RECENT DEVELOPMENTS IN EXCESS INSURANCE AND REINSURANCE

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This article analyzes key legislative, regulatory, and case law developments within the distinct areas of excess insurance and reinsurance between October 1, 2012, and September 30, 2013.

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I. EXCESS INSURANCE

A. *Self-Insured Retentions and Allocation*

The New York high court examined application of self-insured retentions to long-tail claims. In *Roman Catholic Diocese of Brooklyn v. National Union Fire Insurance Co. of Pittsburgh, Pa.*,[1] the New York Court of Appeals determined the number of occurrences in connection with repeated clergy sexual abuse, revisited allocation of liability over multiple policy periods, and answered whether the insured could be made to pay a full self-insured retention (SIR) for each annual policy period during which the abuse occurred. The complaint against the diocese alleged that a "priest sexually abused [the minor plaintiff] on several occasions from [August 1996] through May 2002" and at several different locations.[2] "[T]he Diocese settled the action for $2 million."[3] The diocese sought recovery of the settlement amount under its primary CGL insurance policies, including under three annual CGL insurance policies issued by National Union.[4] The National Union policies afforded coverage for damages because of bodily injury during the policy period, subject to a $250,000 SIR.[5] The court first addressed the number of occurrences from the sexual abuses. National Union asserted that "the incidents of sexual abuse . . . constituted a separate occurrence in each of the seven implicated policy periods and required the exhaustion of a separate $250,000 SIR for each occurrence. . . ."[6] National Union also moved for a declaration that the $2 million settlement be allocated on a pro rata time-on-the-risk basis across each of the seven triggered policy periods.[7] The diocese contended that "the sexual abuse constituted [but] a single occurrence requiring the exhaustion of only one SIR" and that there should be no allocation of the liability.[8] The court revisited its decision in *Appalachian Insurance Co. v. General Electric Co.*,[9] which held that "absent policy language indicating an intent to aggregate separate incidents into a single occurrence, the unfortunate event test should be applied to determine how occurrences are categorized for insurance coverage purposes."[10] "[T]he unfortunate event test requires consideration of 'whether there is a close temporal and spatial relationship between the incidents giving rise to injury or loss, and

1. 991 N.E.2d 666 (N.Y. 2013).
2. *Id.* at 668.
3. *Id.*
4. *Id.* at 669.
5. *Id.*
6. *Id.* at 670.
7. *Id.* at 669–70.
8. *Id.*
9. 863 N.E.2d 994 (N.Y. 2007).
10. *Diocese of Brooklyn*, 991 N.E.2d at 672 (citing *Appalachian Ins.*, 863 N.E.2d 994).

whether the incidents can be viewed as part of the same causal continuum, without intervening agents or factors.' "[11] The court concluded that there was "nothing in the [policy] language . . . [that] evince[d] an intent to aggregate the incidents of sexual abuse into a single occurrence" and that "the incidents of sexual abuse within the underlying action constituted multiple occurrences."[12] Further, the court explained, "[c]learly, incidents of sexual abuse that spanned a six-year period and transpired in multiple locations lack the requisite temporal and spatial closeness to join the incidents."[13] The court noted "the policies define occurrence as including 'continuous or repeated exposure to substantially the same general harmful conditions.' "[14] The court found that "sexual abuse does not fit neatly into the policies' definition of 'continuous or repeated exposure' to 'conditions,' " which it agreed "sounds like language designed to deal with asbestos fibers in the air, or lead-based paint on the walls, rather than with priests and choirboys."[15]

The diocese argued that it could pay a single SIR amount and still access all of the primary limits of insurance without paying a full SIR in each policy period. Following a majority of courts that have considered the issue, the court held that "the Diocese must exhaust the SIR for each occurrence that transpires within an implicated policy from which it seeks coverage."[16] The court noted that "[t]he policies provide that the SIR 'shall apply separately to each occurrence' and only to 'occurrences covered under [the] policy' . . .[;] [thus], [t]he only occurrences that are subject to the policies are those with damages resulting from bodily injuries that occur within the policy period."[17] Accordingly, the court held that "the SIR applies to an occurrence with bodily injuries within the policy period, not to an occurrence with injuries sustained in a subsequent policy year."[18] The result of this is that most of the settlement amount paid by the diocese fell within the SIRs. Finally, the diocese asked the court to adopt a joint and several or "all sums" approach, which would permit it to choose which policy would respond to a loss. The diocese wanted to choose a single period, pay a single SIR, and access coverage. However, the court adhered to the pro rata time-on-the-risk allocation rule that it previously adopted in *Consolidated Edison Co. of New York, Inc. v. Allstate Insurance Co.*[19] In *Con Ed*, the court was not faced with a loss actually being apportioned among multiple policies. In-

11. *Id.* (quoting *Appalachian Ins.*, 863 N.E.2d at 999).
12. *Id.*
13. *Id.*
14. *Id.* at 674.
15. *Id.*
16. *Id.* at 675 (citing Olin Corp. v. Ins. Co. of N. Am., 221 F.3d 307, 328 (2d Cir. 2000)).
17. *Id.*
18. *Id.* at 675–76.
19. 774 N.E.2d 687 (N.Y. 2002).

stead, high-level excess insurers successfully argued that a pro rata allocation rendered the claims against them nonjusticiable because the allocated liability would not reach the excess policies' attachment points. Here, however, the court concluded it was appropriate to actually allocate liability using the pro rata time-on-the-risk approach.[20] Adhering to a pro rata allocation rule, the court explained that "[p]lainly, the policy's coverage is limited only to injury that occurs within the finite one-year coverage period of the policy."[21] In the clergy sex abuse case, the court found that "assuming that the minor plaintiff suffered 'bodily injury' in each policy year, it would be consistent to allocate liability across all implicated policies, rather than holding a single insurer liable for harm suffered in years covered by other successive policies."[22] Accordingly, the court allocated the loss on a pro rata basis.[23]

The Second Circuit was asked to address allocation of liability under policies with a "continuing coverage" provision. In *Olin Corp. v. American Home Assurance Co.*,[24] an environmental property damage case involving environmental contamination over an extended period, the Second Circuit construed the London policy form's "Condition C," titled "Prior Insurance and Non-Cumulation of Liability in excess policies." The court held that Condition C required a following form excess insurer to indemnify Olin 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 noncumulation provision to limit the number of policies required to pay.[25]

Olin claimed insurance coverage for environmental contamination at a California manufacturing site under two excess liability policies issued by American Home with an attachment point of $30.3 million for the years 1966–69 and 1969–72.[26] The district court held that the excess policies' attachment point could not be reached, where total damages of $102 million were allocated over a thirty-one-year trigger period, under New York's pro rata allocation rules, for a per-year damage amount of $3.3 million.[27]

The Second Circuit reversed, however, concluding that the normal pro rata allocation approach was modified by Underwriters at Lloyd's Condition C: "Prior Insurance and Non-Cumulation of Liability."[28] Condition C has two parts: a prior insurance provision and a continuing coverage provision. The primary issue was the effect of the continuing coverage

20. *Diocese of Brooklyn*, 991 N.E.2d at 676–77.
21. *Id.* at 676.
22. *Id.*
23. *Id.*
24. 704 F.3d 89 (2d Cir. 2012).
25. *Id.* at 101–02, 104.
26. *Id.* at 95.
27. *Id.*
28. *Id.* at 101–02.

provision, which provided: "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."[29]

The court held that "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."[30] 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."[31] "The 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."[32] Accordingly, the court ruled that "[b]ecause each of these figures exceeds the $30.3 million attachment point, summary judgment was inappropriate."[33] Effectively, the "continuing coverage" provision rendered the policies liable for the pro rata share of each year in the policy period and each year thereafter.

Addressing the "prior insurance" provision of Condition C, the Second Circuit held "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."[34] 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."[35] Thus, only one of the two excess policies indemnified for the loss.

B. *Exhaustion*

In this survey, we examine several decisions concerning umbrella and excess insurers' rights with respect to underlying exhaustion. In *John Crane, Inc. v. Admiral Insurance Co.*,[36] an Illinois Appellate Court addressing an asbestos bodily injury insurance coverage dispute between an insured and its umbrella and excess insurers held that those insurers have standing to object to a settlement agreement between the insured and one of its primary insurers.[37]

29. *Id.* at 99–100.
30. *Id.* at 101–02.
31. *Id.* at 102.
32. *Id.*
33. *Id.*
34. *Id.* at 104.
35. *Id.*
36. 991 N.E.2d 474 (Ill. App. Ct. 2013).
37. *Id.* at 485.

The insured claimed exhaustion of primary policies on the basis of a settlement agreement with Kemper. The settlement agreement characterized the primary policies issued by Kemper as paying defense costs within the limits, essentially eroding the limits rather than being in addition to the limits. The umbrella and excess insurers objected that the coverage agreement was not proof of exhaustion of the Kemper primary policies.[38] The Illinois Appellate Court held that "[t]his change in the primary policy limits clearly affects a legally cognizable interest of the excess and umbrella insurers."[39] The court concluded that "the horizontal exhaustion doctrine requires Crane to prove that all of Kemper's primary policy limits, as written before the parties entered into the [coverage agreement], were exhausted before the umbrella or excess carriers would be required to contribute to any settlement or judgment."[40] Further, the court applied a joint and several liability rule based on *Zurich Insurance Co. v. Raymark Industries, Inc.*[41] and held that "where coverage for asbestos-related injury claims is triggered for bodily injury or sickness or disease, all triggered policies are jointly and severally liable."[42]

The Second Circuit addressed what constituted proper underlying exhaustion—payment of loss or incurring liability. In *Ali v. Federal Insurance Co.*,[43] a policyholder sought coverage under an excess directors and officers insurance policy "once the total amount of [the Directors'] defense and/or indemnity obligations exceeds the limits" of the underlying insurance.[44] The excess insurer argued its excess insurance coverage attached only after the underlying insurance limits were exhausted "as a result of payment of losses thereunder," in accordance with the policy's exhaustion clause.[45]

The Second Circuit, applying New York law, agreed with the insurer, holding " 'obligations' are not synonymous with 'payments' on those obligations. To hold otherwise would make the 'payment of' language in these excess liability insurance contracts superfluous."[46] In addition, the Second Circuit specifically rejected arguments that *Zeig v. Massachusetts Bonding & Insurance Co.*[47] or a public policy favoring settlements mandated a contrary result.[48]

38. *Id.*
39. *Id.*
40. *Id.* at 487.
41. 514 N.E.2d 150 (Ill. 1987).
42. *John Crane, Inc.*, 991 N.E.2d at 491.
43. 719 F.3d 83, 90 (2d Cir. 2013).
44. *Id.* at 87.
45. *Id.* at 91.
46. *Id.*
47. 23 F.2d 665 (2d Cir. 1928).
48. *Ali*, 719 F.3d at 92.

The Pennsylvania Superior Court addressed exhaustion in connection with a settlement agreement for both covered and noncovered claims. In *Executive Risk Indemnity, Inc. v. Cigna Corp.*,[49] Cigna faced claims in "multi-district litigation where doctors countrywide sued HMOs, including Cigna, alleging the providers had been . . . underpaying claims by billions of dollars."[50] The claims against Cigna included noncovered breach of contract claims and covered RICO claims.[51] Cigna reached a settlement of the claims, agreeing to pay $140 million.[52] Executive Risk, an excess insurer, attached excess of $65 million[53] and "refused to indemnify Cigna" for the settlement, on the basis that its attachment point was not reached because most of the settlement was allegedly paid for the noncovered breach of contract claims and not for the covered RICO claims.[54] The central issue was which party bore the burden of proving how to apportion the settlement as between covered and noncovered claims—the insured or the insurer? The court held that "the insured is the party that should bear the burden of proof for apportionment of claims in this case," concluding that this is "best proven by the insured, the party that has access to the evidence and the parties' intent behind the settlement process."[55] Thus, the insured's apportionment of a settlement between covered and noncovered claims required proof, with the burden on the insured as to its reasonableness.

C. *Priority of Coverage*

The Illinois Appellate Court had occasion to address priority of coverage rules and Illinois's targeted tender rule, holding that priority of coverage trumps targeted tender. In *Vedder v. Continental Western Insurance Co.*,[56] the court addressed a party's attempt 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.[57] Nonetheless, the driver tried to require the excess coverage to defend in place of her own primary coverage.[58]

The driver's insurer attempted to rely on Illinois's targeted tender rule, which permits an insured, where multiple policies each affords primary

49. 74 A.3d 179, 181 (Pa. Super. Ct. 2013).
50. *Id.* at 180 n.2.
51. *Id.* at 181.
52. *Id.* at 182.
53. *Id.* at 183 n.6.
54. *Id.* at 182–84.
55. *Id.* at 183.
56. 978 N.E.2d 1111 (Ill. App. Ct. 2012).
57. *Id.* at 1116.
58. *Id.* at 1114.

coverage, to choose the policy that is to afford it a defense.[59] 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."[60] Indeed, "an insured cannot target tender a defense to his excess insurer while primary coverage remains unexhausted."[61] The court held that the driver could not target tender her defense where she "did not pay a premium for or bargain for coverage under the [ambulance service's] policy"; "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."[62]

The court also addressed priority of coverage in connection with the "all sums" rule. The driver's insurer attempted to rely on the Illinois Supreme Court's all-sums rule in *Zurich Insurance Co. v. Raymark Industries, Inc.*[63] for the proposition 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."[64] 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."[65] Accordingly, the court held that "[t]he excess insurer ha[d] no obligation to defend or indemnify [the driver] until the limits of the primary policy are exhausted."[66]

D. *Late Notice*

The Wisconsin Court of Appeals examined late notice principles under excess policies in connection with an environmental contamination case. In *Ansul, Inc. v. Employers Insurance Co. of Wausau*,[67] the court affirmed a trial court's summary judgment in favor of an excess insurer, holding that the insured's notice of environmental contamination was untimely and prejudicial where the insured delayed providing notice for many years and various forms of prejudice to the insurer were unrebutted.

59. *Id.*
60. *Id.*
61. *Id.* at 1117.
62. *Id.*
63. 494 N.E.2d 634 (Ill. 1986).
64. *Vedder*, 978 N.E.2d at 1118.
65. *Id.* at 1119.
66. *Id.*
67. 826 N.W.2d 110 (Wis. Ct. App. 2012).

The insured caused groundwater contamination at a manufacturing site from the 1950s to 1977. State and federal environmental authorities became involved in the early 1970s, ordering the insured in 1981 "to construct a groundwater treatment system . . . at a cost of over $11 million."[68] In 1990, the U.S. Environmental Protection Agency "determined that significant quantities of arsenic remained"[69] and ordered that it be further remediated.[70] The insured first notified its excess insurer of the contamination and government-ordered remediation in 1997 by commencing a declaratory judgment action against it.[71]

The excess insurer issued multiple excess policies with different policy periods and attachment points ranging from $250,000 to $16 million.[72] The court found 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."[73] However, as early as 1991, the policyholder "began notifying its insurers—but not Lloyd's—that it may be liable for investigation and cleanup."[74] Lloyd's excess policies contained a "notice of occurrence" condition, which provided that "[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 . . . ."[75]

In holding that the notice to Lloyd's was untimely, the court found:

> It is undisputed that, as of 1991, [the insured] 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].[76]

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."[77]

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68. *Id.* at 113.
69. *Id.*
70. *Id.*
71. *Id.*
72. *Id.* at 115.
73. *Id.*
74. *Id.*
75. *Id.* at 116.
76. *Id.*
77. *Id.*

Under Wisconsin's 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."[78] The court held that the insured failed to rebut prejudice where it conceded 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."[79] Accordingly, the court found prejudice existed as a matter of law and the notice defense barred coverage.[80]

E. *Equitable Subrogation and Contribution*

The Oklahoma Supreme Court continued a growing trend of recognizing co-insurers' rights to pursue claims for equitable subrogation and contribution against fellow insurers. In *Steadfast Insurance Co. v. Agricultural Insurance Co.*,[81] the Grand River Dam Authority purchased first-layer excess insurance from Steadfast Insurance Company from 1993 through 2002 and second-layer excess insurance from Agricultural Insurance Company for the same period. Steadfast defended the dam authority against numerous flooding claims made during this period.[82] The flooding took place from 1993 through 2002, but the dam authority and Steadfast entered an agreement that the costs paid by Steadfast for those claims would be allocated to only a single policy in effect from 1993 to 1994.[83] Agricultural objected to this agreement and maintained that it artificially triggered Agricultural's second-layer excess policy by shifting costs payable by Steadfast to Agricultural, in effect permitting premature exhaustion of a Steadfast policy.[84]

Agricultural claimed a right to equitable subrogation against Steadfast for the costs the agreement improperly shifted from Steadfast to Agricultural.[85] The district court had agreed with Steadfast "that equitable subrogation is based on a right derived from the insured and the release in question extinguished all rights [the dam authority] had against Steadfast."[86] In response to a certified question of law from the Tenth Circuit, the Oklahoma Supreme Court held that a second-layer excess insurer had

78. *Id.* at 118.
79. *Id.* at 119.
80. *Id.*
81. 304 P.3d 747 (Okla. 2013).
82. *Id.* at 748.
83. *Id.* at 749.
84. *Id.*
85. *Id.*
86. *Id.*

a right to pursue an equitable subrogation claim against a first-layer excess insurer under these circumstances.[87]

Toward this end, the court discussed the "derivative right rule," accepted by the district court, contrasting it with the "view that equitable subrogation can be pursued in spite of a release by an insured."[88] The court concluded that "the derivative right rule relied upon by Steadfast . . . is inconsistent with Oklahoma's broad view of equitable subrogation."[89] Further, the court found that "Steadfast's notice, if any, of the impact that the settlement and release would have on Agricultural's coverage must be considered in balancing the equities."[90] "Another relevant consideration is whether [the dam authority's] settlement with Steadfast, and its effect on Agricultural's coverage, is consistent with [the dam authority's] implied duty to deal fairly and in good faith with Agricultural."[91] The court emphasized that "[a]n excess insurer has a reasonable economic expectation that it will not be responsible on its policy until the insurance at the level lower to the excess insurer has been exhausted in accordance with the express provisions and obligations of the insurance contract."[92]

II. Reinsurance

A. *Case Law Developments*

Significant case law developments impacting reinsurance addressed a variety of issues in the last year, including consolidation, jurisdiction, vacatur, discovery, expenses, follow-the-fortunes, ex parte communications, and res judicata.

1. Consolidation and Appointment of Umpire

In a key decision involving the expansive role of arbitrators, the court in *Granite State Insurance Co. v. Clearwater Insurance Co.* reaffirmed "that disputes as to the scope of the parties' arbitration agreement are for arbitrators, not the Court," to decide.[93] The court further held that issues of consolidation of arbitrations were within the scope of the arbitration agreement, as well as which "honorable engagement" clause should govern when numerous reinsurance contracts with different language are at issue.[94]

87. *Id.* at 750.
88. *Id.* at 749.
89. *Id.*
90. *Id.*
91. *Id.*
92. *Id.* at 750.
93. No. C 13-2924 SI, 2013 WL 4482948, at *2 (N.D. Cal. Aug. 19, 2013) (citing Cox v. Ocean View Hotel Corp., 533 F.3d 1114, 1119–20 (9th Cir. 2008)).
94. *Id.* at *3.

Granite State involved two cedents making a single demand to their reinsurer under three reinsurance contracts.[95] The arbitrator selection provision under each contract was identical and the parties proceeded to follow those provisions.[96] However, the reinsurer objected to the cedents' demand for a single arbitration covering multiple contracts, expressing concern about which "honorable engagement" clause should govern if a single arbitration was to occur.[97] The cedents petitioned the Court to appoint an umpire in the arbitration, arguing that an impasse had occurred and that, as such, the court was empowered under section 5 of the FAA to do so.[98] The reinsurer objected, arguing that the cedents' initial demand for a single arbitration was invalid.[99] The reinsurer asked the court to exercise its powers under section 4 of the FAA to order the cedents "to participate in three separate arbitrations" or, in the alternative, to rule that its "preferred 'honorable engagement' clause should govern."[100]

The court held that neither of the FAA sections empowered it to decide the scope-of-the-arbitration-agreement questions presented.[101] In reaching this conclusion, the court reasoned that for it to require the parties to appoint three sets of arbitrators, it would have to rule on the validity of the cedents' initial demand for a single arbitration.[102] Such a ruling "would require the [c]ourt to interpret the relevant contracts and decide whether they require[d] one or more arbitrations—a consolidation issue decidedly outside the [c]ourt's purview."[103] Moreover, the FAA did not empower it to order the parties to proceed with three arbitrations where there had not been a proper demand for the same.[104] Lastly, the court reasoned that, "[o]nce selected, the *single* arbitration panel [could] resolve the issues of whether the [cedents]' demand for arbitration was an improper consolidation[ ] [and] which of the three 'honorable engagement' provisions should govern."[105]

95. *Id.* at *1.
96. *Id.*
97. *Id.*
98. *Id.* at *2.
99. *Id.*
100. *Id.*
101. *Id.* at *3 ("To do as either party requests, the Court would necessarily decide the parties' core despite—whether petitioners' November 5, 2012, demand for a single arbitration was improper. Doing so would require the Court to overstep its authority to review arbitration agreements under the FAA.").
102. *Id.*
103. *Id.*
104. *Id.*
105. *Id.* at *4.

2. Proper Jurisdiction

The last year saw three notable cases addressing issues related to the enforcement of jurisdictional clauses. The first case, *Insurance Co. of Pennsylvania v. TIG Insurance Co.*, addressed whether service of suit clauses present in some, but not all, reinsurance contracts under which a cedent sued a reinsurer for payment were sufficient to constitute a waiver to the right of removal to federal court for all of the agreements.[106] The court held that it would suffice.[107]

In *TIG*, the cedent "brought four claims against [its reinsurer] based on the alleged breach of six different facultative certificates, at least three of which did not contain a service of suit clause."[108] The reinsurer removed the action to federal court and the cedent filed a motion to remand the case to state court.[109] The court reasoned that because the action involved a single defendant that had bound itself to service of suit clauses under multiple contracts, the defendant reinsurer had waived its removal rights.[110]

Similarly, in *Employers Insurance Co. of Wausau v. Arrowood Indemnity Co.*, a Wisconsin federal district court addressed the issue of whether it was the proper venue to resolve a dispute between a cedent and its reinsurers over the appointment of arbitrators; the court held that it was not.[111]

Arrowood involved allegations by a cedent that certain of its reinsurers failed to pay claims under a series of reinsurance contracts.[112] As a result, the cedent served each of its reinsurers with an arbitration demand.[113] In proceeding to arbitrate the dispute in accordance with the contracts, the parties could not agree on the appointment of arbitrators and sought court intervention; the cedent filed a petition in New York federal court and the reinsurers filed in Wisconsin federal court.[114] The Wisconsin federal court was thus confronted with the issue of which venue was proper to resolve the parties' dispute.[115]

Central to the court's decision was a provision in the agreement that stated, "arbitration shall take place in New York, New York unless some

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106. 933 F. Supp. 2d 510, 513 (S.D.N.Y. 2013).

107. *Id.* The court found the Eleventh Circuit's reasoning in *Russell Corp. v. American Home Assurance Co.*, 264 F.3d 1040 (11th Cir. 2001), to be persuasive. There, the federal court remanded a state court action brought by an insured "against 23 insurers seeking coverage determinations on 79 policies" because "one of three policies issued by a single defendant contained an operable service of suit clause." *TIG*, 933 F. Supp. 2d at 511. Likewise, here, according to the court: "there [was] even more reason . . . why the service of suit clause should control." *Id.* at 512.

108. 933 F. Supp. 2d at 511.

109. *Id.* at 510–11.

110. *Id.* at 511.

111. No. 12-CV-283-BBC, 2012 WL 5306152, at *4 (W.D. Wis. Oct. 26, 2012).

112. *Id.* at *1.

113. *Id.*

114. *Id.*

115. *Id.*

other place is mutually agreed upon."[116] The cedent principally argued that under section 4 of the FAA, the proper venue was in the court sitting in the jurisdiction where the arbitration would be held.[117] In contrast, the reinsurers argued, among other things, that the provision was merely permissive and that the arbitration did not have to take place in New York.[118] The court agreed with the cedent and transferred the cases to the federal District Court for the Southern District of New York.[119]

Before transferring the case, however, the court engaged in a brief discussion about an argument advanced by both parties in the case: "that the forum selection clause has no bearing on venue in a case brought under [section] 5" of the FAA because, unlike section 4, it "does not include [the] same venue limitation."[120] The court reasoned that a "more natural reading" of the section was "that it set[ ] a condition precedent on obtaining an appointment from the court,[121] not that it provide[d] independent authority to enforce" an arbitration clause about choosing an umpire.[122] According to the court, section 5 was likely meant to be read together with section 4 for a proper understanding of what the court is empowered to do under those sections.[123] Nevertheless, the court stated that even if

116. *Id.*

117. *Id.*

118. *Id.*

119. *Id.* at *4. In doing so, the court observed it was undisputed that this was the proper venue for all asserted claims and counterclaims in the cases. *Id.*

120. *Id.* at *2. Section 5 of the FAA states:

> If in the agreement provision be made for a method of naming or appointing an arbitrator or arbitrators or an umpire, such method shall be followed; but if no method be provided therein, or if a method be provided and any party thereto shall fail to avail himself of such method, or if for any other reason there shall be a lapse in the naming of an arbitrator or arbitrators or umpire, or in filling a vacancy, then upon the application of either party to the controversy the court shall designate and appoint an arbitrator or arbitrators or umpire, as the case may require, who shall act under the said agreement with the same force and effect as if he or they had been specifically named therein; and unless otherwise provided in the agreement the arbitration shall be by a single arbitrator.

9 U.S.C.A. § 5 (West 2014).

121. Namely, "[i]f in the agreement provision be made for a method of naming or appointing an arbitrator or arbitrators or an umpire, such method shall be followed. . . ." *Arrowood*, 2012 WL 5306152, at *3.

122. *Id.*

123. As such,

> [i]t makes sense that § 5 would not address the court's authority to require the parties to follow a particular provision in the arbitration agreement because that authority is provided by section 4. It also makes sense that § 5 would not be limited by a forum selection clause in the arbitration agreement because a § 5 case does not involve interpretation or enforcement of the agreement, but rather relies on the premise that court intervention is needed because the agreement cannot solve the problem.

Id.

its interpretation of section 5 was incorrect, "it would [still] be in the interest of justice to transfer the cases to New York."[124]

Although outside of the reinsurance context, the third case also involved a dispute over the applicability of a jurisdictional provision commonly used in insurance policies. The court in *Union Electric Co. v. AEGIS Energy Syndicate* addressed whether an endorsement incorporating a jurisdictional clause superseded the alternative dispute resolution clause in an excess policy.[125] The court held that it did.[126]

In *Union Electric*, the insured sued its excess insurer to recover on a policy after an accident.[127] One of the policy's conditions provided that disputes between the parties would be resolved in three stages: first negotiation, then mediation, and arbitration last.[128] An endorsement to the contract, however, provided:

> Notwithstanding anything contained in this Policy to the contrary, any dispute relating to this Insurance or to a CLAIM (including but not limited thereto the interpretation of any provision of the Insurance) shall be governed by and construed in accordance with the laws of the State of Missouri and each party agree [sic] to submit to the jurisdiction of the Courts of the state of Missouri.[129]

The excess insurer argued that the endorsement should only be read to complement the mandatory arbitration condition of the policy.[130] The excess insurer further contended that the endorsement was meant to give Missouri courts personal jurisdiction over both parties to only enforce the arbitration provision.[131] The insured, on the other hand, maintained that the endorsement's "plain language" gave Missouri courts jurisdiction over all disputes related to the policy, thus replacing the mandatory arbitration provision, and that in adopting the endorsement the parties intended to conform the policy to Missouri law, which prohibits mandatory arbitration provisions in insurance contracts.[132] The court agreed with the insured, finding the language of the endorsement to be "unambiguously clear" and thus held that it supplanted the condition's mandatory arbitration provision.[133]

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124. *Id.* at *4.
125. 713 F.3d 366 (8th Cir. 2013).
126. *Id.* at 369.
127. *Id.* at 367.
128. *Id.*
129. *Id.* at 368 (parenthetical and "sic" in original).
130. *Id.*
131. *Id.*
132. *Id.*
133. *Id.* at 369.

3. Vacatur

Section 10(a)(4) of the FAA permits a court to vacate an arbitration award where an arbitrator has exceeded her or his powers.[134] Under section 10(a)(4), a court can vacate an arbitration award if the arbitrator has exceeded his or her powers. In a nonreinsurance case, *Oxford Health Plans LLC v. Sutter*, the U.S. Supreme Court held that an arbitrator did not exceed his powers in authorizing class arbitration.[135] Because this ground is one of only a few that parties to a reinsurance dispute may use to challenge an arbitration award, this decision is particularly relevant to reinsurance disputes and to reinsurance arbitrators.

Sutter involved allegations by a physician that Oxford Health Plans failed to fully and promptly pay him and other physicians that had entered into a fee-for-services contract requiring binding arbitration.[136] "The parties agreed that the arbitrator should decide whether their contract authorized class arbitration."[137] However, after the arbitrator concluded that it did, "Oxford filed a motion . . . to vacate the arbitrator's decision, claiming that he had 'exceeded [his] powers' under § 10(a)(4) of the [FAA]."[138]

In its initial analysis of the dispute, the Court reasoned that "the sole question on judicial review [was] whether the arbitrator . . . interpreted the parties' contract, not whether he construed it correctly."[139] "Here, [according to the Court,] the arbitrator twice did what the parties asked: He considered their contract and decided whether it reflected an agreement to permit class proceedings."[140] However "good, bad, or ugly the construction may be," the Court held that, as long as it was based on some construction of the parties' agreement, then it was precisely what the parties bargained for and must now live with.[141] Consequently, the Court held that the arbitrator's actions were sufficient to show that he did not exceed his powers under section 10(a)(4) of the FAA.[142]

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134. 9 U.S.C.A. § 10(a)(4) (West 2014).
135. 133 S. Ct. 2064, 2065 (2013).
136. *Id.*
137. *Id.*
138. *Id.*
139. *Id.* at 2068. According to the Court, "[a] party seeking relief under Section 10(a)(4) of the FAA . . . bears a heavy burden. . . . It is not enough . . . to show that the [arbitrator] committed an error—or even a serious error." *Id.* (citation omitted). Moreover, according to the Court, "[b]ecause the parties 'bargained for the arbitrator's construction of their agreement,' an arbitral decision 'even arguably construing or applying the contract' must stand, regardless of a court's view of its (de)merits." *Id.* (citation omitted).
140. *Id.*
141. See *id.*
142. *Id.*

4. Discovery

Discovery disputes involving reinsurance continue to proliferate. Two significant decisions are highlighted below.

In *Eagle Star Insurance Co. Ltd .v. Arrowood Indem. Co*., the court unsealed documents that parties in a prior case filed under a confidentiality agreement.[143] Here, a group of reinsurers moved the court to unseal certain arbitration documents including the final award.[144] The court considered a number of factors in deciding to grant the reinsurers' motion including whether the documents were "judicial documents," and thus entitled to a presumption in favor of access. Because the documents were "relevant to the performance of the judicial function and useful in the judicial process," the court found that they were entitled to such a presumption.[145] The court weighed the presumption against competing considerations such as "the danger of impairing . . . judicial efficiency" and "the . . . interests of those resisting disclosure."[146] The court found these considerations inadequate to overcome the presumption of access.[147] Specifically, the court reasoned that the confidentiality agreement in itself cannot force the court to keep the documents sealed because the court was not a party to that agreement.[148] Moreover, the court found it significant that the parties in the prior case did not rely heavily on the sealing of the documents because they were warned at the time that they may be unsealed.[149] Accordingly, the court ordered the documents to be unsealed to the public.[150]

In *Mine Safety Appliances Co. v. AIU Insurance Co*., the court considered the extent to which information concerning a defending parties' reinsurance is discoverable.[151] Here, the Delaware Superior Court reviewed a Special Discovery Master's decision concerning Mine Safety Appliance's motion to compel discovery from certain defendant carriers.[152] Specifically, MSA sought discovery of information relating to certain defendants' reinsurance agreements and communications with their reinsurers.[153] The Special Master had granted MSA's request for production of the reinsurance agreements themselves but denied their request for other policy-related information.[154] MSA essentially appealed the Special Mas-

143. No. 13 CV 3410(HB), 2013 WL 5322573 (S.D.N.Y. Sept. 23, 2013).
144. *Id.* at *1.
145. *Id.* at *2.
146. *Id.* at *3 (quoting U.S. v. Amodeo, 71 F.3d 1044, 1050 (2d Cir. 1995)).
147. *Id.*
148. *Id.*
149. *Id.*
150. *Id.*
151. No. 10C-07-241, 2013 WL 3001364 (Del. Super. Ct. June 6, 2013).
152. *Id.* at *1.
153. *Id.*
154. *Id.*

ter's opinion, arguing that any statements that the insurers made "to their reinsurers regarding [the] underlying policies or MSA's handling of claims . . . would be . . . relevant to the[ir] affirmative defenses and [thus] should be produced."[155] The court rejected that argument, holding that the Special Master had appropriately considered the parties' arguments and that the discovery order comported with both the state law rules and precedent concerning civil discovery.[156]

5. Expense Limitations

The Northern District of New York confirmed that under New York law, expense payments are subject to a reinsurance certificate's limit of liability absent express language excluding such expense payments from the limits.[157] In *Utica Mutual Insurance Company v. Munich Reinsurance America, Inc.*, the cedent, Utica, argued that the reinsurer, Munich, was obligated to pay costs and expenses in excess of the $5 million limit of the reinsurance certificate.[158]

Before reaching the substantive issues in the case, the court first disposed of Utica's challenge to the authenticity of the reinsurance certificate.[159] Although Utica argued that the reinsurance certificate may have contained a different page of conditions, the court rejected Utica's argument because the certificate relied upon by Munich was the same certificate attached to Utica's Complaint.[160] The court held that "[a] party that relies upon and attaches a document to its complaint cannot dispute its accuracy."[161]

After determining that New York law applied to the dispute, the court next turned to the substantive issue in the case.[162] Although the reinsurance certificate did not expressly include cost and expense payments within the limits, it did not expressly exclude such payments either.[163] The court granted Munich's motion for summary judgment because under New York law, expense payments are included in certificate limits absent express contract language excluding such payments.[164]

Similarly in *Continental Casualty Co. v. Midstates Reinsurance Co.*, an Illinois state court held that "reinsurance assumed" limits the total amount

155. *Id.* at *2.
156. *Id.*
157. Utica Mut. Ins. Co. v. Munich Reins. Am., Inc., No. 6:12-CV-0196, 2013 WL 5493704 (N.D.N.Y. Sept. 30, 2013).
158. *Id.* at *1.
159. *Id.* at *3.
160. *Id.*
161. *Id.*
162. *Id.* at *4–6.
163. *Id.* at *7. The reinsurance certificate provided: "D. LIMIT OF LIABILITY CEDED TO AND ACCEPTED BY THE REINSURER—$5,000,000 excess of $5,000,000 of the liability shown in B. above." *Id.*
164. *Id.*

of reinsurance available under a reinsurance certificate.[165] Following the reasoning of the Second Circuit and New York Court of Appeals, the court reasoned that "[t]here is nothing in the language of the certificate to suggest that the 'reinsurance assumed' amount did not encompass both the 'reinsurance assumed' for losses and the 'reinsurance assumed' for expenses."[166]

6. Follow-the-Fortunes Clauses

In *U.S. Fidelity & Guaranty Co. v. American Re-Insurance Co.*,[167] New York's highest state court considered whether an insurance company, U.S. Fidelity & Guaranty Co., which had settled hundreds of millions of dollars in asbestos-related claims and then sought partial recovery of the settlement from its reinsurers, had properly been granted summary judgment on challenges to the propriety of its settlement allocation.[168] The court held that summary judgment had been improperly granted as to two issues—(1) "whether USF&G, in allocating the settlement amount, reasonably attributed nothing to the so-called 'bad faith' claims made against it" and (2) "whether certain claims were given unreasonable values for settlement purposes"—but affirmed the summary judgment order in all other respects.[169]

Under the parties' reinsurance agreements, the cedent, USF&G, was responsible for the first $100,000 of every loss; the reinsurers were responsible for loss amounts above $100,000, up to a $200,000 cap.[170] Each agreement also contained a follow-the-settlements clause, which "ordinarily bars challenge[s] by a reinsurer" to the cedent's settlement decisions.[171] The court observed, however, that "the application of a follow the settlements clause to allocation decisions raises problems, because in that context the interests of cedent and reinsurer will often conflict."[172] The court illustrated the potential for conflicts with this example: "If the settlement were allocated entirely to losses amounting to $100,000 or less," then USF&G would bear the entire cost of settlement; if, however, the settlement "were allocated entirely to losses of $200,000 each, [then] the reinsurers would bear half the cost."[173] The reinsurers argued that because these types of conflicts commonly occur, the "cedents' allocation decisions should not bind the reinsurers under a follow the settlements clause"—or, put differently, a follow-the-settlements clause should

165. No. 2012-CH-42911, 2013 WL 4807551, at *8 (Ill. Cir. Ct. Aug. 29, 2013).
166. *Id.* at *4.
167. 985 N.E.2d 876 (N.Y. 2013).
168. *Id.* at 878.
169. *Id.*
170. *Id.* at 880.
171. *Id.* at 881.
172. *Id.*
173. *Id.*

not preclude the reinsurers from challenging a cedent's allocation decisions.[174]

The court first held "that a follow the settlements clause does require deference to a cedent's decisions on allocation."[175] A contrary holding, the court noted, would invite never-ending litigation that courts would be ill-equipped to resolve, thereby creating uncertainty and inefficiency in the reinsurance market.[176]

But while the "cedent's allocation decisions are entitled to deference," they are not "immune from scrutiny": reinsurers are "bound only by a cedent's 'good faith' decisions,"[177] which the court took to mean that the allocation decisions must be reasonable.[178] Thus, the court held, "under a follow the settlements clause. . . , a cedent's allocation of a settlement for reinsurance purposes will be binding on a reinsurer . . . only if[ ] it is a reasonable allocation."[179]

Applying that general rule to the USF&G case, the court considered three assumptions underlying USF&G's settlement allocation.[180] First, the court held that USF&G's decision to attribute the entire settlement amount to claims within the policy limits (which were covered by reinsurance) and none of the settlement to certain bad-faith claims against USF&G (which were not covered by reinsurance) raised a question of fact that precluded summary judgment for USF&G.[181] Second, the court held that USF&G's assumption that claims by lung-cancer claimants were worth $200,000 each, while certain other claims had substantially lower values, raised questions of fact that similarly precluded summary judgment.[182] Finally, the court held that USF&G's decision to allocate "all of the losses encompassed in the settlement to a single insurance policy" (rather than across a variety of different policies) was not unreasonable and raised no issues of fact, and summary judgment on that issue was therefore properly granted.[183]

In *Travelers Indemnity Co. v. Excalibur Reinsurance Corp.*, the court granted a reinsurer's discovery motion concerning information regarding the cedent's allocation decisions.[184] Here, the reinsurance contract in

174. *Id.*
175. *Id.*
176. *Id.* at 882.
177. *Id.*
178. *Id.* at 883.
179. *Id.*
180. *Id.*
181. *Id.* at 883–84.
182. *Id.* at 886.
183. *Id.* at 888.
184. No. 3:-CV-1209 (CSH), 2013 WL 1409889 (D. Conn. Apr. 8, 2013). In reaching its decision, the court placed great weight upon what it considered to be recent persuasive authority from *U.S. Fidelity & Guaranty Co.*, 985 N.E.2d 876 (holding that a cedent's allocation decisions are entitled to deference but they are not immune from scrutiny).

question contained a follow-the-settlements clause. After settling the underlying claims, the cedent allocated the settlement to a year in which the reinsurer was a treaty participant, rather than an earlier year when the reinsurer was not a treaty participant. The reinsurer objected to the cedent's allocation and the cedent took the position that, based upon the "follow the settlements" rule, it was entitled to allocate losses without the court reexamining its decisions. The court disagreed.[185] Based upon the applicable rules, the court found that the reinsurer was "entitled . . . to challenge the reasonableness of [the] post-settlement allocation . . . , and to argue that the . . . allocation violate[d] . . . the reinsurance contract."[186] The court thus allowed the reinsurer's motion to compel discovery related to the cedent's allocation decisions.[187]

7. Challenges to the Validity—Ex Parte Communications

The underlying dispute in *Star Insurance v. National Union Fire Insurance Co. of Pittsburgh, PA* involved claims for workers' compensation.[188] The dispute-resolution provision in the reinsurance contract required that disputes be submitted to three arbitrators who are "not under the control of either party to this Agreement."[189] The arbitration panel received the parties' written submissions and issued a scheduling order that prohibited further ex parte communications between any of the parties and any of the arbitrators.[190] The panel also issued an "Interim Final Award," which resolved some of the liability questions but left unresolved questions involving damages.[191] Several times over the next month, however, one of the attorneys for the reinsurer, National Union, spoke by telephone with the arbitrator it had appointed to the panel.[192] When the insurers found out about these ex parte communications, they filed an emergency motion to stay the proceedings; two of the arbitrators—over the third arbitrator's dissent—denied the insur-

185. In doing so, the court laid forth the following rules: "A follow the settlements clause in a reinsurance contract requires that deference be given to a cedent's decision on the allocation of [a] settlement payment[ ] among reinsurers." However, "[a] cedent's allocation decisions are not immune from scrutiny." The court may consider "whether the allocation is a reasonable one, that is, one that the parties to the settlement of the underlying insurance claims might reasonably have arrived at if the reinsurance did not exist." Moreover, the court may also consider whether "an allocation by a cedent . . . violates or disregards provisions in the reinsurance contract." If the allocation is either unreasonable or inconsistent with the parties' agreement, then it is "invalid and cannot be sustained by a court." *Travelers' Indem.*, 2013 WL 1409889, at *8.

186. *Id.* at *10.

187. *Id.* at *11.

188. No. 13-13807, 2013 WL 5182745, at *1 (E.D. Mich. Sept. 12, 2013).

189. *Id.*

190. *Id.* at *2.

191. *Id.*

192. *Id.*

ers' motion.[193] The insurers sought state court review of the panel's decision; National Union removed the case to federal court, and the insurers moved for injunctive relief.[194]

The insurers' request for injunctive relief was to allow enough time to investigate the nature of the relationship between National Union's attorney and the arbitrator it appointed, to determine whether that relationship violated the contract's dispute-resolution provision.[195] The federal district court held that the insurers' allegations called into question whether the true nature of the relationship between the attorney and the arbitrator was hidden, and that those allegations went to the heart of the contract, which required dispute resolution by disinterested officials not under the control of any party.[196] Finding that the insurers were likely to prevail on the merits of their breach-of-contract claim, the court granted the insurers' motion.[197]

8. Res Judicata

In *National Casualty Co. v. OneBeacon American Insurance Co.*,[198] the federal district court in Massachusetts confirmed "the general rule that the preclusive effect of a prior arbitration is a matter for the arbitrator[—not for the court—]to decide."[199] OneBeacon had entered into a series of reinsurance contracts with a variety of reinsurers over a twenty-year period.[200] These contracts were "identical in all relevant respects."[201] In 2007, a dispute between OneBeacon and Swiss Re resulted in arbitration, and the arbitral panel issued a final decision that rejected OneBeacon's interpretation of a particular provision of its reinsurance contract.[202] Several years later, "OneBeacon demanded arbitration against [several other of its] [r]einsurers," arguing that the same provision at issue in its prior arbitration against Swiss Re should be given the meaning that the prior arbitral panel rejected.[203] The reinsurers then asked the federal district court for a declaratory judgment that the panel's final decision in the Swiss Re arbitration should have preclusive effect on later arbitrations involving identical claims and identical contract language.[204] OneBeacon argued, by contrast, that the court should adhere to the general rule

193. *Id.* at *3.
194. *Id.*
195. *Id.* at *5.
196. *Id.* at *6.
197. *Id.* at *7.
198. No. 12-11874, 2013 WL 3335022 (D. Mass. July 1, 2013).
199. *Id.* at *8.
200. *Id.* at *1.
201. *Id.*
202. *Id.*
203. *Id.* at *2.
204. *Id.* at *4.

that the preclusive effects of prior arbitrations are an issue reserved for the arbitrator.[205]

Against that general rule, the reinsurers argued principally that under the FAA, final judgments of arbitration panels have the same force as final court judgments, and public policy therefore favored having courts—rather than arbitrators—ensure the enforcement of such judgments by, among other things, determining their scope and preclusive effect.[206] The court rejected that argument, noting that even the threshold question—whether the claims in the Swiss Re arbitration and the current arbitration were identical—"would require the [c]ourt to take the inappropriate step" of delving into the merits.[207]

Holding that the final-judgment status of the prior arbitration did not warrant deviating from the general rule that claim-preclusion issues are arbitrable, the court granted OneBeacon's motion to dismiss.[208]

B. *Regulatory Developments*

In 2011, the National Association of Insurance Commissioners passed a number of amendments to the Credit for Reinsurance Model Law and Regulation.[209] The amendments reduce the reinsurance collateral requirements for certain non-U.S. reinsurers.[210] To qualify for the collateral reduction requirements, the non-U.S. reinsurer must be domiciled and licensed to transact insurance or reinsurance in a "qualified jurisdiction."[211] Although approval of qualified jurisdictions is left to the individual states, the Model Law provides that a list of qualified jurisdictions will be created through the NAIC committee process.[212] "[I]ndividual states must consider this list when approving jurisdictions" as qualified jurisdictions.[213]

In a move toward implementing the Model Law and Regulation, the NAIC Executive (EX) Committee and Plenary adopted the Process for Developing and Maintaining the NAIC List of Qualified Jurisdictions on August 27, 2013.[214] The Process for Developing and Maintaining

205. *Id.* at *7.
206. *Id.* at *8.
207. *Id.*
208. *Id.*
209. Credit for Reins. Model Law 785 (Nat'l Ass'n of Ins. Comm'rs 2011); Credit for Reins. Model Reg. 786 (Nat'l Ass'n of Ins. Comm'rs 2011).
210. *See id.*
211. Credit for Reins. Model Law § 2(E)(1)(a).
212. *Id.* § 2(E)(3)(b).
213. Nat'l Ass'n of Ins. Comm'rs, Process for Developing and Maintaining the NAIC List of Qualified Jurisdictions 3 (Aug. 27, 2013), *available at* http://www.naic.org/documents/committees_e_reinsurance_related_qualified_jurisdictions_final_130827.pdf.
214. *Id.* at 1.

the NAIC List establishes "a documented evaluation process for creating and maintaining th[e] NAIC list" of qualified jurisdictions.[215]

Pursuant to the Process for Developing and Maintaining the NAIC List, a jurisdiction may be included on the list of qualified jurisdictions if the NAIC

> reasonably conclude[s] that the jurisdiction's reinsurance supervisory system achieves a level of effectiveness in financial solvency regulation that is deemed acceptable for purposes of reinsurance collateral reduction, that the jurisdiction's demonstrated practices and procedures with respect to reinsurance supervision are consistent with its reinsurance supervisory system, and that the jurisdiction's laws and practices satisfy the criteria required of Qualified Jurisdictions as set forth in the Credit for Reinsurance Models.[216]

To evaluate a jurisdiction, the NAIC will consider a number of factors including the laws and regulations of the jurisdiction "to evaluate whether the jurisdiction has sufficient authority to regulate the solvency of its reinsurers in an effective manner," the regulatory practices and procedures of the jurisdiction to determine "whether the jurisdiction effectively employs baseline regulatory practices and procedures to supplement and support enforcement of the jurisdiction's financial solvency laws and regulations," the jurisdiction's requirements applicable to U.S.-domiciled reinsurers, the jurisdiction's regulatory cooperation and information sharing with U.S. state insurance regulators, the jurisdiction's history of performance of domestic reinsurers, the jurisdiction's historic enforcement of final U.S. judgments, and the jurisdiction's solvent schemes of arrangement.[217]

The adoption of the Process for Developing and Maintaining the NAIC List of Qualified Jurisdictions is a positive step toward implementation of the Model Law and Regulation. The next step will be the evaluation and approval of qualified jurisdictions. To that end, the NAIC is currently "expedit[ing] [the] review of . . . four jurisdictions that [were] previously . . . approved by individual states: Bermuda, Germany, Switzerland and the United Kingdom."[218]

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215. *Id.* at 3.
216. *Id.* at 8.
217. *Id.* at 12–15.
218. Nat'l Ass'n of Ins. Comm'rs, NAIC Adopts Process for Developing and Maintaining the NAIC List of Qualified Jurisdictions (Aug. 27, 2013), *available at* http://www.naic.org/Releases/2013_docs/naic_adopts_process_qualified_jurisdictions.htm.