CPCU SOCIETY INSURING YOUR SUCCESS

Reinsurance Interest Group

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Reinsurance Encounters

Co-Chair Comments

By Timothy D. Foy, CPCU, ARe

Timothy D. Foy, CPCU, ARe, joined the Environmental Group of XL Insurance, located in Exton, Pennsylvania, in 2008 as vice president, strategic alliance program manager. In this role, Tim oversees XL's partnering with either insurance companies or MGA/program administrators to offer environmental coverage to support their casualty books of business under quota share agreements. In Tim's previous underwriting positions, he worked for more than 20 years with various primary commercial companies, as well as reinsurers, specializing within casualty programs and facultative placements. In addition, he worked within the MGU/wholesaling world, developing and designing program solutions. He served five years as the president of the Philadelphia Casualty Underwriters Club and has had various CPCU chapter positions. Tim received his CPCU designation in 1994 and his ARe designation in 1999.

The CPCU Reinsurance Interest Group hosted its annual Reinsurance Symposium on March 14–15, 2012, at the Union League in Philadelphia. The Symposium brought together talents from all sectors of the industry, including retail producers, primary insurance carriers, reinsurance brokers, and reinsurance companies from underwriting and claims disciplines. In addition, the Insurance Society of Philadelphia helped market the Symposium to show their support for this first-class educational event. As **Chuck Haake,** co-chair, noted in the previous newsletter, "the Reinsurance Interest Group strives to provide various seminars throughout the year in Chicago, Philadelphia, and Dallas, along with the CPCU Society Annual Meeting in Washington, D.C. in September." We are open to your ideas and suggestions for topics and speakers, so feel free to call or e-mail us.

The title of the Reinsurance Symposium, "Reinsurance—An Industry in Transition: Is 2012 the End of the World as We Know It?," captured the fluid dynamics of changes we have been facing, such as the aftermath of the economic collapse and various 2011 catastrophe events. This discussion provides some summary notes from the event.

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Steve McElhiney, CPCU, MBA, ARe, AIAF, president of EWI Risk Services and president of the CPCU Society for 2012, presenting the keynote luncheon address.

What's in This Issue

Co-Chair Comments

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The Symposium began with **Frank Nutter,** President of the Reinsurance Association of America, moderating an executive panel discussion of industry executives on current trends and issues. The panel consisted of **Steve McElhiney, CPCU, MBA, ARe, AIAF,** EWI Risk Services; **John Vasturia,** Munich Reinsurance America; **Paul McKeon,** Transatlantic Reinsurance Company; **Kevin Markowski,** Axis Re US; and **Scott Belden,** Travelers Insurance, Ceded Reinsurance.

The panel provided a broad view of the industry from a reinsurance intermediary, a direct and broker reinsurer, and a ceded reinsurance buyer of various reinsurance products. The knowledge shared by this panel was outstanding, and many attendees remarked it was the best panel of executives they have heard in many years.

We were pleased to have **Laline Carvalho** of Standard and Poor's provide an overview entitled "State of the Global Reinsurance and U.S. Personal and Commercial Lines Sectors," which gave all of us some context of where we are in the current underwriting cycle. Standard and Poor's has participated in our event for the past ten years. We always look forward to their informative presentations and welcome their support.

Susan Kearney, CPCU, of The Institutes, coordinated the new ARe Designee Ceremony. Eight ARe designees were recognized during the luncheon ceremony. Also, we were fortunate to have **Steve McElhiney,** president of EWI Risk Services and president of the CPCU Society for 2012, present the keynote luncheon address.

For the afternoon presenters, **Karen Clark,** of Clark and Company, conducted a review, titled "New Generation Technology for Catastrophe Risk Assessment and Management." **Steve Drew,** of Aon Benfield Chicago, presented "Atlantic Hurricanes: Frequencies, Forecasts & Loss Causes." Next, **Bradley Kading, CPCU,** president of the Association of Bermuda Insurers and Reinsurance, presented an overview of the Bermuda Insurers and Reinsurers Marketplace, entitled "2011 Global Cat Losses: Who Paid the Bills? Real Reinsurance Value." The final presentation was made by **Robert W. Diubaldo, J.D.,** and **Gregory S. Hoffnagle, J.D.,** both of Edwards Wildman Palmer LLP, titled "Hydrofracking Risks & Opportunities: What Underwriters Need to Know."

To support the upcoming college talent in our industry, two students were invited to attend from each of these universities: Temple, LaSalle, St. Joseph's, and St. John's. We believe that such visibility for current college students studying risk management will benefit our industry. As the average age of employees in the industry is over fifty, it won't be long until today's students enter and lead the reinsurance and insurance industries. **Connor Harrison, CPCU,** is the liaison to the Reinsurance Interest Group, and he organized the student participation. We thank The Institutes for their sponsorship.

We want to thank Munich Re, Swiss Re, and Mintz Levin law firm for their valuable support. We also thank **Kelli Kukulka** of Munich Re; **Gordon Lahti,** of Swiss Re; and **Steve Torres** and **Nancy Adams** of Mintz Levin Law Firm. Their support in these challenging economic times is greatly appreciated by all of us. We also thank the CPCU Society, especially **Mark Dolinski** who made the Union League arrangements, marketed the event, and handled the finances.

The Reinsurance Interest Group held a committee meeting before the Symposium to discuss future events, including the Annual Meeting being held in Washington, D.C. in September. In addition, it was announced that the Chicago reinsurance seminar is scheduled for May 3 and is titled "Current Issues Facing the Industry." You can register for the Chicago reinsurance seminar via the CPCU Society website. We would like to thank Guy Carpenter in Philadelphia for hosting our Reinsurance Interest Group committee meeting.

During our committee meeting discussion, we learned that several CPCUs are interested in joining the Reinsurance Interest Group. We welcome their participation and will

Terese Peuvion, CPCU, ARe, AIS, and Jon Wit, CPCU, ARe, ARM, RIG Committee Members attending the Reinsurance Interest Group symposium in Philadelphia.

announce the new additions to the committee in an upcoming edition of Reinsurance Encounters. There are plenty of areas where we would welcome help, including launching webinars, headed by **Steve Torres**; Circle of Excellence Programs, led by **Terese Conn Peuvion**; various educational symposiums in Chicago, Dallas, and Philadelphia; and the upcoming Annual Meeting in Washington, D.C. If anyone enjoys writing insurance articles, **Richard G. Waterman, CPCU, ARe,** the editor of Reinsurance Encounters, is always on the lookout for quality content of interest for our membership. If you have an interest in serving on the Reinsurance Interest Group Committee, there are many rewarding areas for leadership participation.

The title for the Philadelphia Symposium, "Reinsurance—An Industry in Transition: Is 2012 the End of the World as We Know It?," demonstrated through various presenters that the reinsurance industry is definitely in transition. Our world and our industry will change economically and politically; however, 2012 is not the end of the world as we know it. Rather, the dynamics are a continued evolution, as we have more tools and more information to insure, and reinsure, risks, hopefully in a more profitable light. There is no doubt 2011 was a challenging year for the entire industry because of worldwide catastrophe-related events. We all hope 2012 will encounter fewer catastrophic events.

It is a pleasure to serve as co-chair with **Charles "Chuck" W. Haake, CPCU**; and we both appreciate the fine legacy of **Tom Pavelko's** leadership over the past three years and hope to continue his model of excellence.

If you were able to join us at the Philadelphia Symposium, we appreciate your attendance, and if not, we hope to see you next year or at an upcoming CPCU Society educational seminar. ■

Kelli Kukula, CPCU, ARe, AFIS, and Richard Waterman, CPCU, ARe, RIG Committee Members bracket hydrofracking presenters Gregory S. Hoffnagle and Robert W. DiUbaldo at the Reinsurance Interest Group symposium in Philadelphia.

Steve Drew, of Aon Benfield Chicago, presenting "Atlantic Hurricanes: Frequencies, Forecasts & Loss Causes."

Editor's Comments

by Richard G. Waterman, CPCU, ARe

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

One of the honors of serving on the Reinsurance Interest Group Committee is the opportunity to congratulate new recipients of the Associate in Reinsurance (ARe) designation during our annual Reinsurance Symposium. This year was no exception. Nine newly minted ARe designees attended the Reinsurance Symposium on March 15 at The Union League of Philadelphia, during which they were honored at a luncheon ceremony. Congratulations to all ARe designation holders!

The Reinsurance Interest Group is especially proud to present its annual Reinsurance Symposium, which attracts top-notch industry talent to serve as faculty and draws a wide audience of reinsurance professional attendees. **Tim Foy's** co-chair column and photographs taken by **Connor Harrison,** who is with The Institutes, give you insight into the quality of the educational program and a glimpse of the atmosphere for networking opportunities. We hope you will plan to attend our next Reinsurance Symposium on March 13 and 14, 2013.

This edition of *Reinsurance Encounters* includes three enlightening articles. The first is an excellent article titled "Number of Occurrences, Policy Periods, Exhaustion and Other Consideration Impacting Allocation of Losses," by **Scott M. Seaman, J.D.,** and **Jason R. Schulze, J.D.,** two distinguished insurance/reinsurance coverage litigation attorneys. The current article is the fourth in a series of previously published articles related to the allocation of continuous damage losses among policyholders, insurers, and reinsurers. In this article, the authors examine the number of occurrences, multi-year policies, and stub periods that must be taken into account in the allocation analysis of covered losses.

Follow-the-fortunes is a provision in reinsurance agreements, not always specifically identified as such, in which it is agreed that the reinsurer is bound to the same fate or underwriting fortunes as the cedent with respect to risks reinsured. Follow-the-settlements provisions, often used interchangeably with follow-the-fortunes, require a reinsurer—in the absence of fraud, collusion, or bad faith—to accept a reinsured's good-faith businesslike reasonable settlement decisions of a particular risk that is covered by the terms of the underlying policy and reinsurance agreement. **Andrew Boris's** instructive article, "The Continued Conflict Between Challenging the Billing and Follow-the-Fortunes," describes the broadness of follow-the-fortunes provisions that require reinsurers to accept reinsurance billings, including in some instances multi-year loss allocation determinations.

The final article, "Mediation: A Process That Really Works," was written by yours truly. I have mediated numerous reinsurance disputes and have participated in many other mediations, either as a company representative or as a mediation consultant. From those varied experiences, I have become a strong proponent of mediation to resolve a wide range of reinsurance disputes. Mediation really works when the parties are willing to consider alternative settlement possibilities.

Have you written about a subject in your day-to-day activities that affects the placement of reinsurance, reinsurance underwriting, or reinsurance claims that you would be willing to share with *Reinsurance Encounters* readers? In many instances, a memorandum or research paper can be adapted into an informative article for publication. If you have written about a topic related to reinsurance, I would be delighted to work with you for publication in an upcoming edition. ■

Number of Occurrences, Policy Periods, Exhaustion and Other Considerations Affecting Allocation of Losses

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

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In our prior articles in this series, we have examined trigger of coverage and satisfaction of claims-made requirements, allocation methodologies, contribution claims and "other insurance" clauses. In this article, we look at some of the other considerations that must be taken into account in the allocation of losses in complex coverage claims: number of occurrences, multiyear policies and stub periods, and proper exhaustion.

Number of Occurrences

In many instances, the determination of precisely how many occurrences are implicated under the subject insurance contracts can be one of the most important issues in a coverage determination or coverage action. In the first instance, the number of occurrences evaluation determines how many sets of "per occurrence" limits are at risk. Thus, in situations where the insurance contracts at issue either are subject to applicable aggregate limits larger than the per occurrence limits, or where they are not subject to any aggregate limits, a policyholder can reap the benefit of a finding of more than one occurrence. On the other hand, where a policyholder has a large per occurrence deductible or retention, a multiple occurrences ruling could result in the policyholder being obligated to satisfy each per occurrence deductible for each claim (or group of claims, depending upon the precise ruling) asserted against it.

Similarly, the number of occurrences issue also may be determinative of whether and to what extent an insurer's contracts are required to respond. A single occurrence or multiple occurrences ruling may affect an insurer differently, depending upon the attachment points of the insurer's contracts, the presence or absence of applicable aggregate limits in the insurer's contracts and the underlying contracts, the dollar amount of the loss associated with any occurrence, and the precise nature of any multiple occurrence determination (e.g., one occurrence per claimant, one occurrence per site, one occurrence per shipment, etc.). Also, insurers often consider their overall portfolio interests before staking out a position with respect to a particular claim or coverage action.

Most courts have labeled their analyses of the number of occurrences issue as either applying the "cause" test, looking to the cause or causes of damage, or the"effects" test, looking to the injuries, damages, or effects resulting from the cause. The majority of courts purport to look to the cause or causes of damage rather than to each individual claimant's injury or the number of claims to determine whether there is one occurrence or multiple occurrences under a contract. Under the cause test, the court examines the cause or causes of the injuries that create the liability of the policyholder. The court determines whether there was but one proximate, uninterrupted and continuing cause that resulted in all of the injuries or damages. Some courts have refined application of the cause test into a test that focuses the number of occurrences analysis on what ultimately is determined to be the "liability-triggering event." Under the cause test, the number of causes determines the number of occurrences.

A minority of courts, mostly courts applying Louisiana law, look to the effects of a claim in determining the number of occurrences. Under the effects test, the number of injuries determines the number of occurrences.

Other courts have refused to adopt either the cause or the effects test. New York courts, for example, employ an "unfortunate event" test that looks to the "event of unfortunate character" that

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Number of Occurrences, Policy Periods, Exhaustion and Other Considerations Affecting Allocation of Losses

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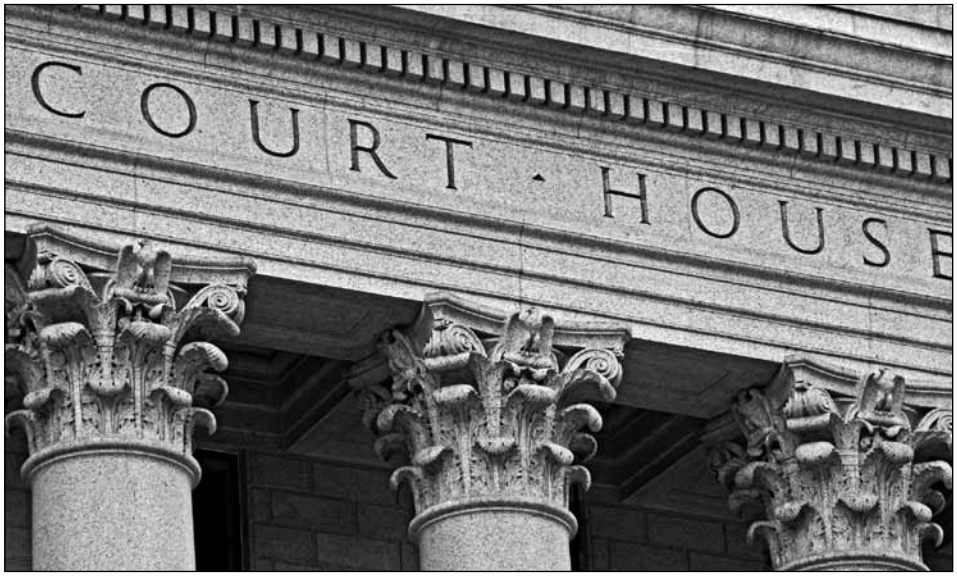
results in the injury or damage. The New York Court of Appeals application of the unfortunate event test in *Appalachian Ins. Co. v. General Elec. Co.*, 863 N.E.2d 994 (2007), is instructive. In that case, the court ruled that a collection of injuries or losses could be grouped together into one occurrence only after a determination of "whether there is a close temporal and spatial relationship between the incidents giving rise to the injury or loss, and whether the incidents can be viewed as part of the same causal continuum, without intervening agents or factors." The court distinguished the New York unfortunate event test from a cause test, stating that common causation is relevant to the analysis, but only after the "incident—the fulcrum of our analysis—is identified" The court emphasized the significance of identifying the relevant event or "incident" and noted that the "cause should not be conflated with the incident."

Generally, the number of occurrences determination cannot be made in a vacuum, but requires reference to and analysis of the subject policy language, the relevant facts as well as the legal standard applied under the controlling law. Yet, courts have rendered disparate decisions even under similar factual circumstances and even while purporting to apply the same test. For example, the supreme courts of Florida and Pennsylvania recently employed a cause test analysis to two incidents that involved multiple gunshot injuries suffered by various individuals, with the courts reaching the exact opposite conclusion on very similar facts. Sometimes the outcomes can be reconciled by distinctions in contract language. Other decisions appear to be result orientated.

Although policyholders often prevailed in the earlier decisions involving number of occurrences determinations, courts in recent years have been more analytical in their approach, considering contract language and claim-specific facts instead of accepting the approach that maximizes the insurance recovery. Accordingly,



insurers have prevailed on the issue of number of occurrences in several important, recent decisions.

Insurers and policyholders have taken a variety of positions with respect to different types of claims on the number of occurrences issue and generally can find a court decision to support these positions. In the context of asbestos claims, for example, parties have advanced various arguments as to what constitutes the occurrence or occurrences, and courts have rendered various rulings, including these: all asbestos claims against a policyholder are attributed to a single occurrence (such as the manufacture and sale of asbestos-containing products or the presence of asbestos); the presence of asbestos at each location constitutes an occurrence; each claimant's exposure to asbestos constitutes an occurrence; each installation of asbestos-containing products constitutes a separate occurrence; each asbestos-containing product or product line constitutes an occurrence; and each shipment of asbestos constitutes an occurrence.

In noise-induced hearing loss claims, some courts have found multiple occurrences to arise even under the cause test. In one case, the court rejected the policyholder's argument that all of the claims stemmed from the policyholder's "systemwide" negligence in failing to protect its employees from the harms associated with their employment and ruled that the hearing loss of each claimant constituted a separate occurrence. Another court reached the opposite conclusion, finding that 3,800 noise-induced hearing loss claims constituted a single occurrence, namely the negligent failure to timely implementation of an effective hearing conservation program that would have protected its workers from excessive noise inherent in railroad operations.

Of course, the language of the subject insurance contract must be considered with respect to the number of occurrences determinations. Some occurrence definitions contain "lot," or "batch," clauses. One such provision states: "all such exposure to substantially the same general conditions existing at or emanating from one premises location shall be deemed one occurrence."

Multiyear Policies and Stub Periods

A model coverage program might contain primary, umbrella and excess insurance contracts, each issued for a full one-year period with matching inception and expiration dates. Corporate policyholders'

coverage programs, however, are not always so tidy. Often they include multiyear contracts that may span two or three years. Sometimes coverage programs include insurance contracts effective for periods of less than a year (either by design or as a result of early cancellation or termination). Such contracts commonly are referred to as "stub" policies, or contracts. Similarly, insurance contracts may be in effect for an entire year and for a fraction of another year. Determining the limits available under such contracts, in some instances, is important to allocating losses from the perspectives of the policyholder, the issuing insurer and other insurers with contracts in effect during the relevant period of time.

Several courts have addressed the issue of the limits available under insurance contracts issued for a multiyear contract period. The issue is whether a multiyear contract (e.g., a three-year contract) with per occurrence limits (e.g., $1 million per occurrence) has three separate annual limits for a single occurrence (e.g., $3 million), or whether each such contract provides a single per occurrence limit (e.g., $1 million) in coverage for a single occurrence causing injury or damage during a three-year contract period. The treatment of the limits of liability in such contracts spanning multiple years often makes a substantial difference, not only with respect to the limits available under such contracts, but also to the overall allocation of large losses. Stated differently, how such contracts are treated in terms of limits also may affect the timing and extent of impact on other insurance contracts and the amount recoverable by the policyholder. The existence of multiyear contracts may influence the parties' positions on the issue of number of occurrences as well.

Excess insurers often take the position that multiyear contracts provide only one set of per occurrence limits. This has the effect of limiting exposures under their contracts once those contracts are triggered by long-tail claims implicating more than one annual period. However, application of only a single set of per occurrence limits may expedite the impact on excess insurers' contracts or affect excess contracts that otherwise may not be reached if annual limits of underlying multiyear contracts are applied. Where an insurer stands on the issue may depend upon where it sits in the coverage chart, giving appropriate weight to the policy language and facts associated with the claim.

With stub contracts, once again, consideration of the policy language and facts, as well as controlling law, is required to determine whether no additional limits, a full set of additional limits, or prorated limits are provided.

Proper Exhaustion

Excess insurance is secondary insurance coverage that attaches only after a predetermined amount of primary insurance or self-insured retentions have been exhausted. Proper exhaustion (whether it is vertical or horizontal under the controlling law) of underlying coverage is required. A determination of proper exhaustion, of course, requires an understanding and application of the various limits of liability. Insurance contracts may contain a host of applicable limits of liability: per occurrence; per claimant; per accident; per claim; and aggregate limits. The limits may apply separately to property damage, bodily injury or personal injury. Alternatively, contracts may contain "combined single limits" such that payments made on bodily injury and property damage combine to reduce the limits of liability. Some contracts contain aggregates; others do not. Aggregate limits may apply to all losses under the contract; to losses on an annual basis; or only to certain types of losses, such as operations, premises or products. Particular claims may be paid on a per occurrence basis or on a aggregate basis.

Accordingly, in the first instance, the insurers and policyholders must identify the limits of liability and determine how they apply to the claims. The application and impact of deductibles and self-insured retentions also must be considered. Concomitantly, the parties must ensure that claims and payment are, and historically have been, applied properly against the limits. For instance, where the insurance contract only contains product aggregates, payments made on ongoing operation claims should not be applied against the aggregate. Similarly, payments made on workers compensation claims, for example, should not be charged against general liability contract limits. Thus, where issues of proper impairment or exhaustion are presented, insurers often require an audit or review to determine the proper status of underlying impairment or exhaustion. Most policyholders cooperate with their insurers and make documents and electronic compilations of materials available to them. Where the parties are engaged in coverage litigation, the process often takes place in the context of discovery or settlement discussions and may be facilitated by execution of a confidentiality agreement. Sometimes a review of each claim and proof of payment of each dollar is required by the insurer. Other times, a random or selective review of certain files will suffice. In the first and final analyses, the policyholder bears the burden of establishing proper exhaustion.

There are numerous other variables that affect the allocation analysis. These include consideration of the impact of insurer insolvencies, coordination of coverage among various lines of coverage, characterization of costs as defense costs or indemnity costs, and determination of allocation start and stop dates. ■

The Continued Conflict Between Challenging the Billing and "Follow-the-Fortunes"

by Andrew S. Boris, J.D.

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

The scenario plays itself out virtually every day. A claim representative at a reinsurer is presented with a billing related to a long-tail loss. As part of the claim process, the representative reviews the information submitted by the insurer and the applicable insurance contract. The contract contains very clear "follow-the-fortunes" language, but the claim representative decides to raise questions about the billing because he or she thinks that the allocation of the loss in the billing may be improper and that the billing impermissibly seeks indemnification of money paid to the underlying insured relating to the insurer's alleged bad faith in handling the underlying claim. Importantly, a recent case from an appellate court in New York found that a reinsurer's ability to raise questions in a similar circumstance was limited.

In *U.S.F.&G., et al. v. Excess and Treaty Management Corp., et al.*, the appellate court was confronted with questions about potential reinsurance cover for billings submitted by the insurer for asbestos claims involving Western MacArthur. Following protracted coverage litigation between U.S.F.&G. (and other insurers) and Western MacArthur, the insurers agreed to pay $975 million in satisfaction of all asbestos-related claims. As part of (and required by) the settlement, Western MacArthur was obligated to seek bankruptcy protection. During the subsequent bankruptcy proceedings, the bankruptcy court found that Western MacArthur was contributing value to the formation of a trust in the form of potential bad-faith claims against U.S.F.&G. for U.S.F.&G.'s previous long-standing refusal to either indemnify, defend, settle, or otherwise pay Western MacArthur's asbestos claims.

Following the settlement between U.S.F.&G. and Western MacArthur, U.S.F.&G. allocated all of the losses tied to the underlying asbestos claims to the 1959 policy year despite having

13 years of coverage at issue. U.S.F.&G. justified its allocation in two main ways: (1) the 1959 policy year provided the injured claimants with the highest payout structure based on policy limits, and (2) the 1959 policy year was the only policy year that covered all potential claims for anyone exposed to asbestos during the period subject to the settlement.

After the presentation of the billing, the reinsurers refused to pay the billing for two central reasons. First, the reinsurers contended that the reinsurance retention for the applicable treaty years was increased from $100,000 to $3,000,000—significantly changing (or eliminating) any liability for the reinsurers. Second, the reinsurers maintained that U.S.F.&G.'s bad faith, beginning with the refusal to pay Western MacArthur's claims as recognized by the bankruptcy court through the process of submitting reinsurance billings, was a breach of the duty of utmost good faith owed to the reinsurers.

The parties subsequently engaged in litigation, with the trial court granting summary judgment in U.S.F.&G.'s favor. The appellate court affirmed the judgment in U.S.F.&G.'s favor. As an initial matter, the appellate court agreed with the trial court that the reinsurance retention for the treaty year at issue had not been changed (and remained at $100,000). In addition, the court ruled that the follow-the-fortunes doctrine required the reinsurers to accept the reinsurance billings. Based on the follow-the-fortunes language in the reinsurance contract, the court viewed several issues as being beyond review, including: (1) whether the settlement amount included bad-faith claims, (2) the decision to allocate the losses to only one year and corresponding failure to spread the loss over thirteen policy years, and (3) the valuation of the settled asbestos claims. Of note, the court did comment that if the court was able to independently examine the questions in dispute, none of the questions raised by the reinsurers would excuse the reinsurers' obligation to pay the billing. A dissenting opinion in the case found that there were genuine issues of fact as to whether the underlying coverage action included payment of bad-faith damages and whether the reinsurers should be obligated to pay for same.

In short, the case provides guidance on three larger points. First, the decision recognizes a very broad application of the follow-the-fortunes doctrine. Thus, insurers will undoubtedly rely on the decision to support their allocation decisions and the argument that reinsurers have limited latitude to review billings. Second, in many ways, the case could lead to additional disputes between reinsurers and insurers. Insurers may use the ammunition provided by the case to support what might be viewed as questionable allocation decisions. Finally, with many reinsurance disputes decided in private arbitration (as opposed to being decided in the court system), the case will likely not curtail the questions raised every day by reinsurers about a cedent's allocation decisions. ■

Mediation: A Process that Really Works

by Richard G. Waterman, CPCU

Mediation is a private proceeding in which a neutral third party, the mediator, acts to encourage and facilitate settlement negotiations to resolve a dispute. The process is voluntary and nonbinding until the parties jointly decide on the terms of a settlement. Unlike a judge in a court proceeding or panel members in an arbitration, a mediator has no authority to impose a decision on the parties.

In mediation, the participants are the most important persons in the process, not the lawyers, not a judge, and not members of an arbitration panel. It is an informal, nonadversarial process that seeks to help the disputing parties reach a mutually acceptable agreement. The parties retain control of the entire process and determine the final terms of the settlement. Thus, when a solution is reached, the parties own it because they agreed to the terms of the settlement. If a settlement cannot be reached, the parties retain all the options they had before they submitted the dispute to mediation.

Mediation is not a new fad. It has been an effective method of resolving labor disputes since the 1930s. Over the years, the principles of mediation have gained greater acceptance as an alternative dispute resolution technique, having a wide range of commercial and professional applications. Increasingly, insurance and reinsurance disputes are being submitted to mediation. The growth of mediation has occurred in response to a search for a more efficient and less costly method of resolving disputes.

Arbitration is the favored method to resolve reinsurance disputes. Nearly all reinsurance agreements contain arbitration provisions. However, those who are familiar with arbitration frequently comment that the process takes too long and costs too much, and they question its fairness. The unpredictable outcome of evidential issues, document discovery, role of witnesses, and the common lack of procedural structure and nonappealable nature of arbitration awards are reasons arbitration is often considered less desirable than litigation. And in many instances, the amount of money in dispute does not justify the delay, expense, and uncertainty of either arbitration or litigation.

Nonetheless, despite the acknowledged drawbacks of arbitration, it has been difficult to convince companies or the attorneys who represent them to consider mediation as a practicable alternative. The reasons most often expressed for shying away from mediation relate to the following perceptions—some false—about the process.

- **Mediation is extra-contractual.** Although mediation may be more desirable as a first alternative in resolving many disputes, provisions for mediation are not an integral part of most reinsurance agreements. In the absence of such provisions, mediation becomes an extra-contractual undertaking that neither party considers a viable alternative.

  To encourage mediation as a first choice in the dispute resolution process, some companies include a "mediation article" in their reinsurance agreements. It states in part that in the event a dispute does arise, the parties agree to meet first to attempt to reach a negotiated settlement. If the parties cannot resolve the controversy on their own, they further agree to employ a neutral mediator and submit the dispute to nonbinding mediation. If mediation fails, the provisions of the arbitration article can be invoked.
- **Mediation represents an unknown risk.** Because most reinsurance executives know little about the mediation process, they fear—or mistakenly assume—that if mediation is used, they may have to agree to something or give up a legal right. The unknown presents a perceived risk they are not willing to take.

  The truth is that mediation is virtually a no-risk process. It is totally voluntary; the participants determine the procedural ground rules; it can be abandoned at any time by either party; and, most important, the parties retain control of the final outcome. Consequently, instead of having someone else impose a solution to the problem, the participants determine their own resolution.
- **Agreeing to mediation is a sign of weakness.** It is often heard that mediation is synonymous with compromise, and that means making concessions, which is perceived as a sign of weakness. Naturally, cooperation and a conciliatory approach to problem solving are important ingredients in the process, but those attributes can only be viewed as strengths when they help to produce a fast, fair, and less expensive solution that benefits both sides.

  Contrary to popular belief, parties in mediation are encouraged to fight hard for their needs based on the principles they believe to be correct. In contrast to adversarial negotiating, however, the parties in mediation focus on business concerns instead of legalisms and strive to find mutual solutions.
- **Mediation is not always a good alternative to arbitration.** Parties or their lawyers often believe that it is worth the gamble to arbitrate reinsurance disputes, even though a dispute may be won or lost in arbitration by the selection of the arbitrators or the luck of the draw in choosing an umpire. If a party to a dispute is extremely polarized in its opinion about the outcome or demands an outright victory, mediation is not considered an acceptable alternative. More often, the parties are seeking to avoid protracted arbitration but also desire a fair resolution of the dispute. When both sides are truly eager to find solutions themselves, why gamble with arbitration?

- **The issues sometimes are too complex to be mediated.** According to another common fallacy, when the factual issues surrounding a dispute are extremely complex, it is believed that only an expert arbitration panel can understand the case sufficiently to determine a fair solution.

  Irrespective of the merits of the case, complexity feeds on itself in a sequence of escalating costs. Attorneys are needed to evaluate the factual complexities in order to protect the parties' legal rights. Document discovery, depositions, and interrogatories become lengthier and more detailed. And outside expert opinion concerning the technical issues of the case becomes justifiably more important.

  When the factual issues of a dispute are so complex that the costs of a lengthy discovery procedure are expected to be quite substantial, the traditional arbitration process often becomes unacceptable. Mediation provides an alternative that saves both money and valuable management time. Senior management who attend and participate in a mediation are accustomed to evaluating factual questions, are most familiar with technical issues, and are capable of making difficult decisions. Consequently, the mediation process provides a setting for the parties to reach their own solution, even in very difficult and complicated cases.

- **Mediation represents a departure from the adversary system.** Perhaps the greatest barrier to the effective use of mediation is our adversarial system of justice. We have been taught to admire fictional heroes who opt for confrontational solutions. Society recognizes the competitive nature of business that produces win/lose results. Similarly, the judicial system encourages people to be competitive in resolving conflicts by encouraging adversarial bargaining.

In addition, even though most attorneys conceptually support mediation principles for certain cases, they are nevertheless highly skilled in positional thinking and adversarial negotiations. Being unaccustomed to the cooperative problem-solving techniques underlying the mediation process, some attorneys may dissuade their clients from engaging in mediation, viewing it as a stalling tactic or fact-finding mission to strengthen the adversarial party's bargaining position.

A Practicable and Efficient Alternative

Critics of arbitration point out that the process is litigation by another name. It is expensive and time consuming, and arbitration panels are thought to have a tendency to award compromise settlements, often with inconsistent results. So why do parties decide to spend the time and money to have an arbitration panel impose a solution on them instead of relying on their own skills to work out a resolution that is mutually acceptable? The answer may be due to prevailing misconceptions about mediation and lack of recognition that mediation really works in improving the chances of obtaining a fair, reasonably quick, less expensive private resolution for a wide range of issues.

Nonetheless, mediation is not suitable in every situation. Parties seeking rescission or reformation based on fraud or misrepresentation are examples of matters that will not be resolved in mediation. Also, if the goal is to establish a clear victory or teach the other party a lesson, mediation most likely should be avoided. In other cases, one party may be unwilling to mediate the dispute or the parties may have become so positioned in their thinking that cooperative decision making is not possible or practical. And in some instances, good-faith negotiations in mediation just do not produce a mutually acceptable determination.

Arbitration as a forum to settle reinsurance disputes will not fade away. The arbitration process has served the industry well for many years and will continue to be the best alternative for certain kinds of intractable disputes. However, with a growing awareness of how mediation can work to efficiently and justly resolve many disputes, industry practitioners are learning what kinds of cases are more likely to be resolved by mediation. Much more needs to be accomplished through educational endeavors to promote the benefits of mediation before the process will be embraced as a customary alternative to arbitration. ■

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