ARE STANDARDS EMERGING FOR ALLOCATION TO

REINSURERS VIA FOLLOW THE SETTLEMENTS?

By

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I. Introduction

Traditionally, the principle of "follow the settlements" (sometimes used interchangeably with "follow the fortunes"), prevents a reinsurer from second-guessing the good faith settlements of a cedent with its insured.[1] However, the principle of follow the settlements has a number of limitations. It does not apply to settlements obtained by fraud or collusion or losses outside the underlying policy.[2] It does not apply to claims handled by the cedent in a grossly negligent fashion.[3] Neither does it apply to *ex gratia* payments by the cedent.[4]

Over the last twelve years, some courts have begun to apply follow the settlements not only to settlement of the insured's claim under the relevant policy(ies), but also to the way such settlements are allocated to the reinsurer(s) under the relevant reinsurance contracts. Some commentators and courts have been critical of such extension.[5] Nonetheless, enough case law has developed to examine the standards used by the courts for evaluating the propriety of allocations pursuant to the follow the settlements principle. The purpose of this article is to examine selected case law to evaluate these emerging standards.

II. First Circuit Case Law

The seminal case applying the follow the settlements doctrine to allocation to reinsurers is **Commercial Union Ins. Co. v. Seven Provinces Inc. Co***.,* 9 F.Supp. 2d 49 (D.Mass. 1998) *aff'd on other grounds* 217 F.3d 33 (1st Cir. 2000) *cert. denied* 531 U.S. 1146 (2001). The cedent brought suit against the reinsurer under a Massachusetts statute for stonewalling the cedent's claim for reinsurance recoverables. Among other defenses, the reinsurer argued that the cedent's allocation of the claim to the reinsurer was improper. The reinsurer contended that the principle of follow the settlements applied to the cedent's settlement with the insured (which the reinsurer did not contest) rather than allocation to reinsurers.

The reinsurer provided excess of loss reinsurance to the cedent on a facultative basis. The underlying claim was for environmental impairment over a period of years at twenty two sites. Contemporaneous records indicate that seven key sites drove the settlement with one being in operation during the effective dates of the reinsurer's facultative certificate. This one site was deemed by the cedent to be the biggest exposure and garnered the largest portion of the settlement dollars, penetrating the reinsurer's layer. After the claim was settled, individuals in the cedent's Reinsurance Ceded Department were instructed by in-house counsel who settled the claim as to "the allocation of settlement $$$ to the various sites and the logic driving such allocation . . . ."[6] The cedent billed the loss to reinsurers accordingly.

The court found as a matter of fact that the allocation of the loss to the reinsurer (*i.e.* in accordance with the documented settlement with the insured) was reasonable and in good faith and that the cedent was not obliged to adopt a different method of allocation that reduced the reinsurance recoverable. The court went on to rule that follow the settlements should apply to allocation since any distinction between settlement and allocation to reinsurers was "a distinction without a difference."[7] The court observed that extending this principle to allocation was necessary to avoid "undermining settlement and fostering litigation."[8] In making this latter comment, the court apparently overlooked the fact that: (a) the claim was settled prior to the issue of allocation being addressed by the Reinsurance Ceded Department; and (b) different people handled the allocation than handled the settlement of the claim. Therefore, it was highly unlikely that the allocation issue influenced the settlement.

Notwithstanding this oversight, the **Seven Provinces** decision does suggest a standard for applying the principle of follow the settlements to allocation *i.e.* a settlement with an insured which is demonstrably reasonable and in good faith, based on contemporary evidence, may not be second-guessed when used as the basis for the allocation of the settlement to reinsurers.

Also on point in the First Circuit is **American Employers Ins. Co. v. Swiss Reinsurance America Corp.**, 413 F.3d 129 (1st Cir. 2005).[9] This case involved pollution losses at 37 sites under multiple year excess polices and multiple year facultative certificates. 10 sites drove the settlement discussions with the insured arguing that limits under the multi-year policies should apply on an annual basis *i.e.* that limits should be annualized. The cedent's counsel opined that the insured was likely to prevail on the annualization issue and the case was settled on this basis with an 80% discount given to the amounts claimed on the 27 secondary sites which received little investigation by the cedent. The reinsurer defended on the basis that the occurrences should not have been annualized and a lack of good faith investigation into the 27 secondary sites. The district court granted summary judgment to the reinsurer but the court of appeals reversed and remanded.

On the annualization issue, the appellate court stated:

> Although the issue may be close, [the cedent's] characterization of the settlement is supportable. There is no case law directly in (*sic*) point and arguments both ways can be made, but [the cedent]did calculate the its ultimate obligation using annualization and

> the settlement roughly matched this figure – this is not a post-hoc characterization or a unilateral post-settlement allocation without grounding in the settlement itself. There is considerable advantage in taking the insurer's own contemporaneous calculus as a starting point and then letting the objections be tested primarily under the rubric of reasonableness and good faith . . . .[10]

The court acknowledged that the language of the relevant facultative certificates could prevent annualization of occurrences for reinsurance purposes but found that they did not do so clearly and in the absence of clear language to that effect, that the principle of follow the settlements applied.

As to the settlement of the 27 secondary sites along with the 10 primary sites, the court stated:

> Here, [the cedent] treated the top 10 sites as a very crude proxy for the rest. The [policyholder's] claims for all of the sites was a common baseline that might be assumed to be biased in [the policyholder's] favor to somewhat the same degree. [The cedent] worked out a range of discounts for the top 10 sites and then appears to have adopted a larger but somewhat similar discount for the remaining sites. The discount was very large and the sites represented small potatoes compared to the claims for the top 10 sites. And [the policyholder] settled for a sum close to [the cedent's] version of its expected liability. . . .
> Settling numerous claims based on detailed information about only a subset of those claims is consistent with modern practice in similar cases.[11]

For a very similar case on annualization of occurrences, *see* **Commercial Union Ins. Co. v. Swiss Reinsurance America Corp.**, 413 F.3d 121 (1st Cir. 2005).

The standard for allocation which seems to be embodied in the **American Employers** and **Commercial Union v. Swiss Re** cases is that a policyholder's allocation accepted by a cedent in settling a claim will be binding on the reinsurer absent language in the reinsurance contract requiring a different allocation.

III. Second Circuit Case Law

North River Ins. Co. v. Ace American Reinsurance Co., 361 F. 3d 134 (2nd Cir. 2004)[12] involved the settlement of Owens-Corning asbestos claims and the impact on five levels of reinsurance. Prior to settlement, the cedent used computer models to examine possible outcomes to litigation based on coverage parameters and various defenses. Some of these models identified exposure to reinsurance layers higher than the second layer which is where the reinsurer in this case had its exposure. After settlement, the cedent allocated losses on a "rising bathtub" basis and losses never rose above the second layer. The reinsurer argued that (a) the cedent should have allocated consistently with its calculation of possible litigation outcomes; and (b) while it did not contest the settlement itself, that the principle of follow the settlements does not apply to allocation to reinsurers.

The court observed:

> [T]he main rationale for the doctrine [of follow the settlements] is to foster the "goals of maximum coverage and settlement" and to prevent courts, through "de novo review of [the cedent's] decision-making process" from undermining "the foundation of cedent-reinsurer relationship."
>
> These goals are served by upholding [the cedent's] allocation here. [The reinsurer's] appeal relies for its success not only on its theory regarding the limits of the follow-the-settlements doctrine, but also on the specific factual information on which it alleges [the cedent] relied in its settlement negotiations. But it is precisely this kind of intrusive factual inquiry into the settlement process, and the accompanying litigation, that the deference prescribed by the follow-the-settlements doctrine is designed to prevent. Requiring post-settlement allocation to match pre-settlement analyses would permit a reinsurer, and require the courts, to intensely scrutinize the specific factual information informing settlement negotiations, and would undermine the certainty that the general application of the doctrine to settlement decisions creates.[13]

Nonetheless, the court stated that the reinsurer is protected by requiring that the allocation be in good faith and that the losses settlement be covered by the reinsurance contract. The court ruled that a pre-settlement evaluation of the risk of loss to higher layers does not create a good faith obligation to allocate losses to such layers once an actual settlement is reached. In addition, the allocation was consistent with the reinsurance contracts.

As a result, the litigation standard for allocation arising out of **North River** appears to be that the cedent will not be bound by pre-settlement models of various possible outcomes of litigation when an actual settlement is to be allocated to reinsurers.

Travelers Casualty & Surety Co. v. Gerling Global Reinsurance Corp., 419 F.3d 181 (2nd Cir. 2005)[14] was the appeal of a summary judgment decision granted in favor of the reinsurer based on the fact that the cedent attempted to allocate the loss to reinsurers on a basis different from the basis upon which the claim was settled. Since the reinsurer was challenging the allocation, rather than the settlement, the lower court found that the principle of follow the settlements was inapplicable.

Coverage consisted of a $1 million primary policy and excess insurance. The reinsurer assumed a portion of the excess insurance. The underlying claims involved asbestos exposure over many years and issues of product v. non-product liability and one vs. multiple occurrences. The insured argued for non-products losses, to avoid aggregate limits, and that each claim was an occurrence. The cedent argued that the claims were products claims and arose from a single occurrence. Prior to trial, the claim was settled without resolving the issues of products vs. non-products or the number of occurrences. The cedent allocated the loss to the reinsurer as a single, non-products occurrence (which produced a much greater reinsurance recoverable). The reinsurer argued that this allocation was improper since the cedent had given up the single occurrence position in the settlement.

The **Travelers v Gerling** court followed **North Star** with respect to determining the facts of the settlement:

> [W]e decline to authorize an inquiry into the propriety of a cedent's method of allocating a settlement if the settlement itself was in good faith, reasonable, and within the terms of the policies. . . . Given that [the cedent] and [the insured] expressly declined to resolve the occurrence issue, there is no cause for us to do so now. Indeed, were we to undertake such an analysis, we would be engaging in precisely the kind of "intrusive factual inquiry" that the follow-the-fortunes doctrine was meant to avoid.[15]

The court found that to support a claim of bad faith allocation, the reinsurer must "make an '*extraordinary showing* of a disingenuous or dishonest failure."[16] To make such a showing, the reinsurer argued that: (1) the cedent's one occurrence argument was inconsistent with the relevant policies and legally without precedent; and (2) the cedent was attempting to maximize its reinsurance recovery by shifting losses from the primary policies to the excess policies. The court rejected both arguments. The court found that a novel legal theory is not bad faith in and of itself and that the insured had submitted and the cedent had paid claims on a one occurrence basis previously. On the second point, the court ruled:

> An allocation that increases reinsurance recovery – when made in the aftermath of a legitimate settlement and when chosen from multiple possible allocations – would rarely demonstrate bad faith in and of itself. In any case, we need not determine when a post-settlement allocation is no longer a reasonable business decision and instead becomes a decision made in bad faith because [the reinsurer] has failed to demonstrate anything approaching the requisite intent on the part of [the cedent].[17]

The allocation standard suggested by this case is that unusual or self-serving allocations by the cedent will not be found to constitute bad faith unless the reinsurer can prove bad intent on the part of the cedent.

National Union Fire Ins. Co. v. American Re-Insurance Co., 441 F.Supp.2d 646 (S.D.N.Y.2006) was a case in which the cedent had covered the insured from April 1, 1988 to April 1, 1995 but the only year reinsured (via facultative excess of loss reinsurance) was the final year. Employees of the insured sued for injuries due to exposure to certain metalworking fluids over a number of years. The claims were settled with the insured attributing the loss to the final two years of coverage on a manifestation basis. After initially questioning this basis, the cedent acceded to it and billed the reinsurer accordingly. The reinsurer rejected the cedent's claim on the following bases: (1) at least some of the losses for which reinsurance recoverables were sought manifested themselves before the effective date of the reinsured policy; and (2) the cedent acted with reckless indifference to the reinsurer's interests in accepting the insured's method of allocation.

On the first defense, the court ruled that the losses were at least arguably within the effective dates of the reinsured policy and, therefore, follow the settlements applies. On the second defense, the court ruled:

> In other words, [the reinsurer] argues that even if [the cedent] accepted [the insured's] allocation of the claims to the [reinsured] policy for purposes of paying those claims, it should have taken it upon itself to re-allocate those same claims internally when considering whether to seek payment from its reinsurer. First, this argument fails for the same reason as [the reinsurer's] first argument - - as discussed above, the allocations by [the insured] to the [reinsured] policy were at least arguably correct, and therefore [the cedent's] acceptance of them could not have been unreasonable. But, in any event, this argument must fail because it is exactly the type of inquiry that the follow-the-fortunes doctrine is intended to prevent [*i.e.* second-guessing allocation makes settlement impossible].[18]

The standard which seems to be embodied in this case is that a cedent who accepts an arguable allocation by the insured is not required to reallocate when ceding the loss to the reinsurer.

IV. Third Circuit Case Law

Travelers Casualty and Surety Co. v. Ins. Co. of North America, 609 F.3d 143 (3rd Cir. 2010) involved liability policies covering the insured between April 1976 and April 1987 with respect to breast implant and chemical product claims. The policies were written in three layers – primary, buffer and excess. (Authors' note: the underlying decision in this case is sealed and the appellate court's description of the policies, other documents, and a number of technical matters, is limited.)

The primary policies covered non-products claims and non-US products claims. They were retrospectively rated up to a loss limit from April 1976 to April 1982 and without a loss limit thereafter. These policies covered defense costs in addition to limits from April 1976 to April 1982 and within limits thereafter. The insured's captive reinsurer [hereinafter "captive") reinsured the cedent for 95% of the loss above a retention and paid defense costs in proportion to liability payments.

The buffer layer policies were in place from April 1976 to April 1982. They covered US products liability and were excess of a primary layer of products liability provided by an affiliate of the insured. This layer was reinsured by the captive 95% from April 1976 to April 1978 and 100% thereafter.

The excess layer covered the period between April 1976 to April 1982 for products and non-products claims. This layer was in excess of all of the insured's other insurance, including the primary and buffer layers. This layer was not subject to captive reinsurance and the reinsurer at issue in this case participated in this layer.

While the cedent negotiated settlement of the breast implant and chemical claims with the insured, in-house counsel for the cedent authored a memo on concerns about reinsurance recoverables. First, there

was concern that the insured would litigate each claim to a conclusion with no ability of the cedent to collect defense costs from the captive reinsurer unless liability was paid. (At that point, the insured had spent $112 million on defending breast implant claims but had paid no losses.) Second, if the claims were determined to be non-product claims with multiple occurrences, the claims might never exceed the primary layer, which had no aggregate limits, and would not reach the excess layer, which had outside reinsurers.

Apparently as a result of these reinsurance concerns, the cedent was adamant in its negotiations with the insured that the breast implant claims were US product claims not covered by the primary policies and were the result of one occurrence. As the court noted:

> Because the [primary] policies possessed per-occurrence limits, but were not (for the most part) subject to aggregate limits, [the cedent's] greatest concern was that the breast implant claims would be characterized as non-products claims arising out of multiple occurrences. Under such a scenario, it was possible that [the cedent's] exposure under the primary policies would be exponentially greater, at least if the liability for each occurrence was below the per-occurrence limit.[19]

Eventually, the insured and cedent settled the claims, net of retrospective premiums and captive reinsurance, with $80 million dedicated to the breast implant claims, which would be treated as non-products, single occurrence claims and $20 million to the chemical claims which would be treated as products claims. The settlement agreement allocated $15 million of the chemical loss to the excess policies and stated that none of the settlement monies were allocated to primary policies after April 1, 1982 or to the buffer policies since there was no transfer of risk under these policies (due to retrospective premium and captive reinsurance) and had been exhausted by the settlement.

When allocating the breast implant claims to reinsurers, the cedent allocated them based on one occurrence and treating the entire $80 million as indemnity rather than defense costs. Ultimately, the cedent claimed nearly $14 million in reinsurance recoverables for breast implant and chemical losses allocated to the excess layer.

In analyzing the reinsurer's defense, the court initially accepted the position of those courts that ruled that follow the settlements applies to post-settlement allocations.[20] The court noted that reinsurers have protection in this context:

> Those allocations must still be in "good faith" to be binding on the reinsurer. We have broadly characterized the insurer's duty of good faith to its reinsurer as a duty not to take advantage of the reinsurer's dependence on the decisions made by the insurer. "[T]he duty of good faith requires the reinsured to align its interests with those of the reinsurer." In the post-settlement context, this means that an insurer breaches its duty when it makes allocation decisions primarily for the purpose of increasing its reinsurance recovery. "A reinsurer is not bound by the follow-the-fortunes doctrine

> where the reinsured's settlement allocation . . . reflects an effort to maximize unreasonably the amount of collectible reinsurance."[21]

The court went on, however, to state the cedent's duty not to allocate *primarily* to increase reinsurance recoveries did not require it to allocate in a fashion that minimizes reinsurance recoveries:

> What this means for the reinsurer's burden of persuasion is that to establish a breach of the duty of good faith, it is not sufficient to demonstrate that a particular decision increased the insurer's access to reinsurance, at least not where the insurer is able to point to some legitimate (*i.e.* non-reinsurance related) reason for the challenged decision.[22]

The reinsurer initially argued that bypassing the post 1982 primary and buffer layer policies in the allocation was a violation of utmost good faith. However, the court found that this was reasonable in light of the fact that the cedent did not have any net liability on such policies.

The reinsurer also argued that the memo from in-house counsel, described above, is direct evidence that the cedent allocated the loss so as to maximize reinsurance recoverables. The court found that the cedent had sufficient incentive to pursue the single occurrence approach to avoid non-products losses without aggregate limits in the primary layer. (It is not evident from the decision that the court understood that this is the standard vertical vs. horizontal allocation of loss method of moving losses off the books of cedents and onto the books of excess of loss reinsurers.) In addition, the court found that memo dealt with the maximizing of indemnity vs. defense cost in relation to the captive reinsurance rather than the reinsurance at issue in this case. (There is not enough information in the decision to determine whether the same issue was present with the latter reinsurance.)

The reinsurer next argued that allocation of the $80 million breast implant settlement exclusively to indemnity rather than to indemnity and defense costs was in violation of utmost good faith, particularly in light of the fact that the insured had already paid $112 million in defense costs on these claims and nothing on indemnity. The court allowed as to how this allocation was unilateral on the cedent's part and not a subject of negotiation between the insured and cedent. The court recognized also that this allocation allowed the cedent to penetrate the reinsured layer more quickly as defense costs would not have counted toward limits on the pre-1982 primary policies. Nonetheless, the court declined to find this allocation unreasonable due to expert testimony that large policyholders tend to focus less on past defense costs than future coverage certainty and the fact that defense was available from another reinsurer. (Apparently the court did not understand that the issue for insureds is total compensation and that the issue of indemnity vs. defense costs is meaningful only to insurers and reinsurers.)

This decision is a difficult one due to some information gaps in the opinion, the sealed opinion of the lower court and the appellate court's apparent lack of understanding of the motives and methods involved in certain types of allocation. Taken at face value, however, the standard evidenced by this

case seems to be that an allocation does not violate utmost good faith if it is motivated by an effort to reduce the cedent's losses, even if the necessary result is to increase the reinsurer's losses.

V. Commentary

Taking these cases together, the standards they espouse for allocation pursuant to follow the settlements seem to be as follows:

> As long as there is no language in the reinsurance contract requiring a different allocation, a reinsurer will not be permitted to second guess a cedent's good faith allocation that: (a) is consistent with the manner in which the underlying claim is settled; (b) is inconsistent with one of several possible litigation outcomes; or (c) increases reinsurance recoverables but was done for legitimate reasons unrelated to reinsurance recoverables.

The courts' rationale in several of these cases contain a number of gaps in logic which make them difficult to reconcile with the standards they seem to espouse as well as industry practice. First, it is very difficult to determine whether or not an allocation is in good faith without an examination of the facts *e.g.* the arguments of the parties, the basis of the settlement and the manner in which the settlement impacts the financial obligations of the insurer vs. the reinsurer. Sophisticated parties seldom announce their intention to act in bad faith in documents subject to discovery so intent often has to be inferred from actions and positions. Thus, the intrusive factual inquires which several of the cases (*e.g.* **North River, Travelers v. Gerling**) wish to by-pass are necessary to the good faith inquiry.

Perhaps more fundamental is the argument that extending follow the settlements to allocation decisions is necessary to support "maximum coverage" and settlement of claims with the insured (*e.g.* **Seven Provinces, North River)**. The maximum coverage concept is clearly related to the claim by the insured against its insurer and is not applicable to the after the fact efforts of insurers and reinsurers to sort out among themselves responsibility for settled claims. Secondly, allocation issues are typically addressed by ceded reinsurance personnel after the claims department has settled the claim. Best practices would suggest that it is not prudent to inform or involve line claims handlers in reinsurance issues to avoid prejudicing them concerning adjusting and settling their primary claims. Therefore, applying follow the settlements to allocation of losses to reinsurers would seem to have little impact on a primary insurer's settlement decisions.

Perhaps a better articulation of the rationale behind extending follow the settlements to reinsurance allocation is necessary to clarify the standards for such extension.

ENDNOTES

[1] Robert M. Hall and Matthew T. Wulf*, Allocation to Reinsurers and Follow the Settlements*, XIII Mealey's Reins. Rpt. 19 at 26 (2003) (hereinafter "Hall and Wulf"); also available on the author's website: robertmhall.com. Matthew Wulf was, at the time of the article, and continues to be, an attorney with the Reinsurance Association of America. Along with Debra Hall, he was the author of *amici* briefs addressing reinsurance allocation issues.

[2] *North River Ins. Co. v. CIGNA Reins. Co.*, 52 F.3d 1194, 1207 (3rd Cir. 1995). The Reinsurance Association of America (hereinafter "RAA"), under the supervision Debra Hall, submitted an *amicus* brief on behalf of the reinsurance industry in this matter. The RAA argued that the follow the settlements doctrine prohibits an insurer from expanding coverage beyond the limits established in the reinsurance agreement.

[3] Robert M. Hall, *Follow the Settlements: Bad Claim Handling Exception*, XIV ARIAS – US Quarterly No. 3 at 24 (2007) also available at the author's website: robertmhall.com

[4] Robert M. Hall, *Follow the Settlements and Ex Gratia Payments*, Reinsurance Vol. 3 No. 6 at 6 (2010) also available at the author's website: robertmhall.com.

[5] *See generally* Hall and Wulf.

[6] 9 F.Supp.2d 49 at 58.

[7] *Id.* at 61.

[8] *Id.* at 62.

[9] The RAA, under the supervision of Debra Hall, submitted an *amicus* brief on behalf of the reinsurance industry in this matter. This brief addressed the application of the follow the settlements doctrine, arguing that it has no application to the interpretation of reinsurance contract language. The RAA's brief outlined the history and rationale behind the follow the settlements doctrine, expressed the importance to the insurance industry of applying the doctrine consistently and reviewed the relevant case law.

[10] 413 F.3d 129 at 136.

[11] *Id.* at 138-9.

[12] The RAA, under the supervision of Debra Hall, submitted an *amicus* brief on behalf of the reinsurance industry in this matter. Supporting the reinsurers' position, the RAA argued, in part, that the follow the fortunes doctrine does not apply to the post-settlement calculation of reinsurance billings

[13] 361 F.3d 134 at 141 (Internal citations omitted).

[14] The RAA, under the supervision of Debra Hall, submitted an amicus brief on behalf of the reinsurance industry in this matter. The RAA advocated application of the follow the fortunes doctrine consistent with longstanding industry understanding, case law, and custom and practice. Based on the nature of the dispute and the case law of New York, the RAA argued that the follow the fortunes doctrine did not prohibit Gerling from raising legitimate questions about the reasonableness and good faith basis of Travelers' reinsurance claim.

[15] 419 F.3d 181 at 189 (Internal citations omitted).

[16] *Id.* at 190 (Emphasis in the original, internal citations omitted).
[17] *Id.* at 193.
[18] 441 F.Supp.2d 646 at 652 referring to **Travelers v. Gerling**, *supra.*
[19] 609 F.3d 143 at 152.
[20] *Id.* at 158.
[21] *Id.*
[22] *Id.* at 158-9.