



# Why Reinsurance Matters, and Other Must-Know Reinsurance Concepts



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## Reinsurance Matters



The quality of the reinsurance security purchased by the direct insurer is what helps to ensure that losses will be paid. It is therefore important to understand the reinsurance function, relationship, claims services, and fronting arrangements.

Risk managers and other purchasers of insurance rarely think about how reinsurance affects their company or the insurance they purchase for their company. Insurance buyers mainly focus on the direct insurers—the primary, excess, and umbrella carriers that provide the coverage.

Smart insurance buyers look for insurance companies with high financial ratings and long histories of standing by their insureds when losses occur. Other buyers rely on their broker to put together the best quality insurance program with the best insurance security available. After all, the insured must rely on the insurance policy issued by the direct insurer.

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But what stands behind the A-rated insurer or the high quality insurance program for a complex commercial risk? Reinsurance. Commercial insurance cannot exist without reinsurance. The quality of the reinsurance security purchased by the direct insurer is what helps to ensure that losses will be paid.

## The Reinsurance Function

Quality reinsurers provide special expertise to their direct insurer clients and assist the direct insurer in providing the best possible protection and risk management for the direct insurer's own clients. Some large professional reinsurers help small insurance companies expand into new areas and provide them with technical, actuarial, and claims expertise and training.

Reinsurance has been defined in various ways by expert commentators and the courts. In simple terms, reinsurance is insurance for insurance companies provided in the form of a contract of indemnity rather than a liability contract. Generally, the direct insurer must first pay a loss and then seek reimbursement for that loss from its reinsurer.

Stated another way, reinsurance essentially is an extension of the theory of insurance itself. The insurance risk is spread from one risk bearer to other risk bearers. This allows the initial risk bearer to continue to provide insurance products to its clients, knowing that when losses occur, others will share those losses. Reinsurance also allows a direct insurer to strengthen its balance sheet by reducing its liability for loss and replacing that liability with an asset.

## The Reinsurer/ Insured Relationship

The relationship between a reinsurer and the insured differs markedly from the insurer/insured

relationship. Generally, there is no contractual relationship between the insured and a reinsurer, and no right of action by the insurer against the reinsurer. The insured must look to its insurer for payment of any claims, not to the reinsurer.

Under normal circumstances, the reinsurer has no interaction with the insured. Usually, the identity and often the existence of the reinsurer are unknown to the insured. Why then should the insurance buyer care about reinsurance if there is no contractual relationship or interaction between the two?

Depending on the insurance program purchased, the reinsurance standing behind that insurance may have a significant impact on the insured when losses arise. A highly leveraged insurance program that predominantly relies on reinsurance may create a substantial risk for the insured. If the reinsurance fails—the reinsurers refuse to pay or become insolvent—the direct insurer may have serious difficulty responding to claims if the direct insurer reinsured or ceded most of the risk to its reinsurance program.

Although the direct insurer is solely responsible to the insured for claims, the failure of a reinsurance program behind the direct insurer may result in the insolvency of the direct insurer. This, in turn, may result in the insured effectively becoming a self-insurer and relying on state security funds for the minimal protection they provide.

## Risk Management/ Claims Services

A highly leveraged insurance program also may be a sign that the direct insurer has very little interest in the program. Where the risk retained by the direct insurer is minimal, the direct insurer

may not provide the level of risk management and claims services that the insured may require.

A direct insurer that cedes the vast majority of the reported loss to its reinsurers may not wish to incur loss adjustment expenses, but would rather its reinsurers shoulder the loss. While this may seem to favor the insured, whose claims will be paid and passed along to reinsurers, the lack of proper claims handling may result in unnecessary loss payments and resistance from reinsurers who expect the reinsured to handle claims properly.

## Fronting Arrangements

The direct insurer's interest in the insurance program may be nonexistent because the direct insurer is merely acting as a front for the reinsurance program. Many commercial risk programs are fronted because the risk bearers with the expertise and interest in insuring the risk are not licensed to do business in the insured's state or are not licensed to write direct insurance. Generally, a fronted program is well-known to the insured and arranged in advance.

For example, it may be that the insurance market for a certain type of insurance is made only in London. The insured may be uncomfortable in accepting direct insurance through the excess or surplus lines market and may insist on licensed or admitted paper. In that case, a licensed direct insurer may write the policy and cede most of the risk to the market that provides the actual coverage.

Sometimes, however, the direct insurer retains enough of the risk so that the insured does not know the program is really fronted. The direct insurer may have little interest in the insurance program if it is merely collecting a fronting fee. The

fronting insurer will even reinsure its retained portion of the risk through a separate reinsurance program, leaving it with none of the risk it originally assumed. Where the direct insurer transfers all of its risk to others, the likelihood that the direct insurer will provide the insured with any risk management services and stand by the insured when claims arise is diminished.

## Conclusion

These doomsday scenarios need not come true if the insurance buyer insists on a high-quality insurer and questions the reinsurance protection standing behind the insurance program it has purchased. Reinsurance is a normal part of the risk transference system, and the insured should have comfort in knowing that its risk is being transferred in an appropriate manner to reinsurers of quality.

If the direct insurer refuses to discuss the reinsurance protection it anticipates for the program it plans to write for the insured, the insured should consider whether doing business with that insurer is the right business decision for the company. □

## Reinsurance Terminology Explained: Bordereau



Reinsurance contracts are filled with exotic and equally mind-numbing terms like facultative certificate, follow-the-fortunes, cede, treaty, honorable engagement, ultimate net loss, and more.

Some of our previous commentaries have addressed a few of these terms, such as [“Understanding Reinsurance Terminology—Follow-the-Fortunes”](#) (October 2001), [“Sorting Out the Reinsurance Contract Morass”](#) (March 2002), and [“Reinsurancese—Time for a Change?”](#) (March 2008).

As one delves into the more technical aspects of a reinsurance contract, the term “bordereau” often comes up. The uninitiated may immediately recoil from a word like bordereau, but those who have been around the block know that a bordereau is just a list or report. But is it just a list?

## Bordereau Defined

The venerable Robert W. Strain, whose final reinsurance and contract wording training course was conducted in July this year, defines bordereau as follows:

Furnished periodically by the reinsured, a detailed report of reinsurance premiums or reinsurance losses. A premium bordereau contains a detailed list of policies (or bonds) reinsured under a reinsurance treaty during the reporting period, reflecting such information as the name and address of the primary insured, the amount and location of the risk, the effective and termination dates of the primary insurance, the amount reinsured and the reinsurance premium applicable thereto. A loss bordereau contains a detailed list of claims and claims expenses outstanding and paid by the reinsured during the reporting period, reflecting the amount of reinsurance indemnity applicable thereto. Bordereau reporting is primarily applicable to pro rata reinsurance arrangements and to a large extent has been supplanted by summary reporting.

Strain, Robert W., ed. *Reinsurance Contract Wording*. Athens, TX: Strain Pub, 1992. The [IRMI.com Glossary definition of bordereau](#) is: “A report providing premium or loss data with respect to identified specific risks. This report is periodically furnished to a reinsurer by the ceding insurers or reinsurers.” A single report or list is a bordereau. When describing more than one bordereau, add an “x” after the “u” to make the term plural: “bordereaux.”

## Why Bordereau?

The word “bordereau” derives from the middle French word “bordrel” and from the old French word “bort,” which means edge or margin. Merriam-Webster’s shows the first known use around 1858, but *A Treatise on the Law of Principal and Agent, Chiefly with Reference to Mercantile Transactions* (Paley, William. 3rd ed. New York: Banks, Gould, 1847) mentions bordereau in the context of a statement or memorandum listing the details of negotiable instruments. Earlier uses can also be found if you search the Internet or hang out in dusty corners of business libraries.

Interestingly, the errors and omissions clause found in many reinsurance contracts was developed in the time when all information received by the reinsurer was presented on comprehensive bordereaux. The errors and omissions clause was created to ensure that coverage was provided even though an item was inadvertently left on a bordereau. Salm, Robert F. “Reinsurance Contract Wording.” In *Reinsurance*. Athens, TX: Strain Pub, 1980. See our Expert Commentary, [“When Errors Occur in a Reinsurance Relationship”](#) (December 2002).

Bordereau is just one of many terms of art used in the reinsurance industry. Terms of art are of-



ten used to set a particular industry or profession apart from others by using jargon that has a “special” meaning only understood by those working in that industry or profession. As Professor Kingman Brewster Jr. said, “[i]ncomprehensible jargon is the hallmark of a profession.” As with most terms of art, “bordereau” was used instead of report or list by reinsurance professionals and became common usage in the industry in the 1800s.

## Types of Bordereaux

The term bordereau is used to describe most lists or reports of premium or losses required under the reinsurance contract from the reinsured to the reinsurer. In the facultative context, where an individual risk is reinsured, a bordereau is not necessary. The premium report is the reinsurance premium paid for the facultative certificate for that individual risk. On the loss side, typically there is individual loss reporting. But if a facultative certificate generates multiple losses emanating from an individual risk, monthly or quarterly reports listing all claims and all payments on claims attributable to that single risk may be deemed a bordereau.

In the treaty context, a premium bordereau is merely a detailed report of the premiums ceded from each of the underlying policies subject to the proportional reinsurance treaty. Typically, the premium bordereau will set out policy-level detail, including the gross premium, the brokerage if any, and the ceded premium, along with basic details for each policy ceded to the treaty. The premium bordereau is also the initial method by which the reinsurer finds out the exact details of the business being written by the reinsured and assumed by the reinsurer.

Typically, the reinsurance contract will specify the reporting requirements for the periodic premium bordereau. Many reinsurers are now standardizing the format for these bordereaux and accepting them electronically either in a proprietary format based on the reinsurance accounting system being used or in a common format like Excel. Certain statistical organizations and industry compilers of information in certain markets have standardized electronic bordereau reporting.

The premium bordereau typically goes directly to the reinsurer’s accounting function so that the ceded premium can be booked. Nevertheless, it is important for the reinsurer to examine the premium bordereau for anomalies in either the premium volume or the risk information being supplied. The premium bordereau also serves as an important tool for the reinsurer when selecting certain risks for audit should the reinsurer engage in periodic audits of the business being ceded to the treaty.

A proportional treaty typically will have reporting requirements for losses, and these often manifest as a loss or claims bordereau. The reinsurance contract will set out the information requirements for the loss bordereau. Generally, the loss bordereau will contain risk details such as the insured’s name, claimant’s name, policy number, claim number, effective date, date of loss, loss reserve, expense reserve, and any paid losses or expenses. The loss bordereau, like the premium bordereau, generally is provided in electronic format and often in a standardized design. On a quota share treaty, the loss bordereau is often the only way the reinsurer will obtain information about the losses being ceded to the treaty unless there are special reporting requirements for certain risks. Like the premium bordereau, the loss bordereau will be

the tool against which the reinsurer will make selections when doing a claims audit.

## Reinsurance Contract Requirements

Not every reinsurance contract requires premium bordereau reporting. Very often, reporting clauses require summary accounting information rather than the individual risk detail typically found in bordereau reporting. For example, a reporting clause may provide simply as follows:

The Company shall render a monthly account within \_\_\_ days after the end of the period. This account shall summarize premiums, return premiums, allowances for commissions, losses paid, loss adjustment expenses paid, and salvage recovered. The account shall also reflect the balance due by either party.

These monthly or quarterly reports are merely account statements summarizing the business under the treaty and do not provide policy-level detail. Where the reinsurance contract does not prescribe detailed bordereau reporting, the reinsurer must audit periodically to test the business being ceded and to ensure compliance with the terms of the reinsurance contract.

Where bordereau reporting is required, the reinsurance contract will express the detailed information required. For example:

The Company shall furnish the Reinsurer with the following:

1. Bordereau within 30 days after the last day of each month, payable within 60 days after the last day of each month.

The bordereau is to include the following items:

- A. Name of Insured
- B. Policy Number
- C. Effective/Expiration Dates
- D. Type of Transaction (New, Renewal, Endorsement, or Cancellation)
- E. Policy Limit
- F. Premium
- G. Ceding Commission
- H. Net Premium

## Conclusion

Although terms of art and industry jargon are off-putting to many, industries like the reinsurance industry are littered with these expressions and words. Yet, words like bordereau, once the meaning is known, are no longer mysterious and are easily understood and put to common use. ☐

## Reinsurance Contract Wording Revisited



Always read the contract—at least that is what the experts say and best practices advise. The trouble with that sage advice is that sometimes the contract is not as clear as it could be.

Ambiguities, as we have discussed before, see ["Adventures in Contract Wording: The Effect of](#)

[Ambiguous Reinsurance Contract Language](#),” lead to problems and sometimes disputes.

## Who Has the Burden of Proof?

When a contract dispute goes to court over an ambiguity, one party has the burden of proving its case. The same is true in reinsurance arbitrations, but the rules are more relaxed, and most arbitrators don't sweat the burden of proof issue. Nevertheless, the parties need to put forth what they can to prove their view of how the contract should be interpreted.

Typically, the plaintiff or the petitioner has the burden of proof. When the issue is proving the existence of a contract, the burden is on the plaintiff to show that there is, in fact, a contract between the parties. In the reinsurance context, things are no different. The party seeking to recover under the reinsurance contract typically has the burden of proof.

If a ceding insurer is seeking to collect reinsurance recoverables from an assuming insurer, the ceding insurer has to prove that there is a real contract between the parties and that the facts and circumstances demonstrate that the payment is required under the contract. Assuming credible and sufficient proof is provided, or there is no issue about whether the parties entered into a real contract, then the ceding insurer must prove that it paid an underlying claim or expense that comes within the reinsurance contract and that a proper billing was delivered to the assuming reinsurer in a timely manner.

Very often the dispute is not about the billing itself but whether the payment was a proper payment under both the underlying insurance contract and the reinsurance contract. Again, in the first instance, the ceding insurer has the burden

to show that the payment was made under a policy that is reinsured by the reinsurance agreement and that the payment was proper within the terms and provisions under both contracts. The burden then shifts to the assuming insurer to prove that payment was improper or that there is some other basis to refuse payment under the contracts.

In direct insurance disputes, it is well known that the insurance company seeking to avoid a claim payment has to prove that an exclusion to coverage applies. All the policyholder has to prove is that there is an insurance contract and there is a claim that falls within the coverage grants of the contract. It is the insurance company's burden to prove that an exclusion precludes coverage.

Similarly, in a reinsurance dispute, where the assuming insurer is claiming an exclusion under the reinsurance contract (or otherwise) applies, the burden falls on the party seeking to get out of the contractual obligation—the assuming insurer—to prove facts to show that payment is not required.

Where one party seeks to terminate the reinsurance contract, the party claiming the right to terminate has the burden to prove that termination is permitted and appropriate under the terms and provisions of the reinsurance agreement. This is true even if, for example, the ceding insurer brings an arbitration seeking an arbitration award declaring that the assuming insurer's attempt to get out of the contract by termination is ineffective and a breach of the reinsurance agreement. Because the assuming insurer is looking to avoid a contractual obligation, it becomes the assuming insurer's burden to prove that termination is permitted under the reinsurance contract.



## How To Prove the Contract

In most cases, there is no real dispute about the contract. In court, the plaintiff will have to show through business records and appropriate testimony that there is a contract. Alternatively, the parties may stipulate to the existence of the contract.

In a reinsurance arbitration, the parties typically put the reinsurance contract in as an exhibit to the prehearing briefs and use the contract throughout the proceeding. In most cases, the arbitration panel will ask the parties to provide the reinsurance contract to the panel at the early stages of the arbitration.

Because reinsurance disputes can involve multiple reinsurance contracts with multiple amendments and attachments, and ones that are decades old, coming up with an agreed-upon contract set is not always easy. The older the reinsurance contract, the more likely it is that it will be missing amendments or schedules or that it will be unsigned. But, unless there is a real dispute about the existence of the reinsurance contract or a particular amendment, small errors or missing documents are not usually problematic.

Where there is a real dispute about whether the parties entered into the contract, then the proponent of the contract will have the task of locating enough evidence to convince the arbitration panel that the contract did come into existence. This might require archive searches and assistance from the reinsurance intermediary if one was used to place the reinsurance.

To prove the contract, there will need to be enough documentary evidence and testimony to show an offer and acceptance, and sufficient

terms and conditions to be able to understand how the contract operates. Proof might be found in the underlying insurance contract if the reinsurance was facultative. Alternatively, it may be pieced together from correspondence (today, emails; back in the day, facsimiles or cables).

## Incorporated Terms

Many contracts expressly incorporate terms and provisions from other contracts or documents. Reinsurance contracts may do this as well. This may complicate determining the meaning of specific terms and provisions of the contract. Ambiguities can easily arise from incorporated wording.

A facultative certificate, which is typically a short form contract, may incorporate the terms and conditions of the underlying insurance policy it reinsures. Many reinsurance contracts expressly state that the reinsurer must follow the form of the underlying contract. This is particularly true in reinsurance structures that are meant to be back to back with the underlying insurance policy.

An excess-of-loss reinsurance treaty might incorporate the terms and conditions of the underlying reinsurance contract that reinsures the lower limits of the underlying policy. For example, if a direct insurer issues a primary policy for \$1 million and a following form excess policy for \$2 million excess of the underlying \$1 million primary policy, the direct insurer—now the ceding insurer—may structure its reinsurance to follow the underlying pattern. It may purchase a facultative certificate for a portion of the primary policy and another, following form facultative certificate for a portion of the excess policy.

Another example of incorporation in the reinsurance context might occur is where the assuming insurer buys its own reinsurance and retrocedes part of its assumed risk to another assuming insurer (a retrocessionaire). In that case, the retrocessional contract may attach or incorporate the underlying reinsurance contract.

For an incorporation to be effective, the contract must make clear reference to the incorporated document and describe it in terms that clearly identifies the document. Some contracts go further than merely referring to another document. Some contracts expressly attach the other document. With a provision expressly attaching another document and with the document actually attached, there can be no doubt about the other documents applicability. But how it works in a specific context may not be as clear.

## Dual Incorporation

Another way to make it clear that the terms of another document are incorporated is not just to attach it but to state expressly that all the terms and provisions of the other document are applicable to this contract as if those terms were contained in this contract. This has been called dual incorporation by some courts. This has been used in some reinsurance contracts, and at least one court that has reviewed dual incorporation provisions in a retrocessional context has stated that it was sufficient to allow the underlying contract's arbitration provision to apply to the retrocessional contract.

The dual incorporation provision emphasizes that not only is the referenced document attached and made a part of the contract but that all the terms and provisions of that document are applied to this contract as if those terms and provisions were contained in this contract.

Often these provisions state that there is a limit to incorporation. Obviously, there are terms and provisions of the contract that are different from the underlying document, so these provisions provide that the incorporation applies except as amended by the contract.

## Does Incorporation Solve the Ambiguity Problem?

Incorporating terms and provisions from another document is helpful in clarifying how to interpret the main contract. But if the main contract does not clearly specify what provisions take precedence when there seems to be an overlap, then ambiguities arise.

A provision that says, "except as amended by this agreement, all terms and provisions of the other agreement apply" is only helpful if "this agreement" specifies what it is amending from the other agreement. When it does, the main agreement will have language such as "section 2 of the referenced document is amended as follows." Without that language, the parties are left to fight over conflicting provisions.

While the general rule is that a later-signed document's terms will prevail and a more-specific provision will prevail, it is not always very easy to make the distinction. For example, if an incorporated reinsurance agreement has an inspection of records clause and the retrocessional agreement that incorporates the underlying agreement has its own inspection of records clause, which one prevails if there is a dispute between the retrocedent and the retrocessionaire?

The answer may be that the provisions have to be read together and reconciled; it all depends on the language.

## Conclusion

There is no doubt that reinsurance contract wording has improved markedly in recent years. Nevertheless, most reinsurance disputes involve older contracts, and some of those contracts have ambiguities. While the burden of proof often rests with the contract's proponent where the other party is claiming relief from compliance, the burden of proof generally shifts.

Incorporated wording adds complexity to determining the meaning of specific terms and provisions of the contract. Lack of clarity may cause ambiguities to rise if it is not clear what provisions of the main contract control over the incorporated provisions.

The bottom line is the contract needs to be read in its entirety and in the context of the structure of the agreement, any incorporated terms and provisions, and with consideration of the customs and practices of the industry. □

## Adventures in Contract Wording: The Effect of Ambiguous Reinsurance Contract Language



Sloppy contract drafting breeds disputes, disputes result in litigation, and it is dangerous indeed to leave it to the courts to determine the provisions of a reinsurance contract. This article examines some of the problems that can occur

because of imprecise reinsurance contract language and what can be done to avoid this scenario.

To some, reinsurance contracts seem at once arcane and boilerplate—arcane because reinsurance terminology goes back hundreds of years, and boilerplate because “standard” clauses appear in contract after contract, year after year. Like all contracts, however, it is crucial that a reinsurance contract set forth the intent of the parties clearly and precisely to avoid legal disputes years later.

High quality cedents and reinsurers have contract wording specialists whose job it is to make sure that the wording for that particular reinsurance contract properly expresses the parties' intent. Sometimes, however, because of the press of business, the volume of reinsurance contracts renewing at the same time, or by the use of reinsurance intermediaries to prepare draft contract wordings, reinsurance contracts are drafted using the old cut-and-paste method. Clauses may be carried over from sample or older contracts that may have no relevance to or meaning in the contract being drafted. Under these conditions, the intent of the parties may not match the contract wording. And if the losses exceed expectations, a dispute will arise.

Sloppy contract drafting breeds disputes, and disputes distract cedents and reinsurers from the business at hand. Ambiguities in reinsurance contracts also may result in a judicial interpretation of the contract that is contrary to the custom and practice in the industry or one that was never even contemplated by the parties. Clarity in reinsurance contract drafting, therefore, is extremely important to a long and stable relationship between a cedent and its reinsurers.

## Ambiguity Breeds Disputes

There have been a number of reinsurance disputes over ambiguous reinsurance contract terms. For example, in *one* case, a dispute arose concerning whether the cedent's use of quota share reinsurance to cover part of a loss that came within the cedent's retention was a breach of the cedent's net retention warranty in the reinsurance agreement [*Commercial Union Ins. Co. v Seven Provinces Ins. Co.*, 217 F3d 33 (1st Cir 2000)]. The facultative certificate issued by the reinsurer required that the cedent retain \$225,000 out of the \$450,000 excess of \$50,000 amount reinsured. The retention, however, could be reduced by "any general excess loss or excess catastrophe reinsurance."

The language used in the net retention clause was extremely difficult to follow (and is not worth repeating here). The cedent took the position that it properly reduced its retention by using its general quota share treaty to cover part of the loss without a proportional reduction in the amount required to be paid by the facultative reinsurer.

The court found that the net retention provision was ambiguous and allowed expert testimony to help clarify whether the quota share treaty qualified as a general excess of loss reinsurance contract. Ultimately, the courts agreed with the cedent's expert and held that the use of the quota share treaty to reduce the cedent's net retention did not violate the net retention clause.

All of this, of course, could have been avoided if the net retention clause was written more precisely. The ambiguity, according to the court, was the phrase "general excess of loss reinsurance contract," which the court did not find to be a term of art in the reinsurance industry as was the phrase "excess of loss reinsurance."

Had the parties made clear in the contract precisely what reinsurance protection the cedent could purchase without violating the net retention warranty, this issue would not have been raised in the dispute. While it is far from clear that the use of quota share reinsurance by the cedent violated the net retention warranty, one has to wonder how the court could equate "general excess of loss reinsurance contract" with a quota share reinsurance contract.

Another issue arising out of the perceived ambiguity in reinsurance contract wordings is whether declaratory judgment expenses are covered under reinsurance contracts. This issue has generated case law and significant industry commentary because of its economic impact on environmental and other long-tail, continuous exposure types of claims.

In *Affiliated FM Insurance Co. v Constitution Reinsurance Corp.*, 416 Mass 839 (1994), the Massachusetts Supreme Court found the language in the facultative certificate unclear on whether the parties intended the contract to include litigation expenses for declaratory relief brought by an insured against its insurer to determine coverage. The word "expenses" was at the crux of this dispute. The court held that because "expenses" was a word with broad import and no fixed definition, it was ambiguous in the context of the facultative certificate. Had the certificate made clear how declaratory judgment expenses would be handled, there would have been no dispute.

## Conflicts between Contract Provisions

Other disputes have arisen because of a perceived conflict between the arbitration and service-of-suit clauses in reinsurance treaties. The

typical arbitration clause makes arbitration the exclusive means of dispute resolution between the cedent and the reinsurer. Most reinsurance treaties—particularly ones involving international reinsurers—also contain a service-of-suit clause, which provides that the reinsurer shall submit to the jurisdiction of any U.S. court at the request of the cedent if the reinsurer fails to pay.

Some reinsurers have argued that the dispute must go to court because the service-of-suit clause overrides the arbitration clause. Most recently, an Ohio federal court rejected this argument and found that the service-of-suit clause was meant to apply to litigation to compel arbitration or to confirm or vacate an arbitration award, and did not override the broad arbitration clause in the reinsurance treaty [*Credit Gen. Ins. Co. v John Hancock Mut. Life Ins. Co.*, No. 1:99 VC 02690, 2000 U.S. Dist. LEXIS 9003 (ND Ohio May 30, 2000)].

The ambiguity here arises not from the lack of clarity of particular phrases, but because provisions in the same contract appear to conflict. While the Ohio federal court did not find a conflict, other courts have held that the service-of-suit clause overrides the arbitration clause where the arbitration clause is not broad. Often, conflicts between contract provisions occur when older agreements are marked up and edited. If care is not taken to make sure that only the relevant clauses are present and that no internal conflicts exist, disputes will arise, and courts may interpret the contract in a way the parties did not contemplate.

## The Dangers of Short-Form Contracts

Another area where ambiguities arise is when the reinsurance contract is merely a slip policy.

A slip is a short-form method of documenting the main terms and conditions of a reinsurance contract in advance of the preparation of the full contract wording. The slip itself stands as an enforceable contract should the formal contract not be drafted. While in most cases a formal reinsurance treaty will be signed by the parties, certain reinsurance markets rely on slips and cover notes as the final expression of the parties contractual arrangements.

Slip policies are fraught with potential ambiguities. If not drafted carefully, they often refer to underlying wordings that might not exist or reference specific forms that are no longer in use. We have seen slips in loss portfolio reinsurance contracts that refer to the arbitration clause “as in the original” when there is no “original” to refer to. We have seen other slips where the parties express the reinsurance limits only, without clarifying the cedent’s retention.

These drafting lapses lead to disputes, which are more difficult to resolve because of the ambiguities in the contract. While some courts have no trouble enforcing an arbitration provision merely based on the words “arbitration clause” in a slip [*Allianz Life Ins. v American Phoenix Life & Reassurance*, Civ. No. 99-802 (DWF/AJB), 2000 U.S. Dist. LEXIS 7216 (D Minn March 28, 2000)], it is dangerous indeed to leave it to the courts to determine the provisions of a reinsurance contract.

## Concluding Thoughts

The law of contracts applies to reinsurance contracts with equal force. While the rules of contract interpretation allow the use of extrinsic evidence to determine the parties’ intent should a provision be found ambiguous, resorting to extrinsic evidence is unnecessary if the contract is



devoid of ambiguity. It is better and less expensive to be clear and precise when drafting a reinsurance contract than to await an expensive arbitration or litigation to find out what a third party thinks the parties originally intended. □

## The Interplay between Fronting and MGA Arrangements



Insurance and reinsurance programs take on many structures. Some are straightforward traditional reinsurance arrangements. For example, a ceding insurer produces a book of business through its agency force or through independent brokers and underwrites the business through its underwriting staff. Claims are then handled by the ceding insurer's claims department. A reinsurer or group of reinsurers contracts with the ceding insurer to provide quota share or excess-of-loss reinsurance protection.

Other structures involve business produced by third parties. These third parties are often non-risk-bearing organizations that contract with the ceding insurer to produce a certain class or line of business that is then subject to reinsurance protection. A different type of structure includes a ceding insurer that bears very little if any risk of loss and reinsures all or almost all of the risk to the reinsurer, which is the real party in interest and assumes the economic risk of loss for the business written. These are called fronting arrangements. Essentially, the ceding insurer

agrees to write the business but then lays off all or most of the risk to the party that really wants to assume those risks.

Sometimes the structure of the deal combines the use of a third-party managing agent that produces and underwrites the business for a ceding insurer, which in turn acts as a fronting insurer for a reinsurer. These hybrid structures conflate the issues parties often confront when dealing with managing agency and fronting arrangements.

In "[The Trouble with Giving Away the Pen](#)" (June 2001) and "[Up-Front about Reinsurance](#)" (January 2004) reinsurance commentaries, we discussed some of the issues that may arise when contracting with a managing agent and the various rationales for creating a fronting arrangement. This commentary will discuss the interplay between the two.

## Overview of Insurance Business Production

There are many ways insurance business is procured, produced, underwritten, and ultimately reinsured. Because there are many specialty lines of insurance, some of which are esoteric or highly specialized, very often they are underwritten by specialty brokers or other third parties that contract with insurance companies to provide the insurance policies necessary to insure that business risk. Sometimes the insurer is actively engaged in the business and participates both economically and with the underwriting and claims handling. Sometimes the insurer merely acts as a pass-through or fronting company for the business, which is ultimately reinsured to a specialty reinsurer created by the producer or an unaffiliated reinsurer that becomes the real party in interest.

The analogy is roughly similar to a market-maker in the securities world. Certain specialized stocks are traded between a few specialty securities brokers who create a marketplace for the securities for that industry. In insurance, certain business is sourced and underwritten only by specialist brokers. Because these brokers typically are not risk-bearing entities, they need to find an insurance company to supply the policy on which the business will be written and a reinsurer or a group of reinsurers willing to assume the risk associated with the policies being written. It is not uncommon for brokers to develop new coverages and insurance products for new risks and then reach out to the risk-bearing insurance market for insurers and reinsurers willing to participate in the new underwriting venture.

## **The Interplay between the Fronting Company and the Agent**

The producer/agent of the business will typically contract with an insurance company as a managing agent to produce the insurance business on the fronting insurance company's policies. If an agent is producing and underwriting business on behalf of an insurance company, most states' insurance laws require that an agency agreement must be entered into between the agent and the insurer. The regulatory climate for agents changed in the 1980s because of perceived abuses by some unscrupulous agents. These agency agreements have provisions that purport to protect the insurer from abuses by an underwriter who has no skin in the game.

If it is the producer/agent who is sourcing and underwriting the business (and owns the renewals as many managing agents do), it is likely then that the producer will look for an insur-

ance company partner or for a fronting insurer that will allow the producing agent to write the business on that insurer's policies. Where the insurer is not a partner in the true sense (does not want to keep the business net), a fronting arrangement is generally created whereby the insurer is merely a pass-through for the business. The insurance policies produced are ultimately reinsured by the insurer that has the real interest in the business.

The insurer with the real interest in the business may be a true independent partner with the producing agent or may be a captive risk-bearing insurer created by the producing agent. Very often, the producer-owned reinsurers of these fronting arrangements are incorporated outside the United States, where the capital and regulatory requirements have lower barriers to entry.

In one scenario, the risk-bearing entity is a reinsurer ultimately owned by the producing agent. In this situation, it is in the producing agent's best interest to produce high-quality business in which the fronting insurer will receive its fronting fee and not have any real risk of being stuck with a book of poorly performing business with no live reinsurer.

In another scenario, the risk-bearing entity is an independent insurer acting as a reinsurer. In this situation, it is often the case that the producing agent's only form of compensation is the fee earned from producing and underwriting the business plus any profit sharing on the profitability of the entire book of business. Here, the independent reinsurer must be vigilant to ensure that the producing agent is producing quality business and not just ramping up the volume to earn a large commission and then disappear.

The reinsurer cannot rely on a fronting insurer to monitor the managing agent where the fronting insurer is not retaining any risk. The fronting insurer is merely collecting a fronting fee as the business is all being reinsured to the reinsurer. If the fronting insurer was brought into the deal by the managing agent, there is even more reason to monitor the business carefully.

### What Can Go Wrong?

At the outset, it is important to be clear that most managing or producing agents do an excellent job in their specialty areas and do their very best to produce high-quality and profitable risks. Nevertheless, where insurance companies allow others to do the producing, underwriting, and claims handling, things can go very wrong.

In a recent case, an insurance company acting as a reinsurer became the real party in interest to a fronting deal created and produced by a managing agency and its affiliates. Essentially, the agent allegedly diverted millions of dollars of funds from the reinsurance arrangement to its affiliates and then to its principals. See *Lincoln Gen. Ins. Co. v. U.S. Auto Ins. Servs., Inc.*, 2015 U.S. App. 8172 (5th Cir. 2015).

In this case, the managing agency produced and underwrote auto insurance policies for a third-party fronting company. The reinsurer reinsured 100 percent of the business written. The agency agreement was between the fronting company and the managing agent. The managing agent issued the policies, collected and handled the premiums paid, and handled the claims. Although there was a premium trust account, the managing agent had the power to manage the money and to retain its commission before depositing any funds into the trust ac-

count. The managing agency engaged an affiliate to handle the claims.

The deal was structured based on a target loss ratio. After paying a small fronting fee from the premiums collected, the managing agent received 20.6 percent of the remaining premium as its compensation. The reinsurer received 10 percent of the premiums assuming the loss ratio target was not exceeded. The balance would pay losses, and if the loss ratio was lower than the target, the managing agent would receive additional commission.

We can stop the narrative here because it is pretty clear what can go wrong. If the loss ratio were somehow manipulated, the reinsurer would not get its 10 percent, but the managing agent would get its 20.6 percent off the top. Also, if the funds meant to be put aside to cover the target loss ratio were siphoned off, there would not be enough money to pay the losses.

In this case, the managing agent allegedly entered into contracts with other affiliates and paid those affiliates \$50 million, which was never put aside for the anticipated losses. Additionally, the managing agent allegedly unilaterally changed the formula used to calculate its commissions and artificially depressed the loss ratio to inflate its own commissions. When the losses finally came in, the trust fund was depleted and the reinsurer had to fund all the claims.

### Lessons Learned

Managing and monitoring a managing agent is absolutely critical to avoiding an unintended loss. If the real party in interest is a reinsurer behind a fronting arrangement, the reinsurer must audit and monitor the managing agent to make sure that the premiums are being allocated and deposited cor-

rectly and that the target loss ratio is being met. The right to audit must be carefully crafted into the reinsurance agreement where the managing agency agreement is solely between the fronting ceding insurer and the managing agent.

Although modern managing agency agreements provide statutory and contractual protections against managing agency abuses, there is no substitute for boots on the ground (or at least virtual boots accessing premiums and claims systems in real time). It is important for the real party in interest to examine any third-party service contracts entered into (or better, proposed to be entered into) by the managing agent to avoid self-serving contracts with affiliated companies that merely increase the fees paid to the managing agent.

Frequent reporting, auditing, and spot-checking are critical to maintaining a healthy managing agency arrangement that works for all parties. Where there is a fronting insurer involved, it is critical to make sure that the reinsurer—the real party in interest—has all the rights to receive reports and monitor and audit the entirety of the fronting and managing agency arrangement. □

## **If It Looks Like a Claim, and Sounds Like a Claim, Is It a Claim for Reinsurance Purposes?**



This article explains why a claim to an insurance company may not be a claim to a reinsur-

er, depending on the nature of the reinsurance provided.

Claims are a natural and expected outcome of any insurance relationship. This is, of course, true in reinsurance relationships as well. But is a claim for insurance purposes a claim for reinsurance purposes? The answer is, it depends.

## **Traditional Insurance Company Claims Responsibilities**

Under a traditional third-party liability insurance contract, the insurance company has the duty to defend the insured against any claims brought against the insured that arguably fall within the scope of the insurance contract. Additionally, the insurance company has a duty to indemnify the insured for payments the insured must make to compensate claimants for damages sustained as a result of the insured's actions that are covered by the insurance policy. Courts have held that the duty to defend is broader than the duty to indemnify, so that loss adjustment expenses incurred in defending against a claim may be the largest loss cost where there is a question as to whether the claim is covered by the policy.

Similarly, under a traditional first-party insurance contract, the insurance company is responsible to indemnify the insured for all damages sustained to covered property or life or health risks that come within the scope of the coverage of the insurance policy. The insurance company has a duty to investigate and adjust claims in a timely and good faith manner and generally cannot disclaim coverage without providing very specific reasons.

All insurance policies contain notice provisions by which the insured must notify the insurance

company of any claims brought against the insured. Many policies require that the insured provide notice of any potential claim, even if the insured has yet to receive a demand letter or summons and complaint. Timely notice usually is required, and there are numerous cases discussing the consequences of the failure of an insured to notify its insurer of a claim in a timely manner.

Generally, when an insurance company receives notice of a claim or potential claim, it sets up a claim file and will post an initial reserve for that claim. Depending on the insurance contract, the insurer likely will engage counsel to defend the insured in a liability case (or accept the insured's selection of counsel) and may engage separate coverage counsel if there is a question about whether the policy covers the claim. The claims examiner will investigate the claim, often with the assistance of professional adjusters, and will negotiate any settlements. The insurance company's claim reserve may change over time as more information is obtained and as the claim adjuster's evaluation of the claim changes.

### Reinsurance Claims Responsibilities

Generally, reinsurers have no duty to defend, do not appoint defense counsel for the insured, and are merely required to reimburse their reinsureds for payments made by their reinsureds on the business that is reinsured. The trigger for payment by a reinsurer is often actual payment by the reinsured of a claim either in settlement or as a judgment. Reinsurance contracts are contracts of indemnity, and generally, unless the insurance company has paid or is required to pay, the reinsurer has no obligation to pay the claim.

Most reinsurance contracts grant the right, but not the duty, of the reinsurer to associate in the defense of a claim by retaining its own counsel to participate in the case. This is a right that is rarely exercised, as reinsurers prefer to preserve the lack of contractual privity (direct contractual relationship) between reinsurers and the underlying insureds to avoid direct actions by insureds against reinsurers.

Reinsurers also have claim departments, but they are not generally involved in the day-to-day adjustment of claims, and are much smaller than the claims departments of insurance companies. The reporting of claims to a reinsurer and whether that report is considered a claim by the reinsurer will depend on the terms of the reporting clause of the reinsurance contract.

On proportional or quota share reinsurance treaties, generally claims are reported in bulk on a periodic accounting basis. In these circumstances, the reinsurer will not know about individual claims unless the reinsurer exercises its right to audit the reinsured and examine the claims files itself. As these claims are reported on an accounting basis, they generally are handled by accounting staff and not by claims examiners at the reinsurer.

On excess-of-loss reinsurance treaties, claims generally are reported on a periodic accounting report or bordereaux, which provides claim level detail about individual claims over a certain attachment point. For example, if the treaty is \$500,000 excess of \$250,000, claims that breach the \$250,000 attachment point will be reported to the reinsurer for payment. Depending on the reporting requirements of the treaty, smaller claims may never be reported to the reinsurer because they will never become the reinsurer's responsibility.



On facultative reinsurance, where the reinsurance is of a specific policy and risk, all claims affecting the reinsured policy will be reported individually to the reinsurer, depending on the attachment point of the facultative certificate and the certificate's reporting requirements.

Generally, the reporting clause in the reinsurance contract requires the reinsured to report all claims to the reinsurer that the reinsured believes will affect the reinsurance contract. This generally means that if the reinsured reserves a claim for an amount that exceeds the attachment point of the reinsurance, that claim should be reported.

Some reinsurance contracts have more specific reporting triggers based on reserves exceeding a specific amount (e.g., the reinsured shall report all claims to the reinsurer where the posted reserve exceeds 50 percent of the limit of liability covered by this contract) or by the nature of the claim or injury. Each reinsurance contract is different and the reporting and claims payment clauses must be examined carefully to understand when claims must be reported to reinsurers.

Reinsurance claims examiners handle a much larger number of claims than claims examiners in insurance companies because they are not involved in the day-to-day adjustment of the claims or supervision of defense counsel. The reinsurer's claims department will often contact the reinsured to obtain periodic updates on the claim, provide input on technical claims issues, and monitor the reinsured's claim activities for compliance with the reinsurance contract.

## **When Is a Claim a Claim for Reinsurance Purposes?**

Unless a claim is likely to affect the reinsurance, a reinsurer's claims department may not consid-

er the mere report of a claim or incident as a "claim" for its purposes. While the reinsured and reinsurer are often aligned for claims purposes, the reinsurer is only concerned with claims that are likely to affect its reinsurance and that are within the scope of the reinsurance contract.

If a reinsurer is providing excess-of-loss protection for claims in excess of \$250,000, a claim of \$10,000 will not hit its radar screen. Particularly in high frequency lines of insurance, like workers compensation or private passenger auto, reinsurers do not want reports and paperwork on claims that are never going to reach their layers. These claims are not claims for purposes of reinsurance unless the reinsurance contract provides aggregate coverage for these claims.

Moreover, what may be a claim to the insurance company may not be a claim to the reinsurer if the coverage provided by the reinsurance policy is not concurrent with the underlying coverage. For example, if the reinsurance provided is limited to boiler and machinery coverage of an all-risks policy, claims outside the specific boiler and machinery coverage will not be considered a claim by the reinsurer. It is important for the insurance company's claims examiners to understand the available reinsurance protection and to cede the losses to the proper reinsurers in a timely manner.

Timeliness of reporting claims to reinsurers is also important. Some notice clauses require reporting within a certain time frame as a condition precedent to coverage. Generally, the courts have found that late notice to a reinsurer will not excuse payment of the claim by the reinsurer without showing specific prejudice,

but not all courts agree, and it often depends on the notice clause of the reinsurance contract.

## Cash Calls

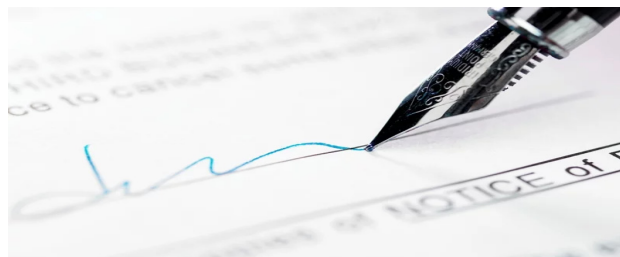
Many reinsurance contracts provide for an exception to the normal reporting and payment of reinsured losses when extraordinary events occur. When a loss occurs of a certain magnitude, the reinsurance contract may permit the insurance company to make a special request to the reinsurer for immediate payment of the claim, called a cash call, to reimburse the insurance company for its payment to its insured.

A recent example of a cash call is the request by the property insurers of the World Trade Center to reinsurers to cover significant immediate payments made to the leaseholder and the Port Authority to pay for the immediate needs following the collapse of the Twin Towers. While reinsurers may dispute aspects of the claim, often cash calls are paid under a reservation of rights in catastrophic events so that the immediate needs of the insureds and insurers are satisfied without further disruption or loss.

## Conclusion

The claims-handling responsibilities of insurance companies and reinsurers are different. Reinsurers are only concerned about claims that are likely to affect their reinsurance coverage and that fall within the scope of that coverage. The reinsurance contract provides for when an insurance company should report a claim to the reinsurer. A claim to an insurance company may not be a claim to a reinsurer, depending on the nature of the reinsurance provided. □

## Playing the Name Game— An Update on Cut-Through Clauses



In our March 2001 article, [“Cut-Through Provisions in Reinsurance Agreements,”](#) we described the nature of cut-through clauses and some of the business reasons why cut-through clauses exist. In this commentary, we take another look at cut-through clauses and how they have been interpreted by the courts.

Because a reinsurance agreement is a contract of indemnity between a ceding insurer and a reinsurer, a contractual relationship exists only between those two parties. Generally, no privity of contract is enjoyed by the original insured (or reinsured in a retrocessional relationship), as it has no contract with the reinsurer.

The exception to this general rule occurs when the reinsurer and the ceding insurer contract around the lack of privity between the original insured and the reinsurer by express language in the reinsurance contract. This language in a reinsurance contract is known as a “cut-through” clause. A cut-through clause allows a party that is not in privity with the reinsurer to have rights against the reinsurer as a part of the agreement between reinsurer and ceding insurer.

## The Cut-Through Clause

A cut-through clause is generally tailored to respond to specific events written into the rein-

insurance contract. It allows the original insured to take direct action against the reinsurer where these specified events prevent the original insurer from paying the claims of its policyholder (the original insured). Cut-through clauses can be particularly useful in situations where, to secure business, the ceding insurer needs to provide extra assurance to its policyholders. Many large commercial insureds may not engage an insurer unless they have some assurance that the reinsurer standing behind the insurer will be liable to the original insured in the event the ceding insurer is unable fulfill its policy obligations.

Additionally, certain insurance programs are structured in such a way that the reinsurer is, for all intents and purposes, the real insurer-in-interest and the ceding insurer is merely fronting the deal. This may happen because of licensing issues affecting the reinsurer's ability to issue policies in a given territory, capital constraints, or brand recognition and penetration.

## Recent Court Rulings Involving Cut-Through Clauses

While most states recognize the validity of cut-through clauses, some caselaw suggests that cut-through clauses must be precisely tailored in order to be effective. Indeed, if any language proffered as a cut-through clause is not precisely worded, courts have shown a clear preference against finding the clause to be a valid cut-through clause.

An excellent example of how the courts interpret cut-through clauses is the decision in *Jurupa Valley Spectrum, LLC v. National Indem. Co.*, 555 F.3d 87 (2d Cir. 2009). In *Jurupa*, the obligee of surety bonds sued the surety's reinsurer to collect on the bonds after the surety be-

came insolvent. The claim arose out of the following language in the reinsurance contract:

[T]he parties to this Reinsurance intend that Reinsurer, through the Claims Administrator, shall pay all amounts ... due Insureds and other persons as and when due directly on behalf of the Reinsured....

The obligee argued that this wording necessarily implied that the reinsurer had granted cut-through rights to all original insureds against the reinsurer. In affirming the district court, the Second Circuit Court of Appeals ruled that this clause did not constitute a cut-through clause. The court stated that "New York law recognizes an exception if the reinsurance agreement contains a so-called 'cut-through' provision granting policyholders a direct right of action against reinsurers, which is apparent on its face." Despite the apparent provision for payment to the original insured, the court found that the provision needed to specifically name those insureds to which payments would be made.

This seemingly minor difference was determined to be the distinguishing factor between the contract in this case and the contract containing substantively similar language that the court found to be a cut-through clause in *Trans-Resources, Inc. v. Nausch Hogan & Murray*, 298 A.D.2d 27 (1st Dept. 2002). The court said the language in *Trans-Resources* included the agreement of the reinsurer "to pay directly to the named insured," while the language above provided that the reinsurer "shall pay all amounts due Insureds." This latter language, the court held, did not specify to whom the payments will be made.

Moreover, Article 14 of the reinsurance contract provided expressly that:

[n]othing ... expressed or implied,... shall be construed to confer upon ... any person [other than the parties] ... any rights or remedies under ... this reinsurance.

This language, said the court, further supported the view that the reinsurance contract did not provide for a cut-through.

The specificity the Second Circuit sought, which required the reinsurance contract to name the direct insured to be paid via a cut-through clause, is an example of the type of detailed construction required for any cut-through clause to be effective. While there are differences between the clauses in *Jurupa* and *Trans Resources*, this should not take away from the importance of careful construction of cut-through clauses to assure their effectiveness. The court's message in *Jurupa* is clear: particular phrasing of any clause creating additional rights for third parties in reinsurance contracts is crucial for the validity of the clause, especially if the wording is to be construed to overcome additional language in the agreement stating that:

[n]othing [herein], express or implied, ... shall be construed to confer upon ... any person ... (other than the parties hereto or their permitted assigns or successors) any rights or remedies under ... this reinsurance.

Thus, the issue of specifically naming the insured to be paid in the event of insolvency, and not the disclaimer language, was the primary issue resulting in the court's finding that no cut-through clause existed in *Jurupa*.

Yet, courts have not backed away from the general rule that reinsurance contracts can still effectively contract around the traditional tenet that there is no right of the original insured

against the reinsurer. Rather, the decision in *Jurupa* serves to advance the idea that, to allow the original insured rights against a reinsurer, a clear intent must be manifest in the specific language of the contract itself.

In *Trans-Resources*, the reinsurer attempted to use fairly standard language to avoid an alleged cut-through clause. The reinsurance contract had a provision stating that the reinsurer "shall have no obligation to the original insured or anyone claiming under the policy(ies) reinsured." The court, however, refused to overlook language in the contract's cover note obliging the reinsurer "to pay directly to the named insured ... with respect to any claim under said policy" and stating that this clause "stipulates direct liability and creates a direct procedural privity as between the original insured and the reinsurer."

When you compare *Trans-Resources* to *Jurupa*, it becomes clear that the major difference between the wordings of the purported cut-through clauses in both cases is the specificity in which the party receiving the reinsurance payments was named. The court in *Trans-Resources* found that a cut-through clause existed because the policyholder (the named insured) was clearly named as the recipient of direct payments from the reinsurer if the ceding insurer could not pay. Although this clause represented a fairly standard "insolvency clause" that is found in many reinsurance contracts, the decision in *Trans Resources* indicates the importance of specific construction of cut-through clauses by expressly naming the policyholder that will be paid upon the ceding insurer's default.

The specificity of naming the party to whom direct payments will be made is often based on

statutory requirements. For example, in Pennsylvania, the statute provides that:

The amount recoverable by the liquidator from reinsurers shall not be reduced as a result of delinquency proceedings, regardless of any provision in the reinsurance contract or any other agreement. Payment made directly to and insured or other creditor shall not diminish the reinsurer's obligation to the insurer's estate except where the reinsurance contract provided for direct coverage of an individual named insured and the payment was made in discharge of that obligation.

40 P.S. § 221.34.

This statute formed the basis for the guidelines established by the court supervising the Reliance Insurance Company liquidation in Pennsylvania. See *Koken v. Reliance Ins. Co.*, No. 269 M.D. 2001 (Apr. 26, 2002). These guidelines set forth the circumstances under which direct payments by reinsurers to insureds would be allowed—essentially the rules for determining the validity of cut-through clauses for reinsurers of Reliance.

In *Koken v. Legion Ins. Co.*, 831 A.2d 1196 (Pa. Commw. 2003), the court noted the Reliance guidelines were instructive in considering cut-through clauses in the Legion Insurance Company insolvency, but were not binding. In *Koken v. Legion*, the court addressed several claims by several insureds claiming direct access to reinsurance proceeds. One insured claimed that the reinsurance contract between the ceding insurer and the reinsurer had an express cut-through right. The insolvency clause in the reinsurance contract provided as follows:

... The reinsurance will be payable by the Reinsurers directly to [the cedent], its liquidator,

receiver, ... except (a) where this Agreement specifically provides another payee of such reinsurance in the event of ... insolvency or (b) where the Reinsurers, with the consent of the direct insured or insureds, have assumed such policy obligations of [the cedent] as direct obligations of themselves to the payees under such policies in substitution for [the cedent's] obligation to such payees. Then, and in that event only, [the cedent] ... is entirely released from its obligation and the Reinsurers will pay any loss directly to the payees under such policies.

The court found that the reinsurer functioned as the direct insurer (it was a fronting situation) and that provision (b) was included in the reinsurance contract to provide the insureds direct access to the reinsurers in the event of the ceding insurer's insolvency. The rationale behind the cut-through provision in the insolvency clause, as expressed by the court, was to give the insureds comfort that if something happened to the insurer, the insureds would be able to obtain coverage directly from the reinsurers.

In rejecting the rehabilitator's attempt to give very narrow meaning to the exception provision in § 221.34, the court in *Koken v. Legion* stated that it is difficult to make any generalizations about cut-through endorsements and how they ought to appear. Expert testimony cited by the court acknowledged that cut-through clauses are distinctive and vary depending on the jurisdiction and the intent of the parties.

## Conclusion

It is clear from the ruling in *Jurupa* that the precise wording of a cut-through provision must clearly indicate its function in allowing a third party to the reinsurance contract the



right to direct access to the reinsurance, as well as sufficiently naming the party to who payment will be made. Yet, jurisdictional differences, statutory distinctions, and the intent of the parties may allow for enforcement of a cut-through clause that does not meet the *Jurupa* standards. If what the parties intend is that the underlying insured should have direct access to the reinsurance should the ceding insurer become insolvent, then the provision should be drafted precisely and clearly to effect that intent. □

## Allocation in the Mind of the Ceding Insurer



When a ceding insurer resolves a long-tail claim or series of long-tail claims (e.g., asbestos) through a settlement, policy buy-back, commutation, or some other mechanism (which could include a judgment after trial), what should it, must it, or can it consider when deciding how to allocate the settlement to multiple policies over multiple years?

We have written and commented a fair amount on the follow-the-settlements doctrine and its application to allocation of a loss to insurance and reinsurance contracts. See our Reinsurance Commentaries, [“Reinsurance and Emerging Risks”](#) (June 2013), [“Follow-the-Fortunes Updated”](#) (April 2004), and [“Understanding Reinsurance Terminology—Follow-the-Fortunes”](#) (October 2001), for example. Here, we examine allocating long-tail losses to the correct insurance

policies and billing the correct reinsurers for their share of those losses.

## When the Settlement Is Done

At some point during the evolution of a claim, it comes to an end. Either the claim is settled, the claim is dismissed, a judgment is rendered by a court, or an award is issued by an arbitrator. While expenses may have been preliminarily allocated to specific policies and even ceded to specific reinsurers during the life of the claim, once the claim is finalized by settlement or judgment and the checks are cut, the insurer has to make a final determination on how the claim—and its actual expenses and indemnity payments—will be allocated to its insurance policies.

In a normal case where there is a single claim that occurred on a specific date, there typically is only one policy to which the claim can and should be allocated. Allocating a settlement to the only possible responsible policy is generally noncontroversial. That determination is generally made up front (as part of the coverage determination), and, depending on the terms of the reinsurance contract covering that policy, notice of the claim to the reinsurers should not be that difficult to accomplish.

But when the claim is a long-tail claim that spans many years and many possible policies, the allocation decision may become more art than science. This is the case with asbestos and other similar latent bodily injury claims. Decades go by and the vagaries of state law may cause many policies to respond to the claims. Policies may or may not exist, insureds may have gaps in coverage, and carriers may have gone insolvent over time. When claims go back many decades, the ability to locate all responsible policies is a difficult task.

But ultimately, when the claim is resolved, the settling insurance company has to decide how to allocate that settlement to the policies it believes must legitimately respond to the claim. And once the policy allocation decision is made, then the insurer—now the ceding insurer—will also have to determine how to allocate that settlement to its reinsurance contracts and bill its reinsurers for their share of the settlement.

### **Objectively Reasonable Settlements and Objectively Reasonable Allocations**

We know from the caselaw that the underlying settlement itself must be objectively reasonable and businesslike. Under most notions of proper business behavior and good faith, only settlements that are reasonable and businesslike and that fall within the terms of the insurance policy are settlements that a reinsurer would expect to receive.

The cases teach us that the claims personnel must handle the claim without regard to reinsurance and must act in good faith in resolving the claim. The cases also teach us that when the claim has to be allocated among multiple insurance policies, that allocation also has to be objectively reasonable and made in good faith. So too must the reinsurance allocation be objectively reasonable and made in good faith. In fact, merely following the allocation of the underlying policies is not, in and of itself, sufficient to establish the reasonableness of the reinsurance allocation.

When, in the ceding insurer's mind, all are done in a businesslike manner, are objectively reasonable, and made in good faith, the ceding insurer will expect nothing less than timely payment of a properly presented reinsurance billing.

### **What's a Reinsurer To Do?**

The conundrum for the reinsurer, sometimes being faced with a billing after decades of limited—if any—information about a claim, is how to determine if the reinsurance allocation was done in an objectively reasonable manner and in good faith. Reinsurers know that some courts in the United States imply the follow-the-settlements doctrine even if the applicable reinsurance contracts do not have follow-the-settlements language. They know that under the follow-the-settlements doctrine, reinsurers cannot second-guess the good faith claims determinations of the ceding insurer. They also know that many courts in the United States have applied the follow-the-settlements principle to allocation.

The cases provide words like “objective reasonableness” and “businesslike manner” when discussing these principles in the context of allocation. But each case is fact-specific, and determining the objective reasonableness and good faith of an allocation will depend on the facts. As the New York Court of Appeals said in *U.S. Fid. & Guar. Co. v. American Re-Ins. Co.*, 2013 N.Y. LEXIS 112, 20 N.Y.3d 407 (2013), a ceding insurer's allocation “must be one that the parties to the settlement of the underlying insurance claims might reasonably have arrived at in arm's length negotiations if the reinsurance did not exist.”

Most reinsurers want to pay legitimate claims quickly. But to pay quickly, reinsurers need to receive sufficient information to satisfy them that the claim came within the underlying contract, was resolved in good faith, and came within the terms of the reinsurance contract. Sometimes it is hard to get that information even on a single claim paid under a single poli-

cy, let alone for 10 or 20 years of policies that are over 30 or even 50 years old, addressing the insured's liability for manufacture or use of asbestos products.

Recent caselaw provides reinsurers, with the right facts and circumstances, some opportunity to question whether an allocation was made with objective reasonableness and in good faith. But that opportunity cannot be squandered with fishing expeditions; there has to be a legitimate basis for inquiry. And, based on the caselaw, that opportunity is limited. The mere fact that the allocation decision has resulted in a significant reinsurance recovery claimed by the ceding insurer may not be enough for a court to question the allocation decision.

## To Maximize or Minimize Reinsurance

In a recent case, a court did what many courts have done, which is to uphold an allocation of an asbestos settlement under the follow-the-settlements doctrine (*Utica Mut. Ins. Co. v. Clearwater Ins. Co.*, 2016 U.S. Dist. LEXIS 6219 (N.D.N.Y. Jan. 20, 2016)). In upholding the ceding insurer's allocation as a reasonable settlement decision, the court commented that a ceding insurer was not required to pick an allocation that minimized reinsurance recovery.

Fair enough—objective reasonableness and good faith should not weigh in favor of either the ceding insurer or the reinsurer. Thus, in making an allocation determination, the ceding insurer should not be forced to pick one out of a number of reasonable alternatives that minimizes its reinsurance recovery if, in making its settlement and allocation determinations, it must do so with a blind eye toward its reinsurance protections.

This comment is consistent with some other courts' pronouncements when discussing objective reasonableness and good faith. In *U.S. Fid. & Guar. Co.*, the court said that "[r]easonableness does not imply disregard of the cedent's own interests. Cedents are not the fiduciaries of reinsurers, and are not required to put the interests of reinsurers ahead of their own." The court concluded that the ceding insurer's motive "should generally be unimportant. When several reasonable allocations are possible, the law, as several courts have recognized, permits a cedent to choose the one most favorable to itself."

As the courts appear to see it, the ceding insurer must address the claim settlement neutrally, as far as reinsurance is concerned; act in good faith; and proceed in a reasonable manner that would be viewed as objectively reasonable by a third party without consideration of reinsurance. In doing so, the ceding insurer does not have to—and should not have to—pick an allocation methodology that minimizes its reinsurance recovery.

So what happens if the ceding insurer actually picks an allocation method that also happens to maximize its reinsurance recovery? All things being equal, if the theory holds, as long as the allocation was done in an objectively reasonable manner and in good faith, many courts will sustain the allocation determination based on follow-the-settlements principles applied to allocation. Where there are multiple reasonable allocations possible, as the New York Court of Appeals said in *U.S. Fid. & Guar. Co.*, the ceding insurer could choose the one most favorable to itself.

Whether the follow-the-settlements doctrine even applies to allocation is a completely different question, which, in the United States, ap-

pears to have been answered by most courts in the affirmative. But assuming that it does apply, the test of objective reasonableness and good faith will depend on the specific facts involved in the settlement and allocation.

Where the evidence shows that the ceding insurer was focused on reinsurance recoveries above all else when settling a long-tail loss and also had the same focus when allocating that loss to its policies and its reinsurance protections, the reinsurer may have a legitimate beef that should be taken up by the courts. But getting that kind proof is no small task. In the more usual case where claims professionals go about their business as they should, an allocation that results in the maximization of reinsurance recoveries may not be so easy to strike down.

## Conclusion

Long-tail claims, such as bodily injuries from exposure to asbestos, have run havoc on many in the insurance industry. Policy-issuing companies that issued policies half a century ago have been called on to pay losses for these exposures. The tasks of addressing these exposures and allocating settlements to the proper policies, and then allocating to and billing the correct reinsurers for their share of those exposures, are complicated and complex tasks.

But if a ceding insurer faced with settling these types of exposures allocates its good faith settlements in a businesslike and objectively reasonable manner, the fact that the ceding insurer's allocation results in the maximization of its reinsurance recoveries may provide little support to a reinsurer's challenge to that allocation. □

## Interplay of Loss Portfolio Transfers and Other Reinsurance Contracts



Let's say you work for an insurance company that issued a portfolio of policies some years ago but no longer writes that type of policy or business. And say that this legacy business is a drain on the insurance company's administration and the company would much rather have its administrative and claims people working on business that the company currently writes and supports.

What can you do to address this problem?

## What Is a Loss Portfolio Transfer?

For decades, insurance and reinsurance companies have used loss portfolio transfers (LPTs) to address the issue of legacy business no longer core to the company. The IRMI [\*Insurance Glossary of Risk Management and Insurance Terms\*](#) defines an [LPT](#) as:

A financial reinsurance transaction in which loss obligations that are already incurred and will ultimately be paid are ceded to a reinsurer. In determining the premium paid to the reinsurer, the time value of money is considered, and the premium is therefore less than

the ultimate amount expected to be paid. The cedent's statutory surplus increases by the difference between the premium and the amount that had been reserved. An insurer seeking to withdraw from writing workers compensation coverage in a given state could, for example, use a loss portfolio transfer to meet its obligations under policies it has written, without the need to continue the day-to-day management of the claims resolution function.

An LPT is a great way to move a legacy book of business off the balance sheet. LPTs often are used for direct written business as well as for assumed reinsurance business. As described in the definition above, an LPT allows an insurer or reinsurer to meet its policy obligations on its original policies without being responsible for the management of the ongoing claims. The LPT reinsurer generally manages the claims and is responsible for the administration of the business. While the ceding insurer is still on the regulatory and contractual hook for those original policies, it is really the LPT reinsurer that is economically and administratively the real party of interest.

### **The Odd Reinsurer Out**

What is often forgotten when considering an LPT transaction, however, is the interplay between the proposed LPT and the existing reinsurance contracts reinsuring the original policies. This is especially so when the LPT is of an assumed reinsurance book of business rather than direct insurance.

Existing reinsurers and retrocessionaires are not always in the loop while an LPT is being negotiated between the ceding insurer and the LPT reinsurer. When they learn about an LPT (some-

times from a press release or at a market conference), they may not be thrilled.

The existing reinsurers have no contractual relationship with the LPT reinsurer. Yet, it's the LPT reinsurer that will now be administering the claims ceded to the existing reinsurers. Reserving may change, claims handling may change, administrative and accounting relationships will change, and motivations will change. Not quite the original bargain entered into by the existing reinsurers.

Many LPTs, if not all, are structured to be net of third-party reinsurance. This means that the liabilities transferred to the LPT reinsurer are only those that should remain after existing reinsurance has paid its share of the liabilities on the original business ceded. This also means that the existing reinsurers have to fulfill their contractual obligations to the original ceding insurer even if the loss advices and requests for payments are now coming from a new party with whom the existing reinsurers have no contractual relationship.

Of course, if the ceding insurer is not highly rated or is mostly in runoff, the existing reinsurers may welcome an LPT, especially if the LPT reinsurer is strong and well managed. Timely settlements and administration cost less money than a poorly managed runoff for all parties. The existing reinsurers may be more comfortable dealing with a new administrator than the original ceding insurer if there were significant problems in claims administration and handling.

### **The Effect of an LPT on Existing Reinsurance Contracts**

The LPT may have an effect on various contract provisions in existing reinsurance contracts.



Consideration should be given to whether the existing reinsurance contracts have antiassignment provisions, retention warranties, or other provisions precluding cessions of retained business.

For example, if the original reinsurance includes a broad quota share treaty with a requirement that the ceding insurer maintains its percentage share, an LPT of the entire reinsured portfolio might result in a breach of the original reinsurance contract. Similarly, if there are excess-of-loss contracts that contain retention warranties or have provisions that preclude assignment of the ceding insurer's retention, an LPT of the entire retained portion of the book may invalidate the excess-of-loss contract.

Clearly, the LPT reinsurer has no interest in losing the value of the existing reinsurance. The LPT reinsurer wants the LPT to cover only those liabilities net of existing reinsurance. The failure to carefully evaluate existing reinsurance and then obtain buy-in from existing reinsurers can result in the LPT turning into something it was not meant to be and result in what should be preventable disputes.

Some reinsurance contracts also have special termination provisions. These provisions are customized to each reinsurance transaction. There are special termination provisions that trigger if the original ceding insurer transfers its liabilities to another reinsurer. An LPT may trigger that kind of special termination provision.

## Can an Original Reinsurer Walk Away after an LPT?

Some reinsurers and retrocessionaires may view their ceding insurer's LPT of an entire book of business as a "get out of jail free card." The

question is whether that is, in fact, true. Of course, review of each relevant reinsurance contract is necessary to determine whether an LPT changes or affects anything about existing reinsurance or retrocessional relationships.

In a recent case, a New York federal court confirmed a final arbitration award between a retrocedent and its retrocessionaire. In [\*Continental Ins. Co. v. AXA Versicherung AG\*](#), No. 18-CV-7349 (VEC), 2019 U.S. Dist. LEXIS 583 (S.D.N.Y. Jan. 2, 2019), a retrocessionaire argued that it was no longer bound by its quota share retrocessional agreement with the retrocedent after the retrocedent entered into an LPT with a third party on the same business. The arbitration panel's final award determined that the LPT did not relieve the retrocessionaire of its responsibility to make retrocessional payments to the retrocedent. The court confirmed the final arbitration award.

The details of the underlying dispute were not available in the decision, and the arbitration information is confidential, so we don't know whether there was a retention warranty, antiassignment clause, or special termination provision in the quota share retrocessional agreement. All of these cases are very fact-specific, and as they say, the devil is in the details.

In addition, while this decision did not involve the merits of the dispute (the petition to confirm was unopposed), it is pretty clear why the arbitration panel ruled the way it did.

The retrocedent remains responsible under its existing reinsurance and retrocessional agreements unless the LPT contains a [\*novation\*](#) agreement or a separate novation agreement accompanies the LPT, which replaces the retrocedent with the LPT reinsurer as a matter of

contract. While the retrocedent's administrative and accounting obligations were shifted to a new reinsurer under the LPT, the retrocedent remained on the hook under the existing retrocessional contract in case the LPT reinsurer fails to perform in the future.

While these principles are more relevant to assumed business than ceded business, the same principles apply. An LPT generally does not alter an existing reinsurance or retrocessional contract unless the original reinsurer or retrocessionaire has agreed to the transfer of all obligations itself in the form of a novation.

There are many scenarios where the outcome may differ because of specific contract wording. For example, the existing reinsurance or retrocessional contract could have had a retention warranty or special termination provision that

might trigger upon the retrocedent entering into an LPT. Each circumstance is different and must be reviewed completely to determine if an LPT has any effect on the liabilities under existing reinsurance or retrocessional contracts.

## Conclusion

Determining how existing reinsurance contracts will interact with an LPT is a critical step to avoiding significant problems and future disputes. While it is easy to think that an LPT cannot affect existing reinsurance contracts because it is a separate and unrelated contract, retention warranties, antiassignment provisions, and special termination clauses in existing reinsurance contracts could be triggered by an LPT. Keeping all parties, including existing reinsurers, in the loop while negotiating an LPT should avoid unwanted surprises. □