



Excess, Surplus Lines and Reinsurance Committee

Terrorism Risk Insurance Act of 2002

By Andrew T. Houghton and Marni J. Galison,* © 2002, Reprinted with permission.

Following the terrorist attacks of September 11, 2001, concerns regarding the availability and cost of insurance coverage for future terrorist attacks have circulated throughout financial markets and businesses. As part of the United States government's efforts to ensure that economic stability is not threatened by possible future terrorist attacks, Congress enacted, and on November 26, 2002, the President of the United States signed into law, the Terrorism Risk Insurance Act of 2002.¹

Effective immediately, the Act creates a three year federal Terrorism Insurance Program, administered by the Department of the Treasury, in which certain primary, excess and surplus lines insurers writing commercial property and casualty insurance are required to make available limited terrorism coverage for losses occurring within the United States

as well as losses occurring outside the United States in the case of domestic air carriers, vessels and United States missions.² The federal government will share the risk — in the form of a backstop — of losses resulting from future terrorist acts. The federal government's share of losses under the Program will be 90% of that portion of the loss exceeding the insurer's deductible as set forth in the Act. The Terrorism Insurance Program will terminate on December 31, 2005. Thus, the Act establishes only a temporary program during which insurance for losses due to terrorist acts is immediately available. It is contemplated that, in the future, insurance for such losses will be available and affordable in the private market.

The Department of the Treasury will issue regulations and procedures for compliance with the requirements of the Act and

implementation of the Terrorism Insurance Program. Pending issuance of these regulations, the Department of the Treasury has issued explanatory notices, titled "Interim Guidance," addressing certain aspects of the Act and, in particular, those portions of the Act having an immediate effect, such as those concerning insurers' disclosure requirements. The first notice, titled: "Interim Guidance Concerning New Statutory Disclosure and Mandatory Availability Requirements of the Terrorism Risk Insurance Act of 2002"³ (hereinafter referred to as "Interim Guidance I") was issued on

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¹ Terrorism Risk Insurance Act of 2002, Pub. L. No. 107-297.

² *Id.* at § 101 (b) and § 103.

³ 67 Fed. Reg. 76206 (December 11, 2002).

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Report From the Chair

The ESLR Newsletter lives! As Committee Chair, I am very proud to contribute to this revitalized publication. Many thanks to our new Newsletter Editor, Andrew Houghton, as well as Larry Schiffer and Ron Gass for their usual tireless efforts.

I would like to take this opportunity to welcome new members to the Committee and to thank our "veteran" members for their continued support. The Committee Leadership is acutely aware that most Members have a limited amount of time to devote to ESLR or any other professional organization. Thus, our primary goal this year is to make ESLR activities more relevant and valuable to you. David Anderson (our Chair-Elect) and I will be continuing the efforts of past Chairs, especially Mike Knoerzer and Linda Lasley, to foster greater cooperation with industry groups such as ARIAS and the Excess & Surplus Lines Association as well as other TIPS Committees. We also will make every effort to increase the involvement of in-house counsel and insurance professionals in ESLR activities.

In this regard, I am happy to report on the success of the ESLR 2002 Annual Meeting Program in Washington, D.C. We gathered a diverse group of speakers, including government officials, lobbyists, academics and industry professionals, to discuss the insurance and reinsurance implications of terrorist acts. The Program received much praise from the TIPS Leadership and was televised by C-Span. Although we had a reasonable turnout, we hope to increase attendance significantly for David Anderson's Program this summer in San Francisco.

Looking to the future, plans are already in the works to co-sponsor a number of programs that will be featured in future Newsletters including Emerging Issues Committee's Annual Program on the Future of Tort Law and Annual ELANY Program in New York.

We also hope that this year's Annual Program will heighten interest in ESLR and provide enough networking opportunities to lure Members (and non-Members) to San Francisco.

The ESLR Committee wants and needs the active participation of additional Members. We cannot accomplish the goals set forth above without your input and assistance. David Anderson and I would greatly appreciate any ideas for programs, offers to participate in Committee events or any other input you can provide. I can be reached at (212) 261-8261 or robert.mangino@mendes.com and David can be reached at (312) 258-5594 or danderson@schiffhardin.com. We look forward to hearing from you soon. ⚖️

Bob Mangino, Jr.

2002-2003 Chair

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December 3, 2002. Interim Guidance I provides information regarding compliance with the Act's requirements for disclosures to policyholders and mandatory availability of terrorism coverage, and explanation of types of commercial property and casualty insurance subject to the Act and the measurement of direct earned premium.

On December 18, 2002, the Department of the Treasury issued a second notice titled "Interim Guidance Concerning Definition of Insurers, Scope of Insurance Coverage, and Disclosures Mandated by the Terrorism Risk Insurance Act of 2002"⁴ (hereinafter referred to as "Interim Guidance II"). This notice provides information regarding what entities will be considered "insurers" subject to the provisions of the Act, the scope of coverage falling under the Terrorism Insurance Program, as well as information on calculation of the "insurer deductible" under the Act and on the Act's disclosure requirements.

Most recently, on January 22, 2003, the Department issued its third Interim Guidance titled: "Interim Guidance Concerning Certain Conditions for Federal Payment, Non-U.S. Insurers, and Scope of Insurance Coverage in the Terrorism Risk Insurance Act of 2002"⁵ (hereinafter referred to as "Interim Guidance III"). Interim Guidance III provides information regarding how insurers may

comply with the Act's disclosure requirements and certification of compliance requirements in order to be eligible for Federal payment, the applicability of the Act's "nullification of pre-existing terrorism exclusions" requirement to non-U.S. insurers, and the scope of the term "insured loss" as it relates to losses to domestic air carriers and flag vessels.

Summary of the Terrorism Risk Insurance Act

For the purposes of the Act, those insurers required to participate in the program include all insurers licensed or admitted in any State to provide primary or excess insurance, eligible surplus lines insurers listed in the NAIC's⁶ Quarterly Listing of Alien Insurers or any successor thereto, insurers "approved for the purpose of offering property and casualty insurance by a Federal agency in connection with maritime, energy, or aviation activity," State residual market insurance entities and workers' compensation funds, or other entities, that receive direct earned premiums for commercial property and casualty insurance, and that meet any other criteria to be prescribed by the Secretary of the Treasury.

The specific types of insurance falling within the provisions of the Act are broadly defined as "commercial lines of property and casualty insurance, including excess insurance, workers' compensation insurance, and surety insurance."⁷ Further, pending issuance of

regulations, Interim Guidance I incorporates the lines of insurance from the NAIC's Exhibit of Premiums and Losses as being included with the scope of the Act.⁸ Notably, reinsurance and retrocessional reinsurance, as well as certain other lines,⁹ are not included within the Program.

The Act mandates that insurers are to provide coverage for losses resulting from an event certified as an "act of terrorism" by the Secretary of the Treasury, in concurrence with the Secretary of State and the Attorney General, according to the definition of "act of terrorism" set forth in the Act. Further, the mandatory insurance created by the Act only applies to "insured losses" as that term is defined in the Act. The definitions of "act of terrorism" and "insured loss," discussed below, reflect Congress' intent that the Act only apply to terrorist acts committed on behalf of foreign persons or interests — thus, not including acts of "domestic" terrorism — and resulting in losses occurring in the United States, but including losses to domestic air carriers, flag vessels and United States missions regardless where the loss occurs.¹⁰ Interim Guidance III clarifies that in the event a loss occurs to a domestic air carrier or vessel overseas, "insured losses" would not include any associated losses incurred by third parties.¹¹

The mechanism for creating the transitional period of available terrorism risk insurance begins

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⁴ 67 Fed. Reg. 78864 (December 26, 2002).

⁵ 68 Fed. Reg. 4544 (January 29, 2003).

⁶ National Association of Insurance Commissioners.

⁷ Terrorism Risk Insurance Act of 2002, Pub. L. No. 107-297, § 102 (12) (A).

⁸ These lines of insurance are, as described in the Treasury's Interim Guidance I: Fire; Allied Lines; Farmowners Multiple Peril; Commercial Multiple Peril (non-liability portion); Commercial Multiple Peril (liability portion); Ocean Marine; Inland Marine; Workers' Compensation; Other Liability; Products Liability; Commercial Auto No-Fault (personal injury protection); Other Commercial Auto Liability; Commercial Auto Physical Damage; Aircraft (all perils); Surety; Burglary and Theft; Boiler and

Machinery. 67 Fed. Reg. 76206, 76208 (Dep't of the Treasury December 11, 2002).

⁹ The Act's definition of property and casualty insurance also does not include: federal crop insurance or other private crop or livestock insurance; private mortgage insurance or title insurance; financial guarantee insurance; medical malpractice insurance; health, life and group life insurance; flood insurance. Terrorism Risk Insurance Act of 2002, Pub. L. No. 107-297, § 102 (12) (B).

¹⁰ H.R. Rep. No. 107-779, at 23 (Joint Explanatory Statement Of The Committee Of Conference) (November 13, 2002).

¹¹ 68 Fed. Reg. 4545 (January 29, 2003).

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with the nullification, effective immediately upon enactment of the Act on November 26, 2002, of all current contractual provisions to the extent they exclude “insured losses” as defined in the Act in classes of business encompassed in the Act.¹² Likewise, the Act pre-empts or voids any state approval of policy language in policies in effect at the time of enactment to the extent they exclude “insured losses” as defined in the Act. An insurer can reinstate pre-existing terrorism exclusions in insurance contracts in force on the date of enactment of the Act if (1) the insured authorizes the reinstatement or (2) if the insurer has provided notice to the insured at least 30 days prior to the reinstatement of the increased premium to be charged for the terrorism coverage, the insured’s rights under the Act with respect to the coverage and the date that reinstatement would take effect, and the insured subsequently fails to pay the additional premium charged to provide coverage for terrorism losses as defined under the Act.¹³

Beginning on November 26, 2002, and continuing for the first two years of the Program (consisting of a Transition Period from the date of enactment on November 26, 2002, to December 31, 2002, Program Year 1 from January 1, 2003, to December 31, 2003, and Program Year 2 from January 1, 2004, to December 31, 2004), insurers are required to make available terrorism coverage for insured

losses (as defined in the Act) in all policies falling within the scope of the Act. The coverage offered by insurers must not materially differ in respect to terms, amounts or limitations for losses than it would for risks other than from acts of terrorism.

The Act further provides that, by September 1, 2004, the Secretary of the Treasury will determine whether the Program is to be extended through Program Year 3 (January 1, 2005, to December 31, 2005). From enactment of the Act until December 31, 2003, rates and forms for terrorism risk insurance are not subject to prior approval or waiting periods under any State’s law. However, a State may invalidate a rate retroactively and conduct subsequent review of policy forms where the State has prior approval authority.¹⁴

In Interim Guidance I, the Department of the Treasury addresses questions concerning the meaning of the Act’s requirement that an insurer “make available, in all of its property and casualty policies, coverage for insured losses. . . that does not differ materially from the terms, amounts, and other coverage limitations arising from events other than acts of terrorism.” Interim Guidance I advises, by way of example, that the requirement that insurers “make available” coverage for acts of terrorism “means that insurers offer coverage for acts of terrorism (as defined in the Act) at deductibles and limits that do not differ materially from coverage provided for other perils.”¹⁵ Moreover, Interim Guidance I advises that:

The “make available” requirement does not mean that insurers must make available coverage for all types of risks. For example, if an insurer does not cover all types of risks, either because the insurer is outside of direct State regulatory oversight or a State permits exclusions for certain types of losses (*e.g.*, nuclear, biological, or chemical events) an insurer would not be required to make such coverage available.¹⁶

Although this portion of Interim Guidance I offers only minimal clarification, it does suggest that insurers are not required to provide coverage for types of losses that are not otherwise covered under their policies, but that coverage cannot be excluded for a loss for which coverage is otherwise available on the ground that the loss resulted from an act of terrorism.

In regard to policies already in place as of enactment of the Act and policies issued after enactment, insurers are required to provide policyholders with “clear and conspicuous” disclosures of the premium charged for the insured losses defined by the Act and the federal government’s share of compensation for such insured losses.¹⁷ For policies already in place, this disclosure must be made within 90 days of enactment and no less than 30 days prior to possible reinstatement of a nullified terrorism exclusion. The Act allows for the imposition of civil penalties against any insurer that fails to comply with its provisions.¹⁸

¹² Terrorism Risk Insurance Act of 2002, Pub. L. No. 107-297, § 105 (a).

¹³ *Id.* at § 105 (c).

¹⁴ *Id.* at § 106.

¹⁵ 67 Fed. Reg. 76206, 76207-08 (Dep’t of the Treasury December 11, 2002).

¹⁶ *Id.* at 76208.

¹⁷ Terrorism Risk Insurance Act of 2002, Pub. L. No. 107-297, § 103 (b)(2).

¹⁸ Specifically, the Act provides that civil penalties may be imposed against any insurer that (A) fails to charge, collect or remit terrorism loss-spreading premiums; (B) intentionally provides erroneous information to the Secretary of the Treasury regarding premium or loss amounts; (C) submits fraudulent claims for insured losses; (D) fails to provide the required disclosures to policyholders; or (E) fails to comply in any other manner with the terms of the Act. Terrorism Risk Insurance Act of 2002, Pub. L. No. 107-297, § 104 (e)(1).

Under the Terrorism Insurance Program, insurers must pay out a prescribed amount of insured losses during the Transition Period or any Program Year, described in the Act as the “insurer deductible,” before they will be entitled to “assistance” from the federal government. The amount of the deductible is calculated as a percentage of the insurer’s direct earned premiums¹⁹ from the calendar year preceding that Transition Period or Program Year. The insurer deductible for the Transition Period is 1% of the previous year’s direct earned premium, and thereafter 7% for Program Year 1, 10% for Program Year 2, and 15% for Program Year 3. Once the deductible amount has been met, insurers then must pay 10% of insured losses exceeding the deductible and the federal government will pay the remaining 90% of the insured losses in excess of the deductible.

In order to obtain the financial assistance provided under the Act, insurers must submit a claim for payment of the federal government’s share providing written certification of the underlying claim and of all payments towards insured losses, as well as certification of the insurer’s compliance with the provisions of Section 103 of the Act, which include the requirements for disclosures to policyholders and that claims be processed in accordance with “appropriate business practices” and any procedures dictated by the Secretary of the Treasury.

Insurers are permitted under the Act to obtain reinsurance for the

deductible amounts as well as for the 10% of insured losses the insurer must pay in excess of the deductible. Such reinsurance will not reduce the amount of financial assistance otherwise payable to the insurer under the Program. However, the total reinsurance and financial assistance under the Program received by an insurer in the Transition Period or any Program Year may not exceed the insurer’s aggregate insured losses for that period.²⁰ To avoid what is termed “duplicative compensation,” the federal government’s portion of an insured loss will be reduced by the amount of compensation provided to any person under other federal programs.²¹

Aggregate insured losses under the Program are capped at \$100 billion. Once the \$100 billion aggregate has been reached, the federal government will not make any further payment towards its 90% portion of insured losses and, further, no insurer that has met its deductible will be liable for its 10% portion of insured losses exceeding the \$100 billion aggregate. The Act provides that Congress will determine the procedures and source of payments for any insured losses exceeding the \$100 billion cap.²²

In the event that during any of the Program Years the federal government is required to reimburse insurers for insured losses as defined under the Act, the Act states that the Secretary of the Treasury is required to recoup a portion of these costs by means of a “terrorism loss risk-spreading premium” to be imposed on

policyholders. According to the Act, the federal government must recoup the difference between either the insurance marketplace retention for that Program Year²³ or the aggregate amount of all insured losses during that period, whichever is less, and the total amount of insured losses not compensated by the federal government (consisting of the insurers’ deductible plus the 10% of the insured losses the insurers must pay exceeding the deductible). If the insurers’ uncompensated insured losses equal or exceed the marketplace retention in any period, no mandatory recoupment will take place. In the event that the total financial assistance paid by the federal government exceeds any mandatory recoupment amount, the Act authorizes the Secretary of the Treasury to recover an additional amount through terrorism loss risk-spreading premiums to be determined based upon the costs to taxpayers if no additional recoupment were to take place, economic conditions in the commercial marketplace, affordability of insurance for small and medium-sized business, and other factors deemed appropriate by the Secretary.²⁴

The terrorism loss risk-spreading premiums to be imposed on policyholders to enable the federal government to recoup these costs are not to exceed 3% of the premium charged for property and casualty insurance coverage under the policy and are to be collected by the insurers and remitted to the federal government. The Act allows the Secretary of the Treasury broad

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¹⁹ Interim Guidance I provides that, with respect to insurers that report to the NAIC, the term “direct earned premium” means the direct premiums earned as reported to the NAIC in the Annual Statement. The Interim Guidance indicates that additional guidance will be issued for entities covered under the Terrorism Insurance Program that do not report to the NAIC. 67 Fed. Reg. 76206, 76208 (Dep’t of the Treasury December 11, 2002).

²⁰ Terrorism Risk Insurance Act of 2002, Pub. L. No. 107-297, § 103 (g).

²¹ *Id.* at § 103 (e)(1)(B).

²² *Id.* at § 103 (e)(2).

²³ The insurance marketplace aggregate retention amounts for the three Program Years are as follows: no more than \$10 billion for Year 1, no more than \$12.5 billion for Year 2, and no more than \$15 billion for Year 3. *Id.* at § 103 (e)(6).

²⁴ *Id.* at § 103 (e)(7)(D).

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discretion in determining when these premiums shall be assessed, how the specific amount of these premiums shall be determined, and any adjustments that may be necessary for certain geographic areas or certain lines of insurance.

Key Provisions of the Act Relevant to the Terrorism Insurance Program

Definitions of “Act of Terrorism” and “Insured Loss”: As provided in the Act, an “act of terrorism” is any act that is certified by the Secretary of the Treasury, in concurrence with the Secretary of State and the Attorney General, (i) to be an act of terrorism; (ii) to be a violent act or an act that is dangerous to human life, property, or infrastructure; (iii) to have resulted in damage within the United States or outside the United States in the case of a domestic air carrier,²⁵ or a United States flag vessel or similarly qualifying vessel, or a United States mission; and (iv) to have been committed by individuals on behalf of any foreign person(s) or foreign interest as part of an effort to coerce the United States civilian population or to influence the policy or affect the conduct of the United States government.²⁶ Based upon these defining factors, the principal characteristic of an “act of terrorism” under the Act is any damage occurring in the United States or to particular United States interests worldwide (but limited to United States air carriers, vessels and missions).

Only the Secretary of the Treasury is authorized to certify an

event as an “act of terrorism,” and this authority cannot be delegated to any other person. Moreover, any decision to certify, or not certify, an event as an “act of terrorism” is final and not subject to review. Beyond the definitions provided by the Act, the only limitations placed upon the certification by the Secretary are that (1) an act committed in the course of war declared by Congress (except with respect to coverage for workers’ compensation) shall not be certified as an “act of terrorism,” and (2) aggregate property and casualty insurance losses resulting from the act must exceed \$5,000,000 before an event can be certified as an “act of terrorism.”²⁷

Notably, the terrorism coverage mandated by the Act is limited by the fact that the definition of “act of terrorism” distinguishes between foreign acts of terrorism, for which the Act does require insurance coverage, and domestic acts of terrorism which do not fall within the scope of the Act. This distinction may give rise to difficulties in administering the Terrorism Insurance Program in certain circumstances, such as in the event a terrorist attack occurs and it is not readily apparent whether the act was committed on behalf of foreign interests or on behalf of domestic interests.

As in the definition of “act of terrorism,” the definition of “insured loss” under the Act is restricted to losses occurring within the United States, as well as losses to domestic air carriers and flag vessels regardless where the loss occurs (or essentially providing worldwide coverage) or at the premises of any United States mission.²⁸ As noted above, Interim Guidance III clarifies that in

the event a loss occurs to a domestic air carrier or vessel overseas, “insured losses” would not include any associated losses incurred by third parties.²⁹ The restriction of insured losses to United States risks likewise limits the operative portions of the Act. For example, the immediate nullification of existing terrorism exclusions and preemption of State approvals of such exclusions are only mandated to the extent such provisions exclude losses that would otherwise be insured losses.³⁰ Thus, the Act only nullifies such provisions to the extent they exclude losses occurring within the United States, losses to domestic air carriers and vessels or at the premises of any United States mission. The remainder, if any, of an existing policy’s exclusion is unaffected by the Act. Similarly, except in the specific cases of domestic air carriers, vessels and United States missions, the mandatory terrorism insurance provided under the Program will not protect an insured’s property or other interests outside the United States.

Definition of “Insurer”: As noted above, the “Insurers” who are subject to the mandatory participation in the Terrorism Insurance Program created by the Act are defined as any entity, “including any affiliate thereof” (A) that is (i) licensed or admitted in any State to provide primary or excess insurance; (ii) eligible surplus lines insurers listed in the NAIC’s Quarterly Listing of Alien Insurers or any successor thereto; (iii) “approved for the purpose of offering property and casualty insurance by a Federal agency in connection with maritime, energy, or aviation activity”; (iv) State residual market

²⁵ Specifically, the definitions of “act of terrorism” and “insured loss” refers to air carriers as defined in Section 40102 of Title 49, United States Code. *Id.* at § 102 (5)(B).

²⁶ *Id.* at § 102 (1)(A).

²⁷ *Id.* at § 102 (1)(B).

²⁸ *Id.* at § 102 (5).

²⁹ 68 Fed. Reg. 4545 (January 29, 2003).

³⁰ *Id.* at § 105 (a) and (b).

insurance entities and workers' compensation funds; or (v) other captive insurers or self-insurance arrangements (subject to future regulations of the Secretary); (B) that receives direct earned premiums for commercial property and casualty insurance, including excess insurance, workers' compensation insurance and surety insurance; and (C) that meets any other criteria to be prescribed by the Secretary.³¹ Due to the complexity of the Act and its broad language, several issues have arisen regarding which insurers are required to participate in the Act's Terrorism Insurance Program. The Department of the Treasury's Interim Guidance II and Interim Guidance III provide some clarification on these points.

Although the Act provides that captive insurers and self-insurance arrangements may be included within the definition of "insurer" provided that the Secretary of the Treasury issues rules to that effect prior to an act of terrorism resulted in an insured loss covered by such entities, Interim Guidance II clarifies that no such rules have been issued.³² Thus, for the time being, captive insurers and other self-insurance arrangements are not "Insurers" within the meaning of the Act, unless such an insurer falls within the requirements of the Act as an admitted or licensed insurer.³³

Interim Guidance II also addresses the circumstances under which an insurer's affiliate, which is defined under the Act as "any entity that controls, is controlled by, or is under common control with the insurer,"³⁴ will be deemed an

"Insurer" required to participate in the Terrorism Insurance Program. According to Interim Guidance II, the Department of the Treasury will consider an insurer and all affiliates, which each individually meet the requirements of the Act's definition of "insurer," as one "insurer" for the purposes of the Program. To the extent that a particular parent entity or affiliate does not meet each of the requirements set forth under § 102 (6)(A) (specific categories of insurers), (B) (that receive direct earned premium), and (C) (any additional requirements, if issued), that parent entity or affiliate will not be included as an "Insurer" within the meaning of the Act.³⁵

With regard to the specific categories of insurers that are required to participate in the Terrorism Insurance Program, Interim Guidance II provides additional information, pending issuance of formal regulations, intended to assist insurers in determining which entities are required to participate, what coverage provided by those entities falls under the requirements of the Program, and how such entities can calculate their respective deductible under the Program.³⁶ For example, in the case of state licensed and admitted insurers, Interim Guidance II provides that, until specific regulations are issued, insurance coverage provided by such an insurer will not be considered to be within the scope of the Program unless the premium for such coverage is reported to the NAIC or to the licensing or admitting State. The insurer's deductible can be calculated based upon that reported premium.³⁷

Interim Guidance III addresses the question of whether the Act's "nullification of pre-existing terrorism exclusions" requirement applies to non-U.S. insurers, reiterating that the Act applies to entities that meet the definition of "Insurer" under the Act and to "insured losses" covered under the Program.³⁸ The guidance then concludes that as long as the insurer meets the definition of insurer under the Act, non-U.S. insurers are required to fully participate in the program and as such are required to nullify pre-existing exclusions and make terrorism risk insurance available as mandated by the Act.

Disclosure Requirements: As noted above, the Act imposes upon insurers strict requirements for disclosures of increased premiums and of the Federal government's role in insuring any covered loss. Specifically, as a condition for receiving reimbursement under the Program, the Act requires that an insurer shall have provided the policyholder "clear and conspicuous" disclosure of the premium charged for the insured losses defined by the Act and the federal government's share of compensation for such insured losses.³⁹ The intention behind this requirement is "to enhance the competitiveness of the marketplace by better enabling consumers to comparison shop for terrorism insurance coverage, and to make policyholders better aware that the Federal government will be sharing the costs of such coverage with the insurers, thereby reducing the insurer's exposure."⁴⁰

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³¹ *Id.* at § 102 (6).

³² 67 Fed. Reg. 78864 (Dep't of the Treasury December 26, 2002).

³³ *Id.* at 78866 (Dep't of the Treasury December 26, 2002).

³⁴ Terrorism Risk Insurance Act of 2002, Pub. L. No. 107-297, § 102 (2).

³⁵ 67 Fed. Reg. 78864, 78864-65 (Dep't of the Treasury December 26, 2002).

³⁶ *Id.* at 78865-67 Interim Guidance II separately addresses state licensed or admitted insurers, eligible alien surplus line carriers, insurers approved by federal agencies, state

residual insurance market and workers' compensation funds, and newly formed insurers.

³⁷ 67 Fed. Reg. 78864, 78865-66 (Dep't of the Treasury December 26, 2002).

³⁸ 68 Fed. Reg. 4545 (January 29, 2003).

³⁹ Terrorism Risk Insurance Act of 2002, Pub. L. No. 107-297, § 103 (b)(2).

⁴⁰ See H.R. Rep. No. 107-779, at 24 (Joint Explanatory Statement Of The Committee Of Conference) (November 13, 2002).

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For policies issued prior to enactment, the foregoing disclosure must be made within 90 days of enactment of the Act on November 26, 2002. For policies issued within 90 days of enactment of the Act, the disclosure must be made at the time of offer, purchase, and renewal of the policy. Finally, for policies issued more than 90 days after enactment, the required disclosure must be made on a separate line item in the policy, and at the time of offer, purchase, and renewal of the policy.⁴¹

The NAIC has published Model Disclosure Forms to meet the disclosure requirements of the Act. According to Interim Guidance I, an insurer's use of the appropriate NAIC Model Disclosure Forms or as appropriately modified, will be deemed by the Department of the Treasury to be in compliance with the Act. Interim Guidance I further provides, however, that use of the appropriate NAIC Model Disclosure Forms is viewed as a "safe harbor" means of compliance and is not the exclusive means by which an insurer may meet the disclosure requirements of the Act.⁴²

Significantly, Interim Guidance I also provides that, pending the issuance of regulations or further guidance, insurers are permitted to provide the required disclosures through a broker or other agent "if the normal form of communication between an insurer and the policyholder is through an insurance broker (or other intermediary acting as agent for the insurer). . . ." Interim Guidance I reiterates, however, that "the responsibility for ensuring that

such disclosures are provided to policyholders still rests with the insurer."⁴³

Interim Guidance II reiterates that insurers may modify the NAIC model forms to fit particular circumstances.⁴⁴ Interim Guidance II also indicates that the regulations to be issued by the Department of the Treasury will describe the means by which insurers will be able to evidence their compliance with the Act's disclosure requirements, such as by proof or certificates of mailing, forms signed and returned by policy holders, and "other methods consistent with the normal forms of communication with policyholders."⁴⁵

Interim Guidance III specifically addresses how an insurer may comply with the "separate line item" requirement for policies issued more than 90 days after the date of enactment, advising that the disclosure may be located on the declarations page of the policy, in the policy itself, or in any rider and endorsement that is made part of the policy.⁴⁶ Interim Guidance III also advises, however, that the guidance simply provides a "safe harbor" means of compliance and does not list the exclusive means by which an insurer may meet the disclosure requirements of the Act.

Additional Provisions of the Act

In addition to creating the Terrorism Insurance Program, the Act contains provisions relating to, *inter alia*, the method in which litigation will be managed in the event an act of terrorism as defined by the Act occurs, the ability of victims to satisfy judgments obtained against terrorists, and the possible expansion of the Act's

provisions to include additional lines of insurance.

With respect to litigation management, the Act mandates that a federal cause of action will be the exclusive remedy for any cause of action for property damage, personal injury, or death arising from an act of terrorism certified by the Secretary of the Treasury as such, and provides for the designation of a district court, or if necessary, multiple district courts, to be vested with exclusive jurisdiction over all actions for any claim arising out of the act of terrorism. The Act provides that any awards for punitive damages in any action arising from an act of terrorism are not included under the Act's definition of insured losses. In addition, the Act mandates that the substantive law to be applied in any action arising from an act of terrorism will be the substantive law of the state where the act occurred. The Act also contains a section designed to enable victims who have obtained judgments against terrorists to satisfy these judgments from the blocked assets of the terrorist parties. A more expansive definition of terrorism is applied in this section, and special rules are set forth with respect to cases against Iran.

Finally, contemplating future amendments to allow other areas of insurance to be covered by its provisions, the Act mandates that an "expedited" study be conducted into whether adequate and affordable catastrophe reinsurance for acts of terrorism is available to life insurers issuing group life policies in the United States. The Act also mandates that an additional study be conducted into the potential effects of terrorism on the

⁴¹ Terrorism Risk Insurance Act of 2002, Pub. L. No. 107-297, § 103 (b)(2).

⁴² 67 Fed. Reg. 76206, 76207 (Dep't of the Treasury December 11, 2002).

⁴³ *Id.*

⁴⁴ 67 Fed. Reg. 78864, 78867-68 (Dep't of the Treasury December 26, 2002).

⁴⁵ *Id.*

⁴⁶ 68 Fed. Reg. 4544 (January 22, 2003).

availability of life insurance and other lines of insurance with a report to be submitted to Congress no later than August of 2003.

Conclusion

The Terrorism Risk Insurance Act is clearly a complex piece of

legislation which will likely prove cumbersome and difficult for the federal government to administer and tedious for insurers to achieve compliance. The Act still leaves vague and ambiguous many of the responsibilities of the Secretary of the Treasury and the mechanisms

by which to comply with certain aspects of the Terrorism Insurance Program. It will be necessary to look to all Interim Guidance issued by the Department of the Treasury, as well as the Regulations to be issued, for clarification of the Act's provisions and requirements. ⚖️

RECENT EXCESS INSURANCE CASES

Alabama Supreme Court Rules

Primary Insurer Owes No Duty of Good Faith to Excess Insurer Regarding Settlement

Answering questions certified by the Eleventh Circuit, the Supreme Court of Alabama has held, in a case of first impression, that a primary insurer owes no duty of good faith to an excess insurance carrier with respect to settlement of a claim. The court further held that an excess insurer may not bring an equitable subrogation claim against a primary insurer where the insured is not subject to a final judgment ordering the payment of money. The underlying dispute involved an action brought by the insured and its excess insurance carrier against the insured's primary insurer for failing to settle a wrongful death action against the insured within the primary policy limits. An Alabama federal district court entered summary judgment in favor of the primary insurer noting the lack of legal precedent on the issues, and the plaintiffs appealed.

The Supreme Court of Alabama analyzed the policy considerations

behind allowing insureds to pursue the tort of bad faith against their insurers and evaluated these considerations in the primary insurer/excess insurer context. The court first observed that in a typical insurance contract the insured relinquishes the right to control the defense and settlement of any action and therefore, is required to rely on the good faith of the insurer, whereas the court noted that in the underlying dispute the excess insurer specifically reserved these rights. The court also emphasized the difference in bargaining power between an insurer and an insured in drafting and negotiating the insurance contract and the resulting contractual shift in financial risk from the insured to the insurer, whose litigation experience is superior to the insured. Thus, the court found that the policy considerations which justify the imposition of the duty of good faith to settle placed upon an insurer are lacking in the primary insurer/excess insurer context.

The court then considered the viability of the excess insurer's claim for bad faith failure to settle against the primary insurer asserted under the doctrine of equitable subrogation. The court noted that it is well-settled under Alabama law that a cause of action arising out of a failure to settle a third-party claim made against an insured does not accrue unless and until the claimant obtains a final judgment in excess of the policy limits. Thus, because an insurer may only assert claims through subrogation that are available to its insured, the court held that a claim for bad faith failure to settle is not available under the doctrine of equitable subrogation where the insured itself is not subject to a final judgment ordering the payment of money. ⚖️

Summary of *Federal Ins. Co. v. Travelers Cas. and Sur. Co.*, 2002 WL 1998282 (Ala. Aug. 30, 2002), prepared by Marni J. Galison, Condon & Forsyth LLP, New York, New York.

Save the Date!

The Women and Minority Involvement Committee of the Tort Trial and Insurance Practice Section, co-sponsoring with the TIPS' Law Student Division and the Task Force on Plaintiffs Involvement, proudly presents a phenomenal CLE program entitled, "Equal Access to Justice: Time to End Lip Service to Diversity" and will feature incoming ABA President Dennis Archer as a keynote speaker. Mr. Archer's inspiring and motivational message will prelude presentations by a panel of nationally recognized members of the legal profession. A reception will follow immediately.

Don't miss this exciting event during the ABA's Annual Meeting!

August 9, 2003, 2:00-5:00 p.m.; CLE Center, San Francisco, California.

RECENT REINSURANCE CASES

2nd Circuit Reverses District Court and Compels Arbitration on Rescission Claim

The Second Circuit Court of Appeals has held that an arbitration clause was broad enough to encompass the parties' dispute regarding fraudulent inducement and contract termination and, accordingly, vacated the District Court's order denying arbitration. The underlying dispute involved health reinsurance. The reinsurance agreement required arbitration as a condition precedent to any right of action "if any dispute shall arise between the parties hereto with reference to the interpretation of this Agreement or their rights with respect to any transaction involved, whether such dispute arises before or after termination of this Agreement." When the losses began coming in, the parties negotiated a proposed restructuring of the deal. The proposal did not mention arbitration, but did state that, with exceptions, the terms of the new reinsurance agreement would be substantially similar to the current contract.

This dispute began when the reinsurer sought a declaratory judgment that the proposal was a binding contract that terminated the existing reinsurance agreement. Simultaneously, the cedent demanded arbitration. The reinsurer amended its complaint to claim fraudulent inducement and sought rescission of the original contract. The parties moved before the District Court respectively to compel and to stay arbitration. The District Court found that the arbitration clause was not narrow, but that it was not broad enough to encompass the fraudulent inducement claim, and stayed the arbitration.

In reversing the District Court, the Second Circuit comprehensively

outlined the test for arbitrability in the Circuit. The court noted that the contract here was not void, but at best voidable, thus not precluding arbitration on its face. The court then analyzed the cases discussing whether an arbitration clause is broad or narrow. It concluded that the arbitration clause here was broad and took the opportunity to distinguish Second Circuit case law that had been relied on by the District Court. Specifically, the court relegated *In re Kinoshita & Co.*, 287 F.2d 951 (2d Cir. 1961) to the junk heap of arbitration cases long since passed by the strong federal policy in favor of arbitration. The court concluded that any ambiguity in the prefatory phrase of the arbitration clause should be resolved in favor of arbitration and that the clause should be construed as broad in scope. It remanded the matter back to the District Court to enter an order compelling arbitration.

The strong federal policy in favor of arbitration is more than evident in this decision by the Second Circuit. Unless an arbitration clause is narrowly drawn to specifically exclude particular disputes from arbitration, applications to avoid arbitration will not be granted in the Second Circuit. ⚖️

Summary of *Ace Capital Re Overseas, Ltd. v. Central United Life Ins. Co.*, 307 F.3d 24 (2d Cir. 2002), submitted by [Larry P. Schiffer](#), *LeBoeuf, Lamb, Greene & MacRae, L.L.P.*, New York, NY, (212) 424-8086, larry.schiffer@llgm.com.

7th Circuit Reverses Arbitrator Partiality Ruling and Reinstates Arbitration Award

In a dramatic reversal, the Seventh Circuit has reinstated an arbitration award that had been

vacated by the District Court based on the alleged "evident partiality" of the reinsurer's party-appointed arbitrator. The District Court's decision was quite critical of the arbitrator's failure to disclose prior engagement as counsel for the reinsurer some four years earlier on unrelated business, and concluded that the failure to disclose displayed evident partiality justifying the court to refuse to enforce the award.

In reversing and reinstating the majority arbitration award in favor of the reinsurer, the Circuit Court noted that the District Court's decision was the first decision since the enactment of the Federal Arbitration Act ("FAA") that a federal court had set aside an arbitration award in a tripartite arbitration because a party-appointed arbitrator displayed evident partiality. In a refreshing display of candor, the court recognized that party-appointed arbitrators are "supposed" to be advocates and that in many industry arbitrations the model is not one of a disinterested generalist judge. The court neatly distinguished the difference between a party-appointed arbitrator and a neutral arbitrator.

Analogizing to the rules for disqualification of federal judges, the Circuit Court determined that the party-appointed arbitrator would not have had to recuse himself for having rendered legal services to a party years before if he had been a federal judge. Even if he had been the umpire, stated the court, the party-appointed arbitrator's prior representation of the reinsurer would not have implied evident partiality. Even taking all of the alleged shortcomings in the disclosures as found by

the District Court as deficiencies, the Circuit Court held that there was no risk of evident partiality. The court stated that full disclosure is not compulsory for its own sake and the absence of full disclosure was not fatal to the award. The cedent's motion for rehearing and petition for rehearing en banc was denied on November 4, 2002. ⚖️

Summary of *Sphere Drake Ins. Ltd. v. All Am. Life Ins. Co.*, 307 F.3d 617 (7th Cir. 2002), Submitted by [Larry P. Schiffer](#), *LeBoeuf, Lamb, Greene & MacRae, L.L.P.*, New York, NY, (212) 424-8086, larry.schiffer@llgm.com.

4th Circuit Affirms Modification of Arbitration Award as Harmless Error

The Fourth Circuit Court of Appeals affirmed a District Court's modification of an arbitration award, holding that the modification was erroneous under the Federal Arbitration Act ("FAA"), but that the error was harmless. The cedents filed suit and simultaneously demanded arbitration against the reinsurer under various reinsurance contracts and a reconfirmation of agreement. The judicial proceedings were stayed pending the completion of the arbitration hearing. The arbitration panel found that the cedents had made material misrepresentations that justified an award in favor of the reinsurer. But the panel specifically stated in its award that it could not apply its findings to the reconfirmation of agreement. The reinsurer moved to confirm the award and the cedents cross-moved to modify the award by striking out the parts of the award concerning the panel's findings on the reconfirmation of agreement. The District Court granted the cross-motion and the reinsurer appealed.

In holding that the modification was erroneous, but nevertheless

was harmless, the court reasoned that the disputed findings did not affect the merits of the arbitral decision. Matters may be stricken from arbitration awards under the FAA only if they relate to an issue not submitted for arbitration and affect the merits. Because that was not the case with the disputed findings, which the court questioned but did not rule as to whether they constituted an award, the decision to strike the findings was erroneous. As the findings could have no collateral estoppel effect, the District Court's action was harmless. The court stated that its decision advanced the congressional purposes underlying the FAA by avoiding challenges to inconsequential portions of arbitral awards that merely prolong litigation.

We have seen a recent flood of challenges to arbitration awards and it is clear that the courts are pushing back those challenges to the narrow limits provided by the FAA. ⚖️

Summary of *Burlington Ins. Co. v. Trygg-Hansa Ins. Co.*, No. 01-2341, 2002 U.S. App. LEXIS 18239 (4th Cir. Sept. 2, 2002), submitted by [Larry P. Schiffer](#), *LeBoeuf, Lamb, Greene & MacRae, L.L.P.*, New York, NY, (212) 424-8086, larry.schiffer@llgm.com. and [Marie Martial](#), *LeBoeuf, Lamb, Greene & MacRae, L.L.P.*, New York, NY, (212) 424-8413, mmartial@llgm.com.

5th Circuit Affirms Finding that Cedent Did Not Waive Arbitration and Reverses District Court's Removal of Arbitrator

In a recent decision, the Fifth Circuit Court of Appeals continued the judicial trend toward favoring arbitration and avoiding interference with the arbitration process. In 1996, the cedent sued its reinsurer on a reinsurance contract. The court stayed the action and compelled arbitration. Four years later, the

cedent filed a second lawsuit claiming that the reinsurer had breached the arbitration agreement. The District Court consolidated the two actions and compelled arbitration a second time. In doing so, it dismissed the cedent's argument that the reinsurer had waived arbitration through allegedly dilatory practices. It also granted the reinsurer's motion to remove one arbitrator.

On appeal, the Fifth Circuit first addressed the question of whether it had jurisdiction to review the trial court's order. Concluding that it had jurisdiction, the appellate court went on to affirm the order compelling arbitration, agreeing with the holding there was no waiver, but reversed the order removing an arbitrator. As a preliminary matter, the appeals court had to determine whether the District Court's ruling was "final" so that it would have jurisdiction to review the decision. Citing U.S. Supreme Court precedent, the court explained that an appellate court may only review an order compelling arbitration if the District Court had dismissed the underlying action. If the court instead stayed proceedings, the order would not be ripe for appeal. Here, the District Court's consolidation of the two actions made it ambiguous whether it dismissed the earlier action. The appellate court assumed jurisdiction after determining that the District Court intended its order to be final and appealable. It based its belief, in part, on the District Court's order staying enforcement of its order compelling arbitration pending appeal.

Turning to the merits, the court considered the cedent's claim that the reinsurer waived its right to arbitrate by disputing aspects of the arbitrator selection process. The cedent argued that the reinsurer

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improperly vetoed the appointment of the third arbitrator. Even if the reinsurer deliberately stalled the arbitration process, the court held that this would be insufficient to waive arbitration. It cited the “strong presumption against finding waiver” and the “heavy burden” on the party claiming the other waived arbitration. Although a party might waive arbitration by pursuing litigation in a manner prejudicial to the other party, the court noted that only the cedent had brought disputes before the courts—the reinsurer “merely defended itself against [the cedent’s] court claims.” Mere delay falls far short of the waiver requirement, and the court affirmed the grant of summary judgment to the reinsurer on this point.

On the other hand, the court reversed the order removing one of the arbitrators. The arbitration agreement called for arbitrators who were “life insurance” executives. The District Court concluded that the cedent’s appointment of a reinsurance executive was the failure of a condition precedent to arbitration. While it was possible the cedent did not choose a properly qualified arbitrator, the appellate court held that the proper remedy would be to challenge the eventual award. The court contrasted removal of an arbitrator with selection, a measure that is possible when parties cannot otherwise amicably select a panel. Unlike selection in certain instances, removal does not advance the arbitration. The court held that even when there is a challenge based on bias, courts should not remove, but rather should consider the bias when deciding on a motion to confirm or vacate an eventual award. ⚖️

Summary of *Gulf Guaranty Life Ins. Co. v. Connecticut General Life Ins. Co.*, 304 F.3d 476 (5th Cir. 2002), submitted by **Larry P. Schiffer**, *LeBoeuf, Lamb, Greene & MacRae, L.L.P.*, New York, NY, (212) 424-8086, larry.schiffer@llgm.com., and **Daniel Paisley**, *LeBoeuf, Lamb, Greene & MacRae, L.L.P.*, New York, NY, (212) 424-8531, dpaisley@llgm.com.

Retrocedent Ordered to Proceed with Umpire Selection over Objections

A Massachusetts federal court recently ordered a retrocedent to proceed with selection of an umpire in accordance with the parties’ arbitration agreement. The dispute arose out of a retrocession agreement for accident and health reinsurance business that was underwritten and administered by the retrocedent’s agent. In the late 1990s, the retrocedent became concerned about the business that its agent was accepting on its behalf. As a result, in February 2000, the retrocedent and various retrocessionaires agreed to defer arbitration to resolve the disputes under the retrocession agreement. After it became clear that settlement could not be reached, the retrocessionaires demanded arbitration. More than eight months later, the parties could not agree on an umpire, prompting the retrocessionaires to petition the court for an order compelling the retrocedent to proceed with the umpire selection. The retrocedent cross-moved for an order directing the retrocessionaires to replace two of their three candidates.

During the umpire selection process, the retrocedent objected to two of the retrocessionaires’ nominees because they were already participating as umpires in other arbitrations involving the retrocedent. In granting the retrocessionaires’ petition, the court rejected the retrocedent’s objections and ordered the retrocedent to select an umpire in accordance with the

arbitration agreement. The court stated that the retrocedent’s “procedural maneuvers” were “utterly frivolous.” The court, clearly upset by the retrocedent’s tactics, imposed additional sanctions by stating that any failure to strictly comply with the court’s order would be deemed a waiver of arbitration, and by requiring the president of the retrocedent to submit an affidavit acknowledging the order and undertaking to strictly comply with the arbitration process in the future. ⚖️

Summary of *Fidelity Security Life Ins. Co. v. John Hancock Life Ins. Co.*, No. 02-11663 (WGY) (D. Mass. Sept. 27, 2002), submitted by **Larry P. Schiffer**, *LeBoeuf, Lamb, Greene & MacRae, L.L.P.*, New York, NY, (212) 424-8086, larry.schiffer@llgm.com., and **Melissa Battino**, *LeBoeuf, Lamb, Greene & MacRae, L.L.P.*, New York, NY, (212) 424-8250, mbattino@llgm.com.

New York Federal Court Reconsiders but Maintains Awards of Prejudgment Security

A New York federal court granted reconsideration on a motion to vacate arbitration awards for prejudgment security, but the result remained the same. The alien reinsurer raised four challenges to the court’s original order. The first challenge was that the court erred in not using a *de novo* standard to review the awards for manifest error in law. The court rejected this ground for reconsideration. Although the Second Circuit reviews a District Court’s determination *de novo*, this does not affect the extensive authority cited regarding the court’s severely limited review of an arbitral award.

The second challenge was a public policy argument based on the interplay between the Inter-American Convention and the

reinsurer's foreign country ownership. The court recognized that the claim was originally made by the reinsurer and was overlooked. In analyzing the public policy argument, the court noted that Section 1609 of the Foreign Sovereign Immunities Act ("FSIA") explicitly states that "a foreign state shall be immune from attachment arrest and execution." Additionally, the Second Circuit has held that this section requires that a foreign state or its instrumentality is generally immune from prejudgment attachment of its assets in the United States unless the state explicitly waives its immunity. The court held that even though the reinsurer correctly identified an explicit public policy, the reinsurer, a party claiming the benefits of the FSIA, waived its immunity by agreeing to arbitration. Because the reinsurer failed to show how enforcing the awards explicitly conflicted with this public policy, reconsideration was denied.

The third challenge was that the court erred in finding that the arbitration panel did not act in manifest disregard for the law. In rejecting this ground, the court explained that existence of three unreported court opinions, all of which approved the award of prejudgment security against a foreign state or instrumentality in the context of an arbitration, merely showed that the law in this area is not well-defined and explicit.

The final challenge was that the arbitration panel erroneously relied on the terms of the reinsurance agreement in the finding that the reinsurer was required to post prejudgment security. The court denied reconsideration on this ground because a court must confirm the award if grounds for the decision can be inferred from the facts of the case. ⚖️

Summary of *Banco De Seguros Del Estado v. Mutual Marine Offices, Inc.*, No. 02 Civ. 467 (SAS), 2002 U.S. Dist. LEXIS 16980 (S.D.N.Y. Sept. 10, 2002), submitted by [Larry P. Schiffer](#), *LeBoeuf, Lamb, Greene & MacRae, L.L.P.*, New York, NY, (212) 424-8086, larry.schiffer@llgm.com. Schiffer, and [Marie Martial](#), *LeBoeuf, Lamb, Greene & MacRae, L.L.P.*, New York, NY, (212) 424-8413, mmartial@llgm.com.

2nd Circuit Affirms Dismissal on *Forum Non Conveniens* Grounds

The Second Circuit affirmed the District Court's dismissal of the cedent's case and vacated the District Court's judgment concerning personal jurisdiction over the reinsurers. The court found that dismissal on the basis of *forum non conveniens* was not an abuse of discretion and that the reinsurance contracts did not incorporate the forum selection clause of the underlying insurance contract. The cedent had issued a policy related to an offering of notes by a film funding company and reinsured those risks with the defendant reinsurers. When the reinsurers failed to make requested payments, the cedent brought suit. The District Court found personal jurisdiction over certain of the reinsurers, but granted all the reinsurers' motion to dismiss for *forum non conveniens*. The reinsurers appealed from the personal jurisdiction finding. The cedent appealed from the dismissal arguing the reinsurance contract incorporated the forum selection clause found in the underlying insurance policy and that the District Court abused its discretion in granting the dismissal.

The Circuit Court reviewed the District Court's dismissal for *forum non conveniens* for a clear abuse of discretion and found no abuse. Regarding the forum selection clause, the court stated that its determination would be the same

under both English and New York law. Under English law, there is a strong presumption against incorporation of collateral terms. New York's standard for incorporation requires a "clear indication of intent." While the court found that New York would look to English law, it found that in either situation, the law did not allow for the incorporation of the forum selection clause from the underlying policy into the reinsurance contract. Finally, because the court affirmed the District Court's dismissal for *forum non conveniens*, it held that the personal jurisdiction issue was moot. It, therefore, vacated the District Court's judgment as to personal jurisdiction. ⚖️

Summary of *New Hampshire Ins. Co. v. Sphere Drake Ins. Ltd.*, Nos. 02-7872, 02-7946, 2002 U.S. App. LEXIS 23120 (2d Cir. Nov. 5, 2002), submitted by [Larry P. Schiffer](#), *LeBoeuf, Lamb, Greene & MacRae, L.L.P.*, New York, NY, (212) 424-8086, larry.schiffer@llgm.com, and [Cristina Lucchetti Ryan](#), *LeBoeuf, Lamb, Greene & MacRae, L.L.P.*, New York, NY, (212) 424-8435, clryan@llgm.com.

8th Circuit Enforces Follow-the-Fortunes Doctrine Against Retrocessionaires

The Eighth Circuit Court of Appeals recently found in favor of a retrocedent on follow-the-fortunes grounds, but remanded the case to the District Court on the issue of damages. The retrocedent reinsured the underlying cedent's short term medical insurance business and retroceded those risks to the retrocessionaire. Losses occurred and the retrocedent billed the retrocessionaires even though it had not made any premium payments to the retrocessionaires. The retrocessionaires cancelled the retrocessional coverage and sought rescission based on non-payment of premium. The retrocedent sued for breach of

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contract and won, based in part on the follow-the-fortunes doctrine.

In affirming the District Court, the Eighth Circuit found that the retrocessionaires failed, as a matter of law, to show sufficient evidence to support their claim. The court rejected the retrocessionaires' argument that the terms and conditions of the underlying reinsurance contract, which required strict proof of coverage, was incorporated in the retrocessional agreement. The court reviewed the language of the retrocessional placement slips and found that it did not explicitly incorporate the underlying conditional procedures. As there was no contractual agreement to preempt application of customary follow-the-fortunes principles, the court affirmed summary judgment against the retrocedent. The court also rejected the retrocessionaires' argument that they were entitled to rescission based on material misrepresentations. In rejecting this argument, the court found no evidence to support the proposition that the retrocedent knew that the program would be unsuccessful.

One interesting point was the claim by the retrocessionaires based on the failure of the retrocedent to pay premiums. The opinion notes that the retrocedent deducted the net premium payments from the losses billed. In other words, traditional net accounting occurred, which cannot form the basis for a breach of contract for non-payment of premium unless the contract has explicit provisions that require premiums to be paid without offsetting against loss payments due.


The opinion also has a nice discussion of the doctrine of utmost

good faith and its relationship with the follow-the-fortunes doctrine. Notably, the District Court found that the retrocedent had fulfilled its obligations under the contract because it had not acted in bad faith, with gross negligence, or recklessly in paying the losses billed to it by its cedent and in subsequently billing the appropriate proportion of those losses to the retrocessionaires. The Eighth Circuit did not offer its opinion on the scope of the follow-the-fortunes doctrine, but expressly adopted the "bad faith" standard adopted by the Eleventh, Third, and Second Circuits and found that the retrocessionaires failed to present sufficient evidence to support their claim of the retrocedent's bad faith. In fact, the court held that the evidence the retrocessionaires pointed to did not amount to "deliberate deception, gross negligence or recklessness." 

Summary of *Reliastar Life Ins. Co. v. IOA Re, Inc.*, 303 F.3d 874 (8th Cir. 2002), submitted by [Larry P. Schiffer](#), *LeBoeuf, Lamb, Greene & MacRae, L.L.P.*, New York, NY, (212) 424-8086, larry.schiffer@llgm.com.

New York Federal Court Grants Rescission to Reinsurer Based on Failure of Cedent to Disclose Insolvency

A New York federal court followed New York state court precedent in granting a reinsurer rescission of its reinsurance contracts with a now insolvent cedent. This case is the latest and hopefully, according to the court, the last chapter in the saga of the insolvency of Delta American Re. The Liquidator sought to obtain amounts due under two reinsurance agreements. The reinsurer claimed that it was entitled to rescission based on the cedent's failure to disclose its insolvency. Quoting liberally and favorably from *Michigan National Bank-Oakland v. American Centennial Insurance Co.*, 89

N.Y.2d 94 (1996), the court granted rescission to the reinsurer. The court found that there were a significant number of judicial admissions made by the Liquidator in earlier proceedings and substantial evidence that the cedent knew it had solvency problems, which it failed to disclose while soliciting the reinsurer's participation on its reinsurance program. While granting rescission in favor of the reinsurer, the court ruled that the reinsurer was not entitled to retain the premiums it received and was obligated to pay interest on those premiums. This case again demonstrates that receivers must be very careful in taking positions against the prior management of the company when they are at the same time seeking to enforce the company's reinsurance agreements. 

Summary of *Nichols v. American Risk Management, Inc.*, No. 89 Civ. 2999 (JSM), 2002 U.S. Dist. LEXIS 22221 (S.D.N.Y. November 18, 2002), submitted by [Larry P. Schiffer](#), *LeBoeuf, Lamb, Greene & MacRae, L.L.P.*, New York, NY, (212) 424-8086, larry.schiffer@llgm.com.

New York Appellate Court Remands Case for Determination of the Materiality of Fronting Company's Identity

A New York intermediate appellate court recently reversed summary judgment and remanded for trial the issue of whether the identity of a fronting insurer was material in a reinsurance agreement. In the underlying case, the insured owned a chemical plant destroyed by a fire. The insured had dealt with a broker who arranged both a fronting company and also reinsurers which ultimately bore all the risk. When one fronting company decided not to continue the relationship, the broker found other insurers. It located a reinsurer before settling on a replacement

fronting company, and it sent a placement slip providing that the reinsurance would cover an “Israeli Company to be agreed.” After finding a fronting company, the broker sent the reinsurer a binder with the new fronting company’s name. The reinsurer’s acknowledgment stated that it would reinsure a different fronting company, the one previously involved with the insured. The broker failed to notice the discrepancy, the reinsurer refused to respond to the loss, and the insured brought suit in New York against the broker for negligence.

The trial court granted summary judgment for the insured on the basis that the broker was negligent as a matter of law. The court did not consider the argument that the identity of the fronting company was immaterial to the reinsurer’s decision to underwrite the underlying risk. This, the Appellate Division held, was error. Affidavits introduced stated that “almost all Israeli facultative reinsurance placements were 100% fronted with the reinsured or ‘fronting company’ playing a strictly ministerial role.” The broker also contended that the reinsurer agreed to reinsure the plant irrespective of the fronting company involved. The broker offered the cut-through provision in the reinsurance agreement, which permitted claims to bypass the fronting company, as evidence of the fronting company’s immateriality. The contention that the broker’s error was not a defense to coverage, the appellate court held, raised an issue of fact enabling the broker to go to trial rather than face summary judgment.

An additional complexity in the case was the reinsurer’s position as the true party in interest. Subject to a settlement agreement between the insured and the reinsurer reached in Israel, the insured assigned its

claims against the broker to the reinsurer. The broker contended this assignment violated public policy because the reinsurer attempted to avoid adjudication of its liability. In dismissing this argument, the Appellate Division noted that the reinsurer merely stepped into the shoes of the insured and its settlement payment was only consideration for the rights against the broker. The court reasoned that the reinsurer could not escape litigation of its liability. This is because to prevail on remand, the reinsurer must show it had no obligation to cover the loss and rebut the contention that the fronting company is immaterial. ⚖️

Summary of *Trans-Resources, Inc. v. Nausch Hogan & Murray*, 746 N.Y.S. 2d 701 (N.Y. App. Div. 1st Dep’t 2002), submitted by **Larry P. Schiffer**, *LeBoeuf, Lamb, Greene & MacRae, L.L.P.*, New York, NY, (212) 424-8086, larry.schiffer@llgm.com, and **Daniel Paisley**, *Le Boeuf, Lamb, Greene & MacRae, L.L.P.*, New York, NY, (212) 424-88531, dpaisley@llgm.com.

Reinsurer’s Action to Recover Claims Payments Erroneously Billed by Cedent Not Arbitrable Under “Narrow” Arbitration Clause

Reversing the trial court’s grant of a stay in favor of arbitration, the Appellate Division of the Supreme Court of New York ruled that the “narrow” arbitration clause in a reinsurer’s facultative certificates was limited to disputes involving contract interpretation and was not triggered when the reinsurer merely sought restitution of certain claims payments because the cedent had incorrectly applied its own environmental pollution allocation methodology.


The cedent issued three successive excess insurance policies providing liability coverage for environmental pollution claims

between 1962 and 1971 to an insured. The reinsurer issued two facultative certificates covering the cedent’s second and third excess policies. When the cedent settled three separate environmental claims against its insured, it misapplied its allocation formula in each instance resulting in about \$3.1 million of loss billings to the reinsurer under the certificates when, in fact, it had no liability.

When the reinsurer’s refund demand was rejected by the cedent, it commenced this restitution action in New York state court. The cedent responded with the affirmative defense that the parties must arbitrate this refund dispute pursuant to the certificates’ identical arbitration clauses, which provided: “Should an irreconcilable difference of opinion arise as to the interpretation of this contract, it is hereby mutually agreed that, as a condition precedent to any right of action hereunder, such difference shall be submitted to arbitration.” The trial court agreed and issued a stay of the restitution action in favor of arbitration.

On appeal to the Appellate Division, the Supreme Court reversed and held that the cedent had failed to meet its burden to demonstrate a “clear and unequivocal” agreement to arbitrate this dispute, which, according to the court, did not require the interpretation of any reinsurance agreement provision. Adopting the Second Circuit’s distinction between “narrow” and “broad” arbitration clauses in *Louis Dreyfus Negoce S.A. v. Blystad Shipping & Trading Inc.*, 252 F.3d 218 (2d Cir.), *cert. denied sub nom. Negoce v. Blystad Shipping & Trading, Inc.*, 534 U.S. 1020 (2001), it ruled that under a “narrow” arbitration clause the court must determine whether the dispute is over an issue that is on its face within the purview

of the clause or over a collateral issue that is somehow connected to the main agreement that contains the arbitration clause. If the latter, then such collateral matters will be ruled beyond the clause's purview. Because the cedent's billing errors did not involve differences over contract interpretation (*i.e.*, the reinsurer

was only challenging the cedent's billing calculations and not the merits of its underlying claims settlements or environmental pollution allocation formulas), they fell within the realm of a non-arbitrable collateral issue and, therefore, were beyond the purview of the certificates' "narrow" arbitration clause. 

Gerling Global Reinsurance Corp. v. The Home Insurance Co., No. 2125N, 2002 N.Y. App. Div. LEXIS 12519 (N.Y. App. Div. Dec. 17, 2002), submitted by [Ronald S. Gass](#), *The Gass Company, Inc.*, Weston, Connecticut, (203) 227-9431, rgass@gassco.com.

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RECENT DECISIONS FROM THE U.K.

Commercial Court Ruling on Aggregation

The aggregation of claims is a topic that comes before the English courts on a fairly regular basis. In this case, the subject matter was the SIB pensions review. For those readers unfamiliar with this topic, the Securities and Investment Board ("SIB") initiated a review of pension sales in the six-year period spanning 1988 and 1994. This highlighted the difference between final salary pension schemes, in which an employee receives a pension based upon their final salary and length of service, and personal pension plans ("PPP"), in which the ultimate pension depends upon the performance of the markets.

During the period in question, a large number of personal pensions were sold with the promise of healthy returns giving investors the chance to have a better pension than they would have achieved in a final salary scheme. Stock markets did not maintain their previously high growth, meaning that many investors (at least on current market performance) would have been better off joining, or keeping their benefits in, a final salary pension scheme. As a result, a large number of people complained they had been badly advised in that they were not made aware that they could receive a lower pension than they would have done with a final salary

scheme. The review required advisers to revisit pensions sold where investors were eligible to have joined their employer's scheme or who had transferred deferred benefits from a former employer's scheme. If it were found in any given case that the sale of the pension did not comply with regulatory guidance (which entailed ensuring the investor was fully aware of the risks associated with a PPP) and that it could not be shown that but for those failures, the investor would have still purchased their relevant pension policy, the adviser was required to compensate the investor accordingly.

Consequently, claims were made on advisers' professional indemnity policies in large numbers—the exposure to the insurance industry has run into billions of pounds. Some advisers found multiple liabilities and, in such cases, both insureds and insurers have attempted to aggregate claims so as to maximize recovery or minimize payments.

Countrywide benefited from a policy which provided that an insurer's liability would not exceed £1,000,000 any one claim but only £125,000 for "financial services division." Under a heading entitled "definitions," it was provided:

'Any claim' or 'any loss' shall mean one occurrence or all occurrences of a series consequent upon or attributable to one source or

original cause. This definition shall also mean the discovery of the dishonesty of any person(s) and shall constitute one occurrence or one original cause.

The limit of indemnity was subject to "each and every claim" excess with an aggregate excess of £1 million. Once the aggregate had been eroded, the policy provided for an excess of £5,000 each and every claim, adding: "in respect of claims arising out of pension transfer activities the excess is to apply on an each and every claimant basis."

The insured wished to aggregate all payments of redress paid to investors under the review to pay a single excess. Insurers argued that an excess was payable for every claimant due to the policy wording. This significantly reduced the total sum recoverable by the insured given that a large proportion of redress payments made were below the £5,000 excess. Thereafter, it was in the primary layer insurer's interest that the claims be aggregated, in order that only one payment need be made and that excess layer insurers could bear the rest. Conversely, it was in the interest of excess layer insurers that each redress payment be dealt with as a separate claim, thus ensuring that they would not have to make any payments on their policies. A hearing was ordered on the preliminary issue of whether or not the claims could be aggregated.

Countrywide maintained that claims should be aggregated because all payments could be traced to an original cause, namely the failure of management to ensure that its sales force had been properly trained to give appropriate advice to customers. For the purposes of the hearing, it was presumed that the insured had been able to prove that it was necessary for the sales force to receive training to enable them to give appropriate advice to customers and that the insured failed to institute a proper scheme. As a consequence, the sales force gave inappropriate advice, resulting in pension mis-selling. The failure to institute a proper scheme of training was therefore claimed to be the “source or original cause” that was capable of aggregating the claims.

Morrison J held that the claims were indeed capable of aggregation, but on the construction of the policy, the excess applied on an “each and every claimant” basis. The judge accepted that whilst a policy would normally be worded so that the aggregation of a claim would also involve the aggregation of the excess, with aggregation for both excess and limit, this would depend upon the policy wording. The proper approach to the construction of policy wording must be without pre-conception as to the result. The policy had been concluded as a result of negotiations between two commercial parties. It was clear that insurers had intended to provide an excess on an each and every claimant basis regardless of whether or not the payments to claimants were subject to aggregation. The judge then went on to consider whether or not the claims could be aggregated.


He first held that the claims were sufficiently related to form part of a

series, given that they all occurred as a result of mis-selling of pensions. Citing *Axa Re —v- Field* [1986] 3 ALL ER 517, he stated:

Whilst an event, occurrence or claim is ‘something which happens at a particular time, at a particular place in a particular way’ a ‘cause’ is not just ‘something altogether less constricted’, it is a word which is fulfilling a different function. The word event, occurrence or claim describes what had happened; the word ‘cause’ describes why something has happened. The words ‘one source or original cause’ are, as Hobhouse L. J. said, ‘wide’. It is, I think, the force of the word ‘original,’ or ‘originating’ in the *Axa Reinsurance* case, that entitles one to see if there is a unifying factor in the history of the claims with which the Claimants were faced. In my view, the lack of proper training of the selling agents and selling employees was behind the whole problem. It was this which . . . was a consistent and necessary factor which allowed the mis-selling to occur . . . [T]he clause entitles one to move back and find a single source or original cause; and in this case, there is one.

The outcome of this case is not entirely surprising in light of *Lloyd’s TSB General Insurance Holdings —v- Lloyd’s Bank Group Insurance Co.* [2001] EWCA CIV 1643, which held (in the context of the aggregation clause), that the term “act or omission” was a reference to the failure by sales consultants to provide best advice and that the failures could

indeed constitute a “related series of acts or omissions.” In *Lloyd’s TSB* the court went on, however, to hold that the failure to train did not come within the definition of an act or omission as contemplated by the insuring clause. This case, which was not referred to in *Countrywide*, is awaiting appeal before the House of Lords.

This case demonstrates that the courts are more willing than they have been on some occasions in the past to aggregate claims, particularly where policy wording is relatively wide. Where the words “original cause” are used, insurers expose themselves to the possibility that the insured will seek to aggregate on the basis of an act or omission, such as a failure to train staff properly, when it would not otherwise be possible. This in turn has a knock-on effect on reinsurers in that if a large number of small claims aggregated, any excess of loss reinsurer is very much more likely to have to pay on their policy. If reinsurance is on a quota share basis, then the amount payable increases in line with insurer’s increased liability. Aggregation will only be in the interest of a reinsurer where it participates on a policy where the level of indemnity is relatively low and there are other layers of cover in place. In such a situation, aggregation will have the effect of passing much of the liability unto excess layer insurers and minimise the number of claims on the primary policy. 

Summary of *Countrywide Assured Group plc —v- AIG Europe* (UK) [2002] All ER (D) 203 submitted by [Peter Gray](#), *LeBoeuf, Lamb, Greene & MacRae*, London, England, 011-44-207-459-5049, peter.gray@llgm.com.

2003 TIPS CALENDAR

March

13-15 **Property Insurance Law
Committee Spring** **New Orleans, LA**

20-21 **Emerging Issues in
Motor Vehicle Product** **Phoenix, AZ**

21-22 **Toxic Torts and Environmental
Law Committee** **Phoenix, AZ**

24-25 **Vision 20/20 Institute** **Hartford, CT**

April

12-16 **TIPS National Trial Academy** **Reno, NV**

17-18 **Transportation MegaConference VI** **New Orleans, LA**

May

1-4 **TIPS Spring Meeting** **Austin, TX**

7-10 **FSLC Spring Meeting** **Chicago, IL**

13-14 **Staff Counsel Meeting** **New York, NY**

August

7-13 **ABA Annual Meeting** **San Francisco, CA**

October

TBA **Aviation Litigation Meeting** **Washington, DC**

TBA **FSLC Fall Meeting** **TBD**

22-27 **TIPS Fall Meeting** **Savannah, GA**