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Every Risk Professional Should Know

An Analysis of the Top 50 Reinsurance Cases and Their Implications

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50 REINSURANCE CASES EVERY RISK PROFESSIONAL SHOULD KNOW

AN ANALYSIS OF THE TOP 50 REINSURANCE COVERAGE CASES AND THEIR IMPLICATIONS.

Squire Patton Boggs (US) LLP

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2. **Ainsworth v. General Reins. Corp.**, 751 F.2d 962 (8th Cir. 1985)
7. **Banco de Seguros del Estado v. Mutual Marine Office Inc.**, 344 F.3d 255 (2d Cir. 2003)
11. **Century Indem. Co. v. Certain Underwriters at Lloyd’s of London**, 584 F.2d 1481 (9th Cir. 1991)
15. **Compagnie De Reassurance D’lle De Fr. v. New Eng. Reins. Corp.**, 57 F.3d 56 (1st Cir. 1995)
17. **Continental Cas. Co. v. Stronghold Ins. Co.**, 77 F.3d 16 (2d Cir. 1996)
21. **Fidelity & Deposit Co. v. Pink**, 302 U.S. 224 (1937)
23. **Fortress Re, Inc. v. Central Nat’l Ins. Co.**, 766 F.2d 163 (4th Cir. 1985)
28. **International Surplus Lines Ins. Co. v. Fireman’s Fund Ins. Co.**, 998 F.2d 504 (7th Cir. 1993)
31. **Keehn v. Excess Ins. Co.**, 129 F.2d 503 (7th Cir. 1942)
40. **Quackenbush v. Allstate Ins. Co.**, 121 F.3d 1372 (9th Cir. 1997)
43. **Sphere Drake Ins. Ltd. v. Clarendon Nat’l Ins. Co.**, 263 F.3d 26 (2d Cir. 2001)
47. **Trustmark Ins. Co. v. John Hancock Life Ins. Co.**, 631 F.3d 869 (7th Cir. 2011)
FOREWORD

For more than 30 years, International Risk Management Institute, Inc. (IRMI), has been a premier provider of risk management and insurance information to corporations, law firms, government, and the insurance industry. This information is developed by the most experienced research and editorial team in insurance reference publishing in partnership with a host of industry practitioners who work with us.

IRMI has been pleased to work with Larry Schiffer as an IRMI.com Expert Commentator, contributing articles on reinsurance issues for more than 14 years. Over these years, he has written nearly 60 articles on a variety of pertinent reinsurance topics, which can be accessed at no cost in the Reinsurance Section of IRMI.com.

Following the success of an IRMI Insights white paper on important insurance caselaw, 50 Insurance Cases Every Self-Respecting Attorney or Risk Professional Should Know, we thought a similar paper on reinsurance case law would be useful to the industry. Larry and his team at Squire Patton Boggs were the natural choice for this project. When I invited him to take it on, he was very enthusiastic.

What follows is the product of that discussion—summaries of 50 U.S. reinsurance cases that are arguably the most influential of all time, along with insightful analysis on the implications of those decisions. (Please read the Introduction on page 1 to see how the authors went about compiling the list.)

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You can learn more about all these services on our website, www.IRMI.com. If you have comments about this publication or perhaps a desire to publish something you’ve written with IRMI, please contact us using the contact us form on our website. We sincerely hope you find “50 Reinsurance Cases Every Risk Professional Should Know” to be interesting and educational.

All the best,

Jack P. Gibson, CPCU, CRIS, ARM
President and CEO
International Risk Management Institute, Inc.
Squire Patton Boggs is one of the world’s largest law firms with 44 offices in 21 countries. With a global team of more than 1,500 lawyers, we are ready to support clients wherever law, business, and government intersect, and in the languages and time zones clients do business.

Squire Patton Boggs’ Insurance Practice offers comprehensive services to insurance and reinsurance industry participants around the globe, including many of the world’s most dynamic, emerging markets. We are at the forefront of representing insurance and reinsurance companies in their most significant and complex disputes. Combining decades of experience with forward-looking innovation, we help clients navigate the business of insurance, using our deep knowledge of the industry to find solutions to a wide range of legal, regulatory, coverage, and disputes questions.
International Risk Management Institute, Inc. (IRMI), was founded in 1978 to provide important risk and insurance information to business, legal, risk management, and insurance professionals. In the years since it was founded, IRMI has published the most comprehensive library (45,000+ pages) of practical manuals, books, and newsletters available. IRMI also sponsors seminars and conferences, and the annual IRMI Construction Risk Conference is the premier national symposium devoted exclusively to the management of construction risks. To maintain objectivity and avoid conflicts of interest in its research, IRMI does not offer insurance sales, consulting, expert witness, underwriting, or similar services.

Our product line addresses virtually all facets of insurance and risk management. The commercial lines library analyzes general liability, umbrella liability, business auto, motor carrier, commercial property, inland marine, commercial crime, D&O liability, E&O liability, employment practices liability, and malpractice liability insurance. The IRMI risk management library addresses risk financing and the alternative market, contractual risk transfer, workers compensation law, safety, and claims management. Other IRMI books and references focus on insurance coverage caselaw developments, specific risk management techniques and practices, risk and insurance developments and trends, and risk management for specific industries. The references comprising these libraries are available in various formats, both individually and in sets.

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In summary, IRMI is committed to providing practical and up-to-date information that can help you succeed in your career and guarantees these products with friendly, state-of-the-art customer service.
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INTRODUCTION

How do you determine the top 50 U.S. reinsurance decisions out of thousands of court decisions touching on reinsurance issues? Although most reinsurance disputes are arbitrated as a matter of longstanding industry practice, many disputes are not. Moreover, many arbitrated disputes end up in court through enforcement proceedings or proceedings to confirm or vacate an arbitration award. We began the winnowing process with the thought that a good measure of relevance was to look at reinsurance decisions that had been cited by other courts more frequently than others. That analysis led us to an initial pool of 215 decisions.

We narrowed down those decisions to the cases we knew were relevant to us as practitioners and to those with the largest frequency of citation by other courts. Did we pick the true top 50 reinsurance decisions? It’s hard to tell. There is no question that many of the decisions we left on the cutting room floor are worthy of mention. Each of you may have a favorite that we failed to include. If we missed your favorite, we apologize. But we believe that this top 50 list provides a diverse and balanced, if not eclectic, collection of interesting and important seminal reinsurance decisions.

We set forth below a series of narrative discussions on certain reinsurance topics from which these decisions are derived. You will see that some of our chosen top 50 appear multiple times for different propositions. This phenomenon is not surprising for a list of the most important reinsurance decisions. Following the topical discussions are summaries of each of the cases.

A few editorial notes are in order. For those not steeped in the traditions of reinsurance, we set forth a few simple definitions.

- An insurance company that purchases reinsurance (an insurance company issuing primary or excess policies to policyholders directly) is called a ceding insurer, ceding company, cedent, or reinsured.
- A reinsurance company that purchases its own reinsurance is called a retrocedent.
- An insurance company that provides reinsurance coverage is called an assuming insurer or, more typically, a reinsurer.
- A reinsurance company that assumes reinsurance obligations from another reinsurance company is called a retrocessionaire.
A reinsurance contract is often called a **facultative certificate of reinsurance** if it reinsures a specific policy and risk, or a **treaty** if it provides broad reinsurance coverage over many policies and risks.

Some reinsurance treaties are proportional and are often called **quota share treaties**.

Other reinsurance treaties are non-proportional and are often called **excess-of-loss treaties**.

These and other reinsurance terms and definitions can be found in the IRMI **Glossary of Insurance and Risk Management Terms**.

Larry P. Schiffer, Editor
October 2014
INTRODUCTION TO REINSURANCE—LARRY P. SCHIFFER

Reinsurance has been called many things by many courts and commentators. The New York Court of Appeals, New York’s highest court, once described reinsurance law as “a field in which differences have often been settled by handshakes and umpires, and pertinent precedents of this court are few in number.” Sumitomo Marine & Fire Ins. Co. v. Cologne Reins. Co. of Am., 75 N.Y.2d 295, 552 N.E.2d 139, 552 N.Y.S.2d 891 (1990). One court has analogized reinsurance to a bookie laying off bets. In describing “reinsurance” at the outset of his opinion in Continental Cas. Co. v. Stronghold Ins. Co., 77 F.3d 16 (2d Cir. 1996), Circuit Judge Joseph M. McLaughlin said:

Reinsurance is not new. It dates back to the time the first bookie, fearful that he could not cover all his bets in the event if he were to lose, decided to spread his risk by “laying-off” some of the risks by getting other bookies to share his exposure.

Click the case name to go to the case summary.
Of course, the judge went on to state “in a more respectable vein” that:

“Reinsurance is a device whereby an insurance company that has assumed uncomfortable levels of risk buys insurance from another insurance company to assume some of those risks. The basic insurer is then referred to as the “reinsured” or, sometimes the “ceding insurer.” The reinsurer is called precisely that. By contract, the reinsurer agrees to assume some or all of the risk that the ceding insurer has assumed.


A more developed definition of reinsurance is found in Skandia Am. Reins. Corp. v. Schenck, 441 F. Supp. 715 (S.D.N.Y. 1977), where the court addressed the interplay between the obligations of the reinsurer and the competing claims to reinsurance proceeds by the ceding company’s receiver and the relevant state’s insurance guaranty association:

Reinsurance is the “ceding by one insurance company to another of all or a portion of its risks for a stipulated portion of the premium, in which the liability of the reinsurer is solely to the ... ceding company, ... [which] retains all contract [sic] with the original insured, and handles all matters prior to and subsequent to loss.” In contrast to an insurer’s obligation to pay and defend against its insured’s liability whether or not the insured has paid injured third parties, the reinsurer’s liability is conditioned upon the insurer’s prior payment of loss.

This formulation of reinsurance tells us that, in many reinsurance contracts, the reinsurer’s obligation to indemnify the ceding insurer is triggered only after the cedent has paid the underlying loss. In an insolvency situation, the issue is compli-
cated by the involvement of state guaranty associations, which will pay a policyholder’s loss subject to statutory limitations and then put in a claim against the insolvent insurer’s estate. As discussed below, the statutorily mandated insolvency clause in most reinsurance agreements requires the reinsurer to pay the receiver without diminution of the reinsurer’s obligations under a reinsurance contract to the receiver even though the insolvent ceding insurer has not actually paid the underlying loss.

As seen above, many courts have opened their opinions by first setting forth a general explanation of the purpose and structure of reinsurance. Another fine example of this judicial reinsurance lesson is provided for in the second paragraph of the opinion in *Travelers Cas. & Sur. Co.*. In addressing a complicated dispute over whether environmental injury claims could be aggregated as a single occurrence under certain reinsurance contracts, the court expanded on its description of reinsurance contained in *Sumitomo* and *Michigan Nat’l Bank-Oakland*:

> When entering into a reinsurance contract, an insurance company agrees to pay a particular premium to a reinsurer in return for reimbursement of a portion of its potential financial exposure under certain direct insurance policies it has issued to its customers. Through this indemnity relationship, the reinsured seeks to “cede” or spread its risk of loss among one or more reinsurers. Reinsurance differs from direct insurance, such as excess insurance, in that the reinsurer is not, in most cases, directly obligated to the original insured; in fact, reinsurance indemnity does not arise until the reinsured has paid a claim.

The court’s succinct explanation of reinsurance led to an effort to describe the different types of reinsurance and the different ways reinsurance is structured.

**Reinsurance comes primarily in two forms: facultative and treaty reinsurance.** Facultative reinsurance is policy-specific, meaning that all or a portion of a reinsured’s risk under a specific contract of direct coverage will be indemnified by the reinsurer in the event of loss. In contrast, a carrier seeking to reduce potential financial losses from policies issued to a class of customers or an industry may purchase treaty reinsurance.
Other courts have also taken up the effort to explain the difference between facultative and treaty reinsurance as best as they could. The court in *Unigard Sec. Ins. Co. v. North River Ins. Co.*, 4 F.3d 1049 (2d Cir. 1993), explained that, "In facultative reinsurance, a ceding insurer purchases reinsurance for a part, or all, of a single insurance policy. Treaty reinsurance covers specified classes of a ceding insurer’s policies." See also *Sumitomo Marine & Fire Ins. Co.*, 75 N.Y.2d at 301; *Michigan Nat’l Bank-Oakland v. American Centennial Ins. Co.*, 89 N.Y.2d at 106; *Christiania Gen. Ins. Corp. v. Great Am. Ins. Co.*, 979 F.2d 268 (2d Cir. 1992); *North River Ins. Co. v. CIGNA Reins. Co.*, 52 F.3d 1194 (3d Cir. 1995).

The key difference between facultative reinsurance and treaty reinsurance is that, in facultative reinsurance, the reinsurer decides whether to assume a specific risk under a specific policy, while under treaty reinsurance, the reinsurer is bound to accept all policies and risks as defined by the reinsurance contract.

Another key difference—which is becoming less and less of a real difference today—is that facultative reinsurance contracts are typically written on a short-form facultative certificate containing only one or two pages while treaty reinsurance is typically written on a long-form reinsurance contract with detailed terms and conditions.

The reinsurance contract formation process is also something that historically has differed from other commercial contracts. In the past, reinsurance contracts were typically formed through the presentation of brief details about the risk and the signing of a short-form agreement called a slip or binder. See *Sumitomo Marine & Fire Ins. Co. v. Cologne Reins. Co. of Am.*, 75 N.Y.2d at 301–02. The full reinsurance contract—the formal treaty wording—often was not drafted and signed for months if not years after the inception of the reinsurance relationship. In many cases, a full reinsurance contract might never be issued. See, e.g., *Great Am. Ins. Co. v. Fireman’s Fund Ins. Co.*, 481 F.2d at 951–52. This “swift, seemingly casual process of contract formation,” *Sumitomo Marine & Fire Ins. Co. at 302*, has given way in more modern times to rules and regulations requiring the execution of the final reinsurance contract at the time of inception or at least within a very short time after the contract commences.

Reinsurance also gives rise to some of the concepts discussed in the sections below such as utmost good faith and follow-the-fortunes. These core reinsurance principles have been described, understood, and applied by
many courts to varying degrees of success. See Michigan Nat’l Bank-Oakland at 106–07; North River Ins. Co. at 1199–1200; Unigard Sec. Ins. Co. at 1054. These concepts focus on the nature of the reinsurance relationship where the reinsurer typically does not examine the underlying risks (except in facultative reinsurance) and does not have direct access to the underlying underwriting and claims information. The reinsurer, instead, relies on the ceding company to describe in good faith the scope and nature of the risks its wants the reinsurer to assume and to provide timely and detailed information about losses. It is the cedent that has the direct relationship with the policyholder—not the reinsurer—and therefore it is the cedent that is privy to important information about the underlying risk that must be passed on to the reinsurer in good faith.

But, as the court in Unigard Sec. Ins. Co. v. North River Ins. Co., 4 F.3d at 1054, said in construing these various concepts, the reality of how utmost good faith is applied has shifted as the reinsurance market has evolved:

However, in recent years, the reinsurance market has witnessed an increase in participants and a decline in profitability due to huge environmental losses. This has led some commentators to question the continued vitality of utmost good faith as a description of the current practices in the reinsurance market ... and argue that the market is now one of caveat emptor. (Citations omitted.)

If these commentators are correct, the reinsurance industry may encounter severe difficulties. It involves a market that has relied upon informal understandings and practices that cause participants to act toward each other with the good faith expected of joint venturers. Whether the industry can thrive if these understandings and practices are eroded and replaced by litigation is an open question.

Reinsurance is often viewed as an anachronism clouded in mysterious terms of art and principles. Yet, without reinsurance, there would be very little modern commerce. Reinsurance stands at the core of our economic system and that of developing countries. Without reinsurance, the extraordinary risks created by yesterday’s and today’s technology would not be insured, and businesses likely would not be able to move forward. So, raise your glass to reinsurance, and enjoy the top 50 reinsurance cases!
Reinsurance contracts are interpreted by the court just like any other commercial contract. Where reinsurance contracts differ from other commercial contracts is in the use of industry terms of art or jargon, and the application of custom and usage where appropriate. Certain judicial construction rules, like construing an insurance contract against the drafter, typically are not applied in the reinsurance context.

Where the reinsurance contract contains a choice-of-law provision, courts generally enforce the contracting parties’ choice of applicable law. For example, in *Skandia Am. Reins. Corp. v. Schenck*, 441 F. Supp. 715 (S.D.N.Y. 1977), the court had to determine which law applied to define the statutory successor to an insolvent ceding insurer. The case was an interpleader battle for reinsurance proceeds between the insolvent cedent’s liquidator and the state insurance guaranty fund. The arbitration clause in the reinsurance contracts provided that New York law would govern any arbitration. The insolvency clauses in the reinsurance contracts all mentioned a section of the New York insurance law. But none of the reinsurance contracts explicitly designated the law by which the contracts should be governed in the event of insolvency.

➤ Click the case name to go to the case summary.
Given the absence of a specific choice-of-law provision, the court was compelled by New York law to determine the governing law by using New York’s governmental interest approach. In making this determination, the court in *Schenck*, stated that, in New York, the “rules for the construction of insurance contracts do not differ from those to be applied for the construction of other contracts.” The court noted that the primary rule in the construction of contracts is to ascertain and effectuate the intent of the parties. See *Excess Ins. Co. v. Factory Mut. Ins. Co.*, 3 N.Y.3d 577, 822 N.E.2d 768, 789 N.Y.S.2d 461 (2004). The court also stated that the law in force at the time the contract is entered into becomes part of the contract and that courts assume that the parties had that law in mind when the contract was made.

Where the terms of a reinsurance contract are ambiguous, the court will look to extrinsic evidence and industry custom and practice to construe the contract just as courts do for other commercial contracts. In *Christiania Gen. Ins. Corp. v. Great Am. Ins. Co.*, 979 F.2d 268 (2d Cir. 1992), the court in a diversity action governed by New York law had to construe whether the ceding company satisfied its obligation of prompt notice under the reinsurance contract. In construing the notice clause of the reinsurance contract, the court stated that, when the terms of a contract are ambiguous, as in this case, reference to extrinsic evidence provides guidance to the parties’ intent. Extrinsic evidence, said the court, may in appropriate cases include industry custom and practice.

Extrinsic evidence carried the day in *International Surplus Lines Ins. Co. v. Fireman’s Fund Ins. Co.*, 998 F.2d 504 (7th Cir. 1993), where a jury was allowed to consider contemporaneous writings and broker testimony to determine the parties’ intent concerning a reinstatement provision. The Seventh Circuit Court of Appeals affirmed the jury verdict holding that the district court had properly allowed a jury to decide the question of the parties’ intent regarding ambiguous contract provisions.

In *Commercial Union Ins. Co. v. Seven Provinces Ins. Co.*, 217 F.3d 33 (1st Cir. 2000), expert evidence of industry trade usage was permitted to construe an ambiguity as to whether the ceding company could use quota share treaty reinsurance to cover a share of its risk without violating the net retention requirement in the subject facultative reinsurance certificate. The First Circuit Court of Appeals in this case was following a long-held principle that the terms of an insurance contract are to be understood according to the ordinary sense and usage of those terms, unless the underwriter knows that a different sense and usage should prevail or that the insured uses the words in a different sense or usage. The First Circuit affirmed the
The district court’s choice of what one plausible explanation of that ambiguous language meant over another plausible explanation. The circuit court found that the district court properly considered extrinsic evidence to determine what the parties meant by the ambiguous contract term—in this case, expert testimony—and was justified in choosing the explanation of one expert over another based on credibility.

In *Continental Cas. Co. v. Northwestern Nat’l Ins. Co.*, 427 F.3d 1038 (7th Cir. 2005), the court had to construe the meaning of a contract reference in a reinsurance commutation agreement. The district court considered a variety of extrinsic evidence to ascertain the meaning of the ambiguous term. Ultimately, the district court reached a conclusion as to the only reasonable interpretation and the Seventh Circuit Court of Appeals affirmed.

But extrinsic evidence of trade usage is not always appropriate or necessary. In *British Int’l Ins. Co. v. Seguros La Republica, S.A.*, 342 F.3d 78 (2d Cir. 2003), the issue was whether the reinsurer was required to pay declaratory judgment expenses under facultative certificates of reinsurance that were silent on the issue. The reinsurer argued that the word “risk” was ambiguous and that trade usage evidence was necessary to determine the meaning of risk. Expert evidence was received, but the district court rejected the evidence because the cedent failed to show that the reinsurer was aware of an alleged industry custom. In affirming, the Second Circuit Court of Appeals rejected the reinsurer’s claim that the language was so broad as to be impossible to interpret without resort to industry custom. The court acknowledged all the canons of construction under New York law (applicable here) concerning ambiguous contracts, but ultimately concluded that the reinsurer failed to articulate any ambiguity in the terms of the facultative certificates.

Reinsurance contracts are typically negotiated at arm’s length by sophisticated parties. Because of this, the canons of contract construction that protect individual purchasers of insurance policies do not apply to reinsurance. In *Unigard Sec. Ins. Co. v. North River Ins. Co.*, 4 F.3d 1049 (2d Cir. 1993), the Second Circuit Court of Appeals addressed a late notice case after having sent the case to the New York Court of Appeals on a certified question concerning whether a reinsurer must prove prejudice to successfully invoke the defense of late notice. As part of its decision, the Second Circuit essentially overrode dicta contained in its decision in *Christiania Gen. Ins. Corp. v. Great Am. Ins. Co.*, 979 F.2d at 268, and specifically recognized that reinsurance contracts are generally not construed against the drafter. It then went on to examine the notice clause in the reinsurance contract under a principle of neutral interpretation.
Over the years, commentators and courts have described the reinsurance relationship in various ways. Among the attributes that stand out when describing the reinsurance relationship is the duty of utmost good faith or *uberrimae fidei*. At its core, the duty requires the ceding insurer to disclose to the reinsurer all material facts about the risk being reinsured. See *General Reins. Corp. v. Southern Sur. Co.*. It is said that the duty of utmost good faith is implicit in every reinsurance contract and that it supplements all other express and implied contractual obligations. This means that the duty of utmost good faith goes beyond the traditional duty of good faith and fair dealing implicit in every contract.

While some courts have questioned whether the utmost good faith doctrine accurately describes the modern relationship between sophisticated insurers bargaining at arm’s length (see *Unigard v. North River*), courts recognize that there continues to be some elevated duty between the parties in some areas of the reinsurance relationship. Without disclosure of the necessary information about the underlying risk, for example, reinsurers would have to duplicate the actuarial and claims practices of ceding insurers, and reinsurance likely would become unavailable. In *North River*, the Second Circuit Court of Appeals recognized that, because information about the risks lies with the cedent, the reinsurance market depends on a high level of good faith to ensure prompt and full disclosure. Accordingly, the court ruled that “[c]ourts should thus adopt information-forcing default rules based on the good faith the reinsurance market demands.”
Some commentators and courts have extended this duty beyond the disclosures at the inception of the reinsurance relationship. The duty of utmost good faith has been applied to the parties’ conduct during the life of the reinsurance contract, the underwriting and administration of ongoing business, the obligation to give notice of a claim, and to the duty of the reinsurer to pay under the reinsurance contract. The duty also has been said to be reciprocal. In other words, the duty runs to both the cedent and the reinsurer. This formulation of the duty of utmost good faith goes to the nature of the reinsurance relationship after the contract has been executed. It is more closely aligned with the notion that the reinsurance relationship is a partnership, where each party to the contract shares in the risk underwritten and reinsured.

Many of the court cases that address the duty of utmost good faith involve claims of rescission for misrepresentation or concealment of material information in the negotiation of the reinsurance contract. For example, in Compagnie De Reassurance D’Ile De Fr. v. New Eng. Reins. Corp., 57 F.3d 56 (1st Cir. 1995), the court found that a retrocedent violated the duty of utmost good faith where the retrocedent had knowledge that the retrocessionaire understood a key term of the reinsurance contract one way, and the retrocedent secretly used the term another way without ever disclosing such special meaning to the retrocessionaire. The basic rule remains the same—the cedent must disclose all material facts concerning the original risk, and the failure to do so renders the reinsurance contract voidable.

Many courts have stated that the cedent’s duty is an affirmative one and that the reinsurer has no duty of inquiry. The burden is on the cedent to disclose all facts that materially affect the risk. Some courts continue to hold the reinsurance contract subject to avoidance even if the cedent innocently failed to disclose a material fact. Other courts, however, have held that, under state law, a claim of fraud may not be founded on innocent misrepresentation and concealment in the non-marine context.

The critical question in determining whether there has been a violation of the duty of utmost good faith and whether the reinsurance contract should be rescinded is whether the undisclosed information was material. Some courts have stated that a fact is material if it would have prevented the reinsurer from entering into the reinsurance contract or would have prompted the reinsurer to change the terms of the contract before execution.
One fact that is treated as material is insolvency. For example, in *Michigan Nat’l Bank-Oakland v. American Centennial Ins. Co.*, 89 N.Y.2d 94, 674 N.E.2d 313, 651 N.Y.S.2d 383 (1996), the court held that a reinsurer was entitled to rescission of a reinsurance contract after finding that the ceding company committed fraud in the inducement by not disclosing its insolvency. The test used by some courts to determine whether something is a material fact is whether a reasonable cedent would have believed the fact to be material to the reinsurer at the time of contracting. This is important because, under this formulation, whether the reinsurer claims the fact was material is irrelevant. It is only what a reasonable cedent believed the reinsurer would consider material that counts.

Although the duty of utmost good faith originally concerned the information available about the risk at the time of contract formation, see *Sun Mut. Ins. Co. v. Ocean Ins. Co.*, 107 U.S. 485 (1883), the duty has been applied to the entirety of the relationship between the cedent and the reinsurer.

Because the cedent remains closest to the risks reinsured as the underlying business is written, and is most familiar with the underlying claims as they are adjusted, many commentators and courts have stated that the cedent must continue to exercise utmost good faith in its dealings with the reinsurer even after formation of the reinsurance contract.

Thus, claims of breach of the duty of utmost good faith have been made concerning a cedent’s handling of underlying losses, its attempts to settle those losses through industry mechanisms, and the timing of notice of these efforts to its reinsurers.
One of the bedrock doctrines in reinsurance is the follow-the-fortunes concept. This doctrine exemplifies the unique business partnership that exists between the cedent and the reinsurer. A related doctrine is the follow-the-settlements concept. Courts in the United States and many practitioners use the terms “follow-the-fortunes” and “follow-the-settlements” interchangeably. The follow-the-fortunes doctrine requires the reinsurer to follow the underwriting fortunes of the ceding insurer while the follow-the-settlements doctrine requires the reinsurer to accept the good faith claims determinations made on losses coming within the underlying policy and the reinsurance contract.
These doctrines are based on the premise that the reinsurer should not be allowed to second-guess the ceding insurer’s good faith underwriting and claims decisions. This, it is said, is intended to prevent the entire system of insurance and reinsurance settlements from breaking down while underlying claim and coverage issues are relitigated at the reinsurance level.

The follow-the-fortunes doctrine provides, generally, that a reinsurer must follow the underwriting fortunes of its reinsured and, therefore, is bound by the claims-handling decisions of its cedent so long as there is no evidence of fraud, collusion with the insured, or bad faith. It is a burden-shifting doctrine that allows the cedent the freedom of making good-faith claims decisions without the fear of having to relitigate those decisions with its reinsurer. Traditionally, courts have interpreted this doctrine to apply to the cedent’s decisions regarding settlement of claims. The doctrine holds that a reinsurer is bound by the cedent’s decisions regarding payment of settled claims so long as the decision was made reasonably and in good faith. See, e.g., Peerless Ins. Co. v. Inland Mut. Ins. Co., 251 F.2d 696 (4th Cir. 1958).

This obligation not to relitigate a cedent’s good-faith claims decisions extends to the cedent’s good-faith decision to waive defenses to which it may have been entitled. Christiania Gen. Ins. Corp. v. Great Am. Ins. Co., 979 F.2d 268 (2d Cir. 1992). This standard is purposefully low in order to preclude a completely new review of the reinsured’s decision-making process.

Although a reinsurer is entitled to inquire into the dispositions of coverage disputes between the ceding insurer and its insured, a reinsurer may not conduct a de novo review of these dispositions. Thus, the follow-the-fortunes doctrine creates an exception to the general rule allowing de novo review of contract interpretation. By prohibiting a court or arbitration panel from conducting a de novo review of the cedent’s claims decisions, the follow-the-fortunes doctrine obligates a reinsurer to reimburse the cedent unless the reinsurer can demonstrate that the cedent did not act in good faith or failed to conduct a reasonable investigation. See North River Ins. Co. v. CIGNA Reins. Co., 52 F.3d 1194 (3d Cir. 1995).

Exceptions to the follow-the-fortunes doctrine exist where the reinsurer demonstrates that the cedent’s decision-making process was fraudulent, collusive, made in bad faith, or that the underlying claim was not arguably within the scope of the reinsurance coverage. See American Ins. Co. v. North Am. Co. for Prop. & Cas. Ins., 697 F.2d 79 (2d Cir. 1982) (holding follow-the-fortunes
clause did not obligate reinsurer to pay settlement where such award compensated insured for a punitive damage award that was excluded from the reinsurance policy). The standard for “bad faith” is usually a high one and generally requires some evidence of gross negligence or recklessness by the cedent, or evidence that the settlement is not within the scope of reinsurance coverage.

In some, but not all, reinsurance contracts, an express follow-the-fortunes or follow-the-settlements clause is part of the contract terms. Some courts have inferred the doctrine into reinsurance relationships that have no following clause in the written contract, but most courts require the contract to expressly contain a following clause to apply the doctrine.

A follow-the-fortunes or follow-the-settlements clause will not override the limits section of the reinsurance contract. Typically, court decisions construing this issue have addressed it in the context of facultative certificates rather than reinsurance treaties. For example, many of the cases involve attempts to charge the reinsurer for declaratory judgment expenses in addition to the reinsurance certificate limits. This argument has been met with stiff resistance in the courts. See, e.g., Bellefonte Reins. Co. v. Aetna Cas. & Sur. Co., 903 F.2d 910 (2d Cir. 1990) (holding that allowing the follow-the-fortunes clause to override the limitation on liability would “strip the limitation clause and other conditions of all meaning”). Courts generally find that the reinsurance terms in facultative certificates are unambiguous and will not allow evidence of custom and practice to override the clear terms of the certificates. See Unigard Sec. Inc. Co. v. North River Ins. Co., 4 F.3d 1049 (2d Cir. 1993); British Int’l Ins. Co. Ltd. v. Seguros La Republica, S.A., 342 F.3d 78 (2d Cir. 2003).

Courts have declined to interpret the follow-the-fortunes doctrine as expanding the reinsurance contract to allow annualization of claims and thereby circumvent the stated limits in the contract. See Travelers Cas. & Sur. Co. v. Certain Underwriters at Lloyd’s of London, 96 N.Y.2d 583, 760 N.E.2d 319, 734 N.Y.S.2d 531 (2001) (holding reinsurer was not bound by cedent’s allocation of environmental injury claims as a single occurrence where such an allocation would negate specific policy language). In Commercial Union Ins. Co. v. Swiss Reins. Am. Corp., 2003 U.S. Dist. LEXIS 4974 (D. Mass. Mar. 31, 2003), a Massachusetts federal court held that the reinsurer was only obligated to follow the fortunes of the cedent’s settlement of environmental claims up to the per-occurrence limit specified in the
facultative certificates. The court refused to allow the cedent’s annualization of the claims, which was not expressly authorized by the certificates, to expand the reinsurer’s liability. The court held that the certificates unambiguously identified all crucial terms and annualized limits should not be read into multiyear reinsurance policies without an express statement that the policy coverage was to be calculated on an annual basis.

A similar, and sometimes related issue, is the application of follow-the-fortunes or follow-the-settlements clauses to the cedent’s allocation of an underlying settlement to its reinsurers. Most courts have held that a reinsurer is bound by the cedent’s allocation methodology, stating that to distinguish between settlement and allocation would undermine the follow-the-fortunes doctrine. See Commercial Union Ins. Co. v. Seven Provinces Ins. Co., 9 F. Supp. 2d 49 (D. Mass. 1998), affirmed on other grounds, 217 F.3d 33 (1st Cir. 2000); see also North River Ins. Co. v. ACE Am. Reins. Co., 2002 U.S. Dist. LEXIS 5536 (S.D.N.Y. Mar. 29, 2002), affirmed on other grounds, 361 F.3d 134 (2d Cir. 2004).

In North River, for example, the cedent settled its asbestos exposure with its insured. The settlement reached only the second layer of its excess policies, and a reinsurer on the second layer objected to the allocation. In rejecting the reinsurer’s arguments, the court held that:


Because the allocation was within the definition of loss contemplated by the underlying insurance contracts, there was no breach of the reinsurance contract by allocating the settlement to the second excess layer of policies.

It is important to note, however, that reinsurers must only follow the allocation decisions of their cedents if those allocations are reasonable, in good faith, and fall within the applicable policies. The standard for reasonableness is “objective rea-
sonableness,” or, in other words, the cedent’s allocation decision “must be one that the parties to the settlement of the underlying insurance claims might reasonably have arrived at in arm’s length negotiations if the reinsurance did not exist.”


While the follow-the-fortunes clause does require a level of deference to a cedent’s allocation decision, these determinations are not immune from scrutiny, and courts do require that reinsurers act reasonably. For example, in Allstate Ins. Co. v. American Home Assur. Co., 43 A.D.3d 113, 837 N.Y.S.2d 138 (1st Dep’t 2007), leave to appeal denied, 10 N.Y.2d 711, 890 N.E.2d 246 (2008), the court found a settlement allocation to a reinsurer was unreasonable where the cedent allocated a multistate environmental settlement to its reinsurer using a one occurrence methodology when all parties in the underlying coverage action argued for the application of a multiple occurrence methodology. Additionally, a jury verdict on one of the sites resulted in a judgment based on multiple occurrences. The court found that this type of manipulation of the allocation process was unreasonable.

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A cedent is generally obligated to notify its reinsurer of potential claims. The failure of a cedent to provide prompt notice to its reinsurer of the filing of a claim, or of an occurrence that may result in the filing of a claim, may provide the reinsurer with a defense to indemnification under the reinsurance contract.

Not surprisingly, the law of late notice in the reinsurance context does not always mirror the late notice rules of direct insurance. In fact, it varies from state to state. Because of this inconsistency, it is important for ceding insurers to understand the rules regarding adequate notice to reinsurers in their particular jurisdiction to avoid the risk that reinsurers will be relieved of their obligations under the reinsurance contract.

Reinsurance contracts generally require that the ceding insurer provide prompt notice to the reinsurer of any claim in which there is a reasonable possibility that the reinsurance will be involved. The form and language of the clause differ from contract to contract. Some contracts require notice based on the size of the reserve set by the cedent as compared to the reinsurance limits. Other contracts require notice of any claim involving a catastrophic injury or death.

Because reinsurance agreements are considered contracts of indemnity, and there is no privity between the insured and the reinsurer, the insured’s notice to the ceding insurer of a claim against it is not notice to the reinsurer. The knowledge that the ceding insurer may have about a claim obtained from the insured will not be imputed to the reinsurer. The purpose of the notice clause in a reinsurance contract is to allow the reinsurer to: (1) reserve properly; (2) adjust premiums to reflect the loss, and (3) determine whether to exercise the option of becoming associated with the ceding insurer in the defense and control of the underlying claim. See, e.g., Keehn v. Excess Ins. Co.,
129 F.2d 503 (7th Cir. 1942) (holding that the reinsurer’s inability to participate in the defense of the underlying case constituted sufficient prejudice to prevent the ceding company from recovering under the reinsurance contract); *Fortress Re, Inc. v. Central Nat’l Ins. Co.*, 766 F.2d 163 (4th Cir. 1985) (holding that the reinsurer was prejudiced as a matter of law because the untimely notice by the cedent denied it the contractual right to participate in the defense and control of the claim for which it had bargained). The ceding insurer’s failure to provide prompt notice to the reinsurer may create a defense to indemnification under the reinsurance contract.

Courts are divided as to whether timely notice is a condition precedent to coverage under a reinsurance contract or whether some element of prejudice to the reinsurer must be shown for a successful late notice defense. *See, e.g., Christiania Gen. Ins. Corp. v. Great Am. Ins. Co.*, 979 F.2d 268 (2d Cir. 1992) (holding that, in the absence of an express provision in the contract making prompt notice a condition precedent, the reinsurer must show that prejudice resulted from the delay). While courts generally recognize the differences between direct insurance and reinsurance, they differ in their application of the law concerning late notice in the context of direct insurance to the reinsurance context. Depending on the prevailing law in the jurisdiction and whether the court applies the law concerning late notice in direct insurance, a reinsurer’s success in making a late notice defense may or may not require a showing of prejudice to the reinsurer.

In New York, for example, the New York Court of Appeals specifically held that a showing of prejudice was required in the reinsurance context in *Unigard Sec. Ins. Co. v. North River Ins. Co.*, 79 N.Y.2d 576, 594 N.E.2d 571, 584 N.Y.S.2d 290 (1992). And, to make it more confusing, the courts disagree as to the implications and effect of good faith by the ceding insurer on the late notice defense.

The duty of utmost good faith also plays a major role in many court decisions regarding late notice in reinsurance. Because information regarding the risk lies with the ceding insurer, the reinsurance market depends on a high level of good faith to ensure prompt and full disclosure. As such, a ceding insurer’s failure to provide prompt notice of a claim may relieve its reinsurer from indemnifying the ceding insurer without showing prejudice if the ceding insurer’s late notice was due to gross negligence or recklessness amounting to a breach of the duty of utmost good faith. Although the cases discussed above do not provide any definitive resolution to the division of courts in addressing the issues surrounding late notice provisions, each case has influenced the legal landscape of reinsurance as it relates to issue.
Reinsurance starts with a simple concept: a reinsurer gets a certain amount of premium from its cedent and shares in the cedent’s risk in an agreed upon proportion or on an agreed amount. For reinsurers, one way of controlling its exposure is to place a cap, or a limit of liability, on how much it is obligated to pay for a certain claim, or in the aggregate for a group of claims. And, while the phrase “limit of liability” would suggest that the number is in fact a hard cap on the reinsurer’s exposure, nothing is quite that simple in the world of reinsurance. Cedents and reinsurers have spent decades litigating the question of whether the limit of liability in a reinsurance contract is really a limit at all.

Few issues have roiled the industry as much as the question of declaratory judgment expenses. When mass tort litigation took off in the age of environmental and asbestos losses, and brought with it complex questions of coverage, insurers found themselves immersed in years and years of costly litigation against their insureds. In seeking declarations regarding their rights and obligations under insurance policies that were rarely drafted with these kinds of exposures in mind, insurers spent millions upon millions on litigation costs. Sometimes, these suits were successful in reducing or limiting indemnity payments. Other times, these costs were in addition to any indemnity payments the insurer ultimately paid out. Indeed, some of these declaratory judgment expenses could be so large as to surpass what the cedent and the reinsurer had agreed to as a limit of liability. Insurers and reinsurers were
faced with a critical question—were these expenses within the overall limit of liability in the reinsurance agreement, or were they payable in addition to limits?

The seminal decision in this area is *Bellefonte Reins. Co. v. Aetna Cas. & Sur. Co.*, 903 F.2d 910 (2d Cir. 1990). The cedent, a primary and excess insurer facing exposure under multiple products liability actions against its insured, engaged in a protracted coverage action. The dispute was eventually settled for an amount substantially in excess of the limit of liability stated in the policies. After signing the settlement agreement, the cedent turned to its facultative reinsurers for a portion of the settlement amount. In addition to billing each reinsurer for the full amount of the limits of liability in the facultative certificates, the cedent billed the reinsurers separately for declaratory judgment expenses incurred in litigating the coverage action, arguing that those expenses were payable by the reinsurers in addition to the reinsurance limits.

The cedent pointed to language in the certificates which stated that the reinsurer was bound by the cedent’s claims settlement and “in addition thereto” responsible for a proportionate share of expenses. The cedent claimed that the phrase “in addition thereto” signified that expenses were paid outside the limits. The reinsurers argued that the overall limit of liability applied to both declaratory judgment expenses and indemnity payments; in other words, the limit of liability was a hard cap on their exposure.

The *Bellefonte* decision came down in the reinsurers’ favor. The Second Circuit Court of Appeals rejected the cedent’s contention that the follow-the-fortunes principal obligated the reinsurer to indemnify the cedent even if payments of expenses and costs brought the total amount due to more than the limit of liability. The court found that the follow-the-fortunes clauses were not intended to override the limit of liability. It also rejected the cedent’s position that the “in addition thereto” language indicated that costs and expenses were in addition to limits. The court held that this language simply differentiated between the components of obligations—loss on one hand, expense on the other—but did not create a category of payable expenses that were carved out from the liability cap.

In the face of *Bellefonte*, cedents have tried to distinguish the language of the facultative certificates in *Bellefonte* from the facultative certificates at issue in other disputes. Those efforts have been largely unsuccessful in New York. In *Allendale Mut. Ins. Co. v. Excess Ins. Co.*, 992 F. Supp. 271
(S.D.N.Y. 1997), the court reaffirmed the Second Circuit’s holding in *Bellefonte*, rejecting the argument that follow-the-fortunes trumped contract language.

The *Bellefonte* decision, which applied New York law, was an accurate predictor of how New York’s state courts would come out on the issue. More than a decade after the decision, the New York Court of Appeals (the state’s highest court) issued its decision in *Excess Ins. Co. v. Factory Mut. Ins. Co.*, 3 N.Y.3d 577, 822 N.E.2d 768, 789 N.Y.S.2d 461 (2004). The court was called on to determine whether the stated limit of liability operated as a hard cap on the reinsurers’ liability, inclusive of expenses. The court concluded that it was indeed a cap and that the reinsurers could not be required to pay loss adjustment expenses in excess of the certificate’s stated limit. Any other holding, the court said, would expose the reinsurers to unlimited expense liability and would render meaningless the negotiated limit of liability.

The *Bellefonte* decision did little to quell the brewing dispute in the reinsurance industry. In that case, the reinsurer conceded that it was liable for declaratory judgment expenses under the terms of the facultative certificates. Other reinsurers have challenged that threshold question. The resolution of that question has turned on the specific language of the reinsurance agreements. In some cases, the language appeared clear to the courts.

For example, in *British Int’l Ins. Co. v. Seguros La Republica, S.A.*, 342 F.3d 78 (2d Cir. 2003), the court rejected an attempt by the cedent to shift declaratory judgment expenses to the reinsurers. The facultative certificates in this case stated that the reinsurer was exposed only to the “same risks” as the cedent on the underlying policies, and those policies did not include the cedent’s own declaratory judgment expenses.

Other courts were not as sure. In *Affiliated FM Ins. Co. v. Constitution Reins. Corp.*, 416 Mass. 839, 626 N.E.2d 878 (1994), the reinsurer also declined to pay declaratory judgment expenses, asserting that the litigation expenses were not risks covered under the facultative certificate. The Massachusetts Supreme Court reversed a lower court order finding that those expenses were not covered, holding that it was unclear whether the parties intended for the reinsurance to cover litigation expenses incurred in declaratory actions. “Expenses,” the court held, was a word with broad meaning that had no fixed definition. As such, evidence of custom and practice, and trade
usage, had to be examined before it could be determined whether the reinsurer was responsible for its share.

While custom and practice may be used to interpret an ambiguous term in a contract, it cannot be used to create an ambiguity where the terms of the contract are clear on its face. See *Allendale Mut. Ins. Co. v. Excess Ins. Co.*, 992 F. Supp. at 271. While some facultative certificates may use the term “expenses” without definition, thus requiring the use of extrinsic evidence, others provide internal definitions that resolve the interpretation of the terms without going beyond the four corners of the contract.

The key takeaway from these cases is this: the language of the reinsurance agreements matters, and neither the follow-the-fortunes doctrine nor custom and practice will override contract language governing the treatment of expenses. See *Unigard Sec. Ins. Co. v. North River Ins. Co.*, 4 F.3d 1049 (2d Cir. 1993).
When a reinsurer or cedent breaches the duty of utmost good faith, the reinsurer or cedent may be held liable for its bad faith. The tort of bad faith provides an extra-contractual remedy to the injured party to a reinsurance contract, as the awarded damages are generally not tied to policy limits, but are rather intended to restore the injured party to the place it was before its injury. Because bad faith tends to depend on the context, there is “no generally accepted correct definition.” Steven Plitt, *The Elastic Contours of Attorney-Client Privilege and Waiver in the Context of Insurance Company Bad Faith: There’s a Chill in the Air*, 34 Seton Hall L. Rev. 513, 524 (2004).

Nevertheless, courts agree that the “proper minimum standard for bad faith” is “gross negligence or recklessness,” but a showing of prejudicial effect on the injured party as a result of the bad faith breach is usually also required. 7–73 *New Appleman on Insurance Law Library Edition* § 73.03. Besides the more obvious examples of bad faith (e.g., outright deception), in the reinsurance context, a “cedent’s failure to implement basic procedures to enable fulfillment of its duties of prompt notice or cooperation,” for example, “may constitute the gross negligence sufficient to support a finding of bad faith.” Where, however, a cedent “has implemented routine practices and controls to ensure notification, but inadvertently fails to do so, the cedent has not acted in bad faith.”

This is because courts agree that the adoption of “a mere negligence standard to demonstrate bad faith would effectively negate the prejudice requirement, as a mere inadvertent disclosure could be held to constitute bad faith.” Although there is no uniform definition of bad faith, the following cases are the
leading examples of how courts have confronted this issue in the context of the reinsurance relationship.

In *Peerless Ins. Co. v. Inland Mut. Ins. Co.*, 251 F.2d 696 (4th Cir. 1958), Inland Mutual Insurance issued a policy to Iota H. Yeatts against liability for personal injuries arising out of the operation of insured vehicles up to $15,000 for injuries to any one person in any one accident. Inland retained $5,000 of this coverage and ceded the excess to Peerless. While the policy and reinsurance treaty were in effect, Yeatts, was sued by John J. Arms. During the litigation, an opportunity to settle the suit was missed. Instead, a verdict substantially in excess of the policy limits was obtained against Yeatts. As a result, Yeatts sued Inland for alleged negligence and bad faith in failing to settle the suit. Inland settled the suit with Yeatts, and brought suit against Peerless to recover two-thirds of the amount paid in the settlement and associated expenses and two-thirds of the expenses incident to the defense of the suit.

Even though the reinsurance contract did not expressly provide coverage for claims in excess of policy limits, the Fourth Circuit Court of Appeals required Peerless to share in the judgment against Inland. According to the court, several factors motivated its decision. First, Peerless knew as much about the underlying case as did Inland. Second, Peerless appreciated the risks involved and had a “sounder” perspective than Inland. Third, because Inland retained $5,000 of the risk, it stood to gain rather than lose by a settlement within the policy limits. Finally, Peerless was consulted by Inland regarding the underlying litigation and left the decision to settle exclusively in Inland’s hand.

In the court’s view, Peerless’s decision to leave the decision to settle exclusively in Inland’s hands made Inland’s resulting decision the joint decision between Peerless and Inland. The court concluded that Peerless was bound along with Inland by the decision in the underlying case, regardless of whether that decision was “sound or unsound, favorable or unfavorable” and that “the liability of Peerless ‘shall follow that of’ Inland.” Thus, Peerless was liable for its share of the extra-contractual damages incurred by Inland.

Whether punitive damages are covered under a reinsurance contract depends on the reinsurance contract’s coverage grants and the public policy of the state in which the coverage is sought. Many states do not allow insurance companies to pay the punitive damages awards obtained against their insureds. In those states, reinsurance reimbursements for punitive damages awards are also prohibited. Other states, however, allow the insurance and
reinsurance of punitive damage awards under limited circumstances or without restriction.

In *American Ins. Co. v. North Am. Co. for Prop. & Cas. Ins.*, 697 F.2d 79 (2d Cir. 1982), the Second Circuit Court of Appeals affirmed the district court’s order that North American Company for Property and Casualty Insurance (NACPAC) was not required under its reinsurance agreement with American Insurance Company (AIC) to reimburse AIC for any part of a punitive damages settlement AIC made with its insured, Dow Chemical Company. The Second Circuit concluded that the settlement between AIC and Dow was primarily designed to compensate Dow for a punitive damage award that was excluded from the reinsurance contract. Therefore, the Second Circuit affirmed the district court ruling that the settlement did not compensate Dow for insured risks in an amount greater than its policy provided and that it would be unfair to NACPAC to hold it liable for damages beyond the scope of its coverage.

In *Commercial Union Ins. Co. v. Seven Provinces Ins. Co.*, 217 F.3d 33 (1st Cir. 2000), the First Circuit Court of Appeals affirmed the district court’s findings in favor of Commercial Union on its claims that Seven Provinces breached a reinsurance contract that it had with Commercial Union’s predecessor in interest, Employers’ Surplus Lines Insurance Company (ESLIC), and committed an unfair trade practice in violation of Massachusetts General Laws Chapter 93A. The case began when ESLIC issued several insurance policies to Teledyne, Inc., a California manufacturing company. ESLIC covered a portion of the risk that it faced from one of those policies by purchasing a facultative reinsurance certificate from Seven Provinces. Under this facultative certificate, Seven Provinces would reimburse ESLIC for half of the covered amount, up to $225,000.

In 1982, Teledyne discovered environmental contamination at several of its plants and filed claims with its insurers to cover the resulting liability. In 1993, Commercial Union settled ESLIC’s share of those claims for $2.2 million. After concluding that $843,000 of the $2.2 million settlement pertained to environmental contamination at the site that was covered by the facultatively reinsured policy, Commercial Union billed Seven Provinces for $225,000 as its half of the first $450,000 of the loss in excess of $50,000.

Commercial Union filed suit against Seven Provinces in May 1995. It alleged that Seven Provinces was obligated to provide $225,000 in reinsurance coverage and that its overall pattern of conduct during the period from the submission of the $225,000 Teledyne reinsurance bill in August 1993 to the trial in January
1998 constituted a violation of Chapter 93A. Seven Provinces, in contrast, argued that its interpretation of the relevant provision of the facultative certificate was plausible, and that this plausible defense shielded it from 93A liability.

The district court ruled in Commercial Union’s favor, finding that (1) Seven Provinces should have provided coverage and (2) its bad-faith conduct in failing to do so violated Chapter 93A and warranted the imposition of double damages and attorney fees. With reference to the district court’s findings, the First Circuit concluded that Seven Provinces’ conduct was:

Unfair in nature—raising a series of constantly shifting defenses while never coming to a decision about coverage; in purpose—to force a settlement of Commercial Union’s claim regardless of its merits; and, in effect, causing, at great expense to Commercial Union, a delay of over 3 years from discovery of the facultative certificate to final judgment (and over 5 years from the initial billing).

In affirming the district court’s opinion, the First Circuit highlighted the exacting standard of *uberrimae fides* (the concept of “utmost good faith”) and found that Seven Provinces’ conduct was “wholly alien to the usual course of dealings between an insurer and a reinsurer.”
RIGHT OF OFFSET—SUMAN CHAKRABORTY

➤ *Employers Ins. of Wausau v. National Union Fire Ins. Co. of Pittsburgh*, 933 F.2d 1481 (9th Cir. 1991)


The reinsurance world can be a small one. Ceding companies and their reinsurers are often engaged in numerous simultaneous transactions, ceding and reinsuring different books of business across different lines of insurance. When a dispute arises under one agreement, its ramifications may affect others. The crux of these disputes invariably boils down to a simple question: Who owes how much to whom?

But even when the amounts are known, the timing of when payments must be made can be influenced by the knowledge that delayed payments can be subject to offset. For example, if a reinsurer does not pay the money owed to its cedent under Contract 1, the cedent may net the amount against sums due to the reinsurer under Contract 2. The greater the number of contractual relationships between the parties, the more elaborate—and contentious—the right of offset can be.

In many instances, the right of offset is contractual in nature. Reinsurance agreements frequently contain language that explicitly permit offset, stating for example, in *Employers Ins. of Wausau v. National Union Fire Ins. Co. of Pittsburgh*, 933 F.2d 1481, 1484 (9th Cir. 1991), that:

> THE REINSURER MAY OFFSET ANY BALANCES, WHETHER ON ACCOUNT OF PREMIUMS, COMMISSIONS, CLAIMS, LOSSES, ADJUSTMENT EXPENSE, SALVAGE, OR ANY OTHER AMOUNTS DUE FROM ONE PARTY TO THE OTHER UNDER THIS CERTIFICATE OF REINSURANCE OR UNDER ANY OTHER AGREEMENT HERETOFORE OR HEREAFTER ENTERED INTO BETWEEN THE COMPANY AND THE REINSURER, WHETHER ACTING AS ASSUMING REINSURER OR AS CEDING COMPANY.

These broad offset clauses allow sums owed under one contract to be netted against sums due under another. Even then, there can be disputes about

➤ Click the case name to go to the case summary.
whether an amount is in fact “due” under one agreement. That was the case in *Employers Ins.*, where the cedent claimed that a request for payment made a claim “due,” whereas the reinsurer argued that the claim was only “due” when litigation between the parties regarding the reinsurer’s obligation to pay the claim was concluded. In this case, the arbitration panel sided with the cedent.

The right of offset becomes critical when a ceding company becomes insolvent. State insurance insolvency statutes provide for a defined order of preference for claims, ensuring that whatever assets remain are distributed to classes of creditors based on that order. Reinsurers fall low on the list. Those same insolvency statutes, however, can provide for a statutory right of offset, allowing reinsurers to offset amounts owed to the insolvent cedent with amounts owed back to them. It is a valuable tool to ensure collection of amounts due, especially when a cedent’s diminished estate would otherwise result in little or no payment to reinsurers in the priority scheme.

Still, even statutory rights of offset are not without controversy. In the case of *In re Midland Ins. Co.*, 79 N.Y.2d 253, 590 N.E.2d 1186, 582 N.Y.S.2d 58 (1992), an action was instituted to determine whether, under New York’s insurance insolvency statute, a reinsurer could offset amounts it indisputably owed to an insolvent insurer against debts that the insolvent insurer owed under a separate and distinct contract. The dispute centered on the question of whether the debts were “mutual.”

The insolvent estate argued that “mutual debts” had to arise out of the same contractual transaction or else the reinsurer’s ability to offset would constitute an unlawful preference over policyholders. The New York Court of Appeals rejected this argument, noting that the statute did not explicitly require that the debts or credits arise under the same transaction.

The question of what constitutes a mutual debt permitting offset has spawned much litigation, including whether a debt is “mutual” if the debts and credits are owed to a party’s affiliate. In the end, whether the right is contractual or statutory, the right of offset is a complicated tool in a company’s arsenal. When facing an intransigent partner who is delaying payment, the ability to offset amounts owed under one contract against debts owed to the partner under a separate contract can be quite valuable. But a company who has a legitimate basis for disputing amounts owed may find itself with little ability (short of litigation) to prevent another company from ignoring that legitimate basis and using offset as a self-help mechanism.
Access to Records/Privilege/Discoverability of Documents—Eridania Perez


The “access to records” clause, also referred to generically as an “inspection” or “audit” clause, is one of the most significant contract rights that a reinsurer has under a reinsurance agreement. The purpose of an access to records clause is to grant the reinsurer the right to inspect the cedent’s books and records applicable to the reinsured business. This inspection is indeed one of the few methods reinsurers have to evaluate the business being ceded to them under their reinsurance agreement and to ascertain whether the cedent is following the terms and conditions of the agreement, in particular the accuracy of cessions and premium calculations.

A typical access to records clause provides as follows:

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THE REINSURER OR ITS DESIGNATED REPRESENTATIVES SHALL
HAVE FREE ACCESS TO THE BOOKS AND RECORDS OF THE COMPANY
ON MATTERS RELATING TO THIS REINSURANCE AT ALL
REASONABLE TIMES FOR THE PURPOSE OF OBTAINING
INFORMATION CONCERNING THIS CONTRACT OR THE SUBJECT
MATTER HEREOF.
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More recent access to records clauses are more limited and specific as to the scope, timing, and method of inspection afforded a reinsurer.

Access to records clause are found in most reinsurance agreements. The right of inspection is so ingrained in the reinsurance industry custom and practice that there is support for the proposition that the reinsurer has this right even in the absence of an express clause. In *Michigan Mut. Ins. Co. v. Unigard Sec. Ins. Co.*, 44 F.3d 826 (9th Cir. 1995), for instance, the Ninth Circuit Court of

➤ Click the case name to go to the case summary.
Appeals upheld an arbitration award that found, in the absence of an access to record clause, that the reinsurer’s failure to disclose information regarding the underlying claim requested by its retrocessionaires constituted a material breach of the reinsurance contract, relieving the retrocessionaires from payment of the claim. The *Michigan Mut.* decision in essence stands for the cedent’s obligation to disclose information that is necessary for the reinsurer’s evaluation and decision regarding the validity of a claim.

While the access to records clause provides a reinsurer broad access to the cedent’s records, it does not require the cedent to grant access to its communications with its attorneys or its attorney’s work product. Customarily, cedent’s provide their reinsurers unlimited access to its records, including privileged documents. But, that can have serious implications in a coverage dispute where a policyholder requests all communications the cedent has shared with its reinsurer regarding the underlying claim, including privilege documents, on the basis that the cedent’s provision of this information to its reinsurer waives any privilege.

For years, cedents have been able to protect privileged information shared with a reinsurer from disclosure to its policyholder in a coverage dispute on the basis of the common-interest doctrine. Generally, a party waives privilege if privileged information is disclosed to a third party. The common-interest doctrine is an exception to this general rule, permitting the sharing of privileged information with third parties who have a common legal interest in the outcome of a dispute. Recent caselaw suggests, however, that the common-interest doctrine does not provide a blanket protection of privileged information shared between the cedent and its reinsurer.

For instance, in *Fireman’s Fund Ins. Co. v. Great Am. Ins. Co. of N.Y.*, 284 F.R.D. 132 (S.D.N.Y. 2012), the court granted a policyholder’s motion to compel the cedent to produce the file of its reinsurer, as well as other communications or documents maintained on the reinsurance contracts. This insurance coverage case involved a dispute over the production of reinsurance documents arising out of the sinking and salvage of a dry dock. The policyholder sought communications related to the cedent’s procurement of, and claims made on, its reinsurance contract for the dry-dock loss. The policyholder initially subpoenaed the reinsurer directly, but, after the reinsurer objected on the ground that the information was protected by the common-interest doctrine, the reinsurer turned over the file to the cedent to handle the dispute. The cedent objected to the policyholder’s reinsurance information requests on the grounds of relevance and the common-interest doctrine.
As to relevancy, the court noted that Federal Rule of Civil Procedure 26(b)(1) provides that a party is entitled to discovery on “any non-privileged matter that is relevant to any party’s claim or defense.” In finding that the information was relevant, the court noted that, although “caselaw is sparse within the Second Circuit” concerning the discoverability of reinsurance information, “the few cases to consider the issue have determined that reinsurance information is indeed discoverable.” The court ruled in favor of disclosure on the basis of these cases, the broad scope of the federal discovery rules, and because of the cedent’s cross-claim asserting fraud, which put what the cedent told its reinsurer about the age and condition of the dry dock at issue. The court held that the cedent’s position that reinsurance documents are generally irrelevant was insufficient to withhold the documents, including information on loss reserves.

In addressing the common interest privilege, the court stated that the doctrine is an exception to the general rule that voluntary disclosure of confidential privileged material to a third-party waives any applicable privilege. Although the doctrine protects the free flow of information from client to attorney whenever multiple clients share a common interest about a legal matter, the court cautioned that the doctrine was not an independent source of privilege or confidentiality. Therefore, the court said, the doctrine will not apply if a communication is not protected by the attorney-client privilege or the attorney work-product doctrine.

The court emphasized that common interest requires a two-part showing. First, the parties must establish a “common legal, rather than commercial interest,” and it is key that the nature of the interest be identical, not similar. Second, the parties must establish that any exchange of privileged information was made in the course of formulating a common legal strategy and that the parties understood that the communication was being shared to further the shared legal interest.

As to the first element, the court noted that the evidence showed that the cedent and its reinsurer did not share an identical legal interest that would entitle the cedent to withhold from the policyholder the documents it produced to its reinsurer. Moreover, the court found that the cedent had not proved or even argued that it disclosed otherwise privileged materials to its
reinsurer in the course of formulating a common legal strategy or for the purpose of obtaining legal advice from the reinsurer. Nor had it presented evidence about the legal necessity of exchanging otherwise protected information. Therefore, to the extent that the cedent shared otherwise privileged information with its reinsurer, the court ruled that any privilege which applied to the documents had been waived.

Whether disclosure of privileged communications to a reinsurer would constitute a waiver of privilege depends wholly on the facts of the disclosure. Recent caselaw, however, raises concern about the free flow of information between cedents and reinsurers, who need to be aware of the possibility that their communications could be discovered if they do not take appropriate measures to ensure that the common-interest elements are satisfied.

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The access to records clause and claims cooperation clause are similar in nature. Like the access to records clause, the claims cooperation clause requires the sharing of information between the reinsured and reinsurer. In essence, it requires the reinsured to cooperate with its reinsurer in the handling of claims and grants the reinsurer a “right to associate” in the defense of any claim, suit, or proceeding that may involve the reinsurance. Where a loss is untimely reported to a reinsurer, a reinsurer may lose its opportunity to associate. As a result, the legal consequences of a breach of a claims cooperation clause or loss of the right to associate clause are similar to the legal consequences of late notice.

In Jefferson Ins. Co. v. Fortress Re, Inc., 616 F. Supp. 874 (S.D.N.Y. 1984), the court decided that, under North Carolina law, the notice clause gave the reinsurer the right to associate with the reinsured in the defense and control of a claims or suit. The court upheld the reinsurer’s defense to coverage because 12 months had passed before the reinsured gave notice of loss and thereby deprived the reinsurer of its right to associate.

A reinsurer generally must show more than the loss of a contractual right to rescind a reinsurance agreement or deny a particular claim because of a breach of the claims cooperation clause. A reinsurer must demonstrate prejudice—that it suffered “tangible economic injury” due to a breach of the claims cooperation clause. See, e.g., Unigard Sec. Ins. Co. v. North River Ins. Co., 4 F.3d 1049 (2d Cir. 1993) (dismissing reinsurer’s coverage defense because the reinsurer failed to prove that the reinsured acted in bad faith and failed to demonstrate prejudice).

A reinsured’s breach of the cooperation clause may also relieve a reinsurer from liability if it can show that the cedent acted in bad faith. Courts have
defined bad faith in this context as “gross negligence or reckless disregard of the reinsurer’s interests.” See North River Ins. Co. v. CIGNA Reins. Co., 52 F.3d 1194 (3d Cir. 1995) (rejecting reinsurer’s coverage defense based on the argument that the reinsured kept it in the “in the dark” regarding key elements of the underlying coverage dispute, and it rejected a settlement without first consulting with the reinsurer); Unigard Sec. Inc. Co. v. North River Ins. Co., 4 F.3d 1049 (2d Cir. 1993) (above).

Although the cooperation clauses is included in many reinsurance agreements, reinsurers rarely exercise their right to associate for fear of exposing themselves to liability in excess of reinsured limits. In Peerless Ins. Co. v. Inland Mut. Ins. Co., 251 F.2d 696 (4th Cir. 1958), the court held that the reinsurer who was involved in the underlying litigation and decisions about settlement, which resulted in a bad faith claim and judgment against the reinsured, was responsible for losses in excess of policy limits even in the absence of a “loss in excess of policy limits” provision in the reinsurance contract.
CUT-THROUGH/DIRECT RIGHT OF ACTION
—CAROLINE BILLET & LARRY P. SCHIFFER

Asociación de Garantía v. Commonwealth Ins. Co., 114 D.P.R. 166 (P.R. 1983)


Generally, a reinsurance contract creates privity exclusively between the insurer and the reinsurer. Unless otherwise expressly stated within the reinsurance contract (or by statute), no third-party rights exist. However, the underlying policyholders of the insurer, the original insureds, may obtain direct rights of action against the reinsurer by operation of a contractual provision in the reinsurance contract called a cut-through clause. A cut-through clause allows the original insured to proceed directly against the reinsurer for losses under certain specified circumstances.

The underlying policyholder may also obtain a direct right of action to proceed against the reinsurer by operation of a cut-through endorsement executed between the underlying policyholders and the reinsurer. See Insurance Code of Puerto Rico, Article 4.130 (providing that “the original insured or policyholder ... shall not have any direct right of action against the reinsurer which is not specifically set forth in the reinsurance contract, or in a specific agreement between the reinsurer and such original insured or policyholder.”).

A cut-through clause in a reinsurance contract provides the original insured with a direct right of action against the reinsurer for losses covered by the underlying insurance policy.

In the absence of a cut-through provision or endorsement, however, the underlying policyholders generally cannot proceed directly against a reinsurer to recover losses covered by the underlying insurance policy. In Jurupa Valley Spectrum LLC v. National Indem. Co., 555 F.3d 87 (2d Cir. 2009), Jurupa Valley

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Spectrum LLC, the holder of an insurance policy issued by Frontier Insurance Company, sought to proceed directly against Frontier’s reinsurer, National Indemnity Company (“NICO”). The U.S. District Court for the Southern District of New York, however, found no cut-through provision within the reinsurance agreement between Frontier and NICO. Accordingly, the court granted NICO’s motion to dismiss for failure to state a claim. The Second Circuit Court of Appeals affirmed.

Even if the reinsurance agreement contains a cut-through clause or the underlying policyholder and the reinsurer execute a cut-through endorsement, the original insured is not always permitted to exercise a direct right of action against the reinsurer. In *Asociación de Garantía v. Commonwealth Ins. Co.*, 114 D.P.R. 166 (P.R. 1983), the Supreme Court of Puerto Rico held that certain underlying policyholders could not exercise a direct right of action against the reinsurers with which they had executed cut-through endorsements. In this case, the underlying policyholders sought to recover losses from the reinsurers for claims under policies issued by an insolvent insurer. Because the insolvent insurer was then in liquidation, the court held that the original insureds could not pursue a direct right of action against the reinsurers pursuant to their cut-through endorsements as the reinsurance amounts due were part of the insolvent’s estate. Permitting the original insureds to recover under the terms of the cut-through endorsements would circumvent the statutory liquidation process and create a priority over other creditors. Accordingly, the court directed the original insureds to pursue their claims pursuant to the statutory liquidation process.
Many jurisdictions within the United States require unlicensed insurers and reinsurers to post security prior to filing an answer in a lawsuit brought against them. These pre-answer security statutes were enacted to ensure that unlicensed insurers and reinsurers maintain sufficient funds within the states in which they operate to satisfy the claims against them. Additionally, these statutes prevent plaintiffs from having to enforce judgments against foreign insurers and reinsurers in distant jurisdictions.

In New York State, for example, New York Insurance Law § 1213(c)(1)(A) requires that all unlicensed foreign insurers and reinsurers post a bond or security prior to filing an answer. Alternatively, the insurers and reinsurers may obtain a license to conduct business within New York. If the insurer or reinsurer neither posts security nor obtains a license to conduct business in New York, the plaintiff may seek a default judgment against the insurer or reinsurer.

Although pre-answer security amounts to a prejudgment attachment, New York courts have held the pre-answer security statute constitutional. Because the insurer or reinsurer can avoid the attachment of its assets by obtaining a license to conduct business in New York, the insurer or reinsurer has no significant constitutional interest at stake. Accordingly, no constitutional violation exists. Additionally, the insurer or reinsurer is given notice and an opportunity to be heard before pre-answer security is imposed and the state and party seeking to impose pre-answer security have a significant interest in applying this remedy. *British Int’l Ins. Co. Ltd. v. Seguros La Republica, S.A.*, 212 F.3d 138 (2d Cir. 2000).
Reinsurance contracts commonly contain arbitration clauses requiring all disputes to be resolved through arbitration rather than litigation in state or federal courts. Courts enforce reinsurance arbitration clauses just as they enforce arbitration clauses in other types of contracts. The Federal Arbitration Act (FAA) applies to arbitrations involving interstate commerce or maritime transaction disputes, which include most reinsurance arbitrations, and establishes a federal policy in favor of arbitration. Most states have enacted similar laws favoring the enforcement of arbitration clauses.

There are many differences between arbitrating and litigating reinsurance disputes. First, reinsurance arbitrations will frequently have a panel of three arbitrators who are considered “experts” in the insurance or reinsurance industry and who will decide the dispute. Second, while litigation is governed by either state or federal procedural rules, there may or may not be procedural rules in arbitration. Parties may choose to adopt rules such as the ARIAS-U.S. Rules for the Resolution of U.S. Insurance and Reinsurance Disputes or may agree to their own procedures with the arbitration panel. This flexibility is a hallmark of arbitration and can extend to all aspects of the process such as where the arbitration is heard or even whether the case can be conducted without a hearing after briefs and oral argument. Third, arbitration is a private, confidential process. Finally, arbitration results in a final

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determination, unlike litigation, which provides for a procedure for potentially multiple levels of appellate review. Parties to reinsurance contracts containing arbitration clauses can nevertheless find themselves in court litigating various issues related to the arbitration of their dispute. Frequent sources of litigation include whether particular claims are subject to arbitration and whether an arbitration award can be upheld. Each one will be explored in more detail below.

The availability of arbitration depends on the parties’ agreement to arbitrate their dispute. In determining whether a claim is subject to arbitration, a court must first determine (1) that there is an agreement to arbitrate and (2) the dispute at issue falls within the scope of that agreement. *Century Indem. Co. v. Certain Underwriters at Lloyd’s of London*, 584 F.3d 513 (3d Cir. 2009). Federal law requires that arbitration contracts be treated as all other contracts, and courts cannot impose higher requirements on agreements to arbitrate than other types of contracts. *Id.* 531–32 (holding a requirement that an agreement to arbitrate be “express” or “unequivocal” would run afoul of federal law). While there is a strong presumption under the FAA in favor of arbitration, this presumption does not apply to the question of whether there is an agreement to arbitrate.

Once a court determines that the parties have agreed to arbitrate, it must next determine whether the dispute falls within the scope of the agreement.

Agreements to arbitrate can be broad or more limited to certain disputes regarding the “interpretation” or “performance” of an agreement. Where the parties have agreed to a broad arbitration clause, the court will require all disputes between the parties to be arbitrated and will resolve all doubts regarding the arbitrability of a particular claim in favor of arbitration.

For example, in *Century Indem. Co.*, the Third Circuit Court of Appeals upheld a district court’s grant of a motion to compel arbitration, finding that the parties agreed to arbitrate even though the retrocessional agreements did not contain arbitration clauses. The Third Circuit’s reasoning rested on its determination that the parties had incorporated the arbitration agreements found in the underlying reinsurance treaties into their retrocessional agreements. The court went on to find that the dispute fell within the purview of the arbitration agreement because the agreement was broad in scope and therefore subject to the presumption of arbitrability.
In *Sphere Drake Ins. Ltd. v. Clarendon Nat’l Ins. Co.*, 263 F.3d 26 (2d Cir. 2001), the Second Circuit upheld, in part, a district court’s order compelling arbitration between parties where the reinsurer sought to have the reinsurance contracts declared void in a declaratory judgment action. The Second Circuit explained that, in analyzing whether to declare an arbitration clause void, there is an important distinction between contracts that are void and voidable contracts. Only where a party alleges that a contract is void can the arbitration clause also be found to be void. Where a party instead alleges that a contract is voidable, the arbitration clause will be valid unless the party specifically alleges that the arbitration clause itself is voidable. Because the reinsurer had only shown that one of the six contracts was void, the remaining five had to be arbitrated.

Once a court determines a particular dispute is arbitrable, the court may compel arbitration. The next flashpoint for litigation is usually after the panel issues an award. Courts have authority to confirm, modify, or vacate arbitration awards upon a party’s request. Awards may be confirmed and reduced to judgment so that they may be enforced through the appropriate statutory means for enforcement of judgments. See *Pacific Reins. Mgmt. Corp. v. Ohio Reins. Corp.*, 935 F.2d 1019 (9th Cir. 1991) (holding that courts can confirm and enforce even temporary equitable awards of arbitrators that grant interim relief). Under the FAA, an award must be confirmed within a year of its issuance.

The grounds for vacating or modifying an award are limited. Section 10 of the FAA provides the grounds upon which an arbitration award may be vacated. They are: (1) where the award was procured by corruption, fraud or undue means; (2) where there was evident partiality or corruption in the arbitrators; (3) where the arbitrators were guilty of misconduct in refusing to postpone the hearing, upon sufficient cause shown, or in refusing to hear evidence pertinent and material to the controversy; or of any other misbehavior by which the rights of any party have been prejudiced; or (4) where the arbitrators exceeded their power, or so imperfectly executed their power that a mutual, final, and definite award on the subject matter submitted was not made. These grounds are applied narrowly by the courts.

The Ninth Circuit Court of Appeals, in *Employers Ins. of Wausau v. National Union Fire Ins. Co. of Pittsburgh*, 933 F.2d 1481 (9th Cir. 1991), provided more detail regarding the limited nature of many of the grounds for vacating an arbitration award. The court first rejected a challenge regarding the arbitrator’s alleged error in interpreting a contract, explaining that its only task was to determine if the arbitrator’s interpretation of the contract was “plausible” and not to revisit the merits of the dispute. Second, the court held that the award should
not be vacated for ambiguity because minor ambiguities are insufficient to warrant vacating an arbitration award. Instead the ambiguity must be substantial and adversely affect a party’s ability to understand or comply with the award. Third, the court found that arbitrator bias was not a valid ground for vacating the award. While one of the party-appointed arbitrators had worked on a prior related matter, the arbitrator disclosed his prior work, had not formulated final opinions on the issues and did not possess an informational advantage. For these reasons, the court determined that disqualification was not required. Finally, the Ninth Circuit found the argument that the arbitration award should be vacated based on the panel’s evidentiary decisions was unavailing.

The court explained that the arbitrators could craft their own rules of procedure under the arbitration agreement and that both parties were subject to the same rules. See Century Indem. Co., 584 F.3d at 556–57 (holding that, because of the wide latitude given to arbitrators in making evidentiary determinations, and because the parties received a fair hearing, there was no statutory basis to vacate arbitration award).

In upholding a district court’s decision confirming an interim final arbitration order for equitable relief, the Ninth Circuit continued the trend of construing the grounds for vacating arbitration awards narrowly, in Pacific Reins. Mgmt. Corp. v. Ohio Reins. Corp., 935 F.2d 1019 (9th Cir. 1991). The Ninth Circuit held that the arbitration panel did not exceed its powers in considering claim payments owed to third parties that were not contemplated by the parties’ agreements. The court declined to engage in a de novo review of the agreements and cited the “wide latitude” the arbitration agreement gave to the arbitrators in resolving disputes.

The Ninth Circuit also dismissed claims of improper ex parte communications between panel members and one of the parties. The court noted that the information communicated ex parte was readily accessible to the other party’s arbitrator did not violate that party’s due process rights. Finally, the court rejected the contention that the arbitration panel’s interim order was in manifest disregard of the law and fact. The Ninth Circuit noted that it was the panel’s “job to choose who to believe” and that the order reflected that belief.

In Scandinavian Reins. Co. v. St. Paul Fire & Marine Ins. Co., 668 F.3d 60 (2d Cir. 2012), the Second Circuit Court of Appeals shed more light on the issue of arbitrator bias when the court reversed an order by the district court vacating an arbitration award under the evident impartiality standard of the FAA. The
district court held that the service by two arbitrators as panel members in a related arbitration was a material conflict of interest, and that the arbitrators’ failure to disclose this conflict required vacatur of the award.

In reversing, the Second Circuit explained that the “core” of the evident partiality standard is arbitrator bias. The Second Circuit noted that it found the following factors, as stated by the Fourth Circuit, helpful in analyzing evident partiality:

(1) THE EXTENT AND CHARACTER OF THE ARBITRATOR’S PERSONAL INTEREST;

(2) THE DIRECTNESS OF THE RELATIONSHIP BETWEEN THE ARBITRATOR AND THE PARTY HE IS ALLEGED TO FAVOR;

(3) THE CONNECTION OF THAT RELATIONSHIP TO THE ARBITRATOR; AND

(4) THE PROXIMITY IN TIME BETWEEN THE RELATIONSHIP AND THE ARBITRATION PROCEEDING.

The Second Circuit distinguished evidence of a potential conflict of interest from evidence of evident partiality and explained that the arbitrators’ involvement in a related case in and of itself did not indicate that they would be predisposed to favor one party over another or that they were predisposed to rule in a certain way. The Second Circuit went on to explain that the arbitrators’ failure to disclose their involvement in the related case was not grounds for vacatur because nondisclosure alone does not demonstrate evident impartiality. While disclosure would have been preferable, it was not required.

In a different procedural context, the Seventh Circuit Court of Appeals also provided additional guidance regarding arbitrator bias. In *Trustmark Ins. Co. v. John Hancock Life Ins. Co.*, 631 F.3d 869 (7th Cir. 2011), the parties conducted an initial arbitration that resulted in an award in favor of the cedent. The parties entered into a confidentiality agreement governing this initial arbitration. After the reinsurer failed to pay the initial award, the cedent initiated a second arbitration and appointed an arbitrator from the first arbitration panel. The reinsurer brought suit in court seeking to enjoin the arbitration because the cedent’s arbitrator was not “disinterested” as required by the parties’ agreement. The reinsurer also contended that, because the cedent’s arbitrator had confidential information, which he
shared with the other members of the arbitration panel, he had also violated the parties’ confidentiality agreement. The district court found that the cedent’s arbitrator violated the confidentiality agreement and that he was not “disinterested.”

The Seventh Circuit reversed and held that the reinsurer did not show the requisite irreparable injury required for the equitable relief of injunction. Notably, the Seventh Circuit went on to explain that it construed the term “disinterested” to mean “lacking a financial or other personal stake in the outcome.” The court explained that the cedent’s arbitrator did not have a “personal stake” in the outcome of the arbitration and that his knowledge of the dispute did not constitute a prohibited “interest” in the suit. Finally, the Seventh Circuit explained that the interpretation of the confidentiality agreement was an issue for the arbitrators to decide because arbitrators are empowered to “resolve ancillary questions that affect their task.” This decision is in line with the larger judicial trend of favoring arbitration and carefully considering arbitrator bias in terms of personal interest and impartiality instead of mere knowledge of a related case.
An “honorable-engagement clause” is often incorporated into the arbitration provision of a reinsurance contract and generally provides that the arbitrators shall interpret the reinsurance contract as an “honorable engagement” rather than as a strict legal obligation. This affords arbitrators more flexibility in resolving a dispute and allows them to consider principles of good faith, equity, and the custom and practice in the reinsurance industry. Arbitrators may decline to apply “strict rules of law” such as those governing the admission of evidence, particular states’ laws, and even a strict construction of the agreement’s text.

Honorable-engagement clauses have traditionally been viewed as embodying the mutual duty of utmost good faith. For example, the New York Court of Appeals, in *Pink v. American Sur. Co.*, 283 N.Y. 290, 28 N.E.2d 842 (1940), explained that the “defendant was bound to act in good faith” due to the inclusion of an honorable-engagement clause. The honorable-engagement clause harkens back to a time when reinsurance contracts were secured by a handshake. While those days are long over, parties continue to use honorable-engagement clauses because the nature of the reinsurance relationship is still considered to require a high degree of trust and confidence between the reinsured and the reinsurer. The honorable engagement is simply the reinsurance contract itself that the parties have entered into with the highest integrity and in utmost good faith.

Because of the good-faith relationship between reinsured and reinsurer, parties expect to resolve their disputes in a businesslike manner consistent with the custom and practice of the reinsurance industry. The honorable-engagement clause embodies this expectation and allows arbitrators to resolve
disputes in a pragmatic and commercially reasonable manner without being bound to follow strict rules of law and contract interpretation. Parties have traditionally believed that allowing arbitrators this latitude would result in decisions that best reflect the purpose and intent behind the transaction at issue.

Courts have read honorable-engagement clauses “generously, consistently finding that arbitrators have wide discretion to order remedies they deem appropriate.” Banco de Seguros del Estado v. Mutual Marine Office Inc., 344 F.3d 255 (2d Cir. 2003). This flexibility and broad discretion may manifest itself in many ways. For example, courts have upheld arbitration panels ordering prehearing security, citing Pacific Reins. Mgmt. Corp. v. Ohio Reins. Corp., 935 F.2d 1019 (9th Cir. 1991) (holding an arbitration panel may order prehearing security where the arbitration agreement contains an honorable-engagement clause).

Strict rules of evidence and procedure need not be followed, and arbitrators have traditionally exercised wide discretion in allowing parties to present evidence and arguments that might not have seen the light of day in a courtroom. While this level of flexibility sometimes avoids the difficulties of the technical admission of evidence, it often widens the scope of what is allowed. Arbitrators will often admit such evidence “for what it is worth.” With high quality, experienced reinsurance arbitrators, that often means that such evidence will carry little weight in the panel’s deliberations.

Substantive caselaw affecting reinsurance issues may also get little attention in the face of an honorable-engagement clause. Because the clause relieves the arbitrators from interpreting the reinsurance contract solely as a legal obligation, arbitrators may be persuaded by caselaw, but are not required to resolve matters based on how they believe a court would decide the issue. While legal precedent is regularly cited in briefs to arbitration panels, it may be given very little weight in resolving disputes about contract interpretation.

While many existing and certainly older reinsurance contracts continue the tradition of the honorable-engagement clause, more recently, reinsureds and reinsurers have been moving away from incorporating honorable-engagement language in their reinsurance contracts.

Although freed from following strict rules of law and contract interpretation, reinsurance arbitrators are still bound to resolve the dispute based on the reinsurance contract before them. The honorable-engagement clause is not an invitation
to the arbitrators to ignore express provisions of the parties’ contract. It is well settled in the courts that the clear provisions of the contract may not be ignored or altered by an arbitrator. Arbitrators may not ignore contract provisions or base their decisions on thoughts, feelings, policy, or law that come from outside of the contract unless the arbitration agreement allows the arbitrators to do so.

If the parties would prefer a business-like resolution to a reinsurance dispute, then giving the arbitrators the flexibility to resolve the matter without construing the reinsurance agreement strictly as a legal obligation may make sense. If, however, the parties wish to have the reinsurance agreement interpreted purely as a legal document, they may decide to forego the honorable-engagement clause.
An insurer’s insolvency often implicates the reinsurance agreements to which it is a party. Courts must interpret whether the reinsurance proceeds under those agreements form a part of the insurer’s liquidation assets and whether any third party has a right to those proceeds. Additionally, the enforceability of arbitration clauses within reinsurance agreements against an insolvent insurer is frequently at issue under the McCarran-Ferguson Act, 15 U.S.C. § 1011, et seq. (the “McCarran-Ferguson Act”). The McCarran-Ferguson Act precludes preemption of state insurance regulation by conflicting federal law, including the Federal Arbitration Act (FAA).

 Courts apply the basic concepts of contract interpretation to determine the rights of insolvent insurers and third parties to the reinsurance proceeds provided under relevant reinsurance agreements. Where the reinsurance contract is unambiguous, the court will interpret its provisions in light of the circumstance to which they apply. In Fidelity & Deposit Co. v. Pink, 302 U.S. 224 (1937), a cedent and a reinsurer executed a reinsurance agreement providing that the cedent would receive its reinsurance proceeds for covered losses only upon the cedent’s delivery of proof of payment of the covered loss to the underlying policyholder. Using ordinary principles of contract interpretation, the U.S. Supreme Court held that the reinsurance contract created an unambiguous condition precedent that precluded the insolvent cedent from recovering the reinsurance proceeds
where it failed to provide the reinsurer with proof of payment of the underlying insurance claim.\textsuperscript{1}

Courts similarly apply the concepts of contract interpretation to determine whether a third party has a right to the reinsurance proceeds under a reinsurance contract upon the insurer’s insolvency. Generally, reinsurance contracts operate solely between the insurer and the reinsurer. Absent an express provision, no third-party rights exist under a reinsurance agreement.

In \textit{Ainsworth v. General Reins. Corp.}, 751 F.2d 962 (8th Cir. 1985), the court precluded a reinsurer from extinguishing its liability to the insolvent insurer by settling reinsurance claims directly with the underlying policyholders. Because the reinsurance contract created no direct right of action on behalf of the underlying insureds and expressly provided that all outstanding reinsurance obligations would be directly payable to the insurer’s receiver in the event of insolvency, the court held that the reinsurer could not settle directly with the underlying insureds. Accordingly, the court deemed the reinsurer liable to the receiver for the amount of the insurer’s liability for the underlying claims.

The court may also take the relationship of the parties into consideration to determine the rights of the parties in bankruptcy. See, \textit{In re Pritchard & Baird, Inc.}, 8 B.R. 265 (D.N.J. 1980), \textit{affirmed without opinion}, 673 F.2d 1299 (3d Cir. 1981). In this case, the court held that the cedent’s delegation of duties and authority to a reinsurance broker evidenced an agency relationship such that the cedent and not the reinsurer, which had no such relationship with the reinsurance broker, was the proper creditor of the reinsurance broker’s bankruptcy estate to recover wrongfully retained reinsurance premiums.

The enforceability of arbitration clauses in reinsurance agreements often arises upon an insurer’s insolvency. Insurance regulation is promulgated at the state level and in virtually every jurisdiction, state insurance law sets forth regulations governing the liquidation of an insolvent insurer. State insurance law often clashes with various federal laws, including the FAA, when rights under the FAA are invoked in the context of an insolvent insurer or reinsurer.

When federal antitrust laws were promulgated, the Congress sought to protect insurance companies that acted under authority of state-based insurance

\textsuperscript{1} \textit{Fidelity & Deposit Co. v. Pink} has been statutorily overturned in most jurisdictions on the reinsurer’s liability to an insolvent insurer. This case caused the creation of the insolvency clause required by statute in virtually all reinsurance contracts issued in the United States.

**No act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance..., unless such Act specifically relates to the business of insurance...”**

Accordingly, the McCarran-Ferguson Act precludes the preemption of state insurance law by conflicting federal law unrelated to the business of insurance.

In the context of reinsurance disputes, the McCarran-Ferguson Act is most commonly implicated when an insolvent insurer is party to a reinsurance agreement that contains an arbitration clause enforceable under the FAA or other applicable federal law. Congress enacted the FAA to enforce arbitration clauses entered into in conjunction with interstate or international commerce. If the enforcement of an arbitration clause under the FAA or other applicable federal law conflicts with state insurance law, the court must determine if the McCarran-Ferguson Act precludes preemption of the state insurance law.


Although New York Insurance Law expressly provides the New York Supreme Court with exclusive jurisdiction to adjudicate claims brought against insolvent insurers or their liquidators, no such express provision exists for claims brought by the liquidator on behalf of the insolvent insurer. Nevertheless, New York courts have held that the New York insurance law evidences a policy requiring the efficient management and supervision of the liquidation process by one court. Therefore, despite the legislature’s silence, New York courts have held that the New York Supreme Court also has exclusive jurisdiction over claims asserted by the liquidator on behalf of the insolvent insurance...
company. Accordingly, the McCarran-Ferguson Act precludes the enforcement of federal arbitration law against insolvent insurers in New York State.

Courts in other jurisdictions, however, have taken the opposite approach. California law, for example, has been interpreted to hold that the McCarran-Ferguson Act does not preclude preemption by the FAA where there is no directly applicable state insurance law that precludes arbitration. In *Quackenbush v. Allstate Ins. Co.*, 121 F.3d 1372 (9th Cir. 1997), the liquidator of an insolvent insurer initiated a claim against a reinsurer for amounts owed under a reinsurance agreement. The reinsurer sought to compel arbitration under the arbitration provision in the reinsurance agreement. The Ninth Circuit Court of Appeals granted the reinsurer’s motion to compel arbitration. Although the California Insurance Code provides the California Superior Court with exclusive jurisdiction over claims brought against insolvent insurers in liquidation, no such provision exists for claims brought by the liquidator on behalf of the insolvent insurer. Accordingly, the circuit court held that the McCarran-Ferguson Act did not preclude enforcement of the arbitration clause under the FAA where no state insurance law applied.
The cedent issued 3 consecutive 1-year excess liability policies to its insured and, for each policy year, facultatively reinsured the risk. The reinsurer in this dispute participated on those facultative certificates, agreeing to reinsure 15 percent of the underlying risk. The insured was the subject of a race and gender discrimination suit for which it sought a defense from the cedent. The cedent denied coverage and defended itself against a declaratory judgment action filed by the insured. The cedent ultimately prevailed, and no duty to defense was owed.

Following the court’s decision on the declaratory judgment action, the cedent billed the reinsurer for its share of the litigation expenses the cedent had incurred in defending the declaratory judgment action. The reinsurer declined to pay, asserting that the declaratory judgment litigation expenses were not risks covered under the facultative certificate. The cedent filed suit seeking reimbursement of litigation expense.

The question before the court was whether the phrase “expenses ... incurred by the Company in the investigation and settlement of claims or suits” included legal expenses incurred in defending a declaratory judgment filed by the insured. While the trial court had ruled that litigation expenses were unambiguously not covered under the facultative certificate, the Massachusetts Supreme Court reversed. The court found that it was unclear whether the parties intended for the reinsurance to cover litigation expenses incurred in declaratory actions. “Expenses,” it held, was a word with broad meaning that had no fixed definition.

Where the contract language is ambiguous as to what the parties intended, evidence of trade usage is admissible to determine the meaning of the agreement. Because the existence and scope of a usage of trade was an issue of fact, the case was remanded to the trial court to allow the parties to submit this evidence.

Read the implications.
In 1971, the reinsurer entered into a reinsurance agreement with the cedent. The cedent subsequently became insolvent, and a receiver was appointed by the Circuit Court of Jackson County, Missouri. The reinsurance agreement provided that, in the event of the cedent’s insolvency, any outstanding liability of the reinsurer under the reinsurance agreement would be paid directly to the receiver and become an asset of the insolvent’s estate.

At the time of the cedent’s insolvency, two claims arising from the underlying insurance policies issued by the cedent remained unpaid. These claims were deemed loss occurrences covered under the reinsurance agreement. The reinsurer settled these claims directly with both claimants without the receiver’s participation.

The receiver subsequently commenced an action against the reinsurer in federal court in Missouri seeking recovery of the reinsurance proceeds. The district court held that the underlying insurance claims provided the cedent with a right to reinsurance proceeds under the reinsurance agreement, which vested in the receiver upon the cedent’s insolvency. Under Missouri law, reinsurance contracts operate solely between the insurer and the reinsurer. Absent an express provision within the reinsurance contract, no privity exists between the underlying insured and the reinsurer. Accordingly, the underlying insured may not proceed directly against the reinsurer absent an express provision within the reinsurance contract providing the underlying insured with a direct right of action against the reinsurer. Because no such provision existed in the reinsurance agreement, and it expressly provided that outstanding reinsurance obligations would be directly payable to the receiver in the event of the cedent’s insolvency, the court held that the reinsurer had no authority to negotiate these settlements.

The court stated that the reinsurer could not extinguish its liability through direct settlement of the underlying claims without the receiver’s participation where its liability was solely to the cedent or, in this case, to the cedent’s receiver. Accordingly, the court found the reinsurer liable to the receiver for the reinsured amount of the cedent’s liability for those two claims. The Eighth Circuit Court of Appeals affirmed.

Read the implications.

This case addressed whether the follow-the-settlements clause in a reinsurance agreement obligated a reinsurer to pay loss adjustment expenses in addition to the reinsurance agreement’s stated limit of liability. The cedent sought $7 million in indemnity payments, $5 million in loss adjustment expenses and interest, and additional amounts for legal fees incurred in the defense of a declaratory judgment action. Although the reinsurance agreement’s limit of liability was $7 million, the cedent argued that the reinsurer was obligated to follow the cedent’s settlement in all respects, and that the follow-the-settlements clause served to expand the reinsurer’s liability.

In a prior ruling, the court had denied the cedent’s claim for loss adjustment expenses on three grounds: (1) the follow-the-settlements clause had to be read in conjunction with the limit of liability clause, and could not render the limit of liability clause meaningless; (2) leading treatises had noted that the follow-the-settlement clause’s purpose was not to expand the reinsurer’s liability; and (3) two prior Second Circuit Court of Appeals’ decisions had already rejected the argument cedent had made.

The cedent moved for reconsideration, and the court issued an opinion clarifying two arguments not addressed in the original decision. First, the court rejected the cedents’ attempts to use extrinsic evidence to show the parties’ intention at the time of contracting. The court noted that extrinsic evidence could not be used to create a question of fact when a proper reading of the contract resulted in only one permissible interpretation.

The court then rejected the cedent’s argument that the prior Second Circuit decisions were distinguishable because those decisions addressed liability policies while the policy here was a property policy. Noting that the reinsurance agreement was entered into after those Second Circuit decisions, the court stated that the cedent could have bargained for different language if it wanted loss adjustment expenses to be outside of the policy limits. Conversely, the reinsurer was entitled to rely on the prior holdings when the parties signed the reinsurance agreement.

*Read the implications.*
The cedent issued a series of commercial property policies to its insured, which had self-insured retentions of $200,000 for any one occurrence. The cedent obtained facultative reinsurance for the policies. The insured sued the cedent over coverage obligations arising from pollution at various sites operated by the insured. During the underlying litigation in federal court, both the insured and the cedent consistently argued that there were multiple occurrences at each site. In addition, the federal court entered judgment on one of the sites based on seven occurrences, with the self-insured retention applying to each occurrence and for each policy period.

After the cedent and the insured settled their dispute over all sites, the cedent had counsel prepare an allocation analysis for reinsurance purposes that treated each site as one occurrence, used the federal court ruling on seven occurrences at one site in a highly selective manner to minimize its liability to the insured, and then ignored the ruling to increase its reinsurance recoverable under the facultative certificates. The reinsurer was billed on a one occurrence per site per year basis, which triggered the facultative certificates.

The reinsurer rejected the allocation analysis and commenced a declaratory judgment action. The parties cross-moved for summary judgment, and the motion court found for the cedent based on the Second Circuit Court of Appeals’ follow-the-fortunes precedent. In reversing the motion court, the appellate court rejected the motion court’s reasoning, which the court characterized as:


The appellate court soundly rejected the notion that the follow-the-fortunes doctrine mandates that courts must ignore obvious manipulation of the allocation process. It also found that the inconsistency between the cedent’s presettlement allocation and its postsettlement allocation was not consistent with good faith. The court was critical of the cedent’s inconsistent application of the underlying federal court occurrence determination, which it found neither reasonable nor based on good faith, and which did not require an intrusive factual inquiry or second-guessing to determine.

Read the implications.

CAPTIVE INSURANCE COMPANY REPORTS

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The Second Circuit Court of Appeals affirmed the district court’s order holding that the reinsurer was not required under its reinsurance agreement to reimburse the cedent for any part of a settlement the cedent made with its insured. The cedent settled a number of Styrofoam cases, including one case that had resulted in a jury verdict for compensatory damages and a much larger punitive damages award. Following the settlement, the cedent allocated $500,000 to the case in which the jury verdict was rendered and ceded $250,000 to the reinsurer. The reinsurer refused to pay.

The cedent argued that the district court wrongfully interpreted the underlying insurance policy when it concluded that, although the policy itself was ambiguous, evidence introduced as to the intent of the parties supported the reinsurer’s view that punitive damages awarded for corporate misconduct were not covered. The cedent claimed that the district court did not give enough weight to evidence suggesting that the insured may have thought the settlement agreement covered punitive damages. The cedent also argued that the follow-the-fortunes doctrine applied.

The Second Circuit concluded that the settlement agreement was primarily designed to compensate the insured for a punitive damage award that was excluded from the reinsurance contract. Therefore, the Second Circuit affirmed the district court’s ruling that the settlement did not compensate the insured for covered risks in an amount greater than its policy provided and that it would be unfair to the reinsurer to hold it liable for damages beyond the scope of its contract.

Read the implications.
The cedent entered into multiple reinsurance agreements with various reinsurers. Certain policyholders, the original insureds of the cedent, then entered into cut-through endorsements with certain of the cedent’s reinsurers, allowing the policyholders to recover claims directly from those reinsurers in the event that the cedent failed to timely satisfy claims. The cedent eventually became insolvent. Thereafter, the reinsurers subject to the cut-through endorsements sought a declaratory judgment precluding the underlying policyholders from satisfying their loss claims against the reinsurers in light of the cedent’s insolvency. The Superior Court of Puerto held that the cut-through endorsements executed between the original insureds and the reinsurers were enforceable by the original insureds under Article 4.130 of the Insurance Code of Puerto Rico: “the original insured or policyholder ... shall not have any direct right of action against the reinsurer which is not specifically set forth in the reinsurance contract, or in a specific agreement between the reinsurer and such original insured or policyholder.”

Because the reinsurers entered into cut-through endorsements with the original insureds, the court held that the original insureds retained a direct right of action against the reinsurers and excluded the reinsurance funds subject to these direct claims from the liquidation assets of the insolvent cedent.

The Insurance Commissioner of Puerto Rico and the affected reinsurers appealed. The appeals were consolidated and heard jointly by the Supreme Court of Puerto Rico. In reversing, the court held that the reinsurance funds subject to distribution under the cut-through endorsements could not be excluded from the liquidation assets. Cut-through endorsements do not alter the relationship between the insured, the insurer, and the reinsurer, nor do they create a priority for the original insured over other creditors of an insolvent insurer. Accordingly, the court determined that the beneficiaries of the cut-through endorsements could not claim losses directly against the reinsurers and should submit their claims though the ordinary liquidation process.

Read the implications.
A reinsurance company wholly owned by the government of Uruguay entered into two separate reinsurance contacts with insurance companies from the United States. Under the reinsurance contracts, the reinsurer agreed to indemnify the reinsureds for a percentage of their net liability on certain insurance policies.

Each of the reinsurance contracts contained an arbitration clause providing that “any dispute” must be referred to arbitration, and that “the arbitrators shall consider this Treaty an honorable engagement rather than merely a legal obligation; they are relieved of all judicial formalities and may abstain from following the strict rules of law.” Another clause provided that the reinsurer must apply for and deliver to the reinsureds a clean irrevocable letter of credit.

The reinsureds commenced separate arbitrations against the reinsurer, claiming that the reinsurer failed to comply with its obligations under the reinsurance contracts. After the arbitration organizational meetings in both arbitrations, the arbitration panels each issued interim orders requiring the reinsurer to post prehearing security.

The reinsurer moved in federal court to vacate the interim prehearing security orders, claiming that the Foreign Sovereign Immunities Act (FSIA), 28 U.S.C. §§ 1330(a), 1441(d), and 1602–11 protected it from the prehearing security orders. The district court denied the reinsurer’s motion to vacate.

The Second Circuit Court of Appeals affirmed the district court judgments, holding that, although foreign sovereigns were immune from prejudgment attachments under FSIA, immunity may be explicitly waived. Here, the arbitration clause provided that the arbitrators were to consider the reinsurance contracts as an honorable engagement rather than merely a legal obligation, and relieved the arbitrators from all judicial formalities, including allowing the arbitrators to abstain from following the strict rules of law. The appellate court cited Pacific Reins. Mgmt. Corp. v. Ohio Reins. Corp., 935 F.2d 1019 (9th Cir. 1991), for the proposition that an arbitration panel may order prehearing security where the arbitration clause includes language similar to that of the arbitration clause at issue in this case.

The Second Circuit conceded that the arbitration clause did not explicitly authorize the arbitration panel to order a letter of credit as security, but in a
A separate clause, the reinsurer agreed to supply a letter of credit equal to its reserves. The court found that this clause “inarguably demonstrates that the parties embraced” the use of letters of credit to secure their obligations under the reinsurance contract.

While the court did not decide whether FSIA applied to arbitration, it held that the reinsurance agreements satisfied the explicit waiver requirement of § 1610(d) of the FSIA. The court rejected the reinsurer’s remaining claims that the arbitration panels exceeded their authority, acted in manifest disregard of the law, offended public policy, and violated fundamental fairness.

*Read the implications.*
The cedent was a primary and excess insurer that issued liability policies to its insured over a 10-year period. As a result of a number of products liability actions, the insured faced significant claims for which it sought a defense. When coverage was denied, the insured initiated a declaratory judgment action, which was eventually settled for an amount substantially in excess of the cap stated in the policies.

After signing the settlement agreement, the cedent turned to its facultative reinsurers for a portion of the settlement amount. In addition to billing each reinsurer for the full amount of the limits of liability in the respective certificates, the cedent sought to collect additional amounts in declaratory judgment expenses, arguing that these expenses were in addition to the reinsurance limits. The reinsurers conceded that they were liable up to the limit of liability of the certificates, but argued that the overall limit placed a hard cap on their liability. The district court agreed with the reinsurers, holding that the limit of liability was an overall limitation, and the reinsurance certificates were capped at that amount.

The sole issue on appeal was whether the reinsurers were liable to pay a share of expenses in addition to the overall limit. The cedent pointed to language in the certificates which stated that the reinsurer was bound by the cedent’s claims settlement and, “in addition thereto,” was responsible for a proportionate share of expenses. The cedent claimed that the phrase “in addition thereto” signified that expenses were paid outside the limits.

In affirming the district court’s ruling, the Second Circuit Court of Appeals rejected the cedent’s first contention that the follow-the-fortunes principal obligated the reinsurer to indemnify the cedent even if payments of expenses and costs brought the total amount due to more than the limit of liability. The follow-the-fortunes clauses did not supplant the limit of liability and could not expand the other provisions of the parties’ agreement, including the liability cap.

The Second Circuit also rejected the cedent’s position that the “in addition thereto” language indicated that costs and expenses were in addition to limits. The court found that this language simply differentiated between the components of obligations—loss on one hand, expense on the other—but did not exempt expenses from the liability cap.

Read the implications.
A reinsurance company failed to pay the ceding company, a predecessor-in-interest of the current cedent, under 26 reinsurance certificates. In a claim brought against the reinsurer, the cedent sought to compel the reinsurer to post pre-answer security. Under New York Insurance Law § 1213(c)(1)(A), unauthorized foreign insurers or reinsurers are required to post security before defending a case on the merits in New York courts. When the reinsurer refused to post security, the district court granted the cedent’s motion to strike the reinsurer’s answer. The district court then entered a default judgment against the reinsurer. The reinsurer appealed the default judgment, asserting that the requirement to post pre-answer security violated its due process rights.

The Second Circuit Court of Appeals affirmed, holding that the requirement to post pre-answer security set forth under § 1213(c)(1)(A) does not violate the due process rights of a foreign insurer or reinsurer. The circuit court recognized the requirement to post pre-answer security amounts to prejudgment attachment where it compels foreign entities to place assets under the exclusive control of the U.S. courts for an indefinite period of time. The circuit court examined the factors set forth by the U.S. Supreme Court in *Mathews v. Eldridge*, 424 U.S. 319 (1976), and *Connecticut v. Doehr*, 501 U.S. 1 (1991), to determine whether the prejudgment attachment violated the reinsurer’s due process rights.

Under the standards set forth in those cases, prejudgment attachment procedures must balance: (1) the private interest involved; (2) the risk of a wrongful deprivation of that interest through the procedures employed to effect the attachment as well as the value of additional safeguards; and (3) the interest of the party seeking prejudgment attachment and those of the government in providing such remedy.

Applying this standard, the circuit court reasoned that the pre-answer security requirement set forth under § 1213(c)(1)(A) did not violate the due process rights of foreign insurers or reinsurers. First, although the pre-answer security requirement deprives the foreign insurer or reinsurer of a significant property interest, the insurer or reinsurer is excused from this requirement if it obtains a license to conduct insurance business in New York. Because foreign insurers and reinsurers have no constitutionally protected right to conduct
insurance or reinsurance business without a license, no significant interest is implicated by § 1213(c)(1)(A).

Second, all foreign insurers and reinsurers are provided with notice and an opportunity to be heard before pre-answer security is imposed. This process is conducted under court supervision, which ensures adequate safeguards are available to prevent the wrongful deprivation of an insurer or reinsurer’s property right.

Finally, both the state and the party seeking pre-answer security share a significant interest in ensuring that foreign insurers and reinsurers maintain adequate funds within the states in which they conduct business to satisfy the claims against them. Additionally, they share an interest in preventing parties from having to enforce judgments against foreign insurers or reinsurers in distant jurisdictions. Accordingly, the circuit court affirmed the district court’s default judgment holding that the imposition of pre-answer security did not violate the reinsurer’s due process rights.

Read the implications.
This reinsurance coverage dispute involved 26 facultative certificates issue by the reinsurer to the cedent. The cedent sought pro rata reimbursement of sums it had paid on behalf of the underlying insureds and for declaratory judgment expenses it had incurred in underlying coverage disputes. The facultative certificates did not explicitly state whether declaratory judgment expenses were covered under the agreement, stating only that the certificate was “subject to the same risks” assumed by the reinsured was meant to include the risk of declaratory judgment expenses.

The district court granted summary judgment to the reinsurer, finding that the reinsurer was exposed only to the “same risks” as the cedent on the underlying policies, and those policies did not include the cedent’s own declaratory judgment expenses. It also rejected the cedent’s argument that the follow-the-fortunes doctrine served to extend coverage of declaratory judgment expenses.

On appeal, the Second Circuit Court of Appeals affirmed the trial court’s decision. It noted that the cedent’s argument rested almost entirely on custom and practice evidence.

But before custom and practice evidence could be admitted, the cedent was required to identify an ambiguous term in the provision whose definition could only be understood by resorting to trade usage. Here, however, there was no single term that was ambiguous. Rather, the cedent argued that an entire clause was so ambiguous that it could not be interpreted without relying on custom and practice evidence.

The Second Circuit rejected this approach, finding that, unless a single term could suggest more than one meaning, extrinsic custom evidence was not appropriate to consider.

The Second Circuit also rejected the cedent’s attempt to supplement the terms of the contract with evidence of customary industry practice. The cedent argued that it was generally understood in the reinsurance market that the
reinsurer was responsible for a share of declaratory judgment expenses, even if those terms were not explicit in the contract. The Second Circuit concluded that, even if this were permissible, the cedent had not shown that the custom was so prevalent in the industry, and known to all parties, such that the reinsurer should be bound by the custom. In the absence of evidence of actual or constructive knowledge about this custom by the reinsurance market, or this specific reinsurer, the cedent’s attempt to supplement the terms of the contract had to fail.

Read the implications.
The cedent entered into three excess-of-loss treaties with the reinsurer. These three reinsurance treaties each contained an arbitration provision. The reinsurer then entered into three retrocessional agreements with the retrocessionaire, thereby ceding some of the risk of the reinsurance treaties and becoming the retrocedent. These retrocessional agreements did not contain arbitration clauses.

Upon incurring litigation expenses in a declaratory judgment litigation with the insured regarding the scope of the insurance policies’ coverage, the cedent received payments from the retrocedent pursuant to the reinsurance treaties. After paying the cedent, the retrocedent turned to the retrocessionaire for payment under the retrocessional agreements. The retrocessionaire refused to pay the retrocedent, contending that the retrocedent should not have paid the cedent’s declaratory judgment litigation expenses. When the retrocedent sued the retrocessionaire to recover the amount allegedly owed under the retrocessional agreements, the retrocessionaire claimed that the dispute was subject to arbitration because the retrocessional contracts incorporated by reference the arbitration provisions of the original reinsurance contracts.

The district court granted the retrocessionaire’s motion to compel arbitration based on the incorporation theory. The arbitration proceeded, and the panel excluded evidence of industry custom and the parties’ course of dealings based on the unambiguous contract language and the irrelevancy of the evidence. A majority award was issued in favor of the retrocessionaire. The retrocedent moved to vacate the award, but the district court denied the motion.

In upholding the district court’s determinations, the Third Circuit Court of Appeals extensively analyzed the relevant law to reach its decision. It began with a detailed discourse on federal arbitration law. The court pointed out that, in spite of the strong federal policy favoring arbitration, to compel a party to arbitrate, the court must determine that there is an agreement to arbitrate and that the dispute falls within the scope of that agreement. In answering these two questions, the court first addressed whether the presumption in favor of arbitration applied to one or both of these questions. The court, after a comprehensive analysis, concluded that the presumption in favor of arbitration probably did not apply to the question of whether there was an agreement to arbitrate.
The court next addressed the question of whether the standard to be applied in determining whether there was an agreement to arbitrate was that the agreement must be express or unequivocal. The court discussed the applicability of the express or unequivocal standard in the context of the existence of a triable issue of fact, which the court stated was not the case here. The court concluded that, under federal law, a purported arbitration agreement cannot be subjected to satisfying requirements more demanding than that applied to other agreements. Accordingly, a substantive requirement that the arbitration agreement be “express” and “unequivocal” to be enforceable is forbidden by federal arbitration law.

Using Pennsylvania law contract principles, the court determined that the parties did, in fact, form an agreement to arbitrate by incorporating by reference the arbitration clauses from the underlying reinsurance treaties. The court found that the general incorporation clause in the retrocessional treaties effectively incorporated the arbitration agreement set forth in the underlying treaties. Moreover, a second paragraph of the retrocessional treaties following the general incorporation clause specifically applied all the terms and provisions of the underlying treaties to the retrocessional treaties. Although the court found some imprecision in the incorporation language, it concluded that the most reasonable and natural construction of the incorporation clause was to apply the clause to include the arbitration provisions of the underlying treaties.

The court then found that the dispute fell within the scope of the arbitration agreement incorporated by reference into the retrocessional treaties. The court held that the arbitration clause was broad in scope and was subject to the presumption of arbitrability. Accordingly, the dispute about whether declaratory judgment expenses were covered fell within the scope of the arbitration agreement. The circuit court found that the district court properly compelled the retrocedent to arbitrate.

Finally, the court addressed whether the exclusion of extrinsic evidence of industry custom and practice, and the retrocessionaire’s historical corporate practice by the arbitration panel, was a ground to vacate the arbitration award. Because of the wide latitude given arbitrators in making evidentiary determinations, and because the panel’s evidentiary rulings did not deprive the retrocedent of a fair hearing, the court held that there was no statutory basis to vacate the award.

Read the implications.
The cedent provided excess products liability insurance to its insured, and reinsured a portion of its excess insurance policies under facultative reinsurance certificates with the reinsurer. By the terms of the agreements, the reinsurer was obligated to indemnify the cedent under the 4 policies up to $3 million. In each policy year, the cedent retained $250,000 of the risk, and the remainder of the $33 million exposure was reinsured with other companies. Each facultative certificate required the cedent to provide the reinsurer with prompt notice of any accident or occurrence likely to involve the reinsurance contract.

The cedent’s broker notified the cedent that its policy might become involved because of the increasing number of serious injuries associated with ATVs that the policyholder distributed. After conducting an audit of policyholder’s account in April 1987, the cedent notified the reinsurer of the impending loss activity involving the reinsurance in June 1987—2 months later. The reinsurer filed an action seeking a declaration that it was absolved of its indemnification obligations under its reinsurance certificates because the cedent had not satisfied the prompt notice requirement.

The Second Circuit Court of Appeals reversed the district court’s dismissal of the reinsurer’s claim, alleging untimely notice, and reinstated the complaint, instructing the lower court to proceed to trial on the question of whether the cedent had satisfied its contractual obligation and, if not, whether the reinsurer suffered prejudice as a result. According to the court, in the absence of an express provision in the contract making prompt notice a condition precedent, the reinsurer must show that prejudice resulted from the delay. Here, even though the reinsurer was unable to demonstrate prejudice as a result of the 2-month delay, if a jury determined that the cedent’s duty to provide notice arose at some point in time before April 1987, the reinsurer might have been able to demonstrate prejudice by virtue of the longer delay.

Read the implications.
The First Circuit Court of Appeals affirmed the district court’s findings in favor of the cedent on its claims that the reinsurer breached a reinsurance contract that it had with the cedent’s predecessor and committed an unfair trade practice in violation of Massachusetts General Laws Chapter 93A. The case began when the cedent’s predecessor issued several insurance policies to its policyholder. The cedent covered a portion of the risk that it faced from one of those policies by purchasing a facultative reinsurance certificate from the reinsurer. Under this facultative reinsurance certificate, the reinsurer was obligated to reimburse the cedent for half of the covered amount, up to $225,000.

In 1982, the policyholder discovered environmental contamination at several of its plants and filed claims with its insurers to cover the resulting liability. In 1993, the cedent settled its share of those claims for $2.2 million. After concluding that $843,000 of the $2.2 million settlement pertained to environmental contamination at the site that was covered by the relevant policy, the cedent billed the reinsurer for $225,000 as its half of the first $450,000 of the loss in excess of $50,000.

The cedent filed suit against the reinsurer, alleging that the reinsurer was obligated to provide $225,000 in reinsurance coverage and that its overall pattern of conduct during the period from the submission of the $225,000 reinsurance bill in August 1993 to the trial in January 1998 constituted a violation of Chapter 93A. The reinsurer, in contrast, argued that its interpretation of the relevant provision of the facultative certificate was plausible and that this plausible defense shielded it from Chapter 93A liability.

The district court ruled in the cedent’s favor, finding that the reinsurer should have provided coverage and that its bad-faith conduct in failing to do so violated Chapter 93A and warranted the imposition of double damages and attorney fees. The First Circuit affirmed and concluded that the reinsurer’s conduct was:
The First Circuit highlighted the exacting standard of *uberrimae fides* (the concept of “utmost good faith”) and found that the reinsurer’s conduct was “wholly alien to the usual course of dealings between an insurer and a reinsurer.”

*Read the implications.*
In this case, the First Circuit Court of Appeals reversed and remanded a district court order that sustained a reinsurer’s challenge to its cedents’ billing of environmental claim settlements on an annualized basis under the applicable certificates of facultative reinsurance. In reversing, the court upheld the cedents’ rights under a follow-the-fortunes clause to bind reinsurers to reasonable and good faith settlements of underlying claims.

The case involved significant environmental claims over multiple sites over multiple years. The reinsurer challenged the cedent’s annualization of the per occurrence limit on 3-year facultative certificates. The facultative certificates followed a series of multiyear umbrella policies, which provided excess coverage over a series of primary policies issued by another insurer. While including definitions of “occurrence,” the excess policies also included following-form clauses that incorporated occurrences covered by the terms of the primary policies.

The settlement with the insured was based on nine “focus” waste sites allocated pro rata across the years of relevant insurance coverage at each site and based on the per occurrence limit on each policy viewed as applying separately to each policy year. The court acknowledged that, on a “mechanical” basis, and without consideration of the following-form and follow-the-settlements language, the reinsurer might have the better argument. But, when considering the “following” clauses, the court held that the cedent’s view on annualization was binding on the reinsurer “so long as the settlement was reasonable and made in good faith.”

The court did, however, point out that, if the settlement were flatly inconsistent with the cedent’s policy, the reinsurer would not be bound by a follow-the-settlements clause in the facultative certificates. The court also indicated that this decision did not control a case where there was extrinsic evidence that better illuminated the dispute.

Read the implications.
This case involved an appeal from a final judgment of the district court in an action brought by a number of foreign reinsurance syndicates, companies, and pools against a domestic reinsurance company and related parties. On appeal, the retrocedent sought reversal of the district court’s judgment in favor of a retrocessionaire on claims for fraud, breach of contract, and violations of the laws of Massachusetts law against unfair methods of competition or deceptive acts or practice.

The issue in this case concerned retrocessional contracts under which the reinsurer agreed to reinsure portions of assumed risks selected and reinsured by the retrocedent. Specifically, the major issue of the case was whether the reinsurance assumed by the retrocedent was “facultative,” as promised under the reinsurance contracts. Facultative reinsurance is one of the two major types of reinsurance, the other being treaty reinsurance. The former type of reinsurance connotes the option to reinsure, or not, each particular risk, as contrasted with the latter type of reinsurance, which is a binding arrangement to reinsure all risks of a particular sort.

After agreeing with the district court that the retrocedent, having obtained by contract the power to impose significant risks and liabilities on the retrocessionaire, owed to the retrocessionaire the utmost good faith in its dealings under the contract, the First Circuit Court of Appeals nevertheless reversed the district court’s finding of fraud. According to the court, the retrocedent owed the retrocessionaire a duty “to exercise good faith and to disclose all material facts,” but that, in the nonmarine context, a claim of fraud may not be founded on innocent misrepresentation and concealment. The retrocessionaire’s claim against the retrocedent could only be sustained if (1) the retrocedent made the false representation of a material fact with knowledge of its falsity for the purpose of inducing the retrocessionaire to act; and (2) that the retrocessionaire relied on the representation as true and acted on it to its damage.

Although the district court found that “[the retrocedent] knew” that the retrocessionaire understood the term “facultative” in its standard and traditional sense of risk-by-risk certificate underwriting and was well aware that it, itself, was secretly using the term in a special sense without ever disclosing
such special meaning to the retrocessionaire, the First Circuit found that the district court’s findings were clearly erroneous insofar as they attributed to the retrocedent an implicit or express representation that they would engage exclusively in classic risk-by-risk, individual certificate underwriting.

The First Circuit did not find any evidence in the record that the retrocedent represented to the retrocessionaire that the facultative business would be limited to individual certificate, risk-by-risk underwriting. Therefore, the First Circuit held as clearly erroneous the district court’s finding that the retrocedent “knew” that the retrocessionaire understood “facultative” to be limited to risk-by-risk certificate underwriting.

Read the implications.
Two groups of companies and their predecessors entered into many reinsurance contracts with each other over the years. In 1996, the parties entered into a commutation agreement, which settled the parties’ obligations to each other under certain reinsurance contracts. This dispute arose when the reinsurer took the position that the 1996 commutation agreement resolved all obligations concerning some 2,200 certificates of facultative reinsurance between 2 of the companies.

A declaratory judgment action was brought in federal court by the reinsured group to resolve the issue. After competing motions for summary judgment were filed, the district court granted the reinsured group’s motion and denied the reinsurer’s motion. The Seventh Circuit Court of Appeals affirmed.

The central issue on the appeal was the meaning of a cryptic phrase used on the list of commuted reinsurance contracts on Schedule A of the 1996 commutation agreement. The commutation agreement recited that the reinsured and reinsurer were parties to the “Treaty Reinsurance Agreements listed in Schedule A.” Schedule A listed specific reinsurance contracts by number, program, layer, and effective date. Schedule A also listed certain other reinsurance contracts under the title “Through Facultatively Placed.” Only one entry was listed under this title—the cryptic phrase “0709 Bellefonte Reins.”

The reinsured group claimed that this phrase meant only three certificates of facultative reinsurance issued to one of the companies in the group “CCC.” The reinsurer claimed that all facultative certificates issued by its predecessor, Bellefonte, to any entity in the reinsured group were commuted. In rejecting the reinsurer’s position, the appellate court held that the only reasonable inference to be drawn from the extrinsic evidence admitted to show the meaning of the ambiguous term (“0709 Bellefonte Reins.”) was that only three certificates of facultative reinsurance issued by Bellefonte to CCC for three risks were commuted. Accordingly, the court agreed with the district court that the parties did not intend for the 1996 commutation agreement to cover any certificates of the 2,200 facultative reinsurance issued by Bellefonte to the other member of the reinsured group.

Read the implications.
In the 1960s, the reinsured issued medical malpractice insurance policies to hospitals and hospital associations. It reinsured those policies under reinsurance contracts with the reinsurers. In the 1980s, the reinsured settled several medical malpractice claims and, sometime later, notified the reinsurers of those payments and demanded indemnity under the reinsurance contracts. The reinsurers refused to pay, and the reinsured brought an action for breach of contract.

Initially, the reinsurers claimed that the reinsured breached the reinsurance contracts by failing to give the reinsurers timely notice of the underlying claims. After reconsidering their defenses in light of the holding in *Unigard Sec. Ins. Co. v. North River Ins. Co.*, 79 N.Y.2d 576, 594 N.E.2d 571, 584 N.Y.S.2d 290 (1992), the reinsurers waived all defenses and moved for summary judgment to dismiss the claims based on statute of limitations grounds. The district court denied the reinsurers’ motion.

The issue on appeal, which the circuit court called “deceptively simple,” was when did the cause of action that the reinsured had for indemnity under the reinsurance agreement accrue under New York law? The reinsured argued that the cause of action accrued when the reinsurers breached the reinsurance agreement by refusing to pay the claims. The reinsurers argued that the cause of action accrued the day the reinsured made payment on the underlying claims. In ruling for the reinsured, the Second Circuit Court of Appeals held that the cause of action accrued when the reinsured notified the reinsurers of its losses under the reinsurance contracts, and the reinsurers subsequently denied coverage. The court, in agreeing with the district court, followed New York law on when a cause of action accrues on a contract of indemnity. Reinsurance contracts are express contracts of indemnity against loss. Under New York law, a claim generally accrues when the indemnitee actually suffers a loss. Under insurance policies, the cause of action accrues when the loss insured against becomes due and payable under the policy. The circuit court found no reason not to apply the due and payable insurance rule to the reinsurance contracts here.

The court found that the timeliness of the reinsured’s claims turned on when its losses were due and payable under the reinsurance policies. Under the reinsurance contracts, the reinsured was required to report any actual...
losses within a reasonable time. The court found that the reinsured was obligated to wait a reasonable time for the reinsurers to decide whether they would pay or not. The court held that, under the reinsurance contracts, the reinsured’s actual losses were not due and payable until a reasonable period of time after the reinsured gave notice of those actual losses to the reinsurers.

The court also made a very important point.

The reinsured, once it suffered a loss on its underlying policies, could not unreasonably delay reporting those losses to the reinsurers. Thus, although the cause of action cannot accrue until the reinsured demands payment of an actual loss, and the reinsurers refuse to pay, unreasonable delay in reporting those losses will not stall the running of the statute of limitations.

Read the implications.
In this case, the ceding company entered into three separate international reinsurance agreements with the reinsurer through which the reinsurer would reinsure certain insurance policies issued by the cedent. Each reinsurance agreement contained an arbitration clause governing all disputes arising under the reinsurance agreement.

When the cedent became insolvent, the then New York State Superintendent of Insurance commenced a liquidation proceeding under Article 74 of the New York Insurance Law. The court supervising the liquidation subsequently appointed the superintendent as liquidator of the insolvent cedent. When the reinsurer refused to satisfy the reinsurance balances owed to the cedent under the reinsurance agreements, the superintendent commenced an action against the reinsurer. The reinsurer sought to dismiss the action and compel arbitration pursuant to the United Nations Convention on the Recognition and Enforcement of Foreign Arbitral Awards (the “Convention”). The Convention provides for the enforcement of arbitration clauses within international commercial agreements, subject to certain exceptions.

The court denied the reinsurer’s motion to dismiss, holding that the reinsurer could not compel arbitration under the Convention where the superintendent had no authority to arbitrate under the applicable domestic law.

Under the McCarran-Ferguson Act (the “Act”), states are authorized to regulate insurance companies. Additionally, the Act precludes state insurance regulation from preemption by inconsistent federal law. The court determined that Article 74 set forth the applicable state law to the dispute. Article 74 provided the superintendent with the authority to liquidate insolvent insurance companies and to bring actions on their behalf. Article 74, however, did not
authorize the superintendent to arbitrate on behalf of an insolvent insurer. Therefore, the court held that the reinsurer could not compel arbitration of the claims asserted by the superintendent under the Act, where the federal law at issue, the legislation implementing the Convention’s requirement to arbitrate, contradicted state insurance regulation. The New York Appellate Division and the Court of Appeals both affirmed.

Read the implications.

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A series of reinsurance agreements between the ceding company and the reinsurer gave rise to a dispute over the right to setoff amounts owed across contracts. The dispute began when the cedent sought to collect unpaid reinsurance proceeds from the reinsurer under an underlying directors and officers (D&O) liability policy. Before arbitration could be initiated on that dispute, the parties found their roles reversed pursuant to a separate reinsurance agreement. Under that agreement, the reinsurer was the cedent and sought to collect on a reinsurance contract with the cedent, which was now acting as a reinsurer. Rather than paying this billing, the cedent elected to offset the amounts sought by the reinsurer against the amounts owed by the reinsurer under the D&O claim. The reinsurer initiated arbitration over the cedent’s right to offset.

A three-member arbitration panel was convened to hear the dispute. During an early hearing, the reinsurer learned that the arbitrator the cedent had selected had previously consulted with the cedent’s outside counsel on the issue of offset under the reinsurance contracts, including on the D&O claim at issue in the arbitration. Despite this prior consultation, the panel rejected the reinsurer’s challenge to the arbitrator’s qualifications and ruled that each member was unbiased. Following a hearing, the panel upheld the cedent’s right to offset the billings and its right to continue offsets in the future for any other amounts that became due.

The district court confirmed the arbitration award and denied the reinsurer’s motion to vacate. On appeal, the reinsurer argued that the award should be vacated because: (1) the decision contradicted the plan language of the contract; (2) the award was ambiguous; (3) the arbitrator was biased; and (4) procedural and evidentiary errors occurred. The Ninth Circuit Court of Appeals rejected all these challenges.

First, the Ninth Circuit held that the Federal Arbitration Act (FAA) strictly demarcated the grounds on which a federal court could vacate an arbitration award. An alleged error in contract interpretation (even if such an error could be shown) was not an appropriate basis for vacatur. A court’s task was only to determine whether the arbitrators’ interpretation was “plausible.” It was not the court’s duty to revisit the interpretation on the merits or decide which side had the better construction of the contract.
Second, the Ninth Circuit rejected the reinsurer’s claim that the award was ambiguous because the panel had not clearly articulated when a billing was “due.” The court held that, not only was the award not ambiguous on this point, but that any minor ambiguity was insufficient to warrant vacatur. For an ambiguity to warrant vacatur, the court held, it must be substantial and adversely affect a party’s ability to understand or comply with the award.

Third, the Ninth Circuit held that, because the cedent’s party-appointed arbitrator had disclosed his prior work on the matter, had not formulated final opinions on the issues, and did not possess an informational advantage, disqualification was not required. The court found it telling that even the reinsurer’s party appointed arbitrator had upheld his opposing arbitrator’s ability to be impartial.

Finally, the court rejected the reinsurer’s arguments that the panel’s evidentiary decisions and decision to allow certain ex parte communication warranted vacatur. The reinsurance contracts empowered the arbitrators to craft their own rules of procedure, and both parties were subject to the same rules. The court also held that the evidence which the panel had excluded was irrelevant to the issue in dispute, and its exclusion had no impact on the outcome of the proceedings.

*Read the implications.*
The insurer provided property insurance to its insured with a limit of liability of $48 million. Following a fire, the insured presented a claim to the insurer, which was rejected based on a belief that the fire was a result of arson. Following lengthy litigation, where the insurer amassed significant loss adjustment expenses, the parties settled, and the insurer sought to bill its reinsurers.

The reinsurers had separately subscribed to a facultative certificate with a limit of liability of $7 million. The insurer not only sought the full $7 million, it also billed the reinsurers an additional $5 million as their share of expenses. The reinsurers refused to pay, arguing in part that expenses were included within the overall $7 million limit.

The lower courts split on the outcome. The trial court ruled first that expenses were in addition to limits, a holding that was reversed by the intermediate appellate court. The court of appeals was thus called on to determine whether the $7 million limit operated as a hard cap on the reinsurers’ liability, inclusive of expenses. It concluded that it was indeed a cap, and that the reinsurers could not be required to pay loss adjustment expenses in excess of the certificate’s stated limit. Any other holding, the court noted, would expose the reinsurers to unlimited expense liability and would render meaningless the negotiated $7 million limit.


Read the implications.
In 1930, the cedent issued a fidelity insurance bond to John DeMartini Co., Inc., (“DeMartini”). The cedent subsequently entered into a reinsurance agreement with the reinsurer to reinsure half of the risk for the bond issued to DeMartini. The reinsurance contract between them incorporated the standard form reinsurance agreement adopted by the Surety Association of America in 1930. This standard form provided that:

REINSURER’S PROPORTIONATE SHARE OF LOSS UNDER THE BOND ...
SHALL BE PAID TO THE REINSURED UPON PROOF OF THE PAYMENT ...
BY THE REINSURED, AND UPON DELIVERY TO THE REINSURER OF
COPIES OF ALL ESSENTIAL DOCUMENTS CONCERNED WITH SUCH LOSS ...
AND THE PAYMENT THEREOF.

DeMartini suffered a loss and claimed coverage from the cedent under the fidelity insurance bond. The cedent subsequently became insolvent and the New York State Superintendent of Insurance began liquidating the cedent. Before discharging payment to DeMartini under the fidelity insurance bond, the superintendent demanded payment from the reinsurer for half of the value of DeMartini’s claim. The reinsurer refused coverage under the terms of the reinsurance contract, asserting that the cedent had not fulfilled the condition precedent to coverage where it failed to submit proof of payment of DeMartini’s claim.

Although the federal district court and the court of appeals held that proof of payment was not a prerequisite to coverage under the standard form reinsurance contract, the U.S. Supreme Court reversed and remanded the claim. In so doing, the court held that liability must be determined by interpreting the language within the contract in light of the circumstances to which it applies.

The court found no ambiguous language within the standard form reinsurance contract incorporated into the agreement between the cedent and the reinsurer, interpreting payment by the reinsured and submission of proof to the reinsurer as a condition precedent to coverage under the reinsurance
agreement. Accordingly, the court reversed the court of appeals and remanded because the cedent failed to fulfill the condition precedent for coverage under the terms of the agreement.

Read the implications.

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This insurance coverage suit involved a dispute over the production of reinsurance documents arising out of the sinking and salvage of a dry dock. The policyholder sought communications related to the reinsured’s procurement of, and claims made on, its reinsurance contract for the dry-dock loss. The policyholder initially subpoenaed the reinsurer directly, but after the reinsurer objected on the ground that the information was protected by the common-interest doctrine, the reinsurer turned over the file to the reinsured to handle the dispute.

The reinsured objected to the policyholder’s reinsurance information requests on the grounds of relevance and the common-interest doctrine. The court granted the insured’s motion to compel the cedent to produce the file of its reinsurer, as well as other communications or documents maintained on the reinsurance contracts.

As to relevancy, the court noted that Federal Rule of Civil Procedure 26(b)(1) provides that a party is entitled to discovery on “any non-privileged matter that is relevant to any party’s claim or defense.” In finding that the information was relevant, the court noted that, although “caselaw is sparse within the Second Circuit” concerning the discoverability of reinsurance information, “the few cases to consider the issue have determined that reinsurance information is indeed discoverable.”

The court ruled in favor of disclosure on the basis of these cases, the broad scope of the federal discovery rules, and the fact that the reinsured’s cross-claim which asserted fraud put what the reinsured told its reinsurer about the age and condition of the dry dock at issue. The court held that the reinsured’s position that reinsurance documents are generally irrelevant was insufficient to withhold the documents, including information on loss reserves. Moreover, the court held that more recent cases on reserve information have held that document requests seeking reserve information should be evaluated on a case-by-case basis. The court said both the reserve amounts and changes to reserves could possibly lead to admissible evidence relating to the insurer’s own beliefs about coverage, liability, and the good-faith handling of the claim.

In addressing the common-interest privilege, the court stated that the doctrine is an exception to the general rule that voluntary disclosure of confidential privileged material to a third party waives any applicable privilege.
Although the doctrine protects the free flow of information from client to attorney whenever multiple clients share a common interest about a legal matter, the court cautioned that the doctrine was not an independent source of privilege or confidentiality. Therefore, the court said, the doctrine will not apply if a communication is not protected by the attorney-client privilege or the attorney work-product doctrine.

The court emphasized that the parties must establish a “common legal, rather than commercial interest,” and it is key that the nature of the interest be identical, not similar. Here, the court noted, the evidence showed that the cedent and its reinsurer did not share an identical legal interest that would entitle the cedent to withhold the documents from the policyholder which it produced to its reinsurer. Moreover, the court found that the cedent had not proved or even argued that it disclosed otherwise privileged materials to its reinsurer in the course of formulating a common legal strategy, or for the purpose of obtaining legal advice from the reinsurer. Nor had it presented evidence about the legal necessity of exchanging otherwise protected information.

Therefore, to the extent that the cedent shared otherwise privileged information with its reinsurer, the court ruled that any privilege that applied to the documents had been waived.

Read the implications.

A reinsurer issued a reinsurance certificate to a cedent whereby the reinsurer agreed to reimburse one-half of the cedent’s liability over $250,000 under the cedent’s policy issued to a manufacturer of swimming pools. As with most reinsurance contracts, the reinsurance certificate provided that “prompt notice shall be given to the Reinsurer by the Company of any occurrence or accident which appears likely to involve this reinsurance....”

The reinsurer’s action against the cedent arose when the cedent received notice of an action filed for personal injuries sustained in a pool manufactured by its insured. The district court granted summary judgment in favor of the reinsurer that it was not obligated to the cedent under a contract of reinsurance because the cedent gave late notice to the reinsurer of the action.

The Fourth Circuit Court of Appeals, however, vacated and remanded the judgment of the district court. Given that late notice was involved, the timeline of the case was especially important.

On September 25, 1978, the cedent received notice of the action filed for personal injuries sustained in a pool manufactured by its insured. The cedent appointed an investigator and local defense counsel. By April 1980, defense counsel informed the cedent that the possible liability exposure was great and that the proposed defenses were insufficient. The cedent’s internal memoranda in November 1980 and July 1981 indicated that it may have been aware of the necessity of providing notice to the reinsurers.

On January 4, 1982, the cedent’s agent discovered that an increased reserve had not been posted and that a clerical error had resulted in no notice to the reinsurer. This discovery occurred 1 week before a settlement conference and the trial. On January 6, 1982, 3 days before trial, the cedent telexed the reinsurer to provide notice of the claim and an invitation to participate in a settlement conference the next day. The cedent also sent the reinsurer a detailed claim analysis. On January 6, the cedent received a telex from the reinsurer stating that the cedent’s notice was not timely and that the reinsurer would file immediately for declaratory relief.

The district court held that the reinsurer was prejudiced as a matter of law because the untimely notice denied it the contractual right to participate in the
defense and control of the claim for which it had bargained. The Fourth Circuit, however, viewed the district court’s rationale as “tantamount to making timely notice a condition precedent” and held that summary judgment was inappropriate because genuine issues of material fact existed. According to the court, among the other issues of material fact that existed, it was unclear what the reinsurer would have done had it received timely notice and whether its intervention in the underlying case would have produced a more favorable result.

*Read the implications.*
A ceding company filed suit against its reinsurer to collect on a policy of reinsurance after the cedent became liable on a fidelity bond that it had issued to a trust company. The reinsurer argued that the cedent fraudulently concealed material facts after the reinsurer had learned from newspaper reports that the trust company engaged in “irregular practices” that raised doubts about the trust company’s continued solvency. The court was called on to determine whether the cedent, in obtaining the reinsurance contract, was guilty of wrongful and fraudulent concealment of material facts.

According to the Eighth Circuit Court of Appeals, good faith on the part of the insured is a determining factor in deciding whether fraudulent concealment exists, except in those cases where specific questions have been asked of and answered by the insured. The court held that fraudulent concealment exists:

(1) [W]here insured, having actual knowledge of material facts, has intentionally failed to disclose them truthfully [and] (2) [W]here insured, though not having actual knowledge of material facts, yet has intentionally, and in bad faith, refused to become acquainted with the facts.

Because there was no substantial evidence showing either intentional concealment of known material facts or bad faith in refusing to ascertain such facts on the part of the cedent, the Eighth Circuit affirmed the judgment against the reinsurer.

Read the implications.
The cedent issued a fire insurance policy to a municipality. Through a dual agent, the cedent obtained reinsurance through a binder of reinsurance issued by the agent in the name of the reinsurer. The binder was never followed by the issuance of the full reinsurance contract.

A fire destroyed a city school building, and the reinsured paid the loss to the city and sought recovery under the reinsurance binder. The reinsurer, however, claimed that the reinsurance binder had been canceled more than 3 months before the fire by a letter of cancellation mailed by the reinsurer to the agent.

After commencing a breach of contract action in state court, the case was removed to the federal court where the district court granted summary judgment to the cedent. The Second Circuit Court of Appeals reversed. In reversing, the court addressed several issues of reinsurance contract formation, but ultimately held that there were many issues of fact that needed to be resolved at trial and not on summary judgment.

In discussing the case, the court adopted a definition of reinsurance from *Friend Bros. v. Seaboard Sur. Co.*, 316 Mass. 639 (1944). “Reinsurance,” the court stated was “an agreement to indemnify the assured, partially or altogether, against a risk assumed by it in a policy issued to a third party.” One of the arguments was whether the cancellation terms of the standard fire insurance policy under Massachusetts law applied to the binder of reinsurance.

The court agreed that, if the parties contemplated that the standard policy would be issued, the applicable terms would be read into the binder.

Nevertheless, the court stated that, even if the notice of cancellation had to conform to the requirements of the standard form, those requirements must be construed with common sense and reason. For example, the court found that, even though the reinsured had paid no premium to the reinsurer under the binder, the cancellation notice did not need to contain the meaningless statement in the standard form concerning the return of excess premiums.
Finally, while reversing the grant of summary judgment and remanding the issues to the district court relevant to the scope of the agency and the intent of the cancellation notice, the court noted that the ordinary rule of interpreting ambiguous language in favor of the insured and against the insurer did not apply when both the insured and insurer were large insurance companies, long engaged in far-flung activities in that field of economic activity. The course of dealing evidence between the parties and the agent was allowed to help resolve the factual issues.

*Read the implications.*
This action was instituted to determine whether, under New York’s insurance insolvency statute, a reinsurer could offset money it indisputably owed to an insolvent insurer against debts that the insolvent insurer owed under a separate and distinct contract. The reinsurer had agreed to reinsure certain lines of business of the ceding company through treaty reinsurance. In an unrelated transaction, the reinsurer facultatively reinsured the cedent on a single excess products liability policy.

When the ceding company was placed into liquidation, the reinsurer owed the cedent $750,000 under the facultative reinsurance certificate, and the cedent owed the reinsurer premium under the treaty reinsurance in an amount allegedly greater than was due under the facultative certificate. When the reinsurer attempted to set off the amount the cedent owed under the treaty against the amount the reinsurer owed under the facultative certificate, the cedent’s liquidator objected, and litigation ensued.

The dispute centered on the question of whether the debts were “mutual.” Under New York’s insolvency statute, “mutual debts” between the insolvent insurer and another person or entity could be set off. The liquidator first argued that “mutual debts” had to arise out of the same contractual transaction, or else the reinsurer’s ability to offset would constitute an unlawful preference over policyholders.

The New York Court of Appeals rejected this argument, noting that the statute did not explicitly require that the debts or credits arise under the same transaction. In the absence of legislative history to the contrary, or a sound public policy reason for disallowing offsets across multiple contracts, there was no statutory barrier to setting off amounts owed under the two reinsurance agreements.

The court next rejected the liquidators’ contention that the insolvency clause in the facultative certificate explicitly prohibited offsets. That clause stated that amounts owed under the reinsurance agreement would be paid to the cedent or its liquidator “without diminution” in the event of the cedent’s insolvency. The liquidator argued that this created an obligation that was absolute and precluded the reinsurer from exercising a right of offset.
The court disagreed with the liquidator’s interpretation of the insolvency clause, noting that its purpose was to require the reinsurer to pay its share of a loss even if the insolvent insurer had not first made a payment to the underlying insured. Nothing in the language or purpose of the clause was intended to negate a right of offset.

*Read the implications.*
From 1970 to 1974, Pritchard & Baird, Inc. (P&B) acted as a reinsurance broker to a ceding company. As the cedent’s reinsurance broker, P&B would secure quotes from various reinsurance companies on the cedent’s behalf. Based on these quotes, the cedent would submit a check payable to the order of P&B specifying the premiums to be paid to each reinsurance company. P&B would then deposit these checks to its own account and apportion funds pursuant to the cedent’s instructions, retaining a portion to cover its own brokerage commission.

Upon the cedent’s determination that a loss claim was due under one of its reinsurance contracts, it would direct to P&B to inform the appropriate reinsurer of the claim. The reinsurer would then provide P&B with a check payable directly to the cedent.

In 1975, P&B suffered financial difficulties and failed to remit premiums to certain reinsurance companies as directed by the cedent. The affected reinsurers threatened to cancel the reinsurance contracts based on the overdue premiums. Accordingly, the cedent was obliged to remit additional premiums directly to these reinsurers to retain coverage. P&B eventually declared bankruptcy.

The cedent commenced an action against the P&B bankruptcy estate to recover the value of the premiums P&B failed to transfer to the appropriate reinsurers. Certain reinsurance companies also filed claims against the estate to recover these same premiums wrongfully retained by P&B. This resulted in multiple claims filed against the estate on the same obligations. In determining the proper claimant, the Bankruptcy Court issued a declaratory judgment holding that an agency relationship existed between the cedent and P&B, but that no such agency relationship existed between the reinsurers and P&B. Accordingly, the cedent—not the reinsurance companies—could maintain an action against the estate to recover the value of the premiums wrongfully retained by P&B.

On appeal, the New Jersey federal court affirmed the Bankruptcy Court’s declaratory judgment. The district court held that an agency relationship existed between the cedent and P&B. The cedent provided P&B with significant authority to secure quotes and reinsurance contracts on its behalf. Additionally, the cedent remitted checks payable to the order of P&B from which
P&B transferred premium payments to the appropriate reinsurance companies and from which P&B was authorized to withdraw its own brokerage fees. By contrast, the reinsurers had no such relationship with P&B.

Once made aware of a loss claim, the reinsurers would provide P&B with checks payable directly to the cedent. P&B merely transferred these checks to the cedent on behalf of the reinsurance companies. Accordingly, P&B was an agent of the cedent and not of the reinsurers. Therefore, the district court affirmed that the cedent could seek recovery of the retained premiums against the estate. The Third Circuit Court of Appeals affirmed without opinion.

*Read the implications.*
The reinsurer issued two reinsurance certificates to the cedent for certain primary insurance policies for personal injury and property damage. The cedent’s primary insurance policies provided for automatic reinstatement after the policies were exhausted. Upon exhaustion of one of the primary insurance policies, the policy automatically reinstated, and the cedent turned to the reinsurer for payment, with limited success. The reinsurer agreed to reinstate the reinsurance for an additional 25 percent premium, following the primary policy terms, but when the primary policy was exhausted for a second time, the reinsurer would not agree to a second reinstatement.

The cedent then sued the reinsurer in the district court, seeking a declaration of the reinsurer’s liability under the reinsurance certificates. The cedent argued that the automatic reinstatement provisions of the insurance policies were incorporated into the reinsurance certificates by virtue of a standard “follow-the-form” or “follow-the-fortunes” clause. The reinsurer argued that the reinsurance did not reinstate.

The district court determined that the reinsurance certificates were ambiguous and denied the reinsurer’s motion for a directed verdict at the close of evidence at trial. The jury found that the reinsurance contracts followed the terms of the primary policies, including the automatic reinstatement provision. The jury’s verdict specifically noted that the reinsurance certificates contained no aggregate limit, nor any exception to the reinstatement provision.

The circuit court upheld the judgment and found that it was not error for the district court to deny the reinsurer’s motion for a directed verdict. The court explained that the cedent introduced strong, uncontroverted evidence of its own intent in entering into the reinsurance certificates, evidence of contemporaneous notes, and a subsequent course of dealing between the parties which demonstrated that the reinsurer intended to reinsure any reinstated aggregates.

*Read the implications.*

This case involved a reinsurance agreement covering payments in excess of $100,000 for claims arising from accident liability coverage issued by the cedent to a New York taxicab company. In June 1975, the insured was involved in an accident in which a cab driver injured two pedestrians. Notice was provided to the cedent in October of that year upon the filing of a complaint by the pedestrians.

Three years into the action, the cedent examined the plaintiffs’ medical conditions for the first time, and concluded that a jury verdict could easily reach $400,000. The case was subsequently settled, and the cedent sought to recover a portion of the settlement payment from the reinsurer. The reinsurer denied the claim because the cedent failed to give timely notice of its claim under the reinsurance agreement. The notice clause also provided for the reinsurer’s right to associate.

The district court, applying North Carolina law, held that the cedent’s provision of notice to the reinsurer after the medical examination was untimely. The court noted that the complaint demanded $450,000, and that the facts made clear that the plaintiffs would prevail on the issue of liability. The court rejected the cedent’s claim that it was not required to notify the reinsurer of a claim until it itself became aware that the claim was likely to involve reinsurance, which, in this case, did not happen until after the medical examination. The court found that the reinsurer was denied the opportunity to participate in the defense of the claim, and held that the fulfillment of timely notice required the cedent to make active inquiries into the merits of the claim and the likelihood that the claim would involve reinsurance.

*Read the implications.*
Plaintiff was the beneficiary of surety bonds issued by the cedent and reinsured by the reinsurer. The reinsurance contract expressly provided that nothing in the contract:

\[
\text{SHALL BE CONSTRUED TO CONFER UPON ANY PERSON, OTHER THAN THE PARTIES \text{[TO THE CONTRACT] OR THEIR PERMITTED SUCCESSORS OR ASSIGNS, ANY RIGHT OR REMEDIES UNDER THIS REINSURANCE.}}
\]

When the cedent became insolvent, Jurupa sought performance of the bonds directly from the reinsurer.

The district court granted the reinsurer’s motion to dismiss based on the beneficiary’s failure to state a claim. The district court held that the beneficiary, as the insured, had no direct right of action against the reinsurer where the beneficiary was not a party to the reinsurance agreement and where no cut-through exception existed. Because the reinsurance agreement explicitly precluded any third-party rights, the district court held that the beneficiary was not a party to the reinsurance agreement. Accordingly, the beneficiary lacked contractual privity with the reinsurer and could not sue the reinsurer directly for performance of the surety bonds.

Additionally, the district court found no evidence of a cut-through exception. Under New York law, a cut-through exception exists where a reinsurance contract contains a provision that expressly grants policyholders a direct right of action against reinsurers. The district court found, however, no such cut-through exception within the reinsurance contract. Accordingly, the trial court granted the reinsurer’s motion to dismiss based on the beneficiary’s failure to state a claim. The Second Circuit Court of Appeals affirmed the district court’s order on appeal.

Read the implications.
Under the reinsurance contract, the reinsurer reinsured the cedent on third-party automobile public liability risks above certain amounts assumed by the cedent. The cedent defended a suit brought by a married couple for injuries they sustained in an automobile collision that resulted in a verdict and judgment in their favor. The cedent refused to pay the judgment, and the judgment was ultimately paid by the surety company on the appeal bond furnished by the cedent out of funds deposited with it as security for the appeal bond.

The cedent then filed an action against the reinsurer seeking to recover under the reinsurance contract. The district court entered judgment in favor of the reinsurer on the ground that the failure to timely notify the reinsurer of the underlying accident, as the reinsurance contract required, prevented any recovery by the cedent. The Seventh Circuit Court of Appeals, however, affirmed the district court’s ruling. In affirming the district court’s ruling, the Seventh Circuit held that there was ample evidence that the ceding company did not notify the reinsurer of the underlying suit until after an appeal of the adverse judgment.

According to the court, the reinsurer’s inability to participate in the defense of the underlying case constituted sufficient prejudice to prevent the ceding company from recovering under the reinsurance contract. Notably, the reinsurer was not required to prove that the results of the underlying case would have been different if it had received prompt notice from the cedent.

*Read the implications.*
In 1950, an insurance company entered into a contract with an insurance agency by which the agency would act as an insurance agent for the insurer. Under the terms of the contract, the agency earned specific rates of commission for policies written. The agency deducted these commissions from the premiums paid by policyholders. The contract required the agency to refund to the insurer any commissions earned on canceled liability or on reductions in premiums. Additionally, the contract provided that all disputes arising under the contract were subject to arbitration.

In 1951, the insurer was declared insolvent, and the New York Superintendent of Insurance was appointed liquidator of the insurer. Under the New York Insurance Law, liquidation of an insolvent insurance company confers the superintendent with title to all contracts, property, and rights of action of the insolvent insurance company. Pursuant to this authority, the superintendent commenced an action against the agency to recover fees and commissions owed to the insurer under the terms of the contract.

The agency sought to stay the proceeding and compel arbitration under the arbitration clause in the contract. The liquidation court granted the agency’s stay and directed the superintendent to proceed to arbitration. The superintendent appealed, and the New York Appellate Division reversed the order compelling arbitration. The agency sought review of the reversal from the New York Court of Appeals.

On review, the agency argued that the superintendent should be compelled to arbitrate according to the terms of the contract it sought to enforce. The New York Court of Appeals rejected this argument, holding that, although the agency could have compelled arbitration against the insurer under the terms of the contract, it could not do so against the superintendent in liquidation.

Article XVI of the New York Insurance Law provides the supreme court with exclusive jurisdiction over claims initiated by creditors against the superintendent as liquidator of an insolvent insurance company. Accordingly, claims brought against the superintendent under these circumstances must be brought in the supreme court and are not subject to arbitration. The law is silent, however, as to whether the supreme court has exclusive jurisdiction.
over claims initiated by the superintendent on behalf of an insolvent insurance company and, therefore, whether these claims are subject to arbitration.

In light of the legislature’s silence, the New York Court of Appeals determined that the policy underlying the New York Insurance Law required the efficient management and supervision of the liquidation process by one court. Accordingly, absent express authority from the legislature permitting the arbitration of claims by the superintendent on behalf of insolvent insurance companies, the supreme court must have exclusive jurisdiction over these claims.

*Read the implications.*
This case involved the interpretation of rights and obligations between a retrocedent and its retrocessionaires under a “Quota Share Retrocessional Contract” in arbitration. The arbitral decision held that a condition precedent to the retrocessionaires’ payment under the retrocessional agreement was that the:

[RETROCEDENT] SHALL CONSULT WITH [RETROCESSIONAIRES], AND OBTAIN [THEIR] AGREEMENT AS TO THE APPLICABILITY OF THE UNDERLYING PRIMARY POLICY COVERAGE, AND AS TO [RETROCEDENT] AND [RETROCESSIONAIRES’] LIABILITY... AND AS TO THE PROPOSED PAYMENT AMOUNT....

Another condition was the provision of information requested by the retrocessionaires, which the retrocedent refused to provide. The retrocedent challenged the imposition of the condition precedent set by the arbitral panel as exceeding the panel’s powers.

The Ninth Circuit Court of Appeals rejected the retrocedent’s argument that the arbitral panel exceeded its authority by improperly ruling on a question not submitted to arbitration because neither party explicitly requested that the panel establish conditions to reimbursement. The court held that the panel’s decision was proper because the issue was implicit in the parties’ submission to arbitrate the enforcement of obligations in the retrocessional agreement.

Read the implications.
The beneficiary of a $2 million surety bond issued by an insolvent insurance company brought an action on the bond against the reinsurers. The liquidator intervened in the action and argued that the reinsurance proceeds were assets of the insolvent cedent and should be paid to the liquidator directly for the benefit ultimately of all policyholders.

The reinsurers counterclaimed that the reinsurance agreements had been procured by fraud because the cedent was operated for improper purposes and failed to disclose its insolvency. The reinsurers sought rescission of their reinsurance agreements with the insolvent cedent.

The New York Court of Appeals upheld the intermediate appellate court’s order of rescission of the reinsurance contracts after finding that the ceding company committed fraud in the inducement by not disclosing its insolvency. The central issue concerned whether the failure of the ceding company to disclose its insolvency to potential reinsurers constituted fraud in the inducement and whether rescission, as part of a fraud finding, was a proper remedy in such a situation. Ordinarily, all material facts relevant to a contract for reinsurance must be disclosed; however, at the time of this case, whether insolvency constituted a material fact in the reinsurance context remained an open issue.

Ultimately, the court reasoned that insolvency has a “potent potential impact on the reinsurers’ risk sufficient to trigger the uberrimae fidei obligation for disclosure.” Accordingly, the court treated the nondisclosure of the ceding company’s insolvency as a material fact, of which disclosure for reinsurance was required under governing precedents and principles.

Read the implications.
This dispute arose over the allocation of a loss arising from asbestos exposure. The cedent issued policies over a 10-year period to its insured manufacturer covering portions of the second, third, fourth, and fifth excess layers of the insured’s coverage program. The cedent’s second excess layer provided a total of $345 million in coverage to the manufacturer, with an additional exposure up to $251 million in the other excess layers. After initially resisting coverage, the cedent settled the claim for $335 million and then sought indemnification from its reinsurers. The cedent’s allocation of the loss resulted in an allocation of the settlement to the second layer excess policies and none to the third, fourth, or fifth layer policies.

One of the reinsurers on the second excess layer challenged the cedent’s allocation decision, which had resulted in a $47 million billing. It noted that a presettlement allocation analysis performed by the cedent showed risk of loss to the higher layer policies. Using that analysis, the reinsurer would have only been responsible for $24 million. The cedent filed suit for recovery of the full amount of the $47 million billing.

The district court granted summary judgment to the cedent, finding that the follow-the-settlements doctrine prevented the reinsurer from contesting the cedent’s postsettlement allocation decisions. The court awarded the cedent the full amount of what was outstanding from the original billing, and prejudgment interest. The reinsurer appealed.

On appeal, the Second Circuit Court of Appeals upheld the district court’s ruling that the follow-the-settlements doctrine prevented the reinsurer from challenging the cedent’s allocation of the settlement. It noted that the doctrine was designed to promote certainty, and allowing a reinsurer to challenge the factual underpinnings of an allocation decision would undermine that certainty. The court held that the follow-the-settlements doctrine extended to postsettlement allocation decisions even if those decisions were inconsistent with presettlement analyses, as long as the allocation met the typical follow-the-settlements requirements: good faith, reasonableness, and within the terms of the applicable policies.

Read the implications.
36. *North River Ins. Co. v. CIGNA Reins. Co.*, 52 F.3d 1194 (3d Cir. 1995)—Kate Woodall & Larry P. Schiffer

The reinsurer issued four facultative reinsurance certificates. The cedent sued to recover defense costs it paid on asbestos losses. The district court held that the certificates did not cover the defense costs. The Third Circuit Court of Appeals reversed and found that coverage of defense costs was reasonably within the terms of the underlying policies as reinsured.

The court analyzed the nature of reinsurance and provided a detailed explanation of the follow-the-fortunes doctrine. While noting that a follow-the-fortunes clause prevents a reinsurer from second-guessing good-faith settlements and obtaining a *de novo* review of judgments of the cedent’s liability to its insured, the court reiterated the teaching of *Bellefonte Reins. Co. v. Aetna Cas. & Sur. Co.*, 903 F.2d 910 (2d Cir. 1990), that the doctrine does not create reinsurance where there is no coverage. A loss is not covered by reinsurance if it was not contemplated by the underlying policy or if it was expressly excluded by the certificate. In this case, the certificate did not expressly exclude coverage for defense costs.

As the Wellington Agreement and the cedent’s arbitration with its insured under the Wellington Agreement were important factors in this case, the court analyzed these events carefully. The court noted that the arbitrator had examined the underlying policy language and determined that it did not expressly exclude payment of defense costs. The arbitrator found that defense costs were covered upon the insurer’s consent, which could not be unreasonably withheld. Because the cedent could not show that defense costs were excluded, the arbitrator found that the costs were covered.

In discussing the scope of its review, the court noted that, under the follow-the-fortunes doctrine, a reinsurer’s challenge may result in only deferential review of a determination of the cedent’s liability to the insured. The court stated that the reinsurer was bound to follow the cedent’s fortunes in settling claims unless the reinsurer could show that the cedent did not act in good faith or conduct a reasonable investigation. Thus, the question on review was whether there was any reasonable basis to find coverage.

The court stated that asking whether the risk was unreinsured was not tantamount to *de novo* review. In fact, the court strongly stated that *de novo* review of the cedent’s decision-making process would undermine the foundation of the cedent/reinsurer relationship.
In finding against the reinsurer, the court stated that the follow-the-fortunes doctrine requires a court to find reinsurance coverage unless the reinsurer demonstrates the liability to the insured was the result of fraud or not reasonably within the scope of the underlying policy. Because the reinsurer could prove neither, the court held that the reinsurer was liable for defense costs.

The court found that the arbitrator’s interpretation of the coverage for defense costs in the underlying policy was not unreasonable and that the reinsurer was unable to prove that the arbitrator’s construction was unreasonable under Ohio law.

The court also held that, as a matter of law, the cedent did not breach its duty of good faith by entering into the Wellington Agreement. The court adopted the standard of bad faith—gross negligence or recklessness—as the test for violations of the duty of good faith, and required that the reinsurer show economic injury resulting from the actions in order to prevail. While finding that the cedent’s parent considered the effect on its reinsurers of signing the Wellington Agreement, the court found that the cedent did not analyze the effect on its policyholders and individual policies. Nevertheless, because the reinsurer could not show, as a matter of law, economic prejudice by the cedent’s entering into the Wellington Agreement, the reinsurer could not prevail.

Remanded for the district court were the issues of noncompliance with the Wellington scheduling procedure and the cedent’s rejection of a settlement offer during the arbitration with its insured, both of which the court held were matters of fact as to whether these circumstances amounted to bad faith and economic injury.

As a final matter, the court rejected the reinsurer’s cross-appeal of the denial of its motion for reconsideration to include, as an alternative basis for summary judgment, that the reinsurance certificates capped the reinsurer’s liability.

Read the implications.
Reinsurers were parties to a management agreement authorizing the manager to underwrite and manage reinsurance business on their behalf. Reinsurers brought claims in arbitration against the manager for fraud and other wrongful conduct occurring during the course of the management agreement. During the arbitration, the arbitral panel entered an interim final order establishing an escrow account for balances due from reinsurers if the management agreements proved valid after arbitration. The validity of the interim order was confirmed and enforced by the district court.

On appeal, the Ninth Circuit Court of Appeals rejected the reinsurers' argument that the interim order was a nonfinal award that could not be confirmed under the Federal Arbitration Act (FAA). The court stated that temporary equitable relief in arbitration may be essential to preserve assets or enforce performance which, if not preserved or enforced, may render a final award meaningless.

Accordingly, the court characterized the interim award as a confirmable, final award on an issue distinct from the controversy on the merits that was subject to judicial review under the FAA. The Ninth Circuit held that temporary equitable orders calculated to preserve assets or performance are final orders that can be reviewed for confirmation and enforcement by district courts under the FAA.

Read the implications.
The cedent issued a policy to its insured against liability for personal injuries arising out of the operation of insured vehicles up to $15,000 for injuries to any one person in any one accident. The cedent retained $5,000 of this coverage and ceded the excess to the reinsurer. While the policy and reinsurance treaty were in effect, the insured was sued. During the litigation, an opportunity to settle the suit was missed. Instead, a verdict substantially in excess of the policy limits was obtained against the insured. As a result, the insured sued the cedent for alleged negligence and bad faith in failing to settle the suit. The cedent settled the suit with its insured and brought suit against its reinsurer to recover two-thirds of the amount paid in the settlement and associated expenses, and two-thirds of the expenses incident to the defense of the suit.

Even though the reinsurance contract did not expressly provide coverage for claims in excess of the underlying policy limits, the Fourth Circuit Court of Appeals required the reinsurer to share in the judgment against the cedent. According to the court, several factors motivated its decision. First, the reinsurer knew as much about the underlying case as did the cedent. Second, the reinsurer appreciated the risks involved and had a “sounder” perspective than the cedent. Third, because cedent retained $5,000 of the risk, it stood to gain rather than lose by a settlement within the policy limits. Finally, the reinsurer was consulted by the cedent regarding the underlying litigation and left the decision to settle exclusively in the cedent’s hand.

In the court’s eyes, the reinsurer’s decision to leave the decision to settle exclusively in the cedent’s hands made the cedent’s resulting decision the joint decision between the reinsurer and the cedent. The court concluded that the reinsurer was bound along with the cedent by the decision in the underlying case, regardless of whether that decision was “sound or unsound, favorable or unfavorable” and that “the liability of Peerless ‘shall follow that of’ Inland.”

Read the implications.

The cedent had entered into two general reinsurance contracts with the reinsurer. The reinsurer became insolvent and was ordered into liquidation. Prior to liquidation, the now-insolvent reinsurer had paid the cedent on losses under the reinsurance contracts. The cedent obtained a salvage recovery on those losses, and the liquidator demanded that the cedent pay the insolvent reinsurer its share of that recovered salvage. The cedent, however, sought to offset that salvaged amount against amounts owed to it by the insolvent reinsurer on a separate indemnity agreement arising from a surety bond issued in its favor.

The motion court struck the defenses and setoff claims and judgment was entered on the amount demanded in the complaint by the liquidator. The intermediate appellate court affirmed, and the matter was appealed by permission to the New York Court of Appeals, which affirmed the judgment.

In affirming the judgment, the court noted that the reinsurance contract contained a follow-the-settlements clause, which binds the reinsurer to pay the claims made by the cedent absent bad faith. Thus, the reinsurer could not question any decision made or action taken by the cedent concerning any claim, but the cedent was bound to act in good faith. The court also noted that, by the express terms of the reinsurance contract, the agreement was “regarded by the parties hereto as an honorable engagement rather than as a mere legal obligation.” Thus, the reinsurer was entitled to its share of the salvage recovery under the terms of the reinsurance agreement and the funds collected by the cedent as a trustee for the reinsurer.

The court noted that the cedent could not avoid this result by proof of general custom or usage because that could not be used to alter, vary, or contradict unambiguous contract provisions or change legal obligations assumed by the parties under their contracts.

On the offset issue, the court found that the claim arose subsequent to the liquidation. Offsets are allowable only if they come within the terms of the insurance law and must be mutual debts or mutual credits. Here, the offset claimed by the cedent was not mutual within the meaning of the statute and could not be offset against the claim for the salvage recovery.

*Read the implications.*
The cedent group was comprised of several property and casualty insurance companies. The members of the cedent group entered into several reinsurance agreements through which the reinsurer agreed to reinsure the risks covered by certain insurance companies within the cedent group. Each reinsurance agreement contained a broad arbitration clause governing all disputes arising thereunder.

In the 1980s, the cedent became insolvent. The court appointed the California Insurance Commissioner as liquidator and trustee for the cedent. Under the California Insurance Code, creditors of an insurance company in liquidation must file proof of their claims with the liquidator to recover debts owed by the insolvent insurer. The liquidator may accept and pay the claim pursuant to a statutory order of priority or reject the claim. If the liquidator rejects the claim, the debtor may seek an order to show cause from the superior court requiring the liquidator to establish the reasoning for rejecting the claim.

At the time of liquidation, one of the cedent companies owed the reinsurer certain outstanding funds under one of the reinsurance agreements. Additionally, the reinsurer owed a different company in the cedent group certain outstanding funds under the terms of another reinsurance agreement. The reinsurer filed a proof of claim with the liquidator against the cedent in 1987 seeking to recover those outstanding funds owed by the cedent. The liquidator rejected this claim. The reinsurer sought an order to show cause from the superior court.

In 1990, the liquidator filed a claim against the reinsurer in superior court seeking to recover the outstanding amounts the reinsurer owed to the cedent. The reinsurer filed and was granted a motion to remove the proceeding to federal court based on diversity of citizenship. Initially, the district court granted the liquidator’s motion to remand the proceeding to state court. That order, however, was vacated by the Ninth Circuit Court of Appeals. The U.S. Supreme Court affirmed the circuit court’s ruling vacating the order of remand. Thereafter, the reinsurer moved to stay the federal court proceeding and compel arbitration. The district court granted Allstate’s motion. The liquidator appealed.

On appeal, the liquidator asserted that the McCarran-Ferguson Act, which precludes state insurance regulation from preemption by federal law, would

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**40. Quackenbush v. Allstate Ins. Co., 121 F.3d 1372 (9th Cir. 1997)—Caroline Billet & Larry P. Schiffer**
prohibit the application of the Federal Arbitration Act (FAA), thereby barring arbitration of the liquidator’s claim against the reinsurer.

The Insurance Code, however, only precluded arbitration for claims asserted by creditors against insolvent insurance companies. There was no provision in the Code that barred arbitration of claims asserted by the liquidator of an insolvent insurance company on its behalf. Accordingly, no conflict existed between the Code and the FAA that would preclude its application under the McCarran-Ferguson Act.

While the liquidator could not be compelled to arbitrate the claim brought by the reinsurer under the Code, the Code contained no restriction preventing arbitration of the claim asserted by the liquidator against the reinsurer. Therefore, pursuant to the broad terms of the arbitration provision contained in the reinsurance agreement at issue, the circuit court affirmed the motion to compel arbitration of the liquidator’s claim against the reinsurer.

*Read the implications.*
Two arbitrators failed to disclose that they were simultaneously serving as panel members in another arbitration that the retrocessionaire contended was related to the arbitration at issue (similar issues, related parties, overlapped in time) and which involved one common witness. The district court concluded that these factors indicated that the two arbitrators’ simultaneous service was a material conflict of interest and that the failure to disclose this conflict of interest required vacatur of the arbitration award under the evident partiality standard of § 10(a)(2) of the Federal Arbitration Act (FAA).

In reversing, the Second Circuit Court of Appeals distinguished evidence of a potential conflict of interest from evidence of evident partiality. The circuit court ruled that the failure to disclose concurrent service in a similar arbitration was not indicative of evident partiality. Concurrent service, the court said, does not, in itself, suggest a predisposition to rule in any particular way. The FAA’s evident-partiality standard, the court held, was directed to the question of bias. Thus, if an undisclosed matter was not suggestive of bias, vacatur based on that nondisclosure could not be warranted under an evident-partiality theory.

In analyzing the underlying facts against the test of bias, the court ruled that the retrocessionaire did not meet its burden of establishing that the arbitrators’ service in the other arbitration was indicative of bias in the present proceeding so as to constitute a nontrivial conflict of interest. While the undisclosed matter was overlapping arbitral service, it was not a material relationship with a party.

The court found no indication that either arbitrator was predisposed to rule in any particular way in the present arbitration because of the other arbitration. The court noted that adverse rulings alone rarely evidence partiality. The court stated that, just because one arbitration resembles another in some respects, it does not suggest the arbitrator is likely to be biased in favor of or against any party.

The circuit court outlined how courts should review these situations. It adopted the Fourth Circuit’s factors in determining the applicability of the evident-partiality test, which in summary form may be outlined as follows:
(1) EXTENT AND CHARACTER OF THE PERSONAL INTEREST;
(2) DIRECTNESS OF THE RELATIONSHIP BETWEEN THE ARBITRATOR AND PARTY;
(3) THE CONNECTION OF THAT RELATIONSHIP TO THE ARBITRATOR; AND
(4) THE PROXIMITY IN TIME BETWEEN THE RELATIONSHIP AND THE ARBITRATION.

The court stated that these factors are useful but not mandatory or dispositive. The court ruled that, to determine if a relationship is material, the district court must look to how strongly the relationship tends to indicate the possibility of bias, not how closely the relationship relates to the facts of the arbitration. It is not appropriate, said the court, to vacate an award solely because an arbitrator fails to consistently live up to the arbitrator’s announced standards for disclosure or conform in every instance to the parties’ disclosure expectations. The court held that the nondisclosure, by itself, did not constitute evident partiality.

While in no way condoning the failure to disclose the arbitrators’ service in the other arbitration, the circuit court explained why it was inappropriate to examine the failure to disclose. The court stated that examining why there was a failure to disclose would interject added uncertainty and subjectivity into an evident-partiality analysis. The court noted that it would have been better for the arbitrators to disclose this relationship, but disclosure was not required to avoid vacatur because the relationship did not significantly tend to establish partiality. The court emphasized that disclosure was the better course, but it was not necessarily the only permissible one.

Read the implications.
Case Summaries

Reinsurers owed reinsurance payments to the reinsured under various reinsurance contracts, but the reinsured had become insolvent. The liquidator of the reinsured sought to collect those reinsurance proceeds from the reinsurers to distribute to all creditors of the insolvent reinsured. Because of the reinsured’s insolvency, the New Jersey Property-Liability Guaranty Association (the “Guaranty Association”) paid claims on behalf of the reinsured to New Jersey policyholders and claimed a right of reimbursement from the assets of the insolvent reinsured. These competing claims for reinsurance proceeds by the liquidator of the insolvent reinsured and the Guaranty Association ended up in federal court for resolution.

In deciding the case in favor of the liquidator, the court provided a detailed analysis of the interplay between insurance liquidation and reinsurance. The case turned on contract interpretation of the insolvency clause in the reinsurance agreements. That clause provided that reinsurance proceeds must be paid in full, regardless of the insolvency, to the statutory successor to the insolvent reinsured. The clause stated that, in the event of the reinsured’s insolvency, reinsurance proceeds shall be payable to its “liquidator, receiver, or statutory successor, except as provided by” a section of the New York Insurance Law not relevant to this determination.

The court explained that reinsurance is the ceding by one insurance company to another of all or a portion of its risks for a stipulated portion of the premium, in which the liability of the reinsurer is solely to the ceding company. The reinsurer’s liability to pay was conditioned on the reinsured’s prior payment of loss. The court noted that New York courts have refused to consider the insured to be a third-party beneficiary of the reinsurance contract even if the reinsured becomes insolvent.

The court also explained the significance of reinsurance. “The primary significance of reinsurance is that the insurer may treat it as an asset on its financial statements.” By using reinsurance, “an insurer can spread the risk it undertakes over a larger number of policies, effectively reduce the amount of reserves required to maintain its business, and increase its profitability.” The court also provided a history lesson into the creation of the insolvency clause in reinsurance contracts by describing the decision in *Fidelity & Deposit Co. v.*

**Pink**, 302 U.S. 224 (1937), in which the U.S. Supreme Court upheld a reinsurer’s narrow reading of the indemnity provision in a reinsurance contract that permitted the reinsurer to escape liability because the reinsured was insolvent and was not paying claims.

As a result of that case, New York enacted a law that required a clause in every reinsurance contract providing for full payment by a reinsurer when a reinsured becomes insolvent or the reinsured would not be able to account for the reinsurance as an asset on its financial statements.

Based on this analysis, the court concluded that the insolvency clause in the reinsured’s reinsurance contracts required that its liquidator recover all reinsurance proceeds. The Guaranty Fund, created after the reinsurance contracts were entered into, made it illogical to suggest that the reinsurance contracts intended to confer the proceeds to a nonexistent party in violation of the principal purpose for entering into the reinsurance transaction.

The decision goes on to explain the then existing pro rata creditor distribution system for insurance insolvencies and how the Guaranty Fund would share equally with all other creditors. That pro rata system has since been altered by a series of statutory changes, and today the guaranty associations receive a priority of distribution of the insolvent’s assets.

*Read the implications.*
The reinsurer agreed to reinsure certain insurance contracts issued by the cedent. Unhappy with the terms of the agreements, the reinsurer sought to have the reinsurance contracts declared void in a declaratory judgment action. The cedent moved to dismiss the action and compel arbitration.

The district court granted the cedent’s motion, finding that the dispute was subject to the agreements’ arbitration clauses. The reinsurer appealed to the Second Circuit Court of Appeals, which affirmed in part and reversed in part the decision of the district court.

On appeal, the reinsurer argued that the district court should not have compelled arbitration because the reinsurance contracts, and therefore the arbitration clauses, were unenforceable. The court explained that, where the making of the agreement to arbitrate is placed in issue, the dispute cannot be arbitrated. The reinsurer argued that it had placed the making of the agreement for arbitration in issue by showing its underwriting agent had failed to act within the scope of its agency in accepting the contracts. Specifically, the reinsurer asserted that the agent “exceeded its underwriting authority by writing premiums in an amount that exceeds the amount authorized by Sphere and that Stirling Cooke, Clarendon’s agent, knew of this.” The reinsurer went on to argue that its agent’s failure to act within the scope of its agency rendered the reinsurance contracts and their arbitration clauses void ab initio.

The court explained that, in analyzing whether to declare an arbitration clause void, there is an important distinction between voidable contracts and contracts that are void. If a party alleges that a contract is void, then the entire contract, including the arbitration clause can be declared void. On the other hand, if a party alleges that a contract is voidable, that party must also specifically allege that the arbitration clause itself is voidable.

The court held that, of the contracts in question, there was sufficient evidence to support finding only one of the contracts was void. In that one instance, the reinsurer was able to produce a memo from the cedent’s agent.
that demonstrated their knowledge of the reinsurer’s agent exceeding its authority. As the reinsurer’s “attack on these contracts relates to the contracts in general, and not the arbitration clauses specifically,” the court held that the reinsurer needed to show for every contract that the entire contract was void. Absent that showing, the reinsurer was only entitled to trial on that one contract. All others were subject to arbitration.

Read the implications.

FUNDAMENTALS OF REINSURANCE AND REINSURANCE MARKETS

Gain a practical grounding in the fundamentals of reinsurance and the marketplace.

Experienced authors Steven M. McElhinney and Teresa Huddleston address the key and unique aspects of reinsurance and also provide an overview of its history and future. This book summarizes the basics and provides an overview of specific aspects such as claims, accounting, and captives.

Those who are new to reinsurance purchasing, underwriting, or sales will benefit from this book. Using examples, easy-to-understand illustrations, and handy checklists, it is a timely, real-world introduction to the highly specialized field of reinsurance.
This case involved an “all-risks” policy issued by the cedent to a New York steel mill. Typical of the industry, the insured used a small quantity of cesium, a radioactive material, in a device that measured the factory’s output. The cedent agreed to provide the same coverage that was issued to the steel mill by its previous insurer, which included losses resulting from radioactive contamination.

The cedent’s offering telex to its reinsurers noted that the insured operated a steel mill and disclosed the identity of the previous insurer, but did not contain any explicit reference to the provision of radioactive contamination coverage. After the reinsurers’ acceptance by telex, but before actual copies of the policies were provided to the reinsurers, the insured suffered a loss arising from radioactive contamination. Formal certificates of reinsurance were issued by the reinsurers after having received notice of the insured’s claims. The reinsurers subsequently refused to contribute to a settlement payment made by the cedent, contending that they would not have entered into the reinsurance agreement had the cedent disclosed that the primary policy covered incidental radioactive contamination.

The New York Court of Appeals rejected the reinsurers’ claim that they were entitled to rescission of the reinsurance agreement due to the cedent’s failure to disclose a material coverage risk. The court held that the reinsurers waived any right to rescission through their conduct, e.g., issuance of the certificates of reinsurance after notice of the insured’s claim, and due to their failure to assert that alleged right within a reasonable time. The court also noted that a cedent is obligated to disclose to potential reinsurers all “material facts” concerning the original risk, but has no obligation to disclose terms that are generally found in policies of that nature.

Read the implications.
The cedent provided ocean marine insurance to a freighter with a charter from New York to San Francisco. The freighter then obtained a second charter, for which the cedent provided additional insurance. Because the insurance on the second charter was also deemed to be in effect during the first charter, the first charter was overinsured. The cedent then purchased reinsurance on the full limits for both charters, but did not reveal the second charter to the reinsurer. The vessel was lost during the first charter, and the reinsurer declined to indemnify the cedent.

The U.S. Supreme Court found for the reinsurer and explained that, “[i]n respect to the duty of disclosing all material facts, the case of reinsurance does not differ from that of an original insurance. The obligation in both cases is one of uberrimoe (sic) fidei.” The court went on to adopt a rule that the cedent has a duty to:

PLACE THE UNDERWRITER IN THE SAME SITUATION AS HIMSELF; TO GIVE TO HIM THE SAME MEANS AND OPPORTUNITY OF JUDGING THE VALUE OF THE RISKS; AND, WHEN ANY CIRCUMSTANCE IS WITHHELD, HOWEVER SLIGHT AND IMMATERIAL IT MAY HAVE SEEMED TO HIMSELF, THAT, IF DISCLOSED, WOULD PROBABLY HAVE INFLUENCED THE TERMS OF THE INSURANCE, THE CONCEALMENT VITIATES THE POLICY.

The U.S. Supreme Court reversed the circuit court and found that the concealment of the overinsurance in this case violated the duty of utmost good faith as the cedent failed to communicate information that would have influenced the judgment of a prudent underwriter. The court also noted that it was immaterial whether the concealment of the overinsurance was intentional or inadvertent.

This decision has become the seminal opinion establishing that the doctrine of utmost good faith applies to reinsurance contracts.

Read the implications.
The cedent settled two large groups of environmental injury claims brought against two insureds. The claims covered multiple sites across the country and contamination that occurred over decades. In settling the claims, the cedent allocated the sites as separate occurrences under its underlying insurance policies.

After ceding losses to facultative reinsurers, the cedent sought to treat each settlement for each insured as a single “disaster and/or casualty” under the terms of the applicable excess-of-loss reinsurance treaties. The definition of “loss” in the treaties provided that a “disaster and/or casualty” included all loss “resulting from a series of accidents, occurrences and/or causative incidents having a common origin and/or being traceable to the same act …” and further provided that such loss “shall be considered as having resulted from a single accident....”

The treaties also contained a “follow-the-fortunes” clause providing that “[a]ny and all payments made by [the cedent] in settlement of loss or losses under [its] policies ... shall be unconditionally binding upon the [reinsurers]...” upon showing proofs of loss and that “[t]he [reinsurers] agree to abide by the loss settlements of [the cedent], such settlements to be considered as satisfactory proofs of loss.”

The reinsurers did not accept the cedent’s allocation, and litigation ensued. In both cases, the trial court held that the cedent’s allocation did not fall within the terms of the applicable reinsurance treaties. The trial court’s determinations were affirmed at the intermediate appellate level.

In affirming the holdings below, the court of appeals first examined whether the cedent’s allocation was allowed under the terms of the reinsurance contracts. In finding for the reinsurers, the court rejected the cedent’s interpretation of the “common origin” language in the treaties and held that the words “series of” modified “common origin.”

Aggregation, the court held, was proper only if the occurrences had a spatial or temporal relationship to one another and a common origin. Here, there was no spatial or temporal relationship among the occurrences, and the claims...
could not be aggregated even if there were a common origin under the terms of the applicable reinsurance treaties. As a matter of law, the court held, the cedent’s single allocations of its settlements did not fall within the “disaster and/or casualty” language in the reinsurance treaties.

Next, the court addressed the cedent’s claim that the reinsurers were bound to accept its allocation under the follow-the-fortunes doctrine. The court rejected this contention, stating that a follow-the-fortunes clause does not alter the terms or override the language of reinsurance contracts. Here, the court held, the “follow-the-fortunes” clause cannot supplant the definition of “disaster and/or casualty” in the treaties.

Moreover, the court noted that cases upholding claims under follow-the-fortunes clauses involved challenges to the cedent’s decision to settle the claims under the terms of the underlying insurance policies. Here, the challenge was to the cedent’s allocation of the settlements based on the language of the reinsurance treaties, rendering those cases inapposite.

Read the implications.
The parties conducted an initial arbitration that resulted in an award in favor of the cedent. A confidentiality order was issued regarding the contents of the award and the arbitration. The cedent alleged that the reinsurer was not abiding by the terms of the first award, and a second arbitration was demanded.

In the second arbitration, the cedent named as its party arbitrator the same individual it had named in the earlier arbitration. The reinsurer objected, claiming that the cedent’s arbitrator had confidential information from the earlier arbitration that he was sharing with the panel members in violation of the confidentiality agreement. According to the reinsurer, this meant that the arbitrator was not disinterested as required in the party’s reinsurance contracts. The reinsurer also claimed that the second panel had erred in issuing an interim order allowing the use of materials used in the first arbitration and prohibiting the reinsurer from litigating issues decided by the previous order.

The district court sided with the reinsurer. It found that the cedent’s arbitrator had violated the confidentiality agreement by disclosing confidential information to other panel members and was no longer disinterested. The district court also found that the arbitration panel could not rule on the scope of the confidentiality agreement because that agreement did not contain an arbitration clause.

The Seventh Circuit Court of Appeals reversed, first finding that the reinsurer could not show the requisite irreparable harm required for an injunction. Although the court noted that, by making the reinsurer wait until after the panel issued an award to challenge the composition of the panel, added delays and expenses would result, delays and expenses were not considered irreparable harm.

The court could have stopped there, but fearing reputational harm to the disqualified arbitrator, the court went on to address the merits of the reinsurer’s argument.

The court noted that “disinterest” merely required that the arbitrator have no financial interest in the outcome of the litigation. Knowledge about a previous proceeding did not and could not make an arbitrator interested.
In fact, the court pointed out that the same district court judge that disquali-
fied the arbitrator also confirmed the first arbitration award and signed off on
the confidentiality agreement. As a result, the district court judge was as inter-
ested as the arbitrator, according to the Seventh Circuit.

Finally, the Seventh Circuit ruled that the arbitration panel was entitled to decide
the scope of the arbitration clause due to the broad arbitration provision.

*Read the implications.*
This case involved a facultative reinsurance certificate covering a high layer excess insurance policy. The cedent’s policy provided $30 million in excess of $76 million. The reinsurer argued that it was relieved from its obligations under the reinsurance certificate because the cedent failed to give prompt notice of its claim. The claims involved settlement of underlying asbestos personal injury claims. The reinsurance certificate provided that:

[P]ROMPT NOTICE SHALL BE GIVEN BY THE [CEDENT] TO THE UNDERWRITING MANAGERS ON BEHALF OF THE REINSURERS OF ANY OCCURRENCE OR ACCIDENT WHICH APPEARS LIKELY TO INVOLVE THIS REINSURANCE....

After a 9-day bench trial, the district court found that the cedent’s obligation to send a notice arose in April 1987, and, therefore, its provision of notice to the reinsurer in September 1987 was untimely. The district court, however, rejected the reinsurer’s late notice defense due to the reinsurer’s failure to show any prejudice arising from the late notice. On appeal, the Second Circuit Court of Appeals certified to the New York Court of Appeals the question of whether the “no-prejudice” rule, where a primary insurer does not need to prove prejudice to establish a late notice of claim defense, existed in the context of reinsurance.

The New York Court of Appeals found that the rationale for the “no-prejudice” rule in the context of primary insurance—loss of opportunity to investigate and vulnerability to fraud—did not apply in the reinsurance context. The court considered and rejected the reinsurer’s argument that the reinsurer’s “right to associate” with the cedent mirrored the rationales for the no-prejudice rule, and held that the loss of that entitlement was not sufficient to warrant a presumption of prejudice.

The court held that the reinsurer must demonstrate how the provision of late notice was prejudicial in order to establish its late notice defense. The court also noted that prompt notice was not made an express condition precedent under the terms of the reinsurance certificate.

Read the implications.
On this appeal, the Second Circuit Court of Appeals held that, for a reinsurer to disclaim coverage based on the loss of the right to associate, the reinsurer had to establish prejudice. The court also stated that the reinsurer bore the burden of proving prejudice. The court held that, to establish prejudice, the reinsurer had the burden of proving tangible economic injury arising from the loss of its “right to associate.”

The court recognized and refused to follow the decisions of other circuits in which the loss of the right to associate constituted prejudice without any actual proof that the reinsurer would have “associated” in the defense or that the association would have resulted in a more favorable ruling. The court stated that its interpretation of *Unigard Sec. Ins. Co. v. North River Ins. Co.*, 79 N.Y.2d 576, 594 N.E.2d 571, 584 N.Y.S.2d 290 (1992), was that more was required to show prejudice, i.e., that the reinsurer bore the burden of showing that it suffered tangible economic injury due to the loss of its right to associate.

Because the reinsurer’s only injury was based on its claim that the loss of contractual rights was prejudicial in and of itself, the court held that the reinsurer did not meet that burden.

*Read the implications.*
The New York Court of Appeals modified the order of the intermediate appellate court to deny summary judgment to the cedent based on two issues of fact raised to challenge the reasonableness of the cedent’s settlement allocation. The court affirmed the judgment rejecting the other defenses to payment raised by the reinsurers.

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

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

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

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

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

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

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

The allocation decision still had to be in good faith and reasonable. The court stated that:

\[
\text{IN OUR VIEW, OBJECTIVE REASONABLENESS SHOULD ORDINARILY DETERMINE THE VALIDITY OF AN ALLOCATION. REASONABLENESS DOES NOT IMPLY DISREGARD OF THE CEDENT’S OWN INTERESTS. CEDENTS ARE NOT THE FIDUCIARIES OF REINSURERS, AND ARE NOT REQUIRED TO PUT THE INTERESTS OF REINSURERS AHEAD OF THEIR OWN.}
\]

The court held that a cedent’s allocation “must be one that the parties to the settlement of the underlying insurance claims might reasonably have arrived at in arm’s length negotiations if the reinsurance did not exist.”

The court concluded that the cedent’s motive “should generally be unimportant. When several reasonable allocations are possible, the law, as several
courts have recognized, permits a cedent to choose the one most favorable to itself.” But, said the court:

\begin{quote}
THE CHOICE MUST BE A REASONABLE ONE, AND WE ALSO CONCLUDE THAT REASONABLENESS CANNOT BE ESTABLISHED MERELY BY SHOWING THAT THE CEDENT’S ALLOCATION FOR REINSURANCE PURPOSES IS THE SAME AS THE ALLOCATION THAT THE CEDENT AND THE INSURANCE CLAIMANTS ACTUALLY ADOPTED IN SETTLING THE UNDERLYING INSURANCE CLAIMS.
\end{quote}

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

In reversing the summary judgment decision, the court of appeals concluded that the reasonableness of the assumptions used in the allocation, that (1) all of the settlement amount was attributable to claims within the limits of the cedent’s policies, and none was attributable to the claims against the cedent for bad faith in refusing to defend the insured; and (2) all claims for lung cancer had a $200,000 value, while certain other claims had values of $50,000 or less, presented issues of fact that required a trial.

The court pointed to evidence in the record to show that a fact finder could conclude that an allocation giving no value to the bad faith claims was unreasonable and that assigning high values to lung cancer claims instead of allocating some of that value to bad faith or other claims was unreasonable. The court pointed to an underlying settlement demand that included a significant amount for bad faith presented just shortly before settlement and the parties’ arguments to the bankruptcy court to approve the plan partly on the basis that the bad faith claims had significant value. The court concluded that it was impossible to find, as a matter of law, that parties bargaining at arm’s length, in a situation where reinsurance was absent, could reasonably have given no value to bad faith claims.

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

Read the implications.
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