CPCU SOCIETY INSURING YOUR SUCCESS

Reinsurance Interest Group

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Reinsurance Encounters

Message from the Chair

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

Thomas M. Pavelko, CPCU, J.D., ARe, is assistant general counsel, contracts and regulatory, for American Agricultural Insurance Company (AAIC), where he has worked for more than 10 years. Previously, he ran an active law practice for 15 years. Pavelko earned his J.D. from Washington University School of Law in St. Louis, Mo., and his bachelor's degree from Marquette University in Milwaukee, Wis. He is currently chair of the Reinsurance Interest Group Committee. In the past, he served on the board of the CPCU Society Chicago-Northwest Suburban Chapter and was its president in 2006–2007.

Welcome to another fine edition of *Reinsurance Encounters*. The authors tackle such critical topics as allocation of continuous damage claims, reinsurance arbitration and globalization of education. Each edition of *Reinsurance Encounters* reminds me that there is a wealth of collective knowledge out there, and we simply need opportunities to tap into it.

The Reinsurance Interest Group Committee is doing its part to provide those opportunities.

Our February Chicago workshop was postponed due to inclement weather. This half-day workshop is now scheduled for the morning of May 5, 2011, at the downtown Chicago offices of DLA Piper. It will include a panel discussion of reinsurance professionals representing reinsurance providers, buyers and brokers, and will also include a panel of reinsurance claim executives. The local reinsurance professionals' group REACH will have its quarterly lunch and presentation immediately following this workshop.

On March 30–31, 2011, the Reinsurance Interest Group will sponsor its annual Reinsurance Symposium in Philadelphia. This year's event, which is entitled "Decade of Disasters — Impact on the Reinsurance Industry," will take place at The Union League of Philadelphia.

At the symposium, we will take an extended look at the decade from 2001 to 2010. History may label it the "Decade of Disasters," which began with 9/11, continued with unprecedented Atlantic hurricanes, and then concluded with tsunamis, earthquakes, economic crises and the Deepwater Horizon disaster. This symposium is a Reinsurance Interest Group premier event.

The program begins on Wednesday, March 30, with a welcome cocktail and networking reception. On Thursday morning, the formal presentations begin with an executive panel discussion. **Franklin W. Nutter, J.D., ARe,** Reinsurance Association of America, will moderate. Panelists will include **Pina C. Albo,** Munich Re; **John Bender,** Allied World Re; 2010–2011 CPCU

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What's in This Issue

Message from the Chair

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Society President-Elect **Steve McElhiney, CPCU, MBA, ARe, AIAF,** EWI Risk Services Inc.; and **William O'Farrell, J.D.,** ACE Group.

Next, **Laline Carvalho,** an analyst with Standard & Poor's, will discuss the effects of this historic decade on the reinsurance industry and how the credit rating agencies have reacted. Lunch will graciously be sponsored by Munich Re and includes a ceremony for recent ARe completers and a keynote address by **Anita Z. Bourke, CPCU, CPIW,** executive vice president of The Institutes.

The afternoon session includes **Sharon A. Binnum, CPA,** Citizens Property Insurance Corporation, who will provide the unique perspective of a Florida insurer; **Wayne Keebler, CPCU, ARe,** Wright Risk Management, who witnessed the events at the World Trade Center on 9/11; **H. Wesley Sunu, J.D.,** Tribler, Orpett & Meyer PC, who will present the legal and regulatory implications of disasters; and **Tom Toth,** Munich Re Claims, who will discuss the property claims implications of this decade.

At the CPCU Society Annual Meeting and Seminars, Oct. 22–25, 2011, in Las Vegas, Nev., the Reinsurance Interest Group will conduct its acclaimed "Reinsurance — State of the Art" seminar. This is a terrific opportunity to hear executive-level personnel from every facet of the reinsurance industry discuss current events, the state of the market and issues that keep them awake at night. We also intend to host a dinner at the Annual Meeting, which will include a presentation on items of interest to the CPCU Society membership.

In addition to these events, the Reinsurance Interest Group regularly issues this newsletter and hosts a website for the benefit of the CPCU Society's membership. The newsletter editor, **Richard G. Waterman, CPCU, ARe,** does a superb job securing and editing content. If you have ideas for future articles or would like to write one yourself, please contact him. Additionally, as emerging topics arise, we are ready to conduct timely informative webinars. The CPCU Society will notify you when webinars are scheduled.

There is a wealth of knowledge out there. I hope you will take part in all that the Reinsurance Interest Group offers and tap into it. If you have additional ideas or would like to help add to the value of our interest group, please let me know. ■

REINSURANCE INTEREST GROUP SYMPOSIUM • PHILADELPHIA, PA.

Decade of Disasters — Impact on the Reinsurance Industry

March 30–31, 2011

The Union League of Philadelphia • Philadelphia, Pa.

Symposium Speakers

Pina C. Albo, Munich Re

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Sharon A. Binnun, CPA, Citizens Property Insurance Corporation

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

Tom Toth, Munich Re Claims

Luncheon Keynote Speaker

Anita Z. Bourke, CPCU, CPIW, The Institutes

Registration Fees

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

Registration fee includes all refreshments, networking reception and luncheon.

For Additional Information

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

Editor's Comments

by Richard G. Waterman, CPCU, ARe

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

Reinsurance underwriters and poker players have a great deal in common. Poker players make strategic decisions on the basis of imperfect information. Sound familiar? Decisions are informed by their assessment of the probability that they hold the best set of cards. Exact calculations of the probability are impossible. Therefore, poker players must use judgment to estimate the probability of obtaining the best cards among all players.

Similarly, experienced reinsurance underwriters engage well-calibrated judgments, including statistical analysis where appropriate, in the assessment of risk and determining the probability of maximizing underwriting profits based on imperfect and limited information. Consequently, many aspects of underwriting and poker playing necessitate complex probability judgments with an element of uncertainty that is informed by specialist knowledge and experience.

Not too dissimilar to a game of chance, professional skill and experience play an important role in making complex strategic decisions in determining how to share the pain by allocating continuous damage claims among other insurers, reinsurers and the policyholder. The lead article in this issue, "A Primer on Allocation Methodologies — The 'All Sums' and Various 'Pro Rata' Approaches," by **Scott M. Seaman, J.D.,** and **Jason R. Schulze, J.D.,** partners in the law firm of Meckler Bulger Tilson Marick & Pearson LLP, is the second in a series of articles related to allocation methodologies of continuous damage losses among the triggered contracts and the policyholder.

Follow form provisions are frequently incorporated in excess insurance and reinsurance policies by referencing the terms and conditions of the underlying policy. **William J. Warfel, CPCU, Ph.D., CLU,** a professor of insurance and risk management at Indiana State University, explains in his article, "Bridging the Gap," the significance of follow form provisions in excess policies and how coverage is triggered when underlying limits are exhausted.

Regular *Reinsurance Encounters* contributor **Andrew S. Boris, J.D.,** with the law firm Tressler LLP in Chicago, authored another very interesting article for this issue titled, "Limits to the Decisions that Arbitrators Make?". The article explains that there are boundaries to the honorable engagement clause included in many reinsurance contracts and limits to arbitrators' authority, notwithstanding their power to issue awards with a view of effectuating the general purpose of the parties in a reasonable manner rather than in accordance with the literal interpretation of contract language.

The strategic decision to arbitrate a reinsurance dispute frequently is also based on imperfect and incomplete information. **Michael S. Olsan, J.D.,** a partner with the law firm White and Williams LLP in Philadelphia, explains in his article, "Altering the Structure of Reinsurance Arbitrations — Are Old Habits Too Hard to Break?", several alternative methods to resolve reinsurance disputes. Among them are arbitration before a single arbitrator, "baseball" arbitration and a mediator-arbitrator settlement conference.

Connor M. Harrison, CPCU, ARe, director of custom products for The Institutes (previously known as the American Institute for Chartered Property Casualty Underwriters and the Insurance Institute of America) presents the article "The Globalization of Insurance Education," which provides illuminating information about The Institutes' Associate in Reinsurance (ARe) educational program.

And finally, for those interested, to estimate the probability of obtaining the best cards in Texas Hold 'em Poker, typically played with a maximum of 10 people per table, there are 1,326 unique starting hand combinations, 19,600 (3-card) flop combinations and 2,118,760 (5-card) community card combinations to consider. Las Vegas here we come! ■

A Primer on Allocation Methodologies — The 'All Sums' and Various 'Pro Rata' Approaches

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

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

Jason R. Schulze, J.D., is a partner at Meckler Bulger Tilson Marick & Pearson LLP in Chicago. He represents insurers and reinsurers in a variety of matters, including mass tort, environmental, construction and professional liability claims. Schulze can be contacted at jason.schulze@mbtlaw.com

In the December 2010 issue of *Reinsurance Encounters*, we addressed the issue of trigger of coverage. After the court determines which contracts are triggered by a particular claim or group of claims, it must then determine how to allocate or apportion the loss among the triggered contracts and the policyholder. Complex allocation issues often are presented by "long-tail" or "delayed manifestation" insurance coverage claims. In this article, we address the most fundamental issue of allocation — the allocation method to be employed. In many jurisdictions, defense costs and indemnity are allocated in the same manner, but that is not always the case.

The 'All Sums' Or 'Joint and Several' Allocation Approach

Policyholders generally advocate the "all sums" approach to allocation — which also is commonly referred to as the "joint and several" or "vertical spike" approach. Under this allocation methodology, any triggered contract is liable for the full extent of the insured's damages, subject to the contract's limits of liability. The policyholder may "pick and choose" the insurance contracts to provide coverage for the loss. This maximizes policyholders' flexibility in settlement discussions, allowing it to target many insurers regardless of policy year or policy attachment point.

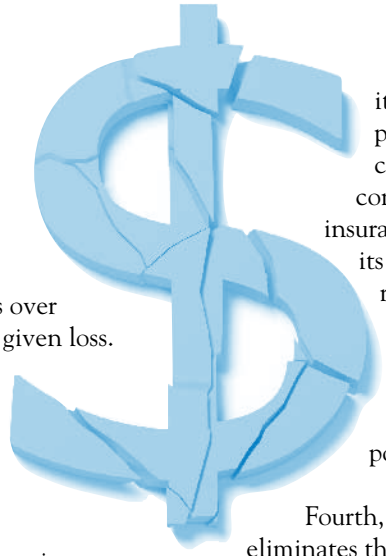
The policyholder selects a year and proceeds vertically up the coverage chart in that year until its loss is fully covered. This permits the policyholder to minimize the amount allocated to it, as it is able to take into account factors such as the amount of any self-insured retentions, the limits of coverage, prior impairment, and the availability of insurance in determining the period in which to drive its "vertical spike." It can avoid multiple retentions, insolvent insurers, and otherwise seek to maximize its recovery.

The genesis of the "all sums" or "joint and several" allocation of losses is the decision of the United States Court of Appeals for the District of Columbia in *Keene Corp. v. Ins. Co. of North America*, 667 F.2d 1034 (D.C. Cir. 1981). In *Keene*, the court held that coverage for asbestos-related bodily injury is triggered during any part of the injurious process from initial exposure to asbestos through manifestation of disease (i.e., a continuous trigger).

Next, it considered the scope of coverage or allocation. Relying upon the "all sums" language of the insuring agreement in the contracts, it determined that each insurer is liable for the full extent of the policyholder's damages subject to its applicable limits of liability and that the policyholder does not bear any share of the liability for uninsured periods. The policyholder's so-called "reasonable expectations" provided a basis for the court to reject the argument that the policyholder should bear a share of its own liability for periods in which it was uninsured.

Importantly, some "all sums" decisions (like *Keene*) limit the policyholder to picking a single year of coverage to recover for an occurrence. So, if the loss is $40 million and the year with the highest limits is $30 million, the insured would be responsible for $10 million. Other decisions, such as *J.H. France Refractories Co. v. Allstate Ins. Co.*, 626 A.2d 502, 509 (Pa. 1993), allow an insurer to "stack" or to select a second year if the first year does not provide sufficient limits to cover a loss. In either case, the policyholder must satisfy any retentions for the period it selects. Thus, even the imposition of "joint and several liability" does not necessarily ensure a full recovery to a policyholder.

'Pro Rata' Allocation



The majority and emerging view of decisions rejects the "all sums" approach in favor of prorating losses over the years triggered by a given loss. Insurers commonly advocate for a "pro rata" allocation and have several arguments in their favor, including the following. First, insurers point out that the "all sums" approach is based upon an improper reading of policy language because it selectively relies upon the "all sums" language in pre-1986 commercial general liability contracts, while ignoring the express limitation to damages or injuries "during the policy period." Many excess contracts are written on an "ultimate net loss" basis and do not even contain "all sums" language, and the "all sums" language was changed to "those sums" by ISO in the CGL form beginning in 1986.

Second, an "all sums" allocation is inconsistent with the continuous trigger and injury-in-fact triggers as applied by many courts. Policyholders should not be permitted to implicate multiple periods in arguing for a multiple policy "trigger" on one hand and then on the other hand artificially truncate the loss by selecting a single year for purposes of allocation.

Third, even if public policy considerations could override the plain contract language, which they should not, public policy nonetheless would require a "pro rata" allocation in which the damages are allocated to, and borne by, the policyholder for periods of no insurance or insufficient insurance. An "all sums" allocation is unfair and, for example, may result in an insurer being liable for the entire loss even where it was on the risk for only one day. In contrast, it is hardly unfair for the policyholder to bear the consequences of its decisions concerning the purchase of insurance and the managing of its liabilities (e.g., decisions relating to self-insurance, under-insurance, the amount of limits purchased or prior exhaustion based on other claims against the policyholder).

Fourth, a "pro rata" approach eliminates the need for reallocation among insurers through cross-claims in the coverage action or in separate litigation. The reality of reallocation properly makes insurers resistant to settling with policyholders based upon the assumption that the insurer is liable for the entire loss. Many times, the imposition of "joint and several liability" serves only to spawn additional litigation and to hinder settlement in complex coverage actions.

The Various 'Pro Rata' Allocation Methods

Courts have applied a variety of "pro rata" allocation methods. The method used may have a significant impact to the policyholder and the various insurers.

- **'Fact-Based' Allocation.**
  The most accurate allocation method, and the one that most closely adheres to the requirements of most insurance contracts, is to determine precisely what injury or damage took place during each contract period or uninsured period and allocate the loss accordingly. Although such an allocation is the most consistent with the contract language, the inability to make such determinations or the litigation costs associated with such an exact allocation has caused courts to use various proxies for deriving a fair apportionment.
- **'Time On The Risk.'**
  'Pro rata' allocation based upon the relative duration of each insurance contract as compared with the overall period during which damages or injuries took place is a common method of proration.
- **'Time and Limits' Method.**
  Apportionment that considers both the insurance contract's relative time on the risk, as well as the contract's limits of liability, has been adopted by some courts. Essentially, this is proration based upon contract limits multiplied by years of coverage.
- ***Owens Illinois/Carter Wallace* Allocation.**
  Allocation under the *Carter-Wallace v. Admiral Ins. Co.*, 712 A. 2d 1116 (N.J. 1998) and *Owens-Illinois v. United Ins. Co.*, 650 A 2d 974 (N.J. 1994) decisions of the New Jersey Supreme Court applies a "pro rata" allocation that takes into account time on the risk and the degree of risk assumed. First, the damages are allocated to each year or period. The formula for this step is as follows: damages allocated to each year equals total limits of insurance coverage in the year (including self-insurance) divided by the total combined limits of the insurance program during the triggered period (including self-insurance) multiplied by the amount of the total damages. Second, the damages allocated to each year or contract period are allocated to the contracts or self-insured retentions on a ground-up basis. In other words, the damages allocated to each year are first allocated to any self-insured retentions or primary contracts, then to first-level excess contracts, and then to additional levels of excess insurance vertically through the ascending levels of insurance. Under this method, larger sums are allocated to years in which the insurance limits are greater, essentially using the relative amounts of insurance

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limits in the various years as a proxy for the degree of perceived risk.

There are a variety of other methods sometimes used in reallocation battles among insurers such as: Apportionment is based upon the amount of premiums paid for the insurance contracts; apportionment among insurers by equal shares regardless of time on the risk, limits, or premiums is another method of proration.

The Policyholder Is Required to Participate in the Allocation

One important feature of a "pro rata" allocation is that courts adopting this type of allocation require the policyholder to participate in the allocation. Where the property damage or bodily injury at issue takes place over many years, thereby triggering multiple periods of coverage as well as years in which there is either no coverage, insufficient coverage, or coverage that was issued with an applicable exclusion, courts require the policyholder to bear the financial burden for those periods of no insurance, self-insurance or insufficient insurance. The vast majority of decisions applying a "pro rata" allocation methodology requires that the policyholder contributes for uninsured periods regardless of whether applicable insurance was "available" or "unavailable" in the marketplace.

A small minority of courts has carved out a narrow exception to the natural consequences of a "pro rata" allocation that the policyholder always bears the consequences of no insurance or insufficient insurance. These courts have held that the policyholder may not be responsible for periods where insurance coverage was not available. The few decisions recognizing an "unavailability" exception have been limited to instances involving later years where a policyholder was unable to obtain coverage in the marketplace for a particular risk and with respect to losses resulting from activities or products placed into commerce before such time as coverage became "unavailable" due to pollution and asbestos exclusions. Although policyholders have attempted to use a limited "unavailability" exception as an opportunity to avoid the rationale and natural consequence of a "pro rata" allocation, to date such attempts have been unsuccessful.

The vast majority of decisions applying a "pro rata" allocation methodology require that the policyholder contribute for uninsured periods regardless of whether applicable insurance was "available" or "unavailable" in the marketplace.

Numerous Other Issues Impacted Allocation

To be sure, the allocation method employed is a very important variable in allocating losses, but it is not the only one. Other issues impacting the allocation include: number of occurrences; treatment of multiyear contracts and stub periods; impact of insurer insolvencies and policyholder bankruptcies; the allocation start and stop dates; coordination of coverage among the various lines of insurance (e.g., occurrence-based CGL and claims-made EIL coverage); proper characterization of costs as defense or indemnity; proper exhaustion (whether vertical or horizontal); determining the sums to be allocated (e.g., excluding non-covered costs and evaluating and discounting future costs); determining how to credit settlements involving other insurers; and reallocation, if any, among triggered policies. ■

Bridging the Gap

by William J. Warfel, CPCU, Ph.D., CLU

William J. Warfel, CPCU, Ph.D., CLU, is a professor of insurance and risk management at Indiana State University's Scott College of Business. His articles have appeared in *Risk Management* magazine, *CPCU eJournal* and *The John Liner Review,* among others. Warfel frequently is called to testify as an expert witness in breach of contract, bad faith and agent/broker errors and omissions cases. He can be reached at wwarfel@indstate.edu.

Editor's note: This article is an abridged version of the CPCU Society's October 2008 *CPCU eJournal,* Vol. 61, No. 10, written by William J. Warfel, CPCU, Ph.D., CLU. © 2008 CPCU Society. Warfel re-titled, updated and condensed this *CPCU eJournal* article for *Reinsurance Encounters.*

Follow Form vs. Stand Alone Excess Liability Insurance

Commercial policyholders customarily rely upon a follow form excess liability policy to address a catastrophic claim. To assure that the excess policy serves this purpose, a follow form provision is usually contained in the excess policy. The terms of coverage contained in the primary policy are thereby incorporated by reference into the excess policy unless a provision to the contrary is contained in the excess policy.

Coverage disputes have arisen in cases where coverage clearly is provided under the primary policy while coverage is excluded by implication under the excess policy. For example, when an excess policy does not contain specific wording that unequivocally excludes specific coverage, inference that coverage is excluded may be based on certain policy language, or the lack thereof, suggesting that coverage is not available under the terms of the excess policy.

To date, a body of case law, in which the courts have upheld the intent and integrity of follow form provisions, appears to be emerging. Commercial policyholders can indeed rely on a follow form excess policy to address a catastrophic claim in the absence of conspicuous wording to the contrary.

Typically, a commercial policyholder purchases at least two layers of liability coverage, oftentimes from the same insurance carrier, for the purpose of addressing various liability exposures connected to its business. The first layer of liability coverage is commonly referred to as primary, or underlying, insurance, and its function is to serve as the first line of defense and indemnity against a claim caused by an accident or occurrence that resulted from an exposure faced by the commercial policyholder, such as the premises exposure or operations exposure.

Generally, the policy limit that applies to this first layer of liability coverage is minimal. Mishaps are bound to occur in connection with any business, but the vast majority of these mishaps result in small-dollar claims. For this reason, the minimal policy limit applicable to the first layer of liability coverage is sufficient to provide insurance coverage for the vast majority of mishaps.

Of course, in a large number of cases, a commercial policyholder is threatened with a lawsuit that is groundless, or where the amount of damages claimed is inflated. Commercial policyholders usually rely on this first layer of liability coverage to provide defense coverage — attorney fees and other costs of litigation — so that a proper response to questionable claims is assured.

In contrast, the second and subsequent layers of liability coverage are commonly referred to as excess or umbrella insurance, and their function is to:

(1) Stand in reserve to back up the primary insurance should the dollar value of a liability claim be unusually large, as may happen were a commercial policyholder to be legally responsible for an uncommon but devastating bodily injury (additional vertical coverage is provided that attaches when the policy limit in the primary insurance is exhausted).

(2) Provide catastrophic coverage in the event that a liability claim is excluded under the primary insurance, but is covered under the umbrella policy (additional horizontal coverage is provided that attaches when the self-insured retention, or deductible, is met by the commercial policyholder). Thus, an umbrella policy is a type of excess policy that not only provided excess coverage but also fills the gaps left by the primary insurance, subject

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Bridging the Gap

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to the self-insured retention, or deductible. Indeed, umbrella coverage has been likened to a circus tent because it covers so much; a pure excess policy simply provides greater limits excess of the primary insurance.

Generally, the policy limit that applies to the second and subsequent layers of liability coverage is substantial. Assuming the (1) inclusion of a follow form provision in the excess insurance, and (2) absence of a conspicuous exclusion that is contained in the excess insurance but not the primary insurance, the assets of the commercial policyholder are sufficiently protected in the event that a rare, catastrophic mishap involving serious damages were to occur.

Most importantly, defense coverage with respect to serious mishaps is assured because the high policy limit contained in the excess policy precludes the insurance carrier from simply paying the policy limit in a high-dollar case for the sole purpose of avoiding the cost of defending a serious liability claim.

Recognition and Significance of Follow Form Coverage

An excess policy that is written on a follow form basis contains a provision that stipulates that the terms, definitions, conditions, limitations and exclusions in the primary policy are incorporated by reference into the excess policy. In this way, the layers of coverage are seamlessly integrated, and redundancies in policy language are avoided. The rights and responsibilities of the insurer under the excess policy are then defined by the primary policy, except to the extent that the excess policy has specific wording contrary to provisions contained in the primary policy.

In cases in which (1) coverage is clearly provided under the primary policy, and (2) coverage is excluded by implication under the excess policy, the issue arises

concerning whether the excess policy was written on a follow form basis. If it was, a case can be made that the applicable primary policy language should control the excess policy coverage. But without a follow form provision, a stand alone excess policy is interpreted based solely on its own agreements, conditions, definitions and exclusions. In short, coverage may be excluded based on the presence, or lack, of a policy provision. While cases of this sort are relatively rare, when such a case does arise, the financial stakes oftentimes are huge, making this determination an important issue.

Follow Form Criteria

Assuming that an excess policy contains a follow form provision, it must meet follow form criteria to qualify as a follow form excess liability policy.

First, the excess policy must match the primary policy in terms of the policy period, the identification of the named insured, the nature of the commercial liability exposure that is addressed and the exclusions.

Second, the excess policy and the primary policy must include the same insuring agreements, and the policy limit in the primary policy must match the retention amount in the excess policy so that coverage under the excess policy is triggered when the primary policy's limit is exhausted. In this way, the excess policy backs up the primary policy in the event of an unusually large liability judgment.

Third, assuming that the same insurance carrier issued both the primary policy and the excess policy, an increased limit factor must be applied to the primary rate for the purpose of determining the excess rate. In this way, the rate per $1,000 for the excess policy is proportionately lower than the rate per $1,000 for the primary policy. This proportionately lower rate per $1,000 for the excess policy reflects the fact that (1) the coverage is the same under the primary policy and the excess policy, and (2) the likelihood that a loss will pierce the policy limit contained in the primary policy is relatively small because most losses are small.

Fourth, assuming that the same insurance carrier issued both the primary policy and the excess policy, the policies must have been issued as companion policies that work in tandem to fully address the commercial policyholder's exposure to loss. For example, the respective policy numbers are similar, there is one billing for both premiums combined. If this is the case, a strong inference is created that the excess policy was written on a follow form basis. The insurance carrier that issued the excess policy knows all the conditions, definitions, agreements, exclusions and limitations of the primary policy, including changes by endorsement and, therefore, should be comfortable from an underwriting standpoint with the concept of incorporating the coverage terms contained in the primary policy into the excess policy.

To the extent that these criteria are met, one can safely conclude that the intent was to write the excess policy on a follow form basis. Otherwise, it will be considered a stand alone policy.

An Illustrative Case

In *Empire Fire and Marine Insurance Company v. Nicholas Keifer, et al.*, Nicholas Keifer was operating a motorhome that was being pushed across the parking lot with a tow truck so it would be ready for auction the following day. Jason Chehi, an employee of Montpelier Auto Auction, was struck by the motorhome, resulting in serious bodily injury.

In the underlying tort action, damages of $1.1 million were awarded based on Keifer's negligence in operating the motorhome, which qualified as a "covered auto." Keifer was not an employee of the auto auction, but was assisting his friend, who was an employee, to move the motorhome. Keifer was a permissive user of the vehicle and, thus, he qualified as an "insured" under the primary policy. While Keifer did not qualify under the definition of an "insured" as expressly defined in the umbrella policy, the policy also did not contain specific wording unequivocally indicating that he did not qualify.

Given that (1) Keifer qualified as an "insured" under the primary policy and (2) the excess policy contained a follow form provision and was written on a follow form basis (the excess policy met the follow form criteria), the court ruled that Keifer did indeed qualify as an "insured" under the excess policy. The definition of "insured" contained in the primary policy, which included all permissive users of a "covered auto," was incorporated by reference into the excess policy because the policy did not contain specific wording that excluded this category.

The question arises concerning why Empire Fire and Marine Insurance Company resisted paying this claim. The obvious reason is that the financial stakes were large. More generally, if the insurers' intent were not to pay this sort of claim, why not change the policy language and make it clear? Only the underwriting executive who drafted the policy can address this question.

For whatever reason, the policy language contained in the excess policy rarely matches exactly the policy language contained in the primary policy. An exact match is rare even in those cases where the same insurer issued both the primary policy and the excess policy. Because unique circumstances, for example, a friend of an employee performing a task that would be normally performed by an employee, cannot be fully anticipated by an underwriting executive who drafts an excess policy, coverage disputes are bound to occur. In general, however, in the absence of a conspicuous exclusion contained in the excess policy to the contrary, the primary policy language controls the excess policy coverage.

Exclusions Must Be Conspicuous

Since commercial policyholders customarily rely upon a follow form excess liability policy to address catastrophic claims, a follow form provision customarily is contained in the excess policy. Under such a provision, the terms of coverage contained in the primary policy are incorporated by reference into the excess policy, unless there is a provision to the contrary in the excess policy.

In cases in which the excess policy is silent, or an inference based on the policy language suggests the existence of an exclusion, insurance carriers have wrongly contended that coverage is inapplicable under the excess policy. Specifically, these insurance carriers have contended that (1) an omission in terms of policy language contained in the excess policy, or (2) the existence of policy language in an excess policy that is different than policy language contained in the primary policy, is sufficient to conclude that the excess policy contains a provision that is contrary to the primary policy.

Commercial policyholders have contended that "contrary" means diametrically opposed to, thus giving rise to a duty on the part of the insurance carrier to unequivocally communicate an exclusion. In other words, an exclusion that is contained in an excess policy that is at odds with the primary policy must be conspicuous.

To date, the courts have sided with policyholders and have allowed follow form excess policies to be used to address catastrophic claims. ■

Limits to the Decisions that Arbitrators Make?

by Andrew S. Boris, J.D.

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

Unfortunately, disputes develop between cedents and reinsurers on a fairly routine basis. These disputes develop for a variety of reasons: (1) a simple breakdown in communication; (2) one party seeking to stretch the limits of a position; and/or (3) a reasonable disagreement over the operation of a reinsurance term or contractual provision. Interestingly, many reinsurance professionals take comfort that an arbitration panel will focus on "intent" or "equity" when addressing the dispute, as opposed to simply reviewing case law.

To that end, many also believe that the presence of an honorable engagement clause in a reinsurance contract certainly supports the belief that a panel does not need to stop its analysis with a review of controlling case law. Although there are different forms of such provisions, many contracts include something similar to:

> [The arbitrators] may interpret this Agreement as an honorable engagement and not merely as a legal obligation. They are relieved of all judicial formalities and may abstain from following the strict rules of law. They will make their award with a view of effectuating the general purpose of the Agreement in a reasonable manner rather than in accordance with the literal interpretation of the language.

The combination of the judicial deference given to arbitration awards and the potential operation of the honorable engagement clause (which some argue should be construed to be quite broad) results in the belief that it is quite hard to challenge an award rendered by an arbitration panel. A recent case by the Third Circuit Court of Appeals addresses some of these issues and establishes some boundaries. See *PMA Capital Ins. Co. v. Platinum Underwriters Bermuda, Ltd.*, No. 09-3963, 2010 U.S. App. LEXIS 23222 (3rd Cir. Nov. 8, 2010).

The facts of the case are relatively straightforward. Platinum Underwriters Bermuda Ltd. ("Platinum") acted as a reinsurer for PMA Capital Ins. Co. ("PMA") pursuant to a reinsurance contract that contained a "deficit carry forward provision." This clause addressed the reinsurance obligations for losses that were carried from one year to the next year of the reinsurance contract. In 2008, a dispute developed between the parties as to the effect and scope of the deficit carry forward provision. The parties were in disagreement as to whether any losses could be carried forward from 1999 through 2001, resulting in a dispute concerning $10.7 million in losses. Platinum subsequently demanded arbitration and requested that the arbitration panel provide clarity as to the operation of the deficit carry forward provision (including issues addressing the future operation of the provision).

After receiving evidence, testimony and oral argument, the arbitration panel issued a one-page order. In the order, PMA was ordered to pay Platinum $6 million within 30 days of the date of the award. Notably, the panel also ordered that all references to a "deficit carry forward" provision in the relevant reinsurance contract be removed effective Jan. 1, 2003. In addition, the panel ruled that any future rights or claims associated with such a clause were extinguished. PMA subsequently challenged the award in the federal district court in the Eastern District of Pennsylvania. The district court vacated the award and an appeal to the Third Circuit Court of Appeals followed.

The principal challenge to the arbitrators' award, both in the district court and before the Third Circuit Court of Appeals, was that the arbitration panel exceeded its power when it awarded $6 million and essentially eliminated the deficit carry forward provision in the contract. The Third Circuit Court of Appeals agreed with the district court's reasoning in vacating the arbitration panel's order.

First, it found that the panel exceeded its power because the relief granted was not sought by either party during the arbitration proceedings.

Second, the court found that the relief provided was "completely irrational" because it wrote material terms of the contract out of existence (after relying upon them to grant monetary relief).

Third, the court also concluded that the honorable engagement clause did not empower the arbitrators to issue the order in question.

With respect to the honorable engagement clause, the court specifically noted that the arbitrators may have been relieved from judicial formalities, but it did not give them the ability to "reinvent" the contract that was placed at issue before them.

This case is instructive and also raises some questions for future arbitrations. The courts presented with this case paid particular attention to the relief that was requested by the parties during the course of the arbitration when evaluating whether the arbitration panel exceeded its authority. Unfortunately, arbitration demands can, at times, be hastily completed to meet deadlines. In addition, parties may not devote adequate time to assess the far-reaching implications of arguments advanced during the course of an arbitration.

This case reminds all involved in the arbitration process of the importance of the arguments advanced (and relief requested) in an arbitration. Of interest, the arbitration award that was subject to review in this case was one-page long and did not provide any reasoning or explanation (which is quite common). There must be some question as to whether the court would have approached the questions presented in the same manner had the panel issued some form of reasoned award with an explanation. It is hard to know whether it would have made a difference, but a court might have been persuaded that the panel did not exceed its authority if the panel explained why it got to the conclusion that it reached.

Finally, for those that profess that the presence of an honorable engagement clause in a reinsurance contract gives a panel near unfettered authority, this case provides an argument in opposition. ■

Altering the Structure of Reinsurance Arbitrations — Are Old Habits Too Hard to Break?

by Michael S. Olsan, J.D.

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Introduction

For over a century, reinsurance disputes, as rare as they may have been in the past, have been resolved through arbitration as opposed to litigation. Ceding companies and reinsurers alike felt so strongly about this method of dispute resolution that it became commonplace to include an arbitration clause in most reinsurance contracts, and this practice largely continues today. Given the important and ongoing business relationship between cedent and reinsurer, arbitration was seen as a better way to resolve disputes.

Some of the advantages to arbitration, which continue to this day, include:

(1) Having a case decided by experienced and knowledgeable decision-makers rather than a judge or jury to whom reinsurance is foreign.

(2) Maintaining the confidentiality of the dispute.

(3) Providing a method of dispute resolution generally considered to be more economical and efficient.

(4) Basing an award on custom and practice in the industry rather than simply on the literal meaning of the contract itself or on applicable state law.

Recently, however, with the proliferation of reinsurance arbitrations combined with increased contentiousness and expense, some in the industry have begun to question the efficacy of arbitration. Among the reasons for this disillusionment include:

(1) The fact that interim procedural rulings are unpredictable.

(2) A few select arbitrators are used over-and-over again by the same party.

(3) There are insufficient ethical boundaries and restraints on arbitrators.

(4) Some arbitrators have an economic incentive to rule in favor of the party most likely to appoint them in the future.

(5) The willingness of certain panel members to issue a compromise award.

These issues have caused some parties to contemplate eliminating arbitration clauses from new reinsurance contracts altogether. But maybe this drastic measure can be avoided and the current concerns about arbitration can be resolved by altering the structural way in which arbitrations are conducted.

The purpose of this paper is to introduce some structural alternatives to what has become the typical arbitration process with two-party appointed arbitrators and an umpire; a process largely controlled by the parties and not the arbitrators, as originally envisioned. Some or all of these structural changes can be achieved under old contracts by agreement of the parties and should be considered by companies when negotiating renewals or new reinsurance agreements.

The Origins of the Three-Member Panel with Two-Party Appointed Arbitrators and an Umpire and the Increased Frequency of Arbitrations

Since the early 1800s, particularly in English marine reinsurance disputes, the reinsurance industry has been using arbitration as a dispute resolution mechanism.[1] The utilization of a three-

member panel is similarly historic. For example, a Munich Reinsurance Company contract from 1895 contained the following provision:

> In the event of any difference hereafter arising between the contracting parties with reference to any transaction under this treaty the same shall be referred to two Arbitrators who are to be chosen amongst the Managers or Secretaries of Accident Insurance Companies, one to be chosen by each Company and to an Umpire chosen by the said two Arbitrators, who shall interpret the present contract rather as an honourable engagement than as a merely legal obligation, and their award shall be final and binding on both parties.[2]

Historically, the industry turned to arbitration, utilizing arbitrators experienced in the business, in part to maximize the chances of resolving a dispute without jeopardizing a business relationship.[3] Before the 1990s, arbitrated disputes were the exception, as cedent and reinsurer worked to amicably resolve any disputes in the interest of their ongoing business relationship.[4] It is not surprising then that the parties had a level of trust that the panel would be selected as envisioned when the treaty was underwritten and not in a way to "game the system," with each side vying for control and undue advantage.

This historical approach dramatically changed with the increase in cessions involving environmental, asbestos and other long-tail claims, coupled with the fact that an increasing number of ceding companies and reinsurers were in runoff. With runoff, the goal of maintaining a future relationship was gone, the need for arbitrations increased, and contentiousness — both in panel formation and in the arbitration process as a whole — rose.

As the stakes got higher, arbitration began to look more like litigation, starting with maneuvering for the "best" panel, similar to some litigants who engage in forum shopping. This maneuvering tactic became most prevalent in umpire selection, as many parties began to feel that the case could be won or lost depending upon the umpire. Many contracts, including the 1895 Munich Re treaty referenced above, require the two party-appointed arbitrators to choose the umpire.

Notice that the umpire was to be selected by the **arbitrators,** not by the parties or counsel. In many contracts that contain a similar provision, it is only if the two arbitrators cannot agree on an umpire that some alternative method, like drawing lots, is undertaken. In other words, drawing lots was designed to be a last resort. Now, however, drawing lots has become the norm, is done with the heavy influence of counsel or the parties, and is often viewed as a mechanism for parties to "game the system."[5] This method of panel selection may also provide an avenue for delay, minimizing one of the advantages of arbitration — quick resolution.[6]

While there are alternatives to this usual arbitration structure, some of which are discussed below, the wheels of change move so slowly that it may be years (or even decades) before we see any real shift in the structure of reinsurance arbitrations. Of course change can come in different shapes and sizes, including how a panel is selected, the number of arbitrators, the role of the arbitrators and the general procedures followed throughout the course of the proceeding.

Arbitration Before a Single Arbitrator

One obvious alternative to the three-person panel is to have a single arbitrator. In the United Kingdom, for example, a single arbitrator is the default mechanism when there is no agreement between the parties or contract provision mandating the number of members on the panel. As the U.K. Arbitration Act of 1996, § 15(3) provides: "If there is no agreement as to the number of arbitrators, the tribunal shall consist of a sole arbitrator."[7] Of course, an obvious benefit to a single arbitrator proceeding is economics; each party pays for half an arbitrator instead of one-and a half arbitrators (party-appointed plus half the umpire).

Where the rubber hits the road in the single arbitrator proceeding is the method of selection. There are some organizations, such as American Arbitration Association (AAA), that provide procedures for the selection of the arbitrator.[8] Pursuant to section R-15 of AAA's Procedures for the Resolution of Intra Industry U.S. Reinsurance and Insurance Disputes Supplementary Rules, "if the arbitration agreement does not specify the number of arbitrators, the dispute shall be heard and determined by one arbitrator, unless the AAA, in its discretion, directs that three arbitrators be appointed."[9] The appointment of a single arbitrator may be achieved in accordance

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with Rule R-11(a) and (b) of AAA's Commercial Arbitration Rules.[10] Under that provision:

> (a) If the parties have not appointed an arbitrator and have not provided any other method of appointment, the arbitrator shall be appointed in the following manner: The AAA shall send simultaneously to each party to the dispute an identical list of 10 (unless the AAA decides that a different number is appropriate) names of persons chosen from the National Roster. The parties are encouraged to agree to an arbitrator from the submitted list and to advise the AAA of their agreement.
>
> (b) If the parties are unable to agree upon an arbitrator, each party to the dispute shall have 15 days from the transmittal date in which to strike names objected to, number the remaining names in order of preference and return the list to the AAA. If a party does not return the list within the time specified, all persons named therein shall be deemed acceptable. From among the persons who have been approved on both lists, in accordance with the designated order of mutual preference, the AAA shall invite the acceptance of an arbitrator to serve. If the parties fail to agree on any of the persons named, or if acceptable arbitrators are unable to act, or if for any other reason the appointment cannot be made from the submitted lists, the AAA shall have the power to make the appointment from among other members of the National Roster without the submission of additional lists.[11]

While the parties and counsel have a role in this method of arbitrator selection, the fact that the original slate is chosen for them should reduce each party's ability to "game the system" and will decrease the "over-use" of certain arbitrators.

The recently enacted AIRROC Dispute Resolution Procedure similarly offers a mechanism for the selection of a single arbitrator.[12] Under that Procedure, AIRROC will select 15 names at random from its list of approved arbitrators, or from an alternative list as agreed by the parties, and submit a disclosure form for those candidates to complete.[13] Once those disclosure forms are returned, AIRROC will notify the parties about those candidates available to serve.[14] Each party will then select just over half of the candidates on the list (e.g., if 11 candidates remain on the list, each party will select six and exchange those names.[15] By selecting just over half, there will be at least one common name on each list.[16] If there is just one match, that person will be the arbitrator.[17] If there is more than one match, AIRROC will decide the arbitrator by lot among the matched candidates.[18]

The Insurance and Reinsurance Dispute Resolution Task Force provides another appointment method for a single neutral in the Procedures for the Resolution of U.S. Insurance and Reinsurance Disputes ("Procedures"). Pursuant to the Alternative Streamlined Procedures contained in the Procedures, selection of the neutral is as follows:

(1) Each party submits a list of eight candidates.

(2) Questionnaires are sent to each candidate.

(3) Each party strikes the other party's list down to three arbitrators.

(4) If there is a common individual, that person is the arbitrator.

(5) If there is more than one common individual, the parties draw lots to select the arbitrator.

(6) If there are no common individuals, each party ranks the six candidates in order of preference (1 being the most preferred) and exchange rankings.[19]

The individual with the lowest combined number is the arbitrator.[20] If there is a tie, the parties draw lots to select the arbitrator.[21]

Finally, ARIAS' Newer Arbitrator Program contains an option for expedited proceedings with a single arbitrator

selected from the newer arbitrator list.[22] The neutral is selected in accordance with the ARIAS Umpire Selection Procedure.[23] Briefly, the process for selecting the neutral consists of:

(1) Obtaining a random list of candidates from ARIAS.

(2) Sending a questionnaire to the first 10 candidates.

(3) Each party selecting five candidates from the list of 10.

(4) Each party selecting three candidates from the other party's list of five.

If there is one name appearing on both lists, that person will be the neutral. If there is more than one common candidate, the neutral is selected by drawing lots. If there is no common candidate, each party will rank the candidates, with the person with the lowest number being named the neutral.[24]

In a single arbitrator proceeding, there may be some time savings. First, for the purposes of scheduling, there is only one calendar with which to contend (in addition to counsel and parties) instead of three. Second, during the course of the arbitration, there is no conferring necessary among decision-makers so discovery or evidentiary rulings may be made quicker. Third, following the hearing, there is no debate among decision-makers so deliberations may be shorter. Fourth, there may be less chance of a compromise award.

There are many who believe that compromise awards are becoming all-too-frequent and are not serving the needs of the parties. One philosophy is that three-person panels issue compromise awards as a way to achieve a unanimous result or as a consequence of one of the two party-appointed arbitrators exerting some influence on the umpire. With only one arbitrator, those reasons for compromise awards disappear.

The Mini-Trial — A Chance for Resolution

The mini-trial was born in 1977 in an effort to resolve a complex patent dispute between TRW Inc. and Telecredit Inc.[25] The Telecredit case had languished in court for years with no imminent trial date set.[26] The parties had each spent several hundred thousand dollars in legal fees and decided there must be another way to resolve the dispute.[27] Over several months, the parties negotiated a procedure for a mini-trial.[28] Once there was an agreement over the procedure, the mini-trial itself took place over a two-day period.[29] After the respective presentations, the parties were able to achieve a settlement within a half-hour.[30]

The basic premise of the mini-trial is to provide an opportunity to a senior executive from each party to assess the strengths and weaknesses of the case in a controlled environment that is not emotionally charged.[31] The senior executives who participate should not be involved in the underlying claim that is at the heart of the dispute.[32] This helps to remove the emotions that the day-to-day handlers have in the dispute.

In a mini-trial, a business executive from each party, as well as a neutral, jointly selected by the parties, sit on a panel to hear the dispute.[33] In Telecredit, each party nominated two people to act as a neutral and then came to an agreement as to whom should be appointed.[34] Subsequently, the parties engaged in an expedited period of targeted discovery, including a limited exchange of documents and abbreviated depositions of key witnesses.[35]

Typically, counsel present each side's "best case;" however, on occasion, witnesses, fact and/or expert, may be used.[36] Questions may be asked by any of the panel members, including the neutral.[37] To make sure the case that is presented is the most comprehensive possible, it is best if the mini-trial takes place towards the end of discovery.[38] Following the presentations, the two business executives meet in an attempt to achieve some amicable resolution.[39] To the extent the executives cannot reach a compromise, they can request the neutral to provide a nonbinding advisory opinion setting forth the strengths and weaknesses of each side's case.[40] Once that advisory opinion is reviewed, the parties may return for another round of negotiations.[41]

The mini-trial process is designed to be flexible rather than a one-size-fits-all.[42] The parties are free to agree on the rules and procedures that will apply to the mini-trial.[43] Although the selection of the umpire in an arbitration is often viewed as the "game changer," the nonbinding nature of the mini-trial puts the neutral in a different light. The neutral should have technical expertise with respect to the issues in dispute and should be someone who both parties respect.[44] Generally, the parties agree that the mini-trial is confidential, that rules of evidence will not apply, and that the scope of evidence presented should not be limited, even if it may be precluded in litigation or arbitration.[45] This elimination of restrictions ensures that the business executives fully appreciate the strengths and weaknesses of both side's case.

An important component of the mini-trial is that it is confidential.[46] This is of critical importance, especially when the procedure is nonbinding.[47] Each party needs assurance, for example, that the neutral's opinion about each side's strengths and weaknesses, and about a likely outcome, to the extent given, is not used in the later arbitration or litigation.[48]

While most mini-trials are nonbinding in nature, there is nothing to prevent the parties from agreeing in advance to make it binding. The parties could agree

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that the business executives will first attempt to reach a resolution, but if that is not achievable, the neutral will issue a binding award. The downside to such an approach is that the selection of the neutral becomes all the more important, which can lead to more contentiousness in the neutral selection process. The prospect of an amicable resolution, however, may outweigh this risk.

Even if there is no final resolution of the dispute following the mini-trial, it can help to narrow the issues that need to be litigated or arbitrated. While some have argued that an unsuccessful mini-trial just adds to the cost of an already expensive litigation or arbitration,[49] others argue that the work done in preparation for the mini-trial needed to be done anyway so any additional cost (i.e., the neutral) is minimal.[50]

'Baseball' Arbitration

As the name suggests, the origin of "baseball" arbitration is Major League Baseball. Certain players in Major League Baseball are eligible for salary arbitration.[51] Prior to the arbitration, the team and the player each submit a proposed salary figure to the panel of three arbitrators.[52] At the hearing, each side presents its case in support of the figure submitted and each side has an opportunity to rebut the other's case. Following the hearing, the Panel only has authority to order one salary or another — that's it.[53]

"Baseball" arbitration can be applicable to other fields, including reinsurance disputes. It could be particularly useful if a reinsurer acknowledges it owes an amount of money to its ceding company, albeit less than the amount claimed by the ceding company. In such a scenario the two sides can present their case to a panel of arbitrators and the arbitrators can award either the amount the reinsurer submitted or the one submitted by the ceding company. This would, of course, eliminate any risk of a compromise award. However, this type of arbitration would be unworkable if, for example, the reinsurer claimed to owe nothing or was seeking declaratory relief or rescission. In other words, "baseball" arbitration would appear to be less appealing if the parties are at opposite extremes.

There are a couple of variations on the "Baseball' arbitration theme that parties may wish to consider. One alternative would be where two amounts are presented to the Panel, but those amounts form a high and a low for the Panel such that it can award either extreme or any number in between. Similarly, the parties can decide on a high and a low figure about which the Panel is unaware. In that case, the parties decide on the highest amount the party seeking damages can recover and the lowest amount. If the Panel awards an amount higher or lower than the extremes, the high-low number will apply. If the Panel awards anything in between, that is the amount that will be awarded. Again, compromise awards under this scenario would be minimized and there would be less risk that the umpire (or party appointed arbitrators) would rule out of a sense of loyalty to one party or the other.

Mediator-to-Arbitrator or Arbitrator-to-Mediator

In litigation, a potential conflict may present itself if the judge who will act as the trial judge compels the parties to attend a settlement conference before him or her. In that situation, parties may be required to reveal weaknesses about their case before the very person who will preside over the case. While some judges recognize this dichotomy and send the parties to another judge for a settlement conference, some see nothing wrong with the practice, believing they can disregard whatever was said during the course of settlement negotiations. Of course, the trial judge who serves as finder-of-fact in a bench trial may be more likely to ask another judge to conduct the settlement conference.

In an arbitration, which is consensual by nature, the parties could agree on almost anything, including having a mediator become the arbitrator if in fact mediation fails. The central problem with such an arrangement is that the parties likely may be disinclined to be forthright during the mediation, fearing that facts (that may otherwise be inadmissible) will be revealed that would hurt their case if arbitration is necessary. On the other hand, the mediator will be familiar with the case as he puts his arbitrator hat on reducing the cost of getting someone else up-to-speed on the case.

The reverse situation, arbitrator turned mediator, may be less of a problem in terms of a conflict situation. This may be particularly so in a single arbitrator scenario. If, at the conclusion of the hearing, but prior to the rendering of any award, the single arbitrator indicated to the parties that she thinks the parties could reach a compromise with her help in light of what she has heard, the parties may want to take advantage of that facilitation service. To protect the parties and encourage absolute candor, the arbitrator could issue an award and seal it. She can then offer her services to the parties in an effort to facilitate a compromise. In the event the case does not settle, the award will be unsealed. This arrangement guarantees that settlement discussions will not sway the decision-maker one way or the other. However, the disadvantage is that the parties have already expended considerable time and expense going

through a full blown hearing. At that point, one or both parties may just prefer to get the award. On the other hand, given the uncertainties of arbitration, business minds may prevail in favor of an amicable compromised resolution.[54]

Conclusion

While it is understandable that some members in the industry are disenchanted with the current structure of reinsurance arbitrations, there are alternatives to consider before parties begin to abandon reinsurance arbitrations altogether. The benefits of arbitration (having experienced decision-makers, maintaining confidentiality, realizing economical benefits, maintaining efficiencies, relying on custom and practice, etc.) still abound and should not be disregarded arbitrarily or casually. The intent of this paper was to provide a few alternative structures that parties in existing contracts should consider and possibly agree upon and contract drafters should contemplate including in new contracts; however, it in no way is meant to be exhaustive. As an industry of experts, all we need is some creativity, and we should be able to reduce some of the negative aspects of arbitration we currently face while holding on to the time-honored custom of arbitrating, rather than litigating, reinsurance disputes. ■

Endnotes

(1) Bank & Winters, *Reinsurance Arbitration: A U.S. Perspective,* 7 Journal of Insurance Regulation 324 (1989).

(2) Reinsurance Association of America, *Manual for the Resolution of Reinsurance Disputes, A Historical Perspective on the Growth of Arbitration in the U.S. and its Introduction to the Reinsurance Industry,* 8 n.17 (2008 ed).

(3) *Id.* at 9.

(4) Bank at 323.

(5) Some contracts provide for the two arbitrators to decide the case with the umpire playing a role only if the two arbitrators are unable to agree on a final disposition. This practice is still followed in the United Kingdom but appears to have been abandoned in the U.S. even if a strict reading of the contract requires it.

(6) One way to minimize this distraction is to select a panel in accordance with the literal language of the contract, that is, let the two-party appointed arbitrators select an umpire without the influence of the parties or counsel as is the case in the United Kingdom.

(7) Arbitration Act, 1996, ch. 23.

(8) AAA's Procedures for the Resolution of Intra Industry U.S. Reinsurance and Insurance Disputes Supplementary Rules can be found at www.adr.org.

(9) American Arbitration Association, *Resolution of Intra-Industry U.S. Reinsurance Disputes Supplementary Rules,* R-15 (2005).

(10) *Id.* at 4.

(11) American Arbitration Association, Commercial Arbitration Rules and Mediation, R-11 (2009).

(12) Association of Insurance and Reinsurance Run-Off Companies, *The AIRROC Dispute Resolution Procedure,* § III (2009).

(13) *Id.*

(14) *Id.* at IIIA.

(15) *Id.* at IIIB.

(16) *Id.*

(17) *Id.*

(18) *Id.*

(19) *Procedures for the Resolution of U.S. Insurance and Reinsurance Disputes,* § 16 (2009).

(20) *Id.*

(21) *Id.*

(22) ARIAS Newer Arbitrator Program, www.arias-us.org.

(23) *Id.*

(24) ARIAS Umpire Appointment Procedure, www.arias-us.org.

(25) Davis & Omlie, *Mini-Trials: The Courtroom in the Boardroom,* 21 Willamette L. Rev. 531, 535 (1985).

(26) E. Green, *The CPR Legal Program Mini-Trial Handbook,* MH-22 (1982).

(27) *Id.*

(28) *Id.*

(29) *Id.*

(30) *Id.*

(31) Davis at 541.

(32) *Id.*

(33) American Arbitration Association, *Mini-Trial: Involving Senior Management, 2* (2007).

(34) Green at MH-23.

(35) *Id.*

(36) Green at MH-24.

(37) Davis at 542.

(38) Id. at 537.

(39) AAA *Mini-Trial* at 3.

(40) *Id.;* Davis at 532.

(41) AAA *Mini-Trial* at 3.

(42) Green at MH21.

(43) *Id.*

(44) Davis at 534.

(45) *Id.* at 539, 543.

(46) *Id.* at 543.

(47) *Id.*

(48) *Id.*

(49) *Civil Litigation: The Judicial Mini-Trial,* Alberta Law Reform Institute 5 (1993).

(50) Davis at 532.

(51) Ray, *How Baseball Arbitration Works: MLB Rules Governing the Eligibility and Process of Arbitration,* www.baseball.suite101.com (2008).

(52) *Id.*

(53) *Id.*

(54) Pursuant to some arbitration clauses in newer reinsurance contracts, the parties agree to attend mediation in advance of any arbitration. Such a clause helps to ensure that parties, especially those in an ongoing business relationship, make an attempt to amicably resolve their disputes short of arbitration. Those responsible for contract drafting would be wise to consider this approach, as well as any other alternatives discussed herein.

The Globalization of Insurance Education

by Connor M. Harrison, CPCU, ARe

Connor M. Harrison, CPCU, ARe, is director of custom products for The Institutes in Malvern, Pa. The Institutes are the leader in delivering proven knowledge solutions that drive powerful business results for the risk management and property-casualty insurance industry. Harrison is responsible for tailoring print and online educational products to meet specific educational needs. He can be reached at harrison@TheInstitutes.org.

In a world where producers reside on Main Street, underwriters analyze applications in Boston and day-to-day business processing takes place in Bangalore, India, there is a demand for international insurance professional credentialing, And The Institutes are uniquely poised to meet it.

Because insurance professionals are geographically diverse, yet bounded by a common body of knowledge, The Institutes have been providing distance learning since being founded in 1909. Over the years, The Institutes have distilled that body of knowledge into 18 different insurance credentials, and in 2009 they unbundled their curriculum into new, customizable configurations.

International Activity Growing

The Institutes have a global reach. In 2009, The Institutes' courses were taken in 52 countries outside the United States. Table 1 on page 19 shows the top 10.

Use of The Institutes' coursework is growing in India, as business processing firms are servicing the needs of insurers — many in the U.S., but elsewhere as well. The knowledge gained through The Institutes coursework is deemed essential for competent performance.

Reinsurance Has Inherent International Appeal

The Institutes' Associate in Reinsurance (ARe) program is one of several credentials that are quite popular. **Susan J. Kearney, CPCU, AU, ARM,** the senior director of knowledge resources responsible for the reinsurance curriculum at The Institutes, remarked, "The reinsurance community is close-knit internationally, and because the knowledge our ARe program conveys has been found valuable, interest in the ARe program has spread. ARe has nearly 300 graduates a year; 25 percent are non-U.S.-based learners. Most of ARe's international graduates are from Bermuda. ARe has become the de facto international reinsurance professional credential."

The coverages course (ARe 143) provides a comprehensive understanding of the coverage provided by the personal and commercial policy forms widely used in the U.S. The principles and practices course (ARe 144) provides an in-depth understanding of reinsurance — beginning with fundamental terminology and concepts and ending with treaty clauses and pricing — which leads to an understanding of reinsurance program design. The readings course (ARe 145) allows learners to select topics of interest to them as well as contemporary, relevant issues. The elective enables learners to study in depth a topic that may be particularly relevant to their work.

ARe's international appeal has increased awareness of The Institutes' programs and thereby expanded educational opportunities around the globe. Insurance professionals have found out how easy The Institutes are to work with and how affordable the coursework is. Table 2 on page 19 describes how international coursework orders are processed and how the assessments are delivered.

The Institutes

The Institutes (previously known as the American Institute for Chartered Property Casualty Underwriters and the Insurance Institute of America) were founded through the combined efforts of the business and academic communities. The Institutes are best known for the Chartered Property Casualty Underwriter (CPCU) designation, but The Institutes have also addressed the professional development needs of individuals working in various niches, such as reinsurance, claims, underwriting, and fidelity and surety bonding — 18 specialty programs in all.

The Institutes' courses have always been provided through distance learning, thereby enabling anyone, regardless of location, to obtain the technical insurance education that is critical to his or her work. All of The Institutes' courses are available in print, and work is underway to make all of The Institutes' courses available through the Internet.

More information about The Institutes can be obtained through its website, www.TheInstitutes.org.

Table 1
The Institutes' Top 10 International Users

Country	Number of Assessments
India	3,551
Bermuda	709
Korea	330
Switzerland	291
China	127
France	86
Japan	51
Netherlands Antilles	51
West Indies	51
Guyana	37

The Associate in Reinsurance Curriculum
The ARe program curriculum consists of four required courses and the free online ethics module plus one elective.

Required Courses
- ARe 143 — Primary Insurance Coverages
- ARe 144 — Reinsurance Principles and Practices
- ARe 145 — Readings in Reinsurance Issues and Developments
- CPCU 520 — Insurance Operations
- Ethics 311 — Ethical Guidelines for Insurance Professionals

Electives (choose one)
- CPCU 540 — Finance and Accounting for Insurance Professionals
- ARM 56 — Risk Financing
- AIAF 111 — Statutory Accounting for Property-Casualty Insurers

Table 2
The Institutes Reach Around the World Delivering Content and Assessments

Resources	
Content	Non-U.S. orders are placed routinely. Our website has the information learners need to purchase materials. (http://www.theinstitutes.org/Students/InternationalStudentInformation.htm)
Assessment	The Institutes allow learners to take their exams at company-sponsored locations (called on-site testing) or at Prometric Testing Centers. Our website has all the assessment information you need. (http://www.aicpcu.org/register/ExamInfo.htm)

Enterprise-Wide Risk Management — Designed for an International Audience

By unbundling their curriculum, The Institutes are positioned to support other insurance educational organizations in reaching their objectives. For example, The Institutes are supporting the Casualty Actuarial Society's (CAS's) creation of a CERA-compliant designation. CERA stands for Chartered Enterprise Risk Analyst, and it has been embraced globally by the 14 actuarial organizations that signed the CERA treaty. As a means to partially meet the CERA standard when approved, CAS is planning to use The Institutes' Enterprise-Wide Risk Management (ERM 57) course and assessments, which were written with a global perspective. The CERA Review Panel's evaluation of The Institutes' ERM textbook is currently underway. More information about The Institutes' ERM course can be obtained at www.TheInstitutes.org/comet/programs/erm/erm.htm.

Designation Programs Becoming the Focus of The Institutes' Online Learning

The Internet has been a boon to distance learning, and The Institutes are at the forefront. We are committed to putting all our content online, and much of it is already available. Anyone can now "log on and learn" the following courses and designations:

- Introduction to Property and Casualty Insurance (Intro).
- Associate in General Insurance (AINS).
- Associate in Risk Management (ARM).
- Associate in Claims (AIC).
- Foundations of Risk Management and Insurance (CPCU 500).
- Insurance Operations (CPCU 520).

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The Globalization of Insurance Education

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As **Karen Skayhan, AIS,** director of online products, explains, "We are putting everything online in anticipation that insurers and others will want their own courses or content matched to competencies, but what we didn't anticipate was the demand for our traditional designation programs online. The Institutes' online product is a solution that offers the employer immediate access, easy redistribution of content and progress tracking. For the learners, they get The Institutes' most up-to-date content, built-in knowledge checks and an engaging, interactive learning environment."

Learning Objects Enable Flexible Delivery

The Institutes have specifically designed content that can be used either in print or online so that learners — no matter how they have prepared — can be successful on the examination. The Institutes recognize that people learn in different ways and that learning online specifically appeals to some. To accommodate multiple modes of delivery, The Institutes invested in technology and the creation of processes that structure writing into learning objects that can be combined, as needed, into an almost infinite number of educational products.

For Insurance Professionals Seeking World-Class Education, the World Couldn't Get Any Smaller

Not so long ago, insurance professionals had to depend on local resources to learn their craft. That's not true today! Distance learning really isn't distant anymore, as The Institutes are as close to you as your computer. ■

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