Committee News

Winter 2013

Excess, Surplus Lines And Reinsurance Committee

SETTLEMENTS WITH UNDERLYING INSURANCE AND FORFEITURE OF EXCESS INSURANCE: TO PROMOTE SETTLEMENT OR ENFORCE THE PARTIES' INTENT

By: Michael A. Kotula, Partner, *Rivkin Radler LLP*

Disputes between policyholders and excess insurers have greatly increased over the consequence of policyholder settlements with underlying insurers for an amount less than the full underlying insurance policy limits. Policyholders have urged that they may make such settlements and still access their excess insurance, provided the excess insurers are not called upon to pay more than they otherwise would have if the underlying insurer had paid its full policy limits. In contrast, excess insurers have maintained that a policyholder's sub-policy limit settlement with an underlying insurer forfeits any available excess insurance when the excess insurance policies so provide, even if the policyholder is prepared to pay the remaining underlying limits out of its own pocket before accessing the excess policies. Often, the language of the exhaustion clause in the excess policy is controlling. As explained below, some jurisdictions value promotion of settlement more than enforcing the exhaustion clause language in excess policies, while other jurisdictions enforce such clauses regardless of how it may affect settlement.

This is an issue that should concern not just policyholders, who risk forfeiting excess coverage, and excess insurers, who may have a defense of lack of exhaustion of underlying insurance to an otherwise covered claim that may bar coverage. It also affects primary, umbrella or excess insurers, who may be unable to settle a claim for an amount less than their full policy limits and obtain a coverage discount with

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IN THIS ISSUE:

Chair

Leah Margaret Quadrino
Steptoe & Johnson LLP
1330 Connecticut Ave NW,
Washington, DC 20036-1795
(202) 429-8012
Fax: (202) 429-3902
lquadrino@steptoe.com

Chair-Elect

Michael Kotula
Rivkin Radler LLP
926 Rxr Plz
Uniondale, NY 11556-3823
(516) 357-3066
Fax: (516) 357-3333
michael.kotula@rivkin.com

Council Representative

Robert P Redemann
Perrine Redemann Berry Taylor & Sloan
1437 S Boulder Ave, Ste 620
Tulsa, OK 74119-3621
(918) 382-1400
Fax: (918) 382-1499
rredemann@pmrlaw.net

Last Retiring Chair

Richard Charles Mason
Cozen O'Connor
1900 Market St
Philadelphia, PA 19103-3572
(215) 665-2717
Fax: (215) 665-2013
rmason@cozen.com

Law Student Vice-Chair

Shelton L Marshall
1408 Summer Wind Dr
Winter Park, FL 32792-5227
sheltonmarshall@hotmail.com

Membership Vice-Chair

Michael Kotula
Rivkin Radler LLP
926 Rxr Plz
Uniondale, NY 11556-3823
(516) 357-3066
Fax: (516) 357-3333
michael.kotula@rivkin.com

Scope Liaison

Juanita B Luis
175 County Road B2 E, Apt 201
Saint Paul, MN 55117-1513
(952) 979-5711
Fax: (952) 979-7810
nita_b_luis@uhc.com

Technology Vice-Chair

Larry P Schiffer
Patton Boggs LLP
1185 Avenue of The Americas, Fl 30
New York, NY 10036-2603
(646) 557-5194
Fax:
lschiffer@pattonboggs.com

Vice-Chairs

Christopher Robert Bello
General Re Corporation
PO Box 10350
Stamford, CT 06904-2350
(203) 328-6002
Fax: (203) 328-5877
cbello@genre.com

Chad Bigalke
chad.bigalke@securian.com

Thomas Bell Caswell III
Zelle Hofmann Voelbel & Mason LLP
500 Washington Ave S, Ste 4000
Minneapolis, MN 55415-1152
(612) 336-9150
Fax: (612) 336-9100
tcaswell@zelle.com

Leslie J Davis
General Re Corporation
120 Long Ridge Rd
Stamford, CT 06902-1839
(203) 328-5583
Fax: (203) 328-5587
leslie.davis@genre.com

Sarah D Gordon
Steptoe & Johnson LLP
1330 Connecticut Ave NW
Washington, DC 20036-1795
(202) 429-8005

Michelle Andrea Jones
Crowell & Moring LLP
1001 Pennsylvania Ave NW, Fl 11
Washington, DC 20004-2595
(202) 624-2571
Fax: (202) 628-5116
mjones@crowell.com

James P Koelzer
Robins Kaplan Miller & Ciresi
2049 Century Park E, Ste 3400
Los Angeles, CA 90067-3208
(310) 229-5443
Fax: (310) 229-5800
jpkoelzer@rkmc.com

Reka Susan Koerner
32 Jefferson Rd
Scarsdale, NY 10583-6436
(914) 828-8661
reka_koerner@swissre.com

John D Labarbera
Cozen O'Connor
333 W Wacker Dr, Ste 19
Chicago, IL 60606-1220
(312) 382-3111
Fax: (312) 706-9756
jlabarbera@cozen.com

Dennis G Lagory
Schiff Hardin LLP
233 S Wacker Dr, Ste 6600
Chicago, IL 60606-6307
(312) 258-5772
Fax: (312) 258-5600
dlagory@schiffhardin.com

John Dennis Madea
3416 Westhampton Way
Gainesville, GA 30506-1066
(678) 795-4047
Fax: (866) 635-5688
dennis.madea@acegroup.com

Anthony J Mormino
Swiss Re America Holding Corporation
475 N Martingale Rd
Schaumburg, IL 60173-2405
(847) 273-1345
anthony_mormino@swissre.com

William C O'Neill
Crowell & Moring LLP
1001 Pennsylvania Ave NW
Washington, DC 20004-2595
(301) 540-3802
Fax: (202) 628-5116
woneill@crowell.com

Stephen Wayne Schwab
DLA Piper
203 N La Salle St, Ste 1900
Chicago, IL 60601-1263
(312) 368-2150
Fax: (312) 630-7343
stephen.schwab@dlapiper.com

Deborah Ann Stalker
Aceina holdings Inc
436 Walnut St, Fl 4
Philadelphia, PA 19106-3703
(215) 640-5257
Fax: (215) 640-5070
deborah.stalker@ace-ina.com

Vice-Chairs (cont.)

Michael J Steinlage
Larson King LLP
30 7th St E, Ste 2800
Saint Paul, MN 55101-4904
(651) 312-6520
Fax: (651) 312-6618
msteinlage@larsonking.com

Wesley Sunu
Tribler Orpett & Meyer PC
225 W Washington St, Ste 1300
Chicago, IL 60606-3408
(312) 201-6400
Fax: (312) 201-6401
hwsunu@tribler.com

Mary Cannon Veed
Arnstein & Lehr LLP
120 S Riverside Plz, Ste 1200
Chicago, IL 60606-3910
(312) 876-7850
Fax: (312) 876-6237
mcveed@arnstein.com

Maxine H Verne
Scor Reinsurance Company
199 Water St, Fl 21
New York, NY 10038-3530
(212) 884-9074
Fax: (212) 480-1329
mverne@scor.com

Vice-Chair (Newsletter)

Michael Kotula
Rivkin Radler LLP
926 Rxr Plz
Uniondale, NY 11556-3823
(516) 357-3066
Fax: (516) 357-3333
michael.kotula@rivkin.com

LETTER FROM THE CHAIR

Dear Committee Members,

Welcome to the Winter 2013 Newsletter. The Excess, Surplus Lines and Reinsurance Committee looks forward to an upcoming year marked with increased programming, publishing, and public service opportunities for our members. Our committee represents a diverse group of attorneys practicing in highly specialized areas of insurance, and we are committed to providing educational opportunities and resources that are relevant to our members' unique interests. We count among our members both plaintiff and defense-side lawyers, and in-house and outside counsel, representing all levels of insurers – from cedents to retrocessionaires. The diversity within our specialties enhances the quality of programs we can offer by providing insight and experiences from these different perspectives.

In the coming year, we have a variety of events planned and are delighted to be partnering with several other TIPS Committees in those endeavors. I look forward to welcoming you at one of the below events planned thus far:

Upcoming Programs

Save the Date!
The National ADR Forum – April 24, 2013, Washington, DC

Key Note Speaker: Kenneth Feinberg

Our flagship event for 2013 is a full-day CLE program, co-sponsored with the Alternative Dispute Resolution Committee, addressing innovations and recent developments in ADR practices and procedures. The event will officially "kick off" the Spring Leadership Meeting, which starts the following day in Washington, DC. We are building multiple panels of former judges, arbitrators, mediators, academics, in-house lawyers and outside counsel to provide their insight and experiences on a wide range of topics, including mediating high-profile disputes, reining in the costs of discovery, and balancing competing interests and their ethical implications in multi-party ADR proceedings. More information and registration details can be found by clicking here. We hope to see you there!

Webinar on Cybersecurity – Late Spring 2013

TIPS is continuing its highly successful webinar series, launched in 2011, addressing a wide range of disaster preparedness topics. ESLR plans to co-sponsor a webinar on cybersecurity issues and related legislation with the Corporate Counsel Committee and the Insurance Coverage Litigation Committee. More details to come soon!

Public Service Projects

The Law in Public Service Committee (LIPS) sponsors hands-on, community service projects at each of our TIPS meetings. These projects always provide great opportunities to give back to the cities hosting our conferences while enjoying the company of our TIPS colleagues in a less formal setting. ESLR recently co-sponsored the LIPS project during the Midyear meeting in Dallas, and plans to co-sponsor the upcoming LIPS project during the Spring meeting in Washington, DC. We hope you will join us!

Midyear Meeting February 2013 – Dallas, TX

Along with our colleagues from LIPS and the Automobile Law Committee, ESLR co-sponsored the

public service project held during the Midyear Meeting in Dallas. The project supported the Tarrant Area Food Bank, which services 13 counties in the Fort Worth area. In this region, one in four children resides in a food-insecure household. Both food and cash donations were accepted at the meeting.

Spring Meeting April 2013 – Washington, DC

ESLR will also be co-sponsoring a public service project with LIPS during the Spring Meeting. The project details are still in their planning stages, but will likely involve mentoring youth about the legal profession.

Interested in getting involved?

Our committee is only as strong as our members are involved. In addition to joining us at the above activities, there are many other ways to get involved in ESLR:

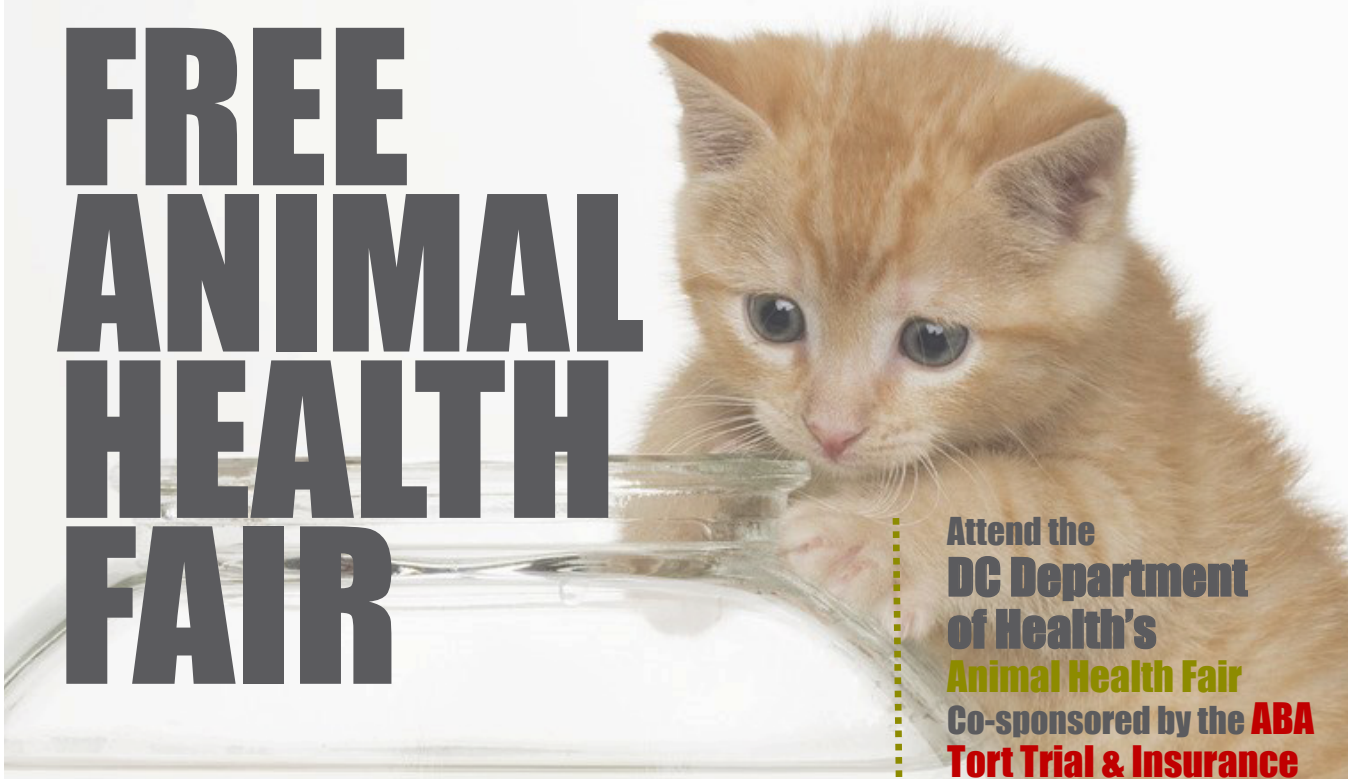
- Join our online community on Linked In and start a discussion on recent legal developments that impact our diverse practice areas.
- Contact us about submitting articles or case notes for our Newsletter.
- Generate new programming ideas! Let us know your ideas for webinars or CLE programs that you would like to see addressed at upcoming conferences.

I hope to see you all at an ESLR event in 2013 and look forward to working with you. ⚖⚖

Sincerely,

Leah M. Quadrino
Chair, ESLR Committee

FREE ANIMAL HEALTH FAIR



Attend the
DC Department of Health's
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Co-sponsored by the **ABA Tort Trial & Insurance Practice Section.**

WHEN
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EVENTS INCLUDE:
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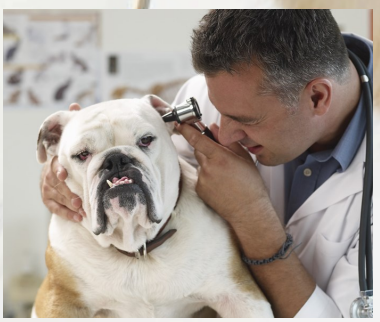
- Learn About Emergency Preparedness
- Learn About Animal Laws
- Ask the Veterinarian



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EXCESS CASE NOTES

Second Circuit Holds That London Form Condition C: "Prior Insurance and Non-Cumulation of Liability" Renders Excess Insurer Liable For Property Damage Occurring After The Policy Period Subject To The Non-Cumulation Limitation

In another chapter of the long running *Olin* environmental property damage case, the Second Circuit, applying New York law, addressed the issue of allocation of liability under certain excess liability policies and the construction of the London form's Condition C, titled "Prior Insurance and Non-Cumulation of Liability. The Court held that Condition C obligated the following form excess insurer to indemnify the policyholder up to the limits of its policies for all property damage that occurred during and after the termination of each policy period, and enforced the non-cumulation provision to limit the number of policies responding.

At issue were Olin Corp.'s claims for insurance coverage for environmental contamination at a California manufacturing site under two excess liability policies issued by American Home Assurance Co., with an attachment point of $30.3 million, for the years 1966-69 and 1969-72. American Home had successfully argued in the Southern District of New York that its excess policies' attachment point could not be reached, where total damages of $102 million were to be allocated over a 31-year trigger period, under New York's pro rata allocation rules, for a per-year damage figure of $3.3 million.

The Second Circuit reversed, however, concluding that the normal pro rata allocation approach was modified by the fact the American Home excess policies followed form to underlying policies issued by Underwriters at Lloyd's, that contained a Condition C: "Prior Insurance and Non-Cumulation of Liability." The Court noted that Condition C has two parts: a prior insurance provision; and a continuing coverage provision. The primary issue was the effect of the continuing coverage provision, which stated in relevant part "in the event that personal injury or property damage arising out of an occurrence covered hereunder is continuing at the time of termination of this Policy, Underwriters will continue to protect the Assured for Liability in respect of such personal injury or property damage without payment of additional premium."

The Court held that, where the requirements of Condition C were met, "American Home thereby could be obligated to indemnify Olin up to the limits of its policies for all property damage caused by the perchlorate plume that occurred during and after the termination of each policy." The Court noted that "[s]ince there is not yet any basis for attributing greater or lesser damage to individual years, we follow the district court in allocating $3.3 million of damage to each year between 1957 and 1987." The Court concluded, "[t]he 1966-69 policy is thus exposed to twenty-two years of damage, a total of $72.6 million" and "[t]he 1969-72 policy is exposed to nineteen years of damage, a total of $62.7 million." Accordingly, the Court ruled that "[b]ecause each of these figures exceeds the $30.3 million attachment point, summary judgment was inappropriate."

Addressing the effect of the prior insurance provision, or non-cumulation of liability clause, of Condition C, the Second Circuit explained "the prior insurance provision reduces American Home's liability only to the extent that a prior insurance policy at the same level of coverage, here $30.3 million, indemnifies for a loss that is also covered by an American Home policy." The Court reasoned that "[t]his accords with Condition C's apparent purpose of sweeping a continuing loss into the earliest triggered policy, with that policy then fully indemnifying the insured for that loss."

Summary of Olin Corp. v. American Home Assur. Co., 704 F.3d 89 (2d Cir. 2012). Submitted by Michael A. Kotula, Rivkin Radler LLP, Uniondale, NY, (516) 357-3000, michael.kotula@rivkin.com.

First Circuit Affirms Allocation Of Environmental Property Damage Costs On Pro Rata Basis Over 121-Year Period

Following the Supreme Judicial Court of Massachusetts' answer to certified questions of law in Boston Gas Co. v. Century Indem. Co., 454 Mass. 337, 910 N.E.2d 290 (Mass. 2009), the First Circuit upheld allocation of environmental clean-up costs over a 121-year trigger period.

The federal district court in Massachusetts held that the policyholder, Boston Gas, was judicially estopped from contradicting its prior statements that contamination was continuous, and allocated damages evenly across the 121-year span. This had the effect of reducing Century Indemnity's share of damages from 100 percent to less than 15 percent.

Prior to the Massachusetts high court's adoption of the pro rata allocation rule, the district court had followed intermediate appellate court decisions in Massachusetts in ruling that Century Indemnity was obligated to pay "all sums." However, upon issuance of the state high court decision, Century Indemnity successfully moved for judgment on the issue of allocation, citing the policyholder's judicial admissions that "the groundwater contamination had been occurring continuously from the time that the MGP was operative through the time of remediation."

Affirming, the First Circuit concluded "[n]o plausible interpretation of the evidence presented at trial would permit a jury to pinpoint damages in time and degree with any level of certainty; indeed, Boston Gas's own expert expressly conceded at trial that he could not determine how much property damage occurred during any given period."

Upholding application of the equitable doctrine of judicial estoppel, the Court explained it "prevents a litigant from pressing a claim that is inconsistent with a position taken by that litigant either in a prior legal proceeding or in an earlier phase of the same legal proceeding." The Court found that two conditions had to be satisfied for judicial estoppel to attach, namely that the estopping position and the estopped position must be directly inconsistent or mutually exclusive, and the responsible party must have succeeded in persuading a court to accept its prior position. The Court held that the policyholder advanced and prevailed at trial on a theory of continuous contamination over a 121-year period and was judicially estopped from taking a different position.

Summary of Boston Gas Co. v. Century Indem. Co., No. 11-1931, 2013 WL 203578 (1st Cir. Jan. 18, 2013). Submitted by Michael A. Kotula, Rivkin Radler LLP, Uniondale, NY, (516) 357-3000, michael.kotula@rivkin.com.

Wisconsin Appellate Court Holds That Policyholder's Notice Of Environmental Contamination To Excess Insurer Was Late And Prejudicial

The Wisconsin Court of Appeals affirmed a trial court's award of summary judgment in favor of an excess insurer that the policyholder's notice of environmental contamination was untimely and prejudicial where the policyholder delayed providing notice for many years and various forms of prejudice to the insurer were unrebutted.

The Court noted that the policyholder caused groundwater contamination at a manufacturing site from the 1950s to 1977, and that state and federal environmental authorities became involved in the early 1970s, ordered the policyholder in 1981 to construct a groundwater treatment system at a cost of over $11 million and, in 1990, the U.S. E.P.A. determined that significant quantities of arsenic remained and ordered that it be further remediated. Notwithstanding this history, the policyholder first notified its excess insurer, Certain Underwriters at Lloyd's & London Market Insurance Cos., of the contamination and government ordered remediation in 1997 by commencing a declaratory judgment action against it.

The excess insurer issued nine excess liability policies with different policy periods and attachment points ranging from $250,000 to $16 million. The Court observed that, in 1990, the policyholder was advised by its brokers not to give notice of the environmental issues because the insurers would likely deny liability and increase premiums. However, as early as 1991, the policyholder began notifying other of its insurers, but not Lloyd's, that it may be liable for investigation and clean-up.

Lloyd's excess policies contained a "notice of occurrence" condition, providing "[w]henever the Assured has information from which they may reasonably conclude that an occurrence covered hereunder involves injuries or damages which, in the event that the Assured shall be held liable, is likely to involve this Policy, notice shall be sent … as soon as practicable …."

First, the Court held that the foregoing notice was untimely, explaining "[i]t is undisputed that, as of 1991, [the policyholder] had spent in excess of $11 million on site investigation and remediation and had established a $5 million reserve to fund future cleanup expenses, which it estimated at 'somewhere between $8 million and $15 million.' Thus, by 1991 at the latest, [the policyholder] should have known its liabilities for the contamination … was likely to reach the $16 million attachment point for [one of the excess policies]." The Court concluded "[n]onetheless, it waited six years to notify Lloyd's of the claim, well after its other insurers had been notified," which "constitutes unreasonable delay."

Next, the Court explained that, under Wisconsin late notice law, "when notice is given more than one year after the time required by the policy, there is a rebuttable presumption of prejudice and the burden of proof shifts to the claimant to prove that the insurer was not prejudiced

by untimely notice." On this issue, the Court held that the policyholder failed to carry its burden, where it had to concede that "some documents, including pre-1990 board minutes, have been lost to time" and "[i]t is likely that, given the length of the delay, witnesses are either unavailable or would not be able to recall the content of those documents or details of the pertinent events." Accordingly, the Court found prejudice as a matter of law.

Summary of Ansul, Inc. v. Employers Ins. Co. of Wausau, 825 N.W.2d 110 (Wis. Ct. App. 2012). Submitted by Michael A. Kotula, Rivkin Radler LLP, Uniondale, NY, (516) 357-3000, michael.kotula@rivkin.com.

Federal Court In Oklahoma Awards Summary Judgment To Insurer On Alleged Missing Excess Policies And Upheld A Daubert Challenge To The Policyholder's Expert Witness's Testimony

The federal district court for the Northern District of Oklahoma held that a putative policyholder's claims for coverage under alleged lost excess policies were insufficient as a matter of law. The Court first examined the putative policyholder's expert witness's basis for opining as to the terms and conditions of alleged lost umbrella policies in connection with a *Daubert* challenge by the umbrella carrier. Next, the Court, having stricken the expert report of Robert Hughes, awarded summary judgment to the alleged umbrella carrier on the basis that the evidence of the terms and conditions of the policies was insufficient as a matter of law.

Specifically, the Court found that the putative policyholder's expert's "methodology in determining the terms and conditions of the alleged policies is not based on facts which would enable him to express a reasonably accurate conclusion as required by *Daubert* and its progeny." The Court concluded that "[t]his dearth of facts creates an unacceptable analytical gap between the evidence considered by Hughes and his ultimate conclusion, connected only by the *ipse dixit* of Hughes himself."

The Court proceeded to consider the alleged umbrella carrier's motion for summary judgment on lost policy issues. The Court held that, under Oklahoma law, a party claiming under an insurance contract bears the burden of proving coverage. The Court recognized that "[t]he question of coverage goes beyond proof of the existence of a policy, on summary judgment an insured must necessarily offer evidence that raises a material question of fact as to whether coverage was available under the specific terms and conditions of a purported policy."

In holding that the evidence of the lost policies was insufficient as a matter of law, the Court explained that the putative insured "may be able to demonstrate the existence of the missing policies and even some of the coverage terms, but the bulk of the conditions of coverage remain unknown and even unknowable." As the Court concluded, "[w]hat [the putative policyholder] cannot present, however, is anything beyond bald speculation as to the actual policy terms defining the alleged coverage."

Summary of Canal Ins. Co. v. Montello, Inc., Case No. 10-CV-411, 2012 WL 4891699 (N.D. Okla. Oct. 15, 2012). Submitted by Michael A. Kotula, Rivkin Radler LLP, Uniondale, NY, (516) 357-3000, michael.kotula@rivkin.com.

Illinois Appellate Court Holds That Excess Insurer Cannot Owe Duty To Defend Under Targeted Tender Rule, Due To De-Selection Of Other Insurance Or On An "All Sums" Theory

The Illinois Appellate Court addressed a party's attempt, in an auto liability case, by targeted tender and otherwise, to deselect her own primary auto coverage in favor of an ambulance service's business auto policy. Under Illinois law, there was no question that the driver's own policy afforded primary coverage and the ambulance service's policy afforded excess coverage. Nevertheless, the driver attempted to require the excess coverage to defend instead of her own primary coverage, relying on a number of different inappropriate theories.

First, the driver's insurer attempted to rely on Illinois' targeted tender rule, which generally permits an insured, where multiple policies each afford primary coverage, to choose the policy that is to afford it a defense. The Court held that the driver's "targeted tender was invalid and ineffective because the principle of horizontal exhaustion does not allow an insured to target tender to an excess insurer." In fact, "an insured cannot target tender a defense to his excess insurer while primary coverage remains unexhausted."

The Court also held that the driver could also not target tender her defense where she "did not pay a premium for or bargain for coverage under the [ambulance service's] policy." Specifically, the Court observed that "an insured does not have a paramount right to deselect its own insurer in favor of another where the insured is not named as an insured or additional insured on the

selected policy and did not pay a premium for or bargain for coverage under the selected policy."

Finally, the driver's insurer also attempted to rely on the Illinois Supreme Court's "all sums" decision in *Raymark* to argue that, where two or more policies have been triggered, and the language of the policies provides that the insurers are obligated to pay "all sums" and defend "any suit," each carrier is independently responsible to the mutual insured for the full cost of the defense. However, the Court concluded "*Raymark* involved only primary carriers that were each independently obligated to provide a full defense and indemnity, up to the limits of the policy, to Raymark. The case at bar does not involve two *primary* insurance policies, but one primary policy and one excess policy." Accordingly, the Court held that the excess insurer had no obligation to defend or indemnify the driver until the limits of the primary policy are exhausted.

Summary of Vedder v. Continental Western Ins. Co., 978 N.E.2d 1111 (Ill. Ct. App. 2012). Submitted by Michael A. Kotula, Rivkin Radler LLP, Uniondale, NY, (516) 357-3000, michael.kotula@rivkin.com.

California Court of Appeal Determines Priority Of Coverage Between Driver's Own Insurance and Employer's Insurance

The California Court of Appeal was asked to determine the priority of coverage in an auto liability case between the driver's own personal auto insurance, a primary and umbrella policy covering an employee while driving his own car in connection with business for his employer, and a primary and umbrella policy only covering the driver's employer. There was no dispute that, under *Insurance Code § 11580.9(d)*, the driver's own personal auto insurance was primary. Rather, the question was how to prioritize the two primary policies and umbrella policies affording coverage for non-owned autos and coverage only for the employer.

The Court held that the Insurance Code provision only provided that a driver's personal auto insurance shall be primary to any other insurance, and that it did not answer the question of how to prioritize the other insurance policies that were not purchased by the driver as personal insurance. To answer that question, the Court drew a distinction between policies, whether primary or umbrella, covering the negligent driver, and policies covering the employer, who was only vicariously liable. Accordingly, the Court held that the primary and umbrella policies covering the driver were primary to the primary and umbrella policies covering only the employer, stating "it is based upon principles of vicarious liability, not more general rules governing primary and excess policies."

Summary of GuideOne Mut. Ins. Co. v. Utica Nat'l Ins. Group, Case No. D059833, 2013 WL 765651 (Cal. Ct. App. Feb. 28, 2013). Submitted by Michael A. Kotula, Rivkin Radler LLP, Uniondale, NY, (516) 357-3000, michael.kotula@rivkin.com.

Federal Court in Pennsylvania Rejects Claim That Excess Insurer Is Estopped From Raising Defenses To Coverage Because It Did Not Reserve Its Rights

The federal district court for the Middle District of Pennsylvania addressed a dispute in which a policyholder claimed that an excess insurer was estopped from raising defenses to coverage because it did not timely reserve its rights. Specifically, the policyholder argued that by failing to reserve rights, the excess insurer induced it to believe that the excess insurer would cover the claims after exhaustion of the first $60 million in coverage. In response, the excess insurer argued that, as an excess insurer, it has no duty to defend its insured and thus cannot later be estopped from raising coverage defenses if it fails to reserve its rights when notified of a claim or suit potentially implicating coverage.

The Court observed that no Pennsylvania case law answered the question presented. Relying on out-of-state case law, the Court held that "[i]t is the duty to defend that gives rise to the duty to reserve rights when defense of a claim is undertaken, and without such a duty an insurer has no obligation to issue a reservation of rights letter. An excess insurer that has no duty to investigate coverage issues or to defend its insured will not be estopped from later asserting coverage defenses by a failure to issue a reservation of rights letter."

Further, the Court recognized that, "under Pennsylvania law, 'an insurer's duty to defend is purely contractual, and an insurer has no duty to defend unless the obligation is expressed in the policy.'" Because the excess insurer at issue "has no contractual duty to defend …, it is under no obligation to issue a reservation of rights letter … and 'will not be estopped from later asserting coverage defenses' for failing to do so."

Summary of TIG Ins. Co. v. Tyco Int'l Ltd., C.A. No. 3:08-CV-1584, 2013 WL 249973 (M.D. Pa. Jan. 23, 2013). Submitted by Michael A. Kotula, Rivkin Radler LLP, Uniondale, NY, (516) 357-3000, michael.kotula@rivkin.com.

REINSURANCE CASE NOTES

New York Court of Appeals Denies Summary Judgment on Follow-the-Settlements Case

In a closely watched asbestos settlement allocation case, the New York Court of Appeals has modified the order of the intermediate appellate court to deny summary judgment to the cedent based on two issues of fact raised to challenge the reasonableness of the cedent's settlement allocation. The court affirmed the judgment rejecting the other defenses to payment raised by the reinsurers.

This case involved asbestos claims arising out of policies issued in the 1950s and 1960s to a distributor of asbestos products. The underlying policies were also not "occurrence" based policies, but were the old form of "per accident" policies with no aggregate limits. The case is further complicated by corporate acquisitions in the 1960s, which led to questions about whether the cedent's policies covered the successor company. Those and other issues were litigated in California, including whether the successor corporation succeeded to the insurance issued by the cedent to the original insured.

Meanwhile, claims came pouring in, resulting in default judgments after the cedent and other insurers refused to defend and the insured agreed not to oppose the entry of default judgments. In the coverage litigation, the insured had alleged that the cedent's refusal to defend breached the implied covenant of good faith and fair dealing. The coverage suit settled while trial was in progress and resulted in the insured's filing for bankruptcy and the creation of an asbestos trust.

After the settlement, the cedent billed the excess-of-loss reinsurers who refused to pay. The motion court granted summary judgment to the cedent and the appellate division affirmed with one judge dissenting. This appeal ensued.

In modifying the appellate division's order, the Court of Appeals presented a detailed analysis of the rules governing reinsurance allocation in the context of follow-the-settlements under New York law. It is important to note that the reinsurance contracts here had a following clause binding the reinsurer to pay claims allowed by the cedent. The court's analysis was premised on the follow-the-settlements clause.

The court articulated the well-established rule that a follow-the-settlements clause (like the one here) ordinarily bars challenge by a reinsurer to the ceding company's decision to settle a case. That rule, said the court, makes sense because there is little risk of unfairness as the parties are typically aligned to pay as low a settlement amount as possible. In this case, the few exceptions to that rule did not apply because the reinsurers did not challenge the cedent's decision to settle or the amount of the settlement. Here, the dispute was about the settlement allocation to the reinsurers.

In discussing the reinsurance allocation, the court accepted that the follow-the-settlements rule raises problems because the interest of the cedent and the reinsurer may often conflict. The court concluded that was the case here, where an allocation of the settlement to losses less than $100,000 would result in no reinsurance recovery, but allocation to losses of $200,000 would result in the reinsurers paying half the cost. Because of this, the reinsurers argued that the cedent's allocation decision should not bind reinsurers under a follow-the-settlements clause.

While finding logic to the reinsurers' argument, the Court of Appeals nevertheless agreed with the majority of courts and held that a follow-the-settlements clause requires a level of deference to a cedent's allocation decision. The rationale for this deference was described by the court as providing for a more orderly and predictable resolution of claims. But the court made it clear that deference did not mean that the cedent's allocation decisions were immune from scrutiny.

The decision still had to be in good faith and reasonable. The court stated that "[i]n our view, objective reasonableness should ordinarily determine the validity of an allocation. Reasonableness does not imply disregard of the cedent's own interests. Cedents are not the fiduciaries of reinsurers, and are not required to put the interests of reinsurers ahead of their own." The court held that a cedent's allocation "must be one that the parties to the settlement of the underlying insurance claims might reasonably have arrived at in arm's length negotiations if the reinsurance did not exist."

The court concluded that the cedent's motive "should generally be unimportant. When several reasonable allocations are possible, the law, as several courts have recognized, permits a cedent to choose the one most favorable to itself." But, said the court, "the choice must be a reasonable one, and we also conclude that reasonableness cannot be established merely by showing that the cedent's allocation for reinsurance purposes is the same as the allocation that the cedent and the insurance claimants actually adopted in settling

the underlying insurance claims." The court rejected the cedent's argument that if the allocation is the same as the underlying settlement it establishes the validity of the allocation. Instead, the court held that under a follow-the-settlements clause (like the one here), a cedent's reinsurance allocation of a settlement will be binding on a reinsurer if, "but only if, it is a reasonable allocation, and consistency with the allocation used in settling the underlying claim does not by itself establish reasonableness."

In denying summary judgment, the Court of Appeals concluded that the reasonableness of the assumptions used in the allocation, that (1) all of the settlement amount was attributable to claims within the limits of the cedent's policies and none was attributable to the claims against the cedent for bad faith in refusing to defend the insured; and (2) all claims for lung cancer had a $200,000 value, while certain other claims had values of $50,000 or less, presented issues of fact that required a trial. The court pointed to evidence in the record to show that a fact finder could conclude that an allocation giving no value to the bad faith claims was unreasonable and that assigning high values to lung cancer claims instead of allocating some of that value to bad faith or other claims was unreasonable. The court pointed to an underlying settlement demand that included a significant amount for bad faith presented just shortly before settlement and the parties' arguments to the bankruptcy court to approve the plan partly on the basis that the bad faith claims had significant value. The court concluded that it was impossible to find as a matter of law that parties bargaining at arm's length, in a situation where reinsurance was absent, could reasonably have given no value to bad faith claims.

The Court of Appeals did find that there was no evidence from which a fact finder could infer that allocating all the losses to a single insurance policy was unreasonable. The court discussed California law and the continuous trigger and related rules to support its holding. It also rejected the reinsurers' argument that the Other Insurance clause precluded allocation to one policy year. Finally, the court rejected the argument concerning an alleged amendment to the retention per loss for the reinsurance contracts.

This case provides the latest and certainly one of the more detailed roadmaps for addressing reinsurance allocation determinations under a follow-the-settlements clause. Reasonableness is the catchword, but reasonableness based on the objective standard of what the underlying parties' to a settlement would consider reasonable if there were no reinsurance. Allocating all of the settlement to claims covered by the cedent's policies and nothing to the bad faith claims may or may not be reasonable – only a trial and a decision by a fact finder will decide that issue.

The ultimate take away here is that the specific facts matter, that a reinsurer will still be bound to a cedent's good faith and reasonable claims determination, and that a follow-the-settlements clause like the one in this case will bind the reinsurer to an objectively reasonable reinsurance allocation decision without regard to the cedent's motive, as long as it could have been derived from an arm's length negotiation by the underlying parties as if no reinsurance existed.

Summary of U.S. Fid. & Guar. Co. v. Am. Re-Ins. Co., 2013 WL 451666 (N.Y. Feb. 7, 2013). Submitted by Larry P. Schiffer, Patton Boggs, LLP, New York, NY, (646) 557-5100, lschiffer@pattonboggs.com.

Second Circuit Holds That Federal Common Law Governs the Interpretation of the Term "Arbitration"

In an insurance coverage dispute over disability insurance, the Second Circuit has joined the majority of federal circuit courts in holding that the question of whether a clause in a contract provides for arbitration is governed by federal common law in a case that falls under the Federal Arbitration Act ("FAA") through its application of the Convention on the Recognition and Enforcement of Foreign Arbitral Awards (the "New York Convention"). The case was removed from state court to federal court by the insurer and the insurer obtained summary judgment. On appeal, the insured challenged the basis for federal jurisdiction and summary judgment.

In affirming the district court, the Second Circuit examined the contractual provision that the insurer claimed was an arbitration clause and agreed with the motion court. The clause provided that the insured and insurer may each examine the insured by a physician of its choice to determine if the insured was permanently disabled and, in the event of a disagreement between each party's physician, the two party-appointed physicians "shall [jointly] name a third Physician to make a decision on the matter which shall be final and binding." The district court applied federal common law to hold that the third-physician clause was an agreement to arbitrate and that the court had subject matter jurisdiction under the FAA via the New York Convention.

In holding that federal common law provides the definition of arbitration under the FAA (not state law), the circuit court recognized that unless there is a plain

indication to the contrary, a federal act is not dependent on state law and will be interpreted under federal common law. This allows for the creation of a uniform national arbitration policy, as intended by Congress. To apply state law would result in a patchwork of varying interpretations of the FAA, said the court.

This case is important because now the Second Circuit has clearly held that questions about whether a clause is an arbitration clause and how it should be interpreted require the application of federal common law, not state law, when the case is governed by the FAA.

Summary of M.D. Imad John Bakoss v. Certain Underwriters at Lloyd's of London, __F3d __, 2013 WL 238708 (2d Cir. Jan. 23, 2013). Submitted by Larry P. Schiffer, Patton Boggs, LLP, New York, NY, (646) 557-5100, lschiffer@pattonboggs.com.

Minnesota Federal Court Stays Litigation Pending Arbitration

A Minnesota federal court granted motions by the successor to a group of off-shore producer-owned reinsurance companies and their owners to stay an action brought by a cedent pending arbitration of the cedent's claims against the reinsurers and their owners. This case involves a complex interwoven reinsurance relationship between the cedent and its reinsurers and whether a dispute about what happened to trust funds deposited as security for reinsurance should be heard in arbitration or by the court.

The cedent reinsured a portion of its life insurance policies with off-shore producer-owned reinsurers through three reinsurance agreements, each of which had an arbitration clause. The 1994 reinsurance contract provided for arbitration of any disputes arising out of the reinsurance agreement. The 1997 agreements provided for arbitration for any disputes or differences arising under, out of, or in connection with, or in any manner relating to the reinsurance agreements. The cedent also entered into an administration agreement with a subsidiary of the owner of the reinsurers. The cedent considered all of these relationships part of one unified program.

Under the reinsurance agreements and for credit for reinsurance purposes, the reinsurers were required to provide security. Originally letters of credit were provided, but in 2005, a trust agreement was entered into. The defendant trustee held the funds for cedent as the beneficiary. The cedent contends that the trust funds were transferred out to another trustee without its knowledge under a new trust agreement to which the cedent was not a party. Eventually, the owner of the reinsurers and the administrator withdrew the trust funds for other purposes.

The cedent sued the reinsurers, the administrator, the principal and the original trustee. One of the defendants, the administrator, filed a motion to dismiss, which was denied, but did not assert any arbitration rights. After an amended complaint was filed and some discovery was taken, the successor reinsurer, after it was finally served, asked whether the cedent would arbitrate. When the cedent refused to arbitrate, the reinsurer filed a motion to dismiss or in the alternative a motion to stay pending arbitration.

In granting the motion to stay pending arbitration, the court discussed the standards for determining arbitrability and the principle that nonsignatories can compel arbitration under certain circumstances. Here, the successor reinsurer was being asked to respond to claims under the reinsurance agreements that contained arbitration clauses. The court agreed that at minimum, equitable estoppel applied to allow the successor reinsurer to enforce the arbitration clause in the agreements. The court found that the arbitration clauses were broad and covered the cedent's claims against the successor reinsurer. The court rejected the claim that the successor reinsurer waived its right to arbitration and that the cedent was prejudiced by the successor reinsurer's actions.

As to the administrator, there was no arbitration clause in the administration agreement, but because the claims were interrelated and intertwined, and the core of the dispute concerned compliance with the provisions of the reinsurance agreements, the court concluded that the claims against the administrator were subject to arbitration as well. The court also concluded that even though the administrator participated in discovery and did not move to stay pending arbitration until the successor reinsurer was served and made the motion, the administrator had not waived its right to seek arbitration.

Finally, the court stayed the action against the trustee because the result of the arbitration had the potential to resolve or narrow the claims against the trustee. The stay was granted to all parties, but the case was not dismissed because of the various non-arbitrable claims alleged in the amended complaint.

Summary of Security Life Ins. Co. of Am. v. Southwest Reinsure, Inc., No. 11-1358 (MJD/JJK), 2013 WL 500362 (D. Minn. Feb. 11, 2013). Submitted by Larry P. Schiffer, Patton Boggs, LLP, New York, NY, (646) 557-5100, lschiffer@pattonboggs.com.

New York Federal Court Denies Preliminary Injunction on Alleged Use of Confidential Information

In a case arising out of alleged breaches of confidentiality agreements and orders, a New York federal court has accepted the recommendations of a magistrate judge and has denied a cedent's motion for a preliminary injunction to prevent the further disclosure of confidential information in a pending arbitration. The cedent and the reinsurer entered into a confidentiality agreement for an audit. Subsequent to the audit an arbitration was commenced and the parties entered into further confidentiality agreements as part of the arbitration process. A dispute arose about the completeness of the earlier audit responses and the cedent produced additional documents, including e-mails relevant to the underlying claims. Counsel for the reinsurer printed out the e-mails and reviewed them.

Another reinsurer also reinsured the cedent for the same underlying risks. A dispute arose between the cedent and the other reinsurer and a lawsuit alleging breach of the reinsurance certificates was commenced. The same law firm that represented the reinsurer in this case also represented the other reinsurer. The same lawyer was involved in both cases for both reinsurers. Shortly after receiving the complaint in the other reinsurer's action, the lawyer discussed certain e-mails obtained in the audit and arbitration on behalf of the reinsurer with those working on the other reinsurer's case.

The cedent claimed that disclosure of those e-mails to the other attorneys in the same firm violated the various confidentiality agreements in the arbitration and audit. In denying the preliminary injunction, the court focused on the requirements for a preliminary injunction and found that there was no irreparable harm. Although it was not required, the court did provide its views on the merits of the claim and found that the cedent had shown a likelihood of success on the merits that the disclosures breached the confidentiality agreements.

Summary of Utica Mut. Ins. Co. v. INA Reinsurance Co., No. 6:12-CV-00194 (DNH/TWD) (N.D.N.Y. Dec. 14, 2012). Submitted by Larry P. Schiffer, Patton Boggs, LLP, New York, NY, (646) 557-5100, lschiffer@pattonboggs.com.

Wisconsin Federal Court Remands Arbitration Counsel Disqualification Action to State Court

The popularity of attorney disqualification applications in reinsurance disputes continues with this dispute venued in Wisconsin. Several reinsurance contracts were entered into, all of which had arbitration provisions. The ceding company and the insured litigated over certain claims presented by the insured and ultimately settled. The cedent billed the reinsurer and the reinsurer questioned its obligation to pay.

This dispute arose when the cedent's counsel demanded arbitration. It turned out that the cedent's counsel had served as defense counsel in the underlying coverage dispute. The reinsurer claimed that this caused a conflict of interest, because counsel represented both the reinsurer's and the cedent's interests in the coverage litigation. When the cedent refused to replace its counsel, the reinsurer filed this action to disqualify counsel in state court, which the cedent removed to federal court.

The Wisconsin federal court remanded the action back to state court after finding that the cedent had not shown that federal subject matter jurisdiction was present. The court originally was concerned whether there was diversity of citizenship, but once that was resolved, the court could not get past the amount in dispute. The reinsurer focused on the amount in dispute in the arbitration. But as the court found, the cedent did not identify the amount in dispute in the arbitration or the cost of replacing arbitration counsel. Although the amount in controversy was eventually identified and exceeded $75,000, the court had an issue concerning whether the amount in controversy in the arbitration was the proper measure for the disqualification action as the object of the disqualification litigation was not compelling arbitration or confirming an arbitration award. The court remanded essentially because it would not adopt the stakes in arbitration as the measure for subject matter jurisdictional purposes.

Summary of Nat'l Cas. Co. v. Utica Mut. Ins. Co., No. 12-cv-657-bbc, 2012 WL 6190084 (W.D. Wisc. Dec. 12, 2012). Submitted by Larry P. Schiffer, Patton Boggs, LLP, New York, NY, (646) 557-5100, lschiffer@pattonboggs.com.

Supreme Court of Washington State Holds That State Statute Prohibits Binding Arbitration Agreements in Insurance Contracts

The Supreme Court of the State of Washington, sitting en banc, unanimously affirmed a trial court's denial of an insurer's motion to compel arbitration, reasoning that a Washington State statute rendered an arbitration clause

present in an insurance agreement unenforceable. The relevant statute, RCW 48.18.200(1)(b), provides that no insurance contract issued in Washington, and covering risks in that state, may contain a condition "depriving the courts of [Washington] of the jurisdiction of the action against the insurer." The insurer argued that the statute only prohibited forum selection clauses within insurance contracts that required an action to be brought outside of Washington, and did not disturb an insurer's ability to compel arbitration. The Supreme Court rejected this argument, stating that the statute was intended to preserve an insured's right to bring an "original action" in a Washington court, where the court would have jurisdiction over the "substance" of the dispute between the parties. Accordingly, the Supreme Court concluded that the statute "prohibits binding arbitration agreements in **insurance** contracts."

Summary of State of Washington, Dep't of Transp. v. James River Ins. Co., 87644-4, 2013 WL 174111 (Wash. Jan. 17, 2013). Submitted by Larry P. Schiffer, Patton Boggs, LLP, New York, NY, (646) 557-5100, lschiffer@pattonboggs.com and Andrew McNally, Patton Boggs, LLP, Newark, NJ, (973) 848-5600, amcnally@pattonboggs.com.

New York Court Grants Cedent's Request to Appoint Umpire

A New York state motion court granted a cedent's petition to appoint an umpire to preside over a series of reinsurance disputes through a combination of the ranking and "strike and draw" methods. The disputes arise out of three reinsurance treaties, one of which provided for the appointment of an umpire should the party-appointed arbitrators disagree on resolving the dispute. The cedent sought the appointment of a single umpire from among the three individuals that its party-appointed arbitrator previously proposed. The reinsurer opposed the petition, and requested that an umpire be selected for each arbitration from among its list of three individuals. Each party had appointed its arbitrator, but the party-appointed arbitrators failed to select an umpire as provided in the treaties.

In granting the petition in part to appoint an umpire, the court noted that while it was undisputed that the two arbitrators failed to select an umpire, the reinsurer objected to the appointment of a court appointed arbitrator on two grounds. First, the court rejected the argument that the court was not permitted to appoint an arbitrator under New York law, CPLR 7504, because the CPLR was not referenced in the treaties. The court held there was no need for the treaties to refer to the CPLR because a contract generally incorporates the state of law in existence at the time of its formation. The CPLR mechanism for appointment of an arbitrator existed well before the formation of the treaties.

Second, the court rejected the argument that CPLR 7504 should not apply because the cedent was to blame for a breakdown in the selection of the umpire. The court rejected this argument because CPLR 7504 provides for the court appointment of an arbitrator "if the agreed method fails or *for any reason is not followed*..." The court noted that the cedent demonstrated that the parties' agreed method of appointing the umpire had failed.

The court next focused on the selection method for the umpire as neither the reinsurance treaties nor CPLR 7504 set forth any substantive criteria for the appointment of the umpire. The cedent urged the court to appoint the umpire from among the three individuals that its arbitrator proposed, or alternatively, that the court use the ARIAS-US ranking method. The reinsurer urged the court to use the strike and draw method or, alternatively that the court appoint the umpire from among the three individuals it proposed.

The court instead adopted Justice Feinman's approach in *Lexington Ins. Co. v. Clearwater Ins. Co.,* No. 651280/2011 (N.Y. Sup Ct., Jan. 6, 2012), which used the ranking method, but modified it to incorporate aspects of the strike and draw method. But to avoid the possibility of a tie, the court added that the umpire must be drawn by random lot in the event of a tie in the rankings of the umpire or third arbitrator.

The arbitration clause in one of the treaties raised the issue of whether the selection of an umpire, before a disagreement among the arbitrators arises at the hearing, is premature because, as the reinsurer contended, the umpire can only be appointed after a dispute arises among the party appointed arbitrators during the hearing. In holding that appointment of the umpire did not have to await a dispute between the arbitrators at the hearing, the court went with the practical approach of choosing the umpire at the outset of the arbitration to avoid the added expense of conducting additional arbitrations should the party-appointed arbitrators disagree.

In conclusion, the court ruled that an umpire was to be chosen within 60 days as follows: Each side shall nominate five candidates, and each side may then strike three of the five candidates on the other's list. Each side shall next rank the remaining candidates in order of preference, and the candidate with the highest

cumulative ranking shall be appointed the umpire. In the event of a tie for the highest cumulative ranking, the umpire will be drawn by random lot.

Finally, the court cautioned that its order should not be read as consolidating the arbitrations under the three separate treaties simply because the method of appointing the umpire and third arbitrator are the same for all arbitrations.

Court intervention in the appointment process can be avoided if arbitration clauses are drafted to address stalemates in the appointment process. In this case, the court adopted a hybrid approach that joined a ranking method with the traditional strike and draw method, including a tie-breaker.

Summary of In re American Home Assurance Co. and Clearwater Ins. Co., 958 N.Y.S.2d 870, No. 653079/12 (N.Y. Sup. Ct. Jan. 15, 2013). Submitted by Larry P. Schiffer, Patton Boggs, LLP, New York, NY, (646) 557-5100, lschiffer@pattonboggs.com.

Second Circuit Refuses to Extend Reinsurance Late Notice Prejudice Rule to P&I Club Certificate

In a summary order involving marine insurance, the Second Circuit Court of Appeals has affirmed a district court's summary judgment in favor of the insurer and specifically addressed the argument by the insurer on late notice. The insured did not give notice to the insurer until two days after a judgment was obtained in favor of the underlying claimant. The insurer disclaimed based on late notice. The district court found that New York's "no prejudice" rule applied and granted summary judgment to the insurer.

In affirming the district court, the circuit court noted the exception to New York's "no prejudice" rule in the context of a reinsurance contract. The court declined to extend the reinsurance exception to marine insurance contracts based on the facts of this case.

Weeks Marine, Inc. v. American Steamship Owners Mut. Protection & Indemn. Ass'n, Inc., No. 11-3774-cv, 2013 WL 377979 (Summary Order) (2d Cir. Feb. 1, 2013). Submitted by Larry P. Schiffer, Patton Boggs, LLP, New York, NY, (646) 557-5100, lschiffer@pattonboggs.com.

Ohio Federal Court Transfers Reinsurance Dispute to Florida

An Ohio federal court has transferred a reinsurance dispute to Florida, where another related action was pending. The cedent, commencing with its predecessor, underwrote an automobile dealership awards program. Reinsurance for the awards program was obtained via a broker allegedly from a Lloyd's coverholder in 2004. This process was repeated in 2006 with another Lloyd's coverholder. The cedent sought to recover under both reinsurance programs.

The reinsurers and their agent for the 2006 program commenced an action in Florida for a declaration that they had no liability to the cedent for failure to comply with certain conditions and requirements. The cedent moved to compel arbitration under the 2004 agreement, which was granted by the Florida court.

Subsequently, the 2004 reinsurers filed suit in Ohio claiming that they never entered into and had no knowledge of the 2004 agreement. The cedent moved to transfer the Ohio action to Florida where the 2006 action was pending.

In granting the motion to transfer, the court found Florida federal court to be convenient because it could have been brought in Florida, neither party had yet requested arbitration as the reinsurers were contesting the contract's validity, that a substantial part of the events leading up to the litigation took place in Florida, the main witness resided in Florida, and that in the interest of justice transfer to Florida was appropriate.

Summary of Certain Underwriters at Lloyd's, London v. Stonebridge Cas. Ins. Co., No. 2:12-cv-160 (S.D. Ohio Dec. 17, 2012). Submitted by Larry P. Schiffer, Patton Boggs, LLP, New York, NY, (646) 557-5100, lschiffer@pattonboggs.com.

Illinois Federal Court Refuses to Strike a Motion to Dismiss on Foreign Sovereign Immunities Act Grounds

Doing reinsurance business with non-U.S. reinsurers owned by foreign governments often raises interesting issues of enforcement and collection. In this case, a receiver of an insolvent reinsurer sold and assigned its receivables from a retrocessionaire, an instrumentality of the Republic of Uruguay. The assignee sought to collect payments allegedly due or to compel arbitration. The retrocessionaire filed a motion to dismiss the cause of action to compel arbitration. The assignee moved to strike the motion to dismiss. The court denied the assignee's motion to strike.

In denying the motion to strike the retrocessionaire's motion to dismiss, the court addressed the assignee's

claim that the motion to dismiss was improper because the retrocessionaire had not paid pre-judgment security as required by state law. The Illinois statute (215 ILCS 5/123) is one of the many pre-answer or pre-judgment security provisions in state insurance laws that require an unauthorized foreign or alien company to post security before it can take any action in court or arbitration. The retrocessionaire argued that the security statute did not apply because the retrocessionaire was an instrumentality of a foreign state and is immune from pre-judgment security under the Foreign Sovereign Immunities Act ("FSIA") (28 U.S.C. § 1602) and that the assignee lacked standing to make the motion.

The court found that the assignee had standing to make the motion. More importantly, however, the court held that the retrocessionaire was immune from pre-judgment security under FSIA. The court rejected the assignee's argument that the pre-judgment security requirement was not an "attachment" within the definitions of FSIA by looking to the practical effect of the security. The court also found that neither the arbitration clause nor the collateral clause in the relevant contracts resulted in an affirmative waiver of the retrocessionaire's immunity.

Summary of Pine Top Receivables of Ill., Inc. v. Banco de Seguros Del Estado, No. 12 C 6357, 2012 WL 6216759 (N.D. Ill. Dec. 13, 2012). Submitted by Larry P. Schiffer, Patton Boggs, LLP, New York, NY, (646) 557-5100, lschiffer@pattonboggs.com.

Utah Federal Court Denies Reinsurers' Recovery of Attorney Fees

A Utah federal court granted underlying defense counsel's motion for partial summary judgment against reinsurers, as subrogees of cedent and its insured, denying their right to recover attorney fees, as consequential damages. The cedent incurred attorneys' fees when it sought reimbursement from its insured for the settlement monies it paid over the policy limits on its behalf in the underlying action.

The dispute arose from an underlying litigation brought on behalf of a minor, injured during an adult softball tournament, which resulted in a verdict in excess of $6 million against the insured and other parties. Even after the cedent settled with the minor for a reduction in the award, the settlement was still in excess of the $2 million policy limit, and the insured refused to pay the amount in excess of the limits. The reinsurers, through its cedent, however, paid the full settlement amount.

The cedent subsequently sued its insured for reimbursement of the amounts it paid beyond the policy limits. The reimbursement question was certified to the Utah Supreme Court as an issue of first impression. The Supreme Court ruled that there was no extra-contractual right to restitution between an insurer and its insured, and denied reimbursement.

The reinsurers, as subrogees of the cedent and the cedent's insured, next brought malpractice claims against counsel retained by cedent in the underlying action to recover attorney fees as damages under the third-party litigation exception. The third-party litigation exception allows recovery of fees only in the limited situation where defendant's wrongful conduct foreseeably causes the plaintiff to incur attorney fees through litigation with a third party. Defense counsel subsequently moved for partial summary judgment to deny reinsurers recovery of their attorney fees.

In granting defense counsel's motion, the court held that defense counsel's actions did not fall within the third-party litigation exception to Utah's long-standing rule allowing recovery of attorney fees as consequential damages where provided by statute or contract. The court focused on the issue of foreseeability to answer the question of whether the reinsurers could recover as damages the attorney fees incurred by the cedent and its insured in determining cedent's reimbursement rights for the settlement monies paid to the minor.

The malpractice claims were based upon tort and contract causes of action. Under the tort allegations, the court held that the third-party litigation exception applies when the foreseeable and natural consequence of one's negligence is another's involvement in a dispute with a third party. For the reinsurers to recover attorney fees in tort under the third-party litigation exception, the court stated that it must be reasonably foreseeable that a contemplated loss resulting from counsel's allegedly negligent acts would be the attorney fees expended in a reimbursement action between cedent and its insured.

Moreover, if the loss of attorney fees was foreseeable, the court noted it would also have to infer that some of the other actions were foreseeable, including whether the cedent would settle with the minor for an amount in excess of policy limits, and subsequently bring a coverage action against its insured.

Similarly, under the breach of contract allegations, the court noted that in order for the reinsurers to recover attorney fees under the third-party litigation exception,

it would have to infer that attorney fees expended in a reimbursement suit were reasonably foreseeable as the natural and usual course of events resulting from a breach of representation contract between an insurer and its retained counsel. The test for reasonable foreseeability was whether it could ". . . fairly and reasonably be said that if the minds of the parties had adverted to breach when the contract was made. . . ." loss of attorney fees would have been within their contemplation.

After careful analysis, the court held that no reasonable jury could return a verdict for the reinsurers' recovery of attorney fees under the third-party litigation exception in either tort or contract causes of action. The court reasoned that the coverage dispute, with its resultant attorney fees, was not the foreseeable natural consequence of counsel's alleged malpractice.

Summary of National Indem. Co. v. Nelson, Chipman & Burt, No. 2:07-CV-996 TS, 2013 WL 226881 (D. Utah Jan. 18, 2013). Submitted by Larry P. Schiffer, Patton Boggs, LLP, New York, NY, (646) 557-5100, lschiffer@pattonboggs.com.

Connecticut Federal Court Grants Cedent's Motion to Amend Complaint Adding Account Stated and CUPTA Claims

A Connecticut federal court granted a cedent's motion to amend its complaint in a dispute with its reinsurer. The underlying dispute involves insurance brokers' errors and omissions policies and the settlement of an underlying E&O claim. The reinsurer refused to pay and this action commenced.

The cedent's motion for an amended complaint adds two additional claims beyond breach of contract: account stated and violation of Connecticut's Unfair Trade Practices Act ("CUTPA"). The reinsurer opposed the motion based on its untimeliness and the legal sufficiency of the additional causes of action. The court, in granting the motion, found no substance to the timeliness objection based on the case being in its early stages. On the sufficiency issue, the court found that the cedent adequately pled a plausible claim for an implied account stated and for violations of CUTPA.

The reinsurer also raised the issue of the cedent's strategy in seeking to amend its complaint to force the reinsurer to post pre-answer security as a basis to deny the motion on bad faith grounds. The court rejected this argument, finding that the pending motion for security did not bear on the cedent's right to add plausible claims to its complaint as a "proper and professional exercise" to further its legitimate purpose of seeking "to transfer money from a defendant's pocket into its own."

Summary of The Travelers Indem. Co. v. Excalibur Reinsurance Corp., No. 3:11-CV-1209 (CDH), 2012 WL 424535 (D. Conn. Feb. 1, 2013). Submitted by Larry P. Schiffer, Patton Boggs, LLP, New York, NY, (646) 557-5100, lschiffer@pattonboggs.com.

Texas Appellate Court Concludes that Foreign Country Judgments Assessing Costs against an Insurer Are Enforceable Under Foreign Country Money-Judgments Statute

A Texas intermediary appellate court affirmed a trial court's denial of a cedent's motion for nonrecognition of certain foreign country judgments. Following the dismissal of a suit brought by the cedent against a reinsurer in the Turks and Caicos Islands ("TCI"), the reinsurer obtained two "judgments" assessing costs against the cedent. The reinsurer then sought to enforce the judgments in Texas, and the cedent moved for nonrecognition.

The cedent contended that the "judgments" were not "judgments on the merits" arising from a cause of action asserted by the reinsurer, because they provided for taxation of costs only. Rejecting this argument, the Texas appellate court held that the Uniform Foreign Country Money-Judgment Act, as implemented in Texas, does not restrict a defendant's ability to enforce a foreign judgment to only those cases where the defendant has prevailed on its own cause of action. The cedent also asserted that the cost assessments were not "judgments" because they were entered by TCI court personnel other than the TCI justices who ruled on the substantive issues of the cedent's action. In response, the Texas court observed that under the law of the United Kingdom (relevant because TCI is a British overseas territory), the term "judgment" includes cost assessments, and further cited a number of U.S. cases where "later-determined cost assessments" were recognized as "judgments" under the Uniform Foreign Country Money-Judgment Act. The court, however, cautioned that its ruling was driven by the facts of the case, and its opinion "should not be construed as holding that in every case, a cost assessment from a foreign country court will be enforceable as a judgment."

Finally, the cedent contended that the "loser pays" principle (the "English rule") is intended to punish unsuccessful litigants, and therefore cost assessments are properly regarded as "penalties," which are expressly

excluded from the definition of "foreign country judgment" under the Act. Rejecting this argument, the court cited authority reasoning that the English rule is designed to compensate a defendant that is forced to defend the suit, rather than penalize the losing plaintiff. Further, the court observed that a judgment is considered "penal" when "its purpose is to punish an offense against the state," but not when it simply affords a "private remedy" to a wronged party. Accordingly, the court affirmed the trial court's order denying the cedent's motion for nonrecognition.

Summary of New Hampshire Ins. Co. v. Magellan Reins. Co. Ltd., 02-00334-cv, 2013 WL 105654 (Tex. App. Jan. 10, 2013). Submitted by Larry P. Schiffer, Patton Boggs, LLP, New York, NY, (646) 557-5100, lschiffer@pattonboggs.com and Andrew McNally, Patton Boggs, LLP, Newark, NJ, (973) 848-5600, amcnally@pattonboggs.com.

Third Circuit Relieves Reinsurer of Indemnity Obligations Due to Late Notice Even Where No Resulting Prejudice Shown

Reversing a lower court decision, the United States Court of Appeals for the Third Circuit ruled that a reinsurer had no obligation to indemnify its reinsured for certain asbestos- related losses due to late-notice of loss given by the reinsured. Applying New York law, the Third Court concluded that the reinsurer did not need to demonstrate it was prejudiced as a result of the late notice.

The dispute arose under a certificate of reinsurance obtained by the reinsured from the reinsurer's predecessor covering an excess policy. Paragraph D of the reinsurance certificate stated that "[a]s a condition precedent, [the reinsured] shall promptly provide the Reinsurer with a definitive statement of loss on any loss or occurrence." The reinsured had received initial notice of the claim in April 2001 and the underlying loss reached the excess layer by 2004. The reinsured advised its broker to keep its reinsurers informed about the claim in 2006, 2007 and 2008, but the broker failed to do so. The reinsurer was first provided notice of the claim in April 2008, with a demand for payment following in September 2009. Having discovered that the reinsured had first received notice in 2001, the reinsurer denied coverage and asserted a late notice defense.

The district court had acknowledged that the reinsurance certificate unambiguously required the reinsured to provide a definitive statement of loss promptly after the initial claim from the underlying insured. It also found that the submission of a definitive statement of loss was a condition precedent to recovery. But, the district court determined that—in the absence of an explicit choice of law provision—it was required to determine which law applied to the dispute. This issue was critical because of the conflict raised by the competing laws. Under New York law, which the reinsurer argued should apply, the reinsurer was not required to show prejudice to succeed on its late notice defense. Under Pennsylvania law, which the reinsured argued in favor of, prejudice was arguably a requirement for succeeding on a late notice defense. Although there was no definitive statement from the Supreme Court of Pennsylvania, the district court agreed with the reinsured and predicted that prejudice would in fact be a requirement under Pennsylvania late notice law. It concluded that the reinsurer had failed to allege facts supporting a finding of prejudice.

On appeal, the Third Circuit reversed. It agreed with the district court that New York law on the subject was not in dispute and that a showing of prejudice was not required for a late notice defense. While acknowledging that there was no clear guidance in Pennsylvania, the Third Circuit agreed that Pennsylvania law would likely require a showing of prejudice because of Pennsylvania's interest in preventing technical forfeitures of coverage. Faced with a true conflict, the Third Circuit conducted a choice of law analysis and determined that, contrary to the district court's conclusion, New York law applied. At the time the agreement was signed in 1980, the reinsurer was located in New York and the reinsured was located in California. The only connection to Pennsylvania was that the reinsured had become a Pennsylvania company in 1999. Although not easily ascertainable because the minimal negotiations of the certificate occurred via telex, the court ultimately decided that the place of contract formation was determined to be New York. Based on the totality of the circumstances at the time of contracting, where a New York reinsurer accepted, in New York, the terms and conditions of an agreement with a California company, there was no reason to believe the parties had any expectation that Pennsylvania law would apply. The court thus ruled that New York law applied and that the reinsurer was not required to show prejudice in order to deny coverage. The Third Circuit therefore reversed the lower court's ruling and ordered that judgment of non-liability be entered in the reinsurer's favor.

As an aside, New York law on late notice requires a showing of prejudice generally, but not when the reinsurance contract has an explicit condition precedent notice requirement as was the case here.

Summary of Pacific Employers Ins. Co. v. Global Reinsurance Corp. of Am., 693 F.3d 417 (3d Cir. 2012). Submitted by Larry P. Schiffer, Patton Boggs, LLP, New York, NY, (646) 557-5100, lschiffer@pattonboggs.com, and Suman Chakraborty, New York, NY (646) 557-5142, schakraborty@pattonboggs.com.

New York Federal Court Confirms Arbitration Awards for Cedent

A New York federal court granted a cedent's petition under the Convention on the Recognition and Enforcement of Foreign Arbitral Awards to confirm multiple arbitration awards in its favor, denied cross-petition to vacate the awards, and denied motions to seal. The arbitration concerned multiple contracts through which the parties had overlapping liability to each other for various insurance and reinsurance obligations. A key dispute before the arbitration panel was the interpretation of a termination provision in one of the underlying contracts, which affected the parties' liability for losses under those contracts.

The panel permitted extensive discovery, pre-hearing briefing, multiple position statements and the use of hundreds of evidentiary exhibits. During a nine-day hearing, the parties presented a total of 11 witnesses, introduced exhibits into evidence, and made opening and closing statements. The panel deemed the hearing a "final hearing on the merits" and ruled in the cedent's favor.

The cedent moved to confirm the award, while the reinsurer moved to vacate. The court granted the petition to confirm, finding that arbitration awards are subject to extremely limited review and are only rarely to be overturned. The court, in a fairly detailed analysis, rejected the reinsurer's allegations that the panel refused to hear evidence and found it had a "full and fair" opportunity to present its case before the panel. The court also found that the panel acted within its authority in interpreting the disputed termination provision, awarding punitive damages where it found the reinsurer had not acted in good faith, and retaining jurisdiction to oversee implementation of its award. Finally, the court rejected the reinsurer's argument that the panel manifestly disregarded governing law (here the law of Belgium). The court noted that the reinsurer had not raised the issue of Belgian law in its briefing or at the arbitration hearing, but raised it for the first time on a petition to modify the award.

Although the parties were at odds as to the propriety of the award, they both moved to file certain documents under seal pursuant to a confidentiality agreement. The court held that the documents at issue were judicial documents to which a presumption of access attaches, and although the confidentiality agreement was binding on the parties, it did not preclude the court from making those documents available to the public. In reaching its decision, the court noted that although parties to arbitration are generally able to keep documents confidential, the "circumstance changes when a party seeks to enforce in federal court the fruits of their private agreement to arbitrate, *i.e.*, the arbitration award."

In short, the court emphasized that overturning an arbitration award is difficult and unlikely in all but the most extreme circumstances. In addition, even parties with confidentiality agreements may not be able to seal material from an arbitration hearing if access to the federal courts is taken.

Summary of Century Indem. ***Co.*** v. AXA Belgium, No. 11 Civ. 7263, 2012 WL 4354816 (S.D.N.Y. Sept. 24, 2012). Submitted by Larry P. Schiffer, Patton Boggs, LLP, New York, NY, (646) 557-5100, lschiffer@pattonboggs.com and Devon Corneal, New York, NY (646) 557-5123, dcorneal@pattonboggs.com.

Wisconsin Federal Court Transfers Arbitrator Selection Dispute to New York

A Wisconsin federal court avoided having to resolve a dispute over arbitrator selection and consolidation by transferring the case to the federal court in New York. Three cases were brought when the parties could not agree on the method for selecting arbitration panels in disputes arising from a series of reinsurance contracts. The cedent argued that venue was not proper in Wisconsin because the contracts all had New York forum selection clauses in their arbitration provisions. In transferring the cases to New York, the court agreed with the cedent and found that the forum selection clause was mandatory and must be enforced under Section 4 of the Federal Arbitration Act ("FAA"). The court rejected arguments that Section 5's appointment of the arbitrator or umpire provisions, which are not affected by venue, would require the case to stay in Wisconsin.

Summary of Employers Ins. Co. of Wausau ***v.*** Arrowood Indemn. ***Co.***, Nos. 12-cv-283-bbc, 12-cv-284-bbc, 12-cv-285-bbc, 2012 WL 5306152 (W.D. Wis. Oct. 26, 2012). Submitted by Larry P. Schiffer, Patton Boggs, LLP, New York, NY, (646) 557-5100, lschiffer@pattonboggs.com.

Texas Federal Court Denies Security Application for De Minimis and Premature Claims

In a dispute between a reinsurer and a managing agent, a Texas federal court declined to award security in aid of arbitration under a Texas statue that permits a party to file a security application with a court either during or after the conclusion of arbitration. In the underlying arbitration, the reinsurer sought $4.5 million in commissions retained by the managing agent, $71,068.82 in retained bonus commissions and pre-award interest, and $2.5 million in additional commissions it believed would be due based on future performance of the book of business. The arbitration panel denied the reinsurers claim for $4.5 million in retained commissions though it did award $71, 068.82 in retained bonus commissions and pre-award interest. The panel deferred its decision on the remaining $2.5 million claim because the necessary reports to validate the claim had not yet been submitted. In court, the reinsurer sought security for both the undisputed $71,068.82 it was owed, and for its still-pending $2.5 million claim. The reinsurer argued that several outstanding federal tax liens levied by the Internal Revenue Service against the managing agent raised doubts about the agent's ability to satisfy any judgment.

In denying the reinsurer's security application, the court noted that although the applicable Texas statute did not specify any procedural safeguards a court must take into account to ensure fairness of any security, a court should, at a minimum, consider both parties' arguments concerning the probable validity of the underlying claims. Because the arbitration panel had deferred deciding on the $2.5 million future commission claim, the court determined that the reinsurer could not establish that it was likely to succeed on the claim. The court therefore concluded that security for claims that the panel had determined were premature was not warranted. Turning to the remaining $71,068.82 component of the security application, the court acknowledged that the managing agent did not dispute the validity of this award. But because that amount was *de minimis,* and was possibly going to be offset by an award for attorney fees in the agent's favor, security was not warranted in this instance either.

Summary of Gen. Fidelity Ins. Co. ***v.*** WFT, Inc., No. 3:11-cv-0448-P, 2012 WL 4900905 (N.D. Tx. Oct. 15, 2012). Submitted by Larry P. Schiffer, Patton Boggs, LLP, New York, NY, (646) 557-5100, lschiffer@pattonboggs.com and Suman Chakraborty, New York, NY (646) 557-5142, schakraborty@pattonboggs.com.

New York Federal Court Grants Reinsurer Summary Judgment on Most Claims Made by Terminated Managing Agent

A New York federal court was faced with cross-motions for summary judgment on a dispute over commissions based on the profitability of reinsurance contracts written by a managing agent. The underwriting agency agreement provided for the calculation of underwriting commissions and contingency commissions based on the reinsurer's annual net profits. By agreement, the parties terminated the relationship, but certain reporting requirements and contingent commission calculations were required as part of the termination agreement.

Subsequent to the termination of the underwriting agreement, the reinsurer commuted a series of underlying reinsurance contracts on programs that were not performing well. The business written by the managing agent represented a fraction of the business commuted, but a substantial portion of the managing agent's income-deriving business with the reinsurer. The reinsurer did not consult with the managing agent on the commutations.

In performing the contingency commission calculation for certain underwriting years, it turned out that there was no profits in the business and therefore no commissions were due. The managing agent claimed that the reinsurer breached its contract by not providing certain reports, failing to properly calculate the commissions, failing to consult when establishing IBNR, and using commuted losses in the commission calculations and other defects. The question for the court was whether any of the reinsurer's actions result in a breach of either the termination agreement or the original underwriting agreement.

The court found that the failure to provide quarterly reports after the commutations was a breach, but that the breach was waived by the underwriting agent because it never inquired about the reports and accepted the periodic reporting it had been receiving. The court also found no contractual requirement that the reinsurer consult with the managing agent on establishing IBNR for the contingent commission calculation. The court also found no breach because the reinsurer included commuted losses in the calculations or in the way the calculations were performed.

Summary judgment was denied on the issue of data quality because enough of a factual issue was raised on whether the reinsurer properly maintained its records

on the managing agent's business. The court ordered that the managing agent may proceed to trial on its data quality breach claim even though the claim may be limited to nominal damages.

Summary of Acumen Re Mgmt. Corp. v. Gen. Sec. Nat'l Ins. Co., No. 09 Civ. 796, 2012 WL 3890128 (S.D.N.Y. Sept. 7, 2012). Submitted by Larry P. Schiffer, Patton Boggs, LLP, New York, NY, (646) 557-5100, lschiffer@pattonboggs.com.

Texas Federal Court Finds for Managing Agent of Cedent Against Reinsurer

A Texas federal court granted an underwriting agent's motion for summary judgment in part in a complicated dispute arising out of the reinsurance of automobile insurance policies written by the underwriting agent and the manner in which losses and commissions were paid and calculated. An earlier action was dismissed after a tentative settlement was reached, but the settlement failed and this action, with additional claims, was filed claiming that the underwriting agent improperly used funds and withheld and misappropriated nearly $18 million by manipulating the calculation of the contingent commission.

The court first addressed the issue of whether there was a fiduciary duty owed by the underwriting agent to the reinsurer. After a detailed analysis of the relevant agreements, the court found that the reinsurer did not demonstrate that the underwriting agent owed it a fiduciary duty. The agreements, consistent with Texas insurance law, required the underwriting agent to hold the premiums as a fiduciary on behalf of the insured or insurer, and must deposit the funds in an escrow account. Essentially, while the underwriting agent acted as an agent for the reinsurer for certain activities, the provisions of the agreement cannot transfer fiduciary duties owed to the cedent directly to the reinsurer. The court made the same findings concerning the interpretation of the relevant insurance code provisions. Accordingly, the court granted the underwriting agent's motion for summary judgment on the reinsurer's claim for breach fiduciary duty.

The court also rejected the reinsurer's claims for conversion because the claims fell within the terms of the contracts and the economic loss rule limited the claim to breach of contract and not the tort of conversion. The court found that nothing in the agreements preserved common law remedies and the reinsurer did not show how there could be damages other than economic loss. The court denied the reinsurer's summary judgment motion for breach of contract because the contracts did not unambiguously establish each party's obligations in case of termination.

Summary of Lincoln Gen. Ins. Co. *v.* U.S. Auto Ins. Servs., Inc., No. 3:10-CV-2307-B, 2012 WL 3777408 (N.D. Tex. Aug. 30, 2012). Submitted by Larry P. Schiffer, Patton Boggs, LLP, New York, NY, (646) 557-5100, lschiffer@pattonboggs.com.

Illinois Federal Court Grants Summary Judgment to Cedent Under Follow-the-Settlements Clause

An Illinois federal court granted summary judgment to a cedent against its reinsurer in a dispute over settlement of a coverage declaratory judgment action following settlement of an underlying wrongful death action. The reinsurer provided a 100 percent quota share treaty covering the first $250,000 of net liability, plus a proportion of loss adjustment expenses. An underlying loss was settled and the reinsurer paid, but the insured brought a coverage action against the cedent claiming that more of the underlying settlement should have been covered. The cedent settled the coverage action and billed the reinsurer for its share of the settlement plus expenses. The reinsurer refused to pay and the cedent drew down on letters of credit that the reinsurer was required to maintain to satisfy a portion of the settlement and commenced this action.

In granting summary judgment to the cedent, the court, construing the contract under Connecticut law, construed the loss settlements, follow-the-settlements, and follow-the-fortunes clauses and found for the cedent. The court sets out a good summary of follow-the-settlements law. On the merits, the court noted that the underlying dispute was about how the term medical incident was construed under the policy. The treaty requires that all loss settlements by the cedent by way of compromise confer liability on the reinsurer. Because there was no evidence of bad faith by the cedent, the court held that the settlement was covered under the treaty.

The reinsurer argued that a portion of the settlement that was allocated to the insured's bad faith claim was not covered, but the court found that it was arguably covered and pointed to the treaty's ECO clause. The court rejected the reinsurer's argument that the claim was reported late and therefore was not covered because the provision of the treaty cited was not a true notice provision and no prejudice had been shown. Finally,

the court required the reinsurer to replenish its collateral as required under the treaty after the draw down on the letters of credit.

Summary *of* *Arrowood* Indemn. Co. v. Assurecare Corp., No. 11 CV 5206, 2012 WL 4340699 (N.D. Ill. Sept. 19, 2012). Submitted by Larry P. Schiffer, Patton Boggs, LLP, New York, NY, (646) 557-5100, lschiffer@pattonboggs.com.

New Jersey Federal Court Grants Partial Summary Judgment to Retrocedent, But Preserves Rescission Claim for Trial

In a complicated retrocessional dispute, the New Jersey federal court granted in part and denied in part the retrocedent's motion for summary judgment and preserved the retrocessionaire's rescission counterclaim for trial. In its opinion, the court provides a nice basic primer on reinsurance and cites many articles and treatises written by reinsurance practitioners, including one footnote citation to an article written by this newsletter's editor.

The dispute centers on the alleged failure of the retrocessionaire to pay under two of the retrocessional agreements. The retrocessionaire alleges various counterclaims and seeks rescission based on misrepresentations it claims it uncovered during discovery.

The court construed the claims under New York law and first addressed the retrocessionaire's rescission claim and whether the claim was asserted within a reasonable period of time. After reviewing the facts, the court denied the retrocedent's motion for summary judgment on the retrocessionaire's rescission claim based on waiver. The court also held neither party's motion for summary judgment on the rescission claim was appropriate because of competing expert testimony. The court also denied the retrocessionaire's motion for summary judgment on late notice holding that the relevant language in the notice clause did not operate as a condition precedent, but held in favor of the retrocedent because the retrocessionaire was unable to carry its burden of demonstrating prejudice.

The court also ruled in favor of the retrocedent on the construction of the retention provision of the retrocessional contract. The retrocedent claimed that the retention provision triggered the retrocedent's obligation when both the retrocedent and the underlying ceded paid a cumulative total of $500,000 on each loss occurrence. The retrocessionaire claimed that the underlying cedent' payments did not count toward ultimate net loss. The court found that the contract language was only susceptible to one reasonable interpretation and that extrinsic evidence supported that same conclusion.

Summary of Munich Reinsurance Am., Inc. v. Am. Nat'l Ins. Co., No. 09:6435, 2012 WL 4475589 (D. N.J. Sept. 28, 2012).

Iowa Federal Court Dismisses Claims Against Bermuda Reinsurance Affiliates

In this long term insurance benefits dispute, claims were brought by the policyholder against Bermuda-based reinsurance companies affiliated with the insurer. The Bermuda companies (and others) filed a motion for judgment on the pleadings. In addressing whether the court had personal jurisdiction over the Bermuda companies, the court found that there were no direct contacts with Iowa, no offices or employees in Iowa, and that they do not conduct business in Iowa. Although the policyholder pointed out that nearly 75 percent of the insurer's risk was reinsured in Bermuda, the court held that the policyholder had not made out a prima facie case showing that the insurer was the alter ego of the Bermuda companies or acted as their agent. The court stated that "[w]hile one can question the wisdom of regulators permitting [the insurer] to purchase reinsurance from a member of the same corporate family, it does not render the contractual relationship a 'sham' or otherwise make [the Bermuda companies] susceptible to suit in Iowa."

Piercing the corporate veil and proving an alter ego corporate theory is very difficult as this case shows. What this case also points out to Bermuda and other off-shore affiliates of U.S. companies is that keeping corporate separateness and observing all the appropriate regulatory and corporate governance compliance rules is crucial to avoid being haled into court.

Summary of Schultz v. Ability Ins. Co., No. C11-1020, 2012 WL 4794365 (N.D. Iowa Oct. 9, 2012). Submitted by Larry P. Schiffer, Patton Boggs, LLP, New York, NY, (646) 557-5100, lschiffer@pattonboggs.com.

California Appeals Court Affirms Quashing of Complaint Against Bermuda Company

A California appeals court has affirmed a trial court's order quashing service of a summons and complaint for lack of personal jurisdiction against a Bermuda insurer. The Bermuda insurer made a special appearance and moved to quash because it did not issue the policies in issue, did not do business in California, and its small number of insureds in California did not subject it to jurisdiction. The policyholder argued that the Bermuda

insurer did substantial business in California and was party to a quota share reinsurance agreement that results in the Bermuda company's sharing in California risks written by XL group members.

In affirming the trial court, the appellate court held that the Bermuda insurer is not subject to general jurisdiction in California. The minimal California policyholders it has and its participation in the reinsurance agreement, the court found, was too *de minimis* to confer jurisdiction. The court also rejected any alter ego theory. The court noted again how the policy in issue was not one issued by the Bermuda company. The case offers a good analysis of what makes for contacts with a state and how off-shore companies can maintain their protection from personal jurisdiction in states where they do not do substantial business.

Summary of Hollander v. XL Ins. (Bermuda) Ltd., No. B230807, 2012 WL 4748956 (Cal. Ct. App. Oct. 5, 2012). Submitted by Larry P. Schiffer, Patton Boggs, LLP, New York, NY, (646) 557-5100, lschiffer@pattonboggs.com.

Florida Appellate Court Affirms Decision Rejecting Forum Non Conveniens Challenge to Foreign Reinsurer's Complaint

In this appeal of a lower court's non-final order denying defendant's motion to dismiss a foreign reinsurer's complaint on the basis of forum *non conveniens*, the Third District Court of Appeals for the State of Florida permitted a Venezuelan reinsurer to avail itself of the forum of its choice.

The foreign reinsurer entered into a transaction with an entity incorporated in the British Virgin Islands ("BVI Entity"). The transaction involved a bond swap and off-shore investments in U.S. dollars. When the BVI Entity refused to return the bonds or transfer them to a designated custodian, the reinsurer filed suit in Florida state court alleging fraud, civil theft, conversion, breach of fiduciary duty, unjust enrichment and breach of contract.

The BVI Entity moved to dismiss the complaint for failure to state a claim and forum *non conveniens*, arguing that Venezuela was the more appropriate forum. On appeal, the court addressed only forum *non conveniens* and applied a four-part analysis, reviewing 1) whether an adequate alternative forum exists; 2) relevant factors of private interest; 3) factors of public interest, where private interests are in balance or near equipoise; and 4) if the plaintiff could reinstate its suit in the alternative forum without undue inconvenience or prejudice. After noting that Venezuela was a suitable alternative forum, the appellate court turned to private interests. Although acknowledging that a plaintiff's choice of forum is generally respected, the court stated that a plaintiff's choice "is given less deference when the plaintiff is not a resident of the forum state, or has little bona fide connection to that state." The court found, however, that the main witness and president of the BVI Entity resided in Miami, the BVI Entity held the bonds in Miami and maintained bank accounts there, other witnesses had traveled from Venezuela to Miami and were able to continue to do so, and all key documents had been translated from Spanish to English. Ultimately, the court held that although the Venezuelan reinsurer was "entitled to less deference" than a plaintiff who resided in Florida, the lower court correctly denied the BVI Entity's motion to dismiss. Finding that the second factor of its analysis was not met, the court did not address the remaining factors.

Summary of ABA Capital Markets Corp. v. Provincial De Reaseguros C.A., No. 3D12-130, 2012 WL 5416441 (Fla. Dist. Ct. App. Nov. 7, 2012). Submitted by Larry P. Schiffer, Patton Boggs, LLP, New York, NY, (646) 557-5100, lschiffer@pattonboggs.com and Devon Corneal, New York, NY (646) 557-5123, dcorneal@pattonboggs.com.

Connecticut Appellate Court Rules That a Commutation Agreement Terminated Reinsurer's Obligations to Cedent

A Connecticut appellate court affirmed a trial court judgment holding that an agreement between the reinsurer and the cedent commuted their prior reinsurance contract. The parties originally entered a reinsurance contract explicitly providing for the reinsurer to accept a portion of the cedent's overall losses in exchange for part of the premiums the cedent collected. Subsequent to this reinsurance contract, the parties entered a commutation agreement. The commutation agreement, by its express terms, terminated all prior "reinsurance agreements" between the parties. The commutation agreement defined "reinsurance agreements" as contracts in which a reinsurer reinsures certain liabilities of the cedent. Despite the commutation agreement, the parties, for four years, continued exchanging reinsurance payments for premiums, as per the terms of the original reinsurance contract. Then, the reinsurer terminated payments citing the global language of the commutation agreement and filed suit seeking restitution for the amounts

unnecessarily paid to the cedent. The cedent argued that the commutation agreement should be reformed because the parties were mistaken as to whether the original reinsurance contract was commuted.

The court refused to reform the contract because the parties agreed to an unambiguous commutation agreement terminating the original reinsurance contract. The court bound the cedent to the commutation agreement because the cedent's experienced officer drafted the commutation agreement with the help of counsel, and the clear language of the agreement terminated all prior reinsurance contracts. Moreover, the commutation agreement was not ambiguous when, by its terms, it terminated all "reinsurance agreements." The commutation agreement's definition of reinsurance as agreements where a reinsurer reinsures certain liabilities of an insurer clearly encompassed the parties' prior reinsurance contract.

The court also affirmed the denial of restitution because both parties for four years performed their respective obligations under the contract notwithstanding the commutation agreement. Because there was no evidentiary foundation for a court to have determined that one party had been unjustly enriched at the expense of the other, restitution was not appropriate.

Summary of Trenwick Am. Reinsurance Corp. v. W.R. Berkley Corp., 54 A.3d 209 (Conn. App. Ct. 2012). Submitted by Larry P. Schiffer, Patton Boggs, LLP, New York, NY, (646) 557-5100, lschiffer@pattonboggs.com and Joseph Kaufman, Washington, D.C., (202) 457-5132, jkaufman@pattonboggs.com.

Illinois State Court Dismisses Cedent's Post-Arbitration Complaint Seeking Attorney Fees for Reinsurer's Alleged Unreasonable Failure to Settle Claim

An Illinois state court dismissed a cedent's complaint seeking attorney fees for a reinsurer's alleged unreasonable failure to settle a claim. The cedent submitted a claim to the reinsurer, but the reinsurer disputed the claim. Under an arbitration clause in the reinsurance contract, the parties commenced arbitration in Illinois and applied Illinois law. Following the arbitration, the cedent filed suit seeking attorney fees under state law after an appeals court ruled that the arbitration panel exceeded its authority in awarding attorney fees and the lower court erred in confirming that award.

The court dismissed the cedent's complaint because under a choice of law analysis, New York law, not Illinois law, applied, and New York law does not provide for attorney fees when an insurer fails to settle a claim. The reinsurance contract did not have a choice-of-law clause applicable to litigation. The only choice-of-law clause in the reinsurance contract governed the applicable law in arbitration. As a result, the court had to apply a two-step choice of law analysis. First, the outcomes would differ if New York or Illinois law applied because only the Illinois Insurance Code, and not New York law, provides for attorney fees when a reinsurer unreasonably fails to settle a claim. Second, New York had more significant contacts because the reinsurer was a New York company, and the place of performance and last act under the reinsurance contract was either in New York or Michigan. The court found that the Illinois contacts were that the cedent had an Illinois attorney and the arbitration took place in Illinois. Despite Illinois' interest in discouraging alleged unreasonable conduct by insurers, the court held that New York had the most significant contacts and that New York law applied. As such, under New York law, the cedent could not recover attorney fees from the reinsurer.

What makes this case interesting is that it is post-arbitration litigation over an alleged state law right to attorney fees after the appeals court held that the arbitrators lacked the authority to award attorney fees. This only becomes an issue in states where statute provides a remedy to parties that cannot be granted by an arbitration panel.

Summary of Amerisure Mut. Ins. Co. v. Global Reinsurance Corp. of Am., No. 10 L 012665 (Ill. Cir. Ct. Nov. 7, 2012). Submitted by Larry P. Schiffer, Patton Boggs, LLP, New York, NY, (646) 557-5100, lschiffer@pattonboggs.com and Joseph Kaufman, Washington, D.C., (202) 457-5132, jkaufman@pattonboggs.com.

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otherwise willing policyholders because of their risk of forfeiting their excess coverage. This dynamic may cause policyholders to include excess insurers in coverage disputes with primary and umbrella insurers and to cause policyholders to attempt to gain the excess insurers' consent to settlements with underlying insurers.

For years, we have been told that public policy favors settlements.[1] We have come to expect in many instances that courts may do what it takes to promote and incentivize settlements. This may include protecting settling insurers from claims for contribution against them by non-settling insurers,[2] and allowing policyholders to settle with primary or umbrella insurers for an amount less than the policy limits and make up the difference out of their own pockets while preserving the coverage afforded under excess policies.[3]

Increasingly, however, courts are enforcing policy language found in excess policies regarding exhaustion of underlying insurance and holding that policyholder settlements with underlying insurers for an amount less than the full underlying insurance policy limits forfeits coverage under otherwise available excess insurance.[4] Because of the importance of the language of the exhaustion clause to this analysis, this discussion makes a point of quoting the language of the cases discussed.

Simplistically, courts examining this issue fall into one of these two approaches, either exalting the goal of promoting settlements over all else or preferring to enforce insurance contract language evincing the intent of the parties even if that makes settlement more difficult. Courts wishing to promote settlement often find the exhaustion clause in the excess policies at issue to be ambiguous, thereby allowing the policyholder to preserve its right to access excess insurance coverage. Other courts, however, hold that the language of the exhaustion clause is clear and unambiguous and that a sub-policy limits settlement with an underlying insurer forfeits available excess coverage. These courts ultimately value enforcing the intent of the parties as expressed in their contracts more than achieving a result, such as settling disputes.

Cases Promoting Settlement

A leading case in favor of promotion of settlement and permitting policyholders to preserve access to excess insurance coverage is *Zeig*.[5] In *Zeig,* the policyholder settled with its primary insurer for an amount less than the primary policy's limits.[6] The excess insurer argued that the consequence of this was that the policyholder could not claim under the excess policy, under a clause that provides the underlying insurance be "exhausted in the payment of claims to the full amount of the expressed limits." The Second Circuit rejected the excess insurer's position as "unnecessarily stringent,"[7] finding the requirement of exhaustion by "payment of claims" to be ambiguous.

The *Zeig* court explained:

> It is doubtless true that the parties could impose such a condition precedent to liability upon the policy, if they chose to do so. But the defendant had no rational interest in whether the insured collected the full amount of the primary policies, so long as it was only called upon to pay such portion of the loss as was in excess of the limits of those policies. To require an absolute collection of the primary insurance to its full limit would in many, if not most, cases involve

1 *See, e.g.* Trinity Homes LLC v. Ohio Cas. Ins. Co., 629 F.3d 653, 659 (7th Cir. 2010) (applying Indiana law) ("Unless the clear language of the contract counsels otherwise, Indiana public policy favors an interpretation that encourages – not discourages – settlement.").

2 *See, e.g.,* One Beacon America Ins. Co. v. American Motorists Ins. Co., 679 F.3d 456, 463 (6th Cir. 2012) (applying Ohio law) ("An insurer would have no incentive to settle with a policyholder if it knew that it would be liable to another insurer down the road."); Koppers Co., Inc. v. Aetna Cas. & Sur. Co., 98 F.3d 1440, 1452 (3d Cir. 1996) (applying Pennsylvania law) (holding non-settled insurers may not claim against settled insurers for contribution, but instead have the benefit of the "apportioned share set-off rule.")

3 *See, e.g.* Zeig v. Massachusetts Bonding & Ins. Co., 23 F.2d 665 (2d Cir. 1928) (applying New York law); Trinity Homes LLC, supra, 629 F.3d 653; Maximus, Inc. v. Twin City Fire Ins. Co., 856 F. Supp. 2d 797 (E.D. Va. 2012); Pacific Employers Ins. Co. v. Clean Harbors Envt'l Services, Inc., No. 08-C-2180, 2011 WL 813905 (N.D. Ill. 2011); *The* Mills Ltd. Partnership v. Liberty Mut. Ins. Co., C.A. No. 09C-11-174FSS, 2010 WL 8250837 (Del. Super. Ct. Nov. 5, 2010); Cincinnati Ins. Co. v. Franck, 644 N.W.2d 471 (Minn. Ct. App. 2002); Rummel v. Lexington Ins. Co., 123 N.M. 752, 945 P.2d 970 (1997); Drake v. Ryan, 514 N.W.2d 785 (Minn. 1994).

4 *See, e.g.,* Citigroup Inc. v. Federal Ins. Co., 649 F.3d 367 (5th Cir. 2011) (applying Texas law); Great American Ins. Co. v. Bally Total Fitness Holding Corp., No. 06-C-4554, 2010 WL 2542191 (N.D. Ill. 2010); Comerica Inc. v. Zurich American Ins. Co., 498 F. Supp. 2d 1019 (E.D. Mich. 2007); Intel Corp. v. American Guar. & Liab. Ins. Co., 51 A.3d 442 (Del. 2012) (applying California law); JP Morgan Chase & Co. v. Indian Harbor Ins. Co., 98 A.D.3d 18, 947 N.Y.S.2d 17 (N.Y. App. Div. 1st Dep't 2012) (applying Illinois law); Qualcomm, Inc. v. Certain Underwriters at Lloyd's, London, 161 Cal. App. 4th 184, 73 Cal. Rptr. 3d 770 (Cal. Ct. App. 2008), *review denied*, (Cal. June 11, 2008).

5 *Id.*

6 The primary policy afforded $15,000 in limits, but the policyholder settled with its primary insurer for $6,000. *Id.* at 665.

7 *Id.* at 666.

> delay, promote litigation, and prevent an adjustment of disputes which is both convenient and commendable. A result harmful to the insured, and of no rational advantage to the insurer, ought only to be reached when the terms of the contract demand it.[8]

Examining the excess policy language at issue, the *Zeig* court concluded it did not require "collection" of the full amount of the primary insurance, only that it be "exhausted in the payment of claims to the full amount of the expressed limits."[9] The court found the term "payment" ambiguous in the context and held "[t]o render the policy in suit applicable, claims had to be and were satisfied and paid to the full limit of the primary policies. Only such portion of the loss as exceeded, not the cash settlement, but the limits of these policies, is covered by the excess policy."[10]

The *Zeig* court's approach has been followed by certain courts.[11] For example, in *Trinity Homes LLC v. Ohio Cas. Ins. Co.,*[12] the Seventh Circuit, applying Indiana law, examined whether a policyholder's settlement with its primary insurers, where the primary insurers "paid at least seventy-five percent of the policy limit and [the policyholder] made up the difference, was sufficient to exhaust the CGL's policy coverage under the umbrella policy."[13] The umbrella policy's exhaustion clause provided that "[i]f the limits of 'underlying insurance' have been reduced by payment of claims, this policy will continue in force as excess of the reduced 'underlying insurance.'"[14] Finding the exhaustion clause to be ambiguous, the *Trinity Homes* court explained:

> While the umbrella agreement does state that a CGL policy is exhausted when the policy limit has been completely expended, it does not clearly provide that the full limit must be paid out by the CGL insurer alone. As such, the policy is ambiguous and susceptible to the meaning put forth by [the policyholder] – that a CGL policy can be exhausted when an insured and a CGL insurer enter into a settlement agreement where the primary insurer will pay a large percentage of the total limit and the insured takes responsibility for the remainder.[15]

In reaching this conclusion, the *Trinity Homes* court distinguished the policy language in the umbrella policy in that case from the exhaustion clauses at issue in *Comerica*,[16] and *Qualcomm,*[17] explaining that in each of those cases "the policy clearly stated that the coverage was not triggered absent a payment of the full CGL policy limit by the insurer."[18] Moreover, the court concluded that this result was consistent with public policy encouraging settlement, reasoning:

> [The umbrella insurer's] reading of the policy would deter parties who have both CGL and excess insurance from settling with their CGL insurers. Rather than agree to a lower payout by a CGL provider as part of a settlement, an insured with an excess policy would be forced to fully litigate each and every one of its CGL policy claims before seeking recourse from its umbrella insurer. Unless the clear policy language of the contract counsels otherwise, Indiana public policy favors an interpretation that encourages – not discourages – settlement.[19]

Similarly, in *Maximus, Inc. v. Twin City Fire Ins. Co.,*[20] the federal district court in Virginia addressed a

8 *Id.*

9 *Id.*

10 *Id.*

11 *See supra* at n. 3.

12 629 F.3d 653 (7th Cir. 2010) (applying Indiana law).

13 *Id.* at 658.

14 *Id.*

15 *Id.*

16 *Comerica Inc. v. Zurich American Ins. Co.*, 498 F. Supp. 2d 1019, 1022 (E.D. Mich. 2007).

17 *Qualcomm, Inc. v. Certain Underwriters at Lloyd's, London,* 161 Cal. App. 4th 184, 73 Cal. Rptr. 3d 770, 778 (2008), review denied, (Cal. June 11, 2008).

18 *Trinity Homes, supra,* 629 F.3d at 658-59.

19 *Id.* at 659. Significantly, as noted below, not all courts have found the same exhaustion clause at issue in *Trinity Homes* to be ambiguous. *See, e.g., Citigroup Inc. v. Federal Ins. Co.*, 649 F.3d 367 (5th Cir. 2011) (applying Texas law); *JP Morgan Chase & Co. v. Indian Harbor Ins. Co.*, 98 A.D.3d 18, 947 N.Y.S.2d 17 (N.Y. App. Div. 1st Dep't 2012) (applying Illinois law); *Danbeck v. American Family Mut. Ins. Co.*, 245 Wis.2d 186, 629 N.W.2d 150 (2001).

20 856 F. Supp. 2d 797 (E.D. Va. 2012).

dispute between a policyholder and high-level excess insurer over whether the policyholder's settlements with underlying primary and excess insurers for amounts less than the full policy limits satisfied the exhaustion clause in the excess policy. The exhaustion clause in the excess policy provided that the policy "shall apply only after all applicable Underlying Insurance with respect to an Insurance Product has been exhausted by actual payment under such Underlying Insurance …."[21] The court concluded that this "neither states that actual payment requires payment of the full limit of an underlying policy by the lower-tier carriers, nor does it expressly preclude the insured from filling the gap to exhaust the underlying policy."[22] The court observed that "[i]ncluding language making clear that exhaustion requires the carriers themselves to pay out the full amount of their policies, or even a clear statement that settling for less than the full amount of coverage voids the excess coverage, would render the exhaustion provision absolutely clear."[23]

Cases Enforcing The Parties' Intent

In contrast, a number of courts have rejected consideration of public policy favoring settlement, preferring instead to focus on the intent of the contracting parties based on the contract language chosen for the exhaustion clause in the excess policy. Courts limiting their construction of the exhaustion language tend to hold that policyholder settlements with underlying insurers for amounts less than the underlying insurance policy limits fail to exhaust the underlying insurance and, thereby, forfeit excess coverage.

For example, in *Qualcomm, Inc. v. Certain Underwriters at Lloyd's, London,*[24] the California Court of Appeal held that a policyholder's settlement with an underlying insurer for a sub-policy limits amount forfeited available excess coverage, The California Court of Appeal rejected the rationale of *Zeig,* for three reasons:

(1) "the [*Zeig*] court appeared to place policy considerations (*i.e.,* the promotion of convenient settlement or adjustment of disputes) above the plain meaning of the terms of the excess policy";

(2) "we disagree with its strained interpretation of the word "payment"; and

(3) differences in language in the exhaustion clause contained in the excess policy at issue.[25]

Indeed, courts following the *Qualcomm* court's approach often cite similar reasons for doing so.

In *Qualcomm,* the policyholder settled with its primary insurer for $16 million on a policy with $20 million in limits.[26] The policyholder sought excess coverage under a policy containing an exhaustion clause providing that "Underwriters shall be liable only after the insurers under each of the Underlying Policies have paid or have been held liable to pay the full amount of the Underlying Limit of Liability," and also providing "[t]his Policy does not provide coverage for any loss not covered by the [underlying policy] except and to the extent that such loss is not paid under the [underlying policy] solely by reason of the reduction or exhaustion of the Underlying Limit of Liability through payments of loss thereunder."[27] The court held that "the phrase 'have paid … the full amount of [$20 million],' particularly when read in the context of the entire excess policy and its function as arising upon exhaustion of primary insurance, cannot have any other reasonable meaning than actual payment of no less than the $20 million underlying limit."[28]

The *Qualcomm* court distinguished and disagreed with *Zeig,* explaining that *Zeig* exalted public policy considerations such as promoting settlements "above the plain meaning of the terms of the excess policy."[29] In addition, the court disagreed with the *Zeig* court's conclusion that the term "payment" in the exhaustion clause was ambiguous,[30] citing cases like the Wisconsin Supreme Court's decision in *Danbeck v. American Family Mut. Ins. Co.*[31] Finally, the court concluded that the exhaustion clause at issue was clear and unambiguous and different than the clause at issue in

21 *Id.* at 799.
22 *Id.* at 801.
23 *Id.* at 803.
24 *Qualcomm, Inc. v. Certain Underwriters at Lloyd's, London,* 161 Cal. App. 4th 184, 73 Cal. Rptr. 3d 770 (2008), review denied, (Cal. June 11, 2008).
25 *Id.,* 73 Cal. Rptr. 3d at 780.
26 *Id.*
27 *Id.,* 73 Cal. Rptr. 3d at 773-74.
28 *Id.,* 73 Cal. Rptr. 3d at 778.
29 *Id.,* 73 Cal. Rptr. 3d at 780.
30 *Id.*
31 245 Wis. 2d 186, 629 N.W.2d 150 (2001).

Zeig.[32] Significantly, the exhaustion clause in *Qualcomm* specifically required the underlying insurers to have paid their full policy limits.

Likewise in *Citigroup, Inc. v. Federal Ins. Co.,*[33] the policyholder reached a settlement with its primary insurer for less than half of the policy limits, and then commenced an action against its excess insurers. The excess insurers maintained, and the district court agreed, that the settlement barred coverage under the excess policies. In affirming, the Fifth Circuit examined the exhaustion clauses in the excess policies that alternatively required payment in cash of the "full amount" of the underlying insurer's limits to be paid by the underlying insurance carriers, payment in legal currency by the underlying carriers of the "total" limit of liability, that underlying insurers shall have agreed to pay or have been held liable to pay the "full amount" of the underlying limits, or that there has been exhaustion of the underlying limits solely as a result of "payment of loss thereunder," before excess coverage attaches.[34] The *Citigroup* 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." In addition, the court held, similarly, that the other exhaustion clauses were not ambiguous. In reaching this result, the court cited with approval the decisions in *Qualcomm* and *Comerica,* and rejected arguments that the exhaustion clauses in the excess policies were ambiguous or that public policy favoring settlements as expressed in *Zeig* required a different result.

Similarly, in *Great American Ins. Co. v. Bally Total Fitness Holding Corp.,*[35]the federal district court in Illinois examined a scenario in which the policyholder settled with its primary and first and second excess layer insurers for $19.5 million under policies with limits of liability of $30 million. The third and fourth excess layer insurers maintained that the settlement voided excess coverage for the claim. The exhaustion clauses provided that "liability for any covered Loss shall attach to the Insurer only after the insurers of the Underlying Policies shall have paid, in the applicable legal currency, the full amount of the Underlying Limit ….", or "[i]n the event of exhaustion of all of the limits of insurance of the Underlying Insurance solely as a result of actual payment of loss or losses thereunder, this Policy shall … apply as Primary Insurance …."[36] The court held that these exhaustion clauses clearly and unambiguously defined how exhaustion must occur and found that the settlements failed to constitute exhaustion of the underlying insurance.[37]

Further, in *Comerica Inc. v. Zurich American Ins. Co.,*[38] the federal district court in Michigan addressed a case in which the policyholder settled with its primary insurer for $14 million under a policy with limits of $20 million. The policyholder had settled underlying cases against it for $21 million and sought coverage of $1 million in indemnity and additional amounts for defense under an excess policy. The excess insurer refused to pay on the basis that the primary coverage had not been exhausted. The exhaustion clause provided that "[c]overage hereunder shall attach only after all such 'Underlying Insurance' has been reduced or exhausted by payments for losses …, " and the policy further provided that "[i]n the event of the depletion of the limit(s) of liability of the 'Underlying Insurance' solely as a result of actual payment of loss thereunder by the applicable insurers, this Policy shall … continue to apply to loss …."[39] The *Comerica* court held:

> [T]he excess policy in this case likewise requires that the primary insurance be exhausted or depleted by the actual payment of losses by the underlying insurer. Payments by the insured to fill the gap, settlements that extinguish liability up to the primary insurer's limits, and agreements to give the excess insurer 'credit' against a judgment or

32 *Id.*, 73 Cal. Rptr. 3d at 780.

33 649 F.3d 367 (5th Cir. 2011) (applying Texas law).

34 The Federal policy provided that coverage attaches only after "(a) all Underlying Insurance carriers have paid in cash the full amount of their respective liabilities, (b) the full amount of the Underlying Insurance policies have been collected by the plaintiffs, the Insureds or the Insureds' counsel, and (c) all Underlying Insurance has been exhausted." *Id.*, 649 F.3d at 372. The St. Paul policy stated that "[t]he Insurer shall only be liable to make payment under this policy after the total amount of the Underlying Limit of Liability has been paid in legal currency by the insurers of the Underlying Insurance as covered loss thereunder." The SR policy provided that coverage attaches "only after an Insurer subscribing to any Underlying Policy shall have agreed to pay or have been held liable to pay the full amount of its respective limits of liability as set forth in Item 5. Of the Declarations." The Steadfast policy provided that coverage attaches "[i]n the event of the exhaustion of all of the limit(s) of liability of such 'Underlying Insurance' solely as a result of payment of loss thereunder."

35 No. 06-C-4554, 2010 WL 2542191 (N.D. Ill. 2010).

36 2010 WL 2542191.

37 *Id.*

38 498 F. Supp. 2d 1019 (E.D. Mich. 2007).

39 *Id.* at 1022.

> settlement up to the primary insurer's liability limit are not the same as actual payment.[40]

In *Intel Corp. v. American Guar. & Liab. Ins. Co.,*[41] the Delaware Supreme Court, applying California law addressed a case in which the policyholder settled with an underlying insurer for $27.5 million under a policy with limits of $50 million. The policyholder then claimed that the excess insurer was obligated to reimburse millions in defense costs excess of the underlying insurance limits. The excess policy provided "[n]othing contained in this Endorsement shall obligate us to provide a duty to defend any claim or suit before the Underlying Insurance Limits … are exhausted by payment of judgments or settlements."[42] It was undisputed that the policyholder had paid significant defense costs out of its own pocket. The 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."[43] 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."[44] The court underscored that "[p]lain policy language on exhaustion, such as that contained in [the policy at issue] will control despite competing public policy concerns."[45]

In *JP Morgan Chase & Co. v. Indian Harbor Ins. Co.,*[46] the New York Appellate Division, First Department, applying Illinois law addressed a case in which the policyholder reached settlements with an underlying insurer and one of its affiliated insurers on a separate insurance program. As a result of the settlements, there was no way to determine that a settling underlying insurer paid the full amount of its policy limits. The excess policy's exhaustion clause 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."[47] 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 underlying insurer paid the full amount of its policy.[48] Relying on *Bally Total Fitness, Citigroup* and *Qualcomm,* 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."[49]

The *JP Morgan* court distinguished the case from *Zeig,* 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."[50] 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.'"[51]

Conclusion

The risk presented by the above cases – that a policyholder's sub-policy limits settlement with an underlying insurer may forfeit its excess coverage – may make for more protracted coverage litigation. A policyholder who would have been willing to provide a substantial coverage discount to primary or umbrella insurers for good coverage defenses may be unable to do so without possibly losing its excess insurance. Cases that may have settled may, therefore, instead have to be litigated to a conclusion. Policyholders may choose

40 *Id.* at 1032.
41 51 A.3d 442 (Del. 2012) (applying California law).
42 *Id.* at 448.
43 *Id.* at 449.
44 *Id.*
45 *Id.* at 450 (citing *Qualcomm, supra,* 73 Cal. Rptr. 3d at 778-79).
46 98 A.D.3d 18, 947 N.Y.S.2d 17 (N.Y. App. Div. 1st Dep't 2012) (applying Illinois law).
47 *Id.*, 947 N.Y.S.2d at 20.
48 *Id.*, 947 N.Y.S.2d at 20-21.
49 *Id.*, 947 N.Y.S.2d at 21.
50 *Id.*, 947 N.Y.S.2d at 22.
51 *Id.*, 947 N.Y.S.2d at 23.

to make excess insurers parties to coverage litigation even where the excess insurers' attachment points are unlikely to be reached in order to try to bind the excess insurers to the terms of their settlements with underlying insurers. Excess insurers may not have priced in the added litigation cost of being made a party to coverage disputes that they may not have previously been made to bear. However, because coverage disputes are supposed to turn on the intent of the parties, as expressed in the plain language of their contracts, here the excess insurance policies, the perceived negative consequences of enforcing exhaustion clauses are not sufficient reason, in the opinion of a number of courts, to disregard clear and unambiguous exhaustion clause language.

2013 TIPS CALENDAR

April 2013

4-5	**Emerging Issues in Motor Vehicle Product Liability Litigation National Program** Contact: Donald Quarles – 312/988-5708	**Arizona Biltmore Resort & Spa Phoenix, AZ**
5-6	**Toxic Torts & Environmental Law Committee Midyear Meeting** Contact: Felisha A. Stewart – 312/988-5672	**Arizona Biltmore Resort & Spa**
13-17	**TIPS National Trial Academy** Contact: Donald Quarles – 312/988-5708	**Grand Sierra Resort Reno, NV**
15	**TIPS Premier Program** Contact: Earnestine Murphy – 312/988-6204	**ABA Center for CLE**
19	**Current Issues in Insurance Regulation** Contact: Ninah F. Moore – 312/988-5498	**New York City Bar New York, NY**
24-28	**TIPS & Judicial Division Joint Spring Meeting** Contact: Felisha A. Stewart – 312/988-5672 Speaker Contact: Donald Quarles – 312/988-5708	**JW Marriott Washington, DC Washington, DC**
24	**ADR National CLE Forum** Contact: Felisha A. Stewart – 312/988-5672 Speaker Contact: Donald Quarles – 312/988-5708	**JW Marriott Washington, DC Washington, D.C.**

May 2013

2- 4	**Fidelity & Surety Committee Spring Meeting** Contact: Donald Quarles – 312/988-5708	**Walt Disney World Swan Orlando, FL**
16-18	**Property Insurance Law Committee Spring CLE Meeting** Contact: Ninah F. Moore – 312/988-5498	**PGA National Resort & Spa Palm Beach Gardens, FL**