RECENT DEVELOPMENTS IN EXCESS INSURANCE AND REINSURANCE

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This article analyzes key case law developments within the distinct areas of excess insurance and reinsurance between October 1, 2013, and September 30, 2014.

I. EXCESS INSURANCE

The area of excess insurance saw many developments over the past year through case law addressing a wide variety of issues. This article discusses

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significant decisions in the areas of self-insured retentions, allocation, exhaustion, priority of coverage, payment or reimbursement of defense costs, drop-down, and the rights and obligations of excess insurers.

A. *Self-Insured Retentions*

In the realm of self-insured retentions, the Florida Supreme Court ruled that an insured could use indemnity payments, made to the insured by another party in an underlying liability action pursuant to contractual indemnity obligations, to satisfy the self-insured retention (SIR) under its own insurance policy in *Intervest Construction of Jax, Inc. v. General Fidelity Insurance Co.*[1] In that case, ICI Homes, Inc., a general contractor, contracted with Custom Cutting, Inc., a subcontractor, to provide trim work in a residence that ICI was building.[2] The trim work included installation of attic stairs. The contract between the two parties contained an indemnification provision requiring Custom Cutting to indemnify ICI for any damages resulting from Custom Cutting's negligence.[3] The purchaser of the residence later sued ICI, but not Custom Cutting, alleging that she had been injured in a fall while using the attic stairs.[4] ICI sought indemnification from Custom Cutting, which had installed the stairs, under the terms of their agreement.[5]

Custom Cutting maintained a commercial general liability (CGL) policy with North Pointe Insurance Co.[6] Although ICI did not qualify as an additional insured under Custom Cutting's CGL policy, ICI had a policy issued by General Fidelity Insurance Co., which included a $1 million SIR endorsement stating that General Fidelity would provide coverage only after ICI had exhausted the $1 million SIR.[7] The policy also included a transfer of rights clause granting General Fidelity certain subrogation rights. In the mediation of the homeowner's negligence claim, all parties—ICI, Custom Cutting, North Pointe, and General Fidelity—participated.[8] The parties agreed to a $1.6 million settlement of the bodily injury claims. As part of the settlement, North Pointe agreed to pay ICI $1 million to settle ICI's contractual indemnity claim against Custom Cutting.[9] ICI, in turn, would pay that $1 million to the homeowner.

1. 133 So. 3d 494 (Fla. 2014).
2. *Id.* at 495.
3. *Id.* at 496.
4. *Id.*
5. *Id.*
6. *Id.*
7. *Id.*
8. *Id.*
9. *Id.*

ICI then filed suit against General Fidelity, demanding that it pay the homeowner the remaining $600,000.[10]

The district court ruled that ICI could not use the $1 million indemnification payment to satisfy its SIR.[11] ICI appealed to the Eleventh Circuit, which certified questions of law to the Florida Supreme Court, including whether the General Fidelity policy allows the insured to apply indemnity payments received from a third party toward satisfaction of its $1 million SIR.[12] The Florida Supreme Court ruled that the General Fidelity policy allowed the insured to apply the indemnity payment by Custom Cutting's insurer to satisfy its $1 million SIR.[13] The court held that "[t]he contract between Custom Cutting and ICI, which included the right to indemnification, was entered into six years before the General Fidelity policy was purchased by ICI."[14] The court reasoned that "ICI paid for the indemnity protection in the purchase price of the Custom Cutting subcontract and therefore hedged its retained risk in this manner."[15] Accordingly, "ICI bargained for and paid for this right to indemnification and, without an express policy provision to the contrary, should be able to use it to satisfy the SIR."[16]

The court also addressed the "made whole doctrine," which provides that, "absent a controlling contractual provision that states otherwise, the insured has priority over the insurer to recover its damages when there is a limited amount of indemnification available."[17] The court noted that in this case, "the transfer of rights clause does not address the priority of reimbursement nor does the clause provide that it abrogates the 'made whole doctrine.'"[18]

B. *Allocation*

The Indiana Court of Appeals adopted a pro rata time-on-risk allocation approach as a matter of Indiana law, notwithstanding Indiana Supreme Court precedent adopting an all-sums approach. In *Thomson Inc. v. Insurance Co. of North America*,[19] the court found specific policy language at issue that provided the insurer would indemnify for "those sums" the insured becomes legally obligated to pay, rather than "all sums," and that

10. *Id.*
11. *Id.*
12. Intervest Constr. of Jax, Inc. v. Gen. Fid. Ins. Co., 662 F.3d 1328, 1332–33 (11th Cir. 2011).
13. *Intervest Constr.*, 133 So. 3d at 503.
14. *Id.* at 503.
15. *Id.*
16. *Id.*
17. *Id.* at 504.
18. *Id.* at 506.
19. 11 N.E.3d 982 (Ind. Ct. App. 2014).

the insurance only applied to bodily injury or property damage that happens during the policy period.[20] The court recognized that the Indiana Supreme Court in *Allstate Insurance Co. v. Dana*[21] had adopted an all-sums approach, permitting the insured to choose the policy period that would respond to defend and indemnify it. In the case at issue, however, the court noted that the policy language was different, in that the insurer had agreed to indemnify the insured for "*those sums* that the insured becomes legally obligated to pay," rather than "all sums" as was the case in *Dana*.[22] The court held that the *Dana* decision "is not controlling in cases involving the decisively different policy language at issue here."[23] The *Thomson* case holds out the prospect that, even in jurisdictions that have adopted an all-sums approach, it is not an immutable rule, unaffected by changes in policy language.

In Maryland, the federal district court examined and applied a horizontal exhaustion rule to asbestos-related bodily injury claims. In *National Union Fire Insurance Co. of Pittsburgh, Pa. v. Porter Hayden Co.*,[24] the court found that excess insurance is not necessarily unavailable simply because "[i]n the course of allocating damages pursuant to the pro rata allocation method, certain years of primary insurance coverage may prove to be exhausted, while other years of primary insurance coverage may not be."[25] Ultimately, the court held that "[i]f the primary insurance as to a particular year on the risk has been exhausted, then an excess policy applicable to that year must pay its pro rata share."[26] Moreover, for certain claims that are not subject to an aggregate limit, excess insurance may be unavailable due to lack of exhaustion.[27] "Where primary coverage has been exhausted, however, excess insurance may be required to pay for those losses."[28] The court held that this interpretation is consistent with the recognition in Maryland law "that certain primary policies may be exhausted sooner than others and, as a result, certain excess policies respond sooner than others."[29]

C. *Exhaustion*

Multiple courts, both state and federal, explored exhaustion over the course of the year, each addressing a different targeted issue.

20. *Id.* at 1017.
21. 759 N.E.2d 1049, 1058 (Ind. 2001).
22. *Thomson*, 11 N.E.3d at 1019.
23. *Id.* at 1020–21.
24. 2014 WL 43506 (D. Md. Jan. 2, 2014).
25. *Id.* at *3.
26. *Id.*
27. *Id.*
28. *Id.* at *12–13.
29. *Id.* at *13.

First, the Washington Court of Appeals addressed the issue of whether an underlying insurance policy was properly exhausted by a settlement for less than the full amount of the underlying policy limits. In *Quellos Group, LLC v. Federal Insurance Co.*,[30] the underlying insurer and the insured entered into a settlement in which the insurer paid only $5 million of the $10 million policy limit. The insured agreed to pay the remaining $5 million and maintain claims against the excess insurers.[31] The court held that "[i]n interpreting the provisions of the excess insurance contracts as a whole, the plain and unambiguous language compels the conclusion that excess coverage was not triggered by the agreement of [the insured] to pay the policy limits of approximately $5 million that [the insurer] refused to pay."[32] The court noted that under the Federal and Indian Harbor policies, "the excess carriers agreed to provide coverage only after exhaustion by payment of the insurer of the underlying policy limits."[33] The court concluded that the insured forfeited coverage afforded under the excess policies because it failed to comply with the exhaustion clause. "The policies require the underlying insurer to pay the full amount of its limits of liability before excess coverage is triggered. The insurer paid only approximately one-half of the $10 million policy limits."[34]

Second, the Fifth Circuit held that the retained limit could be exhausted by payment of claims that were not covered by the umbrella policies. In *Indemnity Insurance Co. of North America v. W&T Offshore, Inc.*,[35] the court examined claims for damage to offshore oil platforms as a result of Hurricane Ike. The umbrella policies afforded coverage for "sums in excess of the Retained Limit" that "the Insured becomes legally obligated to pay by reason of liability imposed by law" because of an event covered by the policy.[36] The term "Retained Limit" was defined as "the greater of (1) the amount of underlying insurance or (2) the amount of SIR that is not covered by the underlying insurance."[37] The greater amount in this case was the total applicable limits of underlying insurance of $161 million. The umbrella insurer argued that the retained limit had not been met because W&T exhausted its underlying policies using claims that were not covered by the umbrella policies.[38] The court observed that "[n]othing in the text of the Coverage provision or the definition of Retained Limit specifies how the $161 million 'limit[] of the underlying

30. 312 P.3d 734 (Wash. Ct. App. 2013).
31. *Id.* at 739.
32. *Id.* at 743.
33. *Id.*
34. *Id.* at 744–45.
35. 756 F.3d 347 (5th Cir. 2014).
36. *Id.* at 353.
37. *Id.*
38. *Id.* at 350–51.

policies' must be reached or states that the Retained Limit refers exclusively to sums covered by the Umbrella Policy."[39] Accordingly, the court held that the insured satisfied the retained limit.

Third, the Pennsylvania Superior Court addressed what constitutes proper underlying exhaustion—whether exhaustion is the date that the insured and the underlying insurer reach a settlement or the later date on which the underlying insurer pays out its policy limits in accordance with the settlement. In *Lexington Insurance Co. v. Charter Oak Fire Insurance Co.*,[40] Charter Oak reached a settlement with the insured to pay its policy limits, but actual payment did not occur for another two months. North River's policy immediately above the Charter Oak policy contained an exhaustion clause that provided North River "will have the right and duty to defend the [i]nsured . . . when the applicable limits of '[u]nderlying [i]nsurance' and '[o]ther insurance' have been exhausted by payment of judgments or settlements."[41] Accordingly, the court held that North River's duty to defend was triggered by the actual payment of the relevant primary insurance, not by the settlement agreement to pay at a later date.[42]

D. *Priority of Coverage*

The Nebraska Supreme Court examined priority of insurance coverage as between two primary policies, where one contains an excess clause and the other a pro rata clause, and as between two umbrella policies with competing excess "other insurance" clauses. In *American Family Mutual Insurance Co. v. Regent Insurance Co.*,[43] the court "agree[d] with the majority of jurisdictions that hold that umbrella policies, as the only true excess insurance policies, incur liability only after the exhaustion of all other policies, including primary policies containing excess insurance clauses."[44] The court explained that "there is a difference between a true excess policy providing coverage conditioned upon the existence of a primary policy, . . . and a primary policy with devices by which the primary insurer attempts to limit or eliminate its liability where another primary policy covers the risk."[45]

The court held that, in the case of two competing primary policies, "[w]here an excess clause and a pro rata clause appear in concurrently effective policies, the pro rata clause is usually disregarded and full effect is

39. *Id.*
40. 81 A.3d 903, 908–09 (Pa. Super. Ct. 2013).
41. *Id.* at 910.
42. *Id.*
43. 846 N.W.2d 170 (2014).
44. *Id.* at 194.
45. *Id.*

given to the excess clause, making the pro rata policy the primary insurance."[46] Because both primary policies had to pay the full $1 million policy limit, regardless of which policy went first, the court affirmed the distribution of common liability of the primary policies. In the case of two competing umbrella policies, each containing an excess "other insurance" clause, the court stated that "[t]he interaction of two or more policies containing excess insurance clauses creates circularity and could provide a windfall to which insurer's policy is read first." The majority rule therefore provides "that the excess insurance clauses are mutually repugnant and that the liability should be shared by the insurers pro rata in the proportion that their respective policy limits bear to the entire loss."[47]

E. *Payment or Reimbursement of Defense Costs*

The Delaware Superior Court ruled that an excess insurer did not have a duty to pay or reimburse the insured for defense costs to which the insurer had not consented. The court in *Mine Safety Appliances Co. v. AIU Insurance Co.*[48] found that there was no requirement that an excess insurer had to act reasonably in withholding its consent to reimburse defense costs. Mine Safety Appliances Co. (MSA) manufactures and sells safety equipment, including heat protection clothing and respirators.[49] Users of MSA's safety products filed thousands of actions against MSA, alleging that as a result of using MSA's products they were exposed to asbestos, silica, and coal dust and suffered bodily injuries.[50] MSA sought a declaratory judgment that its insurers, including its excess insurer American Insurance Co. (AIC), were obligated to defend and indemnify MSA.[51] In response, AIC moved for partial summary judgment on grounds that it was not required to provide a defense in connection with the underlying claims against MSA, which MSA conceded.[52] AIC also asserted that it had no duty to indemnify or reimburse MSA for defense costs unless the costs were incurred with AIC's consent, adding that it had not consented to MSA incurring the defense costs.[53]

The AIC excess policies issued to MSA provided that AIC agreed to "indemnify the Insured for the Insured's ultimate net loss," defining "ultimate net loss" as not including defense costs.[54] Further, the policies provided for

46. *Id.*
47. *Id.* at 195.
48. 2014 WL 605490 (Del. Super. Ct. Jan. 21, 2014). One of the authors, Michael Kotula, represented AIC in the case.
49. *Id.* at *1.
50. *Id.*
51. *Id.*
52. *Id.* at *2.
53. *Id.*
54. *Id.*

reimbursement of a share of "[l]oss expenses and legal expenses . . . which may be incurred by the Insured with the consent of the company in the adjustment or defense of claims, suits or proceedings."[55] The court found that the policies' terms were "clear and unambiguous" and, as a result, declined to consider extrinsic evidence, such as expert testimony on custom and usage.[56] The court noted that several courts had interpreted similar or the same defense costs provisions "as an obligation conditioned on the consent of the insurer."[57] According to the court, those cases "refute MSA's argument that 'Defense Costs' provisions have a special meaning in the insurance industry rising to the level of 'custom and usage.'"[58] MSA argued that an insurer could not unreasonably withhold consent, and as long as the defense costs incurred were reasonable, the insurer's consent was required.[59] The court rejected MSA's argument as being "without merit," finding that the AIC excess policies "do not create a duty that AIC indemnify MSA for defense costs."[60] Such defense costs provisions requiring the insurer's consent "do not have an unwritten meaning—that the provisions are only intended to prevent reimbursement of unreasonable defense costs."[61]

In another case, the Connecticut Superior Court held that an umbrella insurer had no obligation to defend its insured against numerous asbestos bodily injury claims because the umbrella coverage part, which provided for a defense when an occurrence was "not covered" by the underlying insurance, was not triggered where the underlying insurance covered the occurrence but was merely exhausted. In *R.T. Vanderbilt Co., Inc. v. Hartford Accident & Indemnity Co.*,[62] CNA issued a series of umbrella policies that provided excess indemnity coverage "for loss in excess of the total limits of liability stated in the schedule of underlying insurance" (Coverage A), and umbrella coverage with a defense obligation "with respect to an occurrence not covered in whole or in part by underlying insurance, or to which there is no other insurance in any way applicable" (Coverage B).[63] Vanderbilt argued that the underlying actions created a defense obligation "because if the underlying CNA primary policies are exhausted, they are inapplicable and unable to 'cover in whole or in part' the actions against Vanderbilt, thus qualifying Vanderbilt for a defense from CNA" under the umbrella policies' Coverage B.[64]

55. *Id.* at *3.
56. *Id.* at *4.
57. *Id.*
58. *Id.*
59. *Id.* at *5.
60. *Id.* at *14–15.
61. *Id.* at *15–16.
62. 2014 WL 1647133 (Conn. Super. Ct. Mar. 28, 2014).
63. *Id.* at *1.
64. *Id.* at *2.

The court then explained the interplay of the umbrella policies' Coverage A and Coverage B. Coverage A is excess coverage "which picks up indemnity obligations at the point when the underlying primary coverage is exhausted"; it "does not provide for defense costs or investigation costs."[65] Coverage B, in comparison, "is limited primary coverage for risks not covered by underlying insurance."[66] The phrase "not covered by the underlying insurance" used in Coverage B "'refer[s] to the *fact* of coverage, not to the *extent* of coverage.'"[67] In essence, "if a claim would have been covered by the underlying policy had it not become exhausted, then the claim 'is covered by . . . underlying policies' within the meaning of the umbrella policy and there is no defense obligation under the umbrella."[68] The court therefore held that the umbrella policies were not obligated to defend the insured.[69]

F. *Drop-Down*

A federal district court in Oklahoma addressed an issue of first impression as a matter of Oklahoma law concerning whether umbrella and excess insurers, whose policies were above underlying primary CGL insurance policies issued by the now-insolvent Home Insurance Co., were obligated to drop down and assume the primary insurer's coverage obligations in connection with numerous underlying asbestos bodily injury claims. In *Canal Insurance Co. v. Montello, Inc.*,[70] the court surveyed numerous decisions from other jurisdictions and consulted multiple secondary sources. The court ultimately found that "the majority of the courts that have confronted the issue hold that when a primary insurer becomes insolvent, the excess insurer is not required to 'drop down' to assume the primary insurer's coverage obligations."[71] The court concluded that, in accordance with the majority rule, "the Oklahoma Supreme Court would not impose an obligation on the excess insurer to drop down and provide insurance coverage in the absence of language indicating the insurer's intent to do so."[72]

In this case, Canal Insurance Co. issued the first layer of coverage above the insolvent Home primary policy, providing excess insurance over the limits of the underlying insurance and umbrella insurance only

65. *Id.* at *5.
66. *Id.*
67. *Id.* (quoting T. Novak, *The Defense Obligation of Excess and Umbrella Liability Insurance Policies*, 36 BRIEF 12, 15 (2006)).
68. *Id.*
69. *Id.* at *6.
70. 2013 WL 6732658 (N.D. Okla. Dec. 19, 2013).
71. *Id.* at *5 (quoting BARRY R. OSTRAGER & THOMAS R. NEWMAN, HANDBOOK ON INSURANCE COVERAGE DISPUTES §§ 13.03, 13.12, at 875–78 and 900–07 (7th ed. 1994)).
72. *Id.* at *6.

when the underlying insurance is "inapplicable to the occurrence."[73] The court held that the excess insurance provided that the underlying limits had to have been reduced "by payment of loss," and "[t]he underlying insurer's inability to pay a loss is not equivalent to exhaustion by payment of loss."[74] Further, the court held that the umbrella insurance "provides primary coverage only in situations where the underlying insurance provides no coverage at all."[75] The court noted that other courts "considering the identical policy language have held that the underlying policy is not rendered 'inapplicable to the occurrence' merely because the underlying insurer becomes insolvent."[76]

G. *Excess Insurer Rights and Obligations*—IMO Industries

The New Jersey Appellate Division examined excess insurers' rights and obligations in connection with numerous asbestos bodily injury claims and the existing case law addressing allocation of long-tail claims in *IMO Industries Inc. v. Transamerica Corp.*[77] In this case, IMO Industries Inc., the successor to the Delaval Steam Turbine Co., manufactured turbines, pumps, gears, and other machinery with industrial and military uses.[78] Some of Delaval's products manufactured from the 1940s to the 1980s contained asbestos. Consequently, thousands of asbestos claims were brought against IMO.[79] IMO sought insurance coverage for its defense and indemnity costs under a Transamerica risk management program and various other primary, umbrella, and excess policies.[80] In the course of adjudicating unique issues under the Transamerica risk management program and TIG fronting policies, the court also addressed a number of issues presented under the umbrella and excess policies.

Several insurers, including ACE and London Market Insurers (LMI), issued multiyear policies, which they maintained provided a single per-occurrence limit for the duration of each policy.[81] IMO did not dispute that the plain language of the policies would impose per-occurrence limits on a term rather than an annual basis, but it sought a ruling that every year of a multiyear policy should be treated as if a separate annual limit is available for asbestos claims.[82] The court concluded that prior

73. *Id.* at *7.
74. *Id.* at *11.
75. *Id.*
76. *Id.* at *12.
77. 101 A.3d 1085 (N.J. App. Div. 2014), *petition for cert. filed* (N.J. 2014). One of the authors, Michael Kotula, represented several excess insurers in the case.
78. *Id.* at 1092.
79. *Id.* at 1094.
80. *Id.* at 1095.
81. *Id.* at 1106.
82. *Id.*

allocation precedent in New Jersey dictated that the per occurrence limits in the multiyear policies apply on an annual basis.[83] Specifically, the court explained, "[w]ere it not for the pro-rata methodology adopted in *Owens-Illinois*,[84] each asbestos claim filed against IMO that triggered the ACE and LMI policies would be treated as a separate occurrence subject to the per-occurrence limit for the entire multiyear terms of the policies. The aggregate limits of the policies would control the insurers' total liability on the claims."[85]

However, the court stated that "*Owens-Illinois* changed the ground rules and classified all asbestos claims made in a year as a single occurrence."[86] However, to view all three years as a single occurrence would "deprive[] [the insured] of the annual aggregate limits of the policies."[87] Accordingly, the court held that "[b]ecause the imposition of per occurrence limits in multiyear policies contravenes the goals of the pro-rata methodology established in *Owens-Illinois*, such limits are unenforceable."[88]

In reaching this conclusion, the court appeared to find support in a prior New Jersey Supreme Court decision, *Spaulding Composites Co. v. Aetna Casualty & Surety Co.*,[89] which held that non-cumulation clauses in insurance policies, which operate to limit an insurer's liability under multiple sequential policies where losses relate to a single occurrence, were unenforceable. Such non-cumulation clauses were held unenforceable "because [they] would thwart the *Owens-Illinois* pro-rata allocation modality" and because "[o]nce the court turns to pro rata allocation, it makes sense that the non-cumulation clause, which would allow the insurer to avoid its fair share of responsibility, drops out of the policy."[90] The court also held that TIG's multiyear policy had an annual aggregate limit, rather than an aggregate limit that applied to the three-year policy term, concluding that this was "consistent with the *Owens-Illinois* and *Carter-Wallace*[91] allocation methodology."[92]

Significantly, the trial court had also held that ACE, LMI, and other excess insurers were prohibited from litigating coverage issues with respect to already settled asbestos claims after those insurers refused to defend

83. *Id.* at 1108.
84. Owens-Ill., Inc. v. United Ins. Co., 650 A.2d 974 (N.J. 1994).
85. *IMO Indus.*, 101 A.3d at 1108.
86. *Id.*
87. *Id.*
88. *Id.*
89. 819 A.2d 410 (N.J. 2003), *cert. denied sub nom.*, Liberty Mut. Ins. Co. v. Caldwell Trucking PRP Grp., 540 U.S. 1142 (2004).
90. *Id.* at 422.
91. Carter-Wallace, Inc. v. Admiral Ins. Co., 712 A.2d 1116 (N.J. 1998).
92. *IMO Indus.*, 101 A.3d at 1109.

them.[93] The Appellate Division affirmed, holding that "[a]llowing excess insurers to contest coverage is not feasible for long-tail, multiclaim coverage cases and would compromise the allocation methodology mandated by the Supreme Court."[94] As the court observed, IMO had 75,000 asbestos-related claims against it, of which it had settled approximately 15,000 and obtained dismissal of about 30,000.[95] The excess insurers that had begun to be notified declined to involve themselves in the defense of the claims.[96] The court explained that "[a] primary insurer that refuses its obligation to defend claims against its insured without first timely challenging coverage forfeits the right to hold an insured to that burden at a later time," but "[e]xcess insurers, on the other hand, generally have no duty to participate in the defense and may rely on the good faith of the primary insurer in settling claims against the insured."[97] The court held that "[i]t stands to reason that accommodating a challenge to coverage in tens of thousands of individual claims would not only prove daunting but would compromise the integrity of the framework *Owens-Illinois* offers for efficient and equitable allocation of losses among policies."[98] Any policy terms or principles for ordinary coverage litigation "must bend insofar as they conflict with application of the *Owens-Illinois* framework."[99] The court reasoned that a court "could thus impose a greater obligation on the part of excess insurers than specifically stated in their policies to participate in the insured's defense, or risk losing the right to challenge coverage decisions."[100] In short, the court concluded that *Owens-Illinois* directs that "insurers who have declined to associate in the defense of claims against the insured may be precluded from later challenging coverage."[101]

Likewise, the court held that ACE, LMI, and certain other excess insurers were obligated to indemnify defense costs even with respect to non-covered claims. Initially, the court explained that "[t]he excess insurers' obligation to cover IMO's ultimate net losses, which include defense costs, was triggered when IMO manufactured and sold asbestos-containing products and claimants became injured by those products."[102] The court held that the excess insurers were "required to indemnify IMO for the sums it expended in defending all those claims."[103] Further, the

93. *Id.* at 1112.
94. *Id.*
95. *Id.*
96. *Id.*
97. *Id.* at 1112–13.
98. *Id.* at 1113.
99. *Id.* at 1113–14.
100. *Id.*at 1114.
101. *Id.*
102. *Id.* at 1116.
103. *Id.*

court again adverted to the concept that to do otherwise would upset the allocation scheme set forth in *Owens-Illinois*. The court stated that "the need to segregate and classify defense costs according to each individual claim would greatly complicate the already complex allocation process."[104] Moreover, "[c]hallenges among the parties as to whether particular claims were covered or uncovered would increase litigation and require additional judicial attention."[105] Finally, "[t]he reason the Court developed the pro-rata methodology was to reduce the litigation costs and judicial inefficiencies attendant to resolving insurance coverage for long-term environmental damages."[106] Thus, the court found that "[a]dopting the process that the excess insurers suggest would directly contravene those objectives."[107]

II. REINSURANCE

Significant case law developments impacting the reinsurance industry addressed a variety of issues in the last year, including the applicability of arbitration clauses to non-signatories, discoverability of reinsurance information, disqualification of counsel, preliminary injunctions to enjoin arbitration, and the identification of a final award for confirmation. Key decisions in each area are discussed below.

A. *Non-Signatories to Arbitration Agreements*

An arbitration provision in a reinsurance contract compels the parties to that contract to arbitrate disputes that are within the scope of the arbitration provision. Less clear is how such arbitration provisions are enforced against certain third parties. In *Transatlantic Reinsurance Co. v. National Indemnity Co.*,[108] the U.S. District Court for the Northern District of Illinois denied Transatlantic Reinsurance Co.'s motion to compel National Indemnity Co. to join in an arbitration between Continental Insurance Co. and Transatlantic.

Continental entered into a blanket casualty excess of loss reinsurance agreement with Transatlantic, which provided that "if any dispute shall arise between the COMPANY [Continental] and the REINSURERS [Transatlantic] with reference to the interpretation of this AGREEMENT or their rights with respect to any transaction involved," the dispute would be submitted to arbitration.[109] In 2010, Continental purchased reinsurance

104. *Id.*
105. *Id.*
106. *Id.*
107. *Id.*
108. 2014 WL 2862280 (N.D. Ill. June 24, 2014).
109. *Id.* at *1.

from National Indemnity for asbestos and environmental risks pursuant to a loss portfolio transfer agreement (LPT agreement) with National Indemnity.[110] Continental also entered into an administrative services agreement (ASA agreement) with National Indemnity, providing for the administration of "third party reinsurance agreements."[111] Transatlantic stopped making payments to Continental in 2012, and Continental commenced arbitration against Transatlantic in March 2013.[112] Transatlantic subsequently filed suit seeking to compel National Indemnity to arbitrate in the Continental-Transatlantic arbitration.[113]

The court explained that the Seventh Circuit recognizes five doctrines through which a non-signatory can be bound by an arbitration agreement entered into by others: (1) assumption; (2) agency; (3) estoppel; (4) veil piercing; and (5) incorporation by reference.[114] The court held that none of the five applied, rejecting each of Transatlantic's arguments that National Indemnity should be compelled to arbitrate.[115] Most notably, the court rejected Transatlantic's argument that by entering into the loss portfolio transfer, National Indemnity assumed the reinsurance agreement because National Indemnity did not "manifest a clear intent to arbitrate the dispute."[116]

B. *Discovery Disputes*

A number of cases in the past year have considered the discoverability of reinsurance and reserve information in insurance and reinsurance disputes. Although courts sometimes compel production of such information, other courts continue to protect reinsurance and reserve information. As a result, discovery disputes over these categories of documents persist.

In *Progressive Casualty Insurance Co. v. Federal Deposit Insurance Corp.*,[117] an Iowa federal court affirmed an earlier ruling by the magistrate judge granting the bank receiver's motion to compel both an insurer, a party to the litigation, and a reinsurer, subject to a third-party subpoena, to produce reinsurance communications. The court rejected the cedent and reinsurer's arguments that the reinsurance communications were protected by either the work product doctrine or the attorney-client privilege.[118]

First, the court upheld the magistrate's determination that the reinsurance information was created in the ordinary course of the cedent's busi-

110. *Id.*
111. *Id.*
112. *Id.*
113. *Id.*
114. *Id.* at *2.
115. *Id.* at *3–4.
116. *Id.* at *3.
117. 2014 WL 4947721 (N.D. Iowa Oct. 3, 2014).
118. *Id.* at *16.

ness and was provided to the reinsurer and the broker solely for business purposes.[119] Therefore, the court held that the information was not created "in anticipation of litigation" such that the work product doctrine would apply.[120] Next, the court upheld the magistrate's determination that the cedent had waived the attorney-client privilege, to the extent it applied, by disclosing documents to the reinsurer and the broker.[121] Finally, the court rejected application of the common interest doctrine.[122] The court agreed with the magistrate's ruling that the relationship between the insurer and its reinsurers and broker was commercial and financial in nature, not legal, and that the information was disclosed to the reinsurers and broker in furtherance of its business relationship.[123] The magistrate noted that "[t]he unique circumstances of the reinsurance business do not automatically give rise to a common *legal* interest."[124]

Similarly, federal courts in Texas and Minnesota ordered production of reinsurance information in *Klein v. Federal Insurance Co.*[125] and *National Union Fire Insurance Co. of Pittsburgh, PA v. Donaldson Co., Inc.*[126] While both courts acknowledged the insurers' argument that courts generally refuse policyholders' requests regarding reinsurance information for the purpose of interpreting underlying policies, both found that the information could be used if relevant to other questions. The *Klein* court held that the information was relevant to the question of notice,[127] and the *Donaldson* court concluded that the sought-after communications were relevant to the claims for breach of the duty of good faith and fair dealing.[128]

Conversely, the U.S. District Court for the Southern District of Indiana sustained an insurer's objection to the magistrate judge's order compelling production of reinsurance communications in *National Union Fire Insurance Co. of Pittsburgh, PA v. Mead Johnson & Co.*[129] The magistrate ordered production of the reinsurance communications because such communications could "lead to the discovery of admissible evidence about the Insurers' own definition of claims which could fall under its insurance agreements."[130] The district court reversed the magistrate's order and

119. *Id.* at *5–6.
120. *Id.*
121. *Id.* at *7.
122. *Id.* at *9–11.
123. *Id.* at *11.
124. *Id.* at *7.
125. 2014 WL 3408355 (N.D. Tex. July 14, 2014).
126. 2014 WL 2865900 (D. Minn. June 24, 2014).
127. *Klein*, 2014 WL 3408355, at *7–8.
128. *Donaldson*, 2014 WL 2865900, at *5.
129. 2014 WL 931947 (S.D. Ind. Mar. 10, 2014).
130. *Id.* at *4.

held that the policy term at issue was unambiguous and, therefore, communications regarding the claim terms were irrelevant.[131]

C. *Disqualification of Counsel*

In *Utica Mutual Insurance Co. v. Employers Insurance Co. of Wausau*,[132] a New York federal court denied the plaintiff's motion to dismiss the defendants' counterclaim, denied the plaintiff's motion for summary judgment, and granted the defendants' request to defer ruling on the plaintiff's motion for summary judgment until the defendants conducted certain discovery.[133]

In *Utica*, the defendant reinsurers sought to disqualify the plaintiff cedent's law firm from representing the cedent in an arbitration between the cedent and the reinsurers because the same law firm had represented the cedent against the underlying insured and, therefore, represented the "interests" of the reinsurers in that underlying action.[134] The dispute between the cedent and the reinsurers involved the reasonableness of the settlement in the underlying claim.[135] Although the law firm had not directly represented the reinsurers in the underlying claim in the "traditional" sense, the court held that the reinsurers had sufficiently alleged a relationship between the law firm and the reinsurers that warranted inquiry into the potential conflict.[136] Specifically, the reinsurers argued that the rules against concurrent and successive representation and the witness-advocate rule required disqualification.[137]

The court held that the allegations in the counterclaim were sufficient to survive a motion to dismiss and denied the cedent's motion accordingly.[138] The court similarly opined that the cedent was not entitled to summary judgment because it had failed to prove, as a matter of law, that disqualification was unwarranted.[139] The court denied the cedent's motion for summary judgment, without prejudice to refile it after discovery.[140] Finally, the court held that the reinsurers were entitled to discovery regarding the disqualification issue.[141]

131. *Id.*
132. 2014 WL 4715712, at *1 (N.D.N.Y. Sept. 22, 2014).
133. *Id.* at *9.
134. *Id.* at *1–3.
135. *Id.* at *2.
136. *Id.* at *5, *7.
137. *Id.*
138. *Id.* at *5–6.
139. *Id.* at *6–7.
140. *Id.* at *9.
141. *Id.*

D. *Preliminary Injunction to Enjoin Arbitration*

A Massachusetts federal court denied a request for a preliminary injunction to enjoin arbitration in a reinsurance dispute between Allstate Insurance Co. and OneBeacon American Insurance Co.[142] Allstate sought a preliminary injunction to enjoin the arbitration based on OneBeacon's alleged violation of the arbitration agreement's umpire selection protocol.[143] Specifically, Allstate argued that OneBeacon's statement of position, provided to the selected umpire, included an addendum which contained information sufficient for the arbitrators to determine that OneBeacon had proposed the selected umpire.[144] Allstate argued that the umpire's knowledge regarding which party appointed him would "fundamentally corrupt[] the integrity of the process."[145]

In denying the request, the court held that Allstate's motion failed to satisfy any of the factors that a movant needed to demonstrate in order for a preliminary injunction to be granted.[146] Specifically, Allstate could not demonstrate that it was likely to succeed on the merits because it could not "credibly make the case that OneBeacon violated any part of the arbitration agreement," nor could Allstate "reasonably contend that its claim is anything but a dressed-up bias claim against an allegedly impartial arbitrator."[147] The court also held that Allstate did not demonstrate that the movant was likely to suffer irreparable harm in the absence of preliminary relief because a remedy was available through a post-hearing challenge to the arbitration proceeding.[148] The court briefly considered the third and fourth factors, namely the balance of the relative equities and the public interest.[149] The court concluded that "the balance of equities" was not tipped in Allstate's favor, nor did a "technical skirmish" over arbitration procedure involve significant public interest.[150]

Because the reinsurer failed to establish any of the four required factors, the court denied Allstate's request for a preliminary injunction.[151] The court also ruled that, because the same four-factor test applied to permanent injunctions, Allstate's motion for a permanent injunction was similarly denied.[152]

142. Allstate Ins. Co. v. OneBeacon Am. Ins. Co., 989 F. Supp. 2d 143, 150 (D. Mass. 2013).
143. *Id.* at 145.
144. *Id.* at 146.
145. *Id.*
146. *Id.* at 150.
147. *Id.* at 149.
148. *Id.* at 149–50.
149. *Id.* at 150.
150. *Id.*
151. *Id.*
152. *Id.*

E. *Final Award*

In *R & Q Reinsurance Co. v. Utica Mutual Insurance Co.*,[153] a New York federal court granted a reinsurer's motion for summary judgment and confirmed an arbitration award as a "final" award. The cedent argued that the award was not a "final" award, but instead an "interim" award in an arbitration that never reached completion.[154]

The arbitration sought to resolve disputes between a cedent and a reinsurer under nine reinsurance certificates covering umbrella policies that the cedent had written to cover certain losses suffered by its insured.[155] The umbrella policies covered losses arising, at least in large part, out of long-term injuries suffered by employees' exposure to asbestos.[156] The parties agreed that the reinsurance billings could be sorted into four categories: "(1) indemnity payments; (2) defense costs; (3) orphan shares; and (4) declaratory judgment expenses."[157] The arbitration proceeded under an arbitration protocol that did not require a reasoned award.[158]

After the seven-day evidentiary hearing, the panel issued a "final order" that set out its findings.[159] The final order provided that the reinsurer was liable for certain indemnity payments, but not defense costs, orphan shares, or declaratory judgment expenses.[160] The final order also stated that future billings should conform to the final order and the certificates.[161] The final order did not calculate the specific amounts that were owed by the reinsurer.[162]

The court noted that the cedent made only one argument—that the award was not a "final" award because it did not specify the amount the reinsurer owed to the cedent.[163] The court rejected the cedent's argument, reasoning that the parties had tasked the panel with resolving the dispute at a conceptual level rather than at a mathematical level.[164]

In conclusion, the court held that the panel resolved all of the disputes submitted to it.[165] As the court noted, "[t]here was nothing else for the panel to resolve on the evidence before it.[166]

153. 18 F. Supp. 3d 389 (S.D.N.Y. 2014).
154. *Id.* at 390.
155. *Id.*
156. *Id.*
157. *Id.* at 391.
158. *Id.*
159. *Id.*
160. *Id.*
161. *Id.*
162. *Id.* at 392.
163. *Id.* at 393.
164. *Id.*
165. *Id.* at 395.
166. *Id.*