RECENT DEVELOPMENTS IN EXCESS, SURPLUS LINES, AND REINSURANCE LAW

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This article analyzes key case law developments within the distinct areas of excess, surplus lines and reinsurance law between October 1, 2017 and September 30, 2018.

I. EXCESS INSURANCE

The area of excess insurance saw many developments over the past year through case law addressing a wide variety of issues, including allocation, priority of coverage, defense costs, drop-down, the "loss" definition, equitable subrogation, exclusions and brokers.

A. *Allocation of Risk*

In *Nooter Corp. v. Allianz Underwriters Insurance Co.*,[1] the Court of Appeals of Missouri adopted an "all sums" approach to allocation for thousands of asbestos bodily injury claims implicating successive policy years from 1949 through 1985. In that case, the insured, Nooter, argued in favor of an "all sums" allocation approach which permitted it to pick and choose which policy period to erode first.[2] The Missouri Court of Appeals had already previously adopted the "all sums" approach in *Doe Run Resources Corp. v. Certain Underwriters at Lloyd's, London*,[3] in an environmental property damage context. The excess insurers argued in favor of a "pro rata" allocation approach, which would spread the liability across each triggered successive policy period.[4] Relying on the "all sums" language in the excess policies (e.g., "all sums," "the sum," "the sums," or "the total sum") and considering language limiting losses or occurrences to a particular policy period (e.g., "during the [policy] period," "while this policy is in force," "occurring during the policy period," "coming within the terms and limits of this [policy]"), the court held that the "all sums" approach applied.[5] The court opined that although the policies only cover occurrences that take place "during the policy period", this language does not mean that the policy only covers the portion of damages that falls within the policy period.[6] The court also rejected the insurers' argument that the "other insurance" conditions in the excess policies required horizontal exhaustion, finding the conditions to be ambiguous and inapplicable to claims under successive, not concurrent, policies.[7] The *Nooter* case adds to a trend in Missouri courts to adopt an "all sums" approach to allocation.

1. 536 S.W.3d 251, 258–59 (Mo. Ct. App. 2017), *appeal denied* 2018 Mo. LEXIS 35 (Mo. Jan. 23, 2018).
2. *Id.* at 266.
3. 400 S.W.3d 463 (Mo. Ct. App. 2013).
4. *Id.*
5. *Id.* at 266–67.
6. *Id.*
7. *Id.* at 267–68.

An important decision concerning the issue of allocation in California remains pending before the California Supreme Court. As reported in last year's survey, in *Montrose Chemical Corp. v. Superior Court*,[8] the California Court of Appeal ruled that an insured, Montrose, was not entitled to "electively stack" excess policies in any triggered year in connection with a long tail environmental claim, and rejected a general rule requiring horizontal exhaustion in favor of a policy language approach. The court also held that excess policies stating that the policies were excess to only a specific underlying policy applied on a primary basis to excess policies with language stating that the policies were excess to "all" underlying insurance.[9] On November 29, 2017, the Supreme Court of California granted review of the *Montrose* decision.[10] The Supreme Court's decision is awaited.

B. *Priority of Coverage*

In *Great Divide Insurance Co. v. Lexington Insurance Co.*,[11] the Supreme Judicial Court of Massachusetts recently addressed the issue of priority of coverage between a primary automobile policy with an "excess" other insurance condition and an excess automobile policy. In that case, an accident occurred when an employee of a refuse company, EZ, driving a garbage truck owned by another company, Capitol, struck and killed a bicyclist.[12] There was no dispute that a primary automobile policy issued by Commerce to Capitol was primary.[13] However, a dispute arose between Great Divide, which issued a separate primary automobile policy to EZ, and Lexington, which issued an excess policy to Capitol, over which policy applied after the Commerce policy was exhausted.[14] Applying Massachusetts' rules of contract construction, the Court ruled that the policies covered the same level of risk because the language of the "other insurance" clause in Great Divide's primary policy stated the policy is "excess over any other collectible insurance" for automobiles not owned by EZ.[15] Although the court acknowledged that a "majority of courts" in other states have held that "true excess" policies do not apply before "true primary" policies, the court ruled that its interpretation reflected the actual language of the policies and not the perceived intent of the parties.[16]

8. 14 Cal. App. 5th 1306, 1323–29 (2017).
9. *Id.* at 1323–29.
10. 406 P.3d 327 (Cal. 2017).
11. 478 Mass. 264, 265 (2017).
12. *Id.* at 264.
13. *Id.* at 265.
14. *Id.* at 265–66.
15. *Id.* at 267–72.
16. *Id.* at 269–70.

In *Cincinnati Insurance Co. v. Selective Insurance Co.*,[17] the Pennsylvania Superior Court addressed a priority of coverage dispute between an umbrella insurer and a primary insurer.[18] In that case, a bodily injury suit was filed by an injured claimant against Wal-Mart and its general contractor, Fiore, after the claimant was injured in a catastrophic accident at a Wal-Mart construction site while working as an employee of Fiore's subcontractor, Da-Lyn.[19] Fiore requested additional insured coverage from Da-Lyn's primary insurer, Selective, which argued its policy was "excess" to the Cincinnati primary and umbrella policies issued to Fiore.[20] Specifically, the Selective policy contained a blanket additional insured endorsement that provided "[t]his coverage shall be excess with respect to the person or organizations included as an additional insured by its provisions . . . unless this coverage is required to be primary and not contributory in the contract."[21] Cincinnati settled the suit and then filed a declaratory judgment action against Selective, claiming that the Selective policy and Cincinnati umbrella policy applied as coinsurance for settlement amounts paid in excess of the limits of Cincinnati's primary policy.[22]

The Pennsylvania Superior Court affirmed the lower court's ruling that Selective's policy applied after Cincinnati's umbrella policy based upon the specific language in Selective's blanket additional insured endorsement making its coverage excess for the additional insured.[23] Specifically, because the Selective policy applied on an excess basis "unless this coverage is required to be primary and not contributory in the contract, agreement or permit", and the trade contract did not require the coverage to be primary, the Cincinnati umbrella policy applied before Selective's primary policy even though the Cincinnati policy was a "true excess" policy.[24]

C. *Defense Costs Under Excess Policies*

In *Johnson Controls, Inc. v. Central National Insurance Co.*,[25] the Court of Appeals of Wisconsin addressed whether excess insurers owed defense costs incurred by their insured, Johnson Controls, against potential liabilities for environmental contamination. In that case, the primary insurers settled their obligations after extensive litigation and Johnson Controls

17. 179 A.3d 575 (Pa. Super. Ct. 2017), 2017 Pa. Super. Unpub. LEXIS 3892.
18. *Id.*
19. The specific facts are contained in the underlying decision at 2016 Phila. Ct. Com. Pl. LEXIS 728 *1–3.
20. *Id.* at *3–5.
21. 2017 Pa. Super. Unpub. LEXIS 3892 at *4–5.
22. *Id.* at *5, 11–12.
23. 179 A.3d 575.
24. *Id.*
25. 382 Wis. 2d 269 (Wis. Ct. App. 2018) (unpublished).

then sought reimbursement of defense costs from its excess insurers.[26] The excess policies contained language stating that if an occurrence was covered under the underlying insurances, then the excess insurers had no duty to defend.[27] Relying on the plain language in the policies, the court ruled that the excess insurers owed no duty to defend Johnson Controls because the occurrence was in fact covered by the underlying policies and hence, the excess insurers owed no duty to reimburse defense costs.[28] This joins a long line of cases holding that an excess insurer who agrees to pay or reimburse defense costs if they are not covered by the underlying insurance need not do so when the underlying insurance covers such costs.

D. *Drop Down*

In *Citizens Insurance Co. of America v. Risen Foods, LLC*,[29] the Second Circuit addressed whether an umbrella policy dropped down when coverage was excluded under the primary policy for an automobile accident. In that case, a van owned by Risen and driven by Tkach, a Risen employee, collided with a truck driven by Tanner resulting in serious injuries to Tanner.[30] The Risen vehicle was insured under a commercial auto policy issued by State Farm with a liability limit of $1 million per occurrence.[31] Risen also had policies with Citizens, including a primary policy with a limit of $1 million per occurrence and an umbrella policy with a limit of $2 million per occurrence.[32] After disclaiming coverage, Citizens filed a declaratory judgment action arguing that Citizens had no duty to defend or indemnify Risen or Tkach in the suit filed by Tanner.[33]

After the Second Circuit ruled that the Citizen's primary policy did not apply, it addressed whether Citizen's umbrella policy must drop down.[34] The insured argued that the following language required a drop down: "We will have the . . . duty to defend the insured against any 'suit' seeking damages . . . when the 'underlying insurance' does not provide coverage."[35] However, the court noted that the policy language also states: "However, we will have no duty to defend the insured against any 'suit' seeking damages for 'bodily injury' or 'property damage' to which this insurance does not apply."[36] Because the umbrella policy's definition of "[c]overed auto" is

26. *Id.*, ¶¶ 2–6.
27. *Id.*, ¶18.
28. *Id.*, ¶¶ 19, 39.
29. 880 F.3d 73 (2d Cir. 2018).
30. *Id.* at 74.
31. *Id.*
32. *Id.*
33. *Id.* at 76–77.
34. *Id.* at 80.
35. *Id.*
36. *Id.*

"only those 'autos' to which 'underlying insurance' applies" and the underlying insurance did not apply, the umbrella policy also does not apply and was not required to drop down.[37]

In *Motors Liquidation Co. DIP Lenders Trust v. Allstate Insurance Co.*,[38] the Supreme Court of Delaware addressed whether the net loss provision in certain excess policies obligated the insurers to drop down and pay for asbestos-related and environmental claims arising from automotive products. In that case, the trustee for General Motors argued that the excess insurers must drop down after the lower court ruled that the underlying primary policies did not apply for estoppel reasons.[39] The court rejected this argument relying on the "clear and unambiguous" net loss provision in the excess policies which obligated the insurers to pay only sums that were covered by the controlling underlying insurance.[40]

E. *"Loss" Definition*

In *City of Phoenix v. First State Insurance Co.*,[41] the Ninth Circuit considered whether an insurer was required to reimburse defense costs to the City of Phoenix under numerous excess and umbrella policies. In that case, Phoenix settled an asbestos bodily injury suit for $500,000 and then sought reimbursement of $1.4 million in defense costs from its excess and umbrella insurer, Hartford.[42] The court ruled that Hartford was not obligated to reimburse the defense costs because the definition of "ultimate net loss" in the excess policies specifically excluded "all loss adjustment expenses", which included defense costs.[43] The court also ruled that defense costs could not be added to the settlement to trigger the excess coverage and that a "No Costs" provision barred coverage for loss expenses or legal expenses when a claim is "adjusted prior to trial court judgment."[44] Although the City also sought the defense costs under its umbrella policies with Hartford, the umbrella policies did not apply because the City's asbestos liability fell within the scope of the underlying excess policies, thereby requiring exhaustion of the self-insured retention and the underlying limit before they may apply, which exhaustion was not established.[45]

In *Key Safety Systems, Inc. v. AIG Specialty Insurance Co.*,[46] the Sixth Circuit addressed whether the definition of "loss" in an excess policy included

37. *Id.*
38. 191 A.3d 1109 (Del. 2018).
39. *Id.*, ¶16.
40. *Id.*, ¶19.
41. 727 F. App'x 296, 297–98 (9th Cir. 2018).
42. *Id.*
43. *Id.*
44. *Id.*
45. *Id.* at 298.
46. 728 Fed. App'x. 579 (6th Cir. 2018).

post-judgment interest. In that case, a Georgia court awarded judgment of almost $4 million against Key Safety in a products liability action brought by a decedent's estate.[47] After exhausting its appellate options without success, Key sought reimbursement from its excess insurer, AIG, for amounts in excess of its $2 million self-insured retention.[48] Key argued that AIG was liable for post-judgment interest since such interest was compelled by the Georgia post-judgment interest statute and AIG was required to pay "judgments."[49] The Sixth Circuit rejected this argument because the policy did not include post-judgment interest within the definition of "loss" under the circumstances, and the Georgia statute distinguished "interest" from "judgments."[50]

In *John M. O'Quinn, P.C. v. Lexington Insurance Co.*,[51] the Fifth Circuit addressed whether proceeds wrongfully deducted from breast implant litigation settlements qualified as "loss" under an excess professional liability policy issued by AIG to a plaintiffs' law firm. In that case, the insured law firm sought reimbursement of $15 million paid towards a $46.5 million settlement of a class action fee dispute after the primary insurer paid its $5 million limit.[52] The deductions kept by the law firm included professional association dues, other lawyer's fees, flowers, fundraising and office overhead.[53] The court ruled that the excess insurer, Lexington, had no obligation to reimburse any proceeds to the law firm because the proceeds were not "loss", which is defined to exclude "fines, penalties, sanctions . . . reimbursement of legal fees, costs, or expenses."[54] The court also ruled that a wrongful acts exclusion barred coverage for any claim "arising out of, based upon or attributable to a criminal, fraudulent and a malicious...or dishonest Wrongful Act," as here.[55]

F. *Equitable Subrogation Against Primary Insurer*

In *Preferred Professional Insurance Co. v. Doctors Co.*,[56] the Colorado Court of Appeals addressed whether an excess professional liability insurer was entitled to equitable subrogation against a primary professional liability insurer. In that case, the excess insurer, Preferred, settled a medical malpractice suit for $1 million after the primary insurer, Doctors, refused to

47. *Id.* at 580.
48. *Id.*
49. *Id.* at 582.
50. *Id.* at 582–83.
51. 2018 U.S. App. LEXIS 29407 (5th Cir. Oct. 18, 2018).
52. *Id.*
53. *Id.* at *8.
54. *Id.* at *10.
55. *Id.* at *10–11.
56. 419 P.3d 1020 (Col. 2018).

settle within its $1 million limits.[57] Preferred then sought to recover the settlement from Doctors on a theory of equitable subrogation, arguing that it had a separate and independent right to equitable subrogation apart from any rights the insured doctor may have had against Doctors.[58] The Colorado Court of Appeals ruled that Preferred was not independently entitled to equitable subrogation and that its only relief was as a subrogee who "stands in the shoes" of its insured.[59] Thus, in order to obtain reimbursement, Preferred was obligated to plead and prove that Doctors acted in bad faith since this was the only relief available to the insured doctor.[60]

G. *Exclusions*

In *Hartford Roman Catholic Diocese Corp. v. Interstate Fire and Casualty Co.*,[61] the Second Circuit considered whether assault and battery exclusions in various "follow-form" excess policies barred coverage for sexual abuse claims against the Diocese. The court ruled that the assault and battery exclusions did not apply because the exclusions only applied to persons acting within the scope of their duties, and the assailant priests were not acting within the scope of their duties when they committed sexual assaults.[62] The court also ruled that the "by or at the direction of such Assured" language in the exclusion limited the exclusion to those assureds who committed or directed the assault rather than to "all assureds" as the insurer argued.[63]

In *Travelers Property Casualty Co. of America v. Actavis, Inc.*,[64] the California Court of Appeal addressed whether suits alleging that an insured drug manufacturer engaged in a "highly deceptive marketing campaign" aimed at increasing sales of opioids and enhancing corporate profits fell within certain products exclusions in the policies. The exclusions barred coverage for bodily injury "that results from your products" or "arising out of 'your product'."[65] The court ruled that the products exclusions barred coverage because the insured's alleged statements, representations and/or warranties were causally related to its products.[66] The court also found no "occurrence" or "event", defined as an "accident", because an "accident" does not include an insured's "deliberate acts unless the injury was caused by some additional, unexpected, independent, and unforeseen

57. *Id.* at 1022.
58. *Id.* at 1022–23.
59. *Id.* at 1023, 1028.
60. *Id.*
61. 905 F.3d 84 (2d Cir. 2018).
62. *Id.* at 88–89.
63. *Id.*
64. 16 Cal. App. 5th 1026 (2017).
65. *Id.* at 1044.
66. *Id.* at 1044–52.

happening."[67] Although this case involved primary insurance, opioid coverage claims impact excess insurers, and decisions such as *Actavis* will be looked to commonly.

H. *Brokers*

In *Excess Line Ass'n. of N.Y. (ELANY) v. Waldorf & Associates*, the Court of Appeals of New York addressed whether the Excess Line Association of New York (ELANY), a legislatively created advisory association under the supervision of the Department of Financial Services (DFS) that facilitates compliance with filing and record keeping requirements for excess line brokers, has capacity to sue its members to recover fees and to compel an accounting.[68] The court held that ELANY does not have capacity to sue its members.[69]

New York insurance law requires excess lines brokers to remit taxes to DFS on excess line insurance premiums charged, submit to ELANY a document containing basic information for each excess line policy brokered, and pay to ELANY a stamping fee that is calculated based upon collected premiums.[70] All excess lines licensees in New York are deemed to be members of ELANY.[71] The defendants operated an insurance brokerage firm which operated an "independent" or "direct" placement insurance program involving placement of insurance directly with syndicates at Lloyd's of London.[72] In 2010, DFS determined that some of the placements should have been classified as excess line placements, subject to the premium tax. The defendants subsequently entered into a "full" settlement with DFS, agreeing to pay approximately $3.4 million in premium taxes, penalties and interest for placements made from 1995 through 2009. The agreement did not require the defendants to pay ELANY the stamping fees associated with the improperly classified insurance placements.[73]

ELANY thereafter sued the defendants seeking to recover stamping fees for excess line policies procured from 1989 through 2011 and to conduct an examination and accounting.[74] The court concluded that ELANY is "an artificial creature of statute" that had neither an inherent or common law right to sue the defendants.[75] Rather, any capacity to sue had to be derived

67. *Id.* at 1038–44.
68. 87 N.E.3d 117, 121 (N.Y. 2017).
69. *Id.*
70. *Id.* at 122 (citing N.Y. Ins. Law §§ 2118 [b] [1], [b] [3], [d]; 2130 [f]).
71. *Id.* (citing N.Y. Ins. Law § 2130 [a]).
72. *Id.*
73. *Id.* at 123.
74. *Id.*
75. *Id.* (citing Community Bd. 7 of Borough of Manhattan v Schaffer, 639 N.E.2d 1 (N.Y. 1994)).

from the enabling statute, which did not provide any "affirmative suggestion" that ELANY had such right. Indeed, the statutory scheme set forth that DFS, not ELANY, was the primary enforcer of the Insurance Law, providing DFS with the ability to take administrative action against agents and brokers, and empowering DFS to impose monetary penalties that could be enforced by civil action.[76] In "stark contrast," ELANY's enumerated powers relate to record keeping and education, rather than regulatory enforcement.[77]

II. SURPLUS LINES INSURANCE

The area of surplus lines insurance saw many developments over the past year, including case law addressing the interpretation of surplus lines policies as specialized risks, and the application of an arbitration clause to surplus lines insurers.

A. *The Interpretation of Surplus Lines Policies as Specialized Risks*

In *Reynolds Ventures, Inc. v. Scottsdale Insurance Co.*, the U.S. District Court for the Middle District of Florida addressed whether a surplus lines insurer must comply with certain Florida statutory notice requirements.[78] The controversy arose with respect to a surplus lines property policy issued by Scottsdale. The property Scottsdale covered suffered damage as a result of a water event.[79] Scottsdale agreed that the policy covered the damage, but disputed the amount of the loss as to the extent and valuation of the services provided by the plaintiff.[80] Scottsdale then invoked the policy's "Appraisal" clause, but the plaintiff objected, arguing (1) there were disputes over coverage; (2) Scottsdale had not invoked appraisal; and (3) Scottsdale had failed to notify plaintiff of its rights under the policy.[81]

The court determined that because it was undisputed that at least some of the services rendered to the property were covered, the remaining dispute concerning the scope of the services was not exclusively a judicial decision and may be appropriate for appraisal.[82] The court rejected plaintiff's argument that Scottsdale failed to invoke the appraisal, holding that the appraisal clause did not require invocation prior to suit and Scottsdale filed its Motion to Compel Appraisal on the same day it removed the case

76. *Id.* (citing N.Y. Ins. Law § 2105 [a], § 109 [c], [d]).
77. *Id.* at 125 (citing N.Y. Ins. Law § 2130 [a]).
78. Civ. No. 2:18-cv-306, 2018 U.S. Dist. LEXIS 150508, 2018 WL 4215947 (M.D. Fla. Sept. 5, 2018).
79. *Id.* at *2.
80. *Id.* at *3.
81. *Id.*
82. *Id.* at *5.

to federal court.[83] The court also rejected plaintiff's argument that Scottsdale's failure to notify it of its right to participate in mediation pursuant to Florida statute sections 627.7015(2) and (7) constituted a waiver of the appraisal provision.[84] Florida Statute section 626.913 delineates that Chapter 627 does *not* apply to surplus line insurers unless specifically stated otherwise.[85] Because Scottsdale was a surplus lines insurer, the Florida statutory appraisal section cited by the plaintiff did not relieve it of the appraisal provision.[86] Accordingly, the requested appraisal was both mandated by the policy and appropriate under the facts of the case. This case highlights the separate treatment of surplus lines insurers under Florida law.

Like Florida courts, Oklahoma courts also hold that surplus lines policies are not subject to the same statutory and regulatory scheme as policies issued by admitted insurers. In *James River Insurance Co. v. Blue Ox Dance Hall*, the U.S. District Court for the Northern District of Oklahoma addressed interpretation and regulation of a surplus lines policy in the context of an endorsement that allowed the insurer to deduct claims expenses from the limits of insurance.[87] James River argued that the Assault and Battery Endorsement ("A & B Endorsement") in its surplus lines policy expressly allowed it to deduct claims expenses from the limits of insurance under a defense within limits provision.[88] The defendants argued that the defense within limits provision of the A & B Endorsement was unenforceable under Oklahoma Administrative Code (OAC) § 365:15-1-15, which disallows insurance policies from including defense costs within the limits of liability. The defendants further argued that the Oklahoma Insurance Commissioner had not granted a waiver to surplus lines insurers that would exempt James River from compliance with § 365:15-1-15, as contemplated by the statute.[89]

Under Oklahoma law, "surplus lines insurance" is defined as "insurance procured by a non-admitted licensee or broker from a surplus lines insurer . . . ."[90] Surplus lines policies are "fully valid and enforceable" in Oklahoma and are given recognition to "the same effect as like contracts issued by admitted insurers."[91] Relying on jurisprudence from New Jersey

83. *Id.* at *7.
84. *Id.* at *7–8
85. *Id.* (citing Fla. Stat. § 626.913(4) ("Except as may be specifically stated to apply to surplus line insurers, the provisions of chapter 627 do not apply to surplus lines insurance authorized under ss. 626.913-626.937, the Surplus Lines Law").
86. *Id.*
87. Civ. No. 16-CV-0151, 2017 U.S. Dist. LEXIS 185652, *1–2, 2017 WL 5195877 (N.D. Okla. Nov. 7, 2017).
88. *Id.* at *6.
89. *Id.*
90. *Id.* at *9 (citing Okla. Stat. tit. 36, § 1100.1).
91. *Id.* (citing Okla. Stat. tit. 36, § 1109).

and Maryland, the Northern District of Oklahoma acknowledged that surplus lines policies ordinarily cover "substandard" or "unusual" risks that admitted insurers are unwilling to cover.[92] Thus, surplus lines insurers are "relatively free from regulatory requirements otherwise imposed on authorized domestic insurers."[93]

The defendants argued that the surplus lines policy was subject to the same laws and regulations that applied to admitted insurers in Oklahoma and, thus, it followed that James River had a duty to follow Oklahoma statutes and regulations applicable to admitted insurers.[94] The court rejected this argument, reasoning that the Oklahoma Insurance Commissioner would not distinguish between licensed and non-admitted insurers if the waiver applied equally to both types of insurers.[95] The court held that OAC § 365:15-1-15 does not apply to surplus lines insurers such as James River, which as a surplus insurer was "generally subject to less regulation due to nature of the risks being insured."[96] Due to its nature as a surplus lines insurer, James River was able to deduct claims expenses from the limits of insurance pursuant to the terms of the endorsement.

In *Steak in a Sack, Inc. v. Covington Specialty Insurance Co.*, the U.S. District Court for the District of Maryland analyzed whether the surplus lines insurer's notice of cancellation for the policy was required to comply with certain notice provisions contained in the Maryland Insurance Code.[97] In that case, the insured sued its insurer for breach of contract and lack of good faith, following a denial of coverage arising out of a fire that occurred at the insured's restaurant.[98] The insurer had previously performed an inspection of the insured's restaurant, which revealed non-compliance with fire extinguisher requirements. The insurer notified the insured that if the deficiency was not rectified within 20 days, the policy would be cancelled, which is what eventually occurred.[99] Several months later, a fire occurred at the restaurant.[100] The insurer relied on its notice of cancellation in taking the position that the loss was not covered.

The court considered whether certain provisions of the Maryland Insurance Code applied to the insurer's cancellation of the subject policy.[101]

92. *Id.* (citing Piermount Iron Works, Inc. v. Evanston Ins. Co., 963 A.2d 818, 824 (N.J. 2009); Smith v. Underwriters at Lloyd's of London, 606 A.2d 273, 280–81 (Md. 1992)).
93. *Id.* at *9–10 (citing Piermount Iron Works, 963 A.2d at 824).
94. *Id.* at *10–11.
95. *Id.* at *13.
96. *Id.* at *13–14.
97. Civ. No. 17-1369, 2018 U.S. Dist. LEXIS 167319, 2018 WL 4679947 (D. Md. Sept. 28, 2018).
98. *Id.* at *1–2, 6.
99. *Id.* at *2.
100. *Id.*
101. *Id.* at *9.

Importantly, section 27-603 of the Code provides that for cancellation of a "commercial insurance" policy, "at least 45 days before the date of the proposed cancellation or expiration of the policy, the insurer shall send to the insured, by a first-class mail tracking method or by commercial mail delivery service, written notice of intention to cancel for a reason other than nonpayment of premium or notice of intention not to renew a policy issued in the State." While the court acknowledged that the insurer did not comply with this provision, it reasoned that "Maryland courts have made clear that not all provisions of the Maryland Insurance Code apply to surplus lines insurers" because of the specialized nature of the risks covered by surplus lines policies.[102]

Furthermore, the Maryland Insurance Administration, the agency charged with administering the Insurance Code, has taken the position that "§§ 27-603, 27-604, and 27-605 of the Insurance Article of the Annotated Code of Maryland do not apply to a surplus lines carrier."[103] While this determination is not binding on the court, in Maryland, an interpretation of the statute by the agency charged with its administration is given considerable weight.[104] Based on this reasoning, the requirements of § 27-603 did not apply to the insurer as a surplus lines carrier and the insurer was required only to comply with the stated terms of the policy concerning cancellation.[105]

B. *Application of Arbitration Clause to Surplus Lines Insurers*

In *Port Cargo Serv., LLC v. Certain Underwriters at Lloyd's London*, the U. S. District Court for the Eastern District of Louisiana addressed the interesting scenario of domestic insurers invoking an arbitration clause applicable to separately contracting foreign insurers under a surplus lines policy.[106] The insureds had purchased a surplus lines policy that included coverage for a warehouse valued at $7.5 million.[107] The property was subsequently damaged by a tornado, causing property damage and business interruption losses. The City of New Orleans wrote to the insureds, declaring that the damage was 95% and that a complete rebuild would be necessary to achieve code compliance.[108] After the insurers refused to pay, the insureds brought suit in Louisiana state court and the insurers removed the case to federal court on the basis of 9 U.S.C. §§ 202, 203 and 205, because two of the insurers were subject to an arbitration clause covered by the

102. *Id.*
103. *Id.* at *12.
104. *Id.*
105. *Id.* at *13.
106. No. 18-6192, 2018 U.S. Dist. LEXIS 144291 (E.D. La. Aug. 24, 2018).
107. *Id.* at *3–4.
108. *Id.* at *4.

Convention on Recognition and Enforcement of Foreign Arbitral Awards (the "Convention").[109]

The insurers then filed a motion to stay litigation pending New York arbitration, arguing that arbitration as to all insurers was appropriate because two of the insurer defendants were subject to the Convention.[110] While the insureds did not contest that arbitration was appropriate as to their claims against the foreign insurers, they argued that their claims against the domestic insurance companies were not subject to the Convention, and arbitration was inappropriate as to them.[111]

The court determined that the insureds had separate insurance contracts with each of the insurers based on the language of a Contract Allocation Endorsement in the policy, which provided that the policy "shall be constructed as a separate contract between the Insured and each of the [insurers]", and that the evidence of coverage consists of "separate policies issued by the insurance company(ies)." The court conducted a limited inquiry in determining whether the Convention requires compelling arbitration in a case.[112] The test is whether: (1) there is an agreement in writing to arbitrate the dispute; (2) the agreement provides for arbitration in the territory of a Convention signatory; (3) the agreement arises out of a commercial legal relationship; and (4) a party to the agreement is not an American citizen.[113] If the foregoing "requirements are met, the Convention requires the district court to order arbitration, unless it finds that said agreement is null and void, inoperative or incapable of being performed."[114]

The court held that the insureds' claims against the foreign insurers were undisputedly subject to arbitration under the Convention because the insurers were not American citizens and the insurance policies arise out of a commercial legal relationship and contained a written arbitration agreement that provided for arbitration in New York, which is in the territory of the United States, a Convention signatory.[115] The court also ruled that the insureds could not be compelled by the Convention to arbitrate their claims against the domestic insurers because the claims against the domestic insurers did not satisfy the traditional criteria for ordering arbitration under the Convention because the parties to those contracts were all American citizens.[116]

109. *Id.* at *5.
110. *Id.* at *6.
111. *Id.*
112. *Id.* at *15 (citing Freudensprung v. Offshore Tech. Servs., Inc., 379 F.3d 327, 339 (5th Cir. 2004)).
113. *Id.*
114. *Id.*
115. *Id.* at *15–16.
116. *Id.* at *16.

However, the court agreed with the argument by the domestic insurers that they should be able to compel arbitration under the theory of equitable estoppel.[117] Applying the Fifth Circuit's decision in *Grigson v. Creative Artists Agency L.L.C.*, the court recognized that a non-signatory may compel arbitration under an equitable estoppel theory in only two circumstances.[118] The first *Grigson* situation did not apply because the insureds' claims against the domestic insurers did not rely on the existence of the insureds' contracts with the foreign insurers. The insurance policy specified that the insureds had a separate contract with each insurer.[119] However, the second *Grigson* scenario, wherein a signatory to the contract containing an arbitration clause raising allegations of substantially interdependent and concerted misconduct by both the non-signatory and a signatory to the contract, was present.[120] Although the insurance policy stated that the insureds had separate contracts with each insurer, there was one insurance policy document that set forth the terms and conditions of the coverage on the risk. The operative policy language was identical as to all of the insurers, foreign and domestic.[121]

The insureds did not allege that one specific insurer breached the terms of the policy—rather they alleged that all of the insurers breached the terms of the policy together through the shared adjustor.[122] Thus, the coverage arguments as to all insurers would be identical, and the plaintiffs' evidence as to the damage to the property and the alleged breach of the insurance policy was going to be identical as to all insurers.[123] The court reasoned that "[a]llowing plaintiffs to proceed in court against the domestic insurers while simultaneously proceeding in arbitration against the foreign insurers would render meaningless the arbitration clause and thwart the intentions of the Convention and the federal policy in favor of arbitration."[124] The court further reasoned that when the parties negotiated the insurance policy, it was contemplated that all disputes against all of the insurers would be determined in one arbitration.[125] Equitable estoppel in favor of the domestic insurers was warranted and the court held that the insureds were required to proceed in arbitration against all of the insurer defendants.[126]

117. *Id.*
118. *Id.* at *17 (citing Grigson v. Creative Artists Agency L.L.C., 210 F.3d 524, 527 (5th Cir. 2000)).
119. *Id.* at *18.
120. *Id.* at *19.
121. *Id.*
122. *Id.* at *20.
123. *Id.*
124. *Id.*
125. *Id.* at *20–21.
126. *Id.* at *21.

III. REINSURANCE LAW

In the last year, courts around the country issued opinions on a variety of reinsurance issues, including the interpretation of facultative reinsurance certificates, direct actions by policyholders against reinsurers, and the standard applicable to a motion to vacate an arbitration award due to a party-arbitrator's alleged partiality and failure to disclose. Key decisions in each area are discussed below.

A. *The Interpretation of Facultative Reinsurance Certificates*

As previewed in last year's survey, in December 2016 the United States Court of Appeals for the Second Circuit certified a question to the New York Court of Appeals regarding the proper interpretation of a facultative reinsurance certificate under New York law, including whether the stated limits of a facultative certificate are presumptive caps on the facultative reinsurer's liability.[127] One year later, in December 2017, the New York Court of Appeals issued its decision in *Global Reinsurance Corp. of America v. Century Indemnity Co.*,[128] and its reasoning has been cited in several cases. The New York Court of Appeals, New York's highest court, held: "New York law does not impose either a rule, or a presumption, that a limitation on liability clause necessarily caps all obligations owed by a reinsurer, such as defense costs, without regard for the specific language employed therein."[129] Instead, the court stressed that because "[r]einsurance contracts are governed by the same principles that govern contracts generally," a court reviewing a reinsurance contract under New York law "must look to the language of the policy above all else" to determine the contract's meaning.[130]

In May 2018, the Second Circuit applied the Court of Appeals ruling to the *Global* case, concluding that "[t]he decision from the Court of Appeals . . . requires us to remand this case to the district court for consideration in the first instance of the contract terms at issue, employing standard principles of contract interpretation."[131] The Second Circuit added, "it is now clear that the district court's determination that the contract was unambiguous was premised on an erroneous interpretation of New York

127. The Second Circuit's certified question is set forth in *Global Reinurance Corp. of America v. Century Indemnity Co.*, 843 F.3d 120, 128 (2d Cir. 2016). As discussed in prior surveys, the genesis of the certified question was continued litigation concerning the well-known Second Circuit case of *Bellefonte Reinsurance Co. v. Aetna Casualty & Surety Co.*, 903 F.2d 910, 914 (2d Cir. 1990), which held that the stated limit of liability in a facultative certificate unambiguously caps the amount a reinsurer is obligated to pay for both loss and loss adjustment expenses incurred by the ceding company.

128. 30 N.Y.3d 508 (2017).

129. *Id.* at 519.

130. *Id.* at 518–19 (internal quotation marks and citation omitted).

131. Global Reins. Corp. of Am. v. Century Indem. Co., 890 F.3d 74, 77 (2d Cir. 2018).

state law."[132] Quoting the New York Court of Appeals, the Second Circuit directed that, upon remand, the district court "should 'construe each reinsurance policy solely in light of its language and, to the extent helpful, specific context.'"[133]

Later, in September 2018, the Second Circuit again applied the New York Court of Appeals' guidance from *Global* to interpret facultative reinsurance contracts in *Utica Mutual Insurance Co. v. Clearwater Insurance Co*.[134] The case involved facultative reinsurance by the reinsurer (Clearwater) for asbestos-related losses and expenses incurred by the ceding company (Utica) under umbrella policies and pursuant to a settlement agreement with the policyholder. At issue on appeal was whether the reinsurance was capped at the stated limit of the facultative certificate (the *Bellefonte* issue) and whether the reinsurer must indemnify the cedent for its settlement.

On the first issue, the Second Circuit referenced the *Global* opinion and held that a "naked" limitation on liability or reinsurance accepted clause – that is, one which does not say that the reinsurer's obligations are "subject to" the amount of liability – "does not inherently cap the reinsurer's liability" and "says nothing about whether that liability cap is expense-supplemental or inclusive."[135] However, because the reinsurance certificates had a "follow-the-form" clause, the court found that the reinsurer's obligations "must track" the cedent's obligations on the underlying policies.[136] Since the underlying policies at issue were "expense-supplemental," the court ruled that "the . . . certificates likewise are expense-supplemental."[137]

On the second issue, the Second Circuit first held that where a facultative reinsurance certificate does not contain an express "follow-the-settlements" provision, under New York law there was "no reason to read such a term into the contract by implication."[138] Citing the New York Court of Appeals opinion in *Global*, the Second Circuit stated: "the court's repeated emphasis on plain language makes clear that we should not imply so significant a term into a contract negotiated between sophisticated parties."[139] This issue was important because the Second Circuit also held that if the reinsurance contract "does not contain a follow-the-settlements provision, the reinsurer must indemnify the reinsured only for

132. *Id.*
133. *Id*. (citation omitted).
134. Nos. 16-2535, 16-2824, 2018 U.S. App. LEXIS 27311 (2d Cir. Sept. 25, 2018).
135. *Id*. at *14. On the other hand, the Second Circuit also stated if the facultative certificate does say that the reinsurance is "subject to" the amount of liability, then the reinsurer's obligations "would be expense-inclusive and would therefore be capped at" the stated limit. *Id*. at *13.
136. *Id*. at *15.
137. *Id.*
138. *Id*. at *28.
139. *Id*. at *27

the reinsured's *proven* liability under the reinsurance policy."[140] This meant that Clearwater's obligation was to "indemnify Utica according to Utica's proven liability on the umbrella policies."[141] Since the lower court made no findings on that topic, the Second Circuit remanded the case to address it.[142]

Finally, in another case addressing these issues from a different jurisdiction, the Pennsylvania Superior Court affirmed a post-trial ruling by the Pennsylvania Court of Common Pleas that two facultative certificates covered defense expenses in addition to the "Reinsurance Accepted" stated in the certificates.[143] On appeal, the reinsurer relied on *Bellefonte* and the line of cases following that decision to argue that the certificates were unambiguous and that the "Reinsurance Accepted" amount capped its liability for both losses and defense costs.[144] In response, the cedents argued that the *Bellefonte* cases were distinguishable, and that the certificate language was ambiguous in light of the presumption of concurrency in the reinsurance industry, which requires the reinsurer to accept a portion of the risk proportional to its premium share.[145]

The appellate court acknowledged that the certificates contained language similar to the certificates at issue in *Bellefonte*, but concluded that the trial court correctly found that the language – in particular the "subject to" clause, which stated only that "the reinsurance is 'subject to the general conditions set forth on the reverse side'" – was materially different.[146] The appellate court also noted that the certificates required the reinsurer "to pay its proportion of losses, 'and in addition thereto,' its proportion of expenses," and that the certificates did not specifically state that expenses were included in the Reinsurance Accepted limit.[147] Finally, the court explained that the underlying policies provided "coverage for expenses in addition to the limits" and the reinsurance certificates "follow[ed] the underlying policy."[148] Thus, as in the later *Utica Mutual* case, the Pennsylvania appellate court explained that "absent language providing the entire certificate is 'subject to' the 'Reinsurance Accepted' amount, a reasonable interpretation of the language is that where the underlying policy covers expenses in addition to liability limits, the reinsurance certificate provides the same coverage."[149]

140. *Id.* at *6.
141. *Id.* at *29.
142. *Id.* at *30.
143. Century Indem. Co. v. OneBeacon Ins. Co., 173 A.3d 784 (Pa. Super. Ct. 2017).
144. *Id.* at 798.
145. *Id.* at 799–800.
146. *Id.* at 800.
147. *Id.* at 801.
148. *Id.* at 800.
149. *Id.* at 801.

B. *Reinsurer Direct Liability and Contractual Privity*

Multiple decisions during this review period involved suits by individual insureds directly against one or more reinsurers, despite a lack of contractual privity.

First, in February 2018, a Pennsylvania federal court entered summary judgment in favor of a reinsurer, finding that the insured greenhouse could not meet its burden with respect to any of its claims against the reinsurer. In that case, *Three Rivers Hydroponics, LLC v. Florists' Mutual Insurance Co.*, a commercial greenhouse sought coverage for damage resulting from an alleged fire.[150] After the direct insurer denied its claim, the greenhouse filed suit against both the insurer and the insurer's reinsurer, alleging that the reinsurer had breached duties owed to the greenhouse under both the insurance agreement and the reinsurance agreement. The reinsurer subsequently moved for summary judgment, arguing that it was not in privity with the insured under either contract, and as such owed it no contractual obligations.

The district court first found that the reinsurer owed no contractual obligations to the greenhouse under the direct insurance agreement.[151] The court rejected the argument that the reinsurer had assumed direct obligations to the greenhouse under the insurance policy simply because the reinsurance agreement provided that the reinsurer would investigate claims.[152] In the court's view, this provision did not relieve the insurer of its obligations to the greenhouse, it merely memorialized the insurer's and reinsurer's obligations to each other – something the court found to be common in the context of reinsurance and third-party claims investigators.[153]

The court also found that the greenhouse was not a third-party beneficiary of the reinsurance agreement. According to the court, to qualify as a third-party beneficiary, a third-party must be "within [the promisor's] contemplation at the time the contract was entered into and [the promisor's] liability was intentionally assumed by him in his undertaking."[154] Because the court found that the reinsurance agreement (which was entered into 12 years before the direct policy was issued) did not indicate that the parties' contemplated the greenhouse as a potential third-party beneficiary, the court concluded the reinsurer and insurer did not intend the insured to be a beneficiary of the reinsurance agreement.[155]

The court specifically rejected the argument that the reinsurer's claims investigation responsibilities under the agreement, paired with the implied

150. No. 2:15-cv-00809, 2018 U.S. Dist. LEXIS 20699 (W.D. Pa. Feb. 8, 2018).
151. *Id.* at *6.
152. *Id.* at *7.
153. *Id.*
154. *Id.* at *9 (citation omitted).
155. *Id.* at *9–10.

covenant of good faith evidenced the parties' intent for the greenhouse to be a third-party beneficiary.[156] As the court viewed it, the policyholder's argument would mean that every reinsurance agreement was necessarily intended to benefit individual policyholders as third-party beneficiaries, since all reinsurance agreements (like all contracts) contain a duty to act in good faith.[157] As there was no evidence that the greenhouse believed it was buying insurance from the reinsurer, the court found that it was not entitled to third-party beneficiary status under the reinsurance agreement and granted judgment for the reinsurer.[158]

Similarly, in August 2018, a federal court in Washington, D.C. dismissed an insured finance company's claims against the reinsurers of its direct insurer. In *Vantage Commodities Financial Services I, LLC v. Assured Risk Transfer PCC, LLC*, a finance company sought to recover a $22 million arbitration award it won following an arbitration with its direct insurer.[159] The insurer represented that it had reinsured 90% of the risk, and that the only assets it had to pay the award were a $2.2 million letter of credit and its reinsurance agreements.[160] The reinsurers refused to pay, however, alleging that the insurer had failed to provide timely notice of the claim.[161] Eventually, the finance company sued the insurer and each of the reinsurers for breach of contract.

In response, the reinsurers moved to dismiss, asserting a lack of personal jurisdiction and plaintiff's failure to effectuate proper service on them due to a lack of privity. On the first issue, the court found that it had specific jurisdiction over the finance company's claims because they arose from commercial activities the reinsurers directed towards residents of the jurisdiction – namely entering into reinsurance agreements with a D.C.-based insurer.[162] On the second issue, although the finance company had attempted to serve the reinsurers through a service provision in the reinsurance contracts designating an agent for service of process, the court found that such service was improper because the finance company could not show that it was in a direct contractual relationship with the reinsurers.[163]

The court rejected the finance company's argument that it had a separate contractual relationship with the reinsurers because the insurer retained only 10% of the risk and because disclosure of the reinsurers' identities

156. *Id.* at *11–12.
157. *Id.* at *12.
158. *Id.*
159. 321 F. Supp. 3d 49 (D.D.C. 2018).
160. *Id.* at 55.
161. *Id.*
162. *Id.* at 57.
163. *Id.* at 60.

was a condition precedent to its agreement with the direct insurer.[164] The court found that these allegations were not sufficient to overcome the general rule that a reinsurer does not have a direct contractual relationship with the original insured unless the terms of the reinsurance agreement create such a relationship.[165] Because the policyholder could not establish a contractual relationship with the reinsurers, the court found its attempts at service under a provision of the reinsurance agreement ineffective. The court further found that an extension to perfect service would be futile, as the finance company had no contractual claims against the reinsurers.[166]

C. *Arbitrator Disclosures and the Evident Partiality Standard for Party Arbitrators*

This review period saw a significant reinsurance case involving arbitrator disclosures and the proper standard of review for allegations of evident partiality by a party-appointed arbitrator. In *Certain Underwriting Members of Lloyd of London v. Florida*, the Second Circuit held that a party seeking to vacate an award under §10(a)(2) of the Federal Arbitration Act must sustain a higher burden to prove evident partiality on the part of an arbitrator who is appointed by a party than for a neutral arbitrator.[167] The case, which arose from an arbitration between a worker's compensation insurer and its reinsurers, centered on the failure of the insurer's party-appointed arbitrator to disclose the extent of his business relationships with the insurer's employees.[168]

Following a merits hearing, the arbitration panel entered an award in favor of the insurer. The parties subsequently filed cross-petitions in federal court, alternatively seeking to confirm and vacate the award. The district court found that the party-appointed arbitrator's failure to disclose his business relationships called into question his impartiality and required vacating the panel's award. The Second Circuit disagreed.

Specifically, the Second Circuit found that the district court erred when it weighed the conduct and disclosures of the party-appointed arbitrator under the standard applicable to neutral arbitrators.[169] The court found that in industries like reinsurance, where parties seek arbitrators with expertise, the "best informed and most capable potential arbitrators" often have "deep industry connections."[170] Because "[f]amiliarity with a discipline

164. *Id.*
165. *Id.*
166. *Id.* at 60–61.
167. Certain Underwriting Members of Lloyd of London v. Florida, 892 F.3d 501 (2d Cir. 2018).
168. *Id.* at 505.
169. *Id.* at 509.
170. *Id.* at 507 (citation omitted).

often comes at the expense of complete impartiality," the court found that disqualifying arbitrators based solely on their professional dealings with one of the parties "would make it impossible, in some circumstances, to find a qualified arbitrator at all."[171] The court further found that "[e]xpecting of party-appointed arbitrators the same level of institutional impartiality applicable to neutrals would impair the process of self-governing dispute resolution."[172] In doing so, the Second Circuit joined several other federal circuit courts that distinguish between party-appointed and neutral arbitrators in considering evident partiality.[173]

Notably, while the court held that party arbitrators are not subject to the same stringent standards as neutral arbitrators, it did conclude that they are still subject to some "baseline limits to partiality."[174] To that end, the court explained that if there was evidence the party-appointed arbitrator was not disinterested, or if the arbitrator's partiality had a prejudicial impact on the outcome of the proceeding, it could justify an order vacating an award.[175] Thus, the Second Circuit remanded the case for consideration of whether the reinsurers had shown by "clear and convincing evidence" that the arbitrator's failure to disclose his connections to the insurer "violates the qualification of disinterestedness or had a prejudicial impact on the award."[176]

171. *Id.* at 508 (citation omitted).
172. *Id.* at 510.
173. *Id.* at 509.
174. *Id.* at 510.
175. *Id.*
176. *Id.* at 511.