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

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This article provides an analysis of key legislative, regulatory, and case law developments within three distinct areas of insurance: excess insurance, surplus lines insurance, and reinsurance. It addresses developments from October 1, 2011, through September 30, 2012.

I. EXCESS INSURANCE

A. *Exhaustion*

Over the last year, courts have been very active in examining whether a policyholder may settle with an underlying insurer for an amount less than the settling insurer's policy limits and still preserve its rights to access the excess insurance. Significant cases are discussed below.

In *Citigroup Inc. v. Federal Insurance Co.*,[1] the Fifth Circuit examined this issue under Texas law. There, Citigroup had reached a settlement with its primary insurer, Lloyd's, for less than half of the policy limits and provided a release from coverage for the underlying liability claims.[2] Citigroup then commenced coverage litigation against its excess insurers, who maintained that the settlement for an amount less than the primary policy limits meant that the excess policies did not afford coverage for the liabilities.[3] The district court agreed, holding that Citigroup was not entitled to coverage under the excess policies.[4]

In affirming the district court, the Fifth Circuit examined the policy language in the excess policies and concluded that the excess policies alternatively required that the "full amount" of the underlying insurer's limits of liability be exhausted before coverage attaches, or that the "total" limit of liability be paid before coverage attaches.[5] The court explained, "we interpret the use of the phrase 'full amount' in the policy to mean that settlement for less than the underlying insurer's limits of liability does not trigger [the excess] coverage."[6] The court cited with approval the decisions in *Qualcomm, Inc. v. Certain Underwriters at Lloyd's, London*[7]

1. 649 F.3d 367 (5th Cir. 2011) (applying Texas law).
2. *Id.* at 370.
3. *Id.*
4. *Id.*
5. *Id.* at 372–73.
6. *Id.* at 372.
7. 73 Cal. Rptr. 3d 770, 778–79 (Ct. App. 2008).

and *Comerica v. Zurich American Insurance Co*.[8] In reaching this conclusion, the court rejected arguments that the excess insurance policies ambiguously defined "exhaustion," and that under *Zeig v. Massachusetts Bonding & Insurance Co*.,[9] the settlement with Lloyd's exhausted the primary insurance.[10]

Likewise, in *Intel Corp. v. American Guarantee & Liability Insurance Co*.,[11] the Delaware Supreme Court, applying California law, reviewed a trial court decision that an excess insurer had no duty to reimburse the policyholder for defense costs or indemnity claims in connection with Intel's defense of various antitrust lawsuits. The insurer claimed that the underlying insurance policy limits of $50 million were not exhausted as required by the excess policy. Intel argued that the excess policy allowed it to exhaust the limits of the underlying policy issued by XL Insurance Co. by adding Intel's own contributed payments for defense costs to the amount of Intel's settlement with XL.[12] The excess insurer maintained that its policy unambiguously requires the exhaustion of the XL policy by "payments of judgments or settlements," and that this language does not encompass Intel's own contributed payments for defense costs.[13] XL had refused to defend Intel in antitrust litigation, but ultimately paid Intel $27.5 million of its $50 million policy limits.[14] The Delaware Supreme Court held that "[t]he phrase 'payments of judgments or settlements' cannot be construed under California precedent to encompass an insured's own payment of defense costs."[15] Moreover, the court concluded, "California courts generally have construed the phrase [payments of judgments or settlements] to exclude cases where the insured 'credits' the underlying insurance carrier with the remaining policy limits. That is, courts have required the *actual* payment of the full underlying limits."[16]

Similarly, in *JP Morgan Chase & Co. v. Indian Harbor Insurance Co*.,[17] the New York Appellate Division, applying Illinois law, reviewed a trial court decision that several excess insurers were not obligated to afford coverage to its policyholder where the policyholder reached settlements with underlying insurers in which the underlying insurers did not admit

8. 498 F. Supp. 2d 1019 (E.D. Mich. 2007).
9. 23 F.2d 665 (2d Cir. 1928) (applying New York law).
10. *Citigroup*, 649 F.3d at 371–72.
11. 51 A.3d 442, 445 (Del. 2012).
12. *Id.*
13. *Id.* at 446.
14. *Id.* at 445.
15. *Id.* at 449.
16. *Id.* The court further noted that "[p]lain policy language on exhaustion, such as that contained in [the policy at issue], will control despite competing public policy concerns." *Id.* at 450 (citing with approval Qualcomm, Inc. v. Certain Underwriters at Lloyd's, London, 73 Cal. Rptr. 3d 770, 778–79 (Ct. App. 2008)).
17. 947 N.Y.S.2d 17 (App. Div. 2012).

liability and there was no way to determine that a settling underlying insurer paid the full amount of its policy. The excess policy language provided "that liability for any loss shall attach to [Twin City] only after the Primary and Underlying Excess Insurers shall have duly admitted liability and shall have paid the full amount of their respective liability."[18] The court observed that the underlying insurer's settlement stated that it did not constitute an admission of liability, and that certain of the settled claims were paid on behalf of an insurer's affiliated company without an allocation showing that the insurer paid the full amount of its policy.[19] Relying on *Great American Insurance Co. v. Bally Total Fitness Holding Corp.*,[20] as well as the *Citigroup* and *Qualcomm* cases discussed above, the court held that "the excess policies before the court unambiguously required the insured to collect the full limits of the underlying policies before resorting to excess insurance."[21] The court also distinguished the facts of the case from *Zeig*, the Second Circuit case that held to the contrary, explaining, "[h]ere, Twin City's attachment provision stands apart from the one before the court in *Zeig* because of its exacting requirement that the underlying carriers shall have admitted and paid the full amounts of their respective liabilities."[22] Agreeing with *Qualcomm*, the court concluded, "we reject the notion that 'when an insured settles with its primary insurer for an amount below the primary policy limits but absorbs the resulting gap between the settlement amount and the primary policy limit, primary coverage should be deemed exhausted and excess coverage triggered, obligating the excess insurer to provide coverage under its policy.'"[23]

Another issue that continues to be examined is whether the policyholder's insolvency, dissolution, or bankruptcy, and resulting inability to satisfy its obligations under the self-insured retention (SIR), constitutes a breach of the insurance contract. In *Gulf Underwriters Insurance Co. v. Burris*,[24] the Eighth Circuit, applying Wisconsin law, examined whether the named insured's dissolution after expiration of the policy meant that the policyholder could not meet its obligations under the SIR, and therefore materially breached the insurance contract. Gulf issued a CGL insurance policy to Versa Products, Inc., a ladder manufacturer and the named insured, which contained a $50,000 SIR.[25] After an injured claimant com-

18. *Id.* at 20.
19. *Id.* at 20–21.
20. No. 06-CIV-4554, 2010 WL 2542191 (N.D. Ill. 2010).
21. *JP Morgan Chase*, 947 N.Y.S.2d at 21.
22. *Id.* at 22.
23. *Id.* at 23.
24. 674 F.3d 999 (8th Cir. 2012) (applying Wisconsin law).
25. *Id.* at 1001.

menced an action against Versa, the company dissolved.[26] Gulf maintained that Versa breached its obligations under the policy because it was unable to meet its SIR.[27] The Eighth Circuit examined the policy language and concluded that "the policy's drafters did not intend the self-insured endorsement to affect Gulf's obligations under the policy to third party claimants."[28] In reaching this conclusion, the court reviewed Wisconsin's direct action statute and held "*if* the SIR unambiguously provided that non-compliance by the insured voided coverage of existing claims, we would conclude the SIR is void as a matter of public policy under Wisconsin law."[29] Notwithstanding the inability of the named insured to satisfy the SIR, the court held that "[i]f there is coverage, Gulf will be liable to [the injured claimant] for any amount above $50,000 within the policy limits, but Gulf may not be ordered to 'drop down' and pay Versa's self-insured portion of the judgment."[30]

Similarly, in *Rosciti v. Insurance Co. of the State of Pennsylvania*,[31] the First Circuit, applying Rhode Island law, examined whether a policyholder's bankruptcy and inability to satisfy its SIR meant that the excess policy had been breached and therefore did not afford coverage. Monaco, the named insured, manufactured motor homes.[32] The Insurance Company of the State of Pennsylvania (ICSOP) provided excess insurance above a $500,000 SIR.[33] Monaco went bankrupt after the claimants filed their lawsuit.[34] The claimants added ICSOP as a defendant, invoking a Rhode Island statute "allowing tort victims to recover damages directly from liability insurers of a bankrupt tortfeasor."[35] The court examined the interplay between the retained limit provision and the bankruptcy provision, concluding that the former provision stating that ICSOP was liable "only after there has been a complete expenditure of [Monaco's] retained limit" means that "ICSOP is still liable above the retained limit if Monaco is bankrupt, but only after Monaco exhausts the retained limit."[36]

26. *Id.*
27. *Id.* at 1002–03.
28. *Id.* at 1003.
29. *Id.* at 1005.
30. *Id.* at 1006. The court also observed that "[a]s Versa's self-insured obligation expressly included defense costs, there may be a question whether [the injured claimant] would be obligated to reimburse Gulf for any defense costs Gulf incurs. . . ." *Id.*
31. 659 F.3d 92 (1st Cir. 2011) (applying Rhode Island law).
32. *Id.* at 93.
33. *Id.*
34. *Id.*
35. *Id.*
36. *Id.* at 97.

Importantly, however, the court held that this did not end the inquiry, and that it was required to "consider whether this result is compatible with public policy."[37] The court went on to state the following:

> Rhode Island's public policy is to prevent insurance companies from avoiding their obligations when an insolvent insured cannot make an expenditure towards discharging liability. . . . In light of this public policy, we conclude that the Retained Limit Provision cannot be enforced here. To do so would have the ultimate effect of allowing ICSOP to avoid its obligations thanks to Monaco's bankruptcy, a result which is contrary to the public policy of Rhode Island.[38]

B. *Drop-Down*

A number of courts surveyed examined whether an umbrella or excess insurer was obligated to drop down and afford primary coverage when the underlying primary policy did not afford coverage, but the umbrella or excess policy did. In *National Fire & Marine Insurance Co. v. Certain Underwriters at Lloyd's London*,[39] the Washington Court of Appeals addressed whether an umbrella insurer had a duty to defend the insured in a construction defect suit. The court held that "certain claims in the underlying suit are *conceivably* covered under Liberty's umbrella policy and not covered by underlying primary policies, triggering Liberty's duty to defend."[40] Liberty maintained that "the trial court's determination that Lloyd's owed a duty to defend covered and uncovered claims because they were reasonably related means there was no lack of 'coverage' within the meaning of [Liberty's defense provisions] . . . and, thus, Liberty owed no duty to defend."[41] However, the court concluded that Liberty was required to participate in the defense along with the policyholder's primary insurers.[42]

In *Federal Insurance Co. v. Estate of Irving Gould*,[43] the Southern District of New York examined whether excess insurers are required to drop down

37. *Id.*

38. *Id.* at 98. Significantly, the court recognized the merit of the argument that "because Monaco is no longer able to pay claims within the self-insured layer, the [claimants] now have no incentive to settle their case for any amount less than $500,000," which increases the insurer's defense and settlement costs for the case; nevertheless the court found that this did not outweigh the strong policy considerations favoring the claimants. *Id.* at 100 n.8.

39. Nos. 66900-1-I, 66901-0-I, 2012 WL 2877664 (Wash. Ct. App. July 16, 2012).

40. *Id.* at *1, 7.

41. *Id.* at *7.

42. Likewise, in *Federal Insurance Co. v. Steadfast Insurance Co.*, the California Court of Appeal held that liability claims based on discrimination were covered under an umbrella policy but not under the primary policies. 209 Cal. App. 4th 668, 685 (2012).Therefore, the court concluded that the umbrella coverage "'dropped down' to fill the gap in the [primary policies] and provide primary coverage." *Id.*

43. No. 10 Civ. 1160, 2011 WL 4552381 (S.D.N.Y. Sept. 28, 2011).

and fill the gaps in coverage created by the insolvency of certain underlying insurers. The court concluded, "under New York law, 'an excess insurer is not required to drop down to provide coverage merely because the underlying primary insurer is insolvent.' "[44] The court noted that the excess policy language states that, in the event that the policyholders fail to maintain underlying insurance, the insurers "shall not be liable to a greater extent than if this condition had been complied with," and that "[t]his language expressly demonstrates that the coverage provided by the Excess Insurers will not be enlarged to compensate for gaps in underlying coverage."[45]

C. *Priority of Coverage*

A number of courts surveyed examined the issue of priority of coverage as between a true primary policy and a true excess policy, or the rights and obligations of the excess insurer in circumstances where the primary policy is not exhausted or the excess policy's attachment point is not reached.[46] In *Admiral Insurance Co. v. American Empire Surplus Lines Insurance Co.*,[47] a case involving a construction-related bodily injury claim, the New York Appellate Division followed the general rule that primary insurance policies must respond with indemnity before true excess poli-

44. *Id.* at *4.

45. *Id.* at *5.

46. In *Preferred Construction, Inc. v. Illinois National Insurance Co.*, for example, the Second Circuit, applying New York law, addressed whether an excess insurer had a duty to defend a third-party complaint against its named insured where the primary insurance policy limits were not exhausted. No. 11-4339-cv, 2012 WL 3735056 (2d Cir. Aug. 30, 2012). Nova Casualty Company issued a primary CGL policy, and Illinois National Insurance Company issued an umbrella policy to Preferred Construction. An employee of Preferred Construction fell from a roof at a cemetery owned by the Diocese of Rockville Centre. He filed suit against the owners, who qualified as additional insureds under the Nova primary policy. Defendant-owners then filed a third-party action against Preferred Construction, presumably on the basis of a written indemnity agreement between the owners and that company, limited to amounts recovered excess of the primary policy limits of Preferred Construction. Nova, the primary insurer, then tendered the defense and indemnity of the third-party complaint to Illinois National, the excess insurer, who declined to accept the tender. The court held the excess insurer had no duty to defend because the language of the Illinois National policy "is clear that the underlying primary insurance must be exhausted before the excess policy will provide a defense," and there is no dispute that the Nova policy is not yet exhausted. *Id.* at *3. The court observed that the fact that the third-party complaint seeks indemnification only for "any recovery that plaintiff may obtain in excess of the primary policy limits" does not change this result, holding, "[r]equiring Illinois National to defend in these circumstances would effectively permit any claim of excess damages to preemptively trigger the excess insurer's duty to defend—regardless of when (or whether) the limits of the primary policy are exhausted. Such a result would appear to eviscerate the general rule that the excess insurer 'may elect to participate in an insured's defense to protect its interest, [but] . . . has no obligation to do so.' " *Id.* at *3 (quoting Fieldston Prop. Owners Ass'n, Inc. v. Hermitage Ins. Co., Inc., 945 N.E.2d 1013 (N.Y. 2011)).

47. 947 N.Y.S.2d 442, 444 (App. Div. 2012).

cies, and then the excess insurers contribute pro rata.[48] American Empire Surplus Lines Insurance Company (AEI) issued primary insurance policies to the injured worker's employer and the contractor who retained the employer. AEI's combined per occurrence limits of liability were $2 million.[49] The contractor who retained the employer was the only direct defendant and was entitled to $1 million of primary coverage as an additional insured under the policy issued to the employer, as well as $1 million of primary coverage as a named insured under its own policy.[50] The case settled for $2.3 million, of which AEI paid $1,433,333 and Admiral Insurance Company, the contractor's umbrella insurer, paid $866,667, while reserving all of its rights.[51] The court held that, the contractor's status as an additional insured under the policies issued to the employer having been established:

> it follows that AEI should have contributed to the $2.3 million settlement (to which AEI was a party) $2 million, the sum of the applicable limits under the primary policies AEI issued to [the employer] and [the contractor]. Hence, Admiral, as an excess insurer, is entitled to equitable contribution from AEI in the amount of the difference between $2 million and $1,433,333 (the amount AEI actually contributed), which is $566,667. In addition, Admiral is entitled to recover half of the remaining $300,000 from Scottsdale pursuant to [the contractor's] additional insured coverage under the excess policy Scottsdale issued to [the employer].[52]

In doing so, the court held that the "other insurance" clauses were "substantially identical" and "cancel each other out, with the result that the two excess insurers must share ratably the cost of the settlement in excess of the available primary coverage."[53]

48. *Id.* at 447. *See also* Bovis Lend Lease LMB, Inc. v. Great Am. Ins. Co., 855 N.Y.S.2d 459 (App. Div. 2008).

49. *Admiral Ins.*, 947 N.Y.S.2d at 447.

50. *Id.*

51. *Id.* at 444.

52. *Id.* at 447.

53. *Id.* Similarly, in *United States Fidelity & Guaranty Co. v. Coastal Refining & Marketing, Inc.*, the Texas Court of Appeals examined conflicting "other insurance" clauses in excess policies. 369 S.W.3d 559 (Tex. App. 2012). The court observed that "[i]n each of these clauses, the insurer attempts to make the policy excess to any other policy in which it is not identified as underlying insurance." *Id.* at 567. Coastal Refining & Marketing Inc. hired Weaver Industrial Service, Inc. to maintain Coastal's equipment. Weaver agreed to name Coastal as an additional insured on its policies. There was an explosion on Coastal's property in which one of Weaver's employees was injured. A dispute developed between the parties' excess insurers, with each maintaining that the other's coverage came first. Coastal, as an additional insured, argued that Weaver's excess policy had to respond before Coastal's own excess policy. Coastal supported this argument by reference to a trade contract in which Weaver agreed to provide primary coverage to Coastal. The court, however, concluded that "[n]one of the insurers were parties to the agreement between Weaver and Coastal, and while the service agreement may provide context, we cannot read it as varying

D. *Justiciability*

In *Century Indemnity Co. v. Marine Group, LLC*,[54] the District of Oregon examined whether policyholders' claims against excess insurers for liability for pollution of the Portland Harbor Superfund Site were justiciable. The policyholders were named as potentially responsible parties by the U.S. Environmental Protection Agency (EPA) in an action under the Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA) for environmental damage at the Portland Harbor Superfund Site.[55] The EPA estimated the amount of damages related to the action as exceeding $1 billion, not inclusive of costs of investigation and natural resource damages, which the policyholders asserted could equal remediation costs.[56] The policyholders commenced an action for breach of contract and declaratory judgment against several of their excess insurers, whose excess policies attached at $20.5 million.[57] The court held that the policyholders' breach of contract claims were premature as against the excess insurers because the underlying policies had not been exhausted.[58] There was, however, a justiciable case or controversy to support the declaratory judgment claims.[59] Specifically, "[i]n light of the enormity of the potential liability at issue, and the relative smallness of the triggering coverage amount, the court concludes that it is substantially likely that the excess policies will be triggered and the claims asserted present a genuine case or controversy with respect to Excess Insurers."[60]

E. *Late Notice*

In *MHM Services, Inc. v. Assurance Co. of America*,[61] the Illinois Appellate Court examined whether an excess/umbrella insurer was obligated to afford coverage where it received late notice of a claim or suit. The excess/umbrella policy at issue required "notice of *every* claim or suit 'as soon as practicable' regardless of the amount of potential liability or

or contradicting the policies' terms." *Id.* at 568. Coastal also argued that its excess policies were excess to Weaver's excess policy because they were "more specific." The court concluded, however, that that particular argument had already been considered and rejected by the Texas Supreme Court. *Id.* at 568 (citing Hardware Dealers Mut. Fire Ins. Co. v. Farmers Ins. Exch., 444 S.W.2d 583 (Tex. 1969)). Accordingly, the court held that "the other insurance clauses of the [various] excess policies are mutually repugnant" and "coverage under these circumstances is prorated." *Id.* at 569. The excess insurers contributed to the settlement pro rata by limits. *Id.* at 569–70.

54. 848 F. Supp. 2d 1229 (D. Or. 2012).
55. *Id.* at 1232.
56. *Id.* at 1232–33.
57. *Id.* at 1231, 1233.
58. *Id.* at 1234.
59. *Id.* at 1237.
60. *Id.*
61. 975 N.E.2d 1139 (Ill. App. Ct. 2012).

whether [the insured] had reason to believe the Assurance excess policy might be implicated."[62] The court went on to observe that "[t]he notice terms in the Assurance excess policy starkly contrast with excess policies which actually give the insured discretion as to when to notify the insurer."[63] The court then examined the following factors in evaluating whether the insured's excuse for not providing earlier notice was valid:

> (1) the specific language of the policy's notice provision; (2) the insured's sophistication in commerce and insurance matters; (3) the insured's awareness of an event that may trigger insurance coverage; (4) the insured's diligence and reasonable care in ascertaining whether policy coverage is available; and (5) whether the insured's delay caused prejudice to the insurer.[64]

The court concluded that the insured's "late notice was inexcusable and that its breach of the notice clause defeats any right to recovery under the policy."[65]

II. SURPLUS LINES INSURANCE

A. *Nonadmitted and Reinsurance Reform Act*

The Nonadmitted and Reinsurance Reform Act[66] section of the Consumer Protection Act evidences Congress's intent that the states adopt nationwide uniform requirements, forms, and procedures in the regulation of insurance.[67] With respect to surplus lines insurance, the agreed-upon provisions streamline regulation of surplus lines insurance covering risks in multiple states. They also specify that only the insurance regulator of the insured's home state will have the authority to regulate the eligibility standards and premium tax allocation for the particular policy.[68] According to the National Association of Mutual Insurance Companies, the changes to the nonadmitted insurance regulatory system are believed to result in making nonadmitted risk coverage simpler and more affordable for consumers.[69]

62. *Id.* at 1157.
63. *Id.*
64. *Id.* at 1153–54.
65. *Id.* at 1163.
66. *See* Nonadmitted and Reinsurance Reform Act, Pub. L. No. 111-203, §§ 511–542, 124 Stat. 1589 (2010) (codified at 15 U.S.C. §§ 8201–8232).
67. *See* Dodd-Frank Wall Street Reform and Consumer Protection Act, Pub. L. No. 111-203, 124 Stat. 1376 (2010).
68. *Surplus Lines Reform Approved by House/Senate Conferees*, EDWARDS ANGELL PALMER & DODGE, LLP (June 25, 2010, 12:45 PM), http://www.insurereinsure.com.
69. Matt Brady, *House Passes Dodd-Frank Financial Reform Legislation*, INSURANCENEWS NET, (July 1, 2010), http://insurancenewsnet.com/article.aspx?id=204180&type=lifehealth.

1. Overview of the Reform Act

Under the new regulations, the placement of nonadmitted insurance is subject only to the requirements of the insured's home state.[70] Similarly, no state other than the insured's home state may impose licensing requirements on surplus lines brokers who sell, solicit, or negotiate surplus lines policies with respect to such insured.[71] Any current laws, regulations, provisions, or actions of a state that apply to nonadmitted insurance sold to, solicited by, or negotiated with an insured whose home state is another state shall be preempted.[72]

Additionally, a state will only be able to impose eligibility requirements on U.S. nonadmitted insurers in conformance with §§ 5A(2) and 5C(2)(a) of the National Association of Insurance Commissioner (NAIC)'s Non-Admitted Insurance Model Act, if the state has adopted nationwide uniform requirements, forms, and procedures.[73] Any state eligibility requirements that are more stringent than those in the listed sections of the Model Act will be preempted. States will also be prohibited from refusing to allow a surplus lines broker from placing insurance with an insurer domiciled outside of the United States (alien) that is listed on the NAIC Quarterly Listing of Alien Insurers.[74] Further, the Reform Act will preempt states' due diligence requirements for surplus lines agents placing nonadmitted insurance for an exempt commercial purchaser, provided certain conditions are met.[75]

Consistent with case law leading up to the Reform Act, only the home state of an insured will be allowed to assess a premium tax for placement of nonadmitted insurance.[76] All other states not considered the home state but covered in the risk would be preempted from collecting premium taxes.[77]

2. Potential Constitutional Challenges to the Reform Act

The enactment of the Reform Act will result in the preemption of several states' surplus lines legislation. Relying on the nondelegation doctrine,

70. 15 U.S.C. § 8201.
71. *Id.*
72. *Id.*
73. *Id.*
74. *Id.* § 8204(2).
75. *Id.* § 8205.
76. *Id.* § 8201(a).
77. *Id.* § 8201. To facilitate the payment of premium taxes among the states, the home state may require surplus lines brokers and insureds who have independently procured insurance to file tax allocation reports detailing the portion of the surplus lines premium attributable to each state. *Id.* Additionally, in order to allocate the premium taxes paid to the home state to the other states covered by the nonadmitted insurance policy, the states may enter into a compact or otherwise establish procedures to allocate the taxes paid for fair distribution and for the avoidance of forum shopping. *Id.*

critics argue that delegation of the authority to administer governmental functions to the NAIC would create an unconstitutional system.[78] Notwithstanding the preemption of existing legislation, however, for several reasons, the Reform Act is consistent with the McCarran-Ferguson Act and leading case law interpreting a state's ability to regulate and tax insurance transactions that have little nexus with the state. For example, although the Reform Act's creation of the Federal Insurance Office (FIO) may at first glance seem to restrict the McCarran-Ferguson Act's mandate that states regulate insurance,[79] the Reform Act essentially only creates the FIO to focus on gathering information on insurance and to deal with international insurance issues, leaving the regulation of domestic insurance to the states.[80]

B. *SLIMPACT*

The Surplus Lines Insurance Multi-State Compliance Compact (SLIMPACT or the Compact)[81] is an interstate compact[82] designed to implement the provisions of the Reform Act related to the regulation of nonadmitted insurance by the insured's home state, the premium tax of nonadmitted insurance, and the eligibility requirements of nonadmitted insurers.[83] It was drafted with input from numerous insurance professionals representing state regulators, legislators, stamping offices, brokers, and trade associations,[84] and is presently being considered by at least

78. Sandra Tvarian Stevens, *House Unanimously Passes the Nonadmitted Insurance and Reinsurance Reform Act*, WILEY REIN LLP (Sept. 29, 2006), http://www.wileyrein.com/publications.cfm?sp=articles&id=2405&newsletter=14.

79. McCarran-Ferguson Act, 15 U.S.C §§ 1011–1015. *See also* Granholm v. Hearld, 544 U.S. 460, 483 (2005).

80. 31 U.S.C. § 313 (2012) (defining scope of authority of Federal Insurance Office). *See also* Baird Webel, *Insurance and Financial Regulatory Reform in the 111th Congress*, PENNY HILL PRESS (June 25, 2010), *available at* http://www2.pennyhill.com/?tag=h-r-4173.

81. See Tex. H.B. 1535, 82nd Leg., R.S. § 1.01 (2011), which proposes to add Chapter 981A, containing the Surplus Lines Insurance Multi-State Compliance Compact (the "Compact") at § 981A.002, to the Texas Insurance Code.

82. Interstate compacts are contracts between two or more states creating an agreement on a particular policy issue, adopting a certain standard, or cooperating on regional or national matters. *See* Nat'l Ctr. for Interstate Compacts, *10 Frequently Asked Questions*, at Question 1, KNOWLEDGE CTR., COUNCIL OF STATE GOV'TS, http://www.csg.org/knowledgecenter/docs/ncic/CompactFAQ.pdf (last visited Mar. 9, 2011).

83. Specifically, the Compact aims to, among other things, (i) protect premium tax revenues of the states that have enacted SLIMPACT legislation and have not withdrawn or been terminated pursuant to the Compact (Compacting States), (ii) streamline the regulatory requirements applicable to the surplus lines market, (iii) provide for single-state regulatory compliance, and (iv) establish a clearinghouse (Clearinghouse) for the receipt and dissemination of premium tax and other data applicable to nonadmitted insurance transactions. *See* Compact art. I, § 1.

84. *Surplus Lines Insurance Multistate Compliance Compact (SLIMPACT) Executive Summary*, NAT'L ASS'N OF PROF'L SURPLUS LINES OFFICES (2011), http://www.napslo.org/imispublic/PDF/Legreg/SLIMPACT_ExSum92807.pdf (last visited Mar. 10, 2011).

twelve state legislatures.[85] Once operational, the Compact will allow each member state to collect taxes on nonadmitted risks located in such states and will reduce the regulatory burdens imposed on surplus lines agents when placing insurance on multistate risks.

The provisions of the Reform Act authorizing the states to enter a compact regarding the allocation of premium taxes and the development of uniform eligibility requirements constitute congressional consent of SLIMPACT.[86] Where Congress consents to an interstate compact that regulates a subject matter that is appropriate for congressional legislation, the compact becomes federal law.[87] Because SLIMPACT regulates surplus lines insurance, which Congress may regulate as part of interstate commerce,[88] the above provisions give SLIMPACT the status of federal law.

The Compact will become effective upon the legislative enactment of two compacting states.[89] However, the Surplus Lines Insurance Multi-State Compliance Compact Commission will not become effective for the purposes of adopting the mandatory rules and creating a clearinghouse for the receipt and dissemination of premium tax until there are a total of ten compacting states and other states that have entered into contracts with the Commission to utilize the services of and participate in the clearinghouse (contracting states).[90] Alternatively, the Commission will become effective for this purpose when the compacting states and contracting states represent greater than forty percent of the total surplus lines insurance premium volume.[91] The Compact and the Commission's rules will then become effective for each subsequent member state upon the legislative enactment by such state.[92]

85. *See* Press Release, Nat'l Conference of Ins. Legislators, NCOIL to Congress: SLIMPACT Answers NRRA, Needs More Time (Mar. 6, 2011) (reporting that "SLIMPACT is moving in Alabama, Connecticut, Indiana, Kansas, Kentucky, Maryland, New Mexico, North Dakota, Rhode Island, Tennessee, Texas, and Vermont, and is being drafted in New York").

86. *See* Cuyler v. Adams, 449 U.S. 433, 441 (1981) ("Congress may consent to an interstate compact by authorizing joint state action in advance. . . .").

87. *Id.* at 440; Wash. Metro. Area Transit Auth. v. One Parcel of Land in Montgomery Cnty., Md., 706 F.2d 1312, 1317 (4th Cir. 1983).

88. United States v. Se. Underwriters Ass'n, 322 U.S. 533, 553 (1944). It is not clear whether congressional consent was required for SLIMPACT given the delegation to the states to regulate the business of insurance in the McCarran-Ferguson Act, 15 U.S.C. §§ 1011–1105 (1945). Regardless, the McCarran-Ferguson Act did not strip Congress of its authority to directly regulate the business of insurance. Thus, it is a matter for which congressional legislation is appropriate. *See* 15 U.S.C. § 1012 ("No 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.").

89. Compact art. XIII, § 2.

90. *Id.*

91. *Id.*

92. *Id.*

Once effective, the Compact remains in force and binding on each compacting state, unless and until a state withdraws. A state withdraws by enacting a statute specifically repealing the original enacting statute, or being terminated by the Commission for defaulting on its obligations or responsibilities under the Compact.[93] The Compact dissolves upon the withdrawal or termination of the compacting state that reduces the membership in the Compact to one compacting state.[94]

At present only nine states have joined SLIMPACT: Alabama, Indiana, Kansas, Kentucky, New Mexico, North Dakota, Rhode Island, Tennessee, and Vermont.[95] As a result SLIMPACT has not yet taken effect.

III. REINSURANCE

A. *Regulatory Developments*

The NAIC passed a number of amendments to the Credit for Reinsurance Model Law and Regulation (Model Law and Regulation) on November 6, 2011.[96] The amendments reduce the reinsurance collateral requirements for certain non-U.S. reinsurers.[97] Prior to the amendments, the Model Law and Regulation only allowed U.S. ceding companies to receive full credit for reinsurance ceded to non-U.S. licensed reinsurers if the liabilities were one hundred percent collateralized.[98] Under the new amendments, a state may certify a non-U.S. reinsurer and assign it a rating that corresponds to an acceptable level of collateral based upon that rating.[99] The new collateral requirements range from zero percent collateralization for the highest-rated reinsurers to one hundred percent collateralization for the lowest-rated reinsurers.[100]

Under the amendments, the insurance commissioner has the authority to certify a reinsurer or recognize the certification issued by another NAIC-accredited jurisdiction.[101] In order to be eligible for certification,

93. *Id.* art. XIV, §§ 1(a), 2(a). Reinstatement following withdrawal or termination of any Compacting State shall occur upon the effective date of the state's reenactment of the Compact. *Id.* art. XIV, §§ 1(f), 2(c).

94. *Id.* art. XIV, §3(a).

95. The Texas comptroller is believed to have authority from 2007 legislation to enter into the compact but, to date, has not elected to do so.

96. CREDIT FOR REINSURANCE MODEL LAW 785 (Nat'l Ass'n of Ins. Comm'rs 2011); CREDIT FOR REINSURANCE MODEL REGULATION 786 (Nat'l Ass'n of Ins. Comm'rs 2011).

97. News Release, Nat'l Ass'n of Ins. Comm'rs, NAIC Adopts Revisions to Reinsurance Models (Nov. 7, 2011), *available at* http://www.naic.org/Releases/2011_docs/naic_adopts_revisions_to_reinsurance_models.htm.

98. *Id.*

99. CREDIT FOR REINSURANCE MODEL LAW § 2(E); CREDIT FOR REINSURANCE MODEL REGULATION § 8.

100. CREDIT FOR REINSURANCE MODEL REGULATION § 8(A)(1).

101. CREDIT FOR REINSURANCE MODEL LAW § 2(E)(6).

the reinsurer must meet several requirements.[102] Critically, the reinsurer must be domiciled and licensed to transact insurance or reinsurance in a qualified jurisdiction.[103] The insurance commissioner must create and publish a list of qualified jurisdictions, taking into consideration a number of factors, including the effectiveness of the reinsurance supervisory system of the jurisdiction and the reciprocal recognition afforded by the non-U.S. jurisdiction to U.S. reinsurers.[104] To be qualified, jurisdictions must also adequately and promptly enforce final U.S. judgments and arbitration awards.[105]

In addition to the jurisdictional requirement for certification, the reinsurer must (1) maintain financial strength ratings from two or more rating agencies deemed acceptable by the insurance commissioner and a minimum amount of capital and surplus or its equivalent, (2) agree to submit to the jurisdiction of the state, and (3) meet various filing requirements.[106]

Under the amendments, each certified reinsurer is assigned a rating by the insurance commissioner.[107] In assigning ratings, the commissioner must consider the financial strength ratings that have been assigned by nationally recognized statistical rating agencies, including Standard & Poor's, Moody's Investors Service, Fitch Ratings, and A.M. Best Company.[108] Other rating factors include, but are not limited to, the business practices of the reinsurer, the reputation of the reinsurer for prompt payment of claims under reinsurance agreements, regulatory action against the reinsurer, and independent auditor reports.[109] Ratings range from Secure-1 to Vulnerable-6 with corresponding collateralization requirements ranging from zero percent collateralization to one hundred percent collateralization.[110]

The NAIC is not a legislative or regulatory body. Review, adoption, and implementation of the amended NAIC Credit for Reinsurance Model Law and Regulation may take several years. Given the widespread acceptance of NAIC model rules and regulations, it is likely that most states will move to a reduction in collateral requirements for non-U.S. reinsurers, as recommended by the NAIC.

102. *Id.* § 2(E)(1).
103. *Id.* § 2(E)(1)(a).
104. *Id.* § 2(E)(3).
105. *Id.*
106. *Id.* § 2(E)(1)(a)–(f).
107. *Id.* § 2(E)(4).
108. *Id.*; Credit for Reinsurance Model Regulation 786, § 8(B)(4) (Nat'l Ass'n of Ins. Comm'rs 2011).
109. Credit for Reinsurance Model Regulation § 8(B)(4).
110. *Id.* § 8(A)(1).

B. *Case Law Developments*

The last year saw a number of significant case decisions addressing issues impacting the reinsurance industry, including the follow-the-fortunes doctrine and other important contract provisions; the duties of reinsurance intermediaries; discoverability of information by and from reinsurers; and review of arbitration awards. Key decisions are discussed below.

1. Discovery

Discovery disputes involving reinsurance continued to proliferate over the last year. Discovery issues arose both in the context of direct disputes between a reinsurer and cedent and in underlying coverage disputes where reinsurance information was sought.

In *Granite State Insurance Co. v. Clearwater Insurance Co.*, the Southern District of New York denied the cedent's motion to set aside an order compelling it to produce documents concerning its reserving practices.[111] The court concluded that the documents sought were relevant to the reinsurer's affirmative defense that the cedent acted in bad faith by failing to employ adequate procedures to give the reinsurer timely notice.[112] Specifically, the court rejected the cedent's argument that the relevant issue for determining bad faith is whether there were formal procedures in place, and not whether those procedures were adequate or reasonable.[113] It concluded that, even if the cedent had procedures in place, such discovery would be relevant to the action whether those procedures ensured that the reinsurer actually received notice of losses.[114]

In *Travelers Casualty and Surety Co. v. Century Indemnity Co.*, the U.S. District Court for the District of Connecticut addressed cross-motions to compel discovery.[115] In considering the parties' competing demands for discovery, the court observed, "the first step [in the discovery process] should focus on discovery into [the cedent's] evaluation of its losses with regard to a single loss presentation of claims on the reinsurance treaty."[116] Applying this narrow view of discovery, the court denied the reinsurer's request for documents relating to the underlying coverage disputes but granted its request for documentation evaluated or relied on by the cedent

111. No. 09 Civ. 10607, 2012 WL 1520851, at *1 (S.D.N.Y. Apr. 30, 2012).
112. *Id.* at *2.
113. *Id.* at *3.
114. *Id.* The court also noted that such discovery was alternatively permissible under the broad scope of Federal Rule of Civil Procedure 26(b)(1) because "a discovery motion is not the proper forum for deciding the merits of a defense." *Id.* The court concluded that the cedent's objections to the discovery went to the merits of the affirmative defense, not the permissibility of the discovery request. *Id.* As a result, the cedent was required to produce reports and analyses regarding its reserve procedures. *Id.*
115. No. 3:10 CV 400, 2011 WL 5570784 (D. Conn. Nov. 16, 2012).
116. *Id.* at *1.

in reaching its decision regarding the reinsurance presentation.[117] In doing so, the court declined to find a blanket contractual right to privileged materials under the access-to-records clause in the parties' treaty.[118] It also found that the common interest doctrine did not mandate production of privileged information under the circumstances of that case. The cedent retained counsel wholly independent of the reinsurer, the reinsurer had no input into the relationship between the cedent and its counsel, and the parties were clearly adverse to one another.[119]

Discovery of reinsurance information by policyholders also continues to be a perennial issue for courts. Not surprisingly, the most notable decisions are those in which courts have found reinsurance information to be discoverable. In *Fireman's Fund Insurance Co. v. Great American Insurance Co. of New York*, the U.S. District Court for the Southern District of New York was asked to decide whether a policyholder was entitled to information contained in the files of its insurers' reinsurer.[120] The documents sought to be discovered included communications relating to the cedent's procurement of the reinsurance contract and claims made to the reinsurer for the loss at issue.[121] The cedent objected to the discovery on the grounds of relevance and privilege, claiming that the common interest doctrine protected its communications with its reinsurers from disclosure.[122] On the issue of relevancy, the court noted that case law in the Second Circuit concerning the discoverability of reinsurance information was sparse but that "the few cases to consider the issue have determined that reinsurance information is indeed discoverable" where a cedent's positions in the coverage action put its communications with its reinsurers at issue.[123] Finding that the cedent's cross-claim for fraud against its insured put such communications at issue, the court found the requested documents were relevant.[124]

As to the claim of privilege over documents in the possession of its reinsurer, the court noted that the common interest doctrine is not an independent source of privilege, but only applies to avoid waiver of a privilege

117. *Id.*
118. *Id.* at *2.
119. *Id.* Finally, with respect to the discoverability of other reinsurance information, the court denied the reinsurer's request for communications with other reinsurers but granted the cedent's motion asking the reinsurer to produce documents regarding its reinsurance of other companies that insured the underlying insured for asbestos liability. *Id.* at *4. The court referenced the reinsurer's affirmative defenses in support of this decision but did not otherwise explain the ruling on relevance or the distinction between the two requests. *Id.*
120. 284 F.R.D. 132 (S.D.N.Y. 2012).
121. *Id.* at 134–35.
122. *Id.* at 136.
123. *Id.* at 137.
124. *Id.*

that would otherwise attach to documents disclosed to the reinsurer.[125] After examining the nature of the relationship between the cedent and reinsurer and the specific circumstances under which the particular documents in question were disclosed, the court declined to find that the cedent and its reinsurer shared a common legal interest that entitled the cedent to withhold documents produced to its reinsurer where those documents were relevant to claims the insurer had made against its insured.[126]

2. Follow-the-Fortunes Doctrine

Decisions addressing the follow-the-fortunes doctrine also continued to surface over the past year. In *United States Fidelity & Guaranty Co. v. American Re-Insurance Co.*, the Supreme Court of New York upheld the lower court's grant of summary judgment in favor of the cedent on the grounds that the reinsurers' obligations to follow the fortunes required them to accept the presentation.[127] The court considered whether the follow-the-fortunes doctrine precluded the reinsurer from denying a cedent's presentation in light of various objections it had to the form and substance of the presentation. The various objections included the following: (1) that the settlement reached by the cedent with its insured included uncovered payments for bad faith; (2) that the cedent improperly allocated the loss to a single policy year; (3) that the cedent altered the loss presentation from an accident to occurrence basis; and (4) that the cedent improperly valued the claims in question.[128]

In reaching its decision, the court acknowledged that the reinsurance treaty contained a follow-the-fortunes clause, which required the reinsurers to bear the risks that the direct insurer bore under the underlying policy.[129] Therefore, the reinsurers were obligated to reimburse the cedent's good faith payment as long as it was at least arguably within the scope of the insurance coverage that was reinsured.[130] Applying this standard, the court reasoned that the lower court correctly determined that the follow-the-fortunes doctrine required the reinsurers to accept the reinsurance presentation made by the cedent.[131] The court, however, also noted that even if it were to consider the reinsurers' arguments on the merits, those arguments did not excuse the reinsurers from their obligation to pay their share of losses ceded under the treaty.[132]

125. *Id.* at 139–40.
126. *Id.* at 140–41.
127. 93 A.D.3d 14, 23 (N.Y. App. Div. 2012).
128. *Id.* at 24.
129. *Id.* at 22–23.
130. *Id.* at 23.
131. *Id.* at 23–24.
132. *Id.* at 24.

In *Ace Property & Casualty Insurance Co. v. R & Q Reinsurance Co.*, the Common Pleas Court of Pennsylvania applied the follow-the-fortunes doctrine to interpret undefined terms in multiple "excess of loss" reinsurance certificates consistent with the terms of the underlying policies.[133] The legal issue in *Ace Property* centered upon the interpretation of "loss" and "expenses," which were undefined terms in the certificates of facultative reinsurance.[134] The parties disputed whether coverage for both indemnity as well as expenses was included within these terms.[135] The court reasoned that the meaning of these terms within the underlying policies would govern the resolution of this dispute because (1) the reinsurer had access to and knowledge about the terms of the underlying policies and (2) the facultative certificates at issue were excess of loss, and therefore the reinsurer's liability followed that of the ceding company in the underlying insurance policies for which reinsurance was purchased.[136] The court then determined that "loss," as used within the underlying policy, could include both indemnity and expense.[137] In this manner, the court held that the reinsurer was bound to the meaning of undefined terms within the excess of loss treaty as they were defined in the underlying policies.[138]

3. Broker Duties

In a key decision involving the duties of intermediaries, the California Court of Appeal examined the sufficiency of the allegations in support of a cedent's claim that a reinsurance broker breached its fiduciary duty. In *Workmen's Auto Insurance Co. v. Guy Carpenter & Co., Inc.*, the court upheld a lower court's summary judgment in favor of the reinsurance intermediary on the claim that it breached its fiduciary duty to the cedent by failing to obtain the best terms for reinsurance.[139] The court concluded the cedent's response to the broker's special interrogatory, which sought all facts relating to its allegation that the intermediary did not secure the best available terms of coverage, was factually lacking, and demonstrated that the cedent could not establish every element of its claims.[140] Because the cedent could not produce the requisite evidence to establish

133. No. 02290, 2012 Phila. Ct. Com. Pl. LEXIS 128, at *6 (Pa. D. & C. 4th, May 15, 2012).
134. *Id.* at *3.
135. *Id.*
136. *Id.* at *4–5.
137. *Id.* at *5.
138. *Id.* at *6.
139. No. B211660, 2012 WL 681202, at *1 (Cal. Ct. App. Mar. 1, 2012).
140. *Id.* at *2.

every element of its claim, the court concluded summary judgment was appropriate.[141]

Notably, in reaching its decision, the court further acknowledged that even if the cedent had produced sufficient evidence to satisfy a breach of fiduciary duty claim generally, it was unclear whether a fiduciary relationship exists between an insurance broker and an insured under California law.[142] After examining California case law, the court concluded:

> [t]he bottom line is that while these authorities do not close the door on fiduciary duty claims against insurance brokers, they cast doubt on the nature and extent of those claims. In our view, however, a fiduciary duty cause of action against an insurance broker very well might pass muster in an appropriate case.[143]

4. Contract Interpretation: Exclusionary Clauses and Notice Requirements

The last year also saw several notable decisions addressing interpretation of exclusionary clauses and notice provisions in reinsurance contracts.

In *Munich Reinsurance America Inc. v. Tower Insurance Co. of New York*, the New Jersey District Court addressed the issue of which party bears the burden of establishing the extent of a reinsurer's obligation to indemnify its reinsured when the parties' agreement, in its grant of coverage, excludes coverage under certain circumstances.[144] At issue was a reinsuring clause in the retrocessional agreement that provided that the reinsurer would indemnify the cedent for one hundred percent of the loss cession "unless" the underlying claims arose in one of two defined situations, in which case the duty to indemnify was reduced.[145] The cedent argued that the two defined situations were exclusionary in nature, and thus the reinsurer bore the burden of demonstrating that either criterion applied.[146] In contrast, the reinsurer took the position that the cedent had the burden of proving the propriety of the reinsurance presentation because the definitional language at issue was part of the coverage grant.[147]

In rejecting the reinsurer's argument, the court stated, "[e]xclusions do not shed their essential character when they are moved from one section of a policy and are crafted as part of that policy's grant of coverage."[148] Rather, the "focus [is] on 'the effect or character of [a] phrase,' and

141. *Id.* at *3–4.
142. *Id.* at *5.
143. *Id.* at *6.
144. No. 09-CV-2598, 2012 WL 2917576 (D.N.J. July 17, 2012).
145. *Id.* at *2.
146. *Id.* at *3.
147. *Id.*
148. *Id.* at *4 (quoting Carter-Wallace, Inc. v. Admiral Ins. Co., 712 A.2d 1116, 1126 (N.J. 1998)).

where the language behaves like 'an exclusion of the coverage grant by the very operation of its terms,' the insurer should bear the burden of proving that phrase's application."[149] The court noted that allowing an insurer (or, in this case, a retrocessionaire) "to distribute provisions limiting liability throughout a policy, with the expectation that its shouldering of the burden of proof would be limited to the single section entitled 'Exclusions' . . . would create considerable incentive to obfuscation and subterfuge."[150] The court concluded that the definitional criteria at issue were clear and unambiguous and that they had "an exclusionary effect."[151] As such, the court held that the reinsurer had the burden of proving that either criterion applied to the reinsurance presentation made by the cedent.[152]

In *Pacific Employers Insurance Co. v. Global Reinsurance Corp. of America*, the Third Circuit, applying New York law, held that a reinsurer need not prove prejudice as a result of late notice to deny coverage to a reinsured.[153] The court concluded that the reinsured, which was required to provide a definitive statement of loss, must promptly provide such notice after a claim or occurrence is reported to it under the excess insurance policy, not after the reinsured demanded indemnity from the reinsurer.[154] Furthermore, the court noted that the obligation to provide notice was stated as a condition precedent to the reinsurer's duty to make indemnity payments relating to the underlying claim or occurrence, and not merely its duty to make such payments promptly.[155]

5. Developments in Arbitration

Reinsurance disputes are typically resolved through confidential arbitration proceedings. Courts are hesitant to disturb these arbitration awards; however, pursuant to the Federal Arbitration Act, dissatisfied litigants have found some limited success in challenges based on "evident partiality" of one or more of the arbitrators.[156]

Despite this potential vulnerability, the Second Circuit recently made clear that challenges based on alleged "evident partiality" face a very high bar.[157] In *Scandinavian Reinsurance Co. Ltd. v. St. Paul Fire & Marine Insur-*

149. *Id.*
150. *Id.* (quoting Andover Newton Theological Sch., Inc. v. Cont'l Cas. Co., 964 F.2d 1237 (1st Cir. 1992)).
151. *Id.*
152. *Id.* at *5.
153. 693 F.3d 417, 432 (3d Cir. 2012).
154. *Id.* at 439.
155. *Id.* at 432.
156. 9 U.S.C. § 10(a)(2) (2012).
157. Scandinavian Reins. Co. Ltd. v. St. Paul Fire & Marine Ins. Co., 668 F.3d 60 (2d Cir. 2012).

ance Co., the Second Circuit reversed and remanded the federal district court's order vacating an arbitration award on the basis of evident partiality.[158] During an arbitration between Scandinavian Reinsurance and St. Paul Fire & Marine Insurance Company, the umpire and one of the party-appointed arbitrators were simultaneously serving as panel members in another arbitration proceeding involving similar issues and a witness common to both proceedings.[159] The umpire and party arbitrator failed to disclose the concurrent arbitration.[160] The district court held that the simultaneous service and the failure to disclose that service constituted evident partiality and, therefore, vacated the arbitration award.[161]

The Second Circuit reversed.[162] The court first articulated the strong deference due arbitration awards and the arbitration process.[163] It explained that challenges to arbitration awards are strongly disfavored and review of awards should be severely limited to promote the goals of arbitration.[164] Failure to disclose a relationship is not sufficient to justify vacatur without additional evidence of bias, such as a family connection or an ongoing business arrangement with a party or its law firm.[165] Because the relationship between the party arbitrator and the umpire in the concurrent arbitration did not significantly tend to establish partiality, the Second Circuit concluded that the nondisclosure of that relationship did not warrant a finding of evident partiality.[166]

158. *Id.* at 78–79.
159. *Id.* at 68.
160. *Id.*
161. *Id.* at 70–71.
162. *Id.* at 79.
163. *Id.* at 71.
164. *Id.* at 71–72.
165. *Id.* at 72–73.
166. *Id.* at 78.