

In this month's edition

Scheme to Avoid Capital Gains Taxes Through Insurance Policies With Return of Premium Riders Leads to Criminal Conviction

Court Denies Claim by Cedent Against Reinsurer's Managing General Agent, Acknowledges Viability of Verbal Gentleman's Agreement

General Statute of Limitations Governs Suit Against Reinsurer

Broker Acted on Behalf of Insured, Not Insurer; No Breach by Insurer Where Insured's Disclosure Statement Did Not Disclose Potential Claims of Employee Benefit Plan Members

New York's First Department Rejects Well-Established Precedent on Coverage Notices

Court Follows 'Follow-The-Fortunes,' Upholds \$420 Million Judgment Against Reinsurers



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U.S. COURT OF APPEALS DECISIONS

Sixth Circuit Court of Appeals

Scheme to Avoid Capital Gains Taxes Through Insurance Policies With Return of Premium Riders Leads to Criminal Conviction

United States v. Rozin,
(No. 11-3186, Jan. 6, 2012)

On January 6, 2012, the Sixth Circuit upheld the conviction of Leif Rozin on the counts of subscribing a false tax return, attempting to evade taxes, and conspiracy to defraud the government. The charges arose out of corporate and personal income tax returns filed on behalf of Rozin; his company, Rozin Inc.; and the co-owner of Rozin Inc., Burton Kallick. In 1998 Rozin and Kallick began negotiations for the sale of Rozin Inc., which they realized would result in potentially large taxable profits.

Through their long-time insurance broker, Rozin and Kallick learned of purportedly tax-deductible loss of income (LOI) insurance policies offered by the Caduceus Life Insurance Company, licensed in the U.S. Virgin Islands. The LOI policies only insured against losses in a narrow range of circumstances, including: corporate downsizing, changes in technology, or employee layoffs arising within one year from the date of the policy's issuance. In conjunction with the LOI policies, Caduceus also offered return of premium (ROP) riders, which enabled the purchaser to receive a significant portion of the premium paid for the LOI policy if no claim was filed on the policy.

In October 1990, Rozin Inc. purchased two LOI policies and riders, with Rozin and Kallick named as the insured individuals. The premium on each policy was \$600,000 and the amount of coverage was \$720,000. If Rozin or Kallick qualified for coverage during the one-year policy period, the maximum amount that they could receive was \$30,000 per month for 24 months. At the end of 1998, Rozin and Kallick were negotiating the sale of Rozin Inc. A CPA advised them that the tax liability resulting from capital gains upon sale could be up to \$2.2 million. In July 1999, as Rozin Inc. was preparing its 1998 tax return, the October LOI payments were labeled as "general insurance" and deducted. Rozin and Kallick instructed their insurance broker to purchase four additional LOI policies in July or August 1999, backdating the policies to December 1998, so that the deductions could be taken on the 2008 return. Upon the purchase of the August 1999 policies, Caduceus had substituted its ROP riders with a new plan allowing the premium funds to be placed in grantor trusts established by Rozin and Kallick and invested in reinsurance companies in Nevis, an island in the Caribbean. Under this scheme, if no claim was made on the LOI policies, Rozin and Kallick could access the funds after twelve months. In December 1999, Rozin and Kallick purchased additional policies, with Rozin Inc. paying almost \$1.6 million in premiums for these policies. During this time, Rozin also spoke with friends about purchasing LOI policies.

In early 2000, the insurance commission in the Virgin Islands audited Caduceus, and in June or July, Rozin Inc.'s corporate tax return was prepared, with a tax deduction for the LOI policies purchased in December 1999. A federal grand jury returned an indictment charging Rozin

and Kallick, among others. Kallick would pass away prior to the trial, leading to the government's dismissal of the charges against him. Rozin was convicted on all three charges. The circuit court affirmed the conviction, upholding the court's reliance on several factors, including: the lack of a true business purpose for the purchase of the LOI policies, the "dubious nature" of the policies, Rozin's access and control over the funds, and Rozin's description of the policies to friends as "tax-savings product[s]." Rozin was ordered to pay full restitution for both his and his co-conspirator, Kallick's, unpaid taxes.

IMPACT – REINSURANCE: This case illustrates a danger of the use of creative insuring arrangements as a means of avoiding tax liabilities. Where such actions cross the line from legal to illegal schemes to defraud the government, conspiracy liability may apply, making one defendant liable for all co-conspirators' liability for restitution.

U.S. DISTRICT COURT DECISIONS

Middle District of Alabama

Court Denies Claim by Cedent Against Reinsurer's Managing General Agent, Acknowledges Viability of Verbal Gentleman's Agreement

Alabama Mun. Ins. Co., v. Alliant Ins. Servs. Inc.,
(No. 09-CV-928-WKW, Jan. 9, 2012)

On Jan. 9, 2012, the U.S. District Court for the Middle District of Alabama, Northern Division, granted defendant Alliant Insurance Services, Inc. (Alliant)'s renewal of motion for

judgment brought under federal rule of civil procedure 50(b), entering judgment in favor of Alliant as a matter of law. The case arose out of reinsurance policy negotiations that took place in April and May 2000 between Alliant and the plaintiff, Alabama Municipal Insurance Corporation (AMIC), a nonprofit corporation formed by the Alabama League of Municipalities to provide insurance for Alabama municipalities and other entities. Alliant offered a reinsurance program, Public Entity Property Insurance Program (PEPIP), that it sold to public entity insurers, underwritten by various underwriters, including Lloyd's of London (Lloyd's). AMIC joined the PEPIP program by purchasing a reinsurance policy with total insured values of roughly \$650 million. Because the 2000-2001 premium and aggregate deductible quoted to AMIC were so favorable and cheap, AMIC President Steve Wells, during a round of golf in August 2001, told Alliant Vice Presidents Gerry Lillis and Mr. Wozniak that AMIC would not submit reinsurance claims for the 2000-2001 treaty year. Both parties referred to the statement as a gentleman's agreement and whether or not it was a legally binding agreement was never reduced to writing.

In accordance with the gentleman's agreement, AMIC did not submit its 2000-2001 claims until November 2006, when Wells unilaterally decided that AMIC was no longer being treated fairly by Alliant. The 2000-2001 claims were eventually submitted through Alliant to Lloyd's, whose lawyer indicated in 2009 that Lloyd's would not pay, because AMIC's insured values had doubled during the treaty year and no corresponding premium was paid. Issues arose involving: 1) whether in 2000 Alliant agreed to timely transmit notices of loss to Lloyd's; 2) if so, if AMIC subsequently

agreed not to pursue notices of loss with Lloyd's through Alliant, under the Gentleman's Agreement; and 3) if the Gentleman's Agreement was not binding, did the parties' conduct create an equitable bar to enforcement of the alleged contract?

In its complaint, AMIC alleged one count of breach of contract for Alliant's alleged failure to perform contractual obligations. In the complaint, AMIC referred to Alliant as its managing general agent (MGA). At trial, a jury returned a verdict in favor of AMIC on its breach of contract claim in the amount of \$392,429. The jury found that AMIC and Alliant entered into an MGA contract and that Alliant breached the contract, rejecting Alliant's defenses of equitable estoppel, laches, and statute of frauds.

In its renewed motion for judgment as a matter of law, Alliant argued that the jury's verdict was unsupported factually and legally. The court first assessed the legal sufficiency of the evidentiary basis supporting the jury's finding that the parties entered into an MGA contract. The court concluded that there was no MGA contract between Alliant and AMIC. Looking to the testimony presented at trial by AMIC's president and CEO, as well as an expert and broker presented by AMIC, the court found that Alliant was an MGA for the reinsurer, Lloyd's, not AMIC.

Second, the court found that contrary to the jury verdict, AMIC failed to prove any breach of contract claim. The court described AMIC's evidence as that a valid contract existed between Alliant and AMIC as "hopelessly indefinite." AMIC had argued that the written PEPIP manuscript was the contract between AMIC and Alliant, but the court rejected this argument, finding no legally sufficient

basis to establish the existence of a clear and definite contract. Further, even assuming that the contract was valid, the court noted that AMIC nonetheless failed to prove its own performance under the contract due to the fact that it failed to timely notify Alliant of any losses suffered that were covered by the 2000-2001 Lloyd's reinsurance policy. An agent of AMIC testified that he first submitted claims on the policy on Feb. 2, 2005, and again on Oct. 30, 2006. However, at the times when these claims were submitted, the Gentleman's Agreement was still in effect, AMIC had made outward manifestations concerning the agreement, the agent had knowledge that the agreement was still in effect when he submitted the claims, and accordingly, submission of the claims was outside the agent's actual authority and therefore considered not submitted as a matter of law. The court further concluded that the Oct. 30, 2006 submission was untimely as a matter of law, not only because five years had elapsed between the end of the policy term and the submission of the claims by AMIC, but also because AMIC had claims ready to be submitted as of Feb. 2, 2005. Further, the court concluded that AMIC failed to show that it suffered damages as a result of Alliant's alleged breach regarding the timely submission of AMIC's claims.

Finally, the court found that even if AMIC established a binding contract with Alliant, Alliant would still be entitled to judgment as a matter of law on its statute of frauds and equitable estoppel defenses. The court found that AMIC had not established a writing which bound Alliant in any respect to "do whatever it takes to get our claims paid" and thus the Alabama statute of frauds barred AMIC's recovery. According to the court, the evidence AMIC presented to the

jury regarding its damages was legally insufficient to establish with reasonable certainty a causal relationship between Alliant's alleged breach and Lloyd's refusal to pay AMIC's claims. The court further found that no reasonable juror could have found that Alliant failed to prove its equitable estoppel and laches defenses. With respect to the equitable estoppel defense, the court found the elements satisfied, as: (1) Mr. Wells' promise that AMIC would not submit claims unless AMIC decided to submit claims was inherently misleading, (2) Alliant relied upon the misleading statements when it received AMIC's loss claims but did not transmit them to be adjusted or paid; and (3) Alliant's reliance on the communication in not submitting the claims when first received materially harmed Alliant. The court also noted that even if the equitable estoppel defense failed, laches would bar AMIC's recovery, since the gentleman's agreement served as a change of condition that would make the enforcement of a claim unjust.

IMPACT – REINSURANCE: Here, a cedent made a gentleman's agreement with the reinsurer's managing general agent that the court later acknowledged to estop the cedent from pursuing a breach of contract claim against the agent. In the world of reinsurance, gentleman's agreements, even verbal ones, are typically enforced.

STATE COURT DECISIONS

California Court of Appeals

General Statute of Limitations Governs Suit Against Reinsurer

Transport Ins. Co., v. TIG Ins. Co.,
(A122573, Jan. 13, 2012)

On Jan. 13, 2012, the Court of Appeal of California, First Appellate District, affirmed a judgment denying the plaintiff Transport Insurance Company (Transport) motion for a new trial. The case arose out of a blanket excess liability insurance policy that Transport issued to Aerojet-General Corporation (Aerojet) in July 1973. Following issuance of the policy to Aerojet, Transport entered into three reinsurance agreements, the first two with International Surplus Lines Insurance Co., a predecessor to TIG Insurance Company (TIG), one of the two respondents, and the third with Unigard Mutual Insurance Co., a predecessor to Seaton Insurance Co. (Seaton), the other respondent in this appeal. Beginning in 1980, numerous suits were brought against Aerojet and it began submitting claims for property damage to Transport, which Transport denied based on a policy exclusion. Transport did, however, pay some investigative expenses and submitted claims to its reinsurers. In December 1997, a decision by the California Supreme Court held that site investigative expenses could be covered. Thereafter, Transport settled with Aerojet, agreeing to pay \$26.6 million. Transport claimed that over \$12 million of this settlement was covered by the reinsurance agreements, and in December 1999, submitted its billing and final proof of loss. In 2006, Transport filed separate suits against each of its reinsurers, and following a 17-day trial,

a jury decided that the lawsuits were not timely filed, and judgment was entered against Transport.

The primary issue in the case was whether Transport timely sued its reinsurers or whether its suits were time-barred. The court noted provisions of the reinsurance contracts governing when loss was to be paid, which: "payment of [reinsurer's] proportion of loss and expense paid by [Transport] will be made by [reinsurer] to [Transport] promptly following receipt of proof of loss." The court then discussed the origin and characteristics of reinsurance agreements at length, noting that one aspect of reinsurance that distinguishes it from other types of insurance is that reinsurance contracts generally have no limitation provision and no reference to when a suit must be brought on the contract. Since there is typically no special statute of limitations for reinsurance contracts, the general statute of limitations applies. The court also reflected upon the fact that based upon the sophisticated nature of parties to reinsurance agreements, reinsurers and cedents have been referred to as "partners" rather than "adversaries." Reinsurance is relatively new to the courts, as conflicts were often settled by "gentleman's agreements," but now several issues, including statutes of limitations, have been brought to the courts.

The appellate court, and the trial court below, relied heavily on a 1996 decision by the Second Circuit, *Continental Cas. Co. v. Stronghold Ins. Co. Ltd.*, 77 F.3d 16 (Stronghold), which held that for statute of limitation purposes, a cause of action against a reinsurer accrued when the cedent notified the reinsurers of its losses under the reinsurance policies and the reinsurers subsequently denied

coverage. The court further stated that the insured has a duty to report any actual losses to the reinsurer within a reasonable period, and give the reinsurer a reasonable amount of time to decide whether and what amount it would pay. Accordingly, following Stronghold, the statute of limitations on an action against a reinsurer did not commence to run until a reasonable time elapsed after the ceding insurer gave notice of the loss to the reinsurer.

In April 2007, Transport filed a motion for summary adjudication, arguing that as a matter of law, Transport's claims were not barred by the four-year statute of limitations, and both TIG and Seaton filed opposition to the Transport motion as well as motions of their own. In April 2008, the court denied Transport's motion, as well as those of TIG and Seaton, finding that the parties have not found any California decisions addressing the question of when a cause of action for breach of a reinsurance contract accrues. The court followed Stronghold, finding that the cause of action accrued after Transport submitted a proof of loss and the reinsurer either (1) denied a claim or (2) took an unreasonable amount of time to communicate its coverage decision, and from that point, a plaintiff has four years to file its action against its reinsurer. Motions were then denied on the ground that the court found triable issues existed as to whether either reinsurer ever formally denied Transport's claims made in 1999, and when the cause of action nevertheless accrued after a reasonable amount of time passed for the reinsurer to evaluate the claims.

The jury trial began May 12, 2008, and the jury instructions given on the statute of limitations, stated, "In this case, Transport's claims against the defendant

accrued after Transport submitted its claims to defendant and when, one, defendants denied the claims, or, two, a reasonable period of time elapsed after the submission of the claims without a decision by the defendants. If [the reinsurer] either denied the claims or a reasonable period of time elapsed following submission of the claims by Jan. 30, 2002, Transport's claims against [the reinsurer] were filed too late and are time barred." The jury returned a verdict finding that Transport's claims were time-barred, and Transport filed its motion for a new trial. The appellate court upheld the trial court below in denying Transport's motion for a new trial. The court rejected Transport's argument that jury instructions regarding the statute of limitations were prejudicially erroneous because Transport did not object to the jury instructions. Thus, this argument was barred by the doctrine of invited error. The court also rejected Transport's argument that, because its suits were timely filed as a matter of law, the trial court erred by denying Transport's motions for summary adjudication on the statute of limitations. The court denied this argument because this issue had been tried and was adjudicated against Transport. Finally, the court rejected Transport's argument that the trial court prejudicially erred by refusing to give a jury instruction on equitable estoppel because, the court explained, the evidence simply did not support a jury instruction on estoppel.

IMPACT – REINSURANCE: This case supports the proposition that, in the absence of a contractual provision on when a suit must be filed by a cedent against a reinsurer, the general statute of limitations applies. Further, the court supports the general understanding that reinsurance contracts are gentleman's agreements, or honorable engagements

between equal parties, rather than adversaries.

Michigan Court of Appeals

Broker Acted on Behalf of Insured, Not Insurer; No Breach by Insurer Where Insured's Disclosure Statement Did Not Disclose Potential Claims of Employee Benefit Plan Members

Evangelical Presbyterian Church v. American Fidelity Assurance Co.,
(No. 299625, Jan. 12, 2012)

On Jan. 12, 2012, the Court of Appeals of Michigan affirmed the trial court's grant of summary disposition in favor of defendant American Fidelity Assurance Company (AFA) in a breach of contract and negligent misrepresentation action brought by Evangelical Presbyterian Church (the church). The church had a partially self-insured employee benefit plan, under which it paid claims up to a certain dollar amount with its own funds, then purchased stop loss insurance for claims exceeding that amount. For several years, the church had hired Group Health Managers, Inc. (GHM) to shop for its stop loss coverage. GHM advised the church of companies offering stop loss insurance and guide it through the application process, including the completion of a disclosure statement.

In November 2005, Excess Reinsurance, AFA's underwriter, sent GHM a renewal summary for the church's stop loss policy for the proposed policy period of Jan. 1, 2006 to Dec. 31, 2006. The summary required the church to complete a disclosure statement within 15 days before the effective date of the policy. The statement required that the church disclose both covered persons who

incurred charges over 50 percent of the specific deductible during the 12 months preceding the requested effective date, and covered persons who are expected to incur charges in excess of 50 percent of the specific deductible in the next 12 months, as well as covered persons who either have a known diagnosis which might be expected to lead to a specific reimbursement or have been diagnosed with any one of several listed conditions, including cancer. The statement disclosed plan member (PM) one and PM two, and was signed by a church representative on Dec. 8, 2005. The church representative stated that when he signed the statement, it was blank, and it had been customary in the past for GHM to obtain the necessary claims information and complete the statement. Excess Reinsurance issued the excess loss insurance policy on behalf of AFA effective Jan. 1, 2006.

On Jan. 19, 2006, the church completed an application for the excess loss policy with AFA, requesting reimbursement for PM three and PM four. Excess Reinsurance, on behalf of AFA, denied the claims on April 23, 2007, advising that neither PM three or PM four were listed on the Dec. 8, 2005 disclosure statement as required. The church then filed the instant complaint, alleging breach of contract, negligent misrepresentation, and rescission against AFA; breach of contract, negligence, negligent misrepresentation, and rescission against Excess Reinsurance; and negligence, breach of fiduciary duty, negligent misrepresentation, and rescission against GHM. AFA argued that it was entitled to summary disposition on: 1) the breach of contract claims against it because the church had failed to disclose medical and claims

information for two of its plan members as required by the disclosure statement; 2) the negligent misrepresentation claims against it based on its alleged vicarious liability for GHM's actions because GHM was an agent of the church and not AFA; and 3) the rescission claims against it because there was no material breach of contract or detrimental reliance on a false material representation. The trial court agreed and granted summary disposition in AFA's favor.

On appeal, the court first addressed the church's argument that the trial court erred in dismissing its negligent misrepresentation claim against AFA. Rejecting the church's argument that GHM was AFA's agent, the court found that GHM was an independent insurance agent, since it provided the church with information from various companies. Further, the church acknowledged that AFA considered GHM to be an agent of the church, as the renewal statement stated that GHM "act[ed] solely as the agent(s) of [the church]." Since GHM was an independent insurance agent and was not acting as AFA's agent, AFA did not violate Michigan law by failing to appoint GHM as its agent and there was no misrepresentation by AFA.

Secondly, the court disagreed with the church's argument that its breach of contract claim against AFA should stand because the disclosure statement was not incorporated by reference into the policy and it was not required to be accurate. The court disagreed, finding that the disclosure statement was incorporated by reference into the stop loss policy, and also the stop loss policy referenced the disclosure statement, where it stated that the non-disclosed losses provision advises that benefits

would not be paid if the church failed to disclose required information. The court further rejected arguments that: 1) because the disclosure statement was not physically attached to the policy it was not incorporated by reference; and 2) the disclosure statement did not have to be accurate, but rather only required that the church make a reasonable inquiry into the identities of possible claimants.

Finally, the court disposed on the church's argument that summary disposition was improperly granted on its rescission claim, noting that AFA did not make a misrepresentation and did not breach its contract with the church.

IMPACT – REINSURANCE: Whether a broker acts on behalf of an insured or insurer is often critical in coverage disputes, both for insurers and reinsurers. This case supports the general understanding that an agent procuring insurance on behalf of an insured acts for the insured, and does not thereby bind the insurer.

Supreme Court of New York, Appellate Division, First Department

New York's First Department Rejects Well-Established Precedent on Coverage Notices

George Campbell Painting v. National Union Fire Ins. Co. of Pittsburgh, PA (No. 116389/08, 4010, Jan. 17, 2012)

Following a settlement of a personal injury lawsuit brought by a subcontractor's employee against the general contractor and owner, the plaintiffs, the general

contractor and owner, sued the subcontractor's excess insurer (the insurer), seeking a declaration that the insurer's disclaimer of coverage was untimely under former Insurance Law § 3420(d) (current version at § 3420(d) (2)), and seeking recovery, as additional insureds, of the insurer's alleged pro rata share of the employee's personal injury settlement. On appeal, the first department determined that the plaintiffs did not provide Insurer with notice of the employee's personal injury suit against them until two years after it was filed and over a year after they learned that the employee's claim, if successful, would far exceed the subcontractor's primary insurance.

According to the court, pursuant to § 3420(d) of the Insurance Law, once the insurer had all the information it needed to determine that the plaintiffs had failed to give it timely notice of the claim as required by the policy, it had no right to delay disclaiming on the ground of late notice while it continued to investigate whether the plaintiffs were in fact additional insureds. In coming to its decision, the court overruled the case of *DiGuglielmo v. Travelers Prop. Cas.*, which had held that under § 3420(d), an insurer was not required to disclaim on timeliness grounds before conducting a prompt, reasonable investigation into other possible grounds for disclaimer.

The court reasoned that the DiGuglielmo rule was inconsistent with the text of § 3420(d), which requires that a disclaimer be issued "as soon as is reasonably possible." To follow the DiGuglielmo rule would permit an insurer to delay deciding whether to disclaim on grounds known to it while pursuing an investigation of other potential grounds for disclaiming liability or denying coverage. The court noted that the Court of Appeals specifically rejected

an insurer's argument that § 3420(d) should be read to require speed in giving notice once the decision to disclaim has been made, but to permit delay in making the decision. According to the Court of Appeals, the literal language of the statutory provision requires prompt notice of disclaimer after decision to do so, and obligates the insurer to reach the decision to disclaim liability or deny coverage within a reasonable time.

Furthermore, the Court of Appeals has also made it clear that the determination of whether the disclaimer was issued as soon as was reasonably possible is made with reference to the time when the insurer first acquired knowledge of the ground upon which it disclaimed. The timeliness of an insurer's disclaimer is measured from the point in time when the insurer first learns of the grounds for disclaimer of liability or denial of coverage. When the basis for denying coverage was or should have been readily apparent before the onset of the delay of disclaimer, the insurer has no excuse for its delay.

In the opinion of the court, adhering to the DiGuglielmo rule would be tantamount to deliberately setting aside the rule promulgated by the Court of Appeals and flowing naturally from the language of the statute. Additionally, the court concluded that the policy behind § 3420(d) is best served by applying the rule articulated by the Court of Appeals rather than the DiGuglielmo rule. Delay on the part of the insurer to disclaim may detrimentally delay the policyholder's own search for alternative coverage. Thus, the court held that § 3420(d) precludes an insurer from delaying issuance of a disclaimer on a ground that the insurer knows to be valid while investigating other possible grounds for disclaiming.

IMPACT – REINSURANCE: In New York, an insurer that decides to deny a claim on the basis of late notice must immediately notify the insured of such decision, even if the insurer continues to investigate alternative bases for potentially denying coverage, otherwise a denial for late notice may itself be held untimely.

Court Follows 'Follow-The-Fortunes,' Upholds \$420 Million Judgment Against Reinsurers

United States Fidelity & Guaranty Co. v. American Re-Insurance Co.,
(No. 604517/02, Jan. 24, 2012)

The defendants, American Re-Insurance Co. (American Re), Excess Casualty Reinsurance Assoc. (ECRA), ACE Property & Casualty Co., Century Indemnity Co., and OneBeacon America Insurance Co., appealed an October 2010 order of the Supreme Court, New York County which granted the plaintiff, United States Fidelity & Guaranty Co.s (USF&G)'s motion for summary judgment. The conflict arose out of reinsurance treaties that USF&G entered into with American Re and ECRA beginning in 1945. For the treaty years 1957 to 1962, the excess-of-loss contract maintained that the maximum amount of loss payable by the reinsurers, after a \$100,000 retention, was \$4.9 million for any one loss, subject to a limit of \$3 million for personal injury liability or property damage liability. USF&G had provided insurance since the 1950s and 1960s to Western Asbestos, a company that sold, distributed, and installed asbestos-containing products. In 1967, Western Asbestos dissolved and was taken over by Western MacArthur Co. (MacArthur). Beginning in the 1970s, individuals with asbestos-related injuries began to sue MacArthur, and in

1993, MacArthur sued USF&G, seeking coverage under policies allegedly issued to Western Asbestos. In 1997, the California Court of Appeal held that MacArthur was not entitled to coverage under Western Asbestos's insurance policies, which led to MacArthur's resurrection of the then-defunct Western Asbestos in 1997 for the purpose of assigning its insurance rights to MacArthur.

Following the assignment of rights, USF&G settled the insurance coverage action in 2002, agreeing to pay approximately \$975 million in satisfaction of all asbestos injury-related claims. Following the settlement, USF&G submitted its reinsurance billing under the treaties for the reinsurers' share of the loss. USF&G had consulted with MacArthur and decided to allocate the losses to the policy covering the period July 1959 through July 1960, which was one of the years with the highest per-person limits of \$200,000, allowing a higher payout to injured claimants. USF&G thus treated each injury as a separate incident, applying the \$100,000 retention to each claimant's injury, calculating overall liability by multiplying the expected number of claimants by \$200,000, with half of this total amount ceded to reinsurers. American Re and ECRA refused to pay the reinsurance claim because they believed the retention under the 1956 to 1962 treaty had been increased from \$100,000 to \$3 million and because they claimed that it was clear that USF&G was paying for Western's bad faith claims against it, which were not covered by the reinsurance treaty. In December 2002, American Re commenced this lawsuit as a declaratory judgment action, and the court granted USF&G's motion for summary judgment.

On appeal, Defendant reinsurers contend that the increase of retention from \$100,000 to \$3 million was agreed upon by all parties and that the court erroneously applied the "follow the fortunes" doctrine. The Appellate Division affirmed the findings of the trial court, first disagreeing with the reinsurers' contention that USF&G had agreed to increase the retention amount on all of its reinsurance treaties back to 1945. Assessing the evidence in the record, the court concluded that the retention increase to \$3 million was limited to those claims submitted under the 1962 and 1967 treaty and later treaty years only. Also, the court concluded that the court below properly determined that the follow-the-fortunes doctrines required the defendants to accept the reinsurance presentation made by USF&G. Accordingly, all of the reinsurers' efforts to second-guess USF&G's decisions concerning allocation of the loss were precluded from the court's review. As a result, the Appellate Division affirmed the judgment of the Supreme Court in favor of the plaintiffs in the amount of \$420,425,536.15 as well as the order granting plaintiff's motion for summary judgment.

One judge dissented, concluding that there was a genuine triable issue of material fact as to whether a portion of the \$987.3 million settlement that USF&G reached with MacArthur was for bad faith claims, not covered by the reinsurance treaty.

IMPACT – REINSURANCE: Once again, a court requires a reinsurer to follow the fortunes of its cedent.

NEWS AND NOTES

Global Reinsurance Outlook Stable Despite Cat Losses: S&P

Standard & Poor's Corp. reported that despite high catastrophe losses in 2011, the outlook for the global reinsurance sector remains stable. Due largely to losses incurred from flooding in Thailand, the global reinsurance industry will likely post a combined ratio of 100 percent to 115 percent for 2011, but still, the reinsurance industry holds surplus capital and its enterprise risk management capabilities are strong compared to the wider insurance industry.

India Insurance Market Growing, but Profitability a Challenge

A.M. Best released a Special Report, in which it outlined its expectation of future growth for India's insurance market, which has been driven primarily by the life market. The report further notes that despite a slowdown in GDP growth and inflationary pressures, India's long-term prospects remain positive.

Best Puts Partner Reinsurance Ratings Under Review, Citing Catastrophe Losses

A.M. Best Co. Inc. has placed under review with negative implications the financial strength rating of A+ and issuer credit rating of aa- of Hamilton, Bermuda-based Partner Reinsurance Co. Ltd. and its affiliates, also placing under review with negative implications the issuer credit rating of a- and debt ratings of its parent, PartnerRe Ltd. Best is concerned with PartnerRe's aggregation of catastrophe losses, as

it said last week that it expects to post up to a \$130 million loss for the fourth quarter of 2011.

Swiss Re: Global Earthquake Risk 'Vastly Underinsured'

A Swiss Re report found that several countries prone to earthquakes remain underinsured, including Japan, with twelve percent of economic losses covered. The study also determined that losses from earthquakes will ultimately be borne by taxpayers after government intervention, and 2011 saw record claims for earthquakes, exceeding \$47 billion, with \$226 billion in economic losses.

Republican-Led House Rejects National Service for Dissemination of Climate Information

The Republican-led U.S. House of Representatives has rejected in full a proposal by the National Oceanographic and Atmospheric Administration to create a National Climate Service to respond to ever-increasing requests to the agency for information relating to whether and climate forecasts. The plan, first offered by the climate change skeptic Bush administration and approved by the Democrat-led Senate, was nixed by the House on the grounds that it could become a source of "propaganda" on global warming. This, despite NOAA being flooded by requests for such information in 2011 from insurers, urban planners, farmers, and others, a year in which there were at least 12 weather disasters in the U.S. costing over \$1 billion in damage, smashing the previous record of 8 and as many as occurred throughout the entire decade of the 1980s.

Chartis Procures \$575 Million Protection Against Hurricanes, Earthquakes

Compass Re, based in Bermuda, issued to Chartis, a New York-based insurance company, a catastrophe bond in three tranches: \$75 million of Class 1 notes, \$250 million of Class 2 notes, and \$250 million of Class 3 notes. Under the agreements, Chartis will be protected with fully collateralized coverage against losses from U.S. hurricanes and earthquakes through December 2014.

Zurich Estimates Thai Flooding Losses at up to \$250 Million

Zurich Financial Services Ltd. expects catastrophe losses to cost it between \$200 million and \$250 million in the fourth quarter, including losses from flooding in Thailand and increased costs from the February 2011 earthquake in New Zealand. These increased losses are estimated to amount to \$80 million and stem from new building codes and more restrictive requirements, which may impact reconstruction costs.

PartnerRe Expects Thailand Flood Losses of \$120 Million; Says Industry Losses \$15 Billion

PartnerRe Ltd. estimates fourth quarter losses of \$120 million from Thailand flooding, leading to a fourth quarter after-tax operating loss of between \$130 million and \$150 million, when coupled with losses related to the Tohoku earthquake in Japan.

RenRe Expects \$45M in Thai Flooding-Related Losses

Pembroke, Bermuda-based RenaissanceRe Holdings Ltd. stated that it expects \$45 million in losses in the fourth quarter 2011 due to last year's flooding in Thailand. The losses still remain uncertain, given the magnitude and recent nature of the flooding, as well as the limited number of claims received thus far.

Concordia Losses Could Be \$1B for Industry; \$39 Million for Hannover Re

Moody's Investors Service estimates that the Costa Concordia accident, the first major insured loss of 2012, could produce claims reaching \$1 billion. Losses from the accident will be spread among several primary insurers, with claims arising from: marine hull insurance covering damage to the vessel, liability insurance claims from the passengers, costs associated with recovery of the wreck, and possible environmental claims related to any fuel spillage.

Hannover Re Expects 'Major Loss' from Costa Concordia Cruise Ship Disaster

Hannover Re estimated \$38.8 million in claims from the loss of the Costa Concordia cruise ship hull and that a market loss running into the triple-digit millions could result. London-based investment bank Jefferies International Ltd. estimated that the hull loss would likely be \$510.8 million.

Kansas Healthcare System Seeks to Fund Life Risks Through Captive

Via Christi Health Inc., a Wichita, Kan.-based health care system, has resubmitted an application seeking Labor Department permission to fund life insurance risks through the U.S. Virgin Islands branch of its Cayman Island captive insurance company. Earlier this month, the Labor Department gave Microsoft Corp. final authorization to use the Vermont branch of its Bermuda captive to reinsure life insurance and accidental death and dismemberment policies written by Prudential Co.

Best Upgrades Arch Ratings

A.M. Best Co. Inc. upgraded the financial strength ratings of Arch Reinsurance Ltd., as well as its strategic affiliates and its separately rated affiliate, from A to A+, and its issuer credit ratings from a+ to aa-. Best stated that the upgrades reflect Arch's continued superior operating performance amidst challenging market conditions, since Arch has maintained a strong underwriting culture and has held a smaller share of major industry losses.

Liès Named Swiss Re Group CEO

Swiss Re announced that Michel M. Liès, currently chairman global partnerships, has been appointed as the new group chief executive officer. Liès, who has been with Swiss Re for over thirty years, reflected on the healthy state of the company and emphasized his commitment to continue to leverage exceptional underwriting capacity and focus on client centricity.

Aon Plans to Move Headquarters to London While Adding Jobs in Chicago

Aon Corp., currently headquartered in Chicago and employing 6,000, plans to move its headquarters to London as part of its global growth strategy. The move will provide greater access to emerging markets and take advantage of strategic proximity to both Lloyd's and the London market. Chicago will continue to be Aon's headquarters of the Americas, and Aon plans to add more than 1,000 positions across its U.S. operations in 2012 to meet the demand of continued growth and investment opportunities.

Broker BMS Group Opens New York Office

London-based independent insurance broker BMS Group Ltd. opened an office in New York, and CEO Carl Beardmore will use the new office as his base, spending the majority of his time in the United States. BMS is also in the process of moving the servicing of all reinsurance accounts to Minneapolis, expanding its U.S. platform to complement its strong London position and build a truly unified reinsurance platform.

Goldberg Segalla LLP is a Best Practices law firm with offices in Philadelphia, New York, Princeton, Hartford, Buffalo, Rochester, Syracuse, Albany, White Plains and on Long Island. The Global Insurance Services Practice Group routinely handles matters of national and international importance for both domestic and foreign insurers, cedents and reinsurers. This includes: comprehensive audits,

policy reviews, regulatory advice, positioning dispute for resolution at the business level (either through interim funding or non-waiver agreements), negotiations among counsel, mediation or fully-involved arbitration or litigation. For more information on Goldberg Segalla's Global Insurance Services Group, please contact either Daniel W. Gerber or Richard J. Cohen.

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