

ORIGINAL

In the
Supreme Court of Ohio

THE LINCOLN ELECTRIC COMPANY,

Petitioner,

v.

TRAVELERS CASUALTY AND SURETY
COMPANY, *et al.*,

Respondents.

Case No. 2013-1088

On Consideration of the Certified Question
from the United States District Court for the
Northern District of Ohio, Eastern Division,
Case No. 1:11-CV-2253.

**BRIEF OF AMICI INSURANCE LAW PROFESSORS KENNETH S. ABRAHAM,
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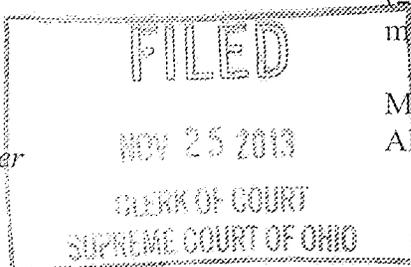
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STATEMENT OF AMICI INTEREST

Certified Question:

May an insured who has accrued indemnity and defense costs arising from progressive injuries, and who settles resultant claims against primary insurer(s) on a pro rata allocation basis among various primary insurance policies, employ an “all sums” method to aggregate unreimbursed losses and thereby reach the attachment point(s) of one or more excess insurance policies?

The amici are eight law professors from across the country whose area of academic focus is insurance law. Their teaching and research agendas give them substantial exposure to, and expertise in, questions involving allocation of loss among multiple insurers, the disputed issue that the certified question presents to this Court for resolution. Specifically, the amici include:

- **Kenneth S. Abraham**, David and Mary Harrison Distinguished Professor of Law, University of Virginia School of Law¹;
- **Donald G. Gifford**, Edward M. Robertson Research Professor of Law, University of Maryland Carey School of Law;
- **Bruce L. Hay**, Professor of Law, Harvard Law School;
- **Max N. Helveston**, Assistant Professor of Law, DePaul University College of Law;
- **Kyle D. Logue**, Wade H. and Dores M. McCree Collegiate Professor of Law, University of Michigan School of Law;
- **Jeffrey W. Stempel**, Doris S. and Theodore B. Lee Professor of Law, University of Nevada Las Vegas William S. Boyd School of Law;
- **Daniel Schwarcz**, Associate Professor of Law, Solly Robins Distinguished Research Fellow, University of Minnesota School of Law; and
- **Robert L. Tucker**, Adjunct Professor of Law, University of Akron School of Law.

The amici do not have an interest in the specific facts of this case, but they do have an interest in the sound and rational development of insurance law. While the amici’s specific research interests vary, they share a belief that insurance law questions should be resolved in a way that

¹ Institutional affiliations are listed for identification purposes only.

promotes efficiency and fairness for both policyholders and insurers, and that promotes settlement in an equitable manner. Applying this common belief to the certified question here, the amici conclude that resolving the question in the affirmative (*i.e.*, as the policyholder here requests) would promote the most efficient and intellectually consistent approach to allocation issues, not only on the facts of this case, but on a going-forward basis. Moreover, the amici further conclude that resolving the issue here in the policyholder's favor would not create any windfall or unfair advantage in favor of Lincoln Electric or future similarly situated policyholders, nor impose any unfair burden on insurers. More specifically, as Ohio has already elected to use an all-sums approach to long-tail loss allocation generally, there is no reason to change that approach in determining whether excess insurer attachment points are met, merely because the insured has settled with the various primary insurers on what could be characterized as a pro-rata basis.

INTRODUCTION

The certified question asks the Court to determine how allocation should work with regard to excess insurers in cases involving so-called long-tail losses. Long-tail losses are continuing losses that stretch across multiple policy periods. Given that they implicate multiple different insurance policies, long-tail losses can present difficult allocation questions. For example, should the losses be allocated to one policy period, or across multiple policy periods?

The two principal approaches to allocation for long-tail claims are referred to as (1) all-sums and (2) pro-rata. Under the first, the insured is allowed to assert the entirety of any loss against any primary policy (subject to policy limits) that has been triggered as a result of the loss, with that primary insurer then having contribution rights against other insurers whose policies were also triggered. Under the latter approach (*i.e.*, pro-rata), by contrast, each primary insurer's

obligation to the insured is limited to a pro-rata portion of the loss. Established Ohio law has held that Ohio is an all-sums state.

The question here, though, is how allocation should work with regard to *excess* insurers, following an insured's *settlement* with its primary carriers. On that issue, Lincoln Electric's brief and the other amici set forth straightforward reasons, based on the insurance policies' plain language and Ohio case law, why a policyholder should likewise be allowed to pursue an all-sums approach to recovery from any non-settled excess insurers, even if it has allegedly used a pro-rata approach in settling with its primary insurers. This brief does not address that Ohio case law, nor does it further explicate the policy language at issue here. Rather, the amici law professors explain why this same result—*i.e.*, allowing policyholders to use an all-sums approach with their excess carriers, even when they have settled with the primary insurers on a pro-rata basis—is the only logically consistent choice based on fundamental principles of insurance law. Using a simplified hypothetical example that replicates in material respect the relevant facts in this case, this brief makes three points:

First, answering the Question Presented in the affirmative (*i.e.*, allowing insureds to use an all-sums approach with non-settling excess insurers) promotes consistency in Ohio law, which has already firmly adopted the all-sums legal regime. The insurer's contrary argument in this case, which at first glance *appears* to be based on claims of "consistency," is in fact based on a fundamentally flawed presumption. In particular, the insurers *presume* that any settlement among an insured and multiple primary insurers that is structured so that all of the various potentially-responsible primary insurers pay directly to the policyholder some portion of the agreed settlement amount, *must* have been predicated on a pro-rata *legal regime*. Based on that flawed presumption, the insurers argue for a rule of consistency that would require the

policyholders that have ostensibly embraced the pro-rata regime for purposes of settlement to stick with that pro-rata regime for purposes of seeking additional coverage from non-settled excess insurers. In fact, however, such so-called “pro-rata” settlements are often made merely to simplify the structure by which a multi-party settlement is funded, even when all of the parties to the settlement agree that the law governing the insurance dispute employs the all-sums rule. Once this flawed presumption is exposed, the insurer’s argument for “consistency” crumbles. The only rule that truly promotes consistency in insurance law is one that consistently applies Ohio’s well-established all-sums regime to all long-tail claim allocation matters, regardless of the irrelevant details of the particular structure of any settlement the insured may have reached with one or more insurers in a particular dispute.

Second, despite the insurers’ claim to the contrary, allowing all-sums allocation to excess insurers in these circumstances does not increase the burden on non-settling excess policyholders any more than what they bargained for in providing the excess coverage in the first place. In particular, to the extent that a settlement with primary insurers leaves a gap between what a primary insurer pays out and the attachment point of the next-level excess insurance policy, the policyholder itself must close that gap with its own funds before it can seek coverage for any remaining loss from excess policies. Thus, regardless of the details of which policy pays what in a multi-party primary-policy long-term claim settlement, allowing a policy holder to use an all-sums approach to pursue additional coverage from excess insurers does not force an excess policy to provide any more coverage than it otherwise would provide absent settlement.

Finally, answering the Question Presented in the affirmative encourages settlement, which benefits policyholders, insurers, and courts alike. Indeed, this preference for settlement

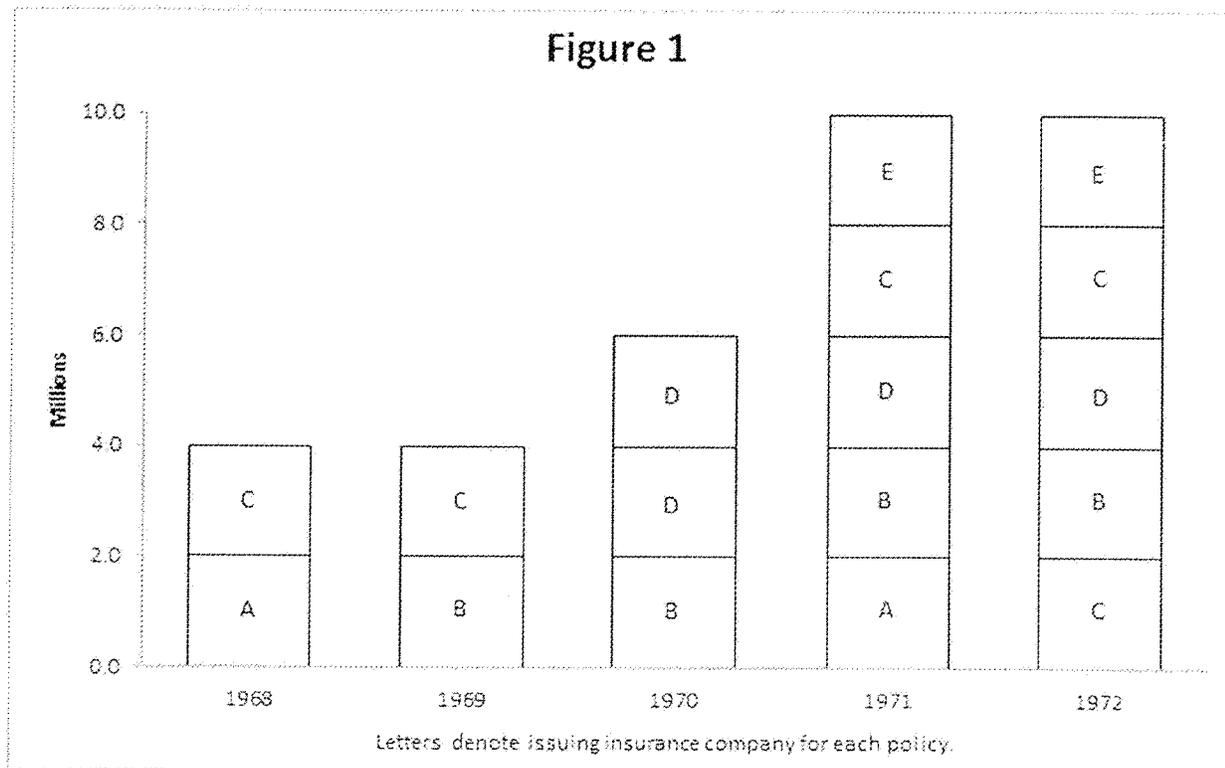
has long been one of the fundamental underpinnings of insurance law, and there is no reason to deviate from that preference here.

Accordingly, amici Insurance Law Professors respectfully urge the Court to answer the Question Presented in the affirmative, a result that will further develop Ohio insurance law in a logical, consistent, fair, and efficient matter for all parties in this case and the many others like it.

STATEMENT OF CASE AND FACTS

The Insurance Law Professors do not base their argument here on the specific facts in this case. Rather, for the purposes of this brief, and to aid the Court in considering the Question Presented within a broader perspective, the following simplified example will be used.

Policyholder “GenCo” faces a long-tail claim, based upon environmental property damage, for \$7 million in potentially-insurable losses covering the five-year period 1968 through 1972. During this period, GenCo had multiple different insurers, both primary and excess (the different insurers being labeled Insurer A through E in Figure 1 below). For each of the calendar years, GenCo had a \$2 million primary policy. Layered on top of that, GenCo also had varying amounts of excess insurance coverage (including one or more excess policies), provided by the various different insurers (A-E) as set forth in the following illustration:



ARGUMENT

Certified Question:

May an insured who has accrued indemnity and defense costs arising from progressive injuries, and who settles resultant claims against primary insurer(s) on a pro rata allocation basis among various primary insurance policies, employ an “all sums” method to aggregate unreimbursed losses and thereby reach the attachment point(s) of one or more excess insurance policies?

A. The Basics Of Long-Tail Claims, Pro-Rata Allocation, And All-Sums Allocation.

Long-tail claims are claims in which an ongoing “occurrence” triggers occurrence-based insurance policies over multiple policy periods, and it is difficult or impossible to specify a single policy as the only policy triggered by the claim. *See, e.g., State v. Continental Ins. Co.*, 55 Cal.4th 186, 195-196, 281 P.3d 1000 (2012). Two of the most common examples of long-tail claims are asbestos bodily injury claims and environmental property damage claims. Which insurance policies are triggered by these claims depends on case law and policy language.

Generally, to determine which *years*' policies are triggered, courts use trigger rules that focus, for example, on when the injury manifested itself, when the injury arose, or when exposure occurred. Other courts hold that *all* policies involved—from the time of initial exposure through the time of injury manifestation—are triggered. *See, e.g., Boston Gas Co. v. Century Indem. Co.*, 454 Mass. 337, 350, 910 N.E.2d 290 (2009).

In addition to primary insurance, insureds often have excess coverage. The excess policies are triggered based on the same triggering rules that govern primary coverage, but only if their attachment points are reached. For example, GenCo's excess coverage in 1970 would be triggered only if the trigger rules triggered coverage under the 1970 primary policy *and* the liability exceeds the \$2 million point where GenCo's 1970 primary policy ends and its 1970 first-layer excess policy begins.

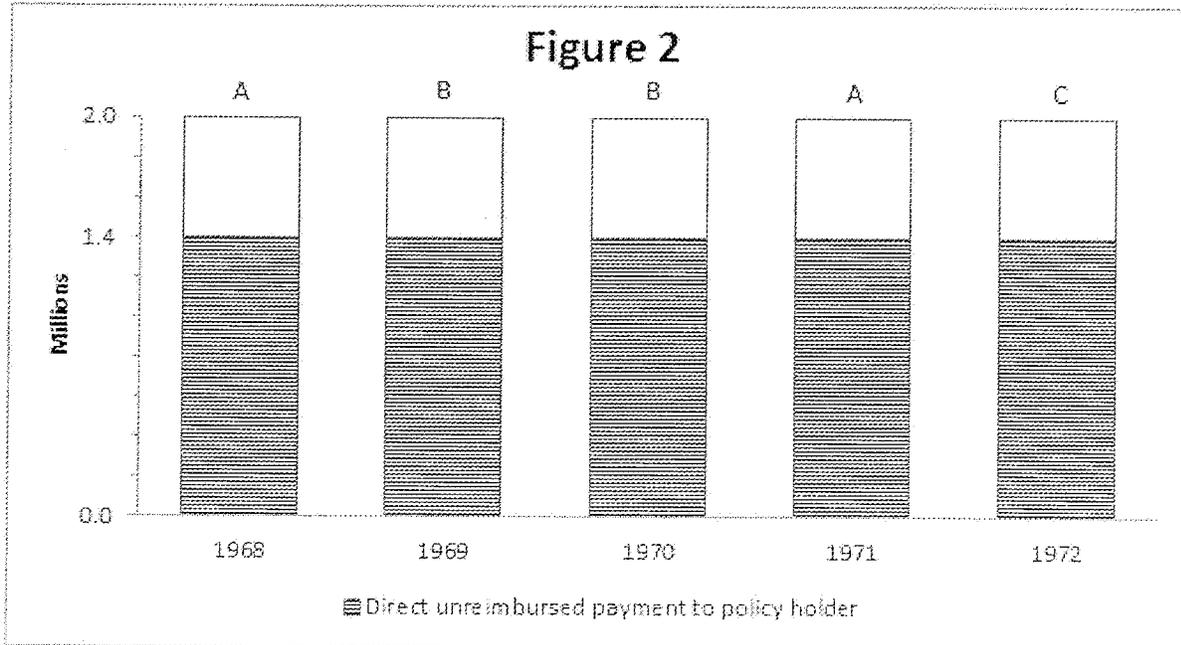
Regardless of the rules for which *years*' policies are triggered, claims such as asbestos and environmental claims often yield *multiple* years of triggered coverage. This is the essence of the long-tail claim: it is impossible to target a single policy as triggered by an ongoing occurrence or set of occurrences, and so *all* triggered policies are eligible to contribute to the insured loss. *See, e.g., Continental Ins. Co.* at 196.

To answer the question of how to *apportion* liability among triggered policies in long-tail claims, courts have essentially divided between two general approaches. Some courts use pro-rata allocation, essentially dividing the liability equally among the policy years triggered. Other courts, including courts in Ohio, employ all-sums allocation, which gets its name from typical policy language stating that the insurer agrees to pay "all sums" for which the policyholder is liable. *See Goodyear Tire & Rubber Co. v. Aetna Cas. & Sur. Co.*, 95 Ohio St.3d 512, 2002-Ohio-2842, 769 N.E.2d 835; *Pennsylvania Gen. Ins. Co. v. Park-Ohio Industries*, 126 Ohio St.3d

98, 99, 2010-Ohio-2745, 930 N.E.2d 800 (“We continue to adhere to the all-sums method of allocation adopted in *Goodyear*”).

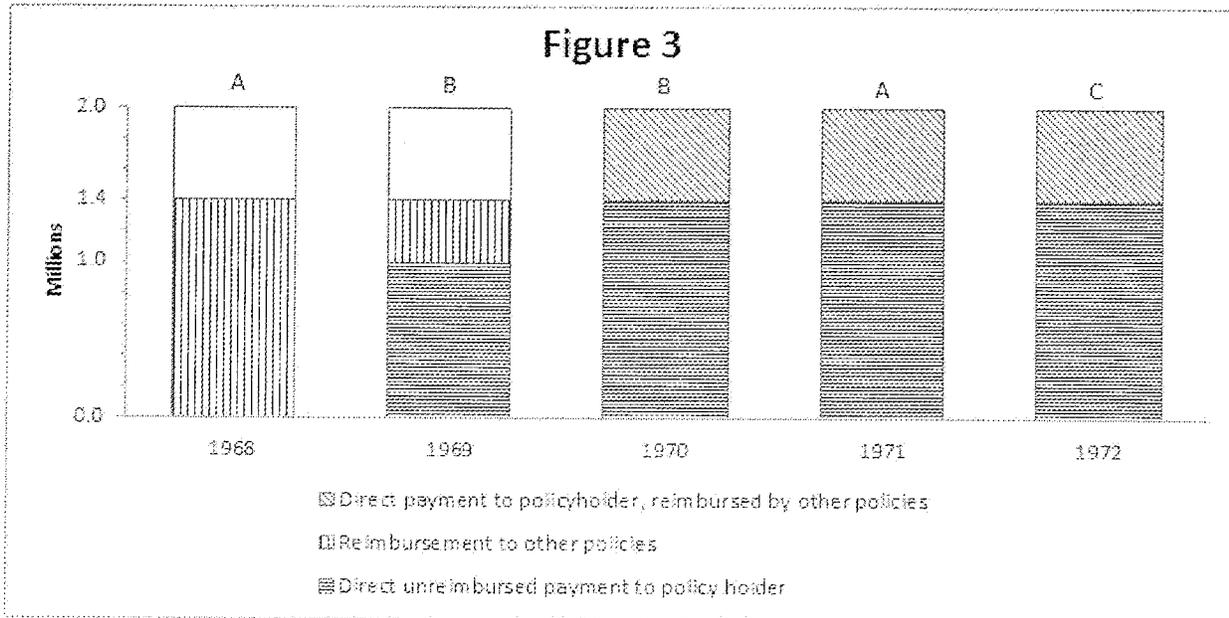
Under the all-sums method, a policyholder can select among any of the triggered policy years, and can assert the entirety of the long-tail losses against the selected policy up to the policy limits, and then move on to any other triggered policy to collect any remaining uninsured losses. Importantly, the insured’s selection of a given policy does not determine the final allocation. Rather, the insurer whose policy was selected can seek contribution from other policies that also cover the subject liability. Accordingly, all-sums allocation works much like joint and several liability in tort claims; a single insurer is originally required to pay, but that insurer can then seek contribution from other policies covering the same liability. (That said, *unlike* joint and several liability, the single policy that a policyholder selects under all-sums allocation is not necessary liable for *all* covered loss during the period. Instead, that single selected policy’s liability is limited by its original coverage limit.)

To illustrate both rules, assume that GenCo’s total liability was \$7 million over the years 1968-1972, and consider only its primary insurance policies. Under the pro-rata system, each primary policy would be responsible for providing \$1.4 million in coverage directly to GenCo as depicted below in Figure 2.



Under the all-sums system, (*i.e.*, the law in Ohio since *Goodyear*), by contrast, GenCo could select 1970 as its target policy, and receive \$2 million (the policy limit) from that year's policy. Importantly, GenCo could not seek the entire \$7 million from Insurer B based on its 1970 primary policy, because even under the all-sums method, a policy's responsibility never exceeds its coverage limit. Thus, GenCo would still have \$5 million in unreimbursed losses left. It could then select 1971 as another target policy, receiving \$2 million (the policy limit) from that insurer as well. With \$3 million in remaining unreimbursed losses, it could likewise collect the \$2 million policy limit from, for example, the 1972 policy, and the remaining \$1 million from the 1969 policy. At that point, the 1970-1972 policies would have paid out their full \$2 million in provided coverage, and the 1969 policy would have paid out \$1 million in provided coverage. The insurers who paid, however, could then seek contribution under the equitable contribution doctrine from the other triggered primary policies. With \$7 million in losses, and a total of \$10 million in triggered policies, generally speaking each insurer would have a right of contribution to the extent that they had paid more than 70% of their policy limits, and any insurer

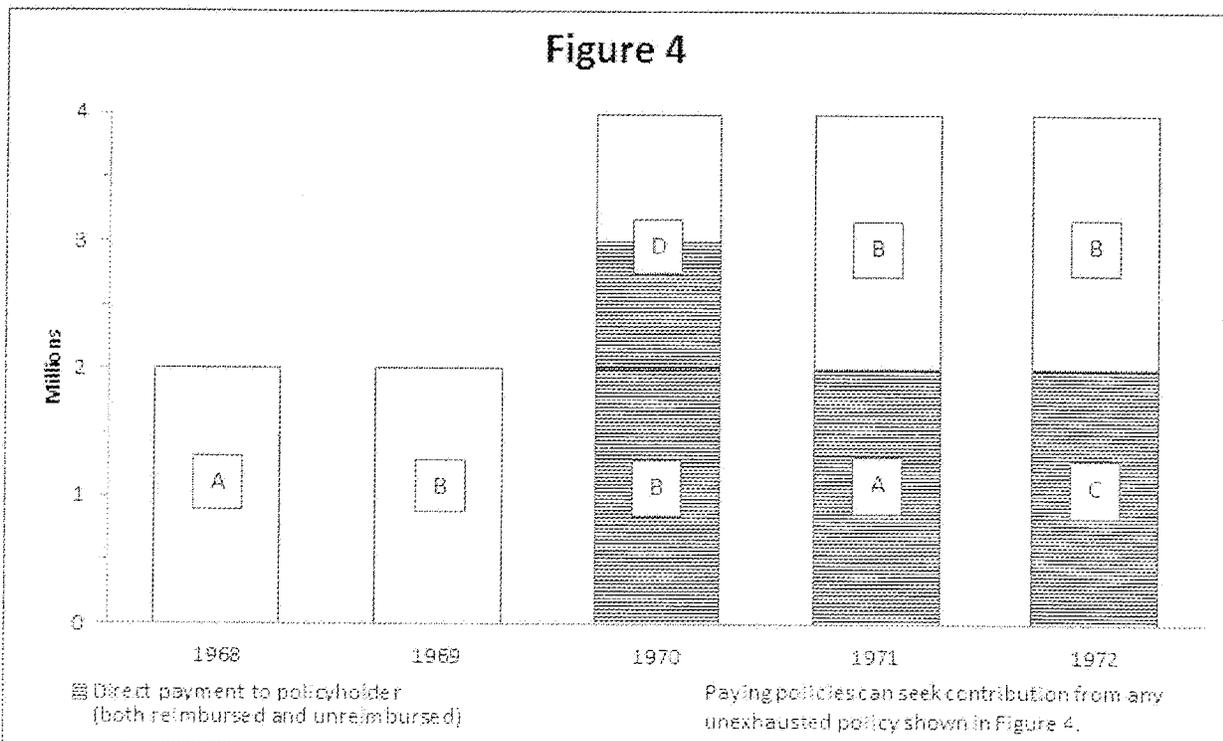
who had paid less than that amount would have a reimbursement obligation. Accordingly, as shown in Figure 3, each of the five, after accounting for contribution, would lose \$1.4 million in the process of making GenCo whole on its \$7 million insurable loss.



As *Goodyear* makes clear, the all-sums approach is preferable to a pro-rata approach for a number of reasons, not the least of which is that it remains faithful to relevant policy language requiring reimbursement for “all sums” an insurer is obligated to pay. *See Goodyear* at ¶ 7. Moreover, the all-sums approach “promotes economy for the insured while still permitting insurers to seek contribution from other responsible parties when possible,” *id.* at ¶ 11, conforming with the typical industry practice under which insurers make policy holders whole first and then use their own resources to seek contribution after the fact where available.

Under the all-sums approach, as an alternative to seeking additional contribution from other *primary* policies after exhaustion of the limit of one or more primary policies, as detailed in Figure 3, GenCo could also seek all-sums coverage from an excess insurance policy, as long as its attachment point has been reached. For example, if GenCo had first sought \$7 million in coverage from the 1970-1972 policies as described above, it could then seek the remaining \$1

million from the first-level (or umbrella) excess policies in any of those same years. This is true because, by exhausting the coverage of the 1970-1972 primary policies, GenCo reaches the \$2 million attachment point of the first-level excess insurance policies in those years. As shown in Figure 4, if GenCo chose the 1970 first-level excess policy to satisfy the remaining \$1 million in loss, then Insurer D could seek contribution from other carriers whose policies were triggered.



This comparative illustration shows a critical difference between the pro-rata and all-sums regimes regarding how and when attachment points are met, triggering excess coverage liability. In a pro-rata regime, because each primary policy must automatically be allocated a proportionate amount of total loss, it takes longer for any excess insurer attachment point to be met. For example, in the first hypothetical in which GenCo’s \$7 million loss is allocated pro-rata (\$1.4 million per policy), none of the primary policies have been exhausted and no excess coverage attachment point has been met. In fact, no excess coverage attachment point could be reached until GenCo’s insurable losses “fill the tub” of all available primary coverage—in this

case, not until GenCo's losses exceed \$10 million. On the other hand, as shown in the alternative all-sums hypothetical, GenCo can seek excess coverage in any given year as long as it exhausts a \$2 million attachment point in that year.

Importantly, although particular excess coverage policies' attachment points may be reached *earlier* in an all-sums system, no one insurance policy is left with more than its fair share of coverage liability. As the example in Figure 4 shows, an excess insurer can still seek contribution from unexhausted primary insurance policies under this system.

In adopting the all-sums allocation method, this Court properly concluded that it is consistent with insurance policies' language and that it "promotes economy for the insured while still permitting insurers to seek contribution from other responsible parties when possible." *Goodyear* at ¶11. In other words, as fully explained in Lincoln Electric's brief, the language of the policies provide that each will cover "all sums"—not some pro-rata portion of sums—for which the policyholder is liable, up to the policy's coverage limit. By definition, in long-tail claims, regardless of the method for determining a coverage trigger, the bodily injury or property damage giving rise to coverage all extend over a period of several policy periods. Accordingly, each policy is liable for the whole of the long-tail claim, but each policy's ability to obtain contribution from other triggered policies ensures that no one policy (or subgroup of policies) ultimately incur more than their fair share of loss.

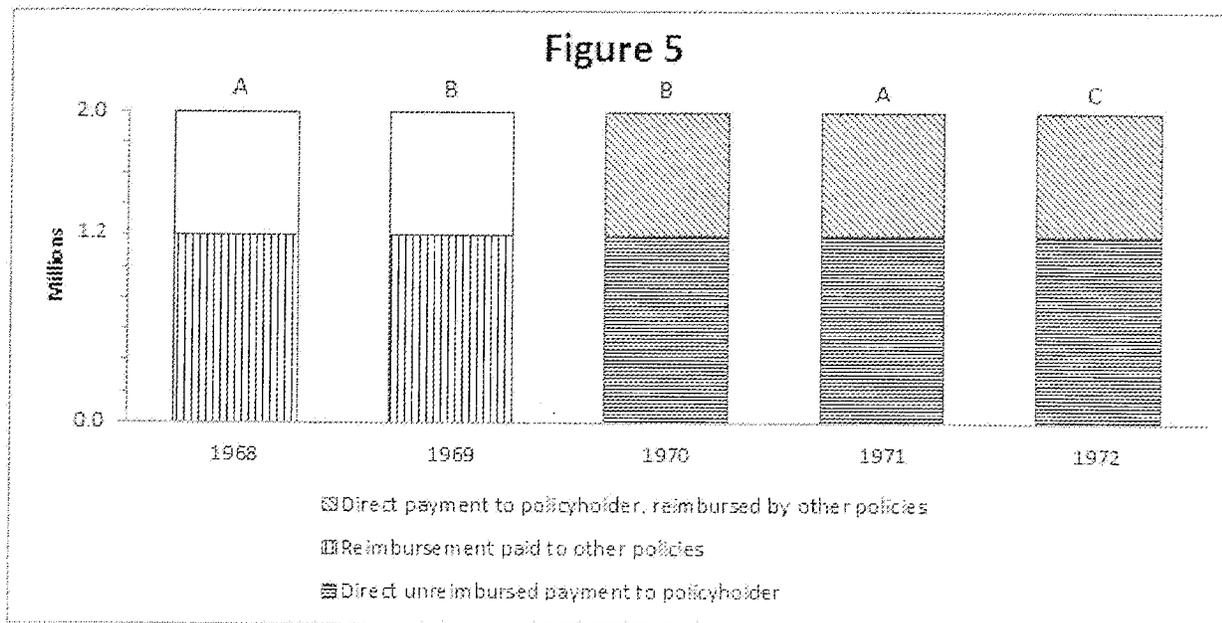
But in any event, while it is critical to understand the basic difference between the pro-rata and all-sums legal regimes in order to answer the Question Presented in this matter, Ohio has already made the *choice* between those regimes. *Goodyear* firmly establishes Ohio as an all-sums state, and no court—federal or state—challenges that well-settled Ohio law. The relevant question in this case is not about revisiting the choice that *Goodyear* made between all-sums and

pro-rata allocation. Instead, the relevant question is a follow-up: Given *Goodyear's* all-sums choice, how does that system play out when policyholders and insurers settle disputes for less than the full amount sought by the policyholder?

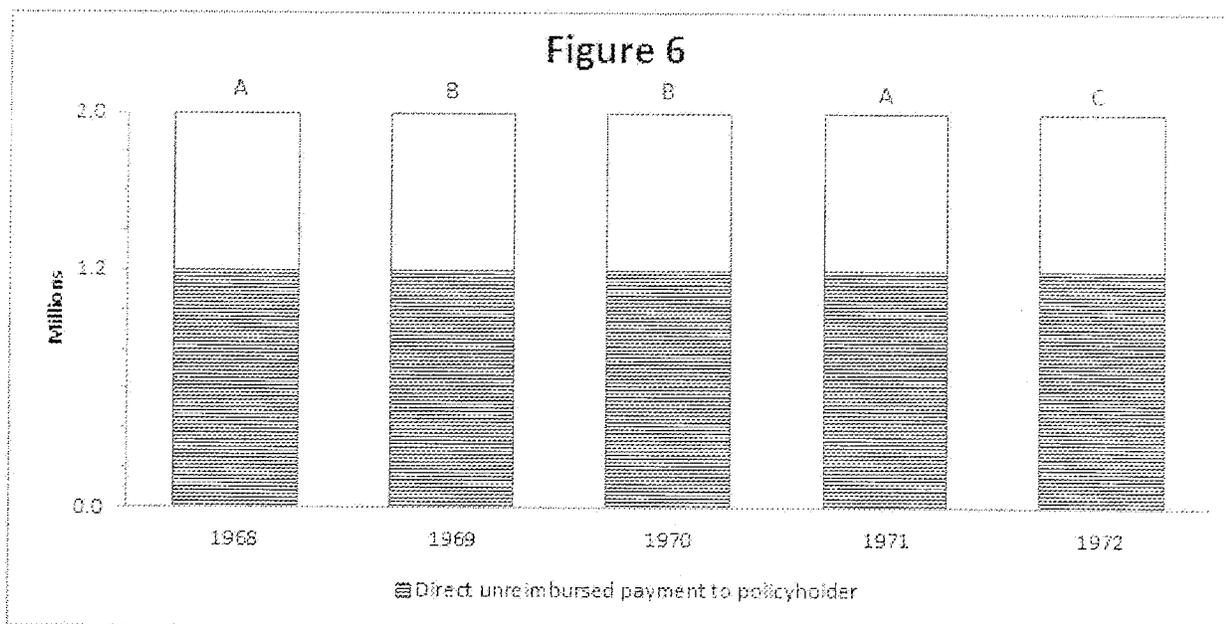
B. The Effect Of Settlement.

All of the above hypotheticals presume one of two situations: either the insurers involved *agreed* that GenCo's \$7 million loss was fully covered by the policies at issue, or the parties litigated that question and GenCo fully prevailed. In reality, many insurance coverage questions are resolved through settlement, whereby the insurers agree to pay, and the policyholder agrees to accept, something less than 100% of the coverage it seeks. For example, GenCo may agree to a blanket settlement with all primary insurance providers for \$6 million instead of the full \$7 million sought. Under this scenario, GenCo and Insurers A, B, and C could structure their agreement in either of the following two ways, among others.

First, GenCo could receive \$2 million from Insurer B under the 1970, \$2 million under the 1971 policy, and \$2 million under the 1972 policy. Then, the insurers could agree to reimburse one another to allow each policy to cover an equal portion of the total agreed payment. In this case, as illustrated in Figure 5 below, that would lead to each policy incurring \$1.2 million of net loss, as opposed to \$1.4 million each as set forth in the \$7 million no-compromise approach above in Figures 2, 3, and 4.



Alternatively, GenCo and Insurers A, B, and C could structure the same settlement more simply. Rather than have each Insurer reimburse the ones selected to pay GenCo, the parties could simply agree, as shown in Figure 6, that each of the five policies will pay \$1.2 million directly to GenCo.



Critically, it is *impossible* to determine, simply by looking at these two hypothetical settlements, whether the parties in either example (a) agreed that a court deciding their dispute

would apply the all-sums system, (b) agreed that a court deciding their dispute would apply the pro-rata system, or (c) agreed on the settlement amount, but never agreed on whether a court would take an all-sums or pro-rata approach to resolving their dispute (perhaps because a particular state's law was unsettled or the parties disputed the choice of applicable state law).

To be sure, if Figure 5 and Figure 6 were outcomes determined by a *court*, it could be concluded that the court used the all-sums regime in Figure 5 and used the pro-rata regime in Figure 6. But when viewed in the context of a voluntary settlement, no such conclusion can be made. Indeed, if this hypothetical were indisputably governed by Ohio law, GenCo and the insurers would no doubt agree that absent a settlement, an Ohio court would allow GenCo to use all-sums to seek full \$2 million payments from the 1970-1972 policies, leaving it to those policies to seek contribution from other policies. But that indisputable reality regarding how a court would allocate loss does not require the parties to structure their settlement in a way that would mirror the payment structure that a court decision would prescribe. Instead, GenCo and the insurer would be free to take a more simplified approach to payments that would ultimately end up at the same net monetary result to all policies (and to GenCo) in fewer payments steps.

In some cases, applying this method could be a prerequisite to settlement, for reasons that have nothing to do with whether a court would select all-sums or pro-rata regime. For example, where a single insurer has policies covering multiple different policy years during the long-tail claim, the insurer typically will require releases as to all of those policies in connection with any settlement, and may demand the right to allocate the settlement among the policy years in the manner that best serves its interests. Accordingly, to accomplish settlement, it may be necessary for the parties to agree that no one policy will pay out the full coverage amount, even if each

policy could face such potential liability in court, and even if all parties understood that contribution payments would even out initially uneven payments to the policyholder.

Indeed, answering the Question Presented in favor of the insurers in this case would likely require a simple and fundamental labeling error. Specifically, there is an important difference between a *pro-rata legal regime*, whereby the law of a given state limits a policy's *total potential exposure* to a portion of the whole that is smaller than its individual coverage limit, and a *pro-rata settlement* whereby the parties agree, for whatever reason, that each policy involved will pay a certain amount below its coverage limit, and no one policy will pay its full coverage amount. The latter settlement may properly be called "pro-rata," in a general sense of the word, but there is no reason to conclude that it was necessarily reached because the pro-rata legal regime was acting as an upper limit on how much each policy could possibly be required to pay.

C. Ohio's Legal Regime For Allocation Of Long-Tail Claims Should Not Change Based On Flawed Assumptions About Private Settlements.

As the example illustrates, the mere fact that a settlement does not require any particular policy to incur all of the loss, or all of the loss up to its coverage limit, does not necessarily mean that the settlement is founded on the pro-rata legal regime. Thus, characterizing a settlement as "pro-rata," merely because multiple different policy years have contributed to the settlement, is a misnomer. And certainly, claims of "consistency" could not be used to in turn mandate a pro-rata approach to excess carriers. Indeed, parties frequently settle legal disputes without coming to an agreement on an interpretation of the applicable law, or even what law applies in the first place. Parties making an independent assessment of the value of claims, or the extent of exposure, may find common ground in nothing more than an amount to be paid and the manner of payment.

Using the *form* of settlement (*i.e.*, payments from multiple different policy years) to create an irrebuttable presumption that the settlement was in fact “pro-rata,” and then mandating the extension of that presumption to the excess layer under the guise of consistency, thus misses the point. Instead, the Court should maintain consistency with its own settled law, *i.e.*, the all-sums approach, which provides an insured the ability to aggregate any remaining uninsured losses against any policy (whether primary or excess) that has been triggered. There is no logical reason, nor any policy-based reason, to set opposing rules in select situations based on settlement characteristics that are ambiguous at best about the parties’ intent regarding governing law. By allowing a policyholder to use the all-sums regime to pursue the remainder of its loss from non-settled insurers, the Court would affirm that the particular form of a settlement should not determine the legal framework governing a policyholder’s rights with regard to other non-settling insurers.

D. Answering The Question Presented In The Affirmative Focuses On The Function Rather Than The Form Of Insurance Settlements And Encourages Settlement, Consistent With Ohio’s Approach To Similar Insurance Issues.

In related contexts, courts have recognized that they should appropriately focus on *function*, not *form*, in deciding how insurance law works. Here, that focus on function counsels in favor of allowing an all-sums approach to excess insurers, as doing so encourages settlement, while also limiting each insurer only to the risk that they have agreed to undertake.

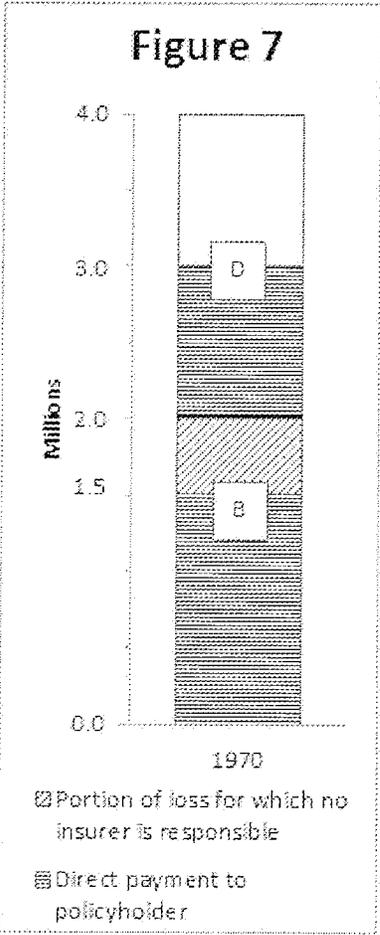
Courts have relied on function over form in the related context of determining that, at least in cases where policy language does not dictate otherwise, an insured can seek coverage from its excess carrier on single-policy-period claims when the attachment point for the excess layer was met through a combination of payments by an insurer and payments by an insured to an injured party. This principle was first articulated in *Zeig v. Mass. Bonding & Ins. Co.*, 23 F.2d 665 (2d Cir. 1928), and Ohio courts and other jurisdictions have followed suit in similar

situations, finding that settlement with some insurers does not preclude seeking coverage from others. *See, e.g., Fulmer v. Insura Prop. & Cas. Co.*, 94 Ohio St.3d 85, 95, 760 N.E.2d 392 (2002); *Triplett v. Rosen*, 10th Dist. No. 92AP-816, 1992 WL 394867, *7 (Dec. 29, 1992); *Elliott Co. v. Liberty Mut. Ins. Co.*, 434 F.Supp.2d 483, 498 (N.D. Ohio 2006).² In *Zeig* and many of its progeny, the excess insurers had argued that the language of the excess policy precluded a finding that the attachment point had been reached until the insurer on the underlying layer—and only that insurer—had paid the entirety of the underlying coverage limit. According to these insurers, if the policy holder *settled* with its primary insurer for less than the full coverage limit and then paid the remainder of that underlying coverage limit on its own, the insured could not seek coverage under its excess policy for any remaining losses.

Zeig and its progeny, however, rejected this formalistic approach to excess coverage. As Lincoln Electric explains in its brief, this line of cases is founded on two sound fundamental principles. *First*, allowing access to excess coverage did not prejudice the excess insurer, specifically because the rule does not force the excess insurer to cover more loss than it would cover if the primary insurer (rather than a combination of the primary insurer and the insured) paid the entire primary insurance coverage amount. To see this, imagine in the GenCo example above a \$3 million single-year claim (*i.e.*, not a long-tail claim) for coverage in 1970. Insurer B may settle with GenCo by agreeing to pay \$1.5 million of its \$2 million potential coverage exposure under its policy. Without the *Zeig* rule, the excess insurer (*i.e.*, Insurer D) could claim that the attachment point for its policy had not been reached (as the primary had not paid the \$2

² To be sure, other courts, considering excess policy language expressly requiring that the insurer alone pay all sums up to an attachment point, have held that an excesses policy attachment point is not reached when a primary insurer settles with a policy holder for less than the attachment point amount, even if the policyholder itself pays the remainder of sums necessary to reach an attachment point. *See, e.g., Great American Ins. Co. v. Bally Total Fitness Holding Corp.*, N.D. Ill. No. 06 C 4554, 2010 WL 2542191 (June 22, 2010).

million policy limit). *Zeig*, however, allows GenCo to pay the remaining \$500,000 that *would have been paid* by Insurer B on the primary policy but for the settlement, and then to seek the remaining \$1 million in coverage from Insurer D under the excess policy. Consistent with the notion that Insurer D's risk does not come into play until the \$2 million level is reach, Insurer D does not pay the remaining \$500,000 that was not paid by Insurer B. Rather, as illustrated in Figure 7, Insurer D pays only the same \$1 million it would have paid if Insurer B had not settled and instead paid the entire coverage limit on the primary policy.



Thus, Insurer D's contractual exposure (*i.e.*, for losses in excess of \$2 million), is exactly the liability that it bears, meaning that it has not been prejudiced.

Second, the *Zeig* rule achieves the benefit of encouraging settlement between insurers and policy holders. As more fully set forth in the amicus brief of Dispute Resolution Professors, there is immense value, for parties and for courts, in developing rules encouraging out-of-court settlement, especially in areas such as insurance coverage, where there is a strong likelihood of a high volume of litigation about fairly standardized and recurring issues. Absent the *Zeig* rule, an insured is essentially penalized for settling with its primary. Without the *Zeig* rule, if an insured settles with its primary for less than 100 cents on the dollar, the insured would essentially lose its excess coverage (as the primary insurer would not have paid the entirety of the underlying limit). But primary insurers, of course, have no incentive to settle for 100 cents on the dollar, as that is the most they can pay in any event. Thus, both parties would be forced to move forward with time-consuming and expensive litigation (expenses that are borne, at least in part, by the taxpayers who fund the judicial system) for no good reason. The *Zeig* rule allows settlement, and thus avoids that otherwise problematic result.

These same two principles—(1) a healthy respect for observing the limits on risk to which an excess has agreed, and (2) an interest in preserving incentives that promote settlement—support answering the Question Presented in the policyholder’s favor here. *First*, such a rule does not prejudice excess insurers. Just as with a typical single-year claim settled with the benefit of the *Zeig* rule, allowing policyholders to use an all-sums to pursue any remaining loss from non-settling excess insurers after “pro-rata” settlement with primary insurers does not increase the burden on the excess insurers.

More specifically, just as in *Zeig*, Lincoln Electric is not seeking “drop down coverage” that would force excess insurers to pick up portions of loss that would have been paid by primary insurers absent settlement. For example, building on Figure 6 above, where GenCo simplified

the payment structure of the \$6 million settlement by having each primary insurer pay \$1.2 million, answering the Question Presented in the affirmative here would *not* allow GenCo to collect the entire remaining \$1 million of its \$7 million loss from excess insurers. Instead, in connection with using an all-sums approach against an excess insurer, GenCo itself would be required to pay the difference between one primary policy's \$1.2 million payment and that policy's \$2 million coverage limit. For example, if GenCo targeted the 1970 insurance policies, GenCo would need to pay injured parties \$800,000 *from its own funds* before it could reach Insurer D's umbrella policy attachment point. Then, Insurer D would be responsible for only the remaining \$200,000 in unreimbursed loss. This would be the same amount that Insurer D would be required to pay if the settlement were structured such that Insurer B paid a full \$2 million in coverage and other primary policies contributed more to the 1970 primary policy to cover its extra share of the \$6 million settlement.

Second, just like the *Zeig* rule, answering the Question Presented in the affirmative encourages settlement, and thereby increases the efficient use of the limited resources of policyholders, insurers, and courts. To be sure, if the Question Presented were answered in the negative, some settlements between policy holders and primary insurers could simply be restructured to cause one primary policy to pay up to its coverage limit and other primary policies to contribute to that disproportionate payment. Indeed, this simple fix—a matter of form over function—is one reason why adopting the insurers argument in this case makes no sense. But as explained above, some settlements would be thwarted by a rule insisting on elevating form over function—for reasons that have nothing at all to do with whether the settlement was somehow predicated on a pro-rata legal regime. Given the false presumption that any settlement in which each insurer pays a discounted amount directly to the policy holder is necessarily based

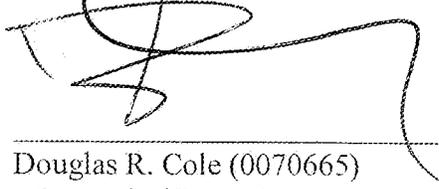
on a pro-rata legal regime, there is no logical reason to adopt a rule that would essentially disqualify some insurance disputes from settling when they otherwise could be resolved without litigation.

CONCLUSION

For the above reasons, the Court should answer the Certified Question in the affirmative.

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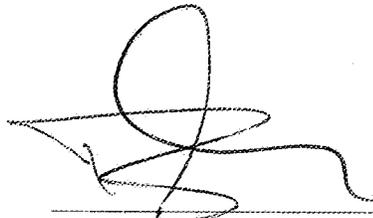
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