic surplus lines insurer were an authorized insurer in Texas.[212] Importantly, while Texas-domiciled surplus lines insurers will now have the ability to write Texas-based risks, they will not be entitled to a certificate of authority to engage in the business of insurance in Texas in the admitted-insurer market.[213]

206. *Id.*
207. *Id.*
208. *Id.* at *6.
209. Texas H.B. 2492, http://www.legis.state.tx.us/tlodocs/85R/billtext/pdf/HB02492F.pdf#navpanes=0.
210. *See* history at https://legiscan.com/TX/bill/HB2492/2017.
211. See Texas H.B. 2492, § 5 (amending TEX. INS. CODE ANN. § 981.072).
212. See *id.* (amending TEX. INS. CODE ANN. § 981.075).
213. See *id.* (amending TEX. INS. CODE ANN. § 981.072(c)).