Excess, Surplus Lines And Reinsurance Committee

CONTINUING DEVELOPMENTS IN THE CREDIT FOR REINSURANCE MODEL LAW

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The 2011 adoption of revisions to the Credit for Reinsurance Model Law (#785) and the Credit for Reinsurance Model Regulation (#786) by the National Association of Insurance Commissioners (NAIC) continued the modernization of reinsurance regulation in the United States. These revisions apply to ceding carrier financial statement credit for reinsurance assumed by certified non-U.S. licensed reinsurers domiciled and licensed in qualified foreign jurisdictions that post less than 100% collateral under applicable standards. This article will provide a brief synopsis of the revised standards of Model #785 and Model #786, as well as an update on adoption of the model laws by individual states; discuss the NAIC’s ongoing process of developing and maintaining a list of jurisdictions that are qualified for reduced reinsurance collateral determinations; and also briefly discuss how the NAIC efforts to revise reinsurance collateral requirements relate to the Nonadmitted and Reinsurance Reform Act, which is part of the Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010.

NAIC Model Criteria

Prior to the revisions to Models #785 and #786, NAIC standards for U.S. ceding insurers to receive 100% reinsurance credit required that the reinsurance either be ceded to a licensed or accredited reinsurer or that the contract obligations of the assuming unauthorized reinsurer be secured by collateral equal to 100% of those obligations. This accreditation standard was considered archaic and overly costly by many industry participants. The adoption by the states of the revised reinsurance credit requirements set forth in Models #785 and #786 are optional and not required in order for a state to maintain NAIC accreditation. However, if an accredited state seeks to reduce reinsurance collateral requirements through the certification of reinsurers, its law must be substantially similar to the key elements of Models #785 and #786.

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LETTER FROM LAST RETIRING CHAIR

The Excess, Surplus Lines and Reinsurance Committee enjoyed a busy spring with many highlights at the Spring Leadership Meeting in Washington, DC. Our committee co-sponsored the dynamic ADR National CLE Forum, held on April 24th, with renowned mediator Ken Feinberg delivering the keynote address, and five engaging panels of judges, arbitrators, mediators, academics and in-house and outside counsel discussing the latest developments in ADR. ESLR also co-sponsored the Law in Public Service project on April 26th, where TIPS volunteers assisted local high school students by conducting mock job interviews with them. And ESLR saved time for socializing too -- taking in a Nats’ game on a beautiful Friday evening at Nationals’ Park.

The Annual Meeting in August capped a stellar year for our committee. ESLR was honored to receive an award from TIPS’ Leadership recognizing our achievements in Diversity Involvement. We also once again co-sponsored the Law in Public Service Committee’s project, which this time involved TIPS volunteers assisting At the Crossroads, a group that works with homeless youth in San Francisco.

The upcoming Fall Leadership Meeting in Minneapolis (Oct. 10-12) promises to be a great weekend. ESLR will be co-sponsoring a CLE program on insurance issues together with the Insurance Coverage Litigation Committee. The program – More Diligence Is Due: What Every Lawyer Must Know About Insurance – will be held on Thursday, Oct. 10 at 10 AM – 12 Noon. Michael Kotula, our incoming Chair, will hold our committee’s business meeting in Minneapolis on Friday, Oct. 11 at 1:30 – 2:30 PM. ESLR will also host a social event at some point during the weekend, so please look out for updates on our website and Linked In.

It has been a great pleasure serving as your Chair! If you are interested in becoming involved, join us at our business meeting or social event in Minneapolis, or email Michael Kotula, our new Chair, at michael.kotula@rivkin.com. I look forward to seeing you at a future TIPS meeting! 

Best regards,
Leah Quadrino
New York Court Of Appeals Reaffirms Pro Rata Time-On-The-Risk Allocation Rule, Holds That Sexual Molestation Constitutes Multiple Occurrences And That The Policyholder Must Bear A Full Self-Insured Retention For Each Policy Period

The New York Court of Appeals examined the significant issue of apportionment of liability for a settlement between the Roman Catholic Diocese of Brooklyn and a minor plaintiff in an underlying civil action alleging sexual molestation by a priest. The underlying complaint alleged that a priest sexually abused the minor plaintiff on several occasions from August 1996 through May 2002, and at several different locations. The Diocese settled the action for $2 million. The Diocese then sought reimbursement of the settlement under various primary CGL insurance policies, including under three annual CGL insurance policies issued by National Union Fire Insurance Company of Pittsburgh, Pa. The National Union policies afford coverage for damages because of bodily injury during the policy period, subject to a $250,000 self-insured retention (SIR).

In a declaratory judgment action between the Diocese and National Union, National Union maintained that the incidents of sexual abuse in the underlying action constituted a separate occurrence in each of the seven policy periods implicated (from 1996 through 2002), and required the exhaustion of a separate $250,000 SIR for each occurrence. National Union also sought a ruling that the $2 million settlement be allocated on a pro rata time-on-the-risk basis across each of the seven triggered policy periods. The Diocese, for its part, maintained that the sexual abuse constituted but a single occurrence, requiring the exhaustion of only one SIR, and that there should be no allocation of the liability, but rather the Court should adopt a “joint and several” or “all sums” approach to permit the Diocese to pick and choose which policy should respond to the loss.

The New York high court revisited its number of occurrences case law, discussing its decision in Appalachian Ins. Co. v. General Elec. Co., 8 N.Y.3d 162, 863 N.E.2d 994, 831 N.Y.S.2d 742 (2007), which held that absent policy language indicating an intent to aggregate separate incidents into a single occurrence, the unfortunate event test should be applied to determine how occurrences are categorized for insurance coverage purposes. The Court explained that the unfortunate event test requires consideration of whether there is a close temporal and spatial relationship between the incidents giving rise to injury or loss and whether the incidents can be viewed as part of the same causal continuum without intervening agents or factors.

Applying this rule to the sexual abuse claims in dispute, the Court concluded that there was nothing in the policy language that evinced an intent to aggregate the incidents of sexual abuse into a single occurrence, and that “the incidents of sexual abuse within the underlying action constituted multiple occurrences.” The Court explained, “[c]learly, incidents of sexual abuse that spanned a six-year period and transpired in multiple locations lack the requisite temporal and spatial closeness to join the incidents.” This was held to be true notwithstanding that the policies define “occurrence” as including “continuous or repeated exposure to substantially the same general harmful conditions.” The Court concluded that “sexual abuse does not fit neatly into the policies’ definition of ‘continuous or repeated exposure’ to ‘conditions,’” which it found sounds like language designed to deal with asbestos fibers in the air or lead-based paint on the walls, rather than with priests and choirboys.

Further, in another significant holding, the Court held that the Diocese had to exhaust the SIR for each occurrence that transpires within an implicated policy from which it seeks coverage. The Court noted that the policies provide that the SIR “shall apply separately to each occurrence” and only to “occurrences covered under [the] policy.” It explained, “[t]he only occurrences that are subject to the policies are those with damages resulting from bodily injuries that occur within the policy period.” Accordingly, the Court held that “the SIR applies to an occurrence with bodily injuries within the policy period, not to an occurrence with injuries sustained in a subsequent policy year.”

Finally, the Court adhered to the pro rata time-on-the-risk allocation rule that it previously adopted in connection with the decision to affirm a ruling that claims against certain high-level excess policies failed to present a justiciable controversy, in Consolidated Edison Co. of New York, Inc. v. Allstate Ins. Co., 98 N.Y.2d 208, 774 N.E.2d 687, 746 N.Y.S.2d 622 (2002). Here, however, the Court concluded it was appropriate to actually allocate liability using the pro rata time-on-the-risk approach. The Court explained that “[p]lainly,
the policy’s coverage is limited only to injury that occurs within the finite one-year coverage period of the policy.” Thus, “assuming that the minor plaintiff suffered ‘bodily injury’ in each policy year, it would be consistent to allocate liability across all implicated policies, rather than holding a single insurer liable for harm suffered in years covered by other successive policies.”


Illinois Appellate Court Holds Umbrella And Excess Insurers Have Standing To Object To Coverage Agreement Between Policyholder And Primary Insurer, The Horizontal Exhaustion Doctrine Requires Policyholder To Prove That All Of The Primary Policy Limits, As Originally Written, Were Exhausted Before The Umbrella And Excess Insurers Afford Coverage, And All Triggered Policies Were Jointly And Severally Liable For Asbestos Bodily Injury Liabilities

An Illinois Appellate Court addressing an asbestos bodily injury insurance coverage dispute between John Crane, Inc. and its umbrella and excess insurers has held that those insurers have standing to object to a coverage agreement between John Crane and one of its primary insurers. Further, the Court adhered to the rule that the horizontal exhaustion doctrine requires the policyholder to prove that all of the primary policy limits, as set forth in the primary policies and not as revised in the coverage agreement, were exhausted before the umbrella and excess insurers afforded coverage. Finally, the Court held that all triggered policies were jointly and severally liable for the asbestos bodily injury liabilities, rejecting application of a pro rata time-on-the-risk allocation rule.

The policyholder attempted to claim premature exhaustion on the basis of an agreement with Kemper that primary policies issued by Kemper that had annual limits of $2 million, with defense costs in addition to the limits, instead had defense costs within the limits. The umbrella and excess insurers objected to the coverage agreement as proof of exhaustion of the Kemper primary policies. The Illinois Appellate Court held that “[t]his change in the primary policy limits clearly affects a legally cognizable interest of the excess and umbrella insurers.” In addition, the Court concluded that the horizontal exhaustion doctrine requires Crane to prove that all of Kemper’s primary policy limits, as written before the parties entered into the [coverage agreement], were exhausted before the umbrella or excess carriers would be required to contribute to any settlement or judgment.

Further, the Court adhered to the joint and several liability rule of Zurich Ins. Co. v. Raymark Industries, Inc., 118 Ill. 2d 23, 514 N.E.2d 150 (1987), and held that “where coverage for asbestos-related injury claims is triggered for bodily injury or sickness or disease, all triggered policies are jointly and severally liable.”


Indiana Appeals Court Holds That Environmental Site Release In Settlement Agreement With Insurer Who Issued Primary And Excess Insurance Policies Covered The Excess Policies

The Indiana Court of Appeals weighed in on whether a settlement agreement between the policyholder, Warsaw Chemical Company, and its insurer, USF&G, containing an environmental site release, but a recital identifying only primary CGL insurance policies issued by USF&G, covered the excess policies issued by USF&G. The Court concluded that the environmental site release was operative to release all claims under any and all policies issued by USF&G.

In 1992, in exchange for $25,000, Warsaw released USF&G from claims or demands related to the environmental remediation of its Warsaw, Indiana facility. The Release and Settlement Agreement contained a recital or “whereas” clause, stating “WHEREAS, USF&G issued to Warsaw the following comprehensive general liability insurance policies for the following policy periods: [identifying primary CGL insurance policy numbers and policy periods].” Nowhere in this recital or in the Release and Settlement Agreement were the excess policies issued by USF&G identified. Nonetheless, the Agreement contained an environmental site release, releasing and discharging USF&G “from any further claims, demands, causes of action, damages, clean-up costs, … costs or losses of
any kind and nature whether known or unknown ... arising from, or in any way related to, the pollution and contamination of the soil and groundwater in, upon or adjacent to the Warsaw facility in Warsaw, Indiana.”

USF&G maintained that the environmental site release covered its excess policies issued to Warsaw, while Warsaw maintained that it did not. The Agreement apparently did not contain a specific provision stating whether the recitals were to be given operative effect. However, the Court held that Indiana courts have held that “preliminary recitals of the contract may be of some value, but they are not contractual, and cannot be permitted to control the express provisions of the contract which are contractual in nature.” The Court concluded that the environmental site release language clearly releases USF&G from “any further claims” related to pollution and contamination at the Warsaw facility, without reference to different types of insurance coverage. Moreover, it found that the recitals referencing only the primary policies may not be used to interpret the unambiguous operative language of the site release.


Massachusetts Appeals Court Holds That The Boston Gas Pro Rata Time-On-The-Risk Allocation Rule Applies To Asbestos Bodily Injury Coverage Dispute

Following the Supreme Judicial Court of Massachusetts’ decision in Boston Gas Co. v. Century Indem. Co., 454 Mass. 337, 910 N.E.2d 290 (2009), which applied a pro rata time-on-the-risk allocation rule in an environmental property damage context, the Massachusetts Appeals Court applied the same rule in an asbestos bodily injury case. In doing so, the Court rejected arguments by the policyholder that the particular CGL policy wording mandated the use of a joint and several liability approach.

The policyholder argued that the primary CGL policies issued by Liberty Mutual, unlike the policies in Boston Gas, defined the term “bodily injury” to incorporate the phrase “during the policy period” and that this had the effect, together with the phrase “including death at any time resulting therefrom,” to provide coverage on a joint and several basis for bodily injuries that occur but do not necessarily end during the policy period.

The Court held that the formulation of “bodily injury” in the Liberty Mutual policies did not mandate use of the joint and several liability approach. It found that the definition simply provides that “in the typical case where the time of injury is easily determined, the policy in place when the injury occurs will cover all consequential damages, even those taking place after the policy period.” The Court concluded that “in cases involving injury that develops insidiously over time, it is not readily apparent how to allocate the loss to a particular policy.” The Court observed that, because in asbestos cases, no less than progressive environmental damage cases, it is scientifically and administratively impossible to allocate to each policy the liability for injuries occurring only within its policy period, there was no persuasive reason to depart from Boston Gas. Accordingly, the Court held that the pro rata time-on-the-risk allocation rule applied and that the policyholder was required, under Boston Gas, to participate in the allocation during periods when it could not buy insurance covering asbestos-related claims.


Fifth Circuit Holds That Policyholder’s Failure To Provide Notice Of An Escape Of Pollutants Within 30 Days As Required By An Endorsement To The Policy Constituted Late Notice And No Showing Of Prejudice Was Required

An excess liability policy contained an absolute pollution exclusion clause, barring coverage for the consequences of a release or escape of toxic chemicals or pollutants. The policy, however, also contained a buy-back provision that deleted the exclusion and replaced it with a new provision providing coverage under certain specific conditions. One such condition was that any discharge or escape of pollutants must be reported “within 30 days after having been known to the assured.” The policyholder did not report a triggering incident until 59 days after it learned of the chemical release.

The United States Court of Appeals for the Fifth Circuit, applying Texas law, held that the excess insurer was justified in denying coverage under the specific terms of the buy-back provision which the parties had negotiated to replace the original pollution exclusion.
This was the holding in a previous Fifth Circuit decision, *Matador Petroleum Corp. v. St. Paul Surplus Lines Ins. Co.*, 174 F.3d 653 (5th Cir. 1999) (Texas law). The Court specifically concluded that, under these circumstances, the plain language of the endorsement had to be respected “regardless of any prejudice suffered” by the excess insurer as a result of the late notice.

The policyholder argued that *Matador* was no longer good law in light of two more recent Texas Supreme Court decisions involving late notice and prejudice requirements. The Fifth Circuit was unconvinced. It found that *Matador* remained good law and that “a notice requirement in this type of supplemental pollution endorsement is essential to the bargained-for coverage.” In addition, the Court rejected an invitation to limit *Matador* to primary policies, finding “no basis for applying a different rule to excess carriers when interpreting the meaning of a contractual provision.”


**Pennsylvania Appellate Court Holds That Policyholder Has The Burden Of Apportioning A Settlement Between Covered Claims And Excluded Claims**

Cigna faced claims in multi-district litigation where doctors countrywide sued HMOs, including Cigna, alleging the providers had been underpaying claims by billions of dollars. The claims against Cigna included excluded breach of contract claims and covered RICO claims. Cigna reached a settlement of the claims, agreeing to pay $140 million. Executive Risk was one of Cigna’s excess insurers, who attached at $65 million. Executive Risk refused to indemnify Cigna for the settlement, maintaining that its attachment point was not reached because the bulk of the settlement was allegedly paid for the excluded breach of contract claims and not because of the covered RICO claims.

The Pennsylvania Superior Court held that “the insured is the party that should bear the burden of proof for apportionment of claims in this case,” concluding that this is “best proven by the insured, the party that has access to the evidence and the parties’ intent behind the settlement process.”


**Oklahoma Supreme Court Answers Certified Question From The Tenth Circuit, Holds That A Second-Layer Excess Insurer Can Assert Claim Against First-Layer Excess Insurer**

The Grand River Dam Authority purchased first-layer excess insurance from Steadfast Insurance Company from 1993 through 2002, and second-layer excess insurance from Agricultural Insurance Company for the same period. Steadfast defended the Dam Authority against numerous flooding claims made during this period. The flooding took place during the full nine year period from 1993 through 2002, but the Dam Authority and Steadfast entered an agreement that the costs paid by Steadfast for those claims would be allocated to only a single policy in effect from 1993 to 1994. Agricultural objected to this agreement and maintained that it artificially triggered Agricultural’s second-layer excess policy by shifting costs payable by Steadfast to Agricultural.

Agricultural claimed a right to equitable subrogation against Steadfast for the costs the agreement improperly shifted from Steadfast to Agricultural. Steadfast convinced the District Court that equitable subrogation is based on a right derived from the insured and the release in question extinguished all rights the Dam Authority had against Steadfast. In response to a certified question of law from the United States Court of Appeals for the Tenth Circuit, the Oklahoma Supreme Court held that a second-layer excess insurer had a right to pursue an equitable subrogation claims against a first-layer excess insurer under these circumstances.

In reaching this result, the Court discussed case law concerning the “derivative right rule,” accepted by the District Court and contrasted it with case law of the view that equitable subrogation can be pursued in spite of a release by an insured. The Court concluded that “the derivative right rule relied upon by Steadfast … is inconsistent with Oklahoma’s broad view of equitable subrogation.” Further, the Court stated that “Steadfast’s notice, if any, of the impact that the settlement and release would have on Agricultural’s coverage must be considered in balancing the equities.” In addition,
“[a]nother relevant consideration is whether [the Dam Authority’s] settlement with Steadfast, and its effect on Agricultural’s coverage, is consistent with [the Dam Authority’s] implied duty to deal fairly and in good faith with Agricultural.” The Court underscored that “[a]n excess insurer has a reasonable economic expectation that it will not be responsible on its policy until the insurance at the level lower to the excess insurer has been exhausted in accordance with the express provisions and obligations of the insurance contract.”


Second Circuit, Applying New York Law, Holds That Excess Coverage Attaches Only After Underlying Insurance Is Exhausted By Payment Of Losses, Not By Obligations That Have Not Been Paid

A policyholder attempted to access excess directors and officers insurance coverage “once the total amount of [the Directors’] defense and/or indemnity obligations exceeds the limits” of the underlying insurance. The excess insurer maintained that its excess insurance coverage attaches only after the underlying insurance limits are exhausted “as a result of payment of losses thereunder,” in accordance with the excess policies’ exhaustion clause.

The United States Court of Appeals for the Second Circuit, applying New York law, agreed with the insurer, Federal Insurance Company, explaining “‘obligations’ are not synonymous with ‘payments’ on those obligations. To hold otherwise would make the ‘payment of’ language in these excess liability insurance contracts superfluous.” In addition, the Second Circuit specifically rejected arguments that Zeig v. Massachusetts Bonding & Ins. Co., 23 F.2d 665 (2d Cir. 1928), mandated a contrary result.


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REINSURANCE CASE NOTES

Eighth Circuit Holds Jurisdiction Clause Endorsement Supersedes ADR Clause

Many cases over the last several years have addressed the perceived conflict between the arbitration clause and the service-of-suit clause. In those cases, most courts have found that the arbitration clause takes precedence and is enforceable. In this case, the Eighth Circuit Court of Appeals affirmed the District Court’s holding that an endorsement incorporating a jurisdictional clause supersedes the alternative dispute resolution clause in an excess policy. As a result, the insurer’s motion to compel arbitration was denied.

While not a reinsurance case, the perceived conflict between the ADR clause and the endorsed jurisdictional clause is important to consider. The original policy had a three-step ADR clause, culminating in arbitration, as part of its Conditions. The clause applied to any controversy or dispute arising out of or relating to the policy, its breach, termination, or validity, and required that all disputes not resolved by mediation “shall be settled by binding arbitration.” The policy had a Missouri choice-of-law clause. The policy also had an endorsement that provided as follows:

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

While the insurer argued that the endorsement only complimented the arbitration clause, the court agreed with the district court, which held that the endorsement entirely supplanted the arbitration clause. The court found highly revealing that the endorsement nowhere indicated an intent to limit its scope to only pre or post-arbitration enforcement. Notably, Missouri law prohibits mandatory arbitration clauses in insurance contracts and the endorsement contained an agreement to submit to the jurisdiction of the courts of Missouri.

The distinction in this case compared to cases addressing competing arbitration and service-of-suit clauses is that the jurisdictional clause was made part of the contract by endorsement, thus was arguably subsequent to the original wording and more specific in its application.

Summary of Union Electric Co. v. AEGIS Energy Syndicate 1225, 713 F.3d 366 (8th Cir. 2013). Submitted by Larry P. Schiffer, Patton Boggs, LLP, New York, NY, (646) 557-5100, lschiffer@pattonboggs.com

New Jersey Federal Court Stays Litigation in Favor of Arbitration of Offset Dispute

A New Jersey federal court stayed litigation brought by a cedent pending the outcome of arbitration over an alleged breach of a reinsurance contract. The alleged breach was caused by the reinsurers offsetting amounts due under one reinsurance contract against amounts owed under another reinsurance contract. The cedent issued medical malpractice policies and obtained reinsurance under two separate, but successive reinsurance contracts. Under the earlier contract, the reinsurers claimed a premium adjustment was due to them. This dispute was in arbitration. Under the latter contract, the cedent was owed certain amounts. The reinsurers did not dispute the amounts owed, but asserted an offset under the offset clause for the amount the reinsurers claimed was due under the earlier contract. The cedent would not agree to arbitrate the second dispute.

In finding for the reinsurers, the court held that the arbitration clause was extremely broad and applied to all disputes and all differences arising out of or connected with the second reinsurance contract. Because what was disputed was whether the amount owed under the second contract may be offset by amounts allegedly due under the first contract, the dispute was one connected to the contract and therefore subject to arbitration. The court also noted that the arbitration clause explicitly applied to the interpretation of the contract and the application of the offset clause was clearly in dispute. Because the dispute was based on the interpretation of contractual terms and because the arbitration clause was so broad, the court found that the dispute fell within the scope of the arbitration clause.

The cedent also argued that the service-of-suit clause permitted certain claims to be litigated and not arbitrated. The court rejected that argument along with a request that the contra proferentem rule be applied against the reinsurer.

Illinois Federal Court Dismisses Cedent’s Assignee’s Pre-answer Security Request and Motion to Compel Arbitration Against Sovereign-owned Reinsurer

An Illinois federal court in two decisions addressed an insolvent cedent’s assignee’s attempt to collect payments allegedly due from the assignor’s reinsurer. In the complaint, the assignee sought an order compelling arbitration (Count I) or, in the alternative, for damages caused by the reinsurer’s alleged breach of contract (Count II). The reinsurer moved to dismiss Count I for failure to state a claim under Federal Rule of Civil Procedure 12(b)(6) and answered Count II. The assignee then moved to strike the motion to dismiss on the ground that the reinsurer failed to comply with the Illinois Insurance Code’s prejudgment security requirement. The court denied the assignee’s motion, finding that, because the reinsurer was a corporation wholly owned by the Republic of Uruguay, its assets were immune from prejudgment attachments under the Foreign Services Immunities Act (“FSIA”). Relying on the Second Circuit’s interpretation of an identical New York insurance statute in Stephens v. Nat’l Distillers & Chemical Corp., 69 F.3d 1226, 1229 (2d Cir. 1995), the court held that “the prejudgment security was functionally equivalent to an attachment under the FSIA” and granted the assignee’s motion to strike. The court also denied the assignee’s motion to amend or correct the order denying the motion to strike on the same grounds.

In a subsequent decision, the court granted the reinsurer’s motion to dismiss Count I without prejudice. The court found that although the underlying reinsurance treaties contained binding arbitration clauses, the plain language of the assignment agreement only granted the assignee limited rights to collect specific debts. Thus, rights under the arbitration clause were not assigned. Indeed, the assignment plainly stated that it “shall not be construed to be a novation or assignment” of the reinsurance treaties themselves. As such, the assignee did not have the power to enforce the treaties’ arbitration clauses.


New York Federal Court Denies Motion to Quash Post-Award and Post-Judgment Enforcement

A New York federal court had confirmed an arbitration award on consent of all parties and after the parties had agreed that 6.5% interest would accrue until the award was paid in full. Apparently, the cedent’s wire transfer was misdirected (to a former affiliate of the reinsurer) and there was some delay in obtaining the misdirected funds back and then re-wiring the reinsurer. Also, the funds ultimately re-wired were short and did not include interest for the period between the misdirected wire and the re-wire. The parties disputed what interest rate should apply to the intervening period.

To enforce its position, the reinsurer served restraining notices and informational subpoenas under New York procedural law, which the reinsurer moved to quash. In denying the reinsurer’s motion, the court held that it had the authority to review the cedent’s motion even though the restraining notices were served under New York state law. As to the interest rate, the court held that the parties’ agreement that resulted in the consent confirmation of the award was a valid agreement to set a post-judgment interest rate by contract that differed from the federal post-judgment interest rate. Thus, the court held that the reinsurer owed interest on the judgment accruing at a rate of 6.5% until the full amount was paid to the cedent.


Parties Must Litigate Disputes After Connecticut Federal Court Declares Void Interpretation of Arbitration Award from Arbitration Panel Acting Functus Officio

A Connecticut federal court denied a cedent’s motion for judgment and contempt against a reinsurer where the motion sought to enforce an arbitration award that had been improperly revisited by the underlying arbitration panel. The court determined that the arbitration panel was acting functus officio, or without authority, to determine the reinsurer’s ultimate responsibility to the cedent.

As outlined by the court, in 2003, an arbitration panel found that the cedent was entitled to reimbursement of more than $9 million in payments made under the
reinsurance contract. The panel also concluded that if the cedent determined that offset would not provide it with timely recapture, the cedent could execute a power of attorney enabling the reinsurer to initiate arbitration or other appropriate legal proceedings in the cedent’s name for cost recovery. The cedent and the reinsurer subsequently litigated whether the reinsurer was in contempt of the terms of the arbitration award, and the reviewing court found on two separate occasions—in 2007 and again in 2010—that the arbitration award was ambiguous and remanded the award to the panel.

The 2010 remand was the subject of this court’s review. The court concluded that the arbitration panel was without authority to further determine the reinsurer’s “ultimate responsibility” to the cedent and the role of the reinsurer’s “best faith efforts” beyond the original award. In revisiting the award in its 2010 decision, the court held that the arbitration panel had acted _functus officio_ and therefore the 2010 ruling was void. The court further held that whatever dispute the parties have now about how the reinsurer carried out its duties under the power of attorney must be litigated in a separate proceeding.


**Texas State Court of Appeals Denies Cedent’s Motion to Compel Arbitration Against Reinsurer**

A Texas appellate court held that a cedent was judicially estopped from compelling arbitration. Litigation between the cedent and reinsurer began when the cedent withdrew funds from the trust account established by the reinsurance agreement and made a demand on the reinsurer to deposit approximately $1.2 million in additional funds into the trust account. The reinsurer disputed the cedent’s claims handling and accounting, demanded an audit, and refused to deposit the additional funds. In response, the cedent sought to force the reinsurer into bankruptcy. Lawsuits were filed in Turks and Caicos, New York, and Texas. In each of the related lawsuits, the reinsurer sought to compel arbitration based upon a provision in the reinsurance agreement that required arbitration for all disputes “arising out of the interpretation” of the reinsurance agreement. In each lawsuit, the cedent argued against arbitration based on its position that the claims in the related cases did not involve interpretation of the reinsurance agreement.

In 2009, a court held that the cedent was not a “creditor” and therefore could not windup the reinsurer’s business. In 2011, the reinsurer revived the Texas lawsuit by filing new claims. In late 2011, the cedent for the first time sought to compel arbitration against the reinsurer. In the trial court, the reinsurer successfully argued that because the cedent had previously argued against arbitration in related lawsuits, the cedent could not compel arbitration under the doctrine of judicial estoppel. This appeal followed.

The court of appeals found that the reinsurance agreement indeed contained a valid arbitration clause and that the scope of the arbitration provision indeed covered the dispute revived in the 2011 Texas litigation. But the court also agreed with the trial court and affirmed that the cedent could not now seek to compel arbitration against the reinsurer. The court also required the cedent to pay all costs for the appeal.


**New York Court Holds Arbitrators Must Determine Limitations Issue**

A New York motion court was presented with a petition to stay arbitration, based on the statute of limitations, of certain claims under reinsurance contracts. The cedent demanded arbitration for reinsurance recoverables under contracts containing an arbitration clause with a New York governing law clause. The reinsurers resisted and brought this petition to stay the arbitration because New York’s six-year statute of limitations for breach of contract allegedly applied to bar the claims.

The cedent moved to compel arbitration arguing that the Federal Arbitration Act (“FAA”) governed the dispute and that the contracts did not state that New York law applied to the enforcement of the contracts. The question was whether the arbitrators or the court would decide the statute of limitations question.

In finding for the cedent, the court held that the statute
of limitations issue was for the arbitrators to determine. The court noted that under New York law, timeliness and arbitrability were for the court to decide while under the FAA, timeliness is generally left to the arbitrators. A contract, stated the court, may be governed by the FAA yet subject to the New York rule if the agreement expressly provides. If the contract states that New York law shall govern both the agreement and its enforcement, gateway matters must be decided under New York law by the court. Without that express language, issues like timeliness are for the arbitrators to decide.

Here, the court found there was no issue that the FAA applied. The court reviewed the contracts and found that there was no express language regarding enforcement. The arbitration clause merely stated that disputes shall be governed by New York law, but it did not express an intent to have New York law govern enforcement. Accordingly, the petition was dismissed.


Connecticut Federal Court Uses Drama to Illuminate a Follow-the-Settlements Discovery Dispute

We all know that reinsurance may not be the most exciting subject to read about. Certainly many judges feel that way. But once in a while, a judge may take the somewhat dry subject of reinsurance and jazz it up within an opinion. Here, a Connecticut federal court was asked by a reinsurer to compel discovery against a cedent. In reaching its decision, the court decided to turn the case into a stage drama. What makes the drama more interesting (at least to us) is that the court took pains to use the New York Court of Appeals’ recent decision in *U.S. Fidelity & Guaranty Co. v. Am. Re-Insurance Co.*, 20 N.Y.3d 407 (2013) as its touchstone for deciding the scope of discovery needed by the reinsurer where a follow-the-settlements argument was being made by the cedent.

We will let you read the decision for yourself for the court’s drama class. We will focus instead on the reinsurance issues. Here, the reinsurance contract was governed by New York law. The court made it clear that the decisions of the New York Court of Appeals bound the court in construing the contract and not the decisions of the 2d Circuit. That is where the *U.S. F&G* case comes in.

The reinsurance contracts had a following clause that obligated the reinsurer to pay losses paid on the underlying policies and “will follow the settlements of the Company, subject always to the terms and the conditions of this Agreement.” Like *U.S. F&G*, this case was a dispute about the post-settlement reinsurance allocation. The reinsurer, on this motion, sought to compel the cedent to produce discovery to aid it in its defense that the cedent’s allocation was unreasonable or that the underlying claims were not covered under the reinsurance contract. In this case, the cedent allocated the settlement to the second of four years, when the reinsurer was a treaty participant, and not to the first year, when the reinsurer was not a treaty participant.

In interpreting New York law on follow-the-settlements, the court enumerated four rules: (1) a follow-the-settlements clause requires deference to the cedent’s post-settlement allocation; but (2) a cedent’s allocation decisions are not immune from scrutiny, which includes; (3) whether the allocation is reasonable as one that the parties to the settlement might reasonably arrive at without consideration of reinsurance; and in any event (4) an allocation that violates or disregards reinsurance contract provisions is void.

After reviewing the competing arguments of counsel, the court found that the reinsurer was entitled to challenge the reasonableness of the post-settlement allocation and to argue that the allocation violated the reinsurance contract. Based on this finding, the court allowed the reinsurer’s motion to compel discovery.


New York Federal Court Holds Illinois Law Applies; Finds for Reinsurer on Late Notice Defense

In a rare late notice case, a New York federal court examined whether the cedent’s notice under nine facultative certificates was late (more than three years) entitling the reinsurer to avoid coverage. None of the fac certs had a choice-of-law clause. The Magistrate Judge concluded Illinois law should apply and recommended granting the reinsurer’s summary judgment motion. The court agreed.
This case arose out of asbestos losses incurred by Foster Wheeler. The cedent, which issued a series of umbrella policies, purchased the fac certs from the reinsurer. The fac certs all had a notice provision that stated “Prompt notice shall be given to the Reinsurer by the Company of any occurrence or accident which appears likely to involve this reinsurance.”

A settlement with Foster Wheeler by one plaintiff prompted the cedent to consider its own settlement, which it finally reached in 2006. Although the cedent was aware of Foster Wheeler’s settlement demand in October 2003, it did not notify the reinsurer about the claim until January 2007; after the settlement. The reinsurer resisted the loss cession based on late notice and this action was commenced.

The case came down to whether Illinois or New York law applied. The court described the choice-of-law analysis and the differences the court found in each jurisdiction’s law concerning late notice. The court agreed with the Magistrate Judge that Illinois law should apply. The court then determined that the 7th Circuit’s ruling on late notice—that the reinsurer need not prove prejudice to avoid coverage—was the rule of law that applied in this case. The court found that the cedent, a sophisticated insurance company, waited more than three years before giving notice to the reinsurer even though the cedent was aware that coverage under the fac certs was available and that the notice provision was triggered. Under Illinois law, held the court, the reinsurer could refuse coverage under the fac certs.

Giving prompt notice of a claim or potential claim is something that affects many types of insurance, including lawyers and brokers errors and omissions policies. Insureds are always advised by good lawyers to give notice to their carrier as soon as possible. That advice also applies to cedents where the loss triggers coverage under a reinsurance contract. Why wait to give notice?


Pennsylvania Federal Court Grants Partial Summary Judgment to Reinsurer Based on Statute of Limitations

A Pennsylvania federal court granted partial summary judgment to a reinsurer on statute of limitations grounds, but denied summary judgment based on genuine issues of material fact on a number of issues. This case involves successor entities dealing with delays in claims cessions under a contract that was never finalized between a U.S. cedent and a U.K. reinsurer. Changes in billing practices were challenged and the parties also entered into a tolling agreement covering certain “catch-up” billings for delayed claims. Ultimately, the cedent terminated the tolling agreement and brought suit to recover various billings.

In deciding the cross-motions for summary judgment, the court focused on the core issue of the statute of limitations. Everyone agreed that the limitations period was four years, but neither could agree on when the limitations period commenced. Because the court found, based on the parties’ stipulation, that the reinsurance agreement (which was never formalized in writing) conditioned the reinsurer’s payment of reinsurance billings, the court held that the statute of limitations ran from the performance of that condition (here, the submission of a claims bordereau). Thus, bordereaux submitted more than four years before the cedent commenced the lawsuit and not subject to the tolling agreement were barred by the statute of limitations.

As to the bordereaux that were the subject of the tolling agreement, the court held that there was a genuine dispute of material fact as to whether the cedent’s delay in billing was reasonable and whether those billings fell within the exception provided for in the agreed-upon errors and omissions clause of the reinsurance agreement.

The court also denied summary judgment on a certain category claims that the cedent argued was controlled by the agreed-upon follow-the-fortunes clause. The dispute was whether the claims were handled in a reasonable fashion or whether the claims handling violated the cedent’s duty of utmost good faith. The court found that there was a genuine dispute of material fact as to whether those claims fell within the follow-the-fortunes clause.

The cedent also disputed the reinsurer’s imposition of additional documentation requirements to validate a billing. The court also found a genuine dispute of material fact as to whether the parties agreed to modify their contract to reflect this additional documentation requirement.

Pennsylvania Federal Court Finds Basis for Equitable Tolling and Denies Cedent and Captive Mortgage Bank Reinsurer Motions to Dismiss RESPA Class Action

An outgrowth of the residential housing bubble was the creation of captive mortgage bank reinsurers. The mortgage banks and their captive reinsurers are now subject to multiple class-action suits across the U.S. While the issues are not traditional reinsurance issues, these cases are multiplying and may be of interest to those who toil in the reinsurance space.

Here, a Pennsylvania federal court denied motions to dismiss filed by the cedent, the reinsurer, and other defendants in a class-action suit alleging violations of the Real Estate Settlement Procedures Act (“RESPA”). Plaintiffs allege that the mortgage lender created its own captive reinsurance company and then referred borrowers to private mortgage insurance providers who agreed to reinsure with lender’s captive reinsurer. Lender allegedly received a fee for the referral and transferred those fees to the captive reinsurer. Plaintiffs also allege that the captive reinsurer assumed little or no actual risk, but that mortgage borrowers paid more for mortgage insurance because the price included those referral fees.

At issue was whether plaintiffs’ claims were barred by RESPA’s one-year statute of limitations. The court concluded that although plaintiffs filed their suit outside of the one-year limitations period, plaintiffs had alleged sufficient facts to permit an extension of the statute of limitations. This holding was based on the equitable-tolling doctrine, including facts regarding alleged fraudulent concealment by defendants. The court noted that in this early stage of litigation, the court must accept plaintiffs’ facts as true, but also ruled that it would allow the parties “a limited amount of time” to present evidence on the limitations issue.


California Federal Court Grants Motion to Compel Production of Reinsurance Documents and Strikes Eight of Reinsurer's Affirmative Defenses

In two separate rulings, a California federal court has granted plaintiffs’ motion for production of reinsurance documents in a putative RESPA class action and struck eight of the reinsurer’s affirmative defenses. Plaintiffs allege that a mortgage lender received illegal referral fees from mortgage insurance companies who agreed to reinsurance with the lender’s captive reinsurance company. Ceded premiums allegedly funded reinsurance trusts, rather than funds from reinsurer, and, therefore, reinsurer allegedly assumed no real or commensurate risk.

The court’s order compelling production of reinsurance documents required reinsurer to produce documents given to the federal Consumer Financial Protection Bureau (“CFPB”) pursuant to a Civil Investigatory Demand into the mortgage lender’s captive reinsurance agreements. The lender and reinsurer resisted plaintiffs’ request for the CFPB documents on grounds that they were not relevant to plaintiffs’ claims and that the request was unduly burdensome. In response, plaintiffs narrowed the scope of their document request, but lender and reinsurer maintained that the narrowed request still reached non-relevant material and was unduly burdensome. The court disagreed and ordered that the reinsurance documents requested under plaintiffs’ narrowed request be produced.

The court’s order striking eight affirmative defenses from mortgage lender’s and reinsurer’s answer to plaintiffs’ complaint rests on the law of the case doctrine. The court previously denied defendants’ motion to dismiss and in so doing explicitly and implicitly ruled on some of the arguments raised by the affirmative defenses and therefore ordered that those affirmative defenses be struck from the record.

The revisions to Model Law #785 provide for a state certification process for reinsurers applying for authorization to post less than 100% collateral for its obligations under the applicable reinsurance contract. The Model provides criteria to be used by a state insurance commissioner for certifying reinsurers. Reinsurers seeking certification must:

- Be domiciled or licensed in a qualified jurisdiction, which will be discussed in greater detail;
- Maintain minimum capital and surplus levels to be determined by the commissioner;
- Maintain minimum financial ratings by two or more rating agencies approved by the commissioner;
- Agree to submit to the jurisdiction of the courts of the state where the reinsurer is seeking certification and appoint an agent for service of process; and
- Provide a certain approved percentage of security for the liabilities attributable to the reinsurance ceded.

Additionally, the commissioner is required to assign a financial strength rating to each certified reinsurer, taking into account financial strength ratings that have been assigned by rating agencies deemed acceptable by the commissioner.

As stated above, reinsurers seeking certification must be licensed and domiciled in a qualified jurisdiction. Model Law #785 requires each state insurance commissioner, as well as the NAIC, to create and publish a list of qualified jurisdictions. In determining whether a non-U.S. jurisdiction is eligible for recognition as a qualified jurisdiction, the commissioner will evaluate the appropriateness and effectiveness of the jurisdiction’s reinsurance supervisory system, as well as consider the rights, benefits, and the extent of reciprocal recognition by the jurisdiction of reinsurers licensed and domiciled in the U.S. Qualified jurisdictions are required to share information and cooperate with the commissioner with respect to all certified reinsurers domiciled in the qualified jurisdiction. Jurisdictions that are determined to not adequately and promptly enforce U.S. final judgments and arbitration awards may not be qualified jurisdictions. If a commissioner approves a jurisdiction not appearing on the NAIC list of qualified jurisdictions, the commissioner will be required to provide the NAIC justification as to why that jurisdiction has been deemed qualified and its applying reinsurers have been certified.

Model regulation #786 provides specific guidance on the ceding carrier financial statement credit allowed based on the percentage of security posting on behalf of the assuming certified reinsurer in accordance with the rating assigned to the certified reinsurer by the commissioner. Model regulation #786 provides the following table for determining the amount of security a certified reinsurer will be required to post in order for the ceding carrier to receive 100% credit for the reinsurance ceded:

<table>
<thead>
<tr>
<th>Ratings</th>
<th>Security Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secure – 1</td>
<td>0%</td>
</tr>
<tr>
<td>Secure – 2</td>
<td>0%</td>
</tr>
<tr>
<td>Secure – 3</td>
<td>20%</td>
</tr>
<tr>
<td>Secure – 4</td>
<td>50%</td>
</tr>
<tr>
<td>Secure – 5</td>
<td>75%</td>
</tr>
<tr>
<td>Vulnerable – 6</td>
<td>100%</td>
</tr>
</tbody>
</table>

**States Enacting Changes**

Ten states have adopted some form of certification of reinsurers for the purpose of providing reinsurance credit. Most states have adopted laws and regulations that are substantially similar to Model #785 and Model #786. However, there are some variations that should be noted. Model #785 requires the certified insurer to maintain minimum capital and surplus requirements to be determined by the commissioner of insurance. The legislatures of California, Florida, and Pennsylvania established statutory minimum capital and surplus requirements for certified reinsurers of at least two hundred fifty million dollars ($250,000,000).

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1. NAIC Model #785 (2) (E)
2. NAIC Model #785 (2) (E) (4)
3. NAIC Model #785 (2) (E) (3)
4. NAIC Model #785 (2) (E) (3)(c)
5. NAIC Model #785 (2) (E) (3)(c)
6. NAIC Model #785 (2) (E) (3)(c)
7. NAIC Model #786 (8) (5)(b)
8. NAIC Model #786 (8) (A)
10. NAIC Model #785 (2) (E) (1)(b)
11. CAL. INS. CODE §922.41(b)(2); §624.610 (3)(d) F.S.; 40 PA. CONS. STAT. §161.3(a)(2)(c)
State legislatures have also provided additional requirements for the rating of reinsurers by commissioners, and additional criteria for the evaluation of qualified jurisdictions. When establishing a financial rating for certified reinsurers in California and Pennsylvania, the commissioners must use the lowest rating assigned by a rating agency as the maximum rating provided by the commissioner. California, Florida, and Indiana provide additional, more specific, statutory criteria for the evaluation of qualified jurisdictions. Commissioners in the aforementioned states are required to evaluate a jurisdiction’s solvency regulatory framework, financial operating standards, and financial reporting requirements. Commissioners in California, Florida, and Indiana must also evaluate the history of performance by reinsurers domiciled in the jurisdiction; the jurisdiction’s willingness to cooperate with U.S. regulators; and any evidence of problems with the enforcement of valid U.S. judgments.

**NAIC Qualified Jurisdiction Development**

As states continue to work on adoption of the revisions to Models #785 and #786, the NAIC is working on a process for developing and maintaining the NAIC’s list of qualified jurisdictions. The NAIC Reinsurance Task Force has been charged with creating a documented evaluation process and has begun drafting protocols in the *Process for Developing and Maintaining the NAIC List of Qualified Jurisdictions*. The evaluation process of non-U.S. jurisdictions is intended to be an outcome based comparison to domestic financial solvency regulation, to adhere to international supervisory standards, and to include relevant international guidance for recognition of reinsurance supervision.

Initially, the NAIC will evaluate and expedite the review of Bermuda, Germany, Switzerland, and the United Kingdom because these jurisdictions have already been certified by Florida and New York prior to the NAIC’s finalization of its revised Credit for Reinsurance Models. The review of other jurisdictions will be prioritized based on factors including ceded premium volume and reinsurance capacity issues, as well as requests made by states and foreign jurisdictions for NAIC evaluation.

The evaluation of a jurisdiction’s regulatory system will begin with a review of the jurisdiction’s most recent Financial Sector Assessment Program (FSAP) report, Report on Observance for Standards and Codes (ROSC), and any other publically available information regarding the laws, regulations, practices and procedures applicable to the reinsurance supervisory system being evaluated. This review will consider the jurisdiction’s laws and regulations related to financial solvency, as well as the administrative practices and procedures of the jurisdiction. The rights, benefits, and reciprocal recognition afforded to reinsurers licensed and domiciled in the U.S. will be evaluated, along with the jurisdiction’s willingness to cooperate with state insurance regulators and enforce valid final U.S. judgments. A historical analysis of the performance of the jurisdiction’s domestic reinsurers will also be considered.

The enforcement of final U.S. judgments by Qualified Jurisdictions has been a topic of great interest to the stakeholders participating in the drafting of the *Process for Developing and Maintaining the NAIC List of Qualified Jurisdictions*. Several U.S. ceding insurers providing comments to the NAIC stressed the essential nature of the requirement that a Qualified Jurisdiction enforce final U.S. judgments in a timely manner. Commenters cited instances of foreign jurisdictions refusing to enforce final U.S. default judgments and instances where foreign jurisdictions required substantial portions of the judgments to be re-litigated locally before determining whether to enforce them.

Stakeholders cited *Rubin v. Eurofinance (Rubin)* as an example of a U.K. court refusing to enforce a valid final U.S. judgment. The default judgment was issued by the U.S. court due to the defendant’s lack of participation in the proceedings. In *Rubin*, the United Kingdom Supreme Court refused to enforce a default judgment issued in a U.S. insolvency proceeding (unrelated to insurance or reinsurance), holding that...
the U.S. court had no jurisdiction over the defendants because they were not present in the U.S. and did not participate in the proceedings.

Stakeholders from the U.K. refuted the proposition that Rubin represented a serious issue with the enforcement of U.S. judgments in U.K. Courts. They argue that Rubin and the concurrently decided New Cap Reinsurance Corporation Ltd v. A. E. Grant (New Cap) case hold that foreign bankruptcy proceedings are not entitled to special enforcement rules in the U.K., and reaffirm the U.K. common law rule. The U.K. common law allows for the enforcement of a judgment by a foreign court if the defendant had agreed to submit to the jurisdiction of the foreign court before the commencement of the proceedings. The U.K. stakeholders cite the requirement for certified reinsurers to submit to the jurisdiction of the certifying state contained in section 2(E)(1)(d) of Model #785 and the requirement for certified reinsurers to include a Service of Suit Clause in their reinsurance contracts contained in section 8(E)(5) of Model #786. The U.K. stakeholders concluded that proper interpretation of Rubin along with the requirements of Model #785 section 2(E)(1)(d) and Model #786 section 8(E)(5) are sufficient to ensure enforcement of final U.S. judgments against certified reinsurers in U.K. courts.

In order to be deemed a Qualified Jurisdiction, the NAIC must conclude that a foreign jurisdiction’s reinsurance supervisory system provides effective financial solvency regulation that is acceptable for the purpose of reinsurance collateral reduction. Further, a foreign jurisdiction’s practices and procedures relating to reinsurance supervision must be consistent with the laws and regulations of the certifying state’s supervisory system, and that the jurisdiction’s laws and practices must satisfy the criteria set forth in Models #785 and #786.

NAIC staff or outside consultants with appropriate knowledge, experience, and expertise will perform the initial review and report findings to an on-site review team, if one is established. Upon completion of the review, the reviewers will report their findings to the Qualified Jurisdictions Working Group. The Qualified Jurisdictions Working Group will then make a determination as to whether the jurisdiction is qualified to be included in the NAIC List of Qualified Jurisdictions. Once the Qualified Jurisdictions Working Group has adopted its Final Evaluation Report of a foreign jurisdiction, a summary of findings and recommendations will be submitted to the Reinsurance Task Force for approval. If a foreign jurisdiction is approved by the Reinsurance Task Force, the summary and recommendations will be submitted to the Executive Committee and Plenary of the NAIC for final approval and inclusion on the NAIC List of Qualified Jurisdictions.

Relationship with the NRRA

All of the NAIC’s work related to reinsurance collateral must be viewed in light of the Nonadmitted and Reinsurance Reform Act (NRRA), which was enacted as part of the Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010. The NRRA prohibits the denial of reinsurance credit by a state if the ceding insurer is domiciled in an NAIC accredited state that recognizes the reinsurance credit claimed by the ceding carrier. This preemption of state law relating to reinsurance credit allows for states to proceed individually with reinsurance collateral reforms, which was the reasoning provided by the NAIC for not requiring uniform adoption by the states of Models #785 and #786.

Conclusion

Only time will tell if the practice of certifying reinsurers will provide any cost savings in the reinsurance market, but there is little debate that mechanisms to control the cost of reinsurance are a necessity. Many consider this initiative as extremely important for the ongoing efforts to provide for more international convergence and consistency in regulatory standards and supervision of insurers in our ever expanding global economy. Some stakeholders commenting on the Process for Developing and Maintaining the NAIC List of Qualified Jurisdictions indicated that requiring individual reinsurers to apply for certification after their domicile was deemed a Qualified Jurisdiction is unreasonable. Those stakeholders held the position that all reinsurers licensed in a Qualified Jurisdiction should be automatically certified. Undoubtedly, this is not the end of the discussion relating to reinsurance collateral.

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23 Process of Developing and Maintaining the NAIC List of Qualified Jurisdictions, NAIC Qualified Jurisdiction Drafting Group, 9 (March 29, 2013)
24 Process of Developing and Maintaining the NAIC List of Qualified Jurisdictions, NAIC Qualified Jurisdiction Drafting Group, 9 (March 29, 2013)
25 Process of Developing and Maintaining the NAIC List of Qualified Jurisdictions, NAIC Qualified Jurisdiction Drafting Group, 8 (March 29, 2013)
26 Process of Developing and Maintaining the NAIC List of Qualified Jurisdictions, NAIC Qualified Jurisdiction Drafting Group, 10 (March 29, 2013)
27 Process of Developing and Maintaining the NAIC List of Qualified Jurisdictions, NAIC Qualified Jurisdiction Drafting Group, 11 (March 29, 2013)
## 2013-2014 TIPS CALENDAR

### September 2013
17. **Using Excel in Complex Insurance Claims**  
   Audio Webinar  
   Contact: Ninah F. Moore – 312/988-5498

### October 2013
8-13. **TIPS Fall Leadership Meeting**  
   Minneapolis Marriott Hotel  
   Contact: Felisha A. Stewart – 312/988-5672  
   Minneapolis, MN  
   Speaker Contact: Donald Quarles – 312/988-5708

13. **Symposium: Animal Shelter and Rescue Law**  
   Contact: Ninah F. Moore – 312/988-5498  
   Jacksonville, FL

17-18. **Aviation Litigation Fall Meeting**  
   Ritz-Carlton, Washington, DC  
   Contact: Donald Quarles – 312/988-5708  
   Washington, DC

### November 2013
6-8. **Fidelity & Surety Committee Fall Meeting**  
   Contact: Donald Quarles – 312/988-5708  
   The Fairmont Copley Plaza Boston, MA

### January 2014
16-18. **40th Annual Midwinter Symposium on Insurance Employee Benefits**  
   Contact: Ninah F. Moore – 312/988-5498  
   The Driskoll Austin, TX

21-25. **Fidelity & Surety Committee Midwinter Meeting**  
   Waldorf-Astoria Hotel New York, NY  
   Contact: Felisha A. Stewart – 312/988-5672  
   Speaker Contact: Donald Quarles – 312/988-5708

### February 2014
5-11. **ABA Midyear Meeting**  
   Swisshotel Chicago  
   Chicago, IL  
   Contact: Felisha A. Stewart – 312/988-5672  
   Speaker Contact: Donald Quarles – 312/988-5708