SETTLEMENT OF COMPLEX LIABILITY COVERAGE DISPUTES

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I. INTRODUCTION

For all the number of complex liability-insurance coverage disputes pending in our nation's courts, few are tried to a jury in their entirety. Usually, some or all parts of complex coverage cases are resolved consensually.

Complex coverage disputes are marked by the size of the dollars at stake as well as their uncertainty, because at issue in most instances is some element of future dollars or future claims. These disputes often involve liability problems that are national in scope, as in the case of products liability, or involving multiple states, as in environmental liabilities scattered among a number of sites. Complex disputes ordinarily involve multiple insurers that have issued insurance policies potentially applicable to indemnify the insured for loss. Complex coverage disputes are marked particularly by legal and factual uncertainty. There is legal uncertainty as to the manner the insurance policies may apply to the particular loss,[1] and often there is factual uncertainty as to, for example, the nature of the underlying problem, whether the product in question actually causes injury, the ultimate scope of the liability problem, and the culpability of the insured's conduct leading to the claims of liability in the first place.

Consequently, high-stakes coverage cases are difficult and expensive to litigate and are uncertain in outcome. These attributes, however, provide the incentive

1. Although the key terms of insurance policies are more or less uniform, the legal meaning of that uniform language is determined under state law, and the state-law rule can vary 100 percent from state to state, though in many states the case law has not developed to the point that there is any governing rule at all. The absence of governing legal standards combined with the discontinuities in outcomes from state to state combine to create tremendous legal instability, thereby creating in turn the incentive to file suit preemptively so as to manipulate choice of law.

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to achieve some form of resolution other than a litigated one.[2] This article addresses the mechanics of resolving complex coverage disputes consensually.

II. A PRIMER ON COVERAGE

A. *Overview*

Insurance policies are legal instruments,[3] and to assess how much an insurer should pay, one must understand the coverage afforded under the particular instruments at issue. As Roger Fisher and his colleagues have long urged, one can adequately evaluate negotiated resolutions only if one considers the best alternative, which—in this context—is an adversarial trial.[4] Although business relationships and market concerns may affect settlement, a settlement takes place in substantial part against the backdrop of a litigated resolution. As a result, the parties will evaluate their respective settlement positions based on their predictions as to how the court or jury will rule on the substance of their dispute. Settlement is also guided by the insurer's own assessment of its "fair share"—a calculus that takes into account its contract obligations, the likelihood of the policyholder's prevailing at trial and for how much, and the relative burden being shouldered by other carriers. This section reviews key background concepts to assess the obligations under any given insurance policy.[5]

B. *Primary and Excess Insurance Policies*

Within a given type of insurance, there are two types of insurance policies: primary and excess. A primary policy applies at "first dollar," that is to say, for any given loss it is the first policy the insured will look to for performance. An excess policy, in contrast, generally will pay only after the underlying primary policy has paid or had its obligation discharged.

In addition to the difference in dollar attachment points between primary and excess policies, perhaps the most salient difference between the two types of policies is that, in addition to a duty to indemnify the insured for judgments against it or settlements it enters, a primary policy typically imposes a duty on the insurer to defend the insured, i.e., the obligation to pay for the cost of defending liability claims against the insured. The duty to defend in primary policies is particularly valuable in two different ways. First, in most states, a primary insurer's duty to

2. For a guide to litigating such cases, see Marc Mayerson, *Managing Complex Insurance Coverage Disputes*, 32 TORT & INS. L.J. 53 (1996).

3. Perhaps more accurately, insurance is a product whose form is that of a legal instrument. This formulation better captures the notions underlying interpretative doctrines such as the reasonable expectations of the insured and bad-faith concepts requiring a carrier to make payment when its liability is "reasonably clear" (or alternate formulations).

4. ROGER FISHER, WILLIAM URY, AND BRUCE PATTON, GETTING TO YES (2d ed. 1992).

5. The points expressed here appear in summary fashion, and the author has not tried to catalogue each of the issues or coverage provisions that may have implications on the monetization of particular insurance policies.

defend the insured is considerably broader than is its duty to indemnify, and the insurer can be held to pay, on an ongoing basis, the costs of defending the insured in a case in which the carrier ultimately will not be required to pay the resulting judgment.[6] Second, monies a primary carrier pays for the defense are usually paid on top of the policy limits; in other words, the dollar limits in a policy typically do not apply to the defense obligation, which as a result is unlimited.[7] In contrast to primary carriers, the defense obligations of excess carriers are less uniform and typically are more circumscribed: they may have no defense obligation at all, may pay defense costs only after the underlying case is over, may pay defense costs subject to policy limits, or may pay defense costs only for claims covered by the policy's duty to indemnify.

As a consequence of how the insurance programs of most companies are put together, a company likely will have several policies of excess insurance, each applying once successively higher levels of loss are reached. This "layering" of insurance is significant in evaluating settlement because each successively higher excess layer generally has no obligation to perform until the underlying policies have performed. Layering is also significant because it is common for a number of insurers concurrently to issue policies that together fill a single layer. Put differently, at a specific dollar of coverage, say, ten million dollars in excess of the first two million dollars of loss, a number of insurers each may have issued policies under which each agreed to pay a relative "quota share" of losses penetrating the particular layer. Each quota-share policy, however, is liable only for its percentage, and policies within a quota-share layer are applied concurrently in shares rather than sequentially (as if each quota-share policy were a separate layer within the dollar layer in question).[8]

In many instances, a number of years of the policyholder's coverage may be implicated. Consequently, the coverage in the different applicable years may (or may not, depending on the state) need to be coordinated and applied. The legal doctrines that govern the allocation of loss to policies across time and layers are the trigger of coverage, the scope of coverage, and ordering of exhaustion.

Though these interrelated issues are complex—and are the subject of divergent and inadequately considered judicial decisions—most insurers and insureds as a practical matter operate by general rules of thumb that are adequate guides for identification of positions and negotiation. The question of trigger is generally what event must occur during the policy period for the policy to apply (subject to its

6. For a comprehensive review of the defense obligation under primary policies, see Marc Mayerson, *Insurance Recovery of Litigation Costs: A Primer for Policyholders and Their Counsel*, 30 TORT & INS. L.J. 997, 999-1000 (1995).

7. *Id.* at 1001.

8. *See generally* American Marine Underwriters, Inc. v. Holloway, 826 F.2d 1454 (5th Cir. 1987); *but cf.* Harding Assocs. Inc. v. London Agency, 1993 U.S. Dist. LEXIS 3546 (N.D. Cal. 1993) (holding that co-subscribers to a policy, though "each for his own part and not one for the other," were jointly and severally liable to perform resulting in solvent subscribers paying the shares of the insolvent KWELM companies).

terms and conditions). As a practical matter, in most environmental or product liability matters in which the process of injury or the etiology of the disease takes place over time, insurers and insureds will assume that policies are triggered across the continuum of the injurious process.[9] Trigger also raises the question of after what time are policies no longer included for purposes of allocation, and whether this end point is based on, for example, the application of policy exclusions, the unavailability of coverage due to the introduction of standard exclusions, the termination of the process of injury, the date of claim against the insured, or the date of the insured's notice to the insurer. The question of scope of coverage is how should the insured's costs and liability be mapped onto the triggered policies. Do the policies pay based on their full policy limits, a time factor alone (e.g., the percentage of time each policy provided coverage relative to all the triggered policies), the relative dollar limits of the triggered policies, or the quantum of damage or injury taking place during the policy period.[10] Particularly in the settlement context the parties may decide to allocate the loss only across years of applicable coverage even though that block or band is not coextensive with the period of injury.

Crucial to the determination of how much a policy is to pay is the ordering of payment among the policies that are triggered. This is the question of exhaustion. There are two principles of exhaustion: horizontal and vertical. Under horizontal exhaustion, coverage is allocated first to the primary layer policies across time before any excess policy applies.[11] Under vertical exhaustion, all policies, both primary and excess, in any given year are called upon to pay, and dollars are allocated upwards. The case law in some states now appears to embrace or permit allocation schema that combine elements of both horizontal and vertical exhaustion.[12]

Another crucial background element to the negotiation of complex coverage disputes is the applicability of policy limits. The allocation issues discussed above address the mapping of the liability onto the coverage generally. The applicability of policy limits concerns how the money in a specific policy applies with respect to the stated policy limits. Here, there are three points that should be considered. First, as indicated above, primary policies that pay defense costs usually do so in addition to the policy limits. As a result, to the extent a particular carrier is called upon or agrees to pay defense, those payments do not reduce the availability of coverage under the policy. Second, most policies pay their indemnity limits in

9. There may be exceptions, of course, depending on the nature and the means of injury. For example, in certain medical device liability cases, triggering policies at the time of their implantation only may be more consonant with the facts and the governing case law.

10. A related question is whether a different rule applies when the insured seeks performance versus when one insurer that has paid the insured seeks contribution against other insurers whose policies also apply to a loss but have not paid the insured. *Compare* J.H. France Refractories Co. v. Allstate Ins. Co., 626 A.2d 502 (Pa. 1993) *with* American Cas. Co. v. PHICO Ins. Co., 702 A.2d 1050 (Pa. 1997).

11. Courts that have embraced horizontal exhaustion have not provided much guidance as to how layers of excess policies should be exhausted horizontally.

12. *See, e.g.*, Chemical Leaman Tank Lines, Inc. v. Aetna Cas. & Sur. Co., 978 F. Supp. 589 (D.N.J. 1997).

terms of dollars "per occurrence." This raises the question of the number of "occurrences," for the number of occurrences determines how many policy limits may be called upon to satisfy the insured's obligations. In the environmental context, it is conventional to apply one per-occurrence set of limits for each environmental site. In the products context, there are two governing theories: either each claimant is said to constitute a separate occurrence or all of the related products liability claims are considered to be a single occurrence.

The third related policy limits issue concerns the applicability of aggregate limits. Most policies specify an overall total maximum dollar amount the policy will pay. This is the aggregate limit, which is a number equal to or greater than the per-occurrence limit. Under most liability policies, the aggregate limits apply based on the "hazard" generating the loss. A hazard is a particular type of risk exposure, and conventionally the categorization of hazards includes, among others, the (1) products/completed-operations hazard and (2) the premises/operations hazard.[13] Typically, there are separate pools of money for occurrences arising from each hazard. Thus, if a policy pays $100,000 per occurrence and provides for an aggregate of $200,000 applicable separately to two hazards, the total amount of coverage available under the policy is $400,000, even though the maximum the policy would pay for any one occurrence is $100,000, and the maximum the policy will pay for occurrences stemming from either hazard is $200,000. Some hazards have aggregate limits, and some do not.

Depending on the nature of the claim and whether there is an aggregate, the settlement dynamic is very different. For hazards like product liability with an aggregate, if the insured's anticipated loss is large enough such that the aggregate limit ultimately will be exhausted, the driving force of the settlement may be to discount the carrier's ultimate anticipated payout to present value, with the carrier paying a lump sum today in exchange for a release of its future obligations. For hazards like the premises operations hazard, within which most environmental claims fall, there is usually *no aggregate limit*.[14] This means that, subject to the per-occurrence limit only, the policy will pay for covered occurrences within that hazard repeatedly. In such circumstances, the carrier will be concerned that claims will arise in the future within the hazard, and it may be interested in buying out the hazard completely, buying out all claims of a certain type within the hazard, or creating a negotiated cap on the hazard to limit its upside risk.

The question of exhaustion of policy limits—both per-occurrence and aggregate—is important not only to monetize the particular policy, but also to access overlying

13. *See generally* Frontier Insulation Contractors Inc. v. Merchants Mut. Ins. Co., 690 N.E.2d 866 (N.Y. 1997).

14. In many primary layer policies, according to the standard policy language, whether an aggregate applies to property damage claims within the premises operations hazard depends on how the particular policy is rated (priced); the policy language usually does not impose an aggregate limit for bodily injury claims except for those arising from the products hazard. Most excess policies impose aggregates only for products and occupational disease claims.

excess coverage, because an excess policy applies upon the exhaustion of the applicable limits of the underlying policy. An excess policy will pay after the underlying policy pays its maximum applicable per-occurrence limit. If the underlying policy is not obligated to pay the full stated per-occurrence limit due to the prior exhaustion of the applicable aggregate, the excess policy will pay upon the payment of the maximum available under the policy.[15] If the insured has released an underlying carrier from paying its full per-occurrence limits or its full aggregate limit, or if the insured has capped a carrier's unlimited (i.e., no aggregate) obligation through the creation of an aggregate limit post hoc via settlement, the insured may be called upon to "self-insure" the difference between the original contract policy limits of the underlying insurer and what it received in settlement. The excess carrier will not be excused from performance, but the excess carrier will seek to have the integrity of the underlying buffer of coverage respected.[16]

Finally, together with the question of coverage allocation, when the insured has policies that impose deductibles or retrospectively rated premium adjustments (retros), the parties must consider how the deductibles or retros are to apply.[17] Some of the issues concerning deductibles and retros are addressed below in Part V.

To sum up, the monetization of the coverage depends on a number of interrelated issues: trigger, scope, allocation, exhaustion, number of occurrences, application of aggregates, and application of deductibles or the like. These issues must be resolved *assuming there is coverage*. Though the parties may—or will—negotiate over the manner the insured may draw upon its coverage, these issues are all separate from the question whether there is coverage or not, such as whether an exclusion applies or whether the insured breached a condition to coverage. For the latter issues, depending on the policy language, the governing law, and the particular facts, the parties will likely figure litigation discounts in the settlement matrix.

III. EXOGENOUS FACTORS, MOTIVATIONS, AND DYNAMICS

The prior section sketched several legal questions that bear on the valuation or monetization of the applicable insurance policies. As in all disputes, additional factors come into play that bear upon both the willingness of a party to negotiate

15. For an unusual application of this rule where the insured was in bankruptcy, see UNR Indus., Inc. v. Continental Cas. Co., 942 F.2d 1101 (7th Cir. 1991).

16. The courts have held for seventy-five years or more that partial payment by underlying coverage does not preclude the overlying excess carrier's obligation to perform. Zeig v. Massachusetts Bonding & Ins. Co., 23 F.2d 665 (2d Cir. 1928) (A. Hand, J.); Koppers Co. v. Aetna Cas. & Sur. Co., 98 F.3d 1440, 1454 (3d Cir. 1996); E.R. Squibb & Sons, Inc. v. Accident and Cas. Ins. Co., 853 F. Supp. 98, 101 (S.D.N.Y. 1994) (requiring excess insurers to "pay amounts due the insured which are unpaid for any reason, including a compromise reached by a first-tier carrier through an arm's length settlement").

17. Insureds may likewise have agreements that are the functional equivalent of a deductible or a retro such as a side indemnity agreement or a captive reinsurance arrangement under which the insured agrees to pay the insurer some amount for each loss under the policy.

and the form that any settlement will take. Several of the more salient factors influencing the shape of settlement are addressed in this section.

Perhaps the dominant motivation to settle a complex coverage case is each party's desire for certainty and peace. The desire for certainty cuts in a number of directions from the differing perspectives of the policyholder and its insurers. From the policyholder's perspective, the desire for certainty may lead it to accept a cash-out of its coverage (for the claim, for the type of hazard, etc.) because the particular carrier had already breached its contract and obtaining money from the carrier in the future could require another lawsuit. On the other hand, in any cash-out deal, the policyholder accepts the transfer back from the insurer of the risk the policyholder paid premiums for the insurer to accept in the first place. From the perspective of the insurer, the transfer back to the policyholder of uncertain upside risk is very attractive. The carrier may desire to rid itself of the policyholder more generally and avoid future claims against it by buying out the hazard, etc., completely. From the policyholder's perspective, however, any type of buyout means that it is accepting the upside risk of not obtaining an adequate amount from the insurer in the settlement.

Financial considerations may dictate the desire by one side or the other for a lump sum payment or a series of future payments from the insurer. A lump sum payment eliminates the risk that the carrier may become insolvent and no longer be able to perform. On the other hand, a lump sum payment may have adverse tax consequences for the insured.[18] The insurer may prefer a series of payments instead of a lump sum to permit it to continue to earn investment return on the amounts owing to the insured.[19]

A related, nonmonetary factor that similarly bears on the structure of any settlement is whether the parties as a practical matter are willing to remain married or want a divorce. In buyouts, the parties go their separate ways (at least for the type of claim settled). Under other types of settlements such as a "coverage in place" arrangement under which the insurer pays a percentage of future costs as they are incurred, the policyholder and the insurer are required to continue working with one another against the backdrop of their dispute. In any type of continuing relationship, there likely will be ongoing friction between the insured and insurer on who, what, when, and how much should be paid. On the other hand, staying married permits the parties to develop a modus vivendi and to develop a relationship of trust and mutual credibility. When the parties enter into an interim agreement (discussed further below), that is, one that temporarily resolves their dispute or resolves a subset of their disputes, working together may permit the parties to

18. *See* William Paul and Bruce McGovern, *Tax Aspects of Environmental Liabilities and Related Insurance Recoveries*, 7 MEALEY'S LITIG. REP.: INS. (Apr. 20, 1993).

19. Even where there is an actual or imputed interest rate applied to such streams of payments, the insurer may believe that it can earn a greater return on the money than what it will be paying the insured for the privilege of holding onto the money, and the delta (less administrative and transaction costs) thus represents pure profit.

develop the confidence to reach a final, comprehensive resolution. An interim agreement also permits the parties to defer resolution, or final resolution, of the more contentious issues dividing them, until such time as the underlying liability becomes more certain, the relevant law becomes more clear, or the parties become more comfortable working together.

Both sides will also be concerned about the precedential value of the settlement. Where the settlement between the policyholder and the insurer resolves only a subset of recurring claims and coverage for future similar claims is preserved, the settlement may establish baselines between the parties for the resolution of the future claims. Insurers (rightly or wrongly) do not want their settlement with one policyholder to establish their obligation to pay another policyholder or the level of payment appropriate for another policyholder. An insured is also concerned about the precedential value of a given settlement with respect to its other carriers. An insured that settles early in a case with one insurer will likely give that insurer some sort of discount for settling early, and the insured will naturally resist a later-settling carrier's effort to obtain similar favorable treatment.

An important, and sometimes driving, factor from an insurance company's perspective is the availability of reinsurance. Reinsurance has three main influences on the perspective of insurance companies. First, the ability of the insurance company to tap its own reinsurance means that the ultimate "loss" to the insurance company is limited. This may increase the insurance company's receptiveness to settlement. Second, where there is a possibility of reinsurance recovery, the insurance company will wish to ensure that, by settling with the policyholder (and not litigating), the insurance company has not somehow prejudiced its ability to tap its reinsurance policies. As a practical matter, if the insurance company settles instead of litigates with the insured, the reinsurers may have a marginally enhanced ability to challenge certain aspects of the settlement with the insured that the reinsurer would not have had were the payment to the policyholder the consequence of a jury verdict. Although most reinsurance contracts expressly contain a "follow the settlements" clause limiting the reinsurer's ability to second-guess the (ceding) insurance company's decision to settle with the insured, reinsurers on occasion have succeeded in refusing to pay all or part of a settlement with an insured.[20] Accordingly, the

20. *See, e.g.*, Commercial Union Assurance Co. v. NRG Victory Reinsurance Ltd., 1996 Folio No. 1350 (English App. Mar. 16, 1998), *reprinted in* 8 MEALEY'S LITIG. REP.: REINS. § B (Mar. 25, 1998). Under a follow-the-settlements clause, the settlement with the insured is deemed to have been within the coverage of the insurance policy, unless the settlement has been entered into collusively or fraudulently; if the insurance company makes payment to the insured but was never obligated to do so under its insurance policy and there was no possibility that the court would find coverage, the payment is considered to be "ex gratia" and the reinsurer has no obligation to cover the loss. *See generally* William Hoffman, *On the Use and Abuse of Custom and Usage in Reinsurance Contracts*, 33 TORT & INS. L.J. 1, 50-78 (1997); Commercial Union Assurance Co. PLC v. NRG Victory Reinsurance Ltd., 1996 Folio No. 1350 (Q.B. 1997), *reprinted in* 8 MEALEY'S LITIG. REP.: REINS. § A (Nov. 12, 1997). The follow-the-settlements clause thus circumscribes, but does not eliminate, the bases that a reinsurer has to challenge the settlement with the insured. *Compare* International Surplus Lines Ins. Co. v. Certain Underwriters at Lloyd's of London, 868 F. Supp. 917 (S.D. Ohio 1994) *with* Hiscox v. Outhwaite, 1990 Folio No. 2491 (Q.B. 1990).

presence of reinsurance may influence the insurance company's decision *away* from settlement, because by settling it naturally increases to some extent the reinsurer's ability to challenge the payment.[21]

Third, the presence of reinsurance may influence the insurance company's desire to allocate portions of the settlement amount to either (1) particular policies or (2) defense versus indemnity costs, so as to increase the insurance company's reinsurance recovery. Although the policyholder owes no duty to the reinsurer to prevent the settling insurance company from manipulating the allocation of the settlement to suit the (ceding) insurance company's own reinsurance needs, insurance companies that manipulate their payments have been denied recovery under their reinsurance policies on this ground.[22] In any event, the policyholder may resist such manipulation on the basis that the allocation may adversely affect the policyholder's ability to tap its other coverage.

IV. NEGOTIATING PARTNERS AND TYPES OF AGREEMENTS

In approaching settlement of a complex coverage claim in which more than one insurance carrier issued applicable coverage, the policyholder needs to make the strategic decision to negotiate collectively with all its affected carriers or to negotiate with each carrier individually. The dynamic and issues for each alternative are different. The parties also need to determine whether to seek a final resolution or an interim one, and each side's interest in seeking a final or an interim agreement may vary over the course of the negotiations.

A. *Bilateral and Multilateral Agreements*

As indicated above, most complex coverage claims involve multiple insurers. The insurers may be from different layers of coverage, primary and excess, may represent portions of a given layer, as with quota share layers, or may have issued policies in different years. A policyholder facing such an array of targets needs to determine whether to seek a resolution with all the insurers concurrently, a subset of the insurers concurrently, or individual insurers seriatim or concurrently.

A policyholder may be inclined to proceed multilaterally because (1) transaction costs are reduced and (2) the policyholder can achieve certainty of result, including reducing the risk that an aggregation of individual settlements would result in a lower recovery. In addition to being unwieldy, multilateral negotiations suffer from the "lowest common denominator" problem. Multilateral negotiations tend to

21. Other aspects of the reinsurance contract may cut in favor of a settlement, such as where the reinsurance policy limits could be exceeded if an adverse verdict against the ceding insurer were rendered.

22. Insurance Co. of the State of Pennsylvania v. Grand Union Ins. Co., [1990] LLOYD'S L. REP. 208 (Hong Kong); American Marine Ins. Group v. Neptune Ins. Co., 775 F. Supp. 703, 708-09 (S.D.N.Y. 1991) *aff'd*, 961 F.2d 372 (2d Cir. 1992); *see also* United States v. Brennan, 938 F. Supp. 1111, 1123 (E.D.N.Y. 1996) (mail fraud conviction); *cf.* Kaiser Found. Hosp. v. North Star Reinsurance Corp., 153 Cal. Rptr. 678 (Cal. App. 1979); Span, Inc. v. Associated Int'l Ins. Co., 277 Cal. Rptr. 828 (Cal. App. 1991); Hartford Acc. & Indem. Co. v. Michigan Mut. Ins. Co., 463 N.E. 2d 608 (N.Y. 1984).

create a dynamic where the party most hawkish on a particular issue tends to drive the other parties towards its position. The phenomenon often intensifies as the number of insurers increases as no one insurer is a hawk on every issue, but the group as a whole may include members with individual positions that taken together are hawkish on a number of the significant issues. Multilateral negotiations can also become bogged down where one or more of the parties are "holdouts" about some matter, when the others are more or less prepared to reach final agreement.

A bilateral negotiation—or a series of concurrent or seriatim bilateral negotiations—avoids the lowest-common-denominator and holdout problems and may be advantageous to the policyholder if only because individual negotiation provides the policyholder with baselines for comparison as the policyholder goes from insurer to insurer. Each individual settlement indicates what is possible given the facts, thus providing an important counterpoint to subsequent insurers' effort to take certain issues or approaches off the table entirely. In this model, the insured uses each individual settlement as a building block to achieving a global resolution.

As a practical matter, the policyholder is likely to embrace both approaches: multilateral and bilateral. It is well-nigh impossible to get all one's insurers to the table simultaneously or—perhaps more accurately—to keep them all at the table simultaneously. A settlement, even if conceived as a comprehensive, multilateral negotiation, is more likely than not to be only partial, with some insurers refusing to engage in meaningful settlement dialogue.

Even when the insured negotiates with a subset of its carriers, such as with all or most of the primary carriers, the insured should consider involving to some degree absent carriers in the negotiations, at least with respect to those issues where the proposed settlement will impact the absent carriers' obligations; in other words, where the absent carriers' obligations to the insured are dependent in part on the resolution with the settling carriers, the insured may wish to seek agreement, or at least acquiescence, to the methodologies being employed in the main settlement. Thus, if the insured and the primaries are settling premised on the particular claim situation being considered to be one occurrence, the insured may want the excess carriers to sign off on that assumption, rather than face later litigating or disputing with the excess carriers whether there were multiple occurrences (that would have the result, subject to the applicability of aggregate limits, of further deferring the excess carriers' obligations to perform). A similar primary/excess split occurs with respect to the allocation of costs to defense versus indemnity buckets. Though the ideal result might be to have the absent carriers agree to the particular methodological assumption, the insured should at least try to put the excess carrier in the position of being estopped from taking a different position.

On the question of bilateral versus multilateral negotiations more generally, it is worth noting that, with respect to London market coverage, there will likely be a coalition of interests on the insurer side, representing, among others, the Lloyd's of London interests and interests in the London "companies" market outside of Lloyd's that may have underwritten part of the risk. As part of the

Lloyd's Reconstruction and Renewal effort, a runoff reinsurer EQUITAS was formed to handle virtually all pre-1993 Lloyd's exposure; as a result, the pre-1993 Lloyd's interests now are being represented by the EQUITAS Claim Unit. Prior to EQUITAS, negotiations would take place with the "leaders" on the slip, who would in turn try to sign up the "following" market, which they usually were able to do; however, some types of claims, such as environmental and asbestos, were handled in a more centralized fashion by Lloyd's even before the establishment of EQUITAS. The London companies have always been separately represented from the Lloyd's qua Lloyd's interests, and that practice continues today. As with Lloyd's, there has been increasing centralization of claims responsibility on the companies' side, which facilitates and streamlines the negotiations to some degree. As a practical matter, most negotiations with the London market will take place jointly or separately with one representative of Lloyd's and one representative of the London companies market, each having some authority with respect to their respective constituencies.

B. *Interim and Final Agreements*

Final agreements resolve the parties' dispute, and a final agreement in effect substitutes for the insurance policy as applied to the particular matter. An interim agreement, in contrast, resolves the matter partially, i.e., in terms of governing time period, dollars, issues, or the like. Whether the agreement is final or not, the parties also must decide what type of settlement they want—a "buyout" or a coverage-in-place arrangement.

The overwhelming uncertainties that imbue complex coverage cases may as a practical matter preclude the sides from achieving finality, though some more limited arrangement may be sensible or appropriate. An agreement can be "interim" as marked by its time period. Thus, an agreement among one or more insurers may involve payment of all past costs and a commitment for one year, automatically renewable, concerning payment of future costs. Alternately, an interim agreement may impose dollar caps instead of time limits, so that the agreement automatically terminates once a level of payout is reached.

An interim agreement stabilizes the relationship among the policyholder and its carriers. Often an interim agreement will avoid the need for litigation or suspend, narrow, or defer existing litigation. An interim agreement permits the parties to build trust as they work together during its course.[23] An interim agreement also permits the parties to defer resolution of divisive issues. As an example, the parties may establish procedures to resolve difficult questions, such as which defense costs are to be covered, via arbitration or other alternative dispute resolution mechanisms.

23. During its term, an interim agreement should specify how the insured is to comply with its obligations under the policy, such as providing notice and the like. *See generally* Marc Mayerson, *Perfecting and Pursuing Liability Insurance Coverage: A Primer for Policyholders on Complying with Notice Obligations*, 32 TORT & INS. L.J. 1002 (1997). The agreement should provide that the performance pursuant to the settlement substitutes for and discharges the obligations of the insured under the policy.

This deferral mechanism thus permits the parties to reach agreement without resolving particularly divisive issues, thereby bracketing the scope of the ongoing dispute.[24] Of course, an interim agreement may form the stepping stone for a final resolution.

In addition and often related to the question whether the settlement will be an interim or final one, the parties need to decide whether the settlement will take the form of a one-time payment by the insurer(s) or whether the settlement will call for ongoing relations between the insurer(s) and the policyholder in the management of the particular claim scenario. For ongoing matters, liquidating the claim in a lump sum settlement (usually referred to as a "buyout") results in the possibility that the insured will have guessed wrong about the size of its ultimate payout and thus may settle for too little. The opposite can happen too: the carrier may guess that the ultimate payout will be worse than it turns out to be. In a buyout the insured achieves the certainty provided by receiving cash and avoids any risk of insolvency on the part of the insurer; the carrier benefits by capping and liquidating its coverage obligation.[25]

In a coverage-in-place arrangement, the insurer or insurers typically agree to make some lump sum payment for costs or losses incurred in the past and commit to fund at least a portion of the future losses. Under a coverage-in-place arrangement, the insured and the insurers continue to work together concerning the subject matter of their dispute.

In any coverage-in-place arrangement in which there are third-party claims against the insured that remain to be resolved at the time of settlement, the parties should reach agreement on control of claims handling, the selection and compensation rate of counsel and experts, processes by which the party not controlling the claims handling can object to a settlement or be deemed to acquiesce, and a process for resolving disputes arising in the course of the coverage-in-place arrangement. Depending on the nature of the anticipated disputes, the parties may agree to some form of alternate dispute resolution.[26]

Finally, due to the complexity of the issues, whether the settlement is final or interim, a buyout or a coverage-in-place arrangement, a bilateral or multilateral negotiation, the process of negotiating and documenting the agreement is typically arduous.

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24. An interim agreement can include irrevocable waivers by either side; a policyholder may waive bad faith claims, for example, and the insurer may waive certain coverage defenses, such as notice.

25. All is not lost if an insurer with continuing obligations becomes insolvent. There is an elaborate state-by-state system governing the operation, rehabilitation, or liquidation of insurance companies admitted to do business in particular states. There are quasi-bankruptcy proceedings, both domestic and international, as well as state-guaranty funds, that the insured can look to for recovery. *See generally* Francine Semaya and Lenore Marema, *An Overview of the State Insurance Receivership System*, 27 THE BRIEF 12 (Fall 1997).

26. Where the parties are operating under a mandatory interim agreement, the parties may wish to agree that all disputes that would otherwise be submitted to ADR under the agreement be aggregated until such time that the balance of the dollars in question reaches a specified level of materiality.