

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

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I. EXCESS INSURANCE

A. Regulatory Developments

The Nonadmitted and Reinsurance Reform Act of 2009 would reduce the complexity of complying with state insurance regulations and tax regimes applicable to policies issued by nonadmitted insurers that cover risk exposures in more than one state.¹ First, the bill provides that only the insured's home state may require the payment of premium tax on nonadmitted insurance.² Second, the bill provides that, with the exception of certain primary and excess workers, compensation placement restrictions, only an insured's home state may regulate the placement of the insured's nonadmitted insurance, and only an insured's home state may require a surplus lines broker to be licensed with respect to insurance placed for the insured.³ Third, the bill prohibits a state from collecting fees for licensure of a surplus lines broker unless it has a regulatory mechanism in effect for participation in the national insurance producer database of the National Association of Insurance Commissioners (NAIC) or its equivalent.⁴ Fourth, the bill prohibits a state from establishing eligibility criteria for nonadmitted insurers domiciled in a U.S. jurisdiction except in conformance with the NAIC's Non-Admitted Insurance Model Act, unless the state has adopted nation-

1. H.R. 2571, 111th Cong. (1st Sess. 2009) (passed by the House in September 2009); S. 1363, 111th Cong. (1st Sess. 2009) (referred to the Senate Committee on Banking, Housing and Urban Affairs) (pending as of May 14, 2010).

2. *Id.* § 101(a). The bill, however, authorizes and encourages states to enter into arrangements for allocating the premium tax paid to an insured's home state such that uniform nationwide requirements, forms and procedures may be developed for the reporting, payment, collection, and allocation of premium taxes on nonadmitted insurance. *Id.* § 101(b). The bill also authorizes an insured's home state to require surplus lines brokers and insureds who have independently procured insurance to annually file a tax allocation report detailing the premiums attributable to properties, risks and exposures in each state. *Id.* § 101(c).

3. *Id.* § 102(a, b).

4. *Id.* § 103.

wide uniform requirements, forms, and procedures that include alternative nationwide uniform eligibility requirements.⁵ Finally, the bill provides that a surplus lines broker seeking to place nonadmitted insurance for an “exempt commercial purchaser” (as defined) does not need to satisfy any state requirement to make a due diligence search for available insurance from the admitted market if the broker has disclosed that insurance may be available from the admitted market that provides “greater protection with more regulatory oversight,” and the purchaser has requested in writing that the broker place the coverage with a nonadmitted insurer.⁶

Notably, the bill has a complex definition of “home state,”⁷ which it defines as the state in which the insured maintains its principal place of business.⁸ However, if 100 percent of the risk is located outside that state, home state means the state to which the greatest percentage of the insured’s taxable premium for the insurance is allocated.⁹ In addition, if the insurance covers more than one insured from an affiliated group under a single policy, the home state is based on the member of the affiliated group that has the largest percentage of the premium attributable to it.¹⁰

B. Case Law Developments

1. Exhaustion

A number of courts addressed the question of whether there is proper exhaustion of underlying insurance or self-insured retentions such that an excess liability insurance policy may be required to respond. In *Royal Indemnity Co. v. C.H. Robinson Worldwide, Inc.*,¹¹ for example, the Minnesota Court of Appeals addressed whether a second layer excess insurer could dispute exhaustion of the underlying primary and first layer excess policies where the underlying insurers had paid out amounts equal to their full respective \$10 million limits of liability. Defense costs of the underlying nationwide class action exhausted the primary policy’s \$10 million liability limit. A settlement was subsequently reached under which the first layer excess insurer agreed to pay \$8.5 million in indemnity and \$1.5 million for defense. The second layer excess insurer agreed to contribute \$6.5 million in indemnity to the settlement, but expressly reserved its rights to continue to dispute

5. *Id.* § 104(1). The bill also provides that a state may not prohibit a surplus lines broker from placing nonadmitted insurance with, or procuring nonadmitted insurance from, a non-admitted insurer domiciled outside the United States if it is listed on the NAIC International Insurers Department Quarterly Listing of Alien Insurers. *Id.* § 104(2).

6. *Id.* § 105(1).

7. *Id.* § 107(6).

8. *Id.* § 107(6)(A)(i).

9. *Id.* § 107(6)(A)(ii).

10. *Id.* § 107(6)(B).

11. 2009 Minn. App. Unpub. LEXIS 772 (Minn. Ct. App. July 21, 2009).

coverage and to seek reimbursement for uncovered claims included in the settlement on the basis that, to the extent the underlying insurers made payments that did not fit within the policy definition of a covered loss, the insured should not be able to rely on those payments to establish that the underlying policies were exhausted. The court agreed with the excess insurer, concluding that the insurer “may assert its claim that under the terms of the [second layer excess] policy, if [the underlying insurers] made payments that did not fit within the policy definition of ‘Loss,’ [the insured] cannot rely on those payments to establish that the underlying policies have been exhausted.”¹² Accordingly, the court permitted the insurer to contest the reasonableness of defense costs incurred and whether amounts paid in settlement fit within the policy definition of loss.

In *North American Capacity Insurance Co. v. Claremont Liability Insurance Co.*,¹³ the California Court of Appeal examined whether an umbrella policy was required to drop down and respond when the underlying primary policy did not afford coverage because the insured failed to comply with a “contractors warranty endorsement.” The insured, a general contractor, was named in a suit brought by a property owner alleging defects in the construction of a home. The primary policy contained a contractors warranty endorsement that provided that the insurance afforded by the policy will not apply to operations performed by independent contractors unless the insured has received a written hold harmless agreement from each of the contractors and has obtained certificates of insurance from each of the contractors indicating that they will maintain similar coverage to that afforded by the primary policy. The umbrella policy contained a similar endorsement. The trial court held that the insured failed to comply with the contractors warranty endorsement on most of the work and therefore was not entitled to insurance coverage under the primary and umbrella policies.

On appeal, the court rejected arguments that if the primary policy does not afford coverage, the umbrella policy was required to drop down. The court observed that the umbrella policy at issue contained a “Coverage A” for excess liability, which affords coverage for those sums “in excess of the amount payable under the terms of any ‘underlying insurance’ . . . provided that the ‘underlying insurance’ also applies or would apply but for the exhaustion of its applicable limits of insurance.” Additionally, the umbrella policy contained “Coverage B” for extended liability coverage, which affords coverage for those sums “that the insured becomes legally obligated to pay as damages because of ‘injury’ to which this insurance applies.” An

12. *Id.* at *9–10.

13. 99 Cal. Rptr. 3d 225 (Cal. Ct. App. 2009).

exclusion provided that “this insurance does not apply to a. ‘Injury’ that is the subject of the insurance policies shown in the Schedule of Underlying Insurance in the Declarations.” The primary policy was specifically shown in the schedule of underlying insurance on the umbrella policy.

The court held that Coverage A of the umbrella policy did not afford coverage because there was no coverage available under the primary policy by virtue of the breach of the contractors warranty endorsement.¹⁴ Moreover, the court held that Coverage B also did not afford coverage because “Coverage B clearly *excludes* from its application injury that is ‘the subject of’ the underlying primary policy” and the homeowner’s claim against the insured “was ‘the subject of’ the underlying . . . primary policy, even if only a portion of the claim was covered as a result of the insured’s failure to comply with the contractors warranty endorsement.”¹⁵ Finally, the court observed that because the insured had other primary insurance, California’s rule of horizontal exhaustion required that “all primary insurance must be exhausted before an excess insurer must ‘drop down’ to defend an insured, particularly in cases of continuing loss as occurred here.”¹⁶

In *Pacific Coast Building Products, Inc. v. AIU Insurance Co.*,¹⁷ the Ninth Circuit applied California’s horizontal exhaustion rule to a scenario involving self-insured retentions (SIRs), a series of policies immediately excess of the SIRs and excess policies. Specifically, the insured maintained a first layer of SIRs of \$300,000. Above the SIRs, the insured maintained what were alternately described as first layer excess policies (according to the insured) or primary policies (according to AIU). AIU issued excess policies above these.

The insured argued that it was entitled to select which policy period it wanted to indemnify it for a given loss and that California precedent holds that a first level insurer called upon to provide coverage cannot reduce its liability by stacking SIRs under other policies that covered the risk during the continuous injury period. Rejecting these arguments, the court held that “the application of the horizontal exhaustion rule does not require [the insured] to exhaust all SIRs applicable to *first level* policies before *any* coverage attaches under such policies. Rather, horizontal exhaustion requires the exhaustion of all *first level* insurance before coverage attaches under the excess policies.”¹⁸ By requiring the exhaustion of all first level policies, the court, in effect, required the exhaustion of all SIRs.

14. *Id.* at 242–43.

15. *Id.*

16. *Id.*

17. 300 Fed. Appx. 546 (9th Cir. 2008) (applying California law).

18. *Id.* at 549.

Likewise, in *California Insurance Co. v. Stimson Lumber Co.*,¹⁹ the Ninth Circuit addressed whether an excess policy was required to drop down in place of insolvent Home Indemnity Company primary policies and had occasion to apply a horizontal exhaustion rule under Oregon law. The insured, a manufacturer of a siding product, purchased primary policies from Home and excess policies from National Union for the 1990 to 1994 period. The excess policies provided that they were liable only for that portion of ultimate net loss excess of “the total of the applicable limits of the underlying policies listed on the schedule of underlying insurance hereof and the applicable limits of any other underlying insurance providing coverage to the insured.”

The insured argued that the phrase “applicable limits” in the excess policies means “amount capable of being applied” and that, when Home became insolvent, the limits no longer existed and the excess coverage applied. The court disagreed with this argument, holding that “the applicable limits of the underlying policy remain in force after Home Indemnity’s insolvency,” and the excess policies do “not drop down to fill the gap created by the insolvency.”²⁰ In addition, the court held that a horizontal exhaustion rule applied in light of the “other insurance” clause indicating that the excess insurance coverage “was designed to be excess over scheduled or unscheduled underlying insurance.”²¹

A number of courts have addressed the issue of whether underlying insurance is exhausted, with many concluding that the insured did not properly exhaust underlying insurance or SIRs.²²

In *Gulfport-Brittany LLC v. RSUI Indemnity Co.*,²³ the Fifth Circuit addressed the applicable limit of liability in an excess policy with respect to Hurricane Katrina-related damage to apartment buildings. An excess policy provided the final layer of excess coverage with policy limits of \$140 million per occurrence, and a scheduled sublimit for the particular apartment buildings of less than \$2.5 million. The insured argued that the excess policy was ambiguous because it was unclear whether the per occurrence limit for damage to the apartments is \$140 million or less than \$2.5 million. Rejecting this argument, the court held that “there is no conflict: the policy creates an overall \$140 million per occurrence limit with scheduled sub-

19. 325 Fed. Appx. 496 (9th Cir. 2009) (applying Oregon law).

20. *Id.* at 500.

21. *Id.*

22. See, e.g., *Trinity Homes LLC v. Ohio Cas. Ins. Co.*, Case No. 1:04-CV-1920, 2009 U.S. Dist. LEXIS 88697 (S.D. Ind. 2009) (settlements for amounts less than full limits of liability do not constitute proper exhaustion of underlying insurance); *Koch Dev. Co., Inc. v. Clarendon Am. Ins. Co.*, 313 Fed. Appx. 928 (8th Cir. 2009) (applying Missouri law) (insured failed to offer sufficient proof that the SIR obligation was met).

23. 339 Fed. Appx. 413 (5th Cir. 2009) (applying Mississippi law).

limits for individual properties, including the Apartments.”²⁴ Likewise, the court also rejected arguments that the excess policy followed form to the underlying insurance with respect to limits of liability, concluding that “it is expressly *not* subject to the ‘amount and limits of liability’ in the [underlying] policy.”²⁵

2. Excess Insurer Duties

Several decisions involved whether an excess insurer has a duty to defend or reimburse defense costs, and in each case the decision turned on the specific policy language contained in the excess policies at issue.

For example, in *AstenJohnson, Inc. v. Columbia Casualty Co.*,²⁶ the Third Circuit addressed whether certain excess liability insurance policies were fairly characterized as indemnity-only policies, which were not obligated to pay or reimburse defense costs. The court determined that the particular terms of an excess liability policy did not impose a duty on the excess insurer to pay defense costs incurred by the insured for which the insurer did not consent. The court examined whether the excess policy’s “consent to defend clause” carried with it an implied prohibition against unreasonable refusals to defend.

The excess policy issued to AstenJohnson provided that the insurer had no duty to “assume charge of the settlement or defense of any claims . . . but shall have the right and opportunity to be associated with the insured in the defense.” Further, the excess policy provided that “[l]oss expenses and legal expenses . . . which may be incurred by the insured with the consent of the Company in the adjustment or defense of claims . . . shall be borne by the Company and the Insured in proportion that each party’s share of the loss bears to the total amount of the loss.” AstenJohnson contended that: (1) A “follow form clause” of the excess policy incorporated the duty to defend clause from the underlying policy, and (2) every “consent to defend” clause is implied by law to prohibit unreasonable refusals to defend.²⁷

The Third Circuit quickly disposed of AstenJohnson’s first argument, noting that the excess policy’s follow form clause excepted from its scope “terms, conditions or exclusions relating to the obligation to investigate and defend.”²⁸ Next, the court disagreed with AstenJohnson’s claim that every “consent to defend” clause contains, by implication, a prohibition against unreasonable refusals to defend. The court observed that the excess policy at issue required only that the insurer indemnify AstenJohnson for

24. *Id.* at 415.

25. *Id.* at 416.

26. 562 F.3d 213 (3d. Cir 2009) (applying Pennsylvania law).

27. *Id.* at 229.

28. *Id.*

its “ultimate net loss,” and that the policy’s definition of that term did not include defense costs. Because the duty to defend is contractual, the court reasoned that if there is no contractual duty to defend, there can be no duty to defend implied by law. The court also distinguished consent to settlement cases, where the insurer is generally required to consent to reasonable settlements because of the potential for a conflict of interest between the insured and its insurer, which could result in the insurer wrongfully denying the insured access to coverage that it is entitled to receive.²⁹ The court determined that no similar conflict existed in the context of defending insurance claims. On that basis, the Third Circuit affirmed the district court’s determination that the excess insurer had no obligation to defend or pay defense costs.³⁰

In contrast, a broad defense clause in an excess policy triggered an obligation of the excess insurers to defend thousands of personal injury lawsuits filed in New York arising from the 9/11 terrorist attacks in *WTC Captive Insurance Co. v. Liberty Mutual Fire Insurance Co.*³¹ The issue in *WTC* concerned whether the excess liability insurers were obligated to defend the City of New York and its contractors for lawsuits filed by workers who participated in cleanup efforts at the World Trade Center alleging respiratory illnesses, various cancers, and other injuries. The insured sought coverage under its \$75 million excess layer of coverage issued by various London market syndicates and insurers (the excess insurers) after the primary insurer’s \$4 million limits were exhausted. The excess insurers denied coverage, relying on the policy’s pollution exclusion.

WTC Captive Insurance Company (WTC), a not-for-profit, captive insurance company formed by the City of New York with a grant funded by the Federal Emergency Management Agency, issued a policy to the city obligating it to defend the insured once the \$75 million policy issued by the excess insurers was exhausted. WTC filed a lawsuit in the U.S. District Court for the Southern District of New York seeking a declaration that the excess insurers were required to defend the city and its contractors in the actions filed by the injured workers under the \$75 million excess layer of coverage.

The excess insurers argued that the pollution exclusion in the policy barred coverage for the claims asserted in the underlying litigation because they all involved exposure to toxic chemicals and pollutants.³² The district court disagreed, reasoning that the underlying plaintiffs sued the city for

29. *Id.* at 230.

30. *Id.*

31. 549 F. Supp. 2d 555 (S.D.N.Y. 2008).

32. *Id.* at 563.

negligently failing to protect them from the harms present at the World Trade Center site, not because the city failed to abate pollution.³³ Further, the court noted that the excess insurers issued their policy after the 9/11 attacks in October 2001 and January 2002 so that enough was known by the underwriters at the time the policy was drafted to enable them to write specific exclusions if they so intended to exclude specific risks.³⁴ The district court reasoned therefore, that the broad defense clause in the excess insurer's policy triggered a duty to defend given the nature of the claims and the breadth of the duty to defend.³⁵

In another case filed in the Southern District of New York, the court granted prediscovery summary judgment in favor of two of three excess liability insurers, declaring they had no obligation to provide coverage to various former directors and officers of Refco, Inc. in connection with an onslaught of litigation following the company's bankruptcy.³⁶ The bankruptcy and ensuing litigation arose from an October 2005 disclosure by Refco that its financial statements could not be relied upon because of a \$450 million uncollectible receivable stemming from certain fraudulent loan transactions. The company's CEO subsequently pled guilty to a number of criminal charges, and in his plea allocution, he acknowledged his role in the receivable scheme.³⁷

The decision turned on the interaction between the policies' respective severability provisions and prior knowledge exclusions. Refco had a primary D&O policy, as well as five excess policies, including the three at issue in the coverage litigation. The excess policies issued by Allied World Assurance Co. and Arch Insurance Co. each followed form of the primary policy, which included a severability provision. The Allied and Arch policies also included their own separate prior knowledge exclusions. The excess policy issued by XL Specialty Insurance Co., however, did not follow form to the primary policy and instead included its own severability provision and prior knowledge exclusion.³⁸

The court held that, as a matter of contract interpretation, the language of the Allied and Arch policies provided that any provisions of the excess policies, including the prior knowledge exclusions, superseded any contradictory provision, including the severability provision in the primary policy.³⁹ Therefore, Allied and Arch were entitled to summary judgment. The court denied XL's motion for summary judgment, finding an ambigu-

33. *Id.*

34. *Id.* at 564.

35. *Id.* at 563-64.

36. *XL Specialty Ins. Co. v. Agoglia*, 2009 U.S. Dist. LEXIS 36601 (S.D.N.Y. 2009).

37. *Id.* at *6-7.

38. *Id.* at *10-11.

39. *Id.* at *42.

ity concerning the interaction between XL's prior knowledge and severability provisions.⁴⁰ Further, the court determined that XL's prior knowledge exclusion may not form part of its policy because it was not included in the binder that was issued at the time the contract arose.⁴¹

In *Northrop Grumman Corp. v. Factory Mutual Insurance Co.*,⁴² the Ninth Circuit considered whether a broadly worded flood exclusion in an excess policy barred coverage for water damage if broader coverage was afforded in the underlying primary policy. Northrop Grumman, a global defense contractor, sued Factory Mutual seeking coverage under an excess policy for water damage caused by a hurricane. Northrop Grumman obtained a primary "all risk" policy that included flood coverage. The company also obtained excess "all risk" coverage from Factory Mutual that excluded coverage for flood damage and did not reference windstorm damage or wind damage. During Hurricane Katrina, Northrop Grumman's ship building subsidiaries were severely damaged, and the company sought coverage from the excess insurer for water damage.

Northrop Grumman argued that there was coverage because the excess policy must be read in the context of the primary policy, which defined the word "flood" using the phrase "whether driven by wind or not." The court disagreed, holding that the excess policy's flood exclusion barred coverage and that no ambiguity exists when an excess policy has a more restrictive definition of flood than a primary policy.⁴³

In *Hilco Capital, LP v. Federal Insurance Co.*,⁴⁴ the Supreme Court of Delaware addressed whether a second layer excess insurer breached the covenant of good faith and fair dealing by failing to attend a mediation and consent to the settlement reached by the parties. The case involved claims of several financial institutions against the insured's officers and directors, alleging they had misrepresented the value and amount of the insured's inventory in connection with a loan transaction. The insureds had three layers of D&O liability coverage with three different insurers. Federal issued a \$10 million first layer excess policy in excess of the insured's \$10 million primary policy. The parties agreed to mediate their dispute prior to trial. Federal's claims examiner talked with defense counsel regarding whether she should attend the mediation, but because National Union and defense counsel valued the case at less than \$10 million, it was agreed that Federal would not attend the mediation. During the mediation, however, the parties negotiated a proposed deal for a high-low arbitration that would potentially implicate

40. *Id.* at *48.

41. *Id.* at *51.

42. 563 F.3d 777 (9th Cir. 2009).

43. *Id.* at 788.

44. 978 A.2d 174 (Del. 2009).

Federal's policy limits. The parties subsequently sought Federal's consent to the high-low agreement, but Federal's claims examiner refused to consent, believing that the claimants would ultimately agree to settle the case for an amount midway between the high and low numbers, and that this amount would probably not implicate Federal's policy limits. The claims examiner asked the parties to wait until after the court-ordered settlement conference before executing their memorandum of understanding. However, the parties subsequently went ahead with the agreement, and the arbitration resulted in the plaintiffs receiving an award of \$15.5 million. After Federal refused to pay its share of the damage award, the insureds assigned their claims under the policy to the financial institutions that subsequently filed suit against Federal.

The trial court granted summary judgment to Federal on two issues: (1) Federal had no duty to negotiate with the insureds under Missouri's implied covenant of good faith and fair dealing; and (2) the consent to settlement provision in National Union's policy applied to Federal. The remaining issues were tried before a jury, which held that: (1) the insureds breached the policy before Federal made any decision about whether to consent to the settlement; (2) Federal did not unreasonably withhold its consent to the settlement; and (3) the insureds did not permit Federal to effectively participate in the negotiation of the settlement. The Supreme Court of Delaware held the rulings and verdict below were all supported by the record and affirmed the judgment in favor of Federal.⁴⁵

3. Excess Insurer Rights

In *H & R Block, Inc. v. American International Specialty Lines Insurance Co.*,⁴⁶ the Eighth Circuit determined that the excess insurers properly denied coverage under successive claims-made excess liability policies for lawsuits involving wrongful acts of which the insured had knowledge before the inception of the policies. The court considered two issues: (1) whether the insured's knowledge of one or more policy class action claims precluded "Prior Acts" coverage for similar class action claims subsequently asserted during the policy period under successive claims-made excess liability policies; and (2) whether the excess liability insurers created an unconscionable gap in coverage by denying prior act coverage for claims for which the insured alleged it could not have obtained "Reported Acts" coverage in an earlier policy period.

H&R Block, a tax preparation service, was sued in a number of class action lawsuits alleging various statutory and common law claims arising

45. *Id.* at 178.

46. 546 F.3d 937 (8th Cir. 2008).

out of a nationwide program offering short-term loans to its clients to be repaid from their federal income tax refunds. H&R Block sought coverage for these lawsuits under successive primary claims-made liability policies fronted by H&R Block, and follow-form excess liability policies issued between 1992 and 1998. Evanston Insurance Company issued first layer excess coverage during this period. In 1996, H&R Block purchased two additional layers of excess coverage from American International Specialty Lines Insurance Company (AISLIC) and Lexington Insurance Company.

Numerous class action lawsuits involving H&R Block's loan program were filed before 1996. The coverage litigation, however, concerned eleven class action lawsuits filed from 1996 to 1998 during the AISLIC and Lexington policy periods. The policies' basic coverage was for "claims first made . . . while this Policy is in effect . . . based on a wrongful act that occurred while this Policy was in effect," provided that the insured gave notice of the claim to the insurer during the policy period. The policies included two provisions that extended the basic coverage to include: (1) "Prior Acts" claims based on wrongful acts that occurred before the policy's effective date, provided the insured had "no knowledge of the prior wrongful act on the effective date of the policy, nor any reasonable way to foresee that a claim might be brought"; and (2) "Reported Acts" claims first made after the policy period ended provided that the insured "has reasonable knowledge that a wrongful act occurred and a claim might be made" and reports "the suspected wrongful act" and "what loss or damage may result" during the policy period.

The district court determined that the AISLIC and Lexington excess policies provided no coverage for the eleven lawsuits based on wrongful acts committed before the effective policy dates. The Eighth Circuit affirmed, observing that when a product or service has been sold nationwide, even if the prior class action was limited to clients in a particular jurisdiction, the prior claims should have put H&R Block on reasonable notice that other contemporaneous clients would assert the same claims alleging that the same wrongful acts infected their individual transactions.⁴⁷

The court also rejected the insured's argument that the excess insurers created an unconscionable gap in coverage by denying Prior Acts coverage for claims for which H&R Block could not have obtained Reported Acts coverage in an earlier policy period. The court rejected this assertion because H&R Block had an excess policy at the time the original class actions were commenced and did not report the claim under that policy's Reported Acts provision. Instead, H&R Block bought two additional excess policies and subsequently asserted claims under the Prior Acts provisions of these

47. *Id.* at 942.

policies.⁴⁸ The court stated that the argument of an unconscionable gap in coverage would have been more persuasive if H&R Block had filed a Reported Acts coverage claim under the prior excess policy and a Prior Acts claim with AISLIC and Lexington and all coverage had been denied.⁴⁹ The court held that an insured cannot transfer Reported Acts coverage to subsequent policies with larger policy limits by failing to report the wrongful acts until the subsequent policies are in effect, and then claim Prior Acts coverage under those policies.⁵⁰

In *SR International Business Insurance Co. v. Allianz Insurance Co., L.L.C.*, the Second Circuit examined whether under the excess insurance policy at issue the insurer had a priority claim to any recoveries won from airlines or other third-party defendants in ongoing tort litigation over the 9/11 attacks (the WTC Tort Litigation).⁵¹ The case turned on the interplay between the policy's subrogation clause, which granted the insurer a priority on amounts recovered from third parties, and other provisions in the policy concerning the calculation of ultimate net loss and application of recoveries, which obligated the insurer to indemnify the insureds for their ultimate net loss.

The court first held that the matter was indeed ripe for determination despite the contingent nature of the underlying claims. The court noted that a declaration of the parties' rights "would 'offer relief from uncertainty' and 'serve a useful purpose in clarifying' the rights of the parties to the proceeds of the WTC Tort Litigation, avoiding additional litigation and assisting the parties in formulating settlement positions and developing settlement strategy."⁵² The court then determined that a plain reading of the policy's language did not support the insureds' interpretation, particularly as the application of the recoveries clause was dedicated to determining the calculation of ultimate net loss when payments were received after a loss settlement had occurred; it did not affect the contractual priority of subrogation.⁵³

In *Federal Insurance Co. v. National Union Fire Insurance Co. of Pittsburgh*,⁵⁴ the Eleventh Circuit addressed whether an excess insurer can recover payments to a tort claimant from a lower-level insurer on grounds that the lower-level insurer acted in bad faith by refusing to accept earlier settlement offers. The underlying case involved a motor vehicle collision causing severe personal injuries to Edwin Mejia and his daughter and resulting

48. *Id.*

49. *Id.* at 943.

50. *Id.*

51. 343 Fed. Appx. 629 (2d Cir. 2009).

52. *Id.* at 632.

53. *Id.* at 633.

54. 298 Fed. Appx. 845 (11th Cir. 2008) (applying Florida law).

in the death of Mejia's wife. The insured defendant had several layers of insurance, including a \$25 million umbrella policy issued by National Union Fire Insurance Company and a \$25 million excess policy issued by Federal Insurance Company. After National Union rejected a settlement demand within its policy limits, the case proceeded to trial, resulting in a \$21 million jury verdict. The plaintiffs, however, were awarded a new trial on non-economic damages, and Federal, fearing that a retrial would result in a verdict exceeding the policy limits of both insurers, executed a settlement with claimants to compromise its excess coverage for \$4.5 million. Under the terms of the settlement, which were not disclosed to National Union, Mejia and his daughter agreed not to enforce any judgment they obtained in the underlying action against the insureds or Federal, but reserved the right to enforce the judgment against National Union.

Instead of proceeding with the second trial, National Union settled the case for its remaining policy limits in exchange for a release of all claims. Thereafter, Federal sought to recover from National Union the \$4.5 million it paid to settle the Mejias claims, alleging that National Union acted in bad faith by failing to timely settle the underlying claims within its policy limits when offered the opportunity to do so. The court explained that Federal's bad faith claim against National Union is derivative of the insureds' bad faith claim against National Union. Therefore, the court held that Federal's bad faith claim against National Union was extinguished by their release of the insureds' liability and satisfaction of the judgment in the underlying tort litigation.⁵⁵

4. Priority of Coverage

Several courts surveyed examined the issue of priority of coverage as between a true primary policy that contains an excess other insurance clause (whether denominated as a true primary policy, coincidental excess policy, or primary excess policy) and a true excess policy that provides it is excess of any insurance. Each decision adopted or recognized the majority rule that true primary policies must be exhausted before true excess policies may be called upon to respond.

In *Guidant Mutual Insurance Co. v. Indemnity Insurance Co. of North America*,⁵⁶ the Supreme Court of Mississippi addressed whether an umbrella liability policy was required to respond before a primary policy affording coverage for the loss. The case arose out of an automobile accident in which a volunteer fireman collided with another car while driving his personal car en route to a fire scene. The fireman was personally insured

55. *Id.* at 850.

56. 13 So.3d 1270 (Miss. 2009).

under a primary auto policy and an umbrella policy issued by Guidant Mutual. Another primary auto policy issued to the county, which included the local fire department as an insured, was issued by IINA. The IINA policy contained an “other insurance” clause purporting to render it excess over any other collectible insurance.

Guidant urged that its umbrella policy should apply in excess of all of the applicable primary policies, including the primary policy issued by IINA. The court agreed, concluding that, although this was an issue of first impression for the court, true primary policies must be exhausted before true excess policies. Specifically, the court explained that “by design, an umbrella policy is for the purpose of true excess coverage above and beyond any other applicable primary excess policy, even where the umbrella policy is held by the owner of the vehicle.”⁵⁷ Further, the court held that “[o]ther-insurance’ clauses from primary automobile policies should not be compared with ‘other-insurance’ clauses in true excess policies, for example, umbrella policies. Since they do not warrant comparison, they cannot be found to have identical, mutually repugnant clauses.”⁵⁸

Similarly, in *Rose v. American Alternative Insurance Corp.*,⁵⁹ the federal court in Vermont examined issues of priority of coverage in a similar factual scenario. An ambulance was transporting a patient to a hospital when it was involved in a head-on collision with another car. The ambulance service was insured under a primary auto policy and a commercial umbrella policy, both issued by AAIC. The patient being transported was an insured under a personal primary auto policy issued by EIC. AAIC sought a declaration that its umbrella policy was excess of the primary policy issued by EIC. EIC argued that its policy was excess to the two AAIC policies because the case involves underinsured motorist provisions and its “other insurance” clause is controlling over AAIC’s clause in the umbrella policy.

The court concluded that AAIC’s umbrella policy was a true excess policy, EIC’s policy was a coincidental excess policy, and EIC’s policy must be exhausted before the umbrella policy responds. The court held that the true-versus-coincidental excess policy distinction was applicable to the UM/UIM context, concluding that “UIM coverage is first party coverage functioning as a surrogate for insufficient third party liability coverage,” and “[e]ven in the UIM context, an insured holding an umbrella policy must purchase underlying primary coverage for the same risk and exhaust that coverage before turning to its umbrella policy.”⁶⁰

57. *Id.* at 1279.

58. *Id.*

59. 2009 U.S. Dist. LEXIS 42764 (D. Vt. 2009).

60. *Id.* at *7–8.

In *Sport Rock International, Inc. v. American Casualty Co. of Reading, Pa.*,⁶¹ the Supreme Court of New York, Appellate Division, addressed the issue of priority of coverage between two primary insurance policies affording concurrently applicable insurance coverage. In doing so, the court had the occasion to observe that “an excess ‘other insurance’ clause will not render a policy sold as primary insurance excess to a true excess or umbrella policy sold to provide a higher tier of coverage” and “insurance purchased as primary coverage must respond to a covered claim before policies specifically purchased as secondary coverage, regardless of the presence of other insurance clauses in the primary policies.”⁶²

Interestingly, two decisions surveyed reached opposite conclusions about whether an insurance policy that sits above an SIR is considered an excess policy or a primary policy. In *Word v. Illinois Union Insurance Co.*,⁶³ the Middle District of Florida held that an insurance policy sitting above an SIR is an excess policy and not subject to Florida’s UIM statute. In contrast, in *Liberty Mutual Insurance Co. v. Pella Windows & Doors, Inc.*,⁶⁴ the Southern District of Iowa held that an insurance policy sitting above an SIR is a primary policy, and the insured need exhaust only one SIR before the policy may be called upon to respond instead of awaiting the exhaustion of all of the SIRs over an extended period.

*AIU Insurance Co. v. Acceptance Insurance Co.*⁶⁵ illustrates difficulties that can arise for excess insurers under California’s horizontal exhaustion rule when an underlying primary insurer allegedly fails to obtain proper contribution from other primary insurers whose coverage is also triggered. In this matter, a window manufacturer was presented with claims that its windows were defective and that such defects resulted in water intrusion that caused property damage during the policy periods of five of its primary insurers. The insured designated Royal/Arrowood, one of its primary insurers, to respond to the claims. AIU, an excess insurer, asserted that Royal/Arrowood had notified it that its policies were exhausted but also failed to obtain the proper contribution from the other primary insurers. AIU asserted various claims against the primary insurers for declaratory relief that the Royal/Arrowood policies were not exhausted because Royal/Arrowood was entitled to reimbursement for defense and indemnity costs of other primary insurers on the risk, as well claims for equitable contribution, indemnification, and contribution.

61. 65 A.D.3d 12 (N.Y. App. Div. 2009).

62. *Id.* at 19 n.5 (quoting I OSTRAGER & NEWMAN, INSURANCE COVERAGE DISPUTES § 11.01, at 892 (14th ed.)).

63. 2009 U.S. Dist. LEXIS 6464, *16–17 (M.D. Fla. 2009).

64. 633 F. Supp. 2d 714, 724–25 (S.D. Iowa 2009).

65. 2008 U.S. Dist. LEXIS 95694 (N.D. Cal. 2008).

Two of the primary insurers, TIG and Acceptance, moved for judgment on the pleadings that AIU failed to state a valid cause of action against them. The court, however, denied their motion to dismiss the claim for declaratory relief, finding that it was premature to determine whether the other primary insurers had an obligation to reimburse Royal, and rejected an argument that claims for declaratory relief were duplicative of other claims for equitable indemnity and contribution and subrogation.⁶⁶ Likewise, the court refused to dismiss the claim for equitable indemnity and contribution, but dismissed the claim for equitable subrogation with leave to amend the complaint on grounds that the excess insurer's damages were not alleged in a stated sum.⁶⁷

III. SURPLUS LINES INSURANCE

A. Federal Legislation

As set forth in Section I above, on September 9, 2009, the U.S. House of Representatives unanimously passed H.R. 2571, the Nonadmitted and Reinsurance Reform Act of 2009 (NRRRA).⁶⁸ This marks the third time that the House has passed a version of the NRRRA. Although the Senate version was introduced in June 2009, no further action has been taken as of June 2010.⁶⁹ The NRRRA is intended to simplify and clarify regulatory issues related to surplus lines and reinsurance, specifically those covering premium taxes, access to the surplus lines market, regulatory authority, and reinsurance financial regulation.

B. State Legislation

On June 12, 2009, Florida Governor Charlie Crist signed into law legislation clarifying the regulation of the surplus lines insurance marketplace.⁷⁰ The legislation amending Section 626.913 of the Florida Statutes restored the regulatory exemption afforded surplus lines insurers retroactively to surplus lines insurance business written on or after October 1, 1988.⁷¹ The amendments were needed to address the possibility that surplus lines insurers' policies and forms would be subject to approval by the commissioner of insurance.⁷² The new law also added consumer protections and a disclosure requirement.⁷³

66. *Id.* at *7.

67. *Id.* at *8–11.

68. H.R. 2571, 111th Cong. (2009).

69. S.B. 1363, 111th Cong. (2009) (introduced and sponsored by Senator Mel Martinez (R-FL)).

70. Surplus Lines Insurers, C/S H.B. 853 (Fla. 2009)

71. FLA. STAT. ANN. § 626.913 (2009).

72. See *Essex Ins. Co. v. Zota*, 985 So. 2d 1036 (Fla. 2008).

73. FLA. STAT. ANN. § 626.9371 (2009).

C. Case Law Developments

In *Valentine Co. v. Commonwealth of Pennsylvania*,⁷⁴ the Pennsylvania Commonwealth Court affirmed the decision of the Pennsylvania Board of Finance and Review imposing surplus lines premium tax on premiums paid by Temple University. Valentine filed a timely tax report with the state department of revenue for 2004 but did not report or collect any surplus lines tax from Temple University for this period under the belief that the university was not subject to the tax.⁷⁵ In opposing the tax, Valentine argued that the university was immune from paying the surplus lines tax because it is a Commonwealth instrumentality under the provisions of the Temple University–Commonwealth Act (Temple Act).⁷⁶ In rejecting Valentine's argument, the court relied on Section 3 of the Temple Act, which preserves the university's status as a nonprofit corporation chartered for educational purposes,⁷⁷ and reasoned that it was not acting as an instrumentality of the Commonwealth but rather as a nonprofit educational organization.⁷⁸

In *Burlington Insurance Company v. Fluid Services, Inc.*, the Alabama Court of Civil Appeals reinforced the concept that strict regulatory compliance is necessary to obtain surplus lines status.⁷⁹ Burlington sought to sue its insured for breach of contract for premiums allegedly due at audit. The insured opposed the action on the grounds that Burlington was a foreign insurer without a certificate of authority to conduct business in the state.⁸⁰ Burlington argued that, as a surplus lines insurer, it was exempt from Alabama's certification requirement to bring suit.⁸¹ The insured argued that, despite the fact that the insurer was eligible to provide surplus lines insurance, the surplus lines exception does not apply because the policy issued by Burlington failed to contain the required endorsement under Alabama Code § 27-10-22.⁸² The court affirmed judgment in favor of the insured and held that failure to issue a policy with the required endorsement rendered the insurance contract as a policy issued by an unauthorized insurer. Therefore, Burlington could not bring suit to enforce its contract.⁸³

In *Guaranty Bank v. Evanston Insurance Co.*, the federal court for the Eastern District of Wisconsin held that a surplus lines insurer was not required

74. 973 A.2d 1101 (Pa. Commw. Ct. 2009).

75. *Id.* at 1104.

76. *Id.* at 1105–06.

77. *Id.* at 1107.

78. *Id.* at 1109.

79. 13 So. 3d 965 (Ala. Civ. App. 2008).

80. *Id.*

81. *Id.* at 968.

82. *Id.* at 970.

83. *Id.*

to post a bond as a condition of pleading in an action brought against it on the insurance policy.⁸⁴ A Wisconsin statute requires unauthorized insurers to post a bond prior to pleading in a court action.⁸⁵ Evanston sought an exemption, which was granted by the court.⁸⁶ In granting the motion, the court declined to determine that the statute in question was procedural in nature and inapplicable in federal court proceedings. Rather, the court found that Evanston had brought forth sufficient evidence that it had sufficient financial ability to pay any potential judgment.⁸⁷

IV. REINSURANCE LAW

A. *Proposed Federal Legislation*

After three years of deliberations and two rounds of public comments, the National Association of Insurance Commissioners (NAIC) approved the Reinsurance Regulatory Modernization Act of 2009 for submission to Congress.⁸⁸ The proposed act is intended to assess the strength of reinsurers, regardless of their state or country of domicile, under a ratings-based system that would require reinsurers to post collateral based on their financial strength and the depth and quality of regulatory oversight of its state or country of domicile.⁸⁹

The Modernization Act would establish two types of reinsurers in the United States: national reinsurers and port of entry (POE) reinsurers.⁹⁰ National reinsurers would be U.S. domiciled reinsurers and POE reinsurers would be non-U.S. reinsurers.⁹¹ Each type of reinsurer would be supervised by a single state; either the home state (where the national reinsurer is licensed and domiciled) or the POE state (where a non-U.S. assuming reinsurer is certified to provide creditable reinsurance to ceding insurers).⁹²

84. 2009 U.S. Dist. LEXIS 28158, *1 (E.D. Wis. Mar. 24, 2009).

85. WIS. STAT. ANN. § 618.47(1).

86. *Id.* at *3.

87. *Id.*

88. Press Release, Nat'l Ass'n of Ins. Comm'rs, NAIC Proposes Reinsurance Regulatory Modernization Act of 2009, New Federal Legislation Would Modernize State Regulation of Reinsurance (Sept. 23, 2009), *available at* www.naic.org/Releases/2009_docs/2009_reinsurance_regulatory_modernization.htm.

89. Memorandum from Bryan Fuller, Senior Reinsurance Manager, National Association of Insurance Commissioners, to Members of the NAIC Reinsurance (E) Task Force (Dec. 2, 2007) (on file with author).

90. Reinsurance Regulatory Modernization Act of 2009 § 2 (2009) ("MODERNIZATION ACT") (draft adopted by the NAIC Reinsurance (E) Task Force, Sept. 15, 2009), *available at* www.naic.org/documents/committees_e_reinsurance_090915_reins_ref_modernization_act.pdf.

91. MODERNIZATION ACT § 2.

92. *Id.* §§ 4, 10(10), (18).

The Modernization Act would establish the Reinsurance Supervision Review Board, comprised of ten insurance regulators and five representatives of U.S. agencies, appointed by the president and with the advice and consent of the Senate.⁹³ The board would have authority to evaluate the regulatory systems of the states to determine if they qualify as home state supervisors or POE supervisors⁹⁴ and to evaluate reinsurance supervisory systems of non-U.S. jurisdictions to determine if they are eligible as a qualified jurisdiction under NAIC standards.⁹⁵

The Act would also authorize a certification mechanism allowing states demonstrating requisite resources, expertise, and experience to regulate reinsurers on a cross-border basis to serve as the home state for U.S. domiciled reinsurers or as the POE state for non-U.S. reinsurers.⁹⁶ POE supervisors would be authorized to enter into reciprocal recognition agreements as well as information-sharing agreements with qualified non-U.S. jurisdictions, in accordance with NAIC standards and approved procedures.⁹⁷ This authorization is intended to eliminate concerns about possible violations of the Compact Clause of the U.S. Constitution, which prohibits states from entering into “any Agreement or Compact with another State, or with a foreign Power” without congressional consent.⁹⁸

Reinsurers would be required to have at least \$250 million in capital and surplus to be eligible as either a national reinsurer or POE reinsurer.⁹⁹ This surplus requirement could be satisfied by a group of underwriters having the required capital and surplus and a central fund of at least \$250 million.¹⁰⁰ To be certified as a POE reinsurer, a company would be required to be organized in and licensed by an eligible non-U.S. jurisdiction.¹⁰¹

Credit for reinsurance ceded by a U.S. domiciled insurer to a national reinsurer or a POE reinsurer would be granted in accordance with the standards set forth in Act.¹⁰² The amount of collateral a reinsurer would be required to post would be based on an evaluation by its home state or POE supervisor, as applicable.¹⁰³ These supervisors would utilize standards recommended by the NAIC and adopted by the board to determine a reinsurer’s financial status.¹⁰⁴

93. *Id.* § 3.

94. *Id.* § 4(b), (c).

95. *Id.* § 4(c), (f).

96. *See id.* §§ 4(e)–(f), 5.

97. *Id.* § 4(h).

98. U.S. CONST. art. 1, § 10, cl. 3.

99. MODERNIZATION ACT § 5(a).

100. *Id.*

101. *Id.* § 10(17).

102. *Id.* § 5(b).

103. *See id.*

104. *Id.* § 5(b)(1), (4).

Reinsurers would be required to operate under the Modernization Act, and all state actions would be preempted to the extent that they are inconsistent with the Act.¹⁰⁵ However, the Act would not preempt any state law, rule, or regulation that regulates credit for reinsurance ceded to reinsurers that are not national or POE reinsurers.¹⁰⁶

B. *State Legislation*

Some states have decided to take action without waiting for the NAIC and the federal government. For example, on September 16, 2008, Florida adopted a new regulation that authorizes the insurance commissioner to establish lower collateral requirements.¹⁰⁷ The new regulation applies to unauthorized and unaccredited foreign and alien reinsurers that have financially secure ratings from at least two nationally recognized rating organizations and meet certain eligibility standards, such as maintaining surplus over \$100 million and being authorized in their domiciliary jurisdiction for the types of insurance to be ceded.¹⁰⁸ After eligibility is determined, the amount of collateral the reinsurer is required to post is determined by a schedule based on the reinsurer's financial strength rating.¹⁰⁹ The state's ratings-based collateral rule applies only to reinsurance ceded by Florida domestic property and liability insurers.¹¹⁰

On December 24, 2008, the New York State Insurance Department published its proposed tenth amendment to a regulation on the ratings-based reinsurance collateral issue.¹¹¹ Although similar to the NAIC proposal, the New York regulation only applies to alien reinsurers. Like Florida, New York bases the amount of collateral on the reinsurer's financial strength ratings from at least two recognized rating agencies; however, unauthorized assuming reinsurers are required to maintain a minimum net worth of \$250 million and be authorized by and meet solvency and capital standards of their domiciliary jurisdictions.¹¹² The highest-rated reinsurers would not be required to post any collateral while the lowest-rated ones would be required to post collateral ranging from 10 percent to 100 percent of their reinsurance obligations.¹¹³

105. *See id.* § 6.

106. *Id.* § 6(d).

107. FLA. STAT. § 624.610 (2009); FLA. ADMIN. CODE ANN. r. 69O-144.007 (2009).

108. *Id.*

109. *Id.*

110. *Id.*

111. N.Y. COMP. CODES R. & REGS., tit. 11, § 125 (Proposed 10th Amendment to Regulation No. 20, Dec. 24, 2008).

112. *Id.*

113. *Id.*

C. Case Law Developments

1. Enforceability of the Arbitration Clause

Whether an arbitration clause means arbitration is the only available relief was at issue in *B.D. Cooke & Partners Ltd. v Certain Underwriters at Lloyd's, London*.¹¹⁴ In that case, an insolvent retrocedent's creditor, B.D. Cooke & Partners Limited, which received an assignment of the retrocedent's claims against Lloyd's, filed suit in New York state court for relief under excess of loss reinsurance contracts included in the assignment. The contracts contained arbitration clauses, prompting Underwriters to remove the case to the Southern District of New York.¹¹⁵ Cooke filed a motion to remand. Underwriters simultaneously filed a motion to stay Cooke's suit and compel arbitration pursuant to the arbitration clauses, the Convention on the Recognition and Enforcement of Foreign Arbitral Awards, and the Federal Arbitration Act (FAA).¹¹⁶

Cooke made three arguments in support of its remand: (1) the dispute was not within the scope of the arbitration clauses; (2) by stepping into the liquidator's shoes, arbitration was no longer appropriate because the Convention exempted contracts that are "null and void, inoperative or incapable of being performed"¹¹⁷; and (3) Underwriters waived removal rights by including a service of suit clause that conflicted with the arbitration clause as both contained forum selection language.¹¹⁸ The court rejected all three.¹¹⁹

The court initially focused on language in the arbitration clauses that required the dispute to "aris[e] under" the contracts," finding that the subject matter of the dispute, i.e., Cooke's claims for coverage, fell within the broad scope of the arbitration clause because it was the only basis upon which Cooke could assert claims against the retrocessionaires.¹²⁰ Next, the court held that the assignment did not render the reinsurance contracts null, void, or incapable of being performed. Although Cooke cited to New York cases that held that arbitration clauses are unenforceable against a statutory liquidator,¹²¹ the court distinguished those cases, finding that an "inability to compel the liquidator to arbitration . . . does not imply an in-

114. 606 F. Supp. 2d 420, 421–22 (S.D.N.Y. 2009).

115. *Id.* at 422.

116. *Id.*

117. *Id.* at 424 (citing Convention on the Recognition and Enforcement of Foreign Arbitral Awards, 21 U.S.T. 2517, June 10, 1958, reprinted at 9 U.S.C. § 201).

118. *Id.* at 423.

119. *Id.* at 423–27.

120. *Id.* at 423–24 (citing *JLM Indus., Inc. v. Stolt-Nielsen SA*, 387 F.3d 163, 172 (2d Cir. 2004) for proposition that arbitration clause with similar "arising" language was broad in scope).

121. *Id.* at 424 (citations omitted).

ability to compel plaintiff to arbitrate.¹²² Finally, the court endorsed the prevailing view that a service of suit clause does not waive the retrocessionaires' right to remove and compel arbitration because it is consistent with the public policy favoring arbitration.¹²³ The court granted the retrocessionaires' motion to compel arbitration.¹²⁴

The Fifth Circuit, sitting *en banc*, recently upheld an arbitration clause notwithstanding a Louisiana state statute prohibiting arbitration agreements in insurance contracts and arguments that the agreement to arbitrate was reverse preempted under the McCarran-Ferguson Act.¹²⁵ In *Safety National Casualty Corp. v. Certain Underwriters at Lloyd's, London*, the Louisiana Safety Association of Timbermen-Self Insurers Fund (LSAT), a self-insurance fund providing workers' compensation benefits to its members, entered into reinsurance contracts whereby Underwriters reinsured claims that exceeded LSAT's self-insured retention.¹²⁶ Safety National alleged that LSAT assigned its rights under the reinsurance contracts to Safety National, but Underwriters refused to recognize the validity of the assignment.¹²⁷ Safety National filed a lawsuit in district court against Underwriters, which responded by filing a motion to stay the proceedings and compel arbitration under the arbitration clause in its reinsurance contracts with LSAT.¹²⁸

After skirmishes regarding the selection of the arbitral panel, LSAT petitioned the district court to quash the arbitration pursuant to a Louisiana statute that prohibited arbitration agreements in insurance contracts.¹²⁹ LSAT argued that because the Louisiana statute "regulated the business of insurance" within the meaning of the McCarran-Ferguson Act,¹³⁰ the statute reverse-preempted the Convention by which the arbitration clause in

122. *Id.* at 425.

123. *Id.* at 426–27 (citing *Travelers Ins. Co. v. Keeling*, 1993 WL 18909 (S.D.N.Y. Jan. 19, 1993), *appeal dismissed*, 996 F.2d 1485 (2d Cir. 1993); *Suter v. Munich Reins. Co.*, 223 F.3d 150, 158 (3d Cir. 2000); *McDermott Int'l, Inc. v. Lloyds Underwriters of London*, 944 F.2d 1199, 1209 (5th Cir. 1991); *NECA Ins., Ltd. v. Nat'l Union Fire Ins. Co. of Pittsburgh, PA.*, 595 F. Supp. 955 (S.D.N.Y. 1984)).

124. *Id.* at 427.

125. 587 F.3d 714 (5th Cir. 2009).

126. *Id.* at 717.

127. *Id.*

128. *Id.*

129. *Id.* at 718–19. The statute provided that "[n]o insurance contract delivered or issued for delivery in this state . . . shall contain any condition, stipulation or agreement: . . . [d]epriving the courts of this state of the jurisdiction of action against the insurer." LA. REV. STAT. ANN. § 22:868. The statute further provides that "[a]ny such condition, stipulation or agreement in violation of this Section shall be void . . ." *Id.*

130. The McCarran-Ferguson Act provides in part: "[n]o Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . unless such Act specifically relates to the business of insurance . . ." 15 U.S.C. § 1012(b).

Underwriters' reinsurance contracts was enforceable.¹³¹ The district court granted LSAT's motion to quash.¹³² On appeal, the Fifth Circuit reversed the district court, holding that the McCarran-Ferguson Act, which only applies to an "Act of Congress," did not apply to a treaty such as the Convention.¹³³

On rehearing, LSAT argued that the Convention was not self-executing and the Convention only took effect when Congress enacted enabling legislation, which is an "Act of Congress." Without directly addressing whether the Convention was self-executing, the court ruled that, using a plain meaning approach, the McCarran-Ferguson Act does not apply to treaties: "[t]he commonly understood meaning of an 'Act of Congress' does not include a 'treaty,' even if the treaty required implementing legislation."¹³⁴ The court also observed that the language mandating the enforcement of arbitration agreements, which is the language in conflict with the Louisiana statute, appears in the body of the Convention itself, not in the implementing legislation.¹³⁵ The court therefore ruled that the Louisiana statute did not reverse-preempt the Convention, and the arbitration clause in Underwriters' reinsurance contracts was enforceable.¹³⁶

As the Fifth Circuit noted,¹³⁷ its decision conflicts with the Second Circuit's decision in *Stephens v. American International Insurance Co.*,¹³⁸ which held that provisions of the Kentucky Liquidation Act reverse-preempted the Convention. It is likely there will be additional rulings involving the McCarran-Ferguson Act in the future, especially in the context of state insolvency statutes that often provide liquidators with the right to proceed in state court.

2. Panel Composition

A federal district court recently discussed how an arbitrator's resignation due to ill health and subsequent recovery affect the composition of a three-person arbitration panel and interim rulings issued by the panel prior to the resignation.¹³⁹ During an arbitration between a reinsurer and cedent,

131. *Safety Nat'l*, 587 F.3d at 720.

132. *Id.* at 717.

133. *Id.* at 717 n.6 (citing *Safety Nat'l Cas. Corp. v. Certain Underwriters at Lloyd's, London*, 543 F.3d 744 (5th Cir.2008), *vacated and reb'g en banc granted*, 558 F.3d 599 (5th Cir. 2009).

134. *Id.* at 723.

135. *Id.* at 723–24.

136. *Id.* at 725.

137. *Id.* at 731.

138. 66 F.3d 41 (2d Cir. 1995).

139. *Ins. Co. of N. Am. v. Pub. Serv. Mut. Ins. Co.*, 2009 WL 2381854 (S.D.N.Y. July 29, 2009). Due to a procedural issue, this decision replaced a substantially identical decision one month earlier. *Id.* at *1 n.1 (discussing disposition of *Ins. Co. of N. Am. v. Pub. Serv. Mut. Ins. Co.*, 2009 WL 1873585 (S.D.N.Y. June 30, 2009)).

the reinsurer's party-appointed arbitrator was diagnosed with cancer that necessitated immediate treatment.¹⁴⁰ When the arbitrator resigned from the panel, the parties could not agree on a method for selecting his replacement.¹⁴¹ Prior to the arbitrator's resignation, the panel issued a summary judgment order with a choice of law decision favorable to the cedent; a motion for reconsideration was pending when the arbitrator resigned.¹⁴² The cedent argued that the arbitration should proceed before the existing panel upon appointment of a substitute arbitrator, leaving the summary judgment order in effect. The reinsurer argued that the arbitration should begin anew before an entirely new three-person panel, which would nullify the effect of the summary judgment order. The parties proceeded according to their respective positions; the reinsurer purported to appoint its party arbitrator in a new arbitration while the cedent purported to appoint a substitute arbitrator for the reinsurer in the existing arbitration.¹⁴³ The umpire in the existing panel suggested that an entirely new panel could be prejudicial since substantive rights had already accrued, but it urged the parties to seek judicial resolution of the issue. The reinsurer filed a petition pursuant to FAA § 4 in federal court for the Southern District of New York.¹⁴⁴

In a decision dated December 12, 2008, the court first ruled that had authority to permanently stay the pending arbitration under appropriate circumstances, among which was the death or resignation of an arbitrator.¹⁴⁵ Next, the court stated that the general rule upon the death of a panel member is to begin a new arbitration with a new panel.¹⁴⁶ The exception is where the panel had issued a partial final award and had no authority to revisit the ruling. The court concluded that this case did not fall within the exception because the panel's interim decision did not address all of the issues before it.¹⁴⁷ Indeed, only the choice of law issue had been decided, and even that was the subject of a pending motion to reconsider. While the court acknowledged the potential for "bad faith manipulation of the arbitration process" if a party could try again with a new panel upon the resignation of an arbitrator, as well as the waste of resources if the case had to resume from the start, the court found no evidence of any party miscon-

140. *Id.* at *1. The factual background of the dispute is best set forth in an earlier decision by the court. *Ins. Co. of N. Am. v. Pub. Serv. Mut. Ins. Co.*, 2008 WL 5205970, at *1-2 (S.D.N.Y. Dec. 12, 2008).

141. 2009 WL 2381854, at *1.

142. 2008 WL 5205970, at *2-3.

143. *Id.* at *3.

144. *Id.*

145. *Id.*

146. *Id.* at *4.

147. *Id.* at *4-5.

duct or any dispute of the serious health issues that caused the arbitrator to resign.¹⁴⁸ Accordingly, the court granted the reinsurer's motion to permanently enjoin the arbitration and ordered the parties to commence a new arbitration proceeding.¹⁴⁹

Just a month after the court's ruling, the cedent learned that the resigned arbitrator's health had improved to the point where he was actively seeking appointments in other reinsurance arbitrations, and that the reinsurer knew one month prior to oral argument that its arbitrator had resumed working.¹⁵⁰ The cedent filed a motion for reconsideration of the court's December 12, 2008, opinion and requested an order reappointing the resigned arbitrator.¹⁵¹ The court granted the motion, reasoning that the resigned arbitrator's recovery constituted "newly discovered evidence." It rejected the reinsurer's arguments that had the cedent exercised reasonable diligence, it could have learned from publicly available conference records that the arbitrator had resumed work.¹⁵² Even though the reinsurer argued that it could not receive a fair and impartial hearing from the arbitrator whose reappointment it had challenged, the court ruled that there was no evidence of bias and, moreover, a challenge for bias was procedurally premature.¹⁵³ The court ordered the parties "to continue the arbitration that was pending at the time of [the] resignation," which encompassed the earlier summary judgment on choice of law.¹⁵⁴ The reinsurer's appeal to the Second Circuit is pending.

In a similar case, the Seventh Circuit held that, where the arbitration agreement is silent on replacing an arbitrator, a party can petition the court to fill the vacancy under FAA § 5.¹⁵⁵ WellPoint Health Networks and John Hancock Life Insurance Co. entered into an arbitration concerning disputes arising out of WellPoint's purchase of various global business operations of Hancock.¹⁵⁶ More than two years after the arbitration started, WellPoint retained new counsel and at the same time asked its party arbitrator to resign.¹⁵⁷ Although Hancock objected to this request, the panel accepted his resignation.¹⁵⁸ WellPoint then proposed two separate replacement arbitrators but Hancock objected to them both.¹⁵⁹ At

148. *Id.* at *6.

149. *Id.* at *7.

150. 2009 WL 2381854, at *2.

151. *Id.* at *2-3, 5-7.

152. *Id.* at *3-5.

153. *Id.* at *5-7.

154. *Id.* at *7.

155. *WellPoint, Inc. vs. John Hancock Life Ins. Co.*, 576 F.3d 643 (7th Cir. 2009).

156. *Id.* at 644.

157. *Id.* at 644-45.

158. *Id.* at 645.

159. *Id.*

this point, Hancock's party arbitrator suggested that the remaining panel members propose three replacement candidates from which WellPoint could choose.¹⁶⁰ WellPoint initially objected to this approach but eventually agreed, and the arbitration proceeded with a candidate selected by WellPoint from a slate proposed by Hancock's party-appointed arbitrator and the umpire.¹⁶¹

With the newly constituted panel in place, the matter proceeded to hearing where WellPoint prevailed.¹⁶² WellPoint moved to confirm the award and Hancock moved to vacate, arguing that the panel was not selected in accordance with the arbitration agreement and therefore had no authority to issue a binding ruling.¹⁶³ The district court rejected Hancock's arguments and Hancock appealed.

In affirming the district court's decision, the Seventh Circuit found that the FAA itself "sets forth a rule that applies to the mid-stream loss of an arbitrator."¹⁶⁴ Specifically, § 5 provides that if no method of selecting the arbitrators is specified in the parties agreement, or if, for any reason, the parties have failed to avail themselves of the methods set forth, "or if for any other reasons there shall be a lapse in the naming of an arbitrator . . . or *in filling a vacancy*, then upon application of either party to the controversy the court shall designate and appoint an arbitrator. . . ."¹⁶⁵ The court thus concluded that the FAA anticipates both the problem of vacancy during the arbitration and the possibility that the parties may not have determined a method for filling that vacancy.¹⁶⁶

The Seventh Circuit rejected Hancock's argument that the "general rule" to be applied where a vacancy is created before a final award is issued is to start the entire process over, calling such an approach "inflexible and wasteful."¹⁶⁷ The court also noted the unfairness of Hancock's position in objecting to the final award after participating in the arbitration before a panel that was selected in part by a substitution process advocated by Hancock's own party-appointed arbitrator.¹⁶⁸

3. Discovery from Nonparties

A common issue faced by parties in reinsurance arbitrations is the extent of the panel's authority to compel discovery from nonparties. Reinsurance

160. *Id.*

161. *Id.*

162. *Id.* at 644.

163. *Id.* at 645–46.

164. *Id.* at 647.

165. *Id.* (emphasis in original).

166. *Id.*

167. *Id.*

168. *Id.* at 647–48.

disputes often involve third parties such as brokers or intermediaries that are not signatories to the reinsurance contract and therefore not bound by the arbitration clause. This issue may also arise when individuals with relevant knowledge no longer work for either party. Courts have recently held that an arbitration panel is without power to compel discovery from nonparties, a significant restraint on the ability to develop a complete factual record in reinsurance arbitrations.¹⁶⁹

The Second Circuit in *Life Receivables Trust v. Syndicate 102 at Lloyd's, London*, joined what the court termed a “‘growing consensus’ that a panel is without the power to compel ‘hearing’ document discovery.”¹⁷⁰ The case involved a dispute over contingent cost insurance (CCI), which pays a benefit in certain situations when a third party purchases life insurance policies from an insured. Peachtree Life Settlements purchased life insurance policies from elderly individuals, paying a price based in large part on its estimate of the insured’s life expectancy.¹⁷¹ Upon purchase, Peachtree continued to pay the policy premiums and was the beneficiary when the insured died.¹⁷²

Peachtree assigned its interest in some of the policies to Life Receivables Trust, which would then receive the net death benefit upon the insured’s death.¹⁷³ To protect its profit margin if the insured outlived his or her projected life expectancy, Peachtree purchased CCI from Syndicate 102.¹⁷⁴ CCI coverage was triggered where the insured outlived his or her life expectancy by more than two years; in that instance, the policy required Syndicate 102 to pay the Trust the net death benefit and assume the life insurance policy.¹⁷⁵ The CCI policy named the Trust as insured and Peachtree as originator and servicer, and contained an arbitration clause.¹⁷⁶

A dispute arose when Syndicate 102 refused to pay the Trust and assume certain life insurance policies under the CCI policy.¹⁷⁷ The Trust filed an arbitration demand against Syndicate 102, but did not include Peachtree in the demand.¹⁷⁸ During the arbitration, Syndicate 102 served discovery

169. *Life Receivables Trust v. Syndicate 102 at Lloyd's of London*, 549 F.3d 210 (2d Cir. 2008). This case is not a reinsurance case but is noteworthy because its ruling is almost certainly applicable to all arbitrations under the FAA, thus encompassing reinsurance arbitrations. *In re Arbitration in London, England*, 2009 WL 1664936 (N.D. Ill. June 15, 2009).

170. *Syndicate 102*, 549 F.3d at 216–17.

171. *Id.* at 212.

172. *Id.*

173. *Id.*

174. *Id.*

175. *Id.*

176. *Id.*

177. *Id.*

178. *Id.* at 213.

requests on both the Trust and Peachtree.¹⁷⁹ While the Trust produced certain of Peachtree's documents in its possession, Peachtree refused to comply with the discovery requests, stating that the panel had no jurisdiction over it as a nonparty.¹⁸⁰ At Syndicate 102's request, the panel served a subpoena on Peachtree. Peachtree also refused to comply with the subpoena, again asserting that it was not bound by the panel's rulings or orders.¹⁸¹ Peachtree filed suit in federal district court to quash the subpoena, and Syndicate 102 cross-moved to compel compliance.¹⁸² The district court granted Syndicate 102's motion to enforce the subpoena, relying on the fact that Peachtree, while not a party to the arbitration, was a party to the arbitration agreement.¹⁸³ On appeal, the Second Circuit reversed.¹⁸⁴

The Second Circuit began its discussion with FAA § 7, noting that the provision only allows arbitrators to "summon in writing any person to attend before them or any of them as a witness and in a proper case to bring with him or them any book, record, document, or paper which may be deemed material as evidence in the case."¹⁸⁵ Relying on the plain meaning of this language, the court ruled: "[S]ection 7 of the FAA does not authorize arbitrators to compel prehearing document discovery from entities not party to the arbitration proceedings."¹⁸⁶

The Second Circuit followed the approach taken by the Third Circuit that § 7 "unambiguously restricts an arbitrator's power to situations in which the nonparty has been called to appear in the physical presence of the arbitrator and to hand over the documents at that time."¹⁸⁷ The court chose not to follow the Eighth Circuit's holding that § 7 allows a panel to compel hearing document discovery as implicit in its right to compel production at a hearing,¹⁸⁸ or the Fourth Circuit's holding that hearing document discovery is permissible upon a showing of "special need."¹⁸⁹

Syndicate 102 argued that § 7 authorized a subpoena to Peachtree on the basis that Peachtree was a party to the arbitration agreement, even if not

179. *Id.*

180. *Id.*

181. *Id.* at 214.

182. *Id.*

183. *Id.*

184. *Id.* at 219.

185. *Id.* at 214–15.

186. *Id.* at 216–17.

187. *Id.* at 215 (quoting *Hay Group, Inc. v. E.B.S. Acquisition Corp.*, 360 F.3d 404, 407 (3d Cir. 2004)).

188. *Id.* at 212, 215 (citing *In re Arbitration Between Sec. Life Ins. Co. of Am.*, 228 F.3d 865, 870–71 (8th Cir. 2000)).

189. *Id.* at 212, 215 (citing *COMSAT Corp. v. Nat'l Sci. Found.*, 190 F.3d 269, 275 (4th Cir. 1999)).

to the arbitration itself.¹⁹⁰ Rejecting this argument, the court stated that a panel's power over parties to the proceedings arises out of the agreement to arbitrate, not § 7.¹⁹¹ Thus, a party seeking full discovery would be well-advised to add to the arbitration proceeding all parties to the arbitration agreement.¹⁹² The court concluded its decision by advising that arbitrators are not powerless to order production of documents by nonparties; the panel can compel the nonparty to appear live with the documents before one or more arbitrators at a specially called hearing.¹⁹³ The court noted that the inconvenience of such a personal appearance "may cause the testifying witness to 'deliver the documents and waive presence.'"¹⁹⁴ Thus, the Second Circuit's decision leaves the door open for nonparty document discovery, but limits the appropriate procedure to personal appearance before the panel as prescribed by § 7.

4. Jurisdiction and Forum Selection for Enforcement of the Arbitration Award

The FAA permits a court to confirm an arbitration award but it does not provide an independent basis for jurisdiction. Absent another basis for federal jurisdiction, the parties must establish diversity and the threshold amount in controversy. In *American Bankers Insurance Co. of Florida v. National Casualty Co.*, the Eastern District of Michigan granted a retrocedent's motion to dismiss its retrocessionaires' petition to confirm an arbitration award for failure to satisfy the \$75,000 minimum required for diversity jurisdiction under 28 U.S.C. § 1332(a).¹⁹⁵ The court noted that for purposes of confirming an arbitration award, "the amount in controversy is necessarily the amount of the award that is sought to be confirmed."¹⁹⁶ The disputed arbitration award did not award any damages but did provide declaratory relief with respect to future claims under the treaties.¹⁹⁷ The court held that neither component of the award demonstrated any "real value," thus requiring dismissal because that the jurisdictional minimum

190. *Id.* at 217.

191. *Id.* The arbitration clause in the CCI policy provides in part that the panel "may in its sole discretion make such orders and directions as it considers to be necessary for the final determination of the matters in dispute." *Id.* at 213.

192. Syndicate 102 attempted to do this by serving a separate notice of arbitration on Peachtree and requesting that Peachtree agree to join the pending arbitration. Peachtree refused and the panel did not order joinder. *Id.* There is no discussion of the panel's ruling or reasoning on this point.

193. *Id.* at 218.

194. *Id.* (quoting *Hay Group*, 360 F.3d at 413 (Chertoff, J., concurring)).

195. 2009 WL 257699, at *4-5 (E.D. Mich. Feb. 3, 2009). The reported decision has little factual detail, however, more factual detail is available in the complaint. Complaint, (Aug. 14, 2008).

196. *Id.* at *4 (citing *Ford v. Hamilton Invs., Inc.*, 29 F.3d 255, 259-60 (6th Cir. 1994)).

197. *Id.* at *5.

had not been met.¹⁹⁸ The court advised that the parties remained free to seek confirmation in a state court.¹⁹⁹

As a threshold matter, a party seeking judicial enforcement must also determine the appropriate forum. Lyndon Property Insurance Co. sought to enforce a panel order requiring its reinsurer, Founders Insurance Co., Ltd., to post \$20 million in prejudgment security.²⁰⁰ Lyndon filed a petition in the federal court for the District of Massachusetts alleging that the reinsurer failed to comply with the panel's order.²⁰¹ The reinsurer filed a motion to dismiss on multiple grounds, including forum selection.²⁰² Founders argued that the reinsurance agreement required the arbitration to be conducted in Missouri, and therefore a petition to enforce the award could be brought in Missouri only. Lyndon asserted it could bring suit in any forum that could properly obtain jurisdiction, including Massachusetts, where the parties had agreed to conduct some of the arbitration proceedings.²⁰³ The court reasoned that because the choice of forum issue was a matter of procedure and not arbitrability, the reinsurance contract vested the arbitrators, not the court, with the authority to decide the issue.²⁰⁴ Accordingly, the court granted Founders' motion to dismiss and remanded the issue to the panel to determine the appropriate judicial forum.²⁰⁵

5. Vacating an Arbitration Award

Under the FAA, federal courts are generally reluctant to vacate arbitration awards and prefer to defer to the broad authority of the arbitrators. Most decisions on petitions to confirm or vacate arbitration awards in the past year were consistent with this trend.²⁰⁶ However, one recent case, in which

198. *Id.*

199. *Id.*

200. *Lyndon Prop. Ins. Co. v. Founders Ins. Co., Ltd.*, 587 F. Supp. 2d 333 (D. Mass. 2008).

201. *Id.*

202. *Id.* at 334.

203. *Id.* at 336.

204. *Id.* at 337.

205. *Id.*

206. *See, e.g.*, *Global Reins. Corp. of Am. v. Argonaut Ins. Co.*, 634 F. Supp. 2d 342 (S.D.N.Y. 2009) (granting retrocedent's petition to confirm and denying retrocessionaire's motion to vacate after noting limited scope of judicial review afforded by FAA); *Global Reins. Corp.-U.S. Branch v. Argonaut Ins. Co.*, 2009 WL 1490590 (S.D.N.Y. May 22, 2009) (granting retrocedent's petition to confirm after noting limited scope of judicial review afforded by FAA); *Global Int'l Reins. Co., Ltd. v. TIG Ins. Co.*, 2009 WL 161086 (S.D.N.Y. Jan. 21, 2009) (granting cedent's petition to confirm and denying reinsurer's petition to vacate after noting limited scope of judicial review afforded by FAA); *TIG Ins. Co. v. Global Int'l Reins. Co., Ltd.*, 640 F. Supp. 2d 519 (S.D.N.Y. 2009) (denying reinsurer's petition to vacate and granting cedent's cross-petition to confirm after noting limited scope of judicial review afforded by FAA); *cf. Century Indem. Co. v. Fencourt Reins. Co., Ltd.*, 640 F. Supp. 2d 626 (E.D. Pa. 2009) (denying petition to vacate due to strong presumption in favor of upholding arbitration awards, but denying petition to confirm as moot due to belief that parties prior petition compliance indicated they would comply with the panel's order without need for confirmation).

a federal district court vacated an award as “completely irrational,” may serve as a check on the authority of future panels.²⁰⁷

In that case, the cedent PMA Capital Insurance Co. successfully petitioned to vacate an award rendered in arbitration against its reinsurer, Platinum Underwriters Bermuda.²⁰⁸ The dispute centered on a “deficit carry forward” provision contained in the parties’ 2003 reinsurance contract.²⁰⁹ The carryforward provision arguably allowed Platinum to carry forward losses from reinsurance contracts issued to PMA in 1999 to 2001 by Platinum’s predecessor and apply the losses against the funds in the parties’ 2003 “experience account.”²¹⁰ The experience account was funded by PMA; once the account was exhausted, Platinum’s obligation to pay claims began.²¹¹ If sums remained in the experience account after Platinum carried forward any losses and certain other contractual conditions were met, then PMA would be entitled to the remaining balance.²¹²

In 2008, a dispute arose regarding whether Platinum was entitled to carry forward losses from the prior reinsurance contracts and, if so, the amount of the deficit to be carried forward.²¹³ Platinum contended the deficit was \$10.7 million while PMA argued there was no deficit even though it had previously reported a deficit of \$6 million to the Pennsylvania Department of Insurance.²¹⁴ Platinum demanded arbitration, and, after a hearing, the panel issued a one-page award ordering PMA to pay Platinum \$6 million and further providing that “any and all references to a ‘deficit carry forward’ in the [2003 Agreement will be] removed from the contract.”²¹⁵ The panel did not provide any reasoning or an explanation for its decision.²¹⁶

PMA filed a petition to vacate the award in the Eastern District of Pennsylvania under FAA § 10(a)(4), arguing that the arbitrators “exceeded their powers.”²¹⁷ While acknowledging that a court’s review of an arbitration award under the FAA is “severely limited”²¹⁸ and highly deferential to the panel, the court noted that it was “neither entitled nor encouraged simply

207. PMA Capital Ins. Co. v. Platinum Underwriters Bermuda, Ltd., 659 F. Supp. 2d 631 (E.D. Pa. 2009).

208. *Id.* at 632 (notably, the decision begins with the judge’s comment that “I will vacate the award because it is not rational”).

209. *Id.* at 633–34.

210. *Id.*

211. *Id.*

212. *Id.*

213. *Id.*

214. *Id.* at 639.

215. *Id.* at 634.

216. *Id.*

217. *Id.* at 635.

218. *Id.* (quoting *Mut. Fire, Marine & Inland Ins. Co. v. Norad Reins., Co.*, 868 F.2d 52, 56 (3d Cir. 1989) (internal citation omitted)).

to ‘rubber stamp’ the interpretations and decisions of arbitrators.”²¹⁹ Under § 10(a)(4), vacatur was appropriate where: (1) the form of the award could not be rationally derived from the reinsurance contract or the parties’ submissions to the panel, and (2) the terms of the award are completely irrational.²²⁰ Finding these elements present, the court vacated the award.²²¹

First, the court determined that the award could, not be derived from the parties’ agreement because “the ‘contract itself’ requires enforcement of the Deficit Carry Forward provision, not its elimination.”²²² Although the arbitration clause contained “honorable engagement” language that relieved the panel of “all judicial formalities” and from following the “strict rules of law,” the court reasoned that such discretion did not authorize the panel to rewrite the contract.²²³ The court also noted that the carryforward provision imposes other contractual conditions before Platinum can recover its deficit from PMA.²²⁴ These conditions had not been met, thus calling into question the panel’s award of \$6 million.

The court further found that the panel’s award could not be supported as rationally derived from the parties’ submissions. The parties asked the panel to calculate the amount of the deficit and determine whether it could be carried forward, but neither party requested removal of the provision.²²⁵ Additionally, Platinum did not request that PMA be ordered to pay the amount of the deficit.²²⁶ The court concluded that deletion of the carryforward provision was completely irrational because it did not draw its essence from the contract.²²⁷ This decision is currently on appeal to the Third Circuit, but in the interim, it is likely to be frequently cited as one of the few cases where a court places limitations on the broad authority of an arbitration panel.

6. Panel’s Award of Attorneys’ Fees

The issue of attorneys’ fee awards by arbitration panels resulting from bad faith or other misconduct remains a contentious issue. In the case of *Relia-Star Life Insurance Co. of N.Y. v. EMC National Life Insurance Co.*, the Second Circuit Court of Appeals recently clarified in a nonreinsurance case involving co-insurance agreements that “a broad arbitration clause . . . confers inherent authority on arbitrators to sanction a party that participates in the

219. *Id.* (quoting *Matteson v. Ryder Sys.*, 99 F.3d 108, 113 (3d Cir. 1996)).

220. *Id.* (citing *Mut. Fire*, 868 F.2d at 56 (internal citation omitted)).

221. *Id.* at 640.

222. *Id.* at 637.

223. *Id.*

224. *Id.*

225. *Id.* at 637–38.

226. *Id.*

227. *Id.* at 638–39.

arbitration in bad faith and such a sanction may include an award of attorney's fees or arbitrator's fees."²²⁸ This decision follows similar reasoning by cases from the Ninth and Tenth Circuits.²²⁹

In *ReliaStar*, the final arbitration award ordered EMC National Life Company as successor to National Travelers Life Company (collectively, EMC) to pay attorneys' fees to ReliaStar Life Insurance Co. of New York (ReliaStar) although the award did not state the specific basis for the award of fees.²³⁰ ReliaStar filed a petition to confirm the award in federal district court and EMC filed a counter-petition to vacate the award to the extent it awarded attorneys' fees.²³¹ The district court granted the petition to partially vacate the award of attorneys' fees on grounds that the applicable coinsurance contracts governing the dispute required each party to "bear the expense of its own arbitrator . . . and related outside attorneys' fees."²³² On appeal, the Second Circuit reversed and remanded with instructions to enter an order confirming the arbitration award in its entirety.²³³

The Second Circuit reviewed the standards for vacating an award under FAA § 10(a)(4). After recounting the general principles on which an award can be vacated,²³⁴ the court determined that the coinsurance contracts contained broad arbitration clauses that provide the arbitrators broad discretion to order such remedies they deem appropriate, including the right to award "sanctions, including attorney's fees" to effectively manage the arbitration.²³⁵ With respect to the provision in the coinsurance contracts that required each party to pay for its own arbitrator and legal expenses, the court reasoned that this was an expression of the general American Rule that each side bears the costs of its own attorneys "in the expected context of *good faith* dealings."²³⁶ However, since bad faith is an exception to the American Rule for attorneys' fees, a recitation of the American Rule in the coinsurance contracts was "insufficient by itself to swallow the exception."²³⁷ A detailed dissent by one of the three judge panel suggests that this case is not the last word on whether an arbitration panel's "inherent authority" overrides an express contract term that each party shall pay its own legal fees.²³⁸

228. *ReliaStar Life Ins. Co. of NY v. EMC Nat'l Life Co.*, 564 F.3d 81, 86 (2d Cir. 2009).

229. *Id.* at 87 (citing *Todd Shipyards Corp. v. Cunard Line, Ltd.*, 943 F.2d 1056, 1064 (9th Cir. 1991); *Marshall & Co. v. Duke*, 114 F.3d 188, 190 (11th Cir. 1997)).

230. *Id.* at 83–84.

231. *Id.* at 85.

232. *Id.*

233. *Id.* at 89.

234. *Id.* at 85–86 (citations omitted).

235. *Id.* at 87.

236. *Id.* at 88.

237. *Id.* at 88–89.

238. *Id.* at 89–95.

An award of attorneys' fees was confirmed in *Certain Underwriters at Lloyd's London v. Argonaut Insurance Co.* There, the federal court for the Northern District of Illinois confirmed an award of attorneys' fees awarded to reinsurers arising from the cedent's bad faith prior to and during the arbitration.²³⁹ In 2004, the cedent tendered a claim to the reinsurers, who requested an inspection of the claim file.²⁴⁰ The cedent served an arbitration demand but then missed the deadline for designating its party-appointed arbitrator, allowing the reinsurers to appoint a second arbitrator to the panel.²⁴¹ The cedent refused to proceed with the arbitration, insisting that Labor Day, a holiday in the United States but not in the United Kingdom where reinsurers were located, and the preceding Sunday should have been excluded from the thirty-day deadline.²⁴² In subsequent court proceedings, a district court ruled and the Seventh Circuit affirmed that the reinsurance contracts called for appointments within a thirty-day period. Since the contracts did not exclude holidays or weekends, the cedent's appointment was late.²⁴³ During the appeal, the cedent's request to stay the arbitration was denied. The cedent avoided an award of sanctions even though the district court described its arguments on the merits as weak.²⁴⁴

Following the ruling, the matter proceeded to arbitration with each party requesting attorneys' fees for the costs of litigating the panel-related issues.²⁴⁵ Reinsurers alleged "bad faith," including filing a frivolous motion in federal court and improper discovery designed to prolong the arbitration process.²⁴⁶ The panel agreed with reinsurers, awarding it "all reasonable legal fees incurred" for a three-year period "arising out of the disputes relating to this arbitration and the constitution of the Panel."²⁴⁷ On November 13, 2008, the cedent filed a petition to vacate the award in the district court, arguing that the panel exceeded its authority under FAA § 10(a)

239. 2009 WL 3126288, at *1-2 (N.D. Ill. Sept. 24, 2009). As the court indicates, earlier decisions in the case offer additional factual details. See *Certain Underwriters at Lloyd's London v. Argonaut Ins. Co.*, 444 F. Supp. 2d 909 (N.D. Ill. 2006), *aff'd* 500 F.3d 571 (7th Cir. 2007).

240. *Certain Underwriters at Lloyd's*, 2009 WL 3126288, at *1-2. Part of the purported reason for the cedent's failure to appoint its party-appointed arbitrator is an interesting lesson in the potential procedural pitfalls of international reinsurance arbitration: the U.S. cedent excluded Labor Day, a holiday in the United States but not in the U.K., from its calculation of the thirty-day appointment window. *Id.* at *2.

241. *Id.* at *1-2.

242. *Id.* at *2.

243. *Id.*

244. *Id.* at *2. See the district court decision for greater detail. *Certain Underwriters at Lloyd's London v. Argonaut Ins. Co.*, 2006 WL 3486882, at *5-6 (N.D. Ill. Nov. 29, 2006).

245. *Certain Underwriters at Lloyd's*, 2009 WL 3126288, at *2.

246. *Id.* at *2.

247. *Id.*

(4) because the award of fees to the Reinsurers conflicted with the court's earlier decision declining to award Rule 11 sanctions.²⁴⁸

The court rejected the cedent's argument, observing that arbitrators typically have broad authority and are afforded substantial deference under the FAA such that "[t]he scope of judicial review in this area is therefore so restrained, 'perhaps it ought not be called 'review' at all.'"²⁴⁹ The court noted the honorable engagement language in the arbitration clause, which granted the panel broad authority. The earlier decision denying the reinsurers' motion for Rule 11 sanctions did not amount to a judicial prohibition of the arbitrators awarding attorneys' fees or a limitation on the arbitrators' powers.²⁵⁰ For similar reasons, the court also rejected the cedent's res judicata argument, reasoning that a denial of Rule 11 sanctions is not tantamount to a final judgment on the merits necessary for claim preclusion purposes.²⁵¹ Accordingly, the court granted the reinsurers' petition to confirm the award of attorneys' fees.²⁵²

248. *Id.* at *3.

249. *Id.*

250. *Id.* at *4-5.

251. *Id.* at *7-8.

252. *Cf.*, *Global Reins. Corp. of Am. v. Argonaut Ins. Co.*, 634 F. Supp. 2d 342 (S.D.N.Y. 2009) (denying a retrocedent's motion for attorney fees absent statutory or contractual authority where the panel did not award fees and quoting *Amalgamated Clothing & Textile Workers Union v. Wal-Mart Stores, Inc.*, 54 F.3d 69, 71 (2d Cir. 1995)).