CPCU SOCIETY INSURING YOUR SUCCESS

Reinsurance Interest Group

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Reinsurance Encounters

Message from the Chair

by Thomas M. Pavelko, CPCU, J.D., ARe

Thomas M. Pavelko, CPCU, J.D., ARe, is assistant general counsel, contracts and regulatory, for American Agricultural Insurance Company (AAIC), where he has worked for 11 years. Previously, he ran an active law practice for 15 years. Pavelko earned his J.D. from Washington University School of Law in St. Louis, Mo., and his bachelor's degree from Marquette University in Milwaukee, Wis. He is currently chair of the Reinsurance Interest Group Committee. In the past, he served on the board of the CPCU Society's Chicago-Northwest Suburban Chapter and was its president in 2006–2007.

"Should auld acquaintance be forgot ... " The 2010 CPCU Society Annual Meeting and Seminars in Orlando felt like New Year's Eve to me. Renewed acquaintances? Yes — many opportunities to get together with committee members, other volunteer leaders and Society staff. Celebrations? Absolutely — for and with new designees and new Society officers; with Reinsurance Interest Group supporters and friends at our second annual luncheon and at our seminars; and with corporate clientele.

But most important, each Annual Meeting ushers in a new year for the CPCU Society and, likewise, the Reinsurance Interest Group Committee. Of the various committee meetings we hold each year, the committee meeting during each Annual Meeting is the most well-attended and most productive. Like the Roman god Janus, we look back to review our accomplishments for the expiring year, and then immediately look forward to begin planning for the upcoming year. The Reinsurance Committee's goal each year is to bring even more value to CPCU Society members who are active or have interest in the reinsurance industry.

Immediately after the Orlando Annual Meeting, we brought added value to you with two new October events. First, on Oct. 7, 2010, we conducted a timely webinar on the Deepwater Horizon disaster. Presenters included attorneys **Andrew S. Boris** and **Thomas G. Drennan** from the Tressler law firm and **Steve McElhiney, CPCU, MBA, ARe, AIAF,** president of EWI Risk Services Inc. and president-elect of the CPCU Society.

Then, on Oct. 21, 2010, the Reinsurance Interest Group conducted a full-day Reinsurance Symposium in Dallas, Texas. We are pleased to report that the event sold out! There were attendees from nine states and three countries. Government officials, a rating agency

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and the press also attended. We hope to make it an annual event.

Planning continued thereafter for the annual Chicago reinsurance workshop, which will take place on Thursday morning, Feb. 3, 2011, at the offices of DLA Piper. This year's program will feature a reinsurance executive-level panel and a reinsurance claims panel. The quarterly lunch meeting of the local reinsurance networking organization REACH will immediately follow the workshop. All workshop attendees are invited to the REACH luncheon, but a separate registration is required for that event.

Join us on Feb. 3, 2011, for the Chicago reinsurance workshop.

Next, the committee continued its planning for the 2011 CPCU Reinsurance Symposium in Philadelphia. This event has been referred to as the Society's "crown jewel" of reinsurance educational events. Because of favorable compliments from the 2010 symposium, we have again scheduled the event for the historic Union League of Philadelphia. The dates are March 30–31, 2011.

The Reinsurance Interest Group will hold its 2011 Reinsurance Symposium, "Decade of Disasters — Impact on the Reinsurance Industry" at the historic Union League of Philadelphia, March 30–31, 2011.

This year's theme is "Decade of Disasters — Impact on the Reinsurance Industry." History may label 2001–2010 the Decade of Disasters, beginning with 9/11 and continuing with unprecedented Atlantic hurricanes, tsunamis, earthquakes and then the Deepwater Horizon. These disasters not only shaped the decade for our industry, but will have a lasting impact well into the future. Expected participants include **Pina Albo** (Munich Reinsurance America Inc.), **John Bender** (Allied World Reinsurance Company),**Sharon A. Binnun, CPA** (Citizens Property Insurance Corporation), **Anita Z. Bourke, CPCU, CPIW** (The Institutes),**Wayne Keebler, CPCU, ARe** (Wright Risk Management), **Steve McElhiney, CPCU, MBA, ARe, AIAF** (EWI Risk Services Inc.), **Franklin W. Nutter, J.D., ARe** (Reinsurance Association of America) and **H. Wesley Sunu, J.D.** (Tribler Orpett & Meyer PC).

We also discussed the success of our outreach programs, through which we get content and information to you. These include our website, our LinkedIn group and this newsletter. Based on the activity level and compliments we receive, we know you appreciate these portals.

Finally, the committee began to focus on the CPCU Society 2011 Annual Meeting and Seminars, which will be in Las Vegas, Oct. 22–25, 2011. We plan to host an interest group dinner this year and at least two seminars of interest to reinsurance professionals.

I am so happy to work with the Reinsurance Interest Group Committee. They are dedicated and resourceful professionals who give selflessly of their time and talents — and "dear auld" acquaintances. ■

Editor's Comments

by Richard G. Waterman, CPCU, ARe

Richard G. Waterman, CPCU, ARe, is president of Northwest Reinsurance Inc., a Minnesota-based management consulting firm specializing in the fields of insurance, reinsurance and alternative dispute resolution. In addition to working with both ceding and assuming companies in his consulting practice, he has served as an arbitrator or umpire on more than 130 panels to resolve industry disputes as well as a neutral mediator, facilitator and fact-finder assisting parties to work out differences in a confidential setting. Waterman has been a member of the CPCU Society since 1978, and has served on the Reinsurance Interest Group Committee for more than 10 years.

Some things change and others don't. Knowledge is how we know which is which.

Inspired by our goal to promote a dynamic discussion of critical issues facing the reinsurance industry in today's challenging global marketplace, committee members of the Reinsurance Interest Group will continue to place particular emphasis throughout 2011 on educational symposia and other activities intended to engage discussion to explore and improve our knowledge of industry concepts and understanding of the interconnected principles and practices affecting the insurance and reinsurance industries.

In pursuit of our goals, the Reinsurance Interest Group will be presenting its highly regarded Reinsurance Symposium in Philadelphia on March 30–31, 2011, as well as other timely specially focused seminars and webinars throughout the year. In addition, we will continue our efforts to publish insightful and educational articles in this newsletter written by leading industry practitioners about important and contemporary topics.

Our lead article in this issue, "Triggering Occurrence-Based Contracts and Understanding Claims-Made Contract Requirements," is the first in a series of articles related to the allocation or apportionment of losses between and among a policyholder, its insurer and how allocation claims are ceded to reinsurers. The articles' co-authors, **Scott M. Seaman, J.D.,** and **Jason R. Schulze, J.D.,** partners in the law firm Meckler Bulger Tilson Marick & Pearson LLP in Chicago, begin with the segment that explains the various occurrence policy claim coverage triggers and distinguishes occurrence-based contracts from claims-made contracts. If you have been looking for an informative reference illuminating how courts have applied the exposure, manifestation or discovery triggers, or the injury-in-fact or discovery trigger, this article is definitely a keeper. Future articles will discuss allocation methodologies, determining the number of occurrences, reinsurance allocations and other exceedingly important topics.

A mutual insurance company is a corporation owned and operated by and for its policyholders. Every owner of the company is a policyholder; every policyholder is an owner. Legally, the policyholders are responsible for the administration of a mutual insurance company; however, mutual companies generally employ experienced personnel who have the technical knowledge and managerial skills similar to stock insurance corporations. Mutual insurance companies have been highly successful in the United States but face severe competitive pressures. In their very interesting article "Mutual Insurers Must Adapt to Survive," co-authors **Charles G. Desmond** and **Eric F. Hubicki, CPCU, ARe, ARM, AU, AFIS,** reflect on the history, organizational model and successful performance of mutual insurance companies, and point out steps that need to be taken to exploit their industry knowledge to secure a sustainable future.

The attorney-client privilege protects communications between a client and his or her lawyer for purposes of seeking or rendering legal advice. In an article published in the December 2007 issue of this newsletter, **Teresa Snider, J.D.,** a law partner at Butler Rubin Saltarelli & Boyd LLP, wrote a perceptive article explaining why ceding companies were becoming concerned about the possibility that they might waive the protection afforded to claim coverage and defense documents by disclosing those documents to their reinsurers. In his article in this issue titled, "The Reinsurer Requests Privileged Information — Now What?," **Andrew S. Boris, J.D.,** a frequent Reinsurance Encounters contributor and a law partner with Tressler LLP, brings to our attention a recent court decision in which it was determined that a ceding company waived any privilege

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associated with materials provided to reinsurers in two contested arbitrations with the reinsurers. The court also rejected the ceding company's assertion the common interest doctrine should apply because the reinsurers had been opponents in arbitrations concerning identical coverage questions. The court's rulings, if upheld, could have significant implications regarding how ceding companies can share information with reinsurers without waiving the attorney-client privilege.

The August 2010 edition of this newsletter contained an article that focused on critical elements of the follow the settlements doctrine in a reinsurance relationship. The follow the settlements doctrine provides that a reinsurer is generally required to indemnify its ceding company for claim settlements reasonably within the terms of the original policy. In most instances, a reinsurer cannot second-guess the good faith liability determinations made by its reinsured. However, there are limitations to the follow the settlements doctrine. One common exception is *ex gratia* payments. In this issue, **Robert M. Hall, J.D.,** a former law firm partner and an astute author of numerous discerning industry-related articles, explains in his article, "Follow the Settlements and *Ex Gratia* Payments," that while a reinsurer in most cases must follow the settlements of its reinsured, a payment that is clearly and unambiguously outside the scope of the underlying insurance policy is *ex gratia* and usually does not bind the reinsurer.

This issue of *Reinsurance Encounters*, published by the Reinsurance Interest Group, is intended to share knowledge concerning important contemporary topics affecting the reinsurance industry. We invite you to contribute to the conversation by writing an article for publication or telling us about an author or article that we can share with our interest group membership. Also, let us know what type of information you would like see in future issues. We would especially appreciate your thoughts about ways to enhance the quality of this publication for the benefit of our membership. ■

Triggering Occurrence-Based Contracts and Understanding Claims-Made Contract Requirements

by Scott M. Seaman, J.D., and Jason R. Schulze, J.D.

Scott M. Seaman, J.D., is a partner in the law firm of Meckler Bulger Tilson Marick & Pearson LLP in Chicago. He is chairman of the firm's Insurance Coverage Litigation and Counseling Practice. Seaman represents insurers and reinsurers in a wide range of insurance and reinsurance litigation and arbitrations. He can be contacted at scott.seaman@mbtlaw.com

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Editor's note: Excerpted and reprinted with permission from *Allocation of Losses in Complex Insurance Coverage Claims* by Scott M. Seaman and Jason R. Schulze (Thomson Reuters 2010), available at www.west.thomson.com. © by Thomson Reuters. All rights reserved.

In the next several issues of *Reinsurance Encounters*, we will be exploring various facets of allocation of losses involving complex insurance coverage claims and reinsurance disputes. We start out by examining the issue of trigger of coverage and distinguishing claims-made contracts from occurrence-based contracts.

The issue of allocation of a loss to a particular insurance contract is presented only where the contract is otherwise required to respond to a loss. With respect to traditional occurrence-based insurance contracts, a prerequisite to allocating a portion of the loss to a particular insurance contract is that the contract must first be "triggered" by the loss. For claims-made insurance contracts, by contrast, satisfaction of the "claims made" and any retroactive date requirements is required.

The Various 'Trigger' Theories

Most occurrence-based general liability contracts expressly limit coverage to bodily injury and property damage that take place during the contract period. For many traditional insurance claims (e.g., claims arising out of fires, explosions, collisions and natural disasters), there is little difficulty determining the date on which the bodily injury or property damage took place. Traditional claims are limited in time, place and space. In the context of long-tail claims (e.g., pollution, mass product or toxic tort exposures), however, damage or injury may take place over time, and often there is a latency period between the date on which the polluting activity or injurious process begins and the date on which the resulting bodily injury or property damage is discovered. In other words, long-tail claims may span several years or even decades. In some instances, the damage is progressive. In others, it is merely continuous.

The phrase "trigger of coverage" is not contained in the insurance contract, but rather is a phrase coined to refer to the issue of which insurance contract or contracts must respond to an otherwise covered claim for property damage or bodily injury that arguably takes place in one or more contract periods. Although most general liability insurance contracts require injury or damage during the contract period, it is important to note that some contracts require that the act or event causing damage or that both the act and damage take place during the contract period. Accordingly, as with most coverage determinations, the contract language should serve as the starting point for the analysis.

When confronted with long-tail coverage claims implicating a number of years, courts generally have applied four principal triggers of coverage: exposure, manifestation (discovery), injury-in-fact (actual injury) and continuous. In characterizing "trigger" theories, it is important to keep in mind that decisions are not always clear on the theory used, sometimes the label used in a decision does not match the theory actually applied by the court, and some decisions provide minimal guidance or simply state the injury or damage, as opposed to the act or occurrence, must take place during the contract period.

Courts applying an exposure trigger find that contracts on the risk during the period when the environment

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was exposed to pollutants (i.e., when waste is released into the environment) or when the person was exposed to harmful substances, such as asbestos, are triggered. By contrast, courts applying a manifestation or discovery trigger hold that only those contracts on the risk on the date that the property damage or bodily injury is discovered are triggered.

Under an injury-in-fact or actual injury trigger, contracts on the risk on the date that property damage or bodily injury actually happens (based on actual proof that the damage was sustained) are triggered. Finally, under a continuous trigger, every contract on the risk from initial exposure through manifestation is triggered.

In the early days of long-tail coverage litigation (i.e., DES and asbestos claims in the late 1970s), the battle was between exposure and manifestation trigger theories. More recently, the majority of decisions throughout the country apply either a continuous trigger or an injury-in-fact trigger to long-tail claims, with several decisions applying a manifestation trigger, particularly in the context of property damage claims. The main distinction between the continuous and injury-in-fact trigger theories is that the injury-in-fact trigger requires the policyholder to prove discrete injury or damage during the insurance contract period.

In many jurisdictions, trigger is well-established. In others, there is an incomplete or conflicting body of cases. Although the same theory often is applied within a jurisdiction for both property damage and bodily injury claims, sometimes the decisions reflect a different approach for bodily injury and property damage claims. See S.M. Seaman, J.R. Schulze, *Allocation of Losses in Complex Insurance Coverage Claims* (2d Ed. Thomson West Legal Works).

The Relationship between Trigger and Allocation

An understanding of the trigger method adopted by a court is important to the issue of allocation because it defines the universe of contracts and periods to which losses may be allocated. Indeed, logic and intellectual honesty require that the trigger theory and the allocation method be consistent. In other words, where the manifestation trigger is adopted, the allocation properly may be limited to the period or contract or contracts in effect on (or in some instances on or after) the date the injury or damage is discovered. Thus, the period over which the loss is allocated is truncated. Where an injury-in-fact or continuous trigger is adopted to result in a span of multiple years or contracts being impacted by a loss, the period over which the loss is spread should be similarly broad. It would seem to be inconsistent and improper to trigger a long span of contracts or years in the first instance by application of an injury-in-fact or continuous trigger, and then artificially limit the allocation among contracts in a single year. Yet, that is often what courts' adopting an "all sums" or "joint and several" allocation approach actually do.

These trigger decisions are based upon the courts' interpretations of the requirement that the injury or damage occur during the policy period. Parties, of course, are free to alter the result by altering the language of the insurance contract. Keep in mind that we have been discussing general liability contracts. Other types of contracts may contain specific trigger requirements. Workers' compensation and employers' liability contracts, for example, often contain "last day of exposure" triggers. One such provision reads, "Bodily injury by disease must be caused or aggravated by the conditions of your employment. The employee's last day of last exposure to the conditions causing or aggravating such bodily injury by disease must occur during the policy period." Accordingly, as with most insurance coverage and reinsurance issues, it is important to review and understand the contract language and apply it to facts of the claim or cession.

Claims-Made Contracts

Claims-made insurance contracts have been available for many years, most notably in the context of professional liability insurance. In the mid-1980s, claims-made contracts were introduced into the general liability insurance market in response to court rulings on the trigger-of-coverage issue under occurrence-based contracts as applied to long-tail bodily injury or property damage claims. Under occurrence-based contracts, the contract or contracts in effect at the time bodily injury or property damage takes place must respond to an otherwise covered loss. Thus, some court rulings resolved the issue of the timing of the bodily injury or property damage by finding that insurance contracts issued in the 1940s, for example, were required to respond to claims brought against policyholders during the 1980s.

Under claims-made contracts, it is the time that the claimant first makes a claim against the policyholder that determines whether the insurance contract must respond to an otherwise covered loss, rather than the timing of bodily injury or property damage. Most claims-made contracts have retroactive dates, which often are the contract inception dates, but can be earlier. Coverage for bodily injury or property damage that took place prior to the retroactive date generally is excluded even where the claim is first made against the policyholder during the contract period. Thus, under most claims-made contracts, coverage is triggered by a claim first made on or after the retroactive date and before the contract expires.

The phrase "trigger of coverage" is not contained in the insurance contract, but rather is a phrase coined to refer to the issue of which insurance contract or contracts must respond to an otherwise covered claim for property damage or bodily injury that arguably takes place in one or more contract periods.

Many claims-made contracts have extended reporting periods or "tails" to provide coverage for claims made for a certain period of time after the expiration of the contract arising from events taking place during the contract period.

The 1986 Insurance Services Organization Inc. (ISO) form for primary claims-made insurance contracts, for example, provides three separate extended reporting periods that apply where the contract is canceled or not renewed, where the policyholder returns to an occurrence-based contract or where the policyholder obtains a new claims-made contract. First, there is a 60-day "mini-tail" for claims arising from unknown events occurring within the original contract period. Second, there is a five-year tail for claims arising from known events occurring within the original contract period and reported to the insurer (but not "claimed") no later than 60 days after the end of the contract period. Finally, for an additional premium, the policyholder may obtain a supplemental tail.

In contrast, excess claims-made contracts vary considerably in terms of the extended reporting periods provided. Generally, the excess contracts are more restrictive in terms of the extended reporting periods. Some contracts require that the claim be made and reported to the insurer during the contract period in order for coverage to exist. Like occurrence-based contracts, claims-made contracts generally require an occurrence, unexpected and unintended damage or injury, and timely notice of the occurrence and claim.

There has been extensive litigation on claims-made contracts. Some common issues include the enforceability of claims-made contracts, the definition of a "claim," when a claim is made, the adequacy of the notice given to the insurer and application of retroactive dates. It is possible for one or more occurrence-based contracts to be triggered along with a claims-made contract. Sometimes, coordination of coverage is decided based upon which contract is "closest to the risk," but usually the various "other insurance" provisions of the contracts must be consulted. ■

March 30–31, 2011
The Union League of Philadelphia
Philadelphia, Pa.

Agenda

Wednesday, March 30, 2011
5:30–7:30 p.m.
Networking Reception

Thursday, March 31, 2011
8 a.m.–4:30 p.m.
Educational Programming and Luncheon

Symposium Speakers

Pina C. Albo, president, Reinsurance Division, Munich Reinsurance America Inc.

John Bender, president, Allied World Reinsurance Company

Sharon A. Binnun, CPA, senior vice president of finance and accounting/chief financial officer, Citizens Property Insurance Corporation

Wayne Keebler, CPCU, ARe, vice president, underwriting, Wright Risk Management

Steve McElhiney, CPCU, MBA, ARe, AIAF, president, EWI Risk Services Inc.

Franklin W. Nutter, J.D., ARe, president, Reinsurance Association of America

H. Wesley Sunu, J.D., director, Tribler, Orpett & Meyer PC

Others to be announced.

Luncheon Keynote Speaker

Anita Z. Bourke, CPCU, CPIW, executive vice president, The Institutes

Registration Fees

$325 CPCU Society members
$350 ARe designation holders
$399 All others

Registration fee includes all refreshments, networking reception and luncheon.

Hotel Reservations

A block of sleeping rooms has been reserved for symposium registrants at The Inn at the Union League of Philadelphia at a discounted group rate of $189, which includes full breakfast and Internet access. To make your hotel reservation, call the Union League at (215) 587-5570 and reference the CPCU Society.

For additional information, contact the CPCU Society's Member Resource Center at (800) 932-CPCU (2728), option 4, or send an e-mail to membercenter@cpcusociety.org.

Mutual Insurers Must Adapt to Survive

by Charles G. Desmond and Eric F. Hubicki, CPCU, ARe, ARM, AU, AFIS

Charles "Chuck" G. Desmond has 29 years of reinsurance intermediary experience. He is responsible for production and servicing of reinsurance programs for the Midwest and Southeast regions for BMS Intermediaries Inc. Desmond is the branch manager of the Chicago office. He joined BMS Intermediaries Inc. in 2002 after spending seven years at Burridge, Storey and Company. Prior to that, he was at Intere Intermediaries. Desmond has a bachelor's degree from Western Illinois University.

Eric F. Hubicki, CPCU, ARe, ARM, AU, AFIS, joined BMS Intermediaries Inc. in 2008 as a vice president in the Chicago branch office. His reinsurance career includes treaty and facultative production underwriting roles for Munich Reinsurance America and SCOR Reinsurance. Prior to his time in reinsurance, Hubicki was a commercial lines territory manager for Safeco Insurance Company. He was the 2008-2009 CPCU Society Chicago-Northwest Suburban Chapter president and has been a member of the CPCU Society Reinsurance Interest Group Committee.

Editor's note: This article was first published by *National Underwriter* in its July 26, 2010, issue and is reprinted with permission. © 2010 by The National Underwriter Company. All rights reserved.

What Are Mutual Insurers?

Mutual insurance companies are owned by their policyholders, unlike stock insurers, which are owned by investors.

Mutuals operate purely to serve the insurance needs of policyholders, rather than to earn investment profits for shareholders.

Mutuals range greatly in size, from one person operating a small company to some of the world's largest insurers.

The nation's first mutual insurer was the Philadelphia Contributorship for the Insurance of Houses From Loss by Fire founded by Benjamin Franklin in 1752.

The national industry body for U.S. and Canadian mutuals is the National Association of Mutual Insurance Companies, whose member companies underwrite more than 40 percent of the p-c business in the United States.

Mutual insurers have a highly successful history in the United States and enjoy a loyal following among their clients, who like the personal service and value they are able to provide. But the competitive landscape is fierce — and mutuals now face tremendous pressures to secure a sustainable future.

Unlike shareholder-owned companies, the mutual financing model restricts access to capital. So, it is reasonable to question how these organizations can stay fit for the future in a fast-changing world.

There are hundreds of mutuals operating across the United States, with a high concentration in the Northeast and Midwest regions. They account for around half of the homeowners market and almost three-quarters of the farmowners market, supplying traditional property and casualty insurance products.

Mutuals are well embedded in local communities, where they can build deep knowledge and understanding of specific policyholder risks and needs. This personal connection means mutuals lay claim to providing a high level of individualized service and value when compared to big national carriers, and indeed regional mutuals can outperform larger stock companies in certain lines of business by being more nimble.

They offer vital service and choice, including underwriting risks that national carriers may overlook. Policyholders repay them with strong loyalty. Our experience has shown that mutuals can enjoy client retention rates up to 90 percent.

However, mutuals face growing threats.

Large non-mutual companies are moving in — keen to diversify away from their coastal exposures — to compete for clients. These organizations benefit from enormous financial resources and scale, which enable them to fine-tune premiums to specific exposures, to add new coverage features and leverage multiple routes to market.

Better funding also allows competitors to invest in state-of-the-art technology to segment clients, evaluate risk, provide loss control services and use interactive Web-based technology to promote and sell products, settle claims and massively reduce their costs to serve.

Staying Relevant — Key Steps

So, how can mutuals stay relevant and competitive?

Among the key steps toward a sustainable future, and probably one of the most important, is mastering technology.

Mutuals need to ensure they continue to invest in technology and have access to the same tools as stock companies for key functions such as risk evaluation, marketing, sales and claims-handling. They need to get a firm grip on data-mining and other analytics used by their competitors to segment their customers and decide what business they really want.

Those that fail to take those steps face the daunting prospect of adverse selection — picking up the risks that others may

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already have rejected based on superior analytical capabilities.

The comparatively smaller mutual companies are embracing new technology such as using automated underwriting and multivariate rating engines to select and evaluate risk. But keeping pace with the big nationals is undoubtedly a struggle, not just because technology is expensive, but also because it has fundamentally changed the way the market works. This approach can commoditize insurance and threaten the personal service model that has served mutuals so well.

Mutuals also need to ensure their Web presence is fully interactive and responds to customer demand for electronic application uploads, real-time quotes, funds transfer and billing. The key is to make doing business with the company easy and efficient. If it isn't easy and efficient, customers simply utilize those that are.

Along this path, and taking on an ever-increasing importance, the emergence of social media channels (Facebook, Twitter and YouTube, for example) will further evolve the way customers research and purchase insurance coverage.

Accelerating this process is the emergence of smart phones and tablet computers. Large companies such as Progressive and GEICO are already at the cutting edge of these new technologies, increasing the pressure on all players to adapt.

Mutuals should also evaluate broker and reinsurance partners to remain competitive. It is vital that mutuals select partners who understand their business and are able to offer a wide range of resources that give them the best opportunity to successfully negotiate the market.

The right reinsurance broker and risk partner can add value in many ways, such as sharing information on risk modeling, helping to fine-tune underwriting guidelines, coverages and rates, and assisting with financial rating agency reviews. The insights these partners offer can help primary mutual companies perform better, make informed decisions and play to their strengths.

For example, a mutual may be interested in entering a new state or a new line of business. However, it may not have the internal resources to properly evaluate whether the exposure, coverage and legal challenges can be successfully overcome.

Strong reinsurance partners can assist by bringing their broader industry knowledge, underwriting/rating resources, actuarial modeling and risk capacity to bear so the mutual can make an effective business decision.

Last but not least, mutuals need to focus on succession planning — seeking to attract talented professionals to lead the business forward and meet the growing demand for risk management skills. This is a tough challenge since they are competing with other financial and consulting industries for the best people.

Companies that promote education, such as support of the Chartered Property Casualty Underwriter designation, appear to have the upper hand in putting the talent they gain to best use.

Mutual insurers continue to have a successful business model and contribute invaluable choice to the market. Although competition is intensifying and we expect some consolidation among smaller mutuals, there is still plenty of opportunity for those that can master technology change, exploit their local knowledge and move swiftly and flexibly into new niche markets. ■

Mutual vs. Stock

Underwriting results compiled using premium, loss and expense data from Highline Data reveal that reciprocal exchanges, as a group, outperformed both stock and mutual insurers in the past two years.

Roughly 70 reciprocal exchanges produced combined ratios of 98.9 for 2009 and 101.9 for 2008.

Close to 400 mutual insurers produced combined ratios of 103.7 in 2009 and 105.2 in 2008.

Approximately 1,500 stock insurance companies had combined ratios of 100.4 in 2009 and 105.8 in 2008.

Comparative combined ratio results are similar when the largest companies for each type of ownership are excluded from the analysis (USAA and Farmers Insurance Exchange for reciprocals, State Farm Mutual for mutuals and Allstate Insurance for stock companies).

Reciprocal exchanges also had the lowest underwriting expense ratios — averaging 25.5 for the last two years, compared to 27.5 for mutuals and 28.2 for stock companies.

From a growth perspective, mutual insurers showed the least amount of net premium decline in 2009, shrinking 1.3 percent to $93 billion.

Net premiums for stock companies fell 4.8 percent to $301 billion in 2009, and premiums for reciprocals fell 4.2 percent to $25 billion.

While reciprocal exchanges are similar to mutuals, the Insurance Information Institute defines a reciprocal exchange as an unincorporated association organized to write insurance for its members, each of whom assumes a share of the risks covered.

Highline Data is a data affiliate of The National Underwriter Company (www.highlinedata.com).

Highline's database also includes information for risk retention groups, U.S. branches of alien insurers and other ownership types.

For more information on Highline Data, contact Chris Rogers at (877) 299-9424.

The Reinsurer Requests Privileged Information — Now What?

by Andrew S. Boris, J.D.

Andrew S. Boris, J.D., is a partner in the Chicago office of Tressler LLP. His practice is focused on litigation and arbitration of insurance coverage and reinsurance matters throughout the country, including general coverage, professional liability, environmental and asbestos cases. Questions and responses to this article are welcome at aboris@tresslerllp.com.

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In the normal course of a ceded reinsurance claim, it is not uncommon for a reinsurer to request information from a ceding reinsurer about a complex claim. It is also not unusual for the reinsurer to ask for information generated by the ceding insurer's outside coverage counsel (that would be otherwise protected by the attorney-client privilege).

To that end, a decision earlier this year by the United States District Court for the District of Oregon continues to be discussed among reinsurance professionals. The case raises questions about the potential waiver of the attorney-client privilege when such materials are provided to a reinsurer. See *The Regence Group, et al. v. TIG Specialty Insurance Company*, 2010 U.S. Dist. LEXIS 9840 (Dist Ct. Or Feb. 4, 2010).

In *Regence*, the Plaintiffs were a group of the Defendant Insurer's policyholders seeking coverage under a Managed Care Organization Liability Insurance Policy. The Plaintiffs sought defense and indemnity from the Defendant insurer related to lawsuits filed against them involving alleged RICO causes of action. The Plaintiffs filed the action seeking (among other things) a declaration that the Defendant Insurer was obligated to defend and indemnify the Plaintiffs in connection with underlying claims.

Of importance, the Defendant Insurer was also a party to several reinsurance treaties that potentially provided reinsurance coverage for the underlying claims placed at issue by the Plaintiffs in the coverage action against the Defendant Insurer. As part of its normal course of business, the Defendant Insurer provided information to its reinsurers about a number of claims that might be covered by the applicable reinsurance treaties — including the underlying RICO claims asserted against the Plaintiffs. As part of the information sharing process, the Defendant Insurer provided some of its outside coverage counsel's opinions related to the underlying claims to its reinsurers.

While the instant coverage litigation was pending between the Plaintiffs and the Defendant insurer, the Defendant Insurer was also a party to several arbitrations with its reinsurers concerning coverage disputes for a variety of claims. Among those claims in dispute were the underlying claims being asserted against the Plaintiffs.

As part of the discovery process in the reinsurance arbitrations, the reinsurers sought information from the Defendant Insurer's files, including reports and opinions generated by outside counsel. Of importance, the Defendant Insurer resisted production of any material that was potentially privileged on the grounds that any production could equate to a waiver of the attorney-client privilege. Nonetheless, the Defendant Insurer was ordered to produce the materials, but the arbitrators noted that the production of the materials was subject to an order of the arbitration panel and did not constitute a waiver of any privileges.

In addition, the materials produced in the arbitrations were designated "confidential" and made subject to the Confidentiality Agreements also executed by the panel members (and all of the

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parties) involved in those arbitrations.

Subsequently and as part of the coverage litigation, the Plaintiffs sought discovery into the materials that were produced by the Defendant Insurer to its reinsurers. The Defendant Insurer again resisted production of the materials contending that they were protected by the attorney-client privilege, work-product doctrine and common interest doctrine. At the forefront of the discovery dispute, the Defendant Insurer contended that it shared a common interest with its reinsurers regarding the coverage questions that were presented by the Plaintiffs. Accordingly, the Defendant Insurer maintained that the requested materials were protected from production.

In the normal course of a ceded reinsurance claim, it is not uncommon for a reinsurer to request information from a ceding reinsurer about a complex claim. It is also not unusual for the reinsurer to ask for information generated by the ceding insurer's outside coverage counsel (that would be otherwise protected by the attorney-client privilege).

The court ordered the Defendant Insurer to produce the materials stating there was no common interest protection because the Defendant insurer and its reinsurers were opponents in arbitrations concerning coverage questions for the very claims placed at issue by the Plaintiffs in the coverage litigation. The Defendant Insurer filed a motion to reconsider, contending that the documents were produced pursuant to the protections of confidentiality agreements and were not otherwise placed in a position where the information would be disclosed to third parties. Again, the Defendant Insurer contended that the documents were protected by virtue of the attorney-client privilege. The court rejected the motion to reconsider and pointedly stated that if the documents at issue were privileged, the Defendant Insurer expressly or impliedly waived that privilege.

The *Regence* case is not the first case to address this issue (nor will it be the last). Nonetheless, the potential effects from this decision are potentially far reaching and many professionals are questioning how to reconcile the effect of the decision with common practice within the industry. In the arbitration context, some have questioned whether a cedent must refuse to produce privileged documents (even after being ordered to do so) because of the straightforward holding of the court that any such production may be deemed a waiver of the attorney-client privilege. Any such refusal could result in a number of negative consequences in the arbitration — potentially leading to additional litigation and, ultimately, a poor result in the arbitration.

When presented with such requests in the context of arbitrations, cedents are likely to vigorously maintain to arbitration panels that any productions could translate into a waiver. Outside of the arbitration process, cedents must also analyze the dangers in providing privileged materials to their reinsurers when presented with valid requests to do so. Of note, this case also presents problems for reinsurers as it inhibits the flow of information with cedents less inclined to provide information (and arbitration panels potentially less inclined to require such disclosure). Of note, the case also teaches that arbitrations commenced prior to the resolution of the underlying claims can create additional challenges. ■

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Kevin Doerschuk — CNA Ceded Claims

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Interpreting the State of the Market Panel

Jim Hawksworth — Willis Re

John Jenkins — SCOR Re Treaty

Brian Kernkamp — Zurich NA

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Follow the Settlements and *Ex Gratia* Payments

by Robert M. Hall, J.D.

Robert M. Hall, J.D., is a former law firm partner and a former insurance and reinsurance executive; he acts as an insurance consultant and expert witness as well as an arbitrator and mediator of insurance and reinsurance disputes.

Editor's note: The views expressed in this article are those of the author and do not reflect the views of his clients. This article has been copyrighted by the author, and is published with his permission. The author's background and other articles may be found at his website, www.robertmhall.com.

Introduction

The follow the settlements doctrine is that reinsurers should not second-guess the settlements of their cedents which are reasonably within the coverage provided to policyholders. There are a number of exceptions or limitations on this doctrine.[1] One such exception is that the settlement by the cedent must not be *ex gratia,* i.e., outside the coverage provided by the cedent to the policyholder and assumed by the reinsurer. The purpose of this article is to explore the selected case law related to this exception.

Changes to Underlying Coverage Not Reinsured

One example of the manifestation of this exception is the recent case of *American Home Assurance Co. v. American Re-Insurance Co.* et al, Index No. 602485/06 (S.C.N.Y. May 24, 2010). This was a ruling on a summary judgment motion by which the reinsurers sought to dismiss claims by the cedent for reimbursement of pollution-related losses incurred by its insured, the Monsanto Company. American Home and Monsanto reached a series of agreements related to coverage for clean-up costs and third-party claims and negotiated several modifications to such agreements. It does not appear that the reinsurers were completely aware of or consented to these agreements or modifications thereof. When the cedent billed the reinsurers, they raised several defenses, including the argument that certain settlements were *ex gratia* with respect to the policy terms that they reinsured.

In essence, the court found that the cedent adjusted and paid the Monsanto claims based not on the policy terms but on the subsequent agreements the cedent reached with Monsanto. The court found that the settlement: (a) included punitive damages which were excluded by the relevant policies; (b) included non-sudden pollution which was excluded with such exclusion in conformance with the law in the relevant state; and (c) ignored the proper application of Monsanto's self-insured retention and other insurance provisions of the relevant policies. As a result, the court granted summary judgment in favor of the reinsurers.

A somewhat similar case is *Granite State Ins. Co. v. ACE American Reinsurance Co.,* 2007 N.Y. App. Div. Lexis 13268. The cedent issued seven policies to the insured, only one of which (the Granite State policy) was assumed by the reinsurer. The cedent initially denied coverage under the Granite State policy, but when it overpaid a loss on another policy entered into an agreement with the insured to the effect that the overpayment would be covered by the Granite State policy. The court denied summary judgment motions concerning follow the settlements and the *ex gratia* exception thereto on the basis that there were outstanding issues to be resolved by the trier of fact.

North River Ins. Co. v. Philadelphia Reinsurance Corp., 831 F.Supp. 1132 (D.N.J. 1993) involved a policy issued to Owens-Corning which did not cover the insured's defense costs. When asbestos-related losses arose, the insured and North River attempted to have them handled pursuant to the Wellington Agreement. North River failed to file the relevant policy as not covering defense costs as required by the Wellington Facility and the insured claimed defense costs. Several Wellington ADR proceedings found the cedent liable for defense costs. The court found that the policy unambiguously excluded defense costs and that payment of such was *ex gratia* with respect to the reinsurance coverage. The court went on to find that the cedent violated its duty of utmost good faith to reinsurers:

> [B]y gross negligence in: (1) failing to recognize how signing the Wellington Agreement materially expanded the defense obligation under the Owens-Corning policies, and (2) triggering the strict penalty in Appendix D of the (Wellington) agreement by failing to schedule the policies (as not covering defense costs) within the 20-day period. These two acts of gross negligence constitute a material breach of the re-insurance certificates which mandated that (the reinsurer) consent to any modification of the risks re-insured.[2]

Payment of Non-Covered Damages

American Ins. Co. v. North American Co. for Prop. and Cas. Ins., 697 F.2d 70 2nd Cir. 1982) involved a layer of casualty reinsurance for $250,000 excess of $250,000 on a policy issued to Dow Chemical. Due to the presence of a Dow product in a building that burned, the court awarded the owner of the building $146,970 in compensatory damages and $750,000 in punitives. The cedent settled this and similar claims with the insured and allocated $500,000 to the burned building loss. The cedent argued that the definition of covered damages in the relevant policy was ambiguous and, in any case, the reinsurer was required to pay the loss pursuant to the doctrine of follow the settlements.

The court found that the policy issued to Dow Chemical did not cover punitive damages awarded for corporate misconduct, as was the case in this matter. Since the compensatory damages were below the attachment point of the

reinsurance, the court found that the cedent was seeking compensation for punitive damages which was an *ex gratia* claim. The court found further that the doctrine of follow the settlements does not apply to *ex gratia* claims.

An attempt to collect reinsurance recoverables for extra-contractual damages was the issue in *National Union Fire Ins. Co. v. Clearwater Ins. Co.*, 2007 U.S. Dist. Lexis 52770 (S.D.N.Y.). The underlying claims involved breast implants manufactured and sold by 3M. The litigation with insurers was split into two phases with the first dealing with coverage issues and the second dealing with the insured's extra-contractual damages resulting from the insured's lost profits due to the insurers' failure to pay defense and indemnity costs. During the second phase, the relevant insurer settled the entire dispute and argued that the reinsurer was obligated to pay its portion of the settlement pursuant to follow the settlements. The court denied the cedent's motion for summary judgment on the basis that there was evidence that a portion of the settlement included extra-contractual (i.e., *ex gratia*) losses.

Wrongful Payment of Claim

In *Independent Ins. Co. v. Republic Nat. Life Ins. Co.*, 447 S.W.2d 462 (Ct.Civ. App.Texas 1969), the CEO of the primary company took out a life insurance policy on the life of an employee on behalf of a separate enterprise in which the CEO was the beneficial owner. After the policy lapsed for nonpayment, the employee died. The cedent, nonetheless, paid the claim and sought to collect 95 percent of the claim from the reinsurer. The court rejected the cedent's follow the settlements argument:

> It is generally held that by such type of stipulation the reinsurer submits itself to any settlement or adjustment of liability on the original policy which (the) reinsured may adopt or assume in good faith. However, it is also settled that a provision of a reinsurance contract authorizing (the) reinsured to settle or adjust a claim of the original insured does not authorize the reinsured to impose liability on the reinsurer by settlement or adjustment of a claim for which no liability exists, as a matter of law. The reinsurer may attack a settlement for fraud or collusion.[3]

Lexington Ins. Co. v. Prudential Reinsurance Co. of America, 1997 Mass. Super. Lexis 593 involved a comprehensive general liability policy purchased by a bank which provided a revolving credit account to an auto dealership. The bank learned that the dealership was fabricating certificates of ownership of autos and other acts which violated the loan agreement. The bank arranged to have itself replaced on the loan but did not inform the new lender of the wrongful acts of the dealership. Ultimately, the fraud was discovered and the bank was sued for fraudulent concealment. The insurer settled the suit and attempted to collect from the reinsurer based on the doctrine of follow the settlements.

The court acknowledged this doctrine but also its limitations: "(W)hile a reinsurer in most cases must follow the fortunes of the reinsured, a payment by an insurer that is clearly and unambiguously outside the scope of the insurance policy is *ex gratia* and does not bind the reinsurer."[4] In this case, the court ruled that the payment of the claim by the cedent was improper since it involved willful conversion by the dealership and a state statute that declared as against public policy contracts intended to exempt anyone from responsibility for violation of law. Since the claim should not have been paid in the first place, it was *ex gratia* with respect to the reinsurer.

Conclusion

The follow the settlements doctrine requires reinsurers to indemnify cedents for claims settled by the cedents which are reasonably within the ambit of the policies in question. Claims which are not reasonably within the ambit are *ex gratia*.

Ex gratia claims may arise in a variety of contexts. For instance, agreements between the insured and insurer over the administration of APH claims may alter the coverage in a fashion that creates a gap between that which was originally insured and reinsured and the claim that was actually paid. In some instances, the insurer might find it necessary to pay some damages which are not covered in order to settle an entire claim. Finally, the insurer might pay claims that are clearly improper due to collusion or statutory prohibition. In all of these situations, the cedent should anticipate an *ex gratia* defense by reinsurers. ■

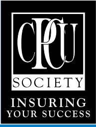
Endnotes

(1) See, e.g., Robert M. Hall, "Follow the Settlements: Bad Faith Claims Handling Exception," XIV ARIAS-US Quarterly No. 3 at 24 (2007).

(2) 831 F. Supp. 1132 at 1146.

(3) 447 S.W. 2d 462 at 469 (internal citations omitted).

(4) 197 Mass. Super. Lexis 593*9.



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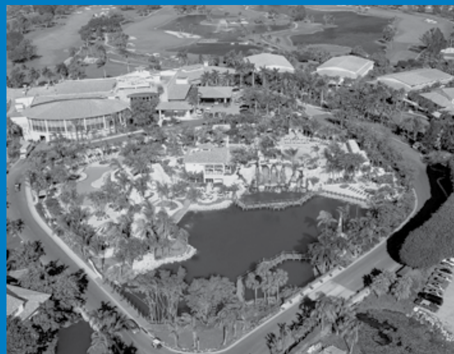

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