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

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I. INTRODUCTION

Insurance and reinsurance are sophisticated forms of risk shifting and finance conducted on an international basis among more than 7,000 insurance and reinsurance firms. The business is heavily regulated in many jurisdictions, but its parameters are frequently explored, if not set and defined, in disputes between the business firms involved. Private and confidential arbitration proceedings, before panels of arbitrators who are not bound by the strict rules of law and evidence (even though failure to abide by clearly articulated rules is one of the few grounds for overturning an award in the United States), are the most frequent forums for dispute resolution. Being confidential, the arbitration decisions typically are not reported. It is all the more important, therefore, to monitor reported dispute resolutions as well as developments in relevant legislation and regulatory pronouncements, including receiverships.

Providing a comprehensive catalogue of every change in excess, surplus lines, and reinsurance law made over a twelve-month period (here July 1, 2002, through June 30, 2003) throughout the world is impossible. This article attempts to survey reported developments in American law,[1] to high-

1. Developments in English reinsurance law, for example, may be gleaned, inter alia, from MEALEY'S LITIGATION REPORTER: REINSURANCE, as well as summaries prepared by English law firms. *See, e.g.*, Charles Russell Solicitors, *Reinsurance Review Round-up of Recent Cases: July 2002—July 2003* (unpublished monograph) (available from authors).

light trends in U.S. law, and to serve as a useful reference for section members, arbitrators, regulators, legislators, receivers, and those engaged in the interrelated businesses of excess, surplus lines, and reinsurance.

II. EXCESS INSURANCE

The majority of excess insurance case law developments over the past year related to allocation. The issue most often decided was whether, in long-tail injury cases, primary insurance policies must be exhausted horizontally or vertically before an excess insurance policy is triggered. Other cases decided whether an excess insurer has a direct cause of action against the primary insurer, whether an indemnitee's primary policy is excess to the indemnitor's primary policy, and the applicability of a renewal rule to the excess insurer.

A. *Exhaustion of Underlying Coverage*

1. Horizontal Exhaustion

In the context of long-tail claims (e.g., pollution, mass product, or toxic tort exposures), damage or injury may take place over time, and often there is a latency period between the date on which the polluting activity or injurious process begins and the date on which the resulting bodily injury or property damage is discovered. In other words, long-tail claims may span several years or even decades. In some instances, the damage is progressive while in others it is merely continuous. As to insurance, excess insurers generally are liable only for the amount of such loss or damage in excess of underlying coverage, including primary coverage. Long-tail claims thus present a fundamental allocation issue: whether the exhaustion must be horizontal (all primary policies in all years are exhausted) or vertical (the primary policy in the period of time covered by the excess policy is exhausted) before an excess policy is triggered.

In the past year, the U.S. Court of Appeals for the Ninth Circuit held that horizontal exhaustion applied. In *Employers Insurance of Wausau v. Granite State Insurance Co.*,[2] a primary insurer, Wausau, brought a subrogation action against an excess insurer, Granite, over a settlement of over $9.5 million paid by Wausau on behalf of its mutual insured, California Water Services.[3] Wausau issued five commercial general liability[4] insurance policies to CWS effective from January 1, 1980, to January 1, 1985. Each Wausau primary policy was subject to a $2 million policy limit. Granite issued five excess liability insurance policies during the same time period,

2. 330 F.3d 1214 (9th Cir. 2003).
3. Hereinafter CWS.
4. Hereinafter CGL.

and each such policy was subject to a $5 million policy limit. Beginning in 1980, a group of homeowners experienced property damage caused by a landslide activated, in part, by ruptures in CWS's underground waterline. Wausau provided a defense to CWS in the action and paid the settlement of over $7.7 million. Wausau then sued Granite seeking contribution.[5]

Granite argued that, because the occurrence took place over a five-year period, and Wausau's policies provided a total of $2 million in coverage for each year during that time period, Wausau effectively provided total coverage of $10 million. Granite argued that Wausau's total coverage had to be exhausted prior to its own excess policies being impacted. Both parties agreed, however, that the property damage arose from a single, continuous occurrence and that continuous damage took place throughout the five years in issue. The court, accordingly, found that the narrow issue was "whether a primary insurer's total exposure can be greater than its annual policy limit, where a single occurrence caused damage during multiple years in which annual 'per occurrence, per year' policies were in effect."[6]

The Ninth Circuit held that the policy limits could be stacked and that all of the triggered policies should be exhausted before any excess coverage was invoked, relying upon the holding of a California appellate court in *Stonewall Insurance Co. v. City of Palos Verdes Estates*.[7] Like the present case, *Stonewall* involved a single, continuous occurrence that took place over multiple years. Moreover, just as in the present case, *Stonewall* involved a stipulation between the parties that the policy limits were per occurrence, per year.[8] Wausau contended that *Stonewall* conflicted with the more recent decision of *FMC Corp. v. Plaisted & Cos.*,[9] where the California Court of Appeal held that an insured could not "stack" the limits of successive policies for a single occurrence, and that an insured may recover an amount no greater than the policy limit for one policy period.[10]

The *Wausau* court disagreed, finding that *FMC* was not applicable to the present case.[11] The Ninth Circuit concluded that California courts have expressly approved "stacking" of successive per occurrence, per year policy limits where, as here, a single occurrence extends through more than one policy period.[12] The court found that the Wausau policies provided $2

5. *Wausau*, 330 F.3d at 1216–17.
6. *Id.* at 1219.
7. 54 Cal. Rptr. 2d 176 (Ct. App. 1996).
8. *Wausau*, 330 F.3d at 1220 (quoting *Stonewall*, 54 Cal. Rptr. 2d at 182, 197).
9. 72 Cal. Rptr. 2d 467 (Ct. App. 1998).
10. *Id.* at 503.
11. *Wausau*, 330 F.3d at 1220. The court noted that the *FMC* court had expressly distinguished *Stonewall* on the ground that the latter case had involved a per occurrence, per year stipulation nearly identical to that at issue in the present case. *Id.* (citing *FMC*, 72 Cal. Rptr. 2d at 503).
12. *Id.* at 1221.

million in coverage each year and that the alleged damage occurred proportionately during each year. Thus, the court found that, because the $7.7 million settlement allocated over the five years was within the per occurrence limits of the five policies, Wausau was responsible for the entire settlement. The Ninth Circuit found that Granite's argument was consistent with horizontal exhaustion and that it supported judgment in its favor.[13]

Meanwhile, the Kansas Supreme Court ruled that self-insured retentions constitute primary insurance for noise-induced hearing loss claims and, as such, are "other insurance" under the excess policies that must be exhausted by the insured before it can seek recovery under the excess policies. In *Atchison, Topeka & Santa Fe Railway Co. v. Stonewall Insurance Co.*,[14] a railroad sought coverage from its insurers for thousands of underlying noise-induced hearing loss claims. During the time period at issue, the railroad was subject to self-insured retentions underlying its excess policies ranging from $1 million to $7 million.

One question addressed by the Kansas Supreme Court was whether the railroad must pay its self-insured retention in each policy, or horizontally exhaust all self-insured retentions, before obtaining coverage under its excess insurance policies. After finding that the noise-induced hearing loss claims arose from a single, continuous occurrence, the court found that the self-insured retentions were "other insurance" because the only insurance policies issued to the railroad were excess insurance policies, which by their nature assume that there is primary coverage.[15] Reasoning that it must give effect to the purpose of indemnification as expressed under the terms of the excess policies, the court concluded that the self-insured retentions were "other insurance" within the meaning of the policies at issue.[16] Following *Missouri Pacific Railroad Co. v. International Insurance Co.*,[17] the Kansas Supreme Court held that the insured must horizontally exhaust all self-insured retentions for implicated policy periods before obtaining coverage under the excess policies.[18] The court adopted the holding of *Missouri Pacific* that the "other insurance" clauses of the policies required exhaustion of the self-insured retentions.[19]

2. Prior Settlements

The primary insurers' payment of their respective policy limits does not necessarily establish proper exhaustion of those limits. In *Dresser Industries*,

13. *Id.*
14. 71 P.3d 1097 (Kan. 2003).
15. *Id.* at 1128–29.
16. *Id.* at 1129.
17. 679 N.E.2d 801, 809 (Ill. App. Ct. 1997).
18. *Atchison*, 71 P.3d at 1129.
19. *Id.*

Inc. v. Underwriters At Lloyd's, London,[20] Dresser previously had been sued by Parker and Paisley in federal court for fraud and negligence in providing a well servicing operation, and it was found liable and assessed damages of $185 million. That judgment was reversed, but a similar state court suit was then filed. Dresser settled that state action for $115 million. Dresser's insurers initially refused to contribute to the settlement, prompting Dresser to file suit; however, on the eve of trial, the underlying insurers paid their limits of liability (except for two insolvent carriers) and one excess carrier paid $5.5 million to Dresser in exchange for a release. Dresser later was sued in asbestos-related litigation and presented those claims to its excess insurers, who denied the claims. Dresser then filed the subject action.[21]

Dresser argued that its primary coverage had been exhausted in the settlement of the Parker and Paisley litigation. It moved for summary judgment on the doctrine of res judicata, asserting that the issue had been addressed and resolved by the same parties in handling prior claims. On the other hand, the excess carrier moved for summary judgment on the basis that the prior claims were not covered losses and did not properly exhaust the underlying coverage. The trial court denied Dresser's motion and granted the excess insurer's motion. On appeal, the central issue was whether Dresser had exhausted its primary coverage in accordance with the underlying policies and, thus, was allowed to recover from the excess carrier for the asbestos-related claims.[22]

The Texas Court of Appeals determined that res judicata did not apply to the unresolved issue of whether the Parker and Paisley claims were covered claims. The court reasoned that the asbestos claims and the Parker and Paisley claims originated from different facts and different transactions. The court held that Dresser had to prove in each case that such losses were covered under the policies.[23] In analyzing whether Dresser had proven proper exhaustion of the primary coverage, the court stated:

> The fact that each one of the (solvent) primary insurers settled for the full amount of their coverages is summary judgment evidence that at least raises a fact issue that primary insurance coverage was exhausted. The additional fact that the excess carrier paid part of its excess coverage to Dresser for those same claims is further support for Dresser's allegation that the primary coverage was exhausted for covered claims.[24]

20. 106 S.W.3d 767 (Tex. App. 2003).
21. *Id.* at 768–69.
22. *Id.* at 769.
23. *Id.* at 772.
24. *Id.* at 776.

Accordingly, the court found that fact issues existed with regard to coverage and exhaustion of the primary insurance policies and remanded the case.[25]

3. Other Insurance Clause Analysis

An "other insurance" clause analysis is inapplicable as between primary insurance policies and true excess insurance policies, as an Illinois Appellate Court recently held in *Travelers Indemnity Co. v. American Casualty Co. of Reading, PA.*[26] There, the underlying claim was a medical malpractice action against two physicians and ten nurses employed at a hospital, as well as the hospital, for the alleged negligence in the prenatal and postnatal treatment of the claimant's wife and son. Three of the nurses were insured under separate professional nursing liability insurance policies issued by American Casualty, two with limits of $500,000 and one with a limit of $1 million.[27] Each of the three American Casualty policies had an excess "other insurance" clause. In addition, Travelers issued a primary CGL policy to the hospital, pursuant to which the doctors and nurses qualified as insureds because they were employees of the hospital and were allegedly acting within their scope of employment. The Travelers primary policy was subject to a limit of $500,000. Travelers also issued a policy of true excess liability insurance to the hospital that had a $10 million limit. The Travelers excess policy contained an excess "other insurance" clause.[28]

In the underlying medical malpractice action, Travelers defended the hospital and the nurses, and the action later settled for $4.5 million. Travelers then filed an action against American Casualty seeking a declaration that the subject policies should respond as follows: (1) the Travelers primary policy up to the $500,000 limit; (2) the three American Casualty policies up to their total limits of $2 million; and (3) the Travelers excess policy up to the $10 million limit. American Casualty denied owing any obligation to contribute on the basis that its policies were excess to both policies issued by Travelers. Alternatively, it argued that the court should require a pro rata allocation between the American Casualty policies and the Travelers excess policy.[29]

The Illinois Appellate Court found that the "threshold issue is whether the policies are on the 'same level.'"[30] The court noted that primary and excess policies inherently serve different functions, cover different risks, and attach at different stages. A "primary policy typically covers claims starting at the first dollar of loss or the first dollar in excess of a deductible

25. *Id.*
26. 786 N.E.2d 582 (Ill. App. Ct. 2003).
27. *Id.* at 584.
28. *Id.*
29. *Id.* at 585.
30. *Id.* at 586.

or self-retention," whereas coverage "under an excess policy is triggered after the limits of the primary policy have been exhausted."[31] The court continued:

> A policy that provides primary coverage in all respects cannot be considered on the same level as an umbrella excess liability policy. In analyzing whether a policy is truly an excess policy, we must not focus solely on the other insurance clauses but "must construe the policies as a whole and [review] the underlying policy considerations."[32]

In light of the nature of excess insurance, the court determined that the American Casualty primary policies and the Travelers excess policy could not be considered on the "same level."[33] As such, the court did not rely upon the general rules regarding excess "other insurance" clauses. Instead, the court construed the Travelers excess policy as a policy of true excess insurance and held that it was not required to contribute until after the American Casualty policies' limits were exhausted.[34]

B. *Duties of Primary Insurer to Excess Insurer*

Courts generally have accepted an excess insurer's right to bring a lawsuit against a primary insurer based upon the doctrine of equitable subrogation. Under the doctrine, the insurer paying a loss under a policy becomes equitably subrogated to a cause of action that the insured may have against a third party who caused the loss. Based on this rule, payment by the excess insurer of the insured's liability has been argued as the basis for an excess insurer to pursue a claim against a primary insurer for breaching its duty to settle within its primary limits. However, during this past year, two courts have limited the remedies available to an excess insurer in this situation.

The Alabama Supreme Court addressed the existence and scope of duties of the primary insurer to the excess insurer in *Federal Insurance Co. v. Travelers Casualty & Surety Co.*[35] The U.S. Court of Appeals for the Eleventh Circuit had certified two questions to the Alabama Supreme Court for review: (1) whether, absent any specific contractual duty, a primary insurer is nevertheless obligated to perform the following duties when defending an insured: the duty of good faith to settle; the duty of good faith in deciding whether to settle; and the duty of good faith to keep the excess carrier informed of settlement negotiations and adverse developments; and (2) whether an excess carrier, whose insured was never subject to a final

31. *Id.*
32. *Id.* (citations omitted) (quoting Illinois Emcasco Ins. Co. v. Cont'l Cas. Co., 487 N.E.2d 110, 112 (Ill. App. Ct. 1985)).
33. *Id.* at 590.
34. *Id.*
35. 843 So. 2d 140 (Ala. 2002).

judgment ordering the payment of money that the insured, and not its insurer, personally would have to pay, can be equitably subrogated to the rights of the insured arising out of any of the foregoing duties against the primary carrier in the conduct of its defense of the mutual insured.[36] The Alabama Supreme Court answered each question in the negative.[37]

The case arose from a judgment entered on a $4.5 million jury verdict in a wrongful death action against Pearce Construction Company.[38] The case had gone to trial after the parties failed to settle; however, evidence indicated that the case could be settled before trial for $350,000. The case later settled for $4.6 million, of which Pearce's primary insurer, Travelers, paid $1 million and Pearce's excess insurer, Federal, paid the remaining $3.6 million. Federal and Pearce sued Travelers to recover the amounts paid to satisfy the settlement and they alleged claims of, inter alia, equitable subrogation and refusal to settle resulting in extracontractual damages.

In addressing the first certified question, the Alabama Supreme Court held that "in the absence of contrary contractual obligations, a primary insurer owes no duty of good faith to an excess insurer with respect to the settlement of a lawsuit against an insured."[39] The court reasoned that the policies that underlie Alabama's tort of bad faith, which is currently available only to insureds against their insurers, are simply not present in the primary insurer/excess insurer scenario where contractual duties with regard to settlement of a claim are absent. The court found that, in a typical insurance contract, the insured expressly relinquishes to the insurer the right to control the defense and settlement of any action arising under the contract and, therefore, the insured's reliance on the abilities and the good faith of the insurer is paramount. However, Federal, the excess insurer, did not expressly relinquish such a right to Travelers, the primary insurer. "Simply put, the primary-insurer/excess-insurer relationship does not involve the same policy considerations that justify imposing on those insurers the duty of good faith to settle that currently exists between an insured and his insurer. Therefore, we answer the first question in the negative."[40]

As to the second certified question, Federal asserted that, even if Alabama law did not recognize a direct duty of good faith with regard to settlement owed to an excess insurer by a primary insurer, Federal should be able to sue as Pearce's subrogee on a claim for bad faith failure to settle. The court initially recognized that the doctrine of equitable subrogation had long been recognized in Alabama and that, under this rule, "an excess insurer, which pays an obligation incurred by its insured, could be equitably

36. *Id.* at 142.
37. *Id.*
38. Hereinafter Pearce.
39. *Federal Ins.*, 843 So. 2d at 143.
40. *Id.* at 143–44.

subrogated to the rights of its insured in order to seek reimbursement from some third-party wrongdoer."[41] However, when equitable subrogation is sought to assert a bad faith failure-to-settle claim in a primary insurer/excess insurer scenario, a "unique analysis must be undertaken."[42] Although the court recognized that an insurer, through subrogation, "stands in the shoes" of its insured and may assert only claims that the insured could validly assert, the court stated that a bad faith failure-to-settle claim does not exist where the insured is subject to no personal loss from a final judgment.[43] Applying those principles to the primary insurer/excess insurer scenario, the court concluded that, because an insured will never be able to assert a bad-faith failure-to-settle claim against an insurer where the insured is never subject to a final judgment ordering the payment of money that the insured, and not its insurer, personally would have to pay, "equitable subrogation is not available to an excess insurer whose insured is subject to no such final judgment."[44] The court further stated: "Simply put, equitable subrogation cannot exist to provide a conduit to assert what are conclusively nonexistent rights. Therefore, we answer the second question in the negative."[45]

Similarly, the Illinois Appellate Court held that Illinois law did not impose on the primary insurer a duty owed to the excess carrier. The court in *U.S. Fire Insurance Co. v. Zurich Insurance Co.*[46] recognized that another panel of the Illinois Appellate Court, in *Schal Bovis, Inc. v. Casualty Insurance Co.*,[47] had rejected a trial court's determination that a primary insurer owed no duty toward an excess carrier. However, the *U.S. Fire* court held that *Schal Bovis* only required that a primary insurer "estimate in good faith the expected verdict of the litigation threatening its *insured* and offer that amount in support of a proposed settlement."[48] The *U.S. Fire* court reached this conclusion despite very specific language in *Schal Bovis* suggesting that a direct duty exists by the primary insurer to the excess insurer.[49]

In *U.S. Fire*, Eastbank constructed a high-rise building that included a hotel, rental apartments, and condominiums. After the building was completed, it experienced serious water intrusion and leaking. An investigation revealed serious defects in the backer board panels supplied by Laticrete. Eastbank brought an action against Laticrete and other contractors for the

41. *Id.* at 144.
42. *Id.*
43. *Id.*
44. *Id.* at 145.
45. *Id.* at 145–46.
46. 768 N.E.2d 288 (Ill. App. Ct. 2002).
47. 732 N.E.2d 1082 (Ill. App. Ct. 1999).
48. *U.S. Fire*, 768 N.E.2d at 297 (quoting *Schal Bovis*, 732 N.E.2d at 1092).
49. *See* Thomas M. Hamilton & Troy A. Stark, *Excess-Primary Insurer Obligations and the Rights of the Insured*, 69 DEF. COUNSEL J. 315 (July 2002).

damages at the building. Laticrete tendered the action to its primary insurer, Zurich, which defended the action under a reservation of rights. Zurich also notified Laticrete's excess insurer, U.S. Fire, of the claim.

Laticrete, the insured, Zurich, the primary insurer, and Eastbank entered into a settlement agreement pursuant to which Laticrete paid Eastbank $6,043,351.89 and Zurich paid Eastbank $956,648.11, which was the remainder of its policy limit, in exchange for a covenant not to enforce any judgment that Eastbank obtained in its action against the assets of Laticrete or Zurich. Laticrete also executed a limited release in favor of Zurich. U.S. Fire then assumed Laticrete's defense following Zurich's exhaustion. U.S. Fire and Eastbank then reached an agreement extinguishing Eastbank's remaining claims, whereunder the amount paid by U.S. Fire to extinguish Eastbank's claims exceeded the limits of the U.S. Fire policy. U.S. Fire filed suit against Zurich seeking recovery of its defense costs incurred following Zurich's withdrawal of the defense. U.S. Fire later added a claim seeking recovery of settlement monies paid by U.S. Fire in the Eastbank litigation based on Zurich's direct duty to U.S. Fire under *Schal Bovis*.

The Illinois Appellate Court found that *Schal Bovis* was distinguishable. The court found that Zurich, Eastbank, and Laticrete had reached a settlement agreement that provided that there was no ability to enforce a judgment against the insured, Laticrete, and that Laticrete entered into the settlement in full knowledge that its insurance coverage could be diminished. The court found that there was a proper settlement. Thus, the court held that Zurich's settlement terminated its duty to defend and triggered U.S. Fire's defense obligation because the U.S. Fire policy provided that it would assume the defense of an action upon the payment of the primary insurer's policy limit.[50] Moreover, the court found that *Schal Bovis* did not hold that a primary insurer owed a direct duty to an excess carrier, but rather the *Schal Bovis* court merely predicted that Illinois would recognize such a duty.[51] Accordingly, the *U.S. Fire* court dismissed U.S. Fire's claim under *Schal Bovis* against Zurich.[52]

Furthermore, the court dismissed U.S. Fire's claim of equitable subrogation against Zurich because it found that U.S. Fire, as a subrogee of Laticrete, was subrogated to the position of Laticrete and acquired no lesser or greater rights than those held by Laticrete as to Zurich. Because Laticrete consented to the settlement with Eastbank, contributed its own money to the settlement, and executed a release of Zurich, the court found that these actions barred any claim by Laticrete against Zurich arising out of Zurich's conduct in the Eastbank action and defeated U.S. Fire's sub-

50. *U.S. Fire*, 768 N.E.2d at 300.
51. *Id.* at 299.
52. *Id.* at 300.

rogated claim against Zurich. Accordingly, the court held that dismissal of U.S. Fire's subrogation claim was appropriate.[53]

C. *Right of Indemnity Renders Indemnitee's Policy Excess*

Insurance obligations often are imposed in business service contracts between parties that provide for both insurance coverage and indemnification. The interplay of those separate obligations impacts the relative coverage positions of the parties' insurers. In one case decided in the past year, the court held that the indemnification provision in a subcontract took precedence over the "other insurance" clauses in the policies in determining which insurer had the primary obligation to defend.

In *American Indemnity Lloyds v. Travelers Property & Casualty Insurance Co.*,[54] the U.S. Court of Appeals for the Fifth Circuit, applying Texas law, held that the carrier insuring the subcontractor whose employee had brought the underlying suit for on-the-job injuries that were within the scope of the subcontractor's agreement to indemnify the contractor had the primary obligation to defend. In this case, Elite Masonry, Inc., entered into a subcontract with Caddell Construction Company by which Elite agreed to provide masonry services to Caddell in connection with Caddell's work on the construction of a prison in Beaumont, Texas. The subcontract contained an indemnification provision that provided:

> [Elite] agrees to indemnify [Caddell] against and hold [Caddell] harmless from any and all claims, demands, liabilities, losses, expenses, suits and actions (including attorneys fees) for or on account of any injury to any person . . . which may arise . . . out of or in connection with the work covered by this Subcontract, *even though such injury . . . may be (or may be alleged to be) attributable in part to negligence or other fault on the part of [Caddell]* or its officers, agents or employees. *This obligation . . . shall not be enforceable if, and only if, it be determined by judicial proceedings that the injury*, death, or damage *complained of was attributable solely to the fault or negligence of [Caddell]* or its officers, agents, or employees. [Elite] agrees to defend all claims, suits, and actions against [Caddell] (in which connection [Elite] shall employ attorneys acceptable to [Caddell]) on account of any injury, death or damage and shall reimburse [Caddell] for all expenses, including reasonable attorney fees, incurred by reason of such claim, suit or action or incurred in seeking indemnity or other recovery from [Elite] hereunder.[55]

The subcontract further required that Elite procure and maintain, at its expense, "public liability insurance . . . as may be necessary to ensure the liability of the parties hereto for any injuries to [Elite's] employees."[56]

53. *Id.*
54. 335 F.3d 429 (5th Cir. 2003).
55. *Id.* at 431.
56. *Id.*

The subcontract did not require that Caddell procure or maintain any insurance.

During the course of construction work pursuant to the subcontract, Elite's employee was injured. The employee later sued Elite and Caddell, claiming negligence and gross negligence. At the time of the injury, Elite carried a CGL insurance policy issued by American Indemnity Lloyds[57] with a policy limit of $1 million. Caddell was named as an additional insured under this policy. Caddell also had a CGL insurance policy issued by Aetna Casualty & Surety Co. with a $1 million policy limit. Travelers became the successor to Aetna's rights and obligations under the policy issued to Caddell. The Aetna and AIL policies contained identical "other insurance" clauses.

Travelers and AIL did not dispute that the AIL policy's "insured contract" provisions afforded Elite with both indemnity and defense coverage for such amounts as Elite might be obligated, under the indemnity provisions of the subcontract, to pay Caddell as reimbursement for payments made by Caddell to discharge or settle the claims made against Caddell in the lawsuit brought by the employee. The parties also did not dispute that the Aetna policy subrogated Travelers to Caddell's rights against Elite under the subcontract's indemnity clause to the extent of any payments Travelers would make under its policy to indemnify or defend Caddell in respect of the claims against Caddell in the the employee's lawsuit.[58]

Travelers initially undertook Caddell's defense in the employee's lawsuit. Travelers demanded that AIL assume Caddell's defense and indemnification in the case, and Travelers then withdrew from the defense. In the employee's lawsuit, the plaintiffs later nonsuited Elite, leaving Caddell as the sole defendant.

AIL took the position that its policy and the Aetna policy provided concurrent primary coverage for Caddell in the employee's lawsuit, and that AIL retained the right to seek contribution from Travelers. AIL later settled the lawsuit for $625,000. AIL had incurred over $230,000 in legal fees and costs in the defense of Caddell in the underlying lawsuit. AIL then demanded that Travelers reimburse it for half of the settlement and defense costs. When Travelers did not respond, AIL filed a lawsuit against Travelers seeking recovery of those sums.[59]

AIL argued that Travelers was required to reimburse AIL for half of the settlement and defense costs based upon the "other insurance" clauses in the respective policies. On the other hand, Travelers argued that the in-

57. Hereinafter AIL.
58. *Am., Indem.*, 335 F.3d at 432–33.
59. *Id.* at 434.

demnity provision in the subcontract was controlling, requiring AIL to pay 100 percent of the defense costs and indemnity for Caddell.

The Fifth Circuit first reasoned that, where each of the two liability policies provides primary coverage to the same insured for the claim at issue, the court examines the "other insurance" clauses in the policies.[60] Under this analysis, the insurer paying more than its share is entitled to contribution from the other carrier based on equitable principles. However, the court found that this rule is subject to a "widely recognized exception" in cases where the policy of the insurer seeking to invoke the "other insurance" clauses also covered another insured who is liable to indemnify the insured in the policy of the other insurer. The court quoted *Couch on Insurance* for the principle that "'an indemnity agreement between the insureds or a contract with an indemnification clause, such as is commonly found in the construction industry, may shift an entire loss to a particular insurer notwithstanding the existence of an "other insurance" clause in its policy.'"[61] Finding that the clear majority of jurisdictions recognized this exception, the Fifth Circuit gave controlling effect to the indemnity obligation of one insured to the other insured over the "other insurance" clauses in the policies.[62]

The court held that, by virtue of the indemnity agreement obligating Elite to pay Caddell any amount that Caddell paid the employee plaintiff to settle his suit or discharge any judgment therein, and by virtue of AIL's policy insuring Elite against such liability to Caddell, AIL could not recover from Travelers which insured only Caddell and would be subrogated to its rights against Elite.[63] Similarly, the court found that AIL was not entitled to recover from Travelers any portion of defense costs incurred in defending Caddell.[64]

D. *Excess Insurer Bound by Renewal Rule*

In a recent decision, the U.S. Court of Appeals for the Sixth Circuit held that an excess insurer is responsible, under its own following form policy, for the failure of the primary insurer to notify the insured that the scope of coverage for "advertising injury" had been reduced on policy renewal from that originally provided.

In *Amway Distributors Benefits Ass'n v. Northfield Insurance Co.*,[65] Amway brought a breach of contract action against its excess insurer, Northfield, after Northfield refused to indemnify Amway for an underlying copyright

60. *Id.* at 435.
61. *Id.* at 436 (quoting 15 Couch on Insurance 219 (3d ed. 1999)).
62. *Id.*
63. *Id.* at 442.
64. *Id.* at 444.
65. 323 F.3d 386 (6th Cir. 2003) (applying Michigan law).

infringement lawsuit. During the time period at issue, Amway was insured under policies of primary general liability insurance issued by Federal and under excess liability policies issued by Northfield. With respect to certain policies, the Northfield policies followed form to the Federal policies. During that time period, the definition of "advertising injury" was changed in the Federal policies to provide more limited coverage. At no time did either insurer notify the policyholders of the changes in the definition of "advertising injury" or the effect that the changes had on coverage.[66] Under Michigan's "renewal rule," when a renewal policy is issued without calling the insured's attention to a reduction in coverage, the insurer is bound to the greater coverage in the earlier policy.[67]

Amway was sued for copyright violations and it tendered the action to Federal and Northfield. Amway then brought suit against the carriers alleging, inter alia, that because they were never notified of the reduction in coverage, Michigan's "renewal rule" precluded the insurers from enforcing the narrower definition of "advertising injury."[68] In addressing the question of whether an excess carrier, such as Northfield, was bound as a matter of law by the underlying primary insurer's failure to comply with the renewal rule, the Sixth Circuit held that it was, because the "'follow form' linkage between an excess insurer and the primary insurer should logically apply to procedural as well as substantive obligations to their common insured."[69] The court further reasoned that "an excess insurer who lives by the sword must die by the sword," but that "an excess insurer might have an indemnity action against the primary insurer for the latter's failure to notify the insureds of the changes in the underlying renewal policy."[70] The court stated:

> This triangular relationship between the primary insurer, the excess insurer, and the insured presents the classic problem of which one of the two relatively "innocent" parties must suffer when the "wrongdoer" causes a loss. In the present situation, we believe that Northfield, as the excess insurer, was in a much better position than the insureds to analyze unannounced changes in the underlying policy that it agreed to follow.[71]

Therefore, as between Northfield and the policyholders, the court held that Northfield "should be bound to provide the greater coverage and be the one to seek indemnity back against Federal."[72]

66. *Id.* at 389.
67. *See* Koski v. Allstate Ins. Co., 539 N.W.2d 561, 563 (Mich. Ct. App. 1995).
68. *Amway*, 323 F.3d at 389–90.
69. *Id.* at 393.
70. *Id.*
71. *Id.*
72. *Id.*

III. SURPLUS LINES INSURANCE

A. *Case Developments*

Recent case law involving surplus lines insurance fell into two categories: (1) the liability of an insurance agent/broker for procuring insurance from a surplus lines insurer who subsequently became insolvent and unable to honor its obligations to its insured; and (2) the impact of failing to comply with specific statutory requirements under state insurance codes when applied to pre-answer security mandates imposed upon surplus lines carriers.

In *American Restaurants, Inc. v. Palomar International Corp., LLC*,[73] the defendant insurance agent procured for its Louisiana insured an insurance policy from Reliance Insurance Company of Illinois, a surplus lines insurer not admitted in Louisiana. During the policy period, the insured suffered property damage from a hail storm and made a claim for repair expenses and costs. After learning of Reliance's insolvency and that Reliance's insureds were not covered under the Louisiana Insurance Guaranty Fund,[74] the insured sued its insurance agent, both individually and as a business, alleging that it was never informed that Reliance was a surplus lines insurer excepted from coverage under LIGA.

The defendant insurance agency moved for summary judgment, arguing that the insured had actual notice that Reliance was a surplus lines insurer from the endorsement on the front page of the renewal policy.[75] Secondarily, the agency contended that it owed no affirmative duty to investigate the financial soundness of a nonadmitted carrier.

Louisiana law requires the following:

> Every insurance contract procured and delivered as a surplus line coverage pursuant to this Part shall have stamped upon it and be signed by the surplus lines broker who procured it, in bold type and on the face of which shall not be less than ten-point type, the following:
>
> **NOTICE**
>
> This insurance policy is delivered as a surplus line coverage under the Insurance Code of the State of Louisiana. . . .[76]

In this case, the statutorily mandated notice did not conform to these requirements, in that it was stamped upside down, and, according to the district court, "basically illegible."[77] Because this "technically deficient" no-

73. No. Civ.A. 02–2142, 2003 WL 1342978 (E.D. La., Mar. 18, 2003).

74. Hereinafter LIGA.

75. Curiously, no mention was made of the fact that this was a renewal policy, insofar as the insured's justifiable reliance was concerned.

76. La. Rev. Stat. Ann. § 22: 1258 (West Supp. 2003) *quoted in Am. Rests.*, 2003 WL 1342978, at *2.

77. *Am. Rests.*, 2003 WL 1342978, at *2.

tice did not comply with the statute, "requirements that easily could have been met," the court denied summary judgment on this ground.[78]

The defendant also argued that it owed no duty to the insured to investigate the financial soundness of the insurer. The court acknowledged that there existed an issue of material fact as to whether the agency knowingly utilized a financially unsound insurer in violation of Louisiana law.[79] However, it rejected the argument that, under the facts of this case, the agency had a duty to ensure that Reliance had capital and surplus of at least $15 million.[80] Reliance was on the Commissioner of Insurance for the State of Louisiana's list of approved unauthorized insurers, compiled and maintained pursuant to the statute. The court explained: "If the list of insurers who satisfy [the statute] is compiled and maintained by the commissioner of insurance, then clearly the commissioner's office, rather than the individual broker, is charged with making sure that the foreign insurer is in compliance with [the statute]."[81] It was undisputed that Reliance was on the list of approved unauthorized insurers at the time the policy was issued. "Therefore, in the absence of actual knowledge of Reliance's problems, Defendants had no further duty to affirmatively investigate Reliance's financial soundness."[82]

The *American Restaurants* decision contrasts with a Pennsylvania decision rendered three days later. In *Al's Café, Inc. v. Sanders Insurance Agency*,[83] the defendant insurance agency placed liquor liability insurance for Al's Café with Pine Top Insurance Company,[84] an Illinois carrier not licensed to do business in Pennsylvania. When Al's Café received notice of a dramshop suit, it notified its insurance agency, who in turn informed Al's Café that Pine Top was in liquidation, and would not provide a defense. Because Pine Top was not an admitted insurer licensed to do business in Pennsylvania, its liquidation did not trigger coverage under the Pennsylvania Property and Casualty Insurance Guaranty Association.[85] Subsequently, Al's Café suffered a judgment of about $430,000 in the dramshop suit.

Al's Café sued its insurance agency on the grounds that the agency was negligent in procuring a liquor license carrier who was unlicensed and

78. *Id.*

79. "'A surplus line broker shall not *knowingly* place surplus line insurance with insurers unsound financially.'" *Id.* at *3 (quoting La. Rev. Stat. Ann. § 22:1262(A) (West Supp. 2003)).

80. *See id.* at *3 (discussing and quoting La. Rev. Stat. Ann. §§ 22:1262(B), 22:1262.1 (West Supp. 2003)).

81. *Id.*

82. *Id.* The court also noted that *Popich Bros. Water Transp., Inc. v. Gulf Coast Marine, Inc.*, 705 So. 2d 1267, 1270 (La. Ct. App. 1998), was consistent with its decision. *Am. Rests.*, 2003 WL 1342978, at *3.

83. 820 A.2d 745 (Pa. Super. Ct. 2003).

84. Hereinafter Pine Top.

85. Hereinafter the Association.

financially unstable. Al's Café assigned its interest in this litigation to the dramshop judgment creditor, who filed a claim in the Pine Top liquidation. The Pine Top liquidator actually paid the assignee over $360,000 toward the judgment of $430,000. The trial court granted summary judgment for the defendants.

On appeal, the defendants argued that the insured suffered no damages because he had received more from Pine Top's liquidator than he would have been entitled to under the Act, had the insurance been placed with a Pennsylvania admitted insurance company that had become insolvent.[86] The appellate court disagreed, holding that the insured's damages also included the loss of the limits of the policy for which it paid. Examining the duty that sellers of insurance have to their customers, the court held:

> [A]n insurance agent's/broker's recognized duty to act with reasonable care, skill and judgment extends to the selection of the insurer and ascertaining whether it is reputable and financially sound and informing the insured of findings if investigation reveals evidence of financial infirmity, but the agent/broker intends to place a policy with that insurer.[87]

Such is the state of the law applied to surplus lines insurers, the court ruled, citing similar conclusions in Arkansas, Tennessee, Texas, Washington, and New Jersey.[88] Noting that in its answer, the insurance agency admitted that it did not know that Pine Top was a surplus lines carrier, and that there were other unanswered questions that gave rise to a reasonable inference that the insured was not properly informed as required by the state surplus lines statute, the court reversed summary judgment.[89]

Although these cases do not completely define the duty to investigate the solvency of a surplus lines insurer, they illuminate the issues that a court will consider significant, such as the notice and information provided to the insured, and whether the surplus lines carrier is on the approved list of the state's department of insurance. The *American Restaurants* case also provides an important reminder that the technical aspects of the relevant state statute must be met. While it may seem obvious, courts take a dim view of illegible notices supposed to alert the insured to the nature of the surplus lines insurance being provided.

86. *Al's Café*, 820 A.2d at 748–49. The Act limits recovery to $300,000, where a Pennsylvania admitted insurer becomes insolvent.

87. *Id.* at 751.

88. *Id.* at 751–52 (citing Williams-Berryman, Ins. Co. v. Morphis, 461 S.W.2d 577, 580 (Ark. 1971); Carter Lincoln-Mercury v. EMAR Group, 638 A.2d 1288, 1298 (N.J. 1994); Nidiffer v. Clinchfield R.R., 600 S.W.2d 242, 246 (Tenn. Ct. App. 1980); Higginbotham & Assocs. v. Greer, 738 S.W.2d 45, 47 (Tex. Ct. App. 1987); Sternoff Metals Corp. v. Vertecs Corp., 693 P.2d 175, 180 (Wash. Ct. App. 1984)).

89. *Id.* at 752–53.

First Specialty Insurance Corp. v. Continental Casualty Co.[90] contains an interesting analysis of the interplay between various sections of the Illinois insurance code, many of which are uniform to various states' insurance laws. First Specialty, a surplus lines carrier not authorized to do business in Illinois, issued a liability policy to a not-for-profit insured. When the insured was sued in Florida and tendered the complaint to First Specialty, it sued both the insured and Continental Casualty Company[91] for a declaration of rights. First Specialty filed an answer to its insured's counterclaim for its attorney fees in the Florida action, and the court granted the insured's motion to strike for failure to post security.[92] First Specialty argued that it should be permitted to file its answer without filing security, because its policy complied with the insurance code and therefore was excepted from that statutory requirement.[93]

To comply with section 445 of the Illinois insurance code, an insurance contract must be permitted under the code, and procured after the producer was unable "after diligent effort" to procure insurance from an authorized insurer.[94] Moreover, (1) the insurer must have at least $15 million in surplus and "standards of solvency and management [ ] adequate for the protection of policyholders," or (2) the producer must provide the insured with "prior written warning" of the insurer's failure to meet these requirements.[95] Finally, section 445 requires the insurance contract to designate the Director of the Department of Insurance as the agent for service for the insurer.[96]

To prove its compliance with section 445, First Specialty submitted its declarations page, which provided: "This contract is issued pursuant to section 445 of the Illinois Insurance Code, by a company not authorized and licensed to transact business in Illinois and as such is not covered by the Illinois Insurance Guaranty Fund."[97] In addition, the declarations page was issued with the stamp of the Surplus Lines Association of Illinois[98] with the signature of the Executive Director. That stamp, First Specialty argued, standing alone, was evidence of compliance with section 445, because it constituted a "certification within section 445 that the producer had made

90. No. 01 C 9175, 2002 WL 31718634 (N.D. Ill. Nov. 27, 2002).
91. Hereinafter Continental.
92. Illinois law requires an "unauthorized foreign or alien company" that seeks to file "any pleadings in any action or proceeding, including arbitration, instituted against it" to file security in "an amount to be fixed by the court sufficient to secure the payment of any final judgment which may be rendered." 215 Ill. Comp. Stat. 5/123.1(5) (2003).
93. *See* 215 Ill. Comp. Stat. § 5/123.1(8) (2003).
94. *Id.* § 5/445(1).
95. *Id.* § 5/445(1)(a)–(c).
96. *Id.* § 5/445(10).
97. No. 01 C 9175, 2002 WL 31718634, at *2 (N.D. Ill. Nov. 27, 2002).
98. Hereinafter SLA.

a diligent effort to place the insurance with an authorized insurer and had otherwise complied with section 445."[99]

The court rejected this argument, holding that submitting insurance contracts to SLA for certification was insufficient to satisfy section 445: "Under First Specialty's interpretation, First Specialty would in effect be 'certifying' to the Court that it meets the requirements of section 445 without any objective proof that such requirements were met."[100] Absent proof by testimony or otherwise that coverage in Illinois was not available or that a diligent search had been conducted, First Specialty was deemed not to have fulfilled the requirement.[101]

The court also faulted First Specialty for ignoring the mandatory provision in section 445 that the Director of Insurance be designated as the agent for service.[102] Merely stating that the insurance policy was issued in conformance with section 445 did not satisfy the explicit requirement of the Director's designation as agent for service. The court noted that a conformity clause amends those sections that are in conflict with the Illinois statutory scheme; it does not serve to add clauses that were not found in the policy and therefore not in conflict with the statutory scheme.[103]

City of Rialto v. G & L Steel Co., Inc.,[104] raised similar issues to the *First Specialty* case, although in an unpublished decision that cannot be cited or relied upon in California. The owners of a property cited as a public nuisance successfully sued the City of Rialto for damages arising out of the performance of the abatement. Rialto sued G & L Steel, the company that it used for the abatement, for indemnification of the fees and costs incurred in the property owners' suit. G & L Steel defaulted. G & L Steel's insurer subsequently intervened in the indemnity action and successfully moved for summary judgment that it was not bound by the default judgment. On appeal, Rialto argued that the insurer was a surplus lines carrier and, as a foreign corporation not qualified to do business in California, was prohibited from intervening under the California Corporations Code.[105] The appellate court found that the provision of the Insurance Code[106] requiring alien insurers to file security before filing pleadings trumped the Corpo-

99. *First Specialty*, 2002 WL 31718634, at *2.
100. *Id.*
101. *Id.* at *3.
102. *Id.*
103. *Id.*
104. No. E029669, 2002 WL 1832819 (Cal. Ct. App. Aug. 9, 2002).
105. *See* CAL. CORP. CODE § 2105 (West 2003) (stating that foreign corporations cannot transact business in California without a certification of qualification from the secretary of state).
106. *See* CAL. INS. CODE § 1616 (West 2003) (requiring alien insurance companies to file security prior to filing any pleadings in any suits).

rations Code.[107] Here, however, the insurance policy was issued properly through a valid California licensed surplus lines broker and therefore the insurer was not required to file security.[108] Interestingly, the court accepted the certificates as "evidencing placement of insurance with nonadmitted foreign insurers if the broker has attempted to place the business with at least three admitted carriers and the carriers refused to place coverage."[109] In other words, there was no need for additional independent evidence of compliance with the surplus lines insurance requirements.

Rialto argued that the provisions of the Insurance Code were not applicable, because the insurer in this case was an intervenor affirmatively seeking relief, not a defendant in a suit against it. The court disagreed, on the ground that the suit against G & L Steel was dispositive of the insurer's coverage obligations; therefore, the insurer was derivatively the defendant.[110] The court ultimately found in favor of the insurer on all counts, affirming summary judgment and concluding that it was not liable to Rialto.[111]

While not of precedential value, *Rialto* raises some interesting points. Unlike in *First Specialty*, this court found that certification of compliance with the surplus lines requirements was sufficient, in itself, to allow application of the surplus lines exception to the pre-answer security statute. In Illinois, the surplus lines broker must work much harder to establish that same point. The *First Specialty* court did not face the argument that the pre-answer security statute did not apply because the surplus lines carrier commenced the action, but it would have been to no avail had the *Rialto* court's analysis been adopted. Finally, the *First Specialty* case suggests that any opportunity to bring a counterclaim against an unauthorized foreign or alien carrier may reap dividends once application of the pre-answer security statute is triggered.

B. *Legislation*

In Florida, H.B. 1353[112] has been reintroduced in a Special Session of the Senate, having passed the House without any action taken on it. H.B. 1353 would increase the capacity of the state's Catastrophe Fund to $11 billion from its current hypothetical limit of $4.4 billion and finance this increase through an expansion of the fund's bonding authority. To cover the cost of the bonds, however, the bill would assess surplus lines policyholders even though the fund only applies to authorized carriers' policyholders.

107. *City of Rialto*, 2002 WL 1832819, at *3.
108. *Id.* at *3–4 (discussing and citing Cal. Ins. Code §§ 1620, 1763 (West 2002)).
109. *Id.* at *3.
110. *Id.* at *4-5.
111. *Id.* at *9.
112. H.B. 3055, 105th Reg. Sess. (Fla. 2003).

The Illinois General Assembly passed S.B. 318,[113] which redefines "diligent effort from authorized insurers" by moving the surplus lines market before the residual market for commercial lines of insurance. Submissions to the residual market would not be permitted unless for personal lines where residual market coverage was available. This bill was in response to the perception by regulators that risks be declined by residual markets before being placed in surplus lines markets.

Since Louisiana has interpreted its pre-answer bond statute to include surplus lines carriers as "unauthorized insurers," legislation has been introduced to exempt eligible surplus lines carriers from that statute.[114] That bill has passed the Louisiana House Committee.

New Jersey has passed a bill that will allow surplus lines carriers freedom of form and rates, by eliminating the approval requirements.[115] It awaits the governor's signature.

Texas has introduced various legislation impacting surplus lines carriers as well as other markets that addresses homeowners insurance, mold, and other personal line issues. S.B. 14,[116] for example, requires that all rates (including surplus lines rates) be "just, fair, reasonable, adequate, not confiscatory and not excessive."

West Virginia has enacted a complete revision of the state's surplus lines law.[117] It is in some parts consistent with the NAIC Model Act, but in other areas far more severe in its regulation of surplus lines. A complete discussion of this legislation is beyond the scope of this article.

C. *Summary*

There is a common theme to the legislative developments and the case law in this area. Allegations of technical defects, such as the failure to provide pre-answer security, are frequently at issue in surplus lines insurance. From a litigation standpoint, one should not assume complete compliance with every aspect of the surplus lines statutes in each and every case. As *First Specialty* and *American Restaurants* demonstrate, technical defects in policy compliance with the surplus lines statutes can have fatal consequences. As the attention paid to pre-answer security in both case law and legislation demonstrates, the stakes are high when pre-answer security is litigated, and technical mistakes can hand one litigant an unexpected result. In other words, the devil remains in the details.

IV. REINSURANCE

American federal and state courts issued many decisions arising out of disputes between parties to reinsurance arrangements, while the U.S. Con-

113. S.B. 318, 93d Gen. Assem. (Ill. 2003).
114. H.B. 1995, 2003 Reg. Sess. (La. 2003).
115. N.J. Assem. 2964, 210th Leg. (N.J. 2002).
116. S.B. 14, 78th Leg. (Tex. 2003).
117. W.Va. Code § 33–12 (2003).

gress enacted a comprehensive terrorism reinsurance statute[118] and receivers grappled with the fallout of troubled reinsurance relationships. Reported decisions covered the gamut of issues, from coverage through the resolution of disputes in arbitral and litigation forums to the relative priority of claimants in insurer insolvencies.

A. *Coverage*

The issue of reinsurance coverage percolated through the courts and legislatures. Courts continued to determine whether an agreement existed, addressed the fundamental principle of *uberrimae fidae* and the related "following liability" doctrines (i.e., following form, follow the settlements, and follow the fortunes), and resolved disputes involving issues of privity and cut-through, allocation of loss-related indemnity and expense among reinsurance agreements, and the prerequisites for rescission of parties' reinsurance agreements.

1. Existence of an Agreement

Whether a contract constitutes insurance or reinsurance has important implications for dispute resolution, including whether state or federal law governs the transaction and resulting dispute, and whether there is an enforceable reinsurance agreement.

a. Governing Regulation—The McCarran-Ferguson Act[119] preserves to the states the virtually exclusive right to regulate the "business of insurance." The Gramm-Leach-Bliley Act[120] confirmed Congress's intent that McCarran-Ferguson "remains the law of the United States,"[121] and that the states should continue to exercise such power, arguably beyond the business of insurance to the broader field of "insurance activities."[122] It remains to be seen whether the U.S. Supreme Court will construe the Gramm-Leach-Bliley declaration as effectively overturning its prior cases interpreting McCarran-Ferguson.[123]

Courts considering the issue have held that the business of insurance includes reinsurance.[124] The fact that an agreement between two parties provides for reinsurance protection does not necessarily preclude the ap-

118. Terrorism Risk Insurance Act of 2002, Pub. L. No. 107–297, codified at various sections of U.S.C. Titles 12, 15, and 28; see Andrew T. Houghton & Marni J. Kalison, *Terrorism Risk Insurance Act of 2002*, Committee News, Excess Surplus Lines & Reinsurance Comm. (ABA/TIPS Winter 2003).

119. 15 U.S.C. §§ 1011–1015 (2000).

120. 15 U.S.C. § 6701 (2000).

121. 15 U.S.C. § 6701(a) (2000).

122. 15 U.S.C. § 6701(d)(3) (2000) ("insurance *activities* other than sales" (emphasis added)).

123. *E.g.*,Union Labor Life Ins. Co. v. Pireno, 458 U.S. 119 (1982); Group Life & Health Ins. Co. v. Royal Drug Co., 440 U.S. 205 (1979).

124. *See, e.g.*, Stephens v. Am. Int'l Ins. Co., 66 F.3d 41 (2d Cir. 1995).

plication of federal law. Thus, a U.S. Department of Labor advisory opinion[125] confirms that a reinsurer may be subject to the fiduciary duties imposed under the Employee Retirement Income Security Act of 1974.[126] The opinion addressed a prepackaged health benefits program that included a plan, a preferred provider organization, an administrative services agreement, and an agreement whereby a "reinsurance company" agreed to accept 100 percent of the subscribing employer's liability under the plan. When a state insurance regulator issued cease and desist orders against the administrator and reinsurer for receiving insurance funds in the course of unauthorized business in the state, the administrator asked the Department of Labor whether compliance with those orders would violate the administrator's fiduciary duty to act in accordance with the plan; in other words, the administrator and reinsurer sought to shield themselves from the reach of state insurance law. The Department of Labor found that the administrator and reinsurer's plans were not employee benefit plans, but determined that they might be fiduciaries of such plans and therefore subject to ERISA standards *as well as* state insurance regulation.[127]

b. What Constitutes a Reinsurance Agreement?—Courts look beyond the nomenclature that contracting parties employ in memorializing their agreements to determine the substance of the transaction. Thus, in *Guibord v. Berry Tire Co.*,[128] an Illinois federal district court held that there was a question of fact as to whether an "Excess Loss Policy" covering an employee medical plan was a reinsurance agreement, where it was described in the document as "treaty excess of loss reinsurance."

Most courts hold that a reinsurance contract is a contract of indemnity and that there is no privity between a policyholder and its insurer's reinsurer, thereby defeating most attempts by insureds to recover from reinsurers. *Guibord* arose out of an action by an employee beneficiary of the medical plan seeking to recover from both the administrator and the putative reinsurer, arguing that the reinsurer was really a primary insurer and that the "excess of loss agreement" was really just an insurance cover over and above the employer's self-insured deductible.[129]

The absence of a fully executed written agreement, standing alone, will not defeat a claim for reinsurance protection. For years, courts were told of legendary reinsurance agreements made upon handshakes or reduced to notes written on the back of a cocktail napkin. In the 1990s, regulators imposed the accounting requirement that parties to a prospective reinsur-

125. Advisory Op. 2003–03A, *cited in* 13 MEALEY'S LIT. REP.: REINS. No. 22, at 19 (Feb. 13, 2003).
126. 29 U.S.C. §§ 1001–1461 (2003) [hereinafter ERISA].
127. Advisory Op. 2003–03A.
128. No. 02 C 1653, 2002 WL 31687669 (N.D. Ill. Dec. 2, 2002).
129. *Id.* at *1.

ance contract (i.e., one covering losses occurring after its effective date) must reduce their agreement to writing within nine months after the effective date,[130] and that reinsurance recoverable balances more than ninety days overdue be reported as such and discounted.[131] Despite this requirement, parties continue to enter into or renew reinsurance agreements that are not signed, and courts continue to enforce those agreements.

The most recent example of this may be found in a New York state trial court decision in *Transatlantic Reinsurance Co. v. AXA Corp. Solutions Reinsurance Co.*[132] In this case, the court held that a reinsurer was bound to the renewal of a reinsurance agreement after the reinsurer accepted premiums for the renewal and retained them until after a loss occurred during the renewal period. The fact that the parties had not expressly agreed on a definition of "loss occurrence" in a renewal proposal that differed from the expired agreement did not prevent the parties from reaching an agreement.

On a related issue, a Texas state appellate court denied summary judgment to the original insurer of a portfolio of disability insurance policies who sought to be dismissed from an action brought against it and its successor by the policyholders to enforce a significant insurance policy premium refund provision, because the prerequisites for a valid novation and assumption agreement had not been established.[133] This case teaches that assumption reinsurance agreements do not relieve the reinsured of liability (if at all) without notice to, approval of, and language effecting a release of the original insurer by the policyholders. Novation is not to be presumed, said the court. There must be a "clear, definite intention on the part of all concerned that such is the purpose of the agreement."[134]

In a similar case, an Oklahoma federal court dismissed a claim by a prior insurer of a self-insured group against the group's reinsurer.[135]

2. Utmost Good Faith

Courts handed down a number of decisions founded upon the hallmark reinsurance principle of *uberrimae fidae*, or utmost good faith. For example, a New York federal trial court granted rescission to a reinsurer due to the cedent's failure to disclose its insolvency, a fact that the court determined

130. *See, e. g.*, Nat'l Ass'n of Ins. Comm'rs, *Accounting Practices and Procedures Manual*, Statement of Statutory Accounting Principles No. 62 ¶ 23, at 62–7 (2003).

131. *See id.* ¶ 52, at 62–13 (2003).

132. No. 12502/2002 (N.Y. Sup. Ct. Feb. 26, 2003).

133. Vandeventer v. All Am. Life & Cas. Co., 101 S.W.3d 703 (Tex. Ct. App. 2003).

134. *Id.* at 713 (quoting J. B. Speed & Co. v. Traylor, 173 N.E. 461, 464 (Ind. App. 1930)).

135. Nat'l Am. Ins. Co. v. Am. Re-Ins. Co., No. CIV-02–0232-HE, 13 Mealey's lit. Rep.: Reins. No. 21, at 3, § 3 (W.D. Okla. Feb. 24, 2003).

was material to the reinsurer's underwriting decision.[136] To restore the status quo ante, the court ordered the reinsurer to disgorge the premiums that it had received, with interest.[137] In another case, a New York state appellate court reversed summary judgment and remanded a case for consideration of whether a fronting insurer's identity was material to the parties' reinsurance agreement, even though the agreement contained a cut-through clause.[138]

Courts also interpreted and applied the principle of utmost good faith with the related following liability doctrines and in the allocation of loss and expense to various reinsurance agreements, as described in the next two sections.

3. Following Liability: Form, Settlements, and Fortunes

Many reinsurance agreements contain clauses obligating the reinsurer to "follow" or be bound by either the "forms," that is, the terms and conditions, of the underlying insurance policy, any settlements that the cedent enters in respect of the policies reinsured, or the cedent's liability in proportion to the reinsurer's assumed obligations (the "fortunes").[139] Courts addressing the following liability doctrine over the last year examined two important questions in this area, i.e., whether a follow the fortunes clause is implied in an otherwise silent contract and whether the doctrine applies to a cedent's allocation decisions.

In the latest court decision emanating from North River Insurance Company's coverage of asbestos manufacturer Dow Corning FiberGlas, *North River Insurance Co. v. Employers Reinsurance Corp.*,[140] the court refused to imply a follow the fortunes clause into the reinsurance contract, finding that the reinsured, North River, failed to meet its burden of proving that the doctrine applied absent an express provision.[141] The court gave significant weight to the testimony of the underwriters of the reinsurer, Employers Re, that North River's alleged losses were not within the scope of the reinsurance policies.[142] The court reasoned that since many of the contracts issued by North River during the relevant time period contained

136. Nichols v. Am. Risk Mgmt., Inc., No. 89 Civ. 2999 (JSM), 2002 WL 31556384 (S.D.N.Y. Nov. 18, 2002).

137. *Id.* at *5.

138. Trans-Resources, Inc. v. Nausch Hogan & Murray, 746 N.Y.S.2d 701 (App. Div. 2002).

139. *See generally* Eric S. Mattson & Sean M. Carney, *The Follow the Fortunes Doctrine in 2002: Evidence, Experts and Allocation*, 13 Mealey's Lit. Rep.: Reins. No. 21, at 24 (Mar. 6, 2003).

140. No. C-2–00–1221, 2002 U.S. Dist. LEXIS 11711 (S.D. Ohio June 3, 2002).

141. *Id.* at *23.

142. *Id.* at *12.

express follow the fortunes clauses, the court would not imply such clauses in *other* reinsurance contracts that the two parties signed that were silent on this issue.[143]

In *ReliaStar Life Insurance Co. v. IOA Re, Inc.*,[144] on the other hand, the Eighth Circuit did imply a follow the fortunes clause into a second retrocession contract between the parties, refusing to require strict proof of the underlying reinsurance contract.[145] ReliaStar reinsured Canada Life Insurance Co.'s travel medical insurance coverage.[146] The reinsurance contract required strict proof of coverage for ceded claims and contained no following liability provision.[147] ReliaStar purchased retrocessional coverage pursuant to a contract with IOA that, like the first contract, contained no following liability clause.[148] When IOA refused to cover ReliaStar's losses, ReliaStar sued, successfully arguing to the district court that a follow the fortunes clause should be implied in the retrocession contract because that contract incorporated the terms and conditions of the underlying contract, which required strict proof of coverage.[149] Unlike the *North River* court, the court of appeals concluded that follow the fortunes clauses were usually implied in reinsurance contracts, and since the retrocession contract did not contain "anti-follow-the-fortunes provisions," the "customary follow-the-fortunes doctrine" applied in this case.[150]

Regardless of whether they may be implied, following liability provisions may not be used to increase a reinsurer's bargained-for limits of liability, as a Massachusetts federal district court decided in a case brought by a cedent to compel its reinsurer to accept the cedent's allocation of a settlement on an annualized limits basis.[151] The primary policies at issue in *Commercial Union Insurance Co. v. Swiss Reinsurance America Corp.* were written with three year terms. The reinsurer's facultative certificates contained following form clauses, and were written on a quota share basis with single per occurrence limits. When the cedent settled a multiyear, multisite environmental coverage dispute with its insured, the cedent allocated the settlement as though the primary policies had annualized limits. The district court upheld the reinsurer's objection that following liability provisions cannot overcome expressed liability limits.

143. *Id.* at *16.
144. 303 F.3d 874 (8th Cir. 2002).
145. *Id.* at 880–81.
146. *Id.* at 876.
147. *Id.* at 881.
148. *Id.* at 876.
149. *Id.* at 878.
150. *Id.* at 880–81.
151. Commercial Union Ins. Co. v. Swiss Reins. Am. Corp., No. Civ.A. 00–12267-DPW, 2003 WL 1786863 (D. Mass. Mar. 31, 2003).

4. Privity and Cut-Throughs

The bottom-line issue in most reinsurance disputes is who owes how much money to whom. As noted above, with very few exceptions (e.g., a reinsurance agreement that contains a "cut-through" clause), the general rule is that there is no privity between an insured and its insurer's reinsurer. Whether the rule is subject to any exceptions becomes the issue when there is a captive insurer or fronting arrangement and one of the parties becomes involved in the reinsurance relationship becomes insolvent.

The general rule was upheld in a recent bankruptcy case, *In re Bennett Funding Group, Inc.*[152] There, the reinsurer agreed to indemnify a bankrupt insured's captive insurer. When investors of the bankrupt claimed a right to certain reinsurance proceeds, the bankruptcy trustee initiated an action to determine their rights. The Second Circuit affirmed the district court's grant of summary judgment in favor of the reinsurer, holding that the investors had no standing under the reinsurance agreement, and that they were not even third-party beneficiaries of the agreement.[153] The court noted that there was no precedent suggesting a different result when a fronting arrangement is involved.[154]

The Pennsylvania Commonwealth Court reached the exact opposite conclusion.[155] In *Koken v. Legion Insurance Co.*, a decision under review by the Pennsylvania Supreme Court at the time this survey article was written, the court supervising the receivership of affiliates Legion Insurance Company and Villanova Insurance Company held that even in the absence of a cut-through clause, a policyholder may claim directly from its insurer's reinsurer where the insolvent insurer merely fronted for the reinsurer and the policyholder and the reinsurer had an established business relationship and course of dealing.[156]

Somewhat related to the law of privity is the remedy of piercing the corporate veil. In *Serio v. Ardra Insurance Co.*,[157] a New York state appellate court affirmed a trial court's holding that the owners of an insolvent Bermuda reinsurer were personally liable for the reinsurer's unfulfilled obligations to its cedents. The appellate court pierced the Bermuda reinsurer's corporate veil because it found that the owners deprived the reinsurer of the funds needed to meet its reinsurance obligations, pursuant to an integrated transaction by which premiums were immediately transferred to other entities owned by the same individuals.

152. No. 02–5021, 60 Fed. Appx. 863 (2d Cir. 2003) (not selected for publication).
153. *Id.* at 865.
154. *Id.* at 865–66.
155. Koken v. Legion Ins. Co., 831 A.2d 1196 (Pa. Commw. Ct. 2003)
156. *Id.* at 1236–38.
157. 761 N.Y.S.2d 1 (App. Div. 2003).

5. Allocation

Allocation continued to receive judicial attention as cedents and reinsurers struggled to resolve disputes over how and when a cedent may bind one or more reinsurers to the cedent's settlement of coverage disputes with a policyholder involving multiple claims of loss crossing multiple years and layers of primary and excess insurance coverage.

A federal district court in *Employers Reinsurance Corp. v. NewCap Insurance Co., Ltd.*[158] accepted the challenge of reinsurer Employers Reinsurance Corporation[159] to the allocation by its cedent NewCap of a settlement of disputed coverage for alleged medical-related liability, and held that the follow the fortunes doctrine did not apply where the parties never agreed on such allocation.[160] The decision turned on the nature of underlying coverage. The insured hospital settled a medical malpractice lawsuit for $7.6 million with the wife of a patient who suffered brain damage when he collapsed in the hospital's parking lot shortly after being released.[161] ERC sued for a declaration that characterized the patient's claim as an unreinsured Hospital Professional Liability claim, which would have absolved ERC from reimbursing NewCap for the loss.[162] In contrast, if the loss fell within CGL coverage, ERC owed the remainder of the settlement due pursuant to ERC's reinsurance of an umbrella policy. NewCap argued that the follow the fortunes doctrine precluded ERC from challenging NewCap's characterization of the claim as implicating CGL coverage. The court reasoned that because the parties never made a settlement allocation with this claim, the follow the fortunes doctrine did not apply.[163]

In a decision going the other way, *Employers Insurance Co. of Wausau v. American Re-Insurance Co.*,[164] a Wisconsin federal court held that a facultative reinsurer must cover legal fees the reinsured incurred in defending a declaratory judgment action brought by an insured. The insured also claimed bad faith by the cedent and sought an award of punitive damages. The parties' facultative certificate excluded punitive damages as unreinsured "extra-contractual damages." When the cedent settled the action, the reinsurer paid its share of the settlement amount, but denied the claim for attorney fees. The court rejected this distinction, reasoning that an interpretation of the language of the facultative certificate should be adopted that fostered "economically rational behavior" by imposing responsibility for the costs in the same proportion as the reinsured liability.[165]

158. 209 F. Supp. 2d 1184 (D. Kan. 2002).
159. Hereinafter ERC.
160. *NewCap*, 209 F. Supp. 2d at 1191.
161. *Id.* at 1187.
162. *Id.* at 1191.
163. *Id.*
164. 256 F. Supp. 2d 923 (W.D. Wis. 2003).
165. *Id.* at 926.

6. Terrorism

Issues continued to emerge in the aftermath of the September 11, 2001, terrorist attacks. Reinsurance cases decided over this last year dealt primarily with the issue of whether courts have jurisdiction to hear disputes arising out of the attacks.

In *Combined Insurance Co. of America v. Certain Underwriters at Lloyd's London*,[166] a New York federal trial court held that it could not exercise subject matter jurisdiction over a breach-of-contract dispute between an insurer and its reinsurer arising out of the September 11 attacks.[167] The action was brought pursuant to the Air Transportation Safety and System Stabilization Act,[168] which granted the U.S. District Court for the Southern District of New York "original and exclusive jurisdiction over all actions brought for any claim, including any claim for loss of property, personal injury or death, resulting from or relating to the terrorist-related aircraft crashes of September 11, 2001."[169] The court dismissed the action, reasoning that the Air Transportation Safety Act only granted jurisdiction over disputes involving "eligible individuals" (i.e., those on board the hijacked airplanes or present at the crash site) and did not encompass insurers and reinsurers within its scope.[170]

Similarly, in *Associated Aviation Underwriters v. Arab Insurance Group (B.S.C.)*,[171] the court dismissed the plaintiff insurer's suit against a reinsurer for lack of personal jurisdiction.[172] Associated Aviation Underwriters Inc.[173] insured various airlines and product manufacturers that incurred liabilities as a result of the September 11 attacks. Arig Reinsurance Company[174] reinsured AAU policies from 1996 to 2001 with a fixed percentage share of the original risks. AAU sued Arig for refusing to pay its proper share of the claims and requested a letter of credit plus damages and attorney fees for a total award of nearly $35 million.[175] The court held that: (1) a reinsurance contract alone does not provide sufficient contact with New York for a court to exercise personal jurisdiction;[176] (2) the key factor for the "transacting business" analysis under New York's long arm statute is

166. No. 01 CIV. 10023(RO), 2002 WL 31056851 (S.D.N.Y. Sept. 13, 2002).
167. *Id.* at *1.
168. Pub. L. No. 107–42, 115 Stat. 230 (2001), *as amended by* the Aviation and Transportation Securirty Act, Pub. L. No. 107–71, 115 Stat. 597 (2001), *codified at* various sections of title 49 and 5, U.S.C. [hereinafter Air Transportation Safety Act].
169. *Combined Ins.*, 2002 WL 31056851, at *1.
170. *Id.*
171. No. 02 Civ. 4983(GBD), 2003 WL 1888731 (S.D.N.Y. Apr. 16, 2003).
172. *Id.* at *23.
173. Hereinafter AAU.
174. Hereinafter Arig.
175. *Arab Ins. Group*, 2003 WL 1888731, at *1.
176. *Id.* at *4.

whether Arig did business in New York, not whether the companies that it reinsured conducted business in that state;[177] and (3) the Air Transportation Safety Act did not confer personal jurisdiction over this dispute.[178] Regarding the last prong of the court's holding, the court reasoned that "the assertion of a reinsurance claim is not the type of dispute Congress intended to benefit from the grant of jurisdiction by the Air Transportation Safety Act."[179] Since neither New York insurance law, the New York long-arm statute, nor the Air Transportation Safety Act granted the court personal jurisdiction over Arig in this matter, the court dismissed AAU's claim.[180]

B. *Arbitration*

The U.S. Supreme Court consistently has held that the Federal Arbitration Act[181] expresses congressional policy favoring the resolution of disputes by private arbitration over public forum litigation. In the last year, the Court's decisions explored this policy's contours by addressing numerous issues arising out of reinsurance arbitrations, from the foundation issue of whether there is an agreement to arbitrate, through arbitrability of particular disputes, to judicial stays of litigation, the composition of arbitration panels, the extent of a panel's jurisdiction, and, ultimately, confirmation or vacation of an arbitral award.

1. Existence of an Agreement to Arbitrate

In a case stemming from the September 11, 2001, terrorist attacks, the court in *Canada Life Insurance Co. v. Guardian Life Insurance Co. of America*[182] determined that a 2001 retrocessional agreement and the arbitration clause that it contained were valid and enforceable.[183] Guardian provided Canada Life with retrocessional coverage "per occurrence" in 2000 and 2001.[184] Guardian alleged that the 2001 agreement never existed because the parties had not agreed on the definition of "per occurrence."[185] Canada Life asserted that the September 11 attacks subjected Guardian to nearly $59 million in liability.[186] The court reasoned that

177. *Id.* at *6.
178. *Id.*
179. *Id.* at *7.
180. *Id.*
181. 9 U.S.C. §§ 1–307 (2000) [hereinafter FAA].
182. 242 F. Supp. 2d 344 (S.D.N.Y. 2003).
183. *Id.* at 362.
184. *Id.* at 346–47.
185. *Id.* at 354. Guardian argued that it accepted a percentage of Canada Life's original reinsurance obligation but only a percentage share once per occurrence—the September 11 attacks in this case—and not multiple payments of its percentage share per occurrence, which Canada Life's original catastrophe reinsurance agreement called for. *Id.* at 348.
186. *Id.* at 347.

> [a] contract was undeniably formed for 2001 at least on the basis of Guardian's interpretation of "per occurrence,' which would constitute insurance coverage up to $5.4 million. Since it is conceded that this much insurance . . . has been agreed to by the parties, a contract has been formed and the arbitration clause is applicable.[187]

The court noted that "[t]he difference in 2001 is that the traumatic events of September 11 created such unforeseen exposure that the limits of the insurance contracts, where catastrophic cover was insufficient, were put to the forefront."[188] In effect, by disputing one of the contract's provisions, Guardian conceded that the contract itself was valid.

In another case, *Underwriters Reinsurance Co. v. ACE American Insurance Co.*,[189] both of the original parties to sixteen different facultative certificates had been replaced by successors. A novation agreement between the original cedent's successors and the original reinsurer's successor substituted the successor reinsurer for the original, and had attached to it a 402-page exhibit of specified reinsurance agreements that were intended to be covered by the novation agreement; the sixteen certificates were not specifically listed. The novation agreement contained an arbitration provision: "Any dispute arising out of or related to the interpretation, performance or breach of this Agreement, or of any of the obligations assumed under this Agreement, shall be submitted to arbitration . . . ."[190] The court held that in light of the federal policy favoring arbitration, and the broad reading given similar arbitration provisions, the plain language of the arbitration agreement encompassed the facultative certificates.

On related points, the U.S. Court of Appeals for the Second Circuit held that the arbitration clause in a reinsurance and assumption agreement survived releases of liability alleged to exist under the agreement, absent an express rescission of the arbitration provision,[191] while an Illinois federal court held that the words "arbitration clause" in a cover note alone were sufficient to establish an agreement to arbitrate, and that custom and practice in the reinsurance industry would supply the missing terms.[192] The Illinois court also noted that when allegations against a parent and subsidiary are based on the same facts and inherently inseparable, the court may refer claims against the parent to arbitration, even though the parent is not formally a party to the arbitration agreement.[193]

187. *Id.* at 359.
188. *Id.* at 360.
189. No. CV-02–08177 CAS (JTLx), *reprinted in* 13 Mealey's Lit. Rep.: Reins. No. 21, at 9 (C.D. Cal. Feb. 10, 2003).
190. *Id.*
191. Con't Ins. Co v. Allianz Ins. Co., 52 Fed. Appx. 557 (2d Cir. 2002) (not selected for publication).
192. Zurich Am. Ins. Co. v. Cebcor Serv. Corp., No. 02 C 2283, 2003 WL 21418237 (N.D. Ill. June 18, 2003).
193. *Id.* at *5.

2. Arbitrability of a Dispute

Whether a dispute is subject to arbitration depends, in part, upon the language of the parties' arbitration agreement.[194] Courts distinguish between "narrow" and "broad" arbitration clauses. For example, in one case,[195] the parties' facultative certificates provided: "Should an irreconcilable difference of opinion arise as to the interpretation of this contract, it is hereby mutually agreed that, as a condition precedent to any right of action hereunder, such difference shall be submitted to arbitration." The court found that this clause was narrow and was not triggered where the reinsurer sought restitution of certain claims payments due to the cedent's misapplication (i.e., billing calculations according to the terms) of its environmental pollution allocation methodology.[196] The court reasoned that under a narrow arbitration clause, the court must determine whether the dispute is over an issue that on its face is within the purview of the clause, as opposed to a collateral issue somehow connected to the reinsurance agreement.[197]

Arbitrability also turns on the nature of the dispute. In *Gerling Global Reinsurance Corp.-U.S. Branch v. ACE Property & Casualty Co.*,[198] the U.S. Court of Appeals for the Second Circuit affirmed a decision rescinding a reinsurance contract due to the defendant's breach of the duty of utmost good faith.[199] Gerling Global Re sought to rescind two facultative certificates, arguing that ACE failed to disclose allegedly material information at the time Gerling Global issued the reinsurance contract. The contract's arbitration clause called for arbitration of "an irreconcilable difference of opinion . . . [as to] the interpretation of the certificates."[200] The court recognized that "'[t]he relationship between a reinsurer and a reinsured is one of utmost good faith, requiring the reinsured to disclose to the reinsurer all facts that materially affect the risk of which it is aware and of which the reinsurer itself has no reason to be aware.'"[201] ACE argued that the dispute with Gerling revolved around an interpretation of the contract and whether it excused the failure to disclose material facts. The Second Circuit rejected this argument, however, and held that nondisclosure of material facts, innocent or not, "renders a reinsurance agreement voidable or rescinda-

194. *See generally* Kenneth R. Pierce, *The Liar's Paradox: Arbitrability Conundrums Under the Federal Arbitration Act*, 13 Mealey's Lit. Rep.: Reins. No. 22 at 22 (Mar. 20, 2003).

195. Gerling Global Reins. Corp. v. The Home Ins. Co., 752 N.Y.S.2d 611 (App. Div. 2002).

196. *Id.* at 618.

197. *Id.*

198. 42 Fed. Appx. 522 (2d Cir. 2002) (not selected for publication).

199. *Id.* at 524.

200. *Id.* at 522–23. The dispute involved losses incurred from asbestos claims. *Id.* at 523.

201. *Id.* at 524 (quoting Christiana Gen. Ins. Corp. of N.Y. v. Great Am. Ins. Co., 979 F.2d 268, 278 (2d Cir. 2002)).

ble."[202] The court reasoned that since Gerling's claims of breach of the duty of utmost good faith implicated the *formation* of the contract, not an *interpretation* of it, the district court properly denied ACE's motion to compel arbitration.[203]

Under a different set of facts, however, the Second Circuit held that the arbitration clause in a reinsurance agreement was broad enough to encompass claims of fraudulent inducement and contract termination.[204] In *ACE Capital Re Overseas Ltd. v. Central United Life Insurance Co.*, the plaintiff filed an action seeking a declaration that the contract was voidable, rather than void, a distinction that the Second Circuit effectively deemed outcome determinative. The arbitration clause contained the following preamble, which the court characterized as a "broad one": "As a condition precedent to any right of action hereunder. . . ."[205] Consequently, arbitration was mandated.

3. Waiver

Claimant cedents in arbitration disputes occasionally argue that a reinsurer has waived its arbitration rights, so that either the court or a jury should determine issues of liability and damages. In *Howsam v. Dean Witter Reynolds, Inc.*,[206] the U.S. Supreme Court noted a presumption that it is for arbitrators to decide allegations of waiver, delay, or other defenses to avoid arbitration.[207] Application of *Howsam* thus depends upon the particular facts and circumstances presented.[208]

Reviewing district court decisions in which cedents asserted waiver by their reinsurers, two federal circuit courts reached differing conclusions. In one, the U.S. Court of Appeals for the Eighth Circuit affirmed a district court order appointing a replacement arbitrator and leaving for the reconstituted panel the issue of whether the reinsurer had waived its arbitration rights.[209] The U.S. Court of Appeals for the Fifth Circuit, however, affirmed a district court finding that a reinsurer had not waived its right to arbitration through alleged delay and dilatory tactics over the course of a four-year arbitration, including a veto of the appointment of the third arbitrator on a panel.[210] Citing the "strong presumption against finding

202. *Id.*
203. *Id.*
204. ACE Capital Re Overseas Ltd. v. Cent. United Life Ins. Co., 307 F.3d 24 (2d Cir. 2002).
205. *Id.* at 27.
206. 537 U.S. 79 (2002).
207. *Id.* at 84.
208. *Id.* at 85.
209. Nat'l Am. Ins. Co. v. Transam. Occidental Life Ins. Co., 328 F.3d 462 (8th Cir. 2003).
210. Gulf Guar. Life Ins. Co. v. Connecticut Gen. Life Ins. Co., 304 F.3d 476 (5th Cir. 2002).

waiver" and the "heavy burden" on the party asserting waiver, the court found that mere delay does not satisfy these standards.

4. Stays Pending Arbitration

Presentation of an arbitrable dispute does not deprive a court of jurisdiction over the dispute, since the FAA provides that final arbitration awards may be presented to federal district courts for confirmation. Accordingly, courts stay actions pending entry of a final arbitration award.

In *Utica Mutual Insurance Co. v. Gulf Insurance Co.*,[211] a New York appellate court held that the FAA preempted New York law and granted Gulf's motion to stay the proceedings pending arbitration. The dispute centered around a 1997 contract whereby Utica agreed to reinsure Gulf for $5 million of the $6 million Gulf owed on a policy issued to Credit Bancorp. Ltd. The agreement contained a clause that required the parties to arbitrate "any dispute arising out of or related in any way" to the agreement.[212] Utica refused to indemnify Gulf for part of the $6 million that Gulf paid as a result of a Securities and Exchange Commission action against Credit Bancorp. for operating a fraudulent scheme.[213] The court held that the trial court erred in: (1) failing to apply the FAA, which required arbitration of this dispute, and (2) determining that Utica made a prima facie showing that fraud permeated the entire reinsurance agreement, including the arbitration provision.[214] The court reasoned that "[a]s with federal law, a broad arbitration clause in New York is separable from the substantive provisions of an agreement and, even if there is fraud in the inducement of the substantive provisions, all issues, including the claim of fraud, are to be determined by the arbitrators."[215] Utica challenged the making of the contract as a whole, but failed to show "that the agreement was not 'the result of arm's length negotiation' or that the arbitration clause was inserted . . . in order to effect the fraudulent scheme."[216] Consequently, the court stayed the proceedings pending arbitration.

5. Panel Composition

In view of the congressional policy favoring arbitration, courts often rebuff legal challenges or petitions that tend to slow the arbitration process. Hence, there is a judicial inclination to refuse to address challenges for bias

211. 762 N.Y.S.2d 730 (App. Div. 2003).
212. *Id.* at 731.
213. *Id.* at 732.
214. *Id.* at 733.
215. *Id.*
216. *Id.* (quoting Info. Sciences v. Mohawk Data Sci. Corp., 392 N.Y.S.2d 737, 738 (App. Div. 1977)).

or other illegality or impropriety involving individual panel members[217] before a final arbitral award is issued. Consistent with this approach, the U.S. Court of Appeals for the Fifth Circuit reversed a district court order removing one of the arbitrators before the arbitration hearing on the merits.[218] The court distinguished actions to compel selection of an arbitrator from those that challenge an arbitrator, reasoning that actions to compel selection may indeed be brought before a final arbitral award because they advance the arbitration process.[219]

In keeping with the panel selection versus panel challenge distinction, a Massachusetts federal court ordered a retrocedent to proceed with selection of an umpire in *Fidelity Secured Life Insurance Co. v. John Hancock Life Insurance Co.*[220] The retrocedent was involved in numerous reinsurance arbitrations. In this particular case, the retrocessionnaires appointed arbitrators who were participating as umpires in the other arbitrations. The retrocedent objected to the appointment of the same individuals in the instant case, and the retrocessionnaires petitioned the court to compel the retrocedent to proceed with appointment of the panel umpire. The court found the retrocedent's tactics to be "utterly frivolous," and warned that any failure by the retrocedent to strictly abide by the court's order would be deemed a waiver of arbitration.[221]

In a case turning on the FAA's requirement of bias, *Nationwide Mutual Insurance Co. v. First State Insurance Co.*,[222] the court confirmed an arbitration award denying aggregation of asbestos bodily injury claim payments, finding no bias on the part of the reinsurer's appointed arbitrator.[223] Cedent First State objected to its reinsurer Nationwide's chosen arbitrator on two grounds: (1) the arbitrator served as an underwriter for INA Re in a previous dispute with First State, and (2) Nationwide had ex parte contacts with its arbitrator before the arbitration proceedings began.[224] Observing that the FAA allows a court to vacate an award where "there was evident partiality or corruption in the arbitrators,"[225] the court held that First State had "not demonstrated that the position [the arbitrator] took in the late 1970s when she was acting as an advocate for one party's point of view was

217. This, of course, is different from challenging the involvement of a party's counsel for alleged conflict of interest. *See, e.g.*, British Int'l Ins. Co., Ltd. v. Seguros la Republica, S.A., No. 90 Civ. 2370JFKFM, 2002 WL 31307165 (S.D.N.Y. Oct. 15, 2002).

218. Gulf Guar. Life Ins. Co. v. Connecticut Gen. Life Ins. Co., 304 F.3d 476 (5th Cir. 2002).

219. *Id.* at 488.

220. No. 01–11663 WGY, 13 Mealey's Lit. Rep.: Reins. No. 12, § C-5 (D. Mass. 2002).

221. *Id.* § C-1.

222. 213 F. Supp. 2d 10 (D. Mass. 2002).

223. *Id.* at 19.

224. *Id.* at 18.

225. *Id.*

so enduring that she was unable or unwilling to reexamine the position when acting as an arbitrator."[226] The court also dismissed the ex parte communications challenge, since the parties had expressly agreed to allow such communications prearbitration.[227]

In a related point, the U.S. Supreme Court denied certiorari review of *Sphere Drake Insurance Ltd v. American General Life Insurance Co.*,[228] Seventh Circuit decision discussed at length in last year's survey article.[229] It is important to note that the Seventh Circuit opinion addressed the standards for deciding challenges made against party-appointed arbitrators, *not* umpires.

The timing of panel appointments was the issue in *Everest Reinsurance Co. v. ROM Reinsurance Management Co., Inc.*[230] There, the parties' arbitration agreement stated deadlines for the appointment of panel members. When the reinsurer missed its deadline, the cedent appointed the reinsurer's party arbitrator. The reinsurer challenged the appointment, arguing that the arbitration clause did not contain a "time is of the essence" clause. The New York state appellate court rejected the argument, relying upon the plain terms of the arbitration clause, which set forth the consequences should the reinsurer "fail to choose."[231]

Whether a new panel should be appointed when a party-appointed arbitrator dies or resigns was the subject of *National American Insurance Co. v. Transamerica Occidental Life Insurance Co.*[232] In that case, the Eighth Circuit held that if the appointing party refuses to designate a replacement, the other party may apply to a federal district court to appoint a substitute pursuant to section 5 of the FAA without first filing a motion to compel arbitration under section 4.[233] This decision stands in opposition to the "general rule" articulated by courts in other jurisdictions that, where a panel member dies after hearing evidence but before rendering an award and the arbitration agreement does not anticipate that circumstance, a new panel must be appointed.[234]

6. Consolidation

To conserve judicial resources, avoid inconsistent results, and fully and finally adjudicate disputes, courts frequently consolidate related proceed-

226. *Id.*
227. *Id.*
228. 307 F.3d 617 (7th Cir. 2002), *cert. denied* 123 S. Ct. 1754 (2003).
229. *See* Dennis G. LaGory, et al., *Recent Developments in Excess, Surplus Lines, & Reinsurance Law*, 38 Tort Trial & Ins. Prac. L.J. 335, 342–44 (2003).
230. 756 N.Y.S.2d 739 (App. Div. 2003).
231. *Id.*
232. 328 F.3d 462 (8th Cir. 2003).
233. 9 U.S.C.A. §§ 4, 5 (West 2003).
234. *See, e.g., Nat'l Am. Ins.*, 328 F.3d at 465 (quoting Marine Prods. Export Corp. v. M.T. Globe Galaxy, 977 F. 2d 66 (2d Cir. 1992)).

ings for discovery and/or trial pursuant to Rule 42 of the Federal Rules of Civil Procedure. There is no equivalent provision in the FAA, so courts addressing the issue usually rely upon the language of the parties' reinsurance arbitration agreement to determine whether individual arbitration proceedings (e.g., between a cedent and different reinsurers under the same agreement, or between the same parties under different agreements) may be consolidated.[235]

For example, in *Bank of America N.A. v. Diamond State Insurance Co.*,[236] the court consolidated separate arbitrations between, on the one hand, the cedent and its reinsurer and, on the other hand, the cedent and the reinsurer's affiliate.[237] PartnerRe-US reinsured cedent Diamond State's fronted program of weather-related insurance. The insured, Bank of America, sued Diamond State for liability under weather-derivative insurance policies. Diamond State had commenced arbitration proceedings against PartnerRe-Bermuda, an affiliate of PartnerRe-US, to indemnify it against any recovery that Bank of America may receive in court. The court consolidated the issue of PartnerRe-US's potential liability with the pending arbitration between Diamond State and PartnerRe-Bermuda, because "the arbitration clause specifically states that 'if more than one reinsurer is involved in the same dispute, all such reinsurers shall constitute and act as one party. . . .'"[238]

In *Philadelphia Reinsurance Corp. v. Employers Insurance of Wausau*,[239] the U.S. Court of Appeals for the Third Circuit extended enforcement of consolidation agreements to informal agreements reached between parties when their arbitration agreement is silent on the point. However, the court noted that the agreement to consolidate must be clear and unambiguous. The court found this to be the case where the parties had previously consolidated two arbitrations arising under ten different reinsurance agreements, and the cedent alluded in a footnote of its petition brief to an "informal" consolidation agreement.

7. Jurisdiction

The general rule is that arbitration panels have no jurisdiction to determine the rights or obligations of nonparties to an arbitration.[240] Accordingly, the U.S. Court of Appeals for the Sixth Circuit affirmed a district court order vacating an arbitration panel's award. The panel had entered an interim

235. *See, e.g.*, Connecticut Gen. Life Ins. Co. v. Sun Life Ass'n Co. of Canada, 210 F.3d 771 (7th Cir. 2000).
236. No. 01 Civ. 0645LMMGWG, 2002 WL 31720328 (S.D.N.Y. Dec. 4, 2002).
237. *Id.* at *4.
238. *Id.*
239. 61 Fed. Appx. 816 (3d Cir. 2003).
240. Nationwide Mut. Ins. Co. v. Home Ins. Co., 330 F.3d 843, 846 (6th Cir. 2003).

award that required the cedent to reimburse the subsidiary of a third-party reinsurer who had purchased the defendant reinsurer's interest in the subject reinsurance agreement pursuant to an assumption contract. The court had earlier refused to compel the third-party reinsurer to arbitrate with the cedent because of a third-party disclaimer provision in the assumption contract.[241]

8. Confirmation/Vacation of Award

The grounds for vacating an arbitral award under the FAA are fairly limited.[242] Misconduct by the panel must be established to overturn an award. In a case illustrating the difficulty of overturning even a harsh award, a New York federal trial court confirmed an award that forced a Uruguayan reinsurer to pay almost $200,000 to its American cedent.[243] Mutual Marine Offices, Inc., demanded arbitration, alleging that Banco de Seguros del Estado[244] had stopped paying under a quota share treaty.[245] The arbitration panel ordered Banco to pay $198,724 and post a $416,532 letter of credit.[246] Banco moved to vacate the award.[247] The court noted that Banco had every chance at a fair hearing and that "[t]here are no allegations of misconduct by the arbitrators and Banco does not challenge the arbitrator's actions nor the arbitration process."[248] Because the arbitrators did not engage in any misconduct, the court confirmed the award.[249]

Even when erroneous, panel awards may be upheld. Thus, despite finding that a district court's modification of an arbitral award was erroneous, the U.S. Court of Appeals for the Fourth Circuit confirmed the award, holding that the modification error was harmless.[250] The cedents had simultaneously sued and demanded arbitration against the reinsurer under various reinsurance contracts and a "reconfirmation" agreement. The arbitration panel ruled in the reinsurer's favor, finding that the cedents had made material misrepresentations to the reinsurer, but that it could not

241. *See id.* at 844.

242. *See* 9 U.S.C. § 10 (2000). There are, however, some limited circumstances beyond those enumerated in the FAA that may justify vacation of an arbitration award. For example, a court may vacate an award when a panel's decision raises due process concerns. *See, e.g.*, Coty Inc. v. Anchor Constr., Inc., No. 601499–02, 2003 N.Y. Slip Op. 50013U at 29 (N.Y. Sup. Ct. Jan. 8, 2003) (award vacated where arbitrators refused to consider defendant's evidence when the defendant did not pay panel's fees).

243. Banco de Seguros del Estado v. Mut. Marine Offices, Inc., 257 F. Supp. 2d 681, 686 (S.D.N.Y. 2003).

244. Hereinafter Banco.

245. *Banco de Seguros*, 257 F. Supp. 2d at 683–84.

246. *Id.* at 684.

247. *Id.*

248. *Id.* at 686.

249. *Id.*

250. Burlington Ins. Co. v. Trygg Hansa Ins. Co., AB, 45 Fed. Appx. 245 (4th Cir. 2002).

apply this finding to the reconfirmation agreement. In the subsequent confirmation proceeding, the district court struck the panel's finding on the reconfirmation agreement. The Fourth Circuit affirmed. Noting that under the FAA, matters may be stricken from arbitration awards only if they relate to an issue that is not submitted for arbitration and that affects the merits, the court found the stricken portion of the award inconsequential and reasoned that its decision was consistent with congressional policy to avoid challenges that merely prolong litigation.[251]

C. *Litigation*

Litigating reinsurance disputes presents a number of issues that are somewhat unique, including whether the reinsurer may be compelled to post security for its alleged obligations, exercise of the court's in personam jurisdiction over the defendant, discovery, and the relative priority of a reinsurance dispute in a cedent's receivership proceeding.

1. Pre-Answer Security

A number of state statutes require foreign or alien reinsurers to post security for their alleged obligations before they may file any pleading. Some courts hold that arbitration panels may enter interim awards in their proceedings enforcing that requirement,[252] and that such an award is reviewable under, for example, the Inter-American Convention on International Commercial Arbitration Act.[253] Other courts hold that the statutes only apply to court proceedings, and do not require the posting of security before a respondent appears in an arbitration or responds to a demand for arbitration.[254] For example, a New York state court recently held that it was for arbitrators to decide the procedural issue of whether the New York statute applies to their proceeding.[255]

2. In Personam Jurisdiction and Indispensable Parties

Reinsurance transactions frequently involve many persons, but whether one or more may be joined in a lawsuit initially depends upon whether the court may exercise jurisdiction over the person of the defendant. Courts analyze this issue under a bipartite analysis of traditional constitutional due process and state long-arm statutes employing general and specific juris-

251. *Id.* at 248.

252. *See*, *e.g.*, Banco de Seguros del Estado v. Mut. Marine Offices, Inc., 02 Civ. 467 (SAS), 13 Mealey's Lit. Rep.: Reins. No. 12, at 8 (S.D.N.Y. Oct. 4, 2002).

253. *See* 9 U.S.C. § 301 (2003), *cited and discussed in* Banco de Seguros del Estado v. Mut. Marine Offices, Inc., 230 F. Supp. 2d 362, 364 (S.D.N.Y. 2002).

254. *See*, *e.g.*, Gen. Reins. Corp. v. Underwriting Members of Lloyd's of London, No. 103047/02, 13 Mealey's Lit. Rep.: Reins. No. 13, § A-9 (N.Y. Sup. Ct. Oct. 8, 2002) (addressing breadth of N.Y. Ins. Law § 1213c(1) and CPLR 7502(a)).

255. *Id.*

diction provisions. Thus, a Texas appellate court upheld a trial court's exercise of jurisdiction over a Bermudian broker in a suit brought by a reinsurance intermediary,[256] and a South Carolina federal court held that a dispute over whether a London broker negligently obtained reinsurance for certain medical stop loss policies should be tried in South Carolina,[257] while a New York federal judge dismissed an action involving an aviation reinsurance pool.[258]

There is no requirement that a reinsurance dispute involve all of the persons involved in the underlying transaction. A defendant who believes that a third party is liable for alleged wrongs may seek to join such persons, but, again, courts may not adjudicate disputes involving persons over whom they do not have personal jurisdiction. Accordingly, a New York state appellate court affirmed the dismissal of a London company involved in financial transactions providing funding for certain films that the defendant reinsurers insured, finding no contacts between the London company and the State of New York.[259] Similarly, the same court dismissed a state court action against an Australian reinsurer, where the agreement was negotiated in London through the cedent's and reinsurer's London affiliates, and the parties' choice-of forum-clause required the cedent to commence the action in federal court.[260]

For the same reasons that courts consolidate actions started independently (to conserve judicial resources, avoid inconsistent results, and fully and finally adjudicate claims), they also dismiss actions when a party to a reinsurance agreement is deemed indispensable and cannot properly be joined in a pending action to adjudicate a dispute over that agreement. This was the case in *United States Fidelity & Guaranty Co. v. American Re-Insurance Co.*[261] The cedent reinsured 50 percent of its liabilities with a domestic reinsurance company and the remainder with a pool of reinsurers, one member of which shared a domicile with the cedent. The interests and liabilities agreement to the contract provided that the reinsurers' liabilities would be separate and distinct. After the reinsured entered a global asbestos settlement, the domestic reinsurer refused to pay and the cedent filed a federal diversity jurisdiction action against the domestic reinsurer in Cali-

256. Allianz Risk Transfer (Bermuda) Ltd. v. S.J. Camp & Co., 117 S.W.3d 92 (Tex. App. 2003).

257. Mega Life & Health Ins. Co. v. Robert Fleming Ins. Brokerage Ltd., No. C/A No.: 3:02–0325–17, 2003 U.S. Dist. LEXIS 10609 (D.S.C. Apr. 23, 2003).

258. Associated Aviation Underwriters v. DAP Holding, N.V., No 02 Civ. 7446(HB), 2003 WL 21277148 (S.D.N.Y. May 30, 2003).

259. Chase Manhattan Bank v. AXA Reins. UK PLC, 779 N.E.2d 186 (N.Y. App. Div. 2002).

260. Chase Manhattan Bank v. AXA Reins. UK PLC, 752 N.Y.S.2d 17 (App. Div. 2002).

261. No. SACV 02–1077 DOC (Anx), 13 Mealey's Lit. Rep.: Reins. No. 22, § D-3 (C.D. Cal. Mar. 12, 2003).

fornia but not against the pool because one member's domicile destroyed diversity. The domestic reinsurer then sued the pool in New York state to determine the members' respective rights and obligations. The California federal court dismissed the action pending before it on the ground that the pool member having the same domicile as the cedent was an indispensable party.

Similarly, in *Universal Reinsurance Co., Ltd. v. St. Paul Fire & Marine Insurance Co.*,[262] the U.S. Court of Appeals for the Second Circuit held that a district court did not abuse its discretion in dismissing an action involving an indispensable party plaintiff whose presence in the case defeated diversity jurisdiction.[263] The case involved claims that a captive insurer, Universal, brought against its investor, St. Paul. The court also sustained the district court's entry of judgment against the remaining plaintiffs under the defendant's counterclaims, finding that the counterclaims had been properly severed, even though the dismissed plaintiff was jointly and severally liable for the counterclaim judgment with the remaining plaintiffs.[264]

3. Forum Non Conveniens and Stays

Courts also continue to face the issue of where a reinsurance dispute should be decided after it has been filed, and to stay actions before them pending resolution of related proceedings in other courts.

Whether one forum was more convenient than another was the subject of a decision by a Louisiana federal court in *Zen-Noh Grain Corp. v. M/V Theogennitor*.[265] The court held that London was an available and adequate forum to hear the reinsurance contract dispute and dismissed the case on forum non conveniens grounds.[266] In 1997, a vessel insured by Ocean Marine Insurance Company collided with a loading tower owned by Zen-Noh Grain Corporation. The agreement between reinsurers Munich Reinsurance Company and General Reinsurance Corporation and cedent Ocean Marine contained a clause providing for the reimbursement of the more than $6 million surety bond paid on behalf of Ocean Marine to prevent the vessel's arrest.

The court held that London was the proper forum to hear the dispute because a pending action in an English court arose out of the same reinsurance contract and addressed whether the reinsurers owed Ocean Marine for the value of the surety.[267] The court also reasoned that "[a]n English court will have a much easier time directing disbursement of those funds

262. 312 F.3d 82 (2d Cir. 2002).
263. *Id.* at 88 (citing FED. R. CIV. P. 19).
264. *Id.* at 89.
265. No. Civ.A. 97–543, 2002 WL 31886745 (E.D. La. Dec. 18, 2002).
266. *Id.* at *6.
267. *Id.* at *5–6.

than will this Court at the conclusion of this litigation" because the funds at issue were in an English bank, an English court could properly assert jurisdiction over all of the parties, and the reinsurance contracts were drafted and held in England.[268]

In an appeal from a case discussed in last year's article,[269] *In re Arbitration between Monegasque de Reassurances S.A.M. (MondeRe) v. Nak Naftogaz of Ukraine*,[270] the U.S. Court of Appeals for the Second Circuit affirmed the district court's application of the doctrine of forum non conveniens to dismiss a petition that sought confirmation of an arbitration award under the Convention on the Recognition of Foreign Arbitral Awards.[271] An arbitration panel in Russia awarded MondeRe over $88 million under a reinsurance contract with Sogaz Insurance Company. MondeRe sought to confirm the award in the Southern District of New York. The Second Circuit noted that an American court can enforce foreign arbitral awards according to the rules of procedure applicable where the party seeks enforcement.[272] The Second Circuit, however, affirmed the district court's application of the "public and private interest" factors. The court found that Ukraine was an adequate alternative forum because "[i]t appears that witnesses are beyond the subpoena power of the district court, that the pertinent documents are in the Ukrainian language and that enforcement or satisfaction of the arbitral award would not be easier here than in Ukraine."[273] In addition, the court held that the district court properly exercised its discretion in ruling on the forum non conveniens issue without first addressing the jurisdictional issue.[274]

On a related point, the Second Circuit upheld a district court's stay of four consolidated federal court actions by two reinsurers seeking rescission of a reinsurance agreement in favor of a later-filed state court action seeking relief from the two federal action plaintiffs and additional reinsurers.[275] The actions grew out of various reinsurers' coverage of numerous film financing loans, but not all of the reinsurers were parties to the district court suit. Applying the strict abstention standard set forth in *Colorado River Water Conservation Dist. v. United States*,[276] the Second Circuit reasoned

268. *Id.* at *6. *See also* Employers Reins. Corp. v. MSK Ins., Ltd., No. Civ.A.01–2608-CM, 2003 WL 21143105 (D. Kan. Mar. 31, 2003).
269. *See* LaGory, *supra* note 227, at 356–57.
270. 311 F.3d 488 (2d Cir. 2002).
271. June 10, 1958, 21 U.S.T. 2517, *as implemented by and reprinted in* 9 U.S.C. §§ 201–208 (2001).
272. *MondeRe*, 311 F.3d at 495.
273. *Id.* at 500–01.
274. *Id.* at 497.
275. Gen. Star Int'l Indem., Ltd. v. Chase Manhattan Bank, 57 Fed. Appx. 892 (2d Cir. 2003) (not selected for publication).
276. 424 U.S. 800 (1976).

that the stay was consistent with the objective of reducing the risk of inconsistent outcomes and piecemeal litigation.[277]

4. Discovery

Notwithstanding all of the ways in which parties assert that reinsurance is not subject to the usual rules governing contract disputes,[278] normal discovery rules govern reinsurance litigation. Accordingly, a New York federal district court compelled General Reinsurance executives to appear for deposition in a case involving reinsurance of weather-derivative contracts.[279]

Discovery is particularly important to reinsurers in allocation disputes, since reinsurers may not second guess their cedents' good faith settlements under the follow the fortunes doctrine. Whether a cedent's settlement has been made in good faith depends upon the facts and circumstances presented. Those facts and circumstances are subject to discovery. At the same time, cedents guard the confidentiality of their disputes and oppose their reinsurers' requests for documents and information produced in other actions. In this way, the independent rights to court-supervised discovery and confidentiality conflict. Thus, in *Travelers Casualty & Surety Co. v. Constitution Reinsurance Corp.*,[280] federal trial courts sitting in Pennsylvania and Michigan were confronted with requests for information from reinsurer Constitution, issued to the same cedent in both cases, Travelers, in respect of losses covered under Constitution's contracts with Travelers. Travelers invoked confidentiality orders entered in both actions to deny Constitution access to documents involved in the case to which Constitution was not a party. The Michigan court ordered Travelers to produce the Pennsylvania case documents and granted Constitution permission to request that the Pennsylvania court modify its confidentiality provision accordingly. The Pennsylvania court denied Constitution's request for the documents, but without prejudice to Constitution's right to seek modification of the Pennsylvania court's confidentiality order.

D. *Insolvency*

It cannot be gainsaid that receivership is not business as usual for any persons affected by an insurer's insolvency, including those involved in reinsurance transactions. As noted above in connection with the liquidation of the Legion group of insurance companies, receivership gives rise to a

277. *Gen. Star*, 57 Fed. Appx. at 892.

278. For example, parties point to the applicability of the duty of utmost good faith, as well as the peculiar nomenclature of reinsurance transactions and statutory accounting rules applicable to them.

279. Gen. Star Indem. Co. v. Platinum Indem. Ltd., 210 F.R.D. 80 (S.D.N.Y. 2002)

280. No. 01–71057, 14 Mealey's Lit. Rep.: Reins. No. 6, § B-6 (E.D. Mich. June 13, 2003).

different set of legal principles that govern the parties to reinsurance transactions. One of the hallmark principles included in state statutory receivership schemes is that policyholder claims are to be paid in full before those of general creditors. In *Covington v. Ohio General Insurance Co.*,[281] the Ohio Supreme Court confirmed that reinsurance claims do not rise to the level of policyholder claims.[282]

V. CONCLUSION

Courts continued to apply traditional contract interpretation rules of construction to excess, surplus lines, and reinsurance disputes over the course of the last survey year. The allocation of loss among primary and excess insurance policies and reinsurance agreements generated numerous disputes, reflecting slowed economies, while excess, surplus lines insurers, and reinsurers jockeyed for last position in the payment chain. Meanwhile, the procedural and substantive rights of parties in both public litigation and private arbitration again occupied a significant amount of judicial attention. At the same time, significant congressional action yielded changes in federal statutory provisions that likely will generate challenges to precedent previously assumed to be well-established, if not unassailable. September 11 disputes continued to percolate through the trial courts, and are starting to appear in reported decisions from reviewing courts that will continue at least into the next survey year.

281. 789 N.E.2d 213 (Ohio 2003).
282. *Id.* at 217.