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

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I. INTRODUCTION

This survey reviews developments from September 1, 2005, through August 31, 2006, in the areas of excess insurance, surplus lines insurance, and reinsurance law, with a view toward assisting the practitioner in monitoring ongoing and developing trends in these substantive areas.

II. EXCESS INSURANCE

The most significant cases in the excess insurance sector focused on whether an excess insurer has a duty to drop down and participate in an underlying claim in cases where the excess policy contains a provision overriding following form coverage or the excess insurer has challenged the assertion that the underlying primary insurance has been exhausted. The courts also reviewed and reaffirmed the majority rules governing the circumstances under which an excess insurer may challenge the settlement decisions of a primary insurer.

A. *Following Form*

In *Rick Franklin Corp. v. State ex rel. Department of Transportation*,[1] the Oregon Court of Appeals held that although the subject environmental cleanup claim was covered by the primary policy, there was no coverage under the following form excess policy because of an exclusionary provision that unambiguously superseded any pollution coverage at the excess layer.

1. 140 P.3d 1136 (Or. Ct. App. 2006).

When a tanker truck owned by the insured transportation company spilled gasoline onto a highway and the surrounding land, the insured hired an environmental cleanup contractor to clean up the spill. The contractor submitted over $1 million in cleanup expenses, which were partially paid by the insured's primary insurer. The contractor sued the insured and its primary insurer, seeking the difference between what the primary insurer paid the contractor and the insured's full policy limits.[2]

The insured cross-complained against its excess insurer, asserting that the excess policy followed form to the primary policy and therefore provided coverage for the unpaid cleanup expenses. The trial court entered summary judgment on the cross-complaint in favor of the insured based on its finding that the excess policy was internally ambiguous because it contained both a following form endorsement and separate absolute pollution exclusion.[3] The court of appeals reversed, concluding that although the excess policy incorporated the coverage grant of the primary policy, another provision in the excess policy expressly excluded contamination costs, "notwithstanding anything contained in this policy," thus unambiguously overriding any grant of pollution coverage.[4]

B. *Exhaustion*

In *A.W. Chesterton Co. v. Massachusetts Insurers Insolvency Fund*,[5] the Massachusetts Supreme Judicial Court addressed the issue of exhaustion of other available excess insurance prior to an insolvency fund paying a claim on behalf of an insolvent insurer. Chesterton manufactured and distributed asbestos-containing products and was faced with more than 300,000 asbestos cases.[6] After the primary carriers' limits were exhausted, Chesterton demanded that its excess insurers provide indemnity and defense. A significant number of its excess carriers declined to do so.

Midland, one of Chesterton's excess insurers, was insolvent, and the Massachusetts Insurers Insolvency Fund became liable to the extent of Midland's obligation on the covered claims against Chesterton.[7] Both parties agreed that the statutory scheme governing the fund "requires the exhaustion of joint and severally solvent policies before a policyholder may submit a 'covered claim' to the Fund." The issue was "whether a policyholder must exhaust the limits of all applicable solvent excess policies before" triggering "the Fund's duty . . . to indemnify with respect to 'covered claims.'" Chesterton had settled with several excess carriers for less than full policy limits. Chesterton argued that by entering into good faith settlements,

2. *Id.* at 1138.
3. *Id.* at 1141.
4. *Id.* at 1142–43.
5. 838 N.E.2d 1237 (Mass. 2005).
6. *Id.* at 1241.
7. *Id.*

those excess policies were "exhausted."[8] The court adopted the reasoning of various other state courts and held that an insured "that settles with his solvent excess insurers for less than policy limits . . . bear[s] the risk of settling too conservatively."[9] Further, the court held that where an insured "fails to exhaust the limits of its solvent excess coverage" (here, by virtue of settlements), "the Fund will be entitled to a credit, against any liability of the Fund to indemnity or defend, in an amount equal to the full limit of the solvent excess policies."[10]

In *Reliance Insurance Co. in Liquidation v. Chitwood*,[11] the Eighth Circuit declined to hold that there is a direct duty of good faith and fair dealing running between primary and excess insurers.[12] The court further held that where the primary carrier settled for less than policy limits, its policy was "exhausted" for purposes of triggering the excess insurer's obligation.[13]

There, Reliance Insurance Company sued Stephen Chitwood and Continental Western Insurance Company for reimbursement of Reliance's cost of settling a lawsuit brought by victims of an automobile accident involving Chitwood. Chitwood had leased a tractor-semitrailer to Foster Brothers and agreed to deliver Foster Brothers' products in a number of states. Pursuant to that arrangement, Chitwood promised to indemnify Foster Brothers for any loss attributable to his negligence. Chitwood and Foster Brothers obtained liability insurance policies covering the operation of the truck. Chitwood bought a policy with a maximum limit of $750,000 from Continental Western, and Foster Brothers bought a

8. *Id.* at 1241–42.

9. *Id.* at 1254.

10. *Id.*; *cf.* Parkwoods Cmty. Ass'n v. Cal. Ins. Guar. Ass'n, 46 Cal. Rptr. 3d 921 (Ct. App. 2006) (because limits of general contractor's excess insurance had not been exhausted by settlement of construction defect action for which general contractor and subcontractors were jointly and severally liable, claim against subcontractor's insolvent insurer was not a "covered claim" that CIGA was obligated to pay).

11. 433 F.3d 660 (8th Cir. 2006).

12. *Id.* at 664–65.

13. *Id.* at 664; *cf. In re* Enron Corp., No. H-01-3624, 2006 WL 1663383 (S.D. Tex. June 12, 2006) (under the plain language of the policy and Texas law, policy proceeds may be exhausted by reasonable partial settlements); Travelers Cas. & Sur. Co. v. Ins. Co. of the State of Pa., No. C04-03875WHA, 2006 WL 149005 (N.D. Cal. Jan. 19, 2006) (court granted partial summary judgment to excess insurer on primary insurer's equitable contribution claim because underlying settlement was within combined limits of six primary policies and the excess policy would not cover a loss or have a duty to defend until all underlying primary insurance had been exhausted); Associated Elec. & Gas Ins. Servs. Ltd. v. Border Steel Rolling Mills, Inc., No. EP-04-CV00389-KC, 2005 WL 3068787 (W.D. Tex. Sept. 27, 2005) (court reaffirmed the majority rule that an excess insurer is not obligated to participate in the defense of a claim until the primary policy limits are exhausted); Shook & Fletcher Asbestos Settlement Trust v. Safety Nat. Cas. Corp., No. 04C-02-087MMJ, 2006 WL 2436193 (Del. Super. Ct. Sept. 29, 2005) (court confirmed that policy limits of all of the primary policies triggered by the individual's asbestos exposure must be exhausted before any excess coverage applicable to such exposure is implicated); John Crane, Inc. v. Admiral Ins. Co., No. 04CH8266, 2006 WL 1010495 (Ill. Cir. Ct. Apr. 12, 2006) (confirming that Illinois follows the doctrine of horizontal exhaustion,

policy providing up to $1 million in coverage from Reliance. Both policies covered Chitwood and Foster Brothers as insured parties.[14]

After an accident involving Chitwood, the injured claimants sued Foster Brothers, and Reliance took the lead in defending the suit. Reliance and Continental agreed that under the terms of the policies, Continental was the primary insurer and Reliance was excess. Before trial, Continental settled with the claimants for $600,000. Thereafter, Reliance settled with the plaintiffs for $250,000 and sued Chitwood and Continental seeking to recover the money it spent in settlement. Reliance claimed that Continental's settlement did not exhaust its policy limits and that by settling for less than policy limits, Continental had breached a duty of loyalty to Reliance.[15]

The court held that Continental's settlement had exhausted its policy limits because the claimants had promised to seek from Reliance only the amount over $750,000 in the event they obtained such a judgment.[16] Further, the court declined to adopt what Reliance termed the "modern trend" of courts imposing duties of good faith and fair dealing on the relationship between primary and excess insurers, noting that Missouri had not yet recognized such a duty.[17]

C. *Other Developments*

As noted above in *Chitwood*, the court held that a primary insurer does not owe a duty of good faith to an excess insurer.[18] However, this does not mean that an excess insurer is without recourse when it believes that a primary insurer is acting inappropriately. In *Fuller-Austin Installation Co. v. Highlands Insurance Co.*,[19] a California appellate court held that an excess insurer not participating in a settlement is entitled to challenge the settlement on the grounds of unreasonableness or that it was the product of collusion between the primary insurer and the insured.

Moreover, although there is generally no right to equitable contribution between primary and excess insurers, in *RLI Insurance Co. v. CNA Casualty of California*,[20] the court clarified the circumstances under which an excess insurer may sue a primary insurer for equitable subrogation. There, the primary and excess insurers each paid $1 million to settle a claim against

which requires that all primary insurance be exhausted across all of the triggered policy periods before the excess layer responds); Lennar Corp. v. Great Am. Ins. Co., No. 14-02-00860-CV, 2006 WL 909937 (Tex. App. Apr. 11, 2006) (court held that coverage under excess policies was not triggered because limits of underlying insurance had not been exhausted).

14. 433 F.3d at 661.
15. *Id.* at 662.
16. *Id.* at 664.
17. *Id.* at 664–65.
18. *Id.*
19. 38 Cal. Rptr. 3d. 716, 741 (Ct. App. 2006).
20. 45 Cal. Rptr. 3d. 667 (Ct. App. 2006).

their insured, who was involved in a fatal car accident. Following the settlement, the excess insurer brought an equitable subrogation action against the primary insurer, alleging that the primary insurer had unreasonably failed and refused to settle the tort claim within its policy limits. The trial court entered summary judgment in favor of the primary insurer on the grounds that, because the tort claim did not go to trial, there was no excess judgment against the insured; and without an excess judgment, the primary insurer's failure to settle was not actionable.[21] The appellate court affirmed, holding that because subrogation is purely derivative, the excess insurer stands in the shoes of the insured and can claim no right the insured does not have.[22]

III. SURPLUS LINES INSURANCE

Several interesting developments occurred in the surplus lines industry over the past year. At the federal level, two significant pieces of legislation are pending before congressional committees. One proposed bill would eliminate the state-by-state disparity in surplus lines regulation. The other proposed bill creates a "national insurance license," which would permit insurers and agents to garner the benefits of having a national license in addition to their state license. At the state level, Rhode Island, Hawaii, Connecticut, and Florida revised certain aspects of their statutes relating to the regulation of surplus lines insurance in their states. Courts in South Dakota, Puerto Rico, Florida, and the Virgin Islands released decisions relating to the requirement of licensed, nonresident insurance agents to obtain a licensed resident insurance agent's countersignature on their policies. California and Ohio released decisions impacting surplus lines agents and brokers specifically in connection with their duty of care to insureds.

A. *Statutory and Legislative Developments*

1. Federal Legislation

There are currently two significant pieces of federal legislation pending before committees in their respective houses that, if passed, will impact the surplus lines industry. Pending before the House Committee on Financial Services is the Nonadmitted and Reinsurance Reform Act of 2006.[23] The Reform Act would vest exclusive regulatory and enforcement authority over the collection and allocation of premium taxes in the home state of the insured.[24] It would authorize the states to enter into compacts or similar arrangements to reallocate surplus lines premium taxes collected

21. *Id.* at 669.
22. *Id.* at 671–72.
23. H.R. 5637, 109th Cong. (2d Sess. 2006).
24. *Id.* §§ 101.

by the insured's home state among other states according to an appropriate premium formula.[25] It would grant the home state of an insured exclusive regulatory authority regarding the placement of surplus lines insurance with an insured, including the licensure of surplus lines agents involved in placing the coverage.[26] It would limit states from collecting any fees relating to the licensure of surplus lines brokers if such states fail to participate in the National Association of Insurance Commissioner's ("NAIC") national insurance producer database within two years from the enactment of the legislation.[27]

The Reform Act also would create uniform standards for surplus lines eligibility. States would be prohibited from imposing eligibility requirements on surplus lines insurers domiciled in the United States except in conformance with §§ 5A(2) and 5C(2)(a) of the NAIC's Nonadmitted Insurance Model Act.[28] Furthermore, states would not be allowed to prohibit surplus lines brokers from placing or procuring surplus lines insurance with nonadmitted insurers domiciled outside the United States if such insurers are not listed on the NAIC's International Insurers Department's Quarterly Listing of Alien Insurers.[29]

Finally, the Reform Act would create a streamlined application process for certain exempted commercial purchasers by preempting state due diligence search requirements.[30] Under this process, surplus lines brokers would be required to disclose to exempted commercial purchasers that the proposed insurance may be available from the admitted market and that the admitted market may provide greater protection and regulatory oversight.[31] Exempted commercial purchasers must then provide to surplus lines brokers a written request that they procure or place the coverage.[32]

Also currently pending before the Senate Committee on Banking, Housing and Urban Affairs is the National Insurance Act of 2006,[33] which would create the Office of National Insurance to be headed by a National Insurance Commissioner within the Department of the Treasury.[34] The Commissioner would have the sole power to issue charters and licenses to national insurers and national agencies and to determine if the provisions of the act are being followed.[35] National insurers would be exempt from state

25. *Id.*
26. *Id.* § 102.
27. *Id.* § 103.
28. *Id.* § 104.
29. *Id.*
30. *Id.* § 105.
31. *Id.*
32. *Id.*
33. S. 2509, 109th Cong. (2d Sess. 2006).
34. *Id.* § 1101(a).
35. *Id.* § 1102(b)(1)(A).

regulations regarding licensing and examinations, or any other regulations related to the sale, solicitation, negotiation, or underwriting of insurance policies.[36] However, national insurers would continue to be subject to state laws regarding participation in mandatory residual market mechanisms designed to provide insurance to those who cannot obtain it through the voluntary market, except to the extent that such mechanisms would mandate that national insurers use a particular rate, rating element, price, or form.[37]

Furthermore, national insurers will be subject to all taxes and assessments levied by any state in which they do business, except that national insurers are not subject to additional taxes imposed by a state due to nonlicensure or lack of authorization to transact insurance business within that state.[38] Thus, national insurers would be subject to all state taxes that are a normal part of transacting insurance business within a given state,[39] except for any relevant nonadmitted insurer taxes that state may require.[40]

2. State Legislation

Rhode Island amended its statute that requires licensed surplus lines agents and their insureds to file affidavits whenever a surplus lines insurance policy is obtained. These affidavits, which must be submitted by both the licensee and the insured, must aver facts showing that the insured or licensee were unable to procure the requested coverage from no less than three authorized insurers.[41] As amended, the affidavit requirement has been lifted when the coverage sought is in one of the following categories:

> amusement parks and devices, environmental improvement and/or remediation sites, vacant property or property under renovation, demolition operations, event cancellation due to weather, railroad liability, discontinued products, fireworks and pyrotechnics, warehouseman's legal liability, excess property coverage, and contingent liability.[42]

Hawaii updated its attorney fees statute[43] to allow the recovery of attorney fees in actions for denial of claims without reasonable cause by an

36. *Id.* §§ 1125(a)(1)–(2). The exemption from state regulation would extend to "any other insurance operations," including marketing and sales practices, claims adjustments, and financial condition and solvency. *Id.* §§ 1125(a)(3).

37. *Id.* §§ 1125(b)(3)(A)–(C).

38. *Id.* §§ 1251(a).

39. A national insurance agency is subject to the tax laws of its state of domicile. *Id.* §§ 1252(a).

40. It should be noted that this exemption from nonadmitted insurer taxes may not totally abrogate such taxes, even in the case of national insurers. States may simply require the tax to be paid by the insured as some states have already done. *See, e.g.*, FLA. STAT. ANN. §§ 626.938(3) (4) (West 2006) (requiring the insured to withhold and remit the tax amount from premiums charged; should the insured fail to do so, he or she becomes liable for the full tax amount).

41. *See* R.I. GEN. LAWS §§ 27-3-38 (2006).

42. 2006 R.I. Pub. Laws ch. 06-632.

43. HAW. REV. STAT. §§ 431:8-209 (2006).

unauthorized insurer, provided the policy was issued or delivered within the state.[44] The previous version of the statute required that the insured be a resident of Hawaii.

Hawaii also revised its licensing requirements for nonresident surplus lines brokers.[45] In addition to the general licensing requirements, the state added the requirement that "[t]he applicant's home state issues nonresident surplus lines broker licenses to residents of [Hawaii] on the same basis."[46] Therefore, the legislature added a reciprocity requirement where previously none existed.

Finally, Hawaii changed its surplus lines law to prohibit a purchasing group from purchasing insurance from an unauthorized insurer in the state, unless the purchase is made through a licensed producer acting pursuant to Hawaii's surplus lines law.[47] Previously, the statute provided that the purchase must be made through a producer acting in accordance with the law of the producer's home state.[48] Thus, Hawaii has shown that it will be active in asserting and enforcing its surplus lines laws.

Connecticut reworked its regulations for licensing of nonresident surplus lines brokers by adding the requirement (in addition to the other general licensing requirements) that the applicant be a licensed insurance agent in the applicant's home state.[49] Most likely, this requirement is intended to ensure agent competence without adding the burden and administrative costs of developing and implementing a licensing examination within the state for brokers of unauthorized insurer's policies.

Florida amended its eligibility requirements for surplus lines insurers to allow alien surplus lines insurers to fund trust funds using clean, irrevocable, unconditional, and evergreen letters of credit issued or confirmed by a qualified U.S. financial institution.[50] Previously, such trusts were only to be funded by investments permitted by the domestic regulator of such alien insurers if the investments were substantially similar in terms of quality, liquidity, and security to eligible investments for like funds of like Florida domestic insurers.[51] Therefore, it appears that this statutory change allows alien surplus lines insurers to provide an alternative and reliable way to fund required policyholder protection trusts.

44. 2006 Haw. Sess. Laws §§ 7.
45. Haw. Rev. Stat. §§ 431:9A-108 (2006).
46. 2006 Haw. Sess. Laws §§ 28.
47. 2006 Haw. Sess. Laws §§ 42.
48. Haw. Rev. Stat. § 431K-8(a)(2) (2006).
49. Conn. Gen Stat. § 38A-769 (2006).
50. 2006 Fla. Laws ch. 12, §10.
51. Florida requires alien surplus lines insurers to maintain a trust fund of at least $5.4 million in the United States for the protection of U.S. policyholders, in addition to a $15 million minimum surplus requirement. *See* Fla. Stat. Ann. § 626.918(2)(d).1 (West 2006).

B. *Case Law Developments*

1. Residency Requirements

U.S. district courts in South Dakota, Puerto Rico, and the Virgin Islands have ruled on challenges brought by the Council of Insurance Agents and Brokers ("CIAB") based upon both the Privileges and Immunities Clause and the Equal Protection Clause of the Fourteenth Amendment: CIAB challenged those jurisdictions' statutory provisions requiring nonresident agents to obtain resident agent countersignatures on policies written to cover risks located in their respective states and territories.[52] "[T]he Privileges and Immunities Clause was intended to create national economic union"[53] and "to help fuse into one nation a collection of independent, sovereign states."[54] The Supreme Court has held that the protection of the Privileges and Immunities Clause is not an absolute bar to discriminatory statutory schemes; discrimination on the basis of residency is allowed where there is a substantial reason for the disparate treatment and the discrimination bears a substantial relation to the state's legitimate objective.[55] Therefore, CIAB needed to show either that there was no substantial reason for the differential treatment or that the discrimination bore no substantial relation to the government's legitimate interest.

In *Council of Insurance Agents & Brokers v. Viken*,[56] CIAB challenged South Dakota's statutes requiring nonresident licensed agents to obtain a countersignature from a licensed resident agent and to pay a countersignature fee for that service.[57] In defense of the countersignature provision, South Dakota argued that it was attempting to safeguard its citizens' best interests by ensuring agent competency, accessibility, and accountability.[58]

The court found that the possibility of personal contact with an agent was not a substantial reason for unequal treatment.[59] Because there was no requirement that the resident agent providing the countersignature be located in geographic proximity to the insured, it was entirely feasible that the resident agent providing the countersignature may be located farther away from the insured than the nonresident agent.[60] Also, because of advances in communication technology, it was unrealistic to think that

52. Because the *Juarbe-Jimenez* (see *infra* note 67) and *Richards* (see *infra* note 76) courts found the statutory provisions unconstitutional under the Privileges and Immunities Clause, neither court reached the question of whether the statutes likewise violated the Equal Protection Clause. CIAB abandoned its equal protection challenge in *Viken*.

53. Supreme Court of N.H. v. Piper, 470 U.S. 274, 279–80 (1985).

54. *Id.* (quoting Toomer v. Witsell, 334 U.S. 385, 395 (1948)).

55. Barnard v. Thorstenn, 489 U.S. 546, 552 (1989).

56. 408 F. Supp. 2d 836 (D.S.D. 2005).

57. S.D. Codified Laws §§ 58-6-62, 58-6-63, 58-6-64 (2006).

58. 408 F. Supp. 2d at 844.

59. *Id.*

60. *Id.* at 840.

insureds would travel to their agent's office to resolve policy questions, and therefore there was no persuasive evidence that nonresident licensed agents were less accessible.[61]

With regard to South Dakota's contention that the countersignature requirement was intended to ensure agent competency, the court did note that South Dakota does not require an examination for a nonresident seeking an insurance license.[62] Applicants must certify only that they are familiar with the requirements of South Dakota law[63] and continue to participate in continuing education in their home states.[64] Rather than holding that agent competency was not a valid state objective, the court held that there are less restrictive means available to advance the state's goals (such as requiring nonresident applicants to pass the same examination as resident applicants before becoming licensed).[65]

The court concluded that the statutes at issue violated the Privileges and Immunities Clause by discriminating against nonresident licensed insurance agents. The court granted CIAB's request for declaratory and injunctive relief by ruling the statutes unconstitutional and enjoining South Dakota from enforcing them to the extent that they deny nonresident licensed agents the same rights and privileges granted to resident licensed agents.[66]

In *Council of Insurance Agents & Brokers v. Juarbe-Jimenez*,[67] CIAB challenged Puerto Rico's countersignature statutes,[68] which prohibited insurers from placing any direct insurance on any person, property, or other subject located, or to be performed, in Puerto Rico, or soliciting insurance in Puerto Rico, except through a licensed resident agent and with the agent's countersignature.[69]

In defending these provisions, Puerto Rico argued that the statutes were designed to "ensure that the insurer, through its agent, be constantly accessible to the insured"[70] and that this was only possible through close geographic proximity. The district court quickly dismissed such an explanation:

> [T]he notion that an agent cannot provide assistance outside his home state is nonsense; whatever may have been said when people traveled by horseback and communicated by regular mail, today people communicate by telephone

61. *Id.*
62. *Id.* at 838.
63. *Id.* at 839. Resident applicants are required to pass an examination before becoming licensed. *Id.* at 838.
64. *Id.* at 838.
65. *Id.* at 844.
66. *Id.*
67. 363 F. Supp. 2d 47 (D.P.R. 2005).
68. P.R. Laws Ann. tit. 26, §§ 329, 927 (2005).
69. *Juarbe-Jimenez*, 363 F. Supp. 2d at 51.
70. *Id.* at 55.

> and facsimile and email and overnight courier, and they travel by jet; state boundaries pose no obstacle.[71]

Puerto Rico's second justification for the statutes was that they were necessary to ensure that agents are proficient Spanish speakers.[72] Again, the district court dismissed this reasoning by noting that both Spanish and English are the official languages of the Island[73] and that if Puerto Rico wanted to remove any possible language barrier, it could easily require a Spanish proficiency test as a requirement for licensing.[74]

Having rejected both of Puerto Rico's proffered justifications for the countersignature requirements, the district court concluded that there was no substantial purpose behind denying nonresident licensed insurance agents the privileges enjoyed by resident licensed insurance agents. The court held that the statutes at issue were unconstitutional and enjoined Puerto Rico from any further enforcement thereof.[75]

In *Council of Insurance Agents & Brokers v. Richards*,[76] CIAB challenged the Virgin Islands statutes mandating that a nonresident licensed agent obtain a resident licensed agent's countersignature on any policy covering risks located within the Virgin Islands[77] and that a countersigning agent be paid a countersignature fee.[78] In defense of its statutes, the Virgin Islands argued that they were necessary because resident agents have a greater knowledge of local law and that they are more accessible during an emergency.[79]

The court rejected the accessibility justification based on the reasoning of both the *Viken* decision[80] and *Council of Insurance Agents & Brokers v. Gallagher*,[81] wherein a similar statute in Florida was declared unconstitutional.[82] The court next disposed of the competence justification by noting that the "Supreme Court has made it clear there is no nexus between residency and competence."[83] Thus, having found no substantial state objective for the statutes, the court declared them unconstitutional.[84]

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71. *Id.* (quoting Council of Ins. Agents & Brokers v. Gallagher, 287 F. Supp. 2d 1302, 1312 (N.D. Fla. 2003)).
72. *Id.*
73. *Id.*
74. *Id.* at n.2.
75. *Id.* at 56.
76. No. 2004-16, 2006 WL 2037587(D.V.I. July 18, 2006).
77. V.I. Code Ann. tit. 22, § 220(a) (2005).
78. V.I. Code Ann. tit. 22, § 772, required that the countersigning agent "receive not less than ten percent of the premium on bonds and all such lines of insurance" but not more than fifty percent of the total premium.
79. *Richards*, 2006 WL 2037587, at *3.
80. *See supra* text accompanying notes 56–66.
81. 287 F. Supp. 2d 1302, 1312 (N.D. Fla. 2003).
82. *Richards*, 2006 WL 2037587, at *11.
83. *Id.* at *12 (citing Barnard v. Thorstenn, 489 U.S. 546, 555–56 (1989)).
84. *Id.* at *13.

The foregoing cases show that statutory schemes discriminating against otherwise qualified and licensed insurance agents on the basis of residency will not survive judicial scrutiny. As seen above, courts have struck down such statutes notwithstanding accessibility arguments where agents and insureds could be separated by hundreds of miles of open ocean (*Juarbe-Jimenez*, *Richards*[85]) and notwithstanding possible language barriers (*Juarbe-Jimenez*[86]).

In *Borden v. East-European Insurance Co.*,[87] the Florida Supreme Court was asked to determine whether as a matter of law, § 626.906(4)[88] of Florida's Unauthorized Insurers Process Law ("UIPL") was available to Florida residents only. The case involved an insurance claim filed by Victor Borden, a resident of Honduras, relating to the sinking of one of his fishing boats in international waters. Borden's daughter, a Florida resident, had contacted a Florida insurance brokerage firm seeking a policy to cover Borden's three vessels; this firm, in turn, had contacted another Florida brokerage firm and a chain of foreign brokerage firms involved in the dealings. Ultimately, East-European Insurance Co. and its successor, Alfa Insurance PLC, (collectively "Alfa") issued a policy covering the vessels.[89] When one of Borden's fishing boats sank, Borden filed a claim with Alfa seeking to recover his loss. Alfa denied the claim because the vessel sank within international waters and thus outside of the coverage area.[90] In addition to asserting a lack of personal jurisdiction, Alfa claimed that § 626.906(4) was only available to residents of Florida and thus was of no avail to Borden, a resident of Honduras.[91]

Sections 626.904–.912 of the Florida Statutes are known collectively as the Unauthorized Insurers Process Law,[92] the purpose of which is to "subject certain insurers and persons representing or aiding such insurers to the jurisdiction of courts of this state in suits by or on behalf of insureds or beneficiaries under insurance contracts."[93] The statute notes that it is a "subject of concern that many residents of this state hold policies of insurance issued or delivered in this state by insurers while not authorized to do business in this state," which, in many cases, may lead Florida residents

85. Puerto Rico and the Virgin Islands, respectively.

86. 363 F. Supp. 2d 47, 55 (D.P.R. 2005) (noting that Spanish is widely spoken on the Island).

87. 921 So. 2d 587 (Fla. 2006).

88. Fla. Stat. Ann. § 626.906(4) (West 2005).

89. There was a disputed question of fact as to whether Alfa issued the applicable policy or if it was a cover note prepared and issued by Barnhardt (one of the foreign brokerages). *See Borden*, 921 So. 2d at 590 n.3. The dispute was rendered moot by the court's holding on the UIPL issue.

90. *Id.* at 590.

91. *Id.*

92. Fla. Stat. Ann. § 626.904 (West 2005).

93. Fla. Stat. Ann. § 626.905 (West 2005).

to pursue claims in distant forums.[94] Section 626.906 designates the Chief Financial Officer of Florida as the representative of unauthorized insurers transacting business within Florida and enumerates certain acts that will subject unauthorized insurers to the jurisdiction of Florida courts:

> (1) [t]he issuance or delivery of contracts of insurance to residents of this state or to corporations authorized to do business therein; (2) [t]he solicitation of applications for such contract; (3) [t]he collection of premiums, membership fees, assessments, or other considerations for such contracts; or (4) [a]ny other transaction of insurance.[95]

As noted by the Florida Supreme Court, only two of the Florida district courts of appeal, the Second and Third District Courts of Appeal, had construed § 626.906(4),[96] and those courts had reached contrary conclusions.[97] The court acknowledged that subsections (1)–(3) by their plain terms were available only to Florida residents,[98] so the only question before the court was whether subsection (4) was intended to act as a freestanding provision or if it was to complement subsections (1)–(3). The court concluded that if "[a]ny other transaction of insurance"[99] was held to encompass the same acts enumerated in subsections (1)–(3), those sections, and the residency requirement contained therein, would be at best wasted verbiage. The court instead interpreted subsection (4) as a complement to subsections (1)–(3) and held that its intent was to address those other transactions of insurance that were not encompassed by subsections (1)–(3); because those subsections apply to Florida residents only, so too would subsection (4).[100]

2. Surplus Lines Agents and Brokers–Duty of Care to Insureds

In *Business to Business Markets, Inc. v. Zurich Specialties*,[101] a California appellate court reversed a trial court's grant of a demurrer without leave to amend to a surplus lines broker alleged to have negligently procured an insurance policy that did not cover the perils for which the insured sought coverage. The trial court sustained the demurrer on the grounds that there was no privity of contract between the parties, and thus the broker owed no duty of care.

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94. *Id.*

95. Fla. Stat. Ann. § 626.906 (West 2005).

96. The court did note that all courts that had construed § 626.906 in its entirety had reached the conclusion that it was available only to Florida residents. *See Borden*, 921 So. 2d at 594 n.7.

97. *See* E.-European Ins. Co. v. Borden, 884 So. 2d 233 (Fla. Dist. Ct. App. 2004) (holding that § 624.906(4) is available only to Florida residents); Winterthur Int'l Ltd. v. Palacios, 559 So. 2d 1214 (Fla. Dist. Ct. App. 1990) (holding there is no language in § 626.906(4) that either explicitly or implicitly limits the law to Florida residents).

98. *Id.* (noting that subsection (1) contains the term *residents of this state*, and subsections (2) and (3) refer to "such contracts"). *Id.*

99. Fla. Stat. Ann. § 626.906(4) (West 2005).

100. *Borden*, 921 So. 2d. at 596.

101. 37 Cal. Rptr. 3d 295 (Ct. App. 2005).

In 2000, Business to Business Markets, Inc., ("B2B") hired Tricon Infotech, an Indian software company, to write custom-made software. To guard against the possibility that Tricon might not deliver in a timely fashion, Tricon was to procure errors and omissions insurance to compensate B2B. B2B contacted Hoyla, a retail insurance broker, and informed Hoyla of its needs, including the fact that Tricon was based in India. Hoyla then contacted Professional Liability Insurance Services, Inc., ("PLIS"), a surplus lines broker, and relayed all the information it had received from B2B. PLIS then contacted Zurich Specialties, which issued the policy to Tricon; however, although Tricon is an Indian company doing business in India, the policy excluded coverage for any and all claims arising from or related to work done in India.[102] After Tricon failed to deliver the product on time, B2B sued Tricon and obtained a default judgment that proved to be uncollectible; thus, B2B sued PLIS for its negligence in procuring a policy that failed to cover the very risk for which the policy was sought.

The issue was whether PLIS owed a duty of care to B2B, notwithstanding the lack of any direct dealing between the two and the fact that B2B was not named at all in the policy. In reaching its conclusion that PLIS did owe a duty of care to B2B, the court looked to four factors set out by the California Supreme Court in *Biakanja v. Irving* for finding a professional duty of care.[103] The court dispensed with the first three *Biakanja* factors quickly, finding (1) that the insurance transaction greatly affected B2B, (2) B2B's injury from Tricon's breach was foreseeable, and (3) a high degree of certainty that B2B suffered injury from PLIS's conduct.[104] The final factor in the analysis, the closeness of the connection between the parties, was "perhaps [the] most problematic."[105]

PLIS dealt exclusively with Hoyla, the broker, and Zurich, the insurer; there were no communications between B2B and PLIS, nor did B2B's name appear anywhere on the insurance policy. B2B was simply a third-party beneficiary of Tricon's insurance policy; the determinative factor was whether B2B was an intended third-party beneficiary or an incidental third-party beneficiary of the contract.[106] To determine if B2B was an intended third-party beneficiary and was owed a duty of care from PLIS, the court analyzed the parties' intent in entering into the contract.[107] Because B2B was the party directly intended to benefit from Tricon's insurance policy,

102. *Id.* at 296.

103. 320 P.2d 16 (Cal. 1958) (finding a notary public owed the intended beneficiary of a will a duty of care, and thus the beneficiary could institute a negligence action for a will prepared by the notary that lacked sufficient attestation).

104. *Business to Business Markets, Inc.*, 37 Cal. Rptr. 3d at 297.

105. *Id.* at 298.

106. *Id.* The court noted that intended third-party beneficiaries are owed a duty of care, whereas incidental third-party beneficiaries are not.

107. *Id.*; *see* Jones v. Aetna Cas. & Sur. Co., 33 Cal. Rptr. 2d 291 (Ct. App. 1994).

it was not merely an incidental beneficiary; but it was not quite an intended beneficiary either. Rather, the court ruled that it was "close enough to being [an intended beneficiary] that imposing a duty of care on PLIS is within the spirit of *Biakanja*."[108]

The court noted that it was B2B that contacted Hoyla about procuring insurance for Tricon, and, most importantly, Tricon was contractually obligated through its dealings with B2B to obtain the policy in question. In conclusion, the court also noted, inter alia, that surplus lines insurance is a specialized service; and because of that fact, clients rely on brokers to obtain policies that cover their needs. As such, PLIS was in a position to prevent the harm to B2B from the inadequate coverage procured for Tricon, and thus owed a duty of care to do so.[109]

In *Southern Ohio Gun Distributors, Inc., v. City Agency, Inc.*,[110] an Ohio appellate court affirmed a summary judgment in favor of an insurance agency in a negligence action brought against it for failing to inform the insured of the risks involved with a surplus lines policy, most notably that the policy was not guaranteed by the Ohio Insurance Guaranty Association. City Agency obtained for Southern Ohio Gun Distributors, Inc. ("SOGD") a general liability policy from United Capitol Insurance Co. to replace its recently canceled liability policy. According to SOGD, it was not informed by City Agency that surplus lines insurance policies were not guaranteed by the state guaranty agency. During the life of the policy, SOGD had a multimillion dollar lawsuit filed against it in Massachusetts state court. SOGD notified United Capitol, which agreed to defend and indemnify SOGD per the terms of its policy. Prior to the trial, United Capitol was declared insolvent in Illinois state court. As SOGD had no other policy that applied to the Massachusetts action, it settled the case rather than risk a large verdict.[111]

SOGD subsequently filed a negligence action against City Agency, alleging that its failure to advise SOGD of the risks of surplus lines policies proximately caused it to bear the cost of settling the Massachusetts lawsuit.[112] The trial court adopted the findings of the magistrate, who ruled that although City Agency breached its common law and statutory duty of care to inform SOGD of the risks inherent in surplus lines policies, that breach was not the proximate cause of SOGD's injuries. The Ohio Court of Appeals, in affirming the judgment from below, noted that at the

108. *Business to Business Markets, Inc.*, 37 Cal. Rptr. 3d at 299.

109. It should be noted that the court did not intend its opinion to extend liability to an at-fault party's insurance broker failing to procure coverage to compensate an injured party in a "more typical case." *Id.* at 300 n.4.

110. No. CA2004-09-116, 2005 WL 2487982 (Ohio Ct. App. Oct. 10, 2005).

111. *Id.*

112. *Id.*

time the policy was written, United Capitol was a financially stable, solvent company; and thus its insolvency was an independent, intervening cause.[113] As such, the "harm sustained by SOGD was not the 'natural and probable consequences' of City Agency's alleged negligence,"[114] and therefore City Agency was not liable to SOGD for damages.

IV. REINSURANCE LAW

A. *Coverage*

1. Follow the Fortunes/Settlements

In *Travelers Casualty & Surety Co. v. Gerling Global Reinsurance Corp. of America*,[115] the Second Circuit considered the cedent's appeal of summary judgment in favor of the reinsurer. Travelers, the cedent, issued insurance to Owens Corning for asbestos exposures, pursuant to a number of annual policies. "Each primary policy had a . . . 'per occurrence' limit of liability. . . . Each policy also had a[n] . . . 'aggregate' limit of liability," but only to the extent the claim arose out of a "products exposure," as distinguished from a "nonproducts exposure." The policy defined *products exposure* as one occurring "after asbestos products were placed into the stream of commerce or after an asbestos-related operation was completed. Non-products coverage protected [the insured] from claims for asbestos-related injuries resulting from asbestos exposure on [the insured's] premises or during its business operations."[116] The policy was exhausted when its aggregate limit was reached, notwithstanding additional occurrences. "However, if claims arising from multiple occurrences triggered non-products coverage, then Travelers was exposed to unlimited liability; each occurrence was subject to a $1 million limit on liability, but there was no cap on total liability."[117]

Travelers bought reinsurance from a number of reinsurers, including Gerling-Global, from which it purchased five facultative certificates. Those certificates provided that Gerling would "be bound by any loss settlements entered into by Travelers with [its insured]," as long as those settlements "fell within the terms and conditions of the original policy and of the certificate."[118]

At first, Owens Corning classified asbestos-related claims as products exposures "and as arising from a single occurrence." After Owens Corning's products coverage was exhausted in the early 1990s, however, it "began to submit its asbestos claims as non-products claims. Travelers . . . disputed

113. *Id.* at *3.
114. *Id.*
115. 419 F.3d 181 (2d Cir. 2005).
116. *Id.* at 183–84.
117. *Id.* at 184.
118. *Id.*

any additional coverage for these claims," and the parties entered into arbitration. In the arbitration, Owens Corning "argued that (1) the claims arising from [its] contracting operations fell under non-products coverage, and (2) each set of the claims arising from a particular job site[] was a separate occurrence." Travelers countered (1) that Owens Corning had not properly documented its assertion that the claims were nonproducts-related and (2) that all of its claims, products, and nonproducts alike arose from one occurrence.[119] The parties ultimately settled the arbitration, expressly disclaiming "any particular theory of coverage," and did not "reach[] agreement as to whether the claims arose from a single occurrence or multiple occurrences."

In order to allocate the settlement among its primary and excess policies, Travelers had to choose one occurrence position or another. Accordingly, it allocated most of the settlement amount as a single occurrence of nonproducts claims. Using the "rising bathtub" methodology, it "allocated the settlement amount evenly among policy years." Once this exhausted each year's per occurrence limit, the remaining amount of the settlement was spread among the various excess policies, including those reinsured by Gerling.[120]

Claiming that Travelers should have used a multiple-occurrence allocation method, Gerling refused to pay the amount that Travelers billed as its share of the settlement. After Travelers filed suit against Gerling, "[t]he district court granted Gerling's motion [for summary judgment], finding that the follow-the-fortunes doctrine did not apply" because Gerling was merely taking the same position regarding the occurrence issue that Owens Corning had asserted in the arbitration.[121]

The Second Circuit reversed, noting that it was not clear that Travelers had ever accepted in the arbitration the multiple-occurrence position being propounded by Owens Corning, and that the settlement expressly declined to resolve the occurrence issue:

> [W]e decline to authorize an inquiry into the propriety of a cedent's method of allocating a settlement if the settlement itself was in good faith, reasonable, and within the terms of the policies. Given that Travelers and OCF expressly declined to resolve the occurrence issue, there is no cause for us to do so now. Indeed, were we to undertake such an analysis, we would be engaging in precisely the kind of "intrusive factual inquiry" that the follow-the-fortunes doctrine is meant to avoid. Judicial review of either the settlement decision or the allocation decision "has an equal likelihood of undermining settlement and fostering litigation."[122]

119. *Id.* at 185.
120. *Id.*
121. *Id.* at 185–86.
122. *Id.* at 189 (citations omitted).

Gerling next argued that the claims had been submitted by Travelers in bad faith, thus obviating application of follow-the-fortunes principles. Specifically, Gerling argued that the allocation of all nonproducts claims to a single occurrence was inconsistent with the definition of *occurrence* in the underlying policies and was "so legally baseless that it has never been adopted by any court in any jurisdiction."[123] Gerling further argued that Travelers intentionally sought to shift the settlement loss from the primary to the excess policies because only the latter were reinsured.

The court rejected the first argument, noting that "allocation on a legally novel theory does not itself constitute evidence of dishonesty or disingenuousness."[124] As to the bad faith argument, the court emphasized that a reinsurer raising a claim of bad faith faces a very heavy burden, as "a cedent choosing among several reasonable allocation possibilities is surely not required to choose the allocation that minimizes its reinsurance recovery to avoid a finding of bad faith."[125] The *Travelers* court determined that

> because Travelers' post-settlement allocation was made in good faith and was reasonable, and because we discern no other material factual dispute that might preclude application of follow-the-fortunes to Travelers' reinsurance claim, we conclude that the doctrine applies. Under follow-the-fortunes, we ask only "whether there is any reasonable basis" supporting the cedent's claims. Having already concluded that Travelers' post-settlement allocation was reasonable, we find that it easily meets this deferential standard of review.[126]

Follow-the-fortunes principles were also the subject of *Travelers Casualty & Surety Co. v. ACE American Reinsurance Co.*[127] There, the court reviewed a reinsurance collection dispute based on ACE's alleged failure to pay on a number of facultative reinsurance certificates. Travelers had issued a number of excess insurance policies with annual aggregates to Dow Corning Corporation. Travelers then reinsured these policies through a group of reinsurers, including ACE. Each of the certificates included a follow-the-form clause stating that the liability of the reinsurer would follow that of the company and, except as specifically provided to the contrary, would be subject in all respects to all terms and conditions of the company's policy.[128]

After Dow filed suit for coverage relating to its exposure for breast implant claims, Travelers entered into a settlement agreement with Dow. Travelers then billed ACE for claims settled pursuant to that settlement agreement. When ACE refused payment on those claims, suit followed.

123. *Id.* at 191.
124. *Id.*
125. *Id.* at 193.
126. *Id.* at 195 (citation omitted).
127. 392 F. Supp. 2d 659 (S.D.N.Y. 2005).
128. *Id.* at 662.

The basis of the parties' dispute turned on whether the facultative certificates provided coverage for up to a single aggregate limit for a three-year period or for three annual aggregate limits. Coverage for three annual aggregate limits would significantly enlarge ACE's exposure. Pointing to the follow-the-form clauses in the certificates, Travelers argued that the document evidenced the intent of the parties to have the facultative certificates mirror the terms of the underlying policies.[129] ACE argued that the language of the certificates unambiguously provided for a single aggregate limit for the three-year coverage period. Moreover, it claimed that because the certificates did not include the word *annual*, the certificates did not lend themselves to more than one reasonable interpretation, thus limiting the interpretation of the documents to the four corners without resort to extrinsic evidence.[130]

Noting that under New York law, reinsurance contracts are interpreted in accord with general contract principles, the court acknowledged that where a reinsurance contract is clear on its face, the intent of the parties is to be determined from the four corners of the instrument.[131] The court recognized, however, that

> these black letter contract rules do not apply perfectly to the interpretation of a facultative reinsurance certificate that contains a "follow the form" clause. This is because these clauses incorporate by reference the terms of the underlying insurance policy (except where explicitly provided to the contrary in the certificate. . .) and, therefore, they necessarily expand the letter of the certificate beyond its four corners.[132]

Citing two recent First Circuit follow-the-fortunes decisions,[133] the court noted that the basic presumption of concurrence between terms of a reinsurance certificate and the underlying policy is subject only to a clear limitation to the contrary in the certificate itself. If sufficiently clear, specific limits in the certificate control over a general aim of concurrence between the two policies.[134] Applying those principles to the instant certificate, the court held that

> since the certificates do not clearly or explicitly limit the coverage terms of the underlying policy, the presumption of concurrency between the excess policy and the Three-Year Certificates is not overridden. Therefore, without considering any extrinsic evidence, the Court concludes that the only reasonable

129. *Id.* at 662–63.
130. *Id.* at 663.
131. *Id.* at 664.
132. *Id.*
133. Commercial Union Ins. Co. v. Swiss Reins. Am. Corp., 413 F.3d 121 (1st Cir. 2005), Am. Employers' Ins. Co. v. Swiss Reins. Am. Corp., 413 F.3d 129 (1st Cir. 2005).
134. *Travelers*, 392 F. Supp. 2d at 665.

> interpretation . . . is that each Three-Year Certificate provides coverage for three annual aggregate limits.[135]

In *National Union Fire Insurance Co. of Pittsburgh, Pennsylvania v. American Reinsurance Co.*,[136] the court considered a breach of contract action between a cedent and its reinsurer. National Union issued an insurance policy to Cincinnati Milacron, Inc., a machine manufacturing company. National Union sought reinsurance of that policy with American Re. Both the policy and the reinsurance policy contained broad pollution exclusion provisions. After a group of General Motors employees filed suit against Cincinnati Milacron alleging exposure to harmful fluids supplied by Milacron, the parties settled the matter. Milacron allocated the claims of the settling plaintiffs evenly between two different insurance policies, only one of which was reinsured. "[W]hen National Union attempted to collect from American Re, [it] refused payment based on the pollution exclusion." This led to litigation, ultimately resolved in favor of National Union, with a finding that American Re was obligated to follow the fortunes of National Union unless the settlement was "clearly or manifestly outside the scope of the reinsured's policy coverage" or the settlement was "fraudulent, collusive or in bad faith."[137]

The court allowed American Re to take discovery to determine whether claims settled as part of "the Milacron settlement were manifestly outside the scope of the policy or whether [the] decision to pay the claims was fraudulent, collusive, or in bad faith." American Re argued that it was not obligated to follow the fortunes of National Union for three primary reasons: the claims were not covered by the policy because the claimants' injuries predated the reinsurance coverage period, the allocation of certain claims to the Milacron policy was unreasonable, and National Union had shown "'reckless indifference'" to American Re's interests and had thus acted in bad faith.[138]

As to the first argument, the court emphasized that the relevant question is whether the payment "was 'at least arguably within the scope of the insurance coverage that was reinsured.' . . . Based on the very documents that American Re cites in support of its position, a reasonable factfinder can only conclude that the manifestation date was at least arguable."[139] The court noted that American Re, bound to follow the fortunes of the reinsured, was not entitled to a de novo review of its decision-making process.

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135. *Id.*

136. 441 F. Supp. 2d 646 (S.D.N.Y. 2006).

137. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa. v. Am. Reins. Co., 351 F. Supp. 2d 201, 212 (S.D.N.Y. 2005).

138. *National Union Fire Insurance Co.*, 441 F. Supp. 2d at 651.

139. *Id.* at 652 (quoting Mentor Ins. Co. (U.K.) Ltd. v. Brannkasse, 996 F.2d 506, 517 (2d Cir. 1993)).

The court also rejected American Re's argument regarding National Union's allegedly unreasonable conduct in accepting the allocation of several of the injured plaintiffs to the reinsured policy. Emphasizing that the follow-the-fortunes doctrine is intended to prevent reinsurers from second-guessing the allocation decisions of its reinsureds, the court held that "follow the fortunes, then, prohibits judicial inquiry into the propriety of a reinsured's post-settlement allocation 'if the settlement itself was in good faith, reasonable, and within the terms of the policies.'"[140]

As for American Re's arguments regarding bad faith, the court emphasized the very difficult burden that a reinsurer making such a claim bears, and it held that National Union had no duty to American Re to minimize its reinsurance recovery through its allocation decisions.[141] The court rejected American Re's argument that its obligation to follow its reinsured's "insurance fortunes" did not require it to follow its "commercial fortunes":

> National Union's unwillingness to litigate the trigger issue with Milacron and reluctance to take a firm position on the trigger issue are not bases for a finding of unreasonableness or bad faith—indeed, they are legitimate business considerations for an insurer considering whether to litigate or settle claims made against it.[142]

In *Suter v. General Accident Insurance Co. of America*,[143] the court again addressed follow-the-settlements principles. In *Suter*, Transit Casualty Company had issued a number of umbrella liability policies to Pfizer, Inc., which manufactured heart valves. Integrity Insurance Company was the excess carrier above Transit, which in turn was reinsured by General Accident.

After Pfizer agreed to settle a large class action regarding allegedly defective heart valves by paying hundreds of millions of dollars to persons whose valves had not failed but who claimed to have suffered anxiety regarding the prospect that they would do so, General Accident refused payment, arguing that Integrity did not act reasonably or in good faith in allowing coverage for such anxiety claims. In particular, General Accident argued that it was not reasonable to use the date the nonfailing valves were implanted into the claimants as the triggering date for insurance coverage. General Accident argued that if the valve was working at the time it was implanted, then no injury occurred at that time.[144] General Accident also argued that it was exempt from the follow-the-settlements doctrine because the cedent had not taken all appropriate steps in assessing the claims.

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140. *Id.* (quoting Traveler's Cas. & Sur. Co. v. Gerling Global Reins. Corp. of Am., 419 F.3d 181, 189 (2d Cir. 2005)).
141. *Id.*
142. *Id.* at 654 (quoting American Re Opinion Brief 31).
143. Civ. No. 01-2686(WGB), 2006 WL 2000881 (D.N.J. July 17, 2006).
144. *Id.* at *1.

The court noted that the case presented a conflict of two legal principles:

> to preserve the doctrine of 'follow the settlements,' this Court cannot conduct a de novo review of the settlement between Pfizer and Integrity; on the other hand, to protect the contractual intent of the parties, the Court is required to reexamine the settlement to determine whether the claim represents a risk that was reasonably within the scope of the original policies.[145]

In analyzing Integrity's claim investigation, the court determined that Pfizer had intentionally determined to apply a "date of implant" trigger for claims rather than an "injury in fact" trigger (as it previously had done) because it knew it would be unable to take advantage of all of its insurance coverage if it were to continue with its prior approach.[146] The court also noted that Pfizer had previously unsuccessfully litigated the correctness of its use of the "date of implant" trigger.[147] The court found that Pfizer never communicated to Integrity the fact that it had lost this coverage issue in *Dairyland* and that Integrity did not take appropriate steps to review the impact of the *Dairyland* decision.[148]

In finding that the reinsurer was not obligated to follow the settlements, the court noted that

> [t]he ceding insurer is required to make a good faith and a reasonable, business-like investigation. If that is done then "the ceding company may bind the reinsurer to follow its settlement fortunes when it concedes that a particular claim falls within the scope of coverage provided by the ceding company's policy."
>
> . . . .
>
> As the reinsurer, the defendant must show bad faith on the part of Integrity, the reinsured. Bad faith in this context amounts to a showing of gross negligence, recklessness, or a showing "that the settlement was not even arguably within the scope of the reinsurance coverage."[149]

The court found that Integrity did not satisfy its duty in that its investigation of Pfizer's claims was superficial and incomplete. General Accident was thus not obligated to follow the settlements of its reinsured.[150]

2. Privity

In *TIG Insurance Co. v. Aon Re, Inc.*,[151] the court considered a suit by a cedent against the intermediary after the reinsurer successfully rescinded through

145. *Id.*
146. *Id.* at *13.
147. Dairyland Ins. Co. v. Shiley, Inc., No. 718166, slip op. (Cal. Super. Ct. Apr. 26, 1996).
148. *Id.* at *19.
149. *Id.* at *23 (internal quotations omitted).
150. *Id.* at *26.
151. No. Civ.A3:04CV1307-B, 2005 WL 3742818 (N.D. Tex. Nov. 7, 2005).

arbitration the reinsurance placed by that intermediary. In *TIG*, the plaintiff had retained Aon Re as its reinsurance intermediary in order to solicit and place reinsurance to cover TIG's workers' compensation business.[152] Aon had placed the reinsurance with United States Life Insurance Company. It appears that the reinsurance package circulated by Aon on behalf of TIG did not contain all the documents and relevant information TIG had provided to Aon. When United States Life subsequently sought to rescind the reinsurance treaty, the arbitration panel allowed it to do so, finding that Aon, as TIG's agent, had omitted the relevant information.[153] TIG then filed a lawsuit against Aon, claiming negligence, negligent misrepresentation, breach of fiduciary duty, and common law indemnity, and sought declaratory relief regarding Aon's obligation to reimburse and indemnify TIG for unreinsured liability.[154]

TIG asserted that the doctrine of collateral estoppel should bar relitigation of any issues decided in the arbitration, including the issue regarding the completeness of the reinsurance package circulated by Aon. Noting that collateral estoppel required a finding that "the party to be precluded from relitigating the issue had a full and fair opportunity to contest the prior issue,"[155] the court concluded this question turned on whether there was identity of the parties to the arbitration and the subsequent litigation, or privity between them.[156] Aon argued that because it was not a party to the arbitration, it had no opportunity to protect its interests therein, therefore precluding the application of collateral estoppel.[157] TIG argued that given that Aon functioned as TIG's agent, there was privity between them sufficient to trigger collateral estoppel principles.[158] Aon countered that the privity analysis turns on the time at which the arbitration took place, not the time when the initial negotiations occurred. Moreover, Aon argued that the court should consider the degree to which the nonparty was able to control and participate in the prior proceeding in determining whether or not privity existed.[159]

The court held that there was no collateral estoppel in effect that would bar Aon from relitigating issues decided in the arbitration:

> First, it is undisputed that Aon Re was not a party to the Arbitration and was not a signatory to the agreement to arbitrate between TIG and U.S. Life.

152. *Id.* at *1.
153. *Id.* at *2.
154. *Id.* at *3.
155. *Id.*
156. *Id.* at *4.
157. *Id.*
158. *Id.* at *5.
159. *Id.*

> Second, TIG has does not [*sic*] dispute that Aon Re was no longer acting as its agent at the time of the Arbitration. Third, although TIG disputes the claim, there is no genuine issue of material fact that TIG and Aon Re had a clear conflict of interest. Finally, it is undisputed that Aon Re had no "control" over, nor did it participate in the Arbitration. Because of these factors, Aon Re cannot be said to have been "in privity" with TIG for purposes of collateral estoppel. . . .[160]

B. *Arbitration*

1. Arbitrability

In *Employers Insurance Co. of Wausau v. Century Indemnity Co.*,[161] the insurer had entered into a number of reinsurance agreements, including two with Wausau. When Century's reinsurers refused to reimburse Century for certain claims, "Century demanded that [they] participate in a consolidated arbitration to determine liability." Wausau acknowledged that it was required to arbitrate but claimed that it could not "be required to participate in a consolidated arbitration." Wausau filed suit in federal district court seeking a declaratory judgment to that effect.[162] "Wausau argue[d] that the issue of whether consolidation [was] allowed" was, in the absence of "clear . . . evidence that the parties had intended the arbitrator to decide," a question of "arbitrability" to be determined by the court. Century took the opposite position, arguing that the question was a procedural one that needed to be resolved by the arbitrator unless the arbitration agreement reserved it for the court.

The trial court determined that the question of whether a consolidated arbitration could be compelled was itself a question for the arbitrator rather than the court. Citing *First Options of Chicago, Inc. v. Kaplan*,[163] the Seventh Circuit affirmed. The court distinguished between questions of arbitrability and issues that are merely procedural in nature but that do not impact on arbitrability. Finding that the question of whether an arbitration agreement forbids consolidated arbitration is a procedural one, the Seventh Circuit held that the question is to be resolved by the arbitration panel.[164]

2. Scope of Arbitration Clause

In *Medical Insurance Exchange of California v. Certain Underwriters at Lloyds, London*,[165] the court analyzed the question of whether a reinsurer and its

160. *Id.* (citations omitted).
161. 443 F.3d 573 (7th Cir. 2006).
162. *Id.* at 574.
163. 514 U.S. 938 (1995).
164. 443 F.3d at 577.
165. No. C 05-2609 PJH, 2006 WL 463531 (N.D. Cal. Feb. 24, 2006).

cedent should be compelled to arbitrate a dispute where the insurer alleged misrepresentation, concealment, nondisclosure, and fraud.

The plaintiff was a physician-owned insurance company providing medical malpractice insurance to health care providers. After hundreds of claims were asserted against a group of cardiologists insured by the plaintiff, the plaintiff agreed to defend those insureds against the claims and provided notice of same to the reinsurers. When a tentative global settlement of the lawsuits was reached, the plaintiff agreed to contribute to the settlement and notified the reinsurers regarding the details of the arrangement. The plaintiff alleged that the reinsurers led the plaintiff to believe that the settlement would be covered under the reinsurance policies in question.[166]

After the insurer made the settlement payment, it requested reimbursement from the reinsurers. The reinsurers rejected that request, asserting that because the plaintiffs had allocated the settlement amount among all the individual claimants such that the individual allocations did not exceed $75,000 per claimant, no reinsurance coverage had been triggered under the policies. The insurer responded that it could have structured the settlement in a different manner had the reinsurers taken that position before the settlement had been finalized.[167]

The plaintiff filed suit, alleging breach of contract and breach of the implied covenant of good faith and fair dealing. The reinsurers demanded arbitration pursuant to the agreements between the parties. The plaintiff rejected that demand, claiming that because the action against the reinsurers involved allegations of misrepresentation, concealment, nondisclosure, and fraud, the dispute fell outside the parties' arbitration agreement.[168] Moving to compel arbitration, the reinsurers claimed the exception for misrepresentation claims was intended to cover contract formation issues leading to rescission claims.[169]

After a detailed analysis of the intent of the parties in inserting into the arbitration provision the exception for allegations of misrepresentation, the court determined that the arbitration provision was not ambiguous on its face but that under California law a provision is ambiguous if it is capable of two or more reasonable constructions.[170] Finding that the language satisfied that test for ambiguity, the court rejected the insurer's argument that there was no need to look to the extrinsic evidence. In proceeding to grant the motion to compel arbitration, the court found "that the lead underwriter intended, and Carvill [the intermediary] and the reinsurers

166. *Id.* at *2.
167. *Id.*
168. *Id.*
169. *Id.*
170. *Id.* at *15.

understood that the lead underwriter intended, that the exception to the arbitration requirement be applied only where the validity or formation of the contract was being challenged."[171] As Carvill was acting as the insurer's intermediary, the court charged the insurer with Carvill's knowledge of the lead underwriter's intent, regardless of whether Carvill had actually communicated that intent to the insurer.[172]

3. Arbitrator Partiality

In *Nationwide Mutual Insurance Co. v. Home Insurance Co.*,[173] the Sixth Circuit analyzed claims of bias regarding a party-appointed arbitrator. Nationwide sought vacatur of an arbitration award issued in a reinsurance dispute with Home Insurance Company, claiming that Home's party-appointed arbitrator evidenced partiality because of his "alleged nondisclosure of certain business and social relationships with Home." The trial court had rejected Nationwide's argument, relying on *Apperson v. Fleet Carrier Corp.*,[174] which held that evident partiality may be found "only where a reasonable person would have to conclude that an arbitrator was partial to one party to the arbitration."[175]

In considering the claim, the Sixth Circuit noted that the Federal Arbitration Act presumes that arbitration awards will be confirmed[176] and that a court may vacate an arbitration award only in limited circumstances, including "where there was evident partiality or corruption in the arbitrators, or either of them."[177] Nationwide argued that the court should only apply *Apperson* in "actual bias" cases "where the evident partiality claim is based on facts known or disclosed and objected to by the challenging party prior to or during the arbitration."[178] In a case where there is an alleged nondisclosure, Nationwide argued, such nondisclosure alone "mandates vacatur under either a 'reasonable impression of bias' or 'appearance of bias' standard."[179] The court disagreed, holding that *Apperson* supplied the correct standard even in nondisclosure cases and that the party alleging bias must show "more than an amorphous institutional predisposition toward the other side."[180] The court wrote, "[T]he alleged partiality must be direct, definite, and capable of demonstration, and 'the party asserting

171. *Id.* at *13.
172. *Id.* at *17.
173. 429 F.3d 640 (6th Cir. 2005).
174. 879 F.2d 1344 (6th Cir. 1989).
175. *Nationwide Mut. Ins. Co.*, 429 F.3d at 644.
176. 9 U.S.C. § 9 (1999).
177. 9 U.S.C. §10(a)(2) (2006).
178. *Nationwide Mut. Ins. Co.*, 429 F.3d at 644.
179. *Id.*
180. *Id.* (quoting Andersons, Inc. v. Horton Farms, Inc., 166 F.3d 308, 329 (6th Cir. 1998)).

it . . . must establish specific facts that indicate improper motives on the part of the arbitrator.'"[181]

Applying *Apperson*, the Sixth Circuit found that the arbitrator had made full and timely disclosures regarding his business relationship with Home and that Nationwide had failed to make any showing as to how those disclosures manifested evident partiality. The court further found that the arbitrator's "social engagements" upon which Nationwide relied to show partiality "did not constitute improper or prohibited *ex parte* contacts."[182] The court rejected Nationwide's argument "that it had a contractual right to withdraw its consent to the second panel's authority because [the allegedly inadequate] disclosures rendered [the arbitrator] unacceptable to Nationwide."[183]

4. Discovery Issues

In *National Casualty Co. v. First State Insurance Group*,[184] the First Circuit considered a challenge to an arbitration award based on the carrier's alleged improper discovery practices. The plaintiff, National Casualty, served as a reinsurer to First State pursuant to a number of reinsurance agreements. Under the agreement of the parties, if First State settled its insureds' asbestos claims on a single-occurrence basis, National Casualty was obligated to reimburse First State to a greater degree than if the claims were settled on a multiple-occurrence basis. After First State settled a number of claims with its insureds, it represented to National Casualty that they had been settled on a single-occurrence basis. National Casualty demanded arbitration because it "suspect[ed] that First State had misrepresented the bases on which the underlying claims had been settled in an effort to maximize [the reinsurance] reimbursement."[185]

In the arbitration proceeding, National Casualty requested that First State provide documents regarding First State's internal assessment of the claims for which it was requesting reinsurance recovery. The arbitrators ordered First State to produce the documents, cautioning that if it refused to do so, "the panel would draw whatever negative inferences it deemed appropriate."[186] Invoking the attorney-client privilege and work product doctrine, First State refused to produce the documents.

National Casualty "requested that the arbitration panel delay" further proceedings until the parties could "brief the prejudicial effect of the

181. *Id.* (quoting Consol. Coal Co. v. Local 1643, United Mine Workers of Am., 48 F.3d 125, 129 (4th Cir. 1995)).
182. *Id.* at 648–49.
183. *Id.* at 649.
184. 430 F.3d 492 (1st Cir. 2005).
185. *Id.* at 495.
186. *Id.*

withholding of the documents," but the panel refused.[187] National Casualty then filed an action in federal court, seeking to enjoin further arbitration proceedings. "While [that] claim [] was pending, the panel ruled in favor of First State, and National Casualty paid" the amount determined by the panel.[188] National Casualty then amended its federal court complaint to request the court overturn the arbitration award in light of First State's refusal to comply with the arbitration panel's order to produce the documents. National Casualty argued that this refusal constituted a breach of contract that voided the arbitration clause and terminated the panel's jurisdiction. It also sought to vacate the award based upon "procedural deficiencies under sections 10(a)(1) and (3) of the Federal Arbitration Act."[189]

The First Circuit affirmed, noting that under § 10(a)(3) there are three separate grounds for vacating an award. A vacatur is appropriate "'where the arbitrators were guilty of misconduct in refusing to postpone the hearing, upon sufficient cause shown, or in refusing to hear evidence pertinent and material to the controversy; or of any other misbehavior by which the rights of any party have been prejudiced.'"[190] National Casualty claimed the second ground justified vacatur of the award, arguing that the arbitrators had refused to hear pertinent evidence. Rejecting that argument, the court wrote thus:

> [W]e find no violation of the statute here, because any failure to hear evidence did not "so affect [] the rights of a party that it may be said that he was deprived of a fair hearing." The arbitrators ruled that as a result of First State's refusal to produce the requested documents, they would draw inferences against First State as to what those documents would show. This is a routine remedy, well within the arbitrator's powers. The drawing of an inference against First State in this case offset any unfairness to National Casualty that resulted from holding a hearing without giving National Casualty access to the actual documents it sought.[191]

The court also rejected National Casualty's argument "that the arbitrators could not have reached the results they reached if they had drawn the promised negative inference," noting that this was little more than "an attack on the merits of the award" and that courts "do not generally review what weight arbitrators give to a single piece of evidence."[192] The court

187. *Id.* at 495–96.
188. *Id.* at 496.
189. 9 U.S.C. § 10(a)(3) 2006).
190. *Nat. Cas. Co.*, 430 F.3d. at 497 (quoting 9 U.S.C. § 10(a)(3)).
191. *Id.* at 498 (quoting Hoteles Condado Beach, La Concha & Convention Ctr. v. Union de Tronquistas Local 901, 763 F.2d 34, 40 (1st Cir. 1985)).
192. *Id.*

emphasized that arbitrators do not have to "give specific reasons for the decisions they reach."[193]

C. *Litigation*

1. Preanswer Security

The Connecticut Supreme Court recently addressed the right to appeal a trial court's decision denying a request for preanswer security. In *Hartford Accident & Indemnity Company v. ACE American Reinsurance Co.*,[194] various insurance companies sought damages from several foreign and domestic reinsurance companies for breach of contract.[195] The insurers filed a motion for an order compelling the defendants to post prepleading security pursuant to a Connecticut statute that required certain "unauthorized" insurers named in a cause of action to post security sufficient to secure any potential final judgment rendered against them.[196] The trial court denied the motion based on a statutory distinction, and the plaintiffs appealed. The appellate court dismissed the appeal, holding that there was no final appealable judgment. The insurers appealed to the Connecticut Supreme Court.

The Connecticut Supreme Court explained that an "otherwise interlocutory order is appealable" when the order (1) "threatens the preservation of a right that is already secured to [a party] and that "will be irretrievably lost" and (2) will cause irreparable harm unless it is immediately appealed.[197] As the court clarified, "For an interlocutory order to be an appealable final judgment it must threaten the preservation of a right that the [party] already holds."[198] The court held that the trial court's denial of the plaintiffs' motion for prepleading security was indeed a final judgment for purposes of appeal. Specifically, the court underscored that the trial court's "evisceration" of the plaintiffs' right to obtain security prior to the defendants' participation in the action constituted an "irretrievably lost" right that would also cause "irreparable" harm to the plaintiffs if they were not allowed to appeal.[199] The court consequently reversed and remanded the case to the appellate court to consider the merits of the trial court's decision.[200]

2. Intervention/Unsealing the Record

The reinsurance industry as a whole has been very receptive to arbitrations because the arbitration process provides several key advantages, one of the most important being confidentiality. A case from the Superior Court of

193. *Id.*
194. 901 A.2d 1164 (Conn. 2006).
195. *Id.* at 1167.
196. *Id.*
197. *Hartford*, 901 A.2d at 1169.
198. *Id.*
199. *Id.* at 1170.
200. *Id.* at 1176.

Connecticut demonstrates the dangers parties face when their disputes are litigated rather than arbitrated. *Hartford Accident & Indemnity Co. v. ACE American Reinsurance Co.*[201] involved a case where sealed confidential filings were unsealed by intervening parties.

Hartford Accident & Indemnity Company initiated a lawsuit against several reinsurers for alleged breach of contract. The presiding court issued two protective orders "to protect the confidentiality of nonpublic and competitively sensitive information (including confidential research and commercial information)."[202] Subsequently, certain materials were submitted to the court to be placed under seal.

United States Fidelity & Guaranty Company and St. Paul Fire & Marine Insurance Company filed a motion to intervene and unseal the records, arguing that they were involved in another similar dispute against Hartford in New York and were, thus, entitled to the information. In balancing the intervenors' "interest in the Controversy" against other factors such as the risk of delay and potential prejudice to Hartford, the court determined that the motion to intervene should be granted.[203] At the core of the court's reasoning was that the current case between Hartford and the defendants was "very similar" to the case between the intervenors and Hartford in New York.[204] Both cases involved the same facts: an insured, Western MacArthur, suing its insurer (in the present case, Hartford; in the second case, the intervenors) for coverage with respect to asbestos-related issues. In both cases, the parties settled; and in both cases, further litigation ensued when the insurers attempted to recover portions of the settlements from their reinsurers.

The facts do not indicate Hartford's precise relationship to the intervenors in the New York case, but the suggestion is that Hartford was acting as a reinsurer. In contrast, it seems Hartford was serving as the cedent company in the present case. As the court stated, the intervenors are "particularly interested in whether or not Hartford has taken a different position in this case than it has in New York."[205] The court found that the intervenors' interest in unsealing the documents generally outweighed Hartford's interest in protecting the confidentiality of such documents, and, consequently, much of the information was unsealed.

3. Discovery

Courts continue to wrestle with the discoverability of reinsurance information in litigation between policyholders and insurers. Although relevance and privilege issues complicate the question, most courts

201. No. CV030178122S, 2006 WL 72994 (Conn. Super. Ct. Mar. 2, 2006).
202. *Id.* at *1.
203. *Id.* at *3.
204. *Id.*
205. *Id.*

agree that reinsurance information is not automatically inadmissible and nondiscoverable. For example, the discoverability of reinsurance contracts by an insured in a dispute with an insurer was an issue in *Ohio Management, LLC v. James River Insurance Co.*[206] There, the insured sought coverage for damages to its properties sustained during Hurricane Katrina. The U.S. District Court for the Eastern District of Louisiana granted the plaintiff's motion to compel a copy of the insurer's catastrophe reinsurance treaty in effect at the time of the hurricane.[207] The court cited several federal cases which held that the discovery of reinsurance agreements is authorized under the Federal Rules of Civil Procedure and that reinsurance information is not privileged per se.[208]

In *Bondex International, Inc. v. Hartford Accident & Indemnity Co.*, the court focused on the issue of privilege and ruled that a reinsurer's reserve information was not discoverable in a dispute between insureds and insurers.[209] The plaintiff insureds requested various reinsurance materials from the defendant insurers relating to "any reinsurers' reserve settings and levels" for the subject policies.[210]

Although the court dismissed the notion that "information about reinsurance is privileged per se," it held that a reinsurer's reserve information was specifically not discoverable. According to the court, the conceptual link between the reinsurer's reserve information and an attorney's mental impressions was just too strong. In other words, reserve information could "give some insight into the mental processes of the lawyers in setting specific case reserves."[211] Further, the attorney input could not be separated from the documents. This was "not a situation where mental impressions are merely contained within and comprise a part of another document and can easily be redacted. Instead, the aggregate and average figures are derived from and necessarily embody the protected material."[212]

Based on similar reasoning, the court refused to compel production of "any risk management department's opinion work product concerning an aggregate reserve."[213] Because they were necessary for the underlying litigation, the court determined that these documents were also protected: the "protective work product is not confined to information or materials gathered or assembled by a lawyer."[214] Such a rule was pivotal for public

206. No. 06-0820, 2006 WL 1985962 (E.D. La. July 13, 2006).
207. *Id.* at *2.
208. *Id.* at n.8.
209. No. 1:03CV1322, 2006 WL 355289 (N.D. Ohio Feb. 15, 2006).
210. *Id.* at *1.
211. *Id.* at *2 (quoting Rhone-Poulenc Rorer, Inc. v. Home Indem. Co., 139 F.R.D. 609, 613–15 (E.D. Pa. 1991)).
212. *Id.*
213. *Id.* at *3.
214. *Id.*

policy reasons. Indeed, "[w]ere such materials open to opposing counsel on mere demand, much of what is now put down in writing would remain unwritten."[215]

In *Continental Insurance Co. v. Garlock Sealing Technologies, LLC & Coltec Industries, Inc.*, the court found reinsurance information relevant for discovery purposes.[216] The insurer sought a declaratory judgment that it was not obligated to pay claims under various insurance agreements because "they were induced by material misrepresentations" regarding asbestos risks.[217] The insured claimed that it was entitled to information regarding the insurer's reinsurance of the subject policies. The insurer argued that such information was privileged and irrelevant for discovery purposes.

The court concluded that such information was "not relevant to the interpretation of the policies at issue," however, "[g]iven the disputed issues of misrepresentation and reliance, information regarding what [the insurer] knew about the risks and when it knew it, is extremely relevant."[218] Such reinsurance documents were "likely to yield information on these issues."[219] In addition, the court ruled that there was "no blanket privilege protecting reinsurance information from disclosure."[220] Certain reinsurance documents might in fact be privileged, but the insurer had to identify such documents specifically and identify the applicable privilege (e.g., attorney-client privilege, attorney work product, etc.). The fact the documents were reinsurance-oriented did not by itself make such documents inaccessible for privilege purposes.

4. Collateral Estoppel

In *Kuhn v. Kehrwald*,[221] after a policyholder failed to win a Racketeer Influenced and Corrupt Organizations ("RICO") claim against her insurer, Chubb, she brought an identical RICO claim against the reinsurer, GE Employers Reinsurance. Although the policyholder's claims faced serious statute of limitation problems, the court also ruled that the RICO claims were barred by the doctrine of collateral estoppel. As the court stated, in "the present case, other than the fact that GE is a reinsurer rather than a direct insurer, the RICO claims that plaintiff asserts are the same as those she asserted in her suit against Chubb and its president."[222] The court concluded that collateral estoppel was appropriate to bar all of the policyholder's claims because the reinsurer was in privity with the ceding company.

215. *Id.*
216. No. 116789/04 (N.Y. Sup. Ct. Mar. 23, 2006) (unpublished).
217. *Id.* at *8.
218. *Id.*
219. *Id.*
220. *Id.*
221. No. 05C1228, 2006 WL 225294 (E.D. Wis. Aug. 4, 2006).
222. *Id.* at *2.

5. Nondisclosure/Misrepresentation

Disputes involving alleged misrepresentation and nondisclosure are becoming more prevalent in reinsurance. Materiality is often a pivotal issue in such cases. In *ERC Frankona Reinsurance v. American National Insurance Co.*, an English court ruled that a reinsurance company could avoid its quota share obligations because the ceding company failed to disclose key information regarding the criminal background of the underwriting officer who placed the contract.[223] Prior to placement of the contract, this officer had been found guilty of securities fraud and had been imprisoned for four years. His record also showed that he had been charged, although not convicted, of conversion.

The court ruled that the officer's criminal background was material and should have been disclosed. The criminal charges were very serious: they resulted in four years of imprisonment, "involved dishonesty," and involved a high-ranking underwriting officer.[224] The court held that "a prudent underwriter would have wanted to take [such information] into account, and weigh its significance after discovering the nature of the charge and the basis for it."[225]

6. Choice of Law

In *Employers Reinsurance Corp. v. Laurier Indemnity Co.*, the court refused to apply a "reinsurance federal common law."[226] The underlying dispute involved myriad reinsurance issues: follow the fortunes, notice, and prejudice. Both parties sought summary judgment on these issues, but because the reinsurance contract in question did not specify a governing state law, a reviewing magistrate first had to determine which law to apply.

Because she was presented with no evidence on the issue, the magistrate rejected both parties' requests for summary judgment. In doing so, she specifically rejected the plaintiff's argument that a "federal common law" should apply "derived from the holdings of cases arising out of the Second Circuit."[227] The magistrate stated that "the fact there is a large body of reinsurance case law arising from the Second Circuit does not mean that these decisions are binding precedent in the Eleventh Circuit or, in a claim brought in diversity, would constitute the substantive law of the state whose law governs the controversy."[228]

223. (July 5, 2005) No. 1381 English High Ct. (QBD), *reported in* 16-9 Mealey's Litigation Report: Reinsurance (Sept. 8, 2005).
224. *Id.* ¶ 139.
225. *Id.* ¶ 141.
226. No. 8:03-CV-1650-T-17MSS, 2006 WL 1679366 (M.D. Fla. June 19, 2006).
227. *Id.* at *16.
228. *Id.*

The district court agreed: "no reinsurance federal common law controls and the matter is properly resolved by first discerning the applicable state law" using the choice of law analysis of the forum state.[229] Here, under Florida law, the case was remanded to the magistrate with instructions to apply the law of the state where the contract was executed, i.e., where the final act to execute the contract occurred.[230]

7. Prearbitration Injunctive Relief

Even when parties have agreed to arbitrate their disputes, they may find themselves in court prior to the arbitration. Parties may, for example, seek injunctive relief in order to maintain the status quo or to prohibit certain activity pending the arbitration.

Such prearbitration injunctive relief was sought in a case arising out of the departure of Maurice Greenberg as CEO of AIG. In *National Union Fire Insurance Co. of Pittsburgh v. Starr Technical Risks Agency*, the parties seeking the injunction were all affiliates of the AIG insurance group of companies.[231] Their managing general agent was C. V. Starr & Co., which acted through its subsidiaries, including Starr Technical Risks Agency ("Starr Tech"). Conflict arose among the parties after Mr. Greenberg left AIG. Despite his departure, it was alleged that Mr. Greenberg still had significant control of C.V. Starr and that this control was being misused.

Under Mr. Greenberg's alleged control, Starr Tech, still serving as AIG's managing agent, entered into a reinsurance agreement with National Indemnity Company ("NICO") whereby NICO would reinsure various risks ceded by AIG. This resulted in a "reduction in premiums which would otherwise be paid to AIG."[232] AIG complained that this agreement was a "product of self-dealing by Greenberg,"[233] and the practical effect of the agreement was to "siphon premiums away from AIG" and toward NICO.[234] The act also allegedly tarnished AIG's business reputation because AIG had promised to other companies the business ceded to NICO.[235]

As the parties proceeded to arbitration, AIG asked the court for an injunction, which the court granted. In reviewing the requirements for an injunction, the court was satisfied that AIG was at risk of "irreparable reputational harm" if the injunction was not granted and if Starr Tech was allowed to "funnel large amounts of reinsurance premiums" away from AIG.[236] The court also ruled that an injunction was needed "to ensure that

229. *Id.* at *5.
230. *Id.* at *8.
231. No. 600263/06, 2006 WL 304746 (N.Y. Sup. Ct. Feb. 8, 2006).
232. *Id.* at *2.
233. *Id.*
234. *Id.*
235. *Id.*
236. *Id.* at *4.

an ultimate arbitration award is not rendered ineffectual."[237] The court was concerned that "[b]y the time an award is issued at the conclusion of arbitration, AIG may no longer be capable of doing business with the reinsurers to whom it made promises" regarding reinsurance business.[238] As part of the preliminary injunction, it was ordered that "Starr Tech may not enter into, or perform, any contract of reinsurance with NICO, on behalf of AIG."[239]

D. *Insolvency*

1. Direct Actions Against Reinsurers

Courts this past year have continued to grapple with the circumstances under which a reinsurer may be regarded as having assumed the direct obligations of a primary insurer such that the insured is entitled to pursue recovery directly from the reinsurer.

Cut-throughs continued to be an issue in Pennsylvania. Policyholders of two insurance companies in liquidation, Legion and Reliance, sought direct access to reinsurance proceeds. In 2004, the Pennsylvania Commonwealth Court ruled that two Florida hospitals were entitled to such direct access because the parties, including Reliance and Reliance's reinsurer, had caused a novation of the reinsurance agreement through their conduct.[240]

While the liquidator's appeal was pending before the Pennsylvania Supreme Court, the same court affirmed a ruling in the Legion case similarly permitting policyholders direct access to reinsurance proceeds.[241] In November 2005, the Pennsylvania Supreme Court vacated and remanded the commonwealth court's ruling in the Reliance case for discovery.[242] Justice Newman, who dissented in the Legion case, filed a concurring statement in which she acknowledged that the commonwealth court's decision in the Legion case, as affirmed by the supreme court, "now reflects the prevailing law on the issue of whether a direct insured is entitled to receive direct payments from reinsurers. . . ."[243]

This past year also yielded a decision in which insureds sought guaranty fund coverage based upon the admitted status of their insolvent insurer's reinsurer where the insurer was not an admitted carrier. In *Aftab v. New Jersey Property-Liability Insurance Guarantee Ass'n*,[244] the plaintiffs were

237. *Id.* at *5.
238. *Id.*
239. *Id.*
240. Koken v. Reliance Ins. Co., 846 A.2d 167, 172 (Pa. Commw. Ct. 2004), *vacated*, 887 A.2d 1216 (Pa. 2005).
241. Koken v. Villanova Ins. Co., 878 A.2d 51, 53 (Pa. 2005).
242. Koken v. Reliance Ins. Co., 891 A.2d 704 (Pa. 2005).
243. *Id.* (Newman, J., concurring).
244. 898 A.2d 1041 (N.J. Super. Ct. 2006).

New Jersey attorneys who were "named defendants in legal malpractice suits." American National Lawyers Insurance Reciprocal ("ANLIR"), their professional liability insurer, became insolvent, and the attorneys subsequently "sought defense and indemnification from" the state guaranty association, the New Jersey Property-Liability Insurance Guaranty Association ("PLIGA").[245] The insurer was a risk retention group, which was not an admitted carrier for guaranty fund coverage in the state, so PLIGA denied the attorneys' claims. After the trial court granted PLIGA's motion for summary judgment, the plaintiffs argued that they were entitled to payment because ANLIR's reinsurer, Reciprocal of America ("ROA"), had assumed the obligations of ANLIR, and the reinsurer was a PLIGA member.[246] The plaintiffs asserted that the reinsurer "exerted" such a "controlling influence over ANLIR" that the two companies merged into a "single enterprise" such that the reinsurer was the insurer and vice versa.[247]

The New Jersey Superior Court rejected the plaintiffs' argument, stating "that the terms of the reinsurance agreement plainly describe[d] a traditional insurer-reinsurer relationship" and did not provide for an insured's "direct claims" against the reinsurer.[248] The court held that there was no evidence to support the claim that the reinsurer had assumed charge or control of the underlying claims, evaluated them, or facilitated their resolution; and no "corporate interconnectedness" argument could justify coverage.[249] Even if such evidence had been persuasively presented, the court remained steadfast that the plaintiffs would not be entitled to coverage given that state guaranty association coverage applied only to direct insurance, and "[a]llowing ANLIR's insureds access to the PLIGA Fund based on its connection with ROA would be contrary to public policy."[250]

2. Priority of Distribution

A recent decision involving the liquidation of the Home Insurance Company could have significant implications for both creditors and debtors of insolvent insurers by allowing a receiver to bypass a priority of distribution statute when to do so would benefit the estate.[251]

The Home Insurance Company was a New Hampshire domiciled insurance company that wrote insurance and reinsurance in the United Kingdom as a member of the American Foreign Insurance Association ("AFIA").[252]

245. *Id*. at 1042.
246. *Id*. at 1042–45.
247. *Id.*
248. *Id*. at 1053.
249. *Id.*
250. *Id*. at 1054.
251. *In re* Liquidation of the Home Ins. Co., No. 03-E-0106 (N.H. Super. Ct. Sept. 22, 2005), *reported in* 16-11 Mealey's Litigation Report: Reinsurance B-1 (Oct. 6, 2005).
252. *Id.* at B-2.

In 1983, CIGNA Corporation purchased AFIA from Home and six other companies. In connection with the AFIA purchase, a CIGNA subsidiary, Insurance Company of North America ("INA"), entered into an Insurance and Reinsurance Assumption Agreement ("Assumption Agreement") with Home and the other companies whereby INA agreed to assume as its direct obligation the insurance and reinsurance liabilities of the Home UK Branch business, pay those liabilities on behalf of Home, and administer and bear the related costs and expenses.[253]

On June 13, 2003, Home was placed into liquidation after a long period of supervision.[254] Reinsurance recoverables from ACE (as INA's successor) under the Assumption Agreement comprised the largest asset of the estate. AFIA cedents who asserted claims against Home were required to file proofs of claims in the New Hampshire liquidation proceeding, which were then subject to the review and approval of the liquidator and court. The AFIA cedents, however, were Class V claimants; and it became evident that as general creditors under the state priority of distribution statute, they would not recover on their claims against the estate.[255] The liquidator became concerned that these creditors would either not pursue claims against the estate or would seek recovery directly from ACE. Either scenario would result in the estate losing the ability to collect reinsurance recoverables on such claims from ACE.[256] Consequently, the liquidator agreed to pay fifty percent of the net proceeds (as much as $72 million) of any recoveries from ACE to the AFIA cedents in exchange for the latter's agreement that they would not deal directly with ACE but would instead pursue claims against the estate.[257]

The liquidator sought court approval of the agreement, and ACE objected. Following an appeal and remand of the superior court's initial approval of the agreement, the superior court in September 2005 approved the agreement a second time. The court held that the agreement, reviewed with the "paramount interest of creditors" in mind, was "fair and reasonable" and that a reasonable liquidator under the circumstances would have concluded the agreement was necessary to maximize reinsurance recoverables.[258] The court held that payments to the AFIA cedents were indeed administrative expenses as they were necessary costs to preserve and recover Home's assets. The court credited the liquidator's conclusion that "absent creation of a more attractive alternative, [c]edents would not file and fully prosecute claims, and . . . they would move in a more commercially favorable direction

253. *Id.* at B-3.
254. *Id.*
255. *Id.* at B-5.
256. *Id.*
257. *Id.* at B-4.
258. *Id.* at B-11.

to the disadvantage of the estate."[259] It also credited evidence suggesting that cedents would not prosecute their claims without the incentive of an economic return. The court dismissed ACE's argument that payments to the small class of AFIA cedents (who were general creditors) to induce them to file proofs of claims deprived higher-level creditors of their rightful assets under a normal priority of distribution statute and gave these cedents special benefits not available to other creditors. ACE's appeal to the New Hampshire Supreme Court has since been rejected.[260]

3. Assignment of Reinsurance Recoverables

In *B.D. Cooke & Partners Ltd. v. Nationwide Mutual Insurance Co.*,[261] a New York state justice ordered Nationwide Mutual Insurance Company to pay $4.3 million to a creditor of an insolvent casualty reinsurance pool, plus future sums that would become due. In 1962, Citizens Casualty Company of New York and Nationwide participated in a casualty reinsurance pool. B.D. Cooke was a major cedent to this pool and became the largest creditor after Citizens was ordered into liquidation in 1971. Citizens remained liable for losses that occurred before it was ordered into liquidation, and its liquidator allowed cedents to file proofs of claims even when no actual loss had been reported. By 1996, the liquidator predicted that cedents would continue to file claims, thus delaying final resolution of Citizens' total reinsurance liabilities.[262]

In 1996, the New York County Supreme Court "approve[d] a plan to expedite the closing of Citizens' liquidation" by fixing Citizens' liability to B.D. Cooke based upon the losses paid as of June 30, 2004. B.D. Cooke subsequently agreed to withdraw $30.72 million in outstanding but unreported claims and the liquidator agreed to assign to B.D. Cooke all of the reinsurance recoverables owed to Citizens by pool members, reinsurance sums due the liquidator as of June 30, 1994, and all reinsurance agreements in favor of Citizens effective from July 1, 1994.[263]

When the liquidation closed in 1998, B.D. Cooke sued Nationwide for over $2 million and sought a declaratory judgment that Nationwide was obligated to reimburse it for all future amounts due. The court dismissed all of Nationwide's defenses and held that B.D. Cooke's entitlement to reinsurance proceeds was not limited by the estate's closing. The court thus ordered Nationwide to pay $4.3 million and all amounts that either had or would become due after May 4, 2005.[264]

259. *Id.* at B-10.
260. No. 2005-740 (N.H. Dec. 15, 2006), *reported in* 17-15 Mealey's Litig. Rep. C-1 (Dec. 17, 2006).
261. No. 600655/02 (N.Y. Sup. Ct. Jan. 26, 2005), *reported in* 17-11 Mealey's Litigation Report: Insurance Insolvency 12 (Mar. 2006).
262. *Id.*
263. *Id.*
264. *Id.* at 13.