ARIAS U.S.

QUARTERLY

Loss Development Without Tears

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I hope all of you who attended the Fall Conference on Nov. 3-4, 2022, had a great time. I am sorry I was not there, but I hope to see everyone at the Spring Conference in May 2023 at The Ritz Carlton, Amelia Island.

Speaking of the Spring Conference, our 2022 Spring Conference Recap appears in this issue of the Quarterly. Those of you who presented at the 2022 Spring Conference or at the Fall Conference should leverage your hard work and turn your panel presentations into articles for the Quarterly. The deadline for Q1 2023 is January 3, 2023.

This issue of the Quarterly has three interesting articles. First, we have "Loss Development Without Tears: What Is Loss Development and How Do Actuaries Use It? Part 1," written by Gary Blumsohn, FCAS, Executive Director, Underwriting and Actuarial, Arch Reinsurance Company. I know, why would we publish an actuarial article? Well, we have several members who are actuaries and actuaries are fun. In any event, Gary's article explains loss development, which is very important in understanding loss and loss costs. And Gary has agreed to a multi-part series so stay tuned for more. We can all learn a lot from Gary's article.

Second, our prolific editorial committee member and arbitrator Bob Hall, of Hall Arbitrations, discusses his view on the differences between follow-the-fortunes and follow-the-settlements. His article, "How Follow-the-Fortunes Differs from Follow-the-Settlements," discusses the historical underpinnings of these doctrines and draws out the similarities and differences. A little birdy told me that we may have a counter-point article coming our way in the future taking the opposite view.

Third, we have an article suggesting how we might leverage the relatively new Panel Rules for the Resolution of Insurance and Contract Disputes to help ARIAS certified neutrals obtain direct insurance dispute appointments. Titled, "A Proposal For Utilizing ARIAS·U.S.-Certified Neutrals in Direct Insurance Disputes: Practical Next Steps in Promoting the ARIAS·U.S. Panel Rules for the Resolution of Insurance and Contract Disputes," Joseph P. Monteleone, of Weber Gallagher Simpson Stapleton Fires & Newby LLP, sets out several ideas that might expand the reach of ARIAS and its certified neutrals.

Going forward, we do need more of you to contribute to future issues. The deadlines and requirements are on the ARIAS website. We welcome committee reports, original articles, and repurposed articles from ARIAS CLE programs or from company or firm publications. Publishing an article in the Quarterly gives you a chance to leverage your thought leadership within the industry!

We hope you enjoy this issue of the Quarterly.

Larry P. Schiffer
Editor

Loss Development Without Tears

What Is Loss Development and How Do Actuaries Use It?

By Gary Blumsohn

Part 1

The expert witness is talking about loss development, long tails, LDFs. He throws in an occasional B-F or chain ladder. Is he making sense, or is it just actuarial obfuscation?

Loss development is simply actuarial terminology for the pattern along which insurance claims are paid or reported. If it's a quick-paying type of business, say auto physical damage, the majority of the losses may be paid three months after an accident happens. If it's a slow-paying line of business, say medical malpractice, after three months the lawyers are just starting to get warmed up and while a few claims might be settled quickly, most will drag on for years before they are settled or decided in court. Occasionally, a claim may still be going after a decade or more.

The loss development pattern describes how much of the total loss is expected to be paid or reported each year. So perhaps 20% of the losses pay in the first year, 35% in the second year, 25% in the third year, 15% in the fourth year, and 5% in the fifth year – always, of course, adding up to 100%. Notice that we are talking here about the settlement of a book of claims, not an individual claim.

Actuaries are called upon to estimate how much the total losses will be when everything has been paid out and the claims are closed. So maybe an insurer bought quota share reinsurance for workers' compensation policies written in 2018. At the end of 2021, the insurer has reported $1 million of case incurred losses to the reinsurer, of which $350,000 has been paid. The reinsurer wants to know from its actuaries how much they should expect to ultimately pay. The loss development pattern is one of the key tools in the casualty actuarial toolkit used to answer such questions.

A Non-insurance Example

Consider the following non-insurance example: Your commute home from work is a 60-mile drive down the highway. From past experience, you average 60 miles per hour, so it takes you an hour to get home. Your husband needs half an hour to cook dinner, so when you've been driving for 30 minutes, and you've covered about 30 miles, you call to let him know it's time to put the food in the oven.

One night it's snowing lightly and the traffic is slow, so it takes you 45 minutes to travel the first 30 miles. What do you tell your husband? The stakes are high: if you underestimate how long the remainder of the journey is, you're going to be eating dry, overcooked food; overestimate and you're going to have to wait around for dinner to be ready, and you are starving. Since it's taken you 45 minutes to travel the first 30 miles, it'll likely take you 45 minutes to travel the remaining 30 miles, so the journey will take 90 minutes in all, rather than the usual 60 minutes. You call your husband, tell him you're going to be home 30 minutes later than usual, and dinner comes out of the oven right as you walk in the door. You feel pretty good about your prediction skills.

The next night it again takes you 45 minutes to travel the first 30 miles and you make the same phone call estimating that you'll be home 30 minutes later than usual. As you end the call, you pass a three-car accident on the road, and you realize that this was the source of the slowdown. Now you need to rethink. The traffic is flowing smoothly and you realize there's no reason to think it's going to take another 45 minutes to get home. You're likely to drive the remaining 30 miles in the usual 30 minutes, so your total commute will be 75 minutes, not 90 minutes. Now, do you make another call and fess up to not-such-good prediction skills or do you pull into a rest area along the highway and spend 15 minutes over a cup of coffee so you can keep your reputation for accurate predictions intact?

As you drink that cup of coffee, ponder the dilemmas faced by your actuary who is trying to predict the ultimate losses. If he's lucky, he's got good data about what happened to the losses in the past. The data tells him that on average the losses developed in a particular way, and the data even provides a sense of how volatile that development is. And he may have data that tells him historically what the total losses have been – on average. But like your commute, the question being asked is to predict a *particular* outcome, not an average outcome.

An Actuarial View

Let's stick with the highway commute and ask how an actuary might deal with it. Let's say the actuary knows that one night you've taken 45 minutes to travel the first 30 miles.

1. First approach: The actuary knows you are halfway home, so the actuary does just what you did on the first night so *if you assume the second half will be just as delayed as the first half*, the total trip will take 90 minutes. The actuary calls this the "loss development" method or sometimes the "chain-ladder" method.
2. Second approach: The actuary knows that you are delayed by 15 minutes relative to your normal travel time so *if you assume there are no further delays ahead*, your total commute will be 15 minutes longer than usual, or 75 minutes. The actuary calls this the "Bornhuetter-Ferguson" method, "B-F" for short, named after two actuaries, Ronald Bornhuetter and Ronald Ferguson who wrote a paper in 1972 describing the method and who both later went on to lead major reinsurance companies.[1]

If the actuary has no further information about which approach is better, the answer might be expressed as a type of range. The actuary might say that the best estimate is that it will take you somewhere between 75 and 90 minutes to get home. Notice that this range doesn't cover all possible outcomes. There might be a much worse accident five minutes further down the road and you'll take two hours to get home. The range is simply a range of the actuary's *best* estimate.

Often the actuary will have, or will seek out, further information. The actuary might listen to the radio to get a forecast on whether the snow is about to stop, or maybe intensify. Or the actuary will hear a traffic report that tells exactly where on the road there an accident is. With this additional information, the actuary might have reason to believe that one estimate is better than the other. If the snow is expected to continue for the whole journey home, the actuary might put more weight (say 75% weight) on the chain ladder prediction than on the B-F prediction. Why not all the weight on the chain ladder? Because while it might be expected to snow the whole way home, the snow might not be the only reason for the delay – there may also be an accident, and once past

that accident, the traffic might speed up.

Note that actuaries frequently hedge and provide ranges of answers, rather than exact predictions. This isn't due to a desire to obfuscate, but rather because there's real doubt about the exact answer. The actuary is being asked to make a prediction and as the adage goes, predictions are difficult, especially about the future.[2]

"The actuary is being asked to make a prediction and as the adage goes, predictions are difficult, especially about the future."

An Insurance Example

We will next proceed to give a more typical insurance example of how an actuary will use these techniques. The context is different, but the thought process is the same as the actuary's thought process about the time taken to commute.

Suppose an insurer wrote $100 million of premium in 2015. Based on historical results, the insurer expects a loss ratio of 60%, so its best estimate of the ultimate losses is $60 million. Furthermore, its analysis of the historical loss development shows it expects to pay 10% of the losses each year for 10 years. In other words, it expects to pay $6 million (10% of $60 million) in 2015, $6 million in 2016, $6 million in 2017, and so on, until the last $6 million is paid in 2024.

At the end of year six (2020), it has paid $42 million. If it had paid $6 million per year, at the end of year six, it would have paid $36 million, so things are running worse than expected. The actuary is asked to project how much it will ultimately pay. Just as the actuary did when predicting the length of your commute, the actuary tries two approaches:

1. First approach ("loss development" method or "chain ladder" method): We are 60% of the way through the loss payment pattern and we've paid $42 million. If we keep paying at that rate (analogous to maintaining our speed down the highway) then at the end of the pattern we will have paid ($42 million ÷ 60% =) $70 million, rather than the $60 million we originally expected.
2. Second approach ("Bornhuetter-Ferguson" method): This method assumes the loss payments in the first six years aren't particularly predictive of loss payments in the remaining four years. Back in 2015 when the company wrote the business, it expected to pay $6 million per year – and perhaps that is still the best estimate of what it will pay in the remaining years. If that's the case, we expect to pay another $24 million (i.e., $6 million per year for another four years), so the prediction for how much will be paid at ultimate is the $42 million already paid after six years plus the $24 million projected to be paid in the last four years, for a total of $66 million.

Depending on the circumstances, the actuary might have an inkling that one of these two approaches is better than the other, and so more weight might be put on that estimate, or maybe the actuary cannot distinguish between them, in which case the actuary might express the findings by splitting the difference — maybe saying that the best estimate is $68 million, with a range of $66 million to $70 million.

How might an actuary get an inkling that one method is better than another in a particular circumstance? It's very similar to what we saw on the highway where an understanding of the reason for the slowdown (snow or an accident) allows for further insight into what might happen on the rest of your journey.

In the insurance example, the actuary will look for reasons why the paid losses after six years are higher than expected. Perhaps there was one unusually large claim that paid very quickly and accounts for most of the additional loss

paid to date. If that large claim seems to be a case of bad luck that's unlikely to repeat, it may be reasonable to assume the past losses are not predictive of future losses, so the Bornhuetter-Ferguson estimate is better than the chain-ladder estimate. On the other hand, if there's a consistent pattern of higher-than-expected losses paying each month, the chain ladder might well be the better estimate.

Paid Losses and Reported Losses

So far, this example has used paid losses. Usually, we have information about both paid losses and reported losses (also known as case-incurred losses). The reported losses include the paid amounts as well as the reserve estimates that the claims department assesses for each individual claim. All the discussion above about the actuarial thought process for the paid losses applies equally to the reported losses. The reporting pattern will be quicker than the payment pattern because there is a lag between a claim being reported to the insurer and the claim being paid. Sometimes that lag is short, such as in auto physical damage claims, which are typically paid within weeks of being reported to the company. Other times the lag between a claim being reported and paid is long, such as in medical malpractice claims, which generally take years to settle or litigate after they are reported.

Continuing the insurance example from above, the reporting pattern might be 30% of the claims reported in year one, 20% in year two, and then 10% each in years three through seven. Let's suppose that at the end of year six, when the actuary is being asked to come up with an estimate of the ultimate losses, that the reported losses are $57 million. We know that at the end of year six, the reporting pattern is at 90% (from adding up 30% in year one, 20% in year two, and 10% each in years three through six). Repeating what was done before, except now using the reported loss information:

1. First approach ("loss development" method or "chain ladder" method): We are 90% of the way through the reporting pattern and we've got $57 million of reported losses. If losses continue being reported at that rate, then at the end of the pattern we will have ($57 million ÷ 90%) = $63.3 million of losses, compared to the $60 million we originally expected.
2. Second approach ("Bornhuetter-Ferguson" method): this method assumes the reported losses in the first six years aren't necessarily predictive of loss reports in the remaining year. In 2015, when the company wrote the business, it expected $60 million of ultimate losses, and expected 90%, or $54 million, to be reported at the end of year six. The remaining 10% of the expected reported losses, another $6 million, are expected to report in year seven. So, the ultimate projection is the $57 million reported in the first six years plus the $6 million expected in year seven, for a total of $63 million.

The actuary now has four different projections of the ultimate loss that are bolded in the table below:

	Paid Losses	Reported Losses
Percent developed at end of year 6	60%	90%
Losses at end of year 6	$42 million	$57 million
Chain ladder projection of ultimate	$70 million	$63.3 million
Bornhuetter-Ferguson projection of ultimate	$66 million	$63 million

The actuary will need to make some judgment about the quality of each of the four methods to come up with a best estimate.

Part 2 of this discussion will delve deeper into how the actuary comes up with development patterns that are used in these calculations.

NOTES

1 Bornhuetter, Ronald L. and Ronald E. Ferguson (1972): "The Actuary and IBNR," *Proceedings of the Casualty Actuarial Society*, Vol. LIX, pp. 181-195, https://www.casact.org/sites/default/files/database/proceed_proceed72_72181.pdf

2 This insight has been attributed to everyone from Nostradamus and Niels Bohr to Mark Twain and Yogi Berra. *See* https://quoteinvestigator.com/2013/10/20/no-predict/#:~:text=Nostradamus%20allegedly%20said%2C%20"Prediction%20is,%2C%20especially%20about%20the%20future." (Website accessed on 8/17/2022.)

Gary Blumsohn has more than 30 years of experience as an actuary at insurance and reinsurance companies, including 16 years as the chief actuary at Arch Reinsurance Company. He is also an ARIAS-certified arbitrator.

How Follow-the-Fortunes Differs from Follow-the-Settlements

By Robert M. Hall

I. Introduction

In recent years, an unfortunate tendency has developed to use interchangeably the terms "follow-the-fortunes" and "follow-the-settlements" to refer to the custom and practice that, with certain exceptions, reinsurers should accept their cedents' reasonable, good faith claim settlements. However, this does a disservice to the historical development and separate meaning of follow-the-fortunes.

II. Historical Development of Follow-the-Fortunes

One industry commentator noted that the "follow-the-fortunes" doctrine originated in France hundreds of years ago and "was used to bind the reinsurer by the broad aleatory 'underwriting fortunes' of the ceding company under the original policy . . ."[1] Moreover:

> "Follow the fortunes" is an aspect of reinsurance risk transfer that obligates the reinsurer, to the extent of the risk underwritten, to accept the reinsured's underwriting fortunes as respects the original risk reinsured, even if underwriting results are unlucky or unfortunate owing to an unforeseen change in the object or risk insured, or in our knowledge or in the law.[2]

Noted reinsurance expert Klaus Gerathewohl opined that the follow-the-fortunes doctrine developed with respect to underwriting issues, not claim settlements:

> [T]he follow-the-fortunes principle relates to the original risk which, in this context, comprises the "underwriting" risk only.[3]

. . . .

Basically, such "original risk" consists of the underwriting risk made up of the moral hazard with the insured's control and physical hazard – i.e. the risk of events occurring beyond the control of both the insured and the direct insurer.[4]

Another reinsurance expert characterized the original follow-the-fortunes concept as a transfer of "insurance risk" which:

> [H]as two components: underwriting and contractual. The underwriting component can be illustrated by the ceding company evaluating and underwriting the original risk and issuing the policy. Changes in the ceding company's underwriting position may be caused by any of the following: a change in the nature of the original insured (e.g. an additional insured being named, or exposure changes due to the operations of the insured); an amendment in statutory requirements which requires a change in the policy; . . . The contractual component, on the other hand, can change by a court interpretation which differs from the company's original intent.[5]

III. More Recent Treatment

In recent years, the distinction has been blurred between follow-the-fortunes and follow-the-settlements. One industry expert, Larry Schiffer, observed:

> [T]here is often confusion between the follow-the-fortunes doctrine (or clause) and the follow-the-settlements doctrine (or clause). Many conflate the two. . . The follow-the-fortunes doctrine refers to the underwriting fortunes of the ceding company and the reinsurer's obligation to stick with its cedent when the cedent's underwriting produces poor or unexpected results . . . . The follow-the-settlements doctrine refers to the reinsurer's obligation to indemnify the ceding company for judgments or settlements paid in a good faith in a reasonable and business-like manner that are arguably consistent with the terms of the underlying policies and the reinsurance contract.[6]

Likewise, the court in *Aetna Casualty and Surety Co. v. Home Insurance Co.*, F. Supp. 1328 (S.D.N.Y. 1995) at 1346 n. 9 observed:

> The term "follow the fortunes" has been used imprecisely to describe the reinsurer's duty to follow the claims adjustment decisions of the ceding company, thereby giving rise to some ambiguity as to the meaning. "Follow the fortunes" more accurately describes the obligation to follow the reinsured's underwriting fortunes whereas "follow the settlements" refers to the duty to follow the actions of the cedent in adjusting and settling claims.

IV. Comments

Follow-the-fortunes and follow-the-settlements have different meanings and apply to different aspects of the reinsurance business. Follow-the-fortunes deals with the cedent's risk selection and pricing. Absent bad faith or violation of mandatory underwriting guidelines by the cedent, the reinsurer cannot challenge the cedent's judgment calls about choice of risks to insure or the premium charged for the risk.

NOTES

1 William C. Hoffman, *Common Law of Reinsurance Loss Settlement Clauses: A Comparative Analysis of the Judicial Rule of Enforcing the Reinsurer's Contractual Obligation to Indemnify the Reinsured for Settlements,* 28 Tort & Ins. L.J. 659 at 665 (1993)

2 William C. Hoffman, *Facultative Reinsurance Contract Formation, Documentation, and Integration*, 38 Tort & Ins. L.J. 763 at 820 (2003).

3 Klaus Gerathewohl, *Reinsurance Principles and Practice*, Vol. 1 at 714, Verlag Versicherungswirtschaft e. V. Karlsruhe (1980) (hereinafter "Gerathewohl").

4 *Id.* at 711.

5 John Langen, *Special Clauses and Endorsements article in Reinsurance Contract Wording,* edited by Robert Strain Publishing & Seminars, Inc. at 584 (1992)

6 Larry Schiffer, *The Conundrum of Following Clauses in Reinsurance Contracts*, https://www.lexology.com/library/detail.aspz?g=255657b-42c0-4a5a8c9a-00059f3b0518. *See also* Thomas F. Segalla, *Reinsurance Professional's Desk Book, A Practical Guide*, Thomas Reuters 2019 - 2020 edition at 262 – 3 (hereinafter "Segalla").

Robert Hall is an attorney, a former law firm partner, a former insurance and reinsurance executive and acts as an insurance consultant as well as an arbitrator of insurance and reinsurance disputes and as an expert witness. He is a veteran of more than 200 arbitration panels and is certified as an arbitrator and umpire by ARIAS•US. The views expressed in this article are those of the author and do not reflect the views of his clients. Copyright by the author 2022. Mr. Hall has authored more than 100 articles and they may be viewed at his website: robertmhalladr.com.

A Proposal For Utilizing ARIAS ·U.S.-Certified Neutrals in Direct Insurance Disputes

Practical Next Steps in Promoting the ARIAS·U.S. Panel Rules for the Resolution of Insurance and Contract Disputes

By Joseph P. Monteleone

ARIAS·U.S. arbitrators and mediators serve frequently in disputes between reinsurers and cedents, but ARIAS and its certified arbitrators and mediators are available to extend these services to policyholder vs. insurer and inter-insurer disputes.

Since its inception, ARIAS has focused primarily on disputes arising between reinsurers and their cedent companies and resolving those disputes by using a distinguished panel of certified arbitrators. Arbitration panels are typically comprised of two party-appointed arbitrators and an umpire. Perhaps not as frequently as is the case with arbitrations, ARIAS-U.S. certified individuals may also serve as mediators in these disputes, either prior to or in the course of the arbitral process.

Reinsurers, cedents and their counsel appear to be comfortable with the traditional reinsurance dispute resolution structure supported by ARIAS and its panels of available arbitrators, umpires, and neutrals. However, reinsurer vs. cedent disputes probably take place less frequently than coverage disputes between policyholders and insurers, which I reference in this article as direct insurance disputes.

The primary issue I consider here is how to best expand the reach of ARIAS and its arbitrators and mediators into the direct insurance arena. This, of course, is one person's thoughts on how this expansion may be accomplished.

Preliminarily, of course, the question is *should* ARIAS so expand its reach. With the advent of the ARIAS·U.S. Panel Rules For The Resolution of Insurance and Contract Disputes (the "Rules") in September 2019, ARIAS has answered that question with a resounding yes.[1]

As to how to accomplish the expansion, I propose it would not necessarily entail any major changes in the ARIAS organizational structure or its membership beyond the Rules and perhaps an expanded list of arbitrator criteria for this purpose. Additionally, continued outreach to the relevant constituencies is critical.

While there are several policyholder counsel who have joined or supported ARIAS and who participated in drafting the Rules, more outreach is necessary to best make insurers and policyholders aware of what ARIAS and its certified arbitrators and mediators can do for them. In so doing, it is important for ARIAS to continue to inform policyholders of the considerable flexibility it has shown in adapting the Rules to better accommodate policyholder concerns.[2]

How to best reach out to insurers

Many ceding insurers are affiliated with larger insurance operations including reinsurance companies. Senior personnel in the Claims or Law departments should be the initial and perhaps the key contacts to make it known that ARIAS arbitrators and mediators can be of invaluable assistance to them in resolving direct insurance disputes. Specifically, outreach should be to the chief claims officer for direct insurance operations, as well as the contact in the Law department responsible for overseeing coverage litigation. The least problematic initial step would entail using members of the ARIAS certified panel as party-appointed arbitrators because, as discussed below, many policyholder lawyers are justifiably concerned that the ARIAS pool may have an overall pro-insurer bias.

How to best reach out to policyholders

Large corporate policyholders are typically represented by a small number of law firms with a well-developed "insurance recovery" practice. Otherwise, the policyholder bar is more fragmented than the insurer-side bar. Although there are several organizations in which the policyholder bar participates, I am only aware of two that bring together a number of the foremost practitioners in the policyholder and insurer side coverage bar. The first is the Insurance Coverage Litigation Committee of the American Bar Association's Litigation Section (the "Insurance Committee").[3] The second is the American College of Coverage Counsel (ACCC)[4] in which I am proud to be a member. More on those organizations below.

Perhaps the optimal approach to policyholders would be through one of the organizations in which prominent members of the policyholder bar participate. Both the ACCC and the Insurance Committee nicely fit the bill.

> "The primary issue to be considered here is to how best expand the reach of ARIAS and its arbitrators and mediators into the direct insurance arena."

These groups would be ideal because the policyholder and insurance bar can be reached simultaneously through the same organization. The outreach could be facilitated through an article in an ACCC quarterly journal, supplemented by a discussion panel at their annual meeting that typically takes place in May in Chicago. With respect to the Insurance Committee, the members typically meet annually in Tucson, Arizona in late winter and also accept articles from time to time during the year.

Of course, this should not be to the exclusion of other policyholder organizations, including the Risk and Insurance Management Society (RIMS).[5]

What needs to be done to make any arbitration or mediation forum attractive to policyholders

An initial hurdle would be to present policyholders with a pool of potential arbitrators and mediators with which they can be comfortable. One issue facing ARIAS and the certified individuals will admittedly be a perceived bias in favor of insurers. That is because ARIAS is in most respects an insurance industry organization and its arbitrators (this author included) have had long careers in the insurance and reinsurance industry or with law firms that typically represent insurers and reinsurers. Indeed, this issue was recognized in the excellent ARIAS·U.S. Quarterly Article by Peter A. Halprin, David W. Ichel and Peter A. Rosen for Q4 2019 in which the Rules were introduced to the ARIAS membership.[6]

One important means of addressing this concern is highlighting how the Rules differ from the existing ARIAS Neutral Rules (the "Neutral Rules"). the Rules require that the arbitrators selected under the Rules follow the strict rules of law.[7] The Neutral Rules, on the other hand, allow for following industry custom and practice in lieu of applying applicable law. In providing for the application of strict rules of law, the Rules should ensure greater predictability and fairness to both sides in the process.

ARIAS, however, might consider providing the pool from which the insurer party could appoint its arbitrator and a new pool that allows the policyholder to appoint a neutral from a broader pool designed to meet the needs of policyholders similar to customary sources. This would address any policyholder concerns that they might not be able to appoint a party arbitrator other than from the current ARIAS panel.

As in many other arbitral proceedings, the two party-appointed arbitrators and/or their respective appointing parties could then endeavor to select an appropriate umpire.

> "One advantage of these administrative services, however, is that the administration organization can be a source of statistical information as to the number of disputes handled and certain non-confidential information as to their disposition."

If ARIAS may not provide administrative services to the extent as does JAMS or the AAA, would this be a help or a hindrance?

In my opinion, self-administered arbitrations and mediations have worked just fine. While I do not want to denigrate the value of the administrative services that an efficient case manager can bring to the table, oftentimes this is only an unnecessary added layer of fees and expenses that does little to facilitate an effective dispute resolution.

One advantage of these administrative services, however, is that the administration organization can be a source of statistical information as to the number of disputes handled and certain non-confidential information as to their disposition. Of course, ARIAS could also consider acting as a repository of this information.

The Rules in fact provide for ARIAS to have an administrative role and there is an administrative fee of $1,000 to be split equally between the Petitioner and Respondent parties. The Rules can help facilitate the process by dealing with umpire challenges and similar issues.[8]

Should the arbitrations or mediations be mandatory or just voluntary endeavors in lieu of first resort to litigation?

Many policyholder advocates do not favor a mandatory arbitration process, although I believe this opposition is not as fierce as it once was. Some insurers already address this issue in their policy forms, and it is noted that the Rules "are not intended to supersede any express contractual agreement between the Parties."[9] The following is typical of insurance policy wording found or followed in many D&O policy forms in use over the past several years.

Alternative Dispute Resolution

ADR Options

All disputes or differences which may arise under or in connection with this policy, whether arising before or after termination of this policy, including any determination of the amount of Loss, shall be submitted to an alternative dispute resolution (ADR) process as provided in this clause. The Named Entity may elect the type of ADR process discussed below; provided, however, that absent a timely election, the Insurer may elect the type of ADR. In that case, the Named Entity shall have the right to reject the Insurer's choice of the type of ADR process at any time prior to its commencement, after which, the Insured's choice of ADR shall control.

Mediation

In the event of mediation, either party shall have the right to commence a judicial proceeding; provided, however, that no such judicial proceeding shall be commenced until the mediation shall have been terminated and at least 90 days shall have elapsed from the date of the termination of the mediation.

Arbitration

In the event of arbitration, the decision of the arbitrator(s) shall be final, binding and provided to both parties, and the arbitration award shall not include attorney's fees or other costs.

ADR Process

Selection of Arbitrator(s) or Mediator

The Insurer and the Named Entity shall mutually consent to: (i) in the case of arbitration, an odd number of arbitrators which shall constitute the arbitration panel, or (ii) in the case of mediation, a single mediator. The arbitrator, arbitration panel members or mediator must be disinterested and have knowledge of the legal, corporate management, or insurance issues relevant to the matters in dispute. In the absence of agreement, the Insurer and the Named Entity each shall select one arbitrator, the two arbitrators shall select a third arbitrator, and the panel shall then determine applicable procedural rules.

ADR Rules

In considering the construction or interpretation of the provisions of this policy, the mediator or arbitrator(s) must give due consideration to the general principles of the law of the State of Formation of the Named Entity. Each party shall share equally the expenses of the process elected. At the election of the Named Entity, either choice of ADR process shall be commenced in New York, New York; Atlanta, Georgia; Chicago, Illinois; Denver, Colorado; or in the state reflected in the Named Entity Address. The Named Entity shall act on behalf of each and every Insured under this Alternative Dispute Resolution Clause. In all other respects, the Insurer and the Named Entity shall mutually agree to the procedural rules for the mediation or arbitration. In the absence of such an agreement, after reasonable diligence, the arbitrator(s) or mediator shall specify commercially reasonable rules.

This is not the only ADR provision in use in policies today[10], but it has several features that make it attractive to both policyholders and the insurer as follows.

- The arbitration process is not mandatory. Although the insurer can initially elect arbitration, the policyholder can "opt out."
- Mediation is also not mandatory and, if elected and the mediation fails, it essentially provides a 90-day "cooling off period" before coverage litigation can be commenced by either party.
- Arbitration when pursued shall be binding.
- The ADR Rules section on arbitration venues is fairly flexible in that it allows for arbitration to take place where the policyholder is effectively headquartered. The remaining locations are large metropolitan areas and can easily be expanded to add a few more. This should be convenient to all parties and neutrals with respect to in-person hearings.
- This particular policy provision is not overly restrictive with regard to the composition and qualifications of any arbitration panel. To this end, it is much more liberal and less detailed than § 6 in the Rules.[11] In my opinion based upon my experience, policyholders would be apt to object to any unduly restrictive and costly provision in this regard.

Where do we go from here?

Logical next steps should begin with renewed efforts in getting the word out to policyholders that arbitration and mediation alternatives to litigation exist. In many cases, that will not be new news to them, but what will be news is that ARIAS-certified arbitrators can be a vital part of this process along with the ARIAS organization.

Having dispute resolution provisions in insurance policies similar to the one set forth above would undoubtedly enhance this initiative, but one should expect at least initial resistance from the insurance brokerage community. Brokers have historically resisted the insertion of dispute resolution provisions in policies, particularly if they are mandatory in nature. In this respect, the brokers are aligned with a number of policyholder lawyers who do not want to forego a litigation option and be compelled to arbitrate. For this reason, the suggested ARIAS wording set forth in Endnote 11 should be modified to render it non-mandatory along the lines of the exemplary provision set forth above.

Nonetheless, it is my strong belief that this initiative should be pursued promptly and vigorously. Feedback from the ARIAS membership and certified arbitrators is encouraged.

NOTES

1 The author is especially appreciative of the very helpful comments of Larry P. Schiffer, Steven R. Gilford, Peter A. Halprin, David W. Ichel and Kim D. Hogrefe in reviewing drafts of this article.

2 Rules, § 15.1 provides for a mediation process and procedures if the parties elect to pursue mediation during the course of an arbitration. This should be attractive to both insurers and policyholders.

3 For more information on this ABA Committee, please visit their website at https://www.americanbar.org/groups/litigation/committees/insurance-coverage/

4 For more information on ACCC, please visit their website at https://www.americancollegecoverage.org

5 For more information on RIMS, please visit their website at https://www.rims.org

6 Halprin, Ichel, and Rosen, *Introducing the ARIAS-US Panel Rules for the Resolution of Insurance and Contract Disputes*, ARIAS-US Quarterly 2019

7 Rules, § 13.3

8 Rules, § 16.9

9 Rules, § 1.2

10 Although not presently set forth in any insurance policy forms, the Rules suggest an arbitration clause as follows:

> *Any dispute or claim arising out of or relating to this Policy (or contract), including its formation and validity, shall be referred to arbitration. The arbitration shall be conducted in accordance with the current version of [the Rules].*

11 § 6.19 of the Rules sets forth some rather detailed procedures for challenging the selection of an umpire *after* one is chosen, including submission of the challenge to a sub-committee of members of the ARIAS Ethics Committee and the Board of Directors. That challenge would be subject to a charge by the sub-committee of either $5,000 for hearing the challenge on the papers alone to a daily rate of $2,400 plus costs and expenses for an in-person hearing.

Joseph P. Monteleone is an ARIAS·U.S. certified arbitrator and a partner in the Bedminster, New Jersey office of Weber Gallagher Simpson Stapleton Fires & Newby LLP. He is also frequently retained as an expert witness in various coverage disputes, in addition to providing legal services and advice to insurers and reinsurers. He can be reached at jmonteleone@wglaw.com or at 973.242.1630

Does 'Follow-the-Settlements' Doctrine Obligate a Reinsurer Regarding Some Expenses?

The plaintiff, Utica Mutual Insurance Company ("Utica"), issued both primary and umbrella policies to non-party Burnham Corporation ("Burnham"). Burnham was sued in asbestos related lawsuits for which Utica paid defense costs under its primary policies. After the primary coverage was exhausted, Utica declined to pay defense costs under the umbrella policies asserting that they were not covered. Burnham refuted Utica's position.

Eventually Utica and Burnham settled their dispute. Per the settlement, Utica agreed to pay defense costs and losses under the umbrella policies for those occurrences that had triggered coverage under the then-exhausted primary policies. Utica then ceded the loss to the defendant, its reinsurer, Abeille General Insurance Company, now known as 21st Century National Insurance Company ("21st Century"). However, 21st Century refused to pay Utica arguing that Utica had no obligation to pay defense expenses under its umbrella policies.

Utica commenced this declaratory judgement action against 21st Century and both parties moved for summary judgement. In deciding the motions, the New York Supreme Court found that the 'unambiguous terms of the umbrella policies established that the disputed defense costs were not covered under those [Utica] policies and thus likewise were not covered under the reinsurance policies.' The Court denied summary judgment finding that an issue of fact existed regarding the follow-the-settlements doctrine.

The subject reinsurance policies each contain a follow-the-settlements clause and, where it applies, the follow-the-settlements doctrine "ordinarily bars challenge by a reinsurer to the decision of [the cedent] to settle a case for a particular amount."

While 21st Century appealed the New York Supreme Court decision denying summary judgement, the Appellate Court affirmed the lower court's holding that Utica's umbrella policies did not cover defense costs. In addition, the Appellate Court concluded, "…the reimbursement sought by plaintiff from defendants was beyond the scope of coverage in the umbrella policies and, thus, the follow-the-settlements doctrine does not apply under the circumstances." The Appellate Court modified the order granting defendants' motion for summary judgment accordingly.

Case: *Utica Mutual Insurance Company v. Abeille General Insurance Co., Now Known as 21st Century National Insurance Co.,* et. al., Appellate Div. of the Supreme Court of NY, 4th Dept., 189 CA 21-00536, 2022 NY Slip Op 03815.

Issue Discussed: Follow the Fortunes/Settlements

Court: Appellate Division of the Supreme Court of New York, Fourth Department

Date Decided: June 10, 2022

Issue Decided: Whether the "follow-the-settlements" doctrine obligates a reinsurer regarding expenses that are not covered by underlying umbrella policies

Submitted by: Polly Schiavone, Vice President, Swiss Reinsurance America Holding Corp.

Are Certain Documents Withheld by a Reinsurer from Discovery Protected from Disclosure?

Tower Insurance Company of New York ("Tower") issued a commercial general liability policy to Hinde Development, LLC ("Hinde"), effective for the policy period of May 6, 2014 to May 6, 2015 (the "Tower Policy"). Due to Tower's insolvency, its reinsurer and successor in interest, Technology Insurance Company, Inc. ("TIC"), assumed the defense of Hinde in an underlying personal injury lawsuit pursuant to a "Cut-Through" Endorsement in the Tower Policy. The underlying suit alleges plaintiff was injured due to an allegedly defective condition on the public sidewalk abutting premises owned by Hinde and leased to the Puerto Rican Family Institute, Inc. ("PRFI"). Philadelphia Indemnity Insurance Company ("PIIC") issued commercial general liability coverage to PRFI for the policy period July 6, 2014 to July 6, 2015, which covers Hinde as an additional insured with respect to liability arising out of the ownership, maintenance, or use of the premises leased by PRFI (the "PIIC Policy").

TIC, on Hinde's behalf, tendered defense and indemnity of the underlying lawsuit to PIIC. After PIIC denied coverage on various grounds, TIC brought this action seeking a declaration that PIIC has a duty to defend and indemnify Hinde in the underlying action as an additional insured under the PIIC Policy. During discovery, a dispute arose between the parties in which PIIC alleged TIC was improperly withholding certain allegedly relevant documents on the grounds they were protected by the attorney-client privilege and/or work product doctrine, including portions of TIC's claims file.

The Court directed TIC to produce the documents for which it claimed privilege to the Court ex parte for an in-camera review. With regard to TIC's privilege contentions for the claims file material withheld or redacted, the Court articulated the operative standard in New York as follows:

> In determining whether claims files qualify for work product protection, it is necessary to distinguish between "documents prepared in the ordinary course of the insurer's business (which by its nature, involves claim investigation and analysis) and documents prepared 'in anticipation of litigation.' *(citation omitted)*. An insurer's decision to decline coverage is typically the point at which the ordinary course of business ends and the anticipation of litigation begins. *(citations omitted)*. In some cases, however, the retention of counsel by the insurer prior to formal declination signals the anticipation of litigation. *(citation omitted)*.

The Court ruled that all documents withheld by TIC were protected by the attorney-client privilege or the work product doctrine, with one exception, and that PIIC had not met its burden of showing a substantial need and undue hardship warranting production of the withheld material. First, the Court found that certain documents containing the mental impressions, opinions, and conclusions of counsel prepared in anticipation of litigation in the underlying action related solely to Hinde's liability and potential defense strategies,

Case: *Technology Ins. Co., Inc. v. Philadelphia Indem. Ins. Co., 2022 WL 624556 (S.D.N.Y. March 3, 2022)*

Issues Discussed:Attorney-client privilege; work product doctrine

Court: U.S. District Court Southern District of New York

Date Decided: March 3, 2022

Issue Decided: Whether certain documents withheld by a reinsurer from discovery in an insurance coverage dispute, including claims file materials, are discoverable or protected from disclosure by the attorney-client privilege and work product doctrine.

Submitted by: Robert W. DiUbaldo*

and thus were properly withheld. Second, the Court found that certain other withheld material was either not relevant to the claims at issue in the declaratory judgment action, might be available to PIIC through other means, or plainly constituted attorney-client communications, communications that relay internally the content of such, or attorney work product concerning both the coverage action and the underlying action. However, the Court noted that documents withheld pertaining to TIC's case reserves might be discoverable under the applicable Federal Rules of Civil Procedure and invited further briefing on the issue to the extent PIIC elected to pursue such discovery.

* Robert W. DiUbaldo is a Shareholder at Carlton Fields, P.A.

> "The Court ruled that all documents withheld by TIC were protected by the attorney-client privilege or the work product doctrine, with one exception, and that PIIC had not met its burden of showing a substantial need and undue hardship warranting production of the withheld material."

Should Materials Filed in Furtherance of a Motion to Determine Arbitrability be Maintained under Seal?

Washington Schools Risk Management Pool ("WSRMP") filed an action in the U.S. District Court for the Western District of Washington, seeking reinsurance from Sompo International Reinsurance ("Sompo") and American Re-Insurance Company. WSRMP moved for Partial Summary Judgment, seeking a ruling that the arbitration clause in the reinsurance policy was void. In turn, defendant reinsurer Sompo filed a Motion to Compel Arbitration and dismiss the complaint. In conjunction with the briefing on these Motions, Sompo petitioned the court to seal certain pleadings and supporting materials.

Sompo based its request to seal on the ARIAS-US Form Confidentiality Agreement and Protective Order (referred to by the court as the "ARIAS-US Form") which requires that parties seek to file information pertaining to arbitration either in redacted form or under seal. At the time of the ruling, however, neither the parties nor the arbitration panel had executed the ARIAS-US Form. Sompo argued that there was a "substantial likelihood" that the parties would agree to the ARIAS-US Form. WSRMP did not oppose the request to seal.

The court noted that two standards generally govern requests to seal documents: The "compelling reasons" standard and the (lesser) "good cause" standard. *Wash. Schools Risk Mgmt. Pool v. Am. Re-Insurance Co.*, No. C21-0874-LK (W.D. Wash., April 20, 2022) at 2. The "compelling reason" standard applies to documents directly related to the underlying causes of action, including documents attached to pleadings. *Id.* The court chose this standard because it grants greater access for the public. However, even under the "compelling reason" standard, the court concluded that sealing was warranted. The court reasoned that the ARIAS-US Form requires the parties to seal and/or redact court filings that disclose arbitration information, and that the parties were likely to employ that form or similar language. The court relied on decisions from the Seventh Circuit and the Eastern District of California, each holding that a presumption of public access to a judicial record is overcome by rules of arbitration requiring confidentiality. *Id., citing, GEA Grp. AG v. Flex-N-Gate Corp.*, 740 F.3d 411, 420 (7th Cir. 2014); *Mastronardi Int'l Ltd. v. Sunselect Produce (California), Inc.*, No. 1:18-CV-00737-AWI-JLT, 2020 WL 469351 at *2 (E.D. Cal. Jan. 29, 2020).

Case: *Wash. Schools Risk Mgmt. Pool v. Am. Re-Insurance Co.*, No. C21-0874-LK (W.D. Wash., April 20, 2022)

Issue Discussed: Confidentiality of Arbitration Materials

Court: U.S. District Court for the Western District of Washington, Seattle Division

Date Decided: April 20, 2022

Issue Decided: Materials filed in furtherance of a motion to determine arbitrability should be maintained under seal pursuant to the terms of the ARIAS-US Form Confidentiality Agreement and Protective Order and intent of the parties to abide by its provisions.

Submitted by: Martha Conlin, Partner, Troutman Pepper LLP

On the Beach: The Spring Conference Returns to Florida

By Steve Schwartz, Spring Conference Co-Chair

Three years after the last live Spring Conference—and after a seeming eternity of COVID-19 restrictions—the Spring Conference returned to Florida this year. From May 11-13, roughly 200 ARIAS members convened at the Ritz-Carlton on Amelia Island to celebrate a tentative return to normality.

Of course, COVID-19 was not entirely absent. The planned keynote speaker, and at least one panelist, had to cancel after testing positive. But COVID-19 was also an opportunity for substantive discussion. For example, an all-star panel moderated by Guy Carpenter's Michael Sevi—joined by David Attisani, Curtis Leitner, Jonathan Sacher and Larry Schiffer—debated the reinsurance issues raised by COVID-19. And a breakout featuring Kelly Lankford, Erika Lopes-McLeman, Seema Misra and Stephanie Panico focused on COVID-19-related insurance issues.

Fortunately, the illness of our keynote speaker was only a minor problem—both for him and for the Conference. Without missing a beat, Mike Knoezer and Doug Maag stepped into the keynote spot. They transformed what was to have been a breakout session on political risk into a timely presentation on the insurance implications of the war in Ukraine.

The Conference also featured other presentations on substantive issues. For example, one lively panel led by Laura Foggan discussed Environmental, Social and Governance ("ESG") issues. Another featuring Lisa Simon and Alison Nisonger of Swiss Re and Stan Figura of BatesCarey explored the impact of climate change on both the claims and underwriting sides of the business. Swiss Re representative also took the stage for a breakout session on "forever" chemicals known as PFAS, as well as the impact of litigation funding on the industry.

Other panels focused on issues affecting reinsurance contracts. A breakout featuring Marnie Hunt of Aon and David Bradford of Zurich addressed hot topics in reinsurance wordings. And, proving that at least some opponents can get along with each other, Jon Hacker and Sean Keely discussed their multi-round battle that culminated in the Second Circuit's overruling of its Bellefonte decision.

No ARIAS Conference would be complete without a discussion of arbitration topics, and this one was no exception. A panel led by Patricia Fox discussed the rules of evidence and their potential implications for reinsurance arbitration. Continuing ARIAS's broadening focus on insurance arbitration, Michael Carolan and Ellen Kennedy compare insurance arbitration with its reinsurance counterpart. On another panel, Susan Claflin, Andrew Meerkins and David Thirkill debated the suitability of sanctions in arbitration. And, to close out the conference, Deirdre Johnson moderated a lively ethics debate among arbitrators Mark Gurevitz, Susan Mack and David Raim.

See you in Amelia Island May 17-19, 2023.

New Certified Arbitrators

David Anderson is the founder and principal of Anderson Risk Consultants, which provides arbitration, expert witness and credit and political risk insurance (CPRI) advisory services. He also serves as the Head of Political Risk Insurance for Starr Insurance Companies – North America. As an expert witness, he has handled cases across the New York, London, Singapore, and Hong Kong jurisdictions, engaged by seven different major law firms.

Anderson has a 24-year career in CPRI, mainly with Zurich Insurance Group AG, where he was the global head of CPRI 2016-2018. He has direct experience insuring a wide variety of investments and loan structures, including short term trade receivables and trade finance, structured trade finance, project finance, sovereign and sub-sovereign loans, PRI for property and mobile assets, and PRI for infrastructure projects in over 100 countries.

His professional designations include ARIAS Certified Arbitrator and accredited Member of the Chartered Institute of Arbitrators (CIArb).

Kevin Davidson is a seasoned reinsurance executive with more than 40 years of experience in both property and casualty insurance and reinsurance. In various roles as CEO, President and EVP, Davidson brings a wide range of experience on the reinsurance company side as well as the MGU side of the business in both the domestic US and LLoyd's marketplace. Progressing through the underwriting ranks, Davidson has extensive experience in property, casualty, treaty, facultative, catastrophe and excess insurance. As a divisional President of Munich Re, Davidson was responsible for the profit and loss on a portfolio in excess of $1 billion, staff of greater than 250 and twelve domestic branches. In addition, he has first-hand experience in MGU start-ups. Davidson holds a B.A. and M.B.A. His professional designations include Chartered Property and Casualty Underwriter (CPCU), Associate in Reinsurance (ARe).

Margarita Echevarria has worked in the insurance industry since 1979 as either in-house counsel or a Chief Compliance Officer for major multi-line insurance carriers and a global bank. In addition to the broad exposure to various products and markets required in her capacity as an insurance executive for these firms, her roles required advising the different operational and administrative units such as Product Development, Underwriting, Marketing, Policyholder Service, Claims, Licensing, Sales and Actuarial on their legal, regulatory, and contractual concerns.

Echevarria's experience as an advisor included offshore programs, captive insurance, and online sales. Her roles also required active membership on several risk committees concerned with investment policy, business strategy, and operational risks such as the Asset & Liability, Operations Risk and Executive Committees. Her in-depth knowledge of the legal and regulatory requirements for insurers and insurance products facilitated her role as an adjunct professor of US Insurance Law at Seton Hall Law School.

Echevarria is active in the Section on Dispute Resolution, Arbitration Committee of the American Bar Association having served as Membership Co-Chair, Women in Dispute Resolution having served as Co-Chair of the Regional Chairs, and a member of the Section on Dispute Resolution of the NY State Bar Association, currently serving as Co-Chair of the Securities Arbitration Committee for the Commercial-Federal Litigation Section. She is Vice-President of the NJ Association of Professional Mediators.

Tom Forsyth is an attorney with 40 years of experience representing insurance and reinsurance companies. He has held General Counsel and claims and contracts management roles at both insurers and reinsurers.

Forsyth's experience and expertise includes claims and contract matters related to accident and health, adverse development covers, allocation, asbestos, the COVID pandemic, environmental property damage and cumulative injury, financial products, life recapture and mortgage guaranty issues.

His prior executive positions include: General Counsel of Partner Reinsurance Company of the U.S. and Secretary of PartnerRe Life Reinsurance Company of America; General Counsel of One Beacon Insurance Company; General Counsel of Swiss Re America and Head of Claims and Liability Management of the Americas division of Swiss Re; and Deputy General Counsel of the Travelers Insurance Companies. In addition to his role as an attorney, Forsyth also had management responsibility for claims and reinsurance contract drafting units.

Forsyth is a former President and Chair of the Board of Directors of ARIAS, a member of its Long Range Planning Committee and a former chair of the Law Committee of the Reinsurance Association of America. Prior to going Travelers, Tom was an attorney in private practice in Los Angeles.

Patricia Taylor Fox has more than 20 years experience in the insurance and reinsurance industry. She currently serves as Deputy General Counsel in the Reinsurance Legal Division of AIG, where she is the head of the Dispute Resolution Unit. Fox began her career in reinsurance as an associate attorney at Werner & Kennedy. Before joining AIG's legal department, she was an associate with the law firm of Simpson Thacher & Bartlett LLP, where she concentrated her practice in the resolution of reinsurance litigations and arbitrations. Fox has co-authored articles on evidence in arbitrations, attorney-client privilege, the common-interest privilege and developments in reinsurance law, and is a frequent speaker on issues relating to the arbitration of reinsurance disputes.

Henry French owns Bitfrost LLC, through which he provides consulting, expert witness, and arbitration services. He founded Bifrost in early 2020 after retiring from AXA XL, where he had worked for 19 years. He attended law school at the University of Wisconsin, graduating in 1986, and he's been working in the insurance/reinsurance industry ever since. French has served in various roles, including: General Counsel of business units, Head of Litigation, Head of Claims, Compliance Director, and Head of Operational Risk. He's managed significant litigation, arbitrations, and bad faith lawsuits. French also has served as an expert witness on claims handling, the Bermuda market, and Form.

New Certified Arbitrator, Neutral Arbitrator, Mediator

John C. Lenzen, FCIArb is an international arbitrator, mediator accredited by the Centre for Effective Dispute Resolution (CEDR), and dispute-resolution specialist. For twenty-five years, he served the insurance industry as outside counsel and in a variety of senior Legal and Claims roles, principally based in Bermuda. These included General Counsel to a number of insurance and reinsurance companies, General Counsel to and Head of Claims for Chubb (previously ACE) Bermuda, and both Worldwide Head of Litigation and Chief Litigation Counsel, Global Claims to the ACE and Chubb Groups – positions he held consecutively for fifteen years.

Lenzen has fairly assessed, determined, and resolved countless high-severity claims under commercial policies involving excess liability (with a particularly heavy emphasis on the Bermuda Form), financial lines, property, political risk, reinsurance and retrocessions, and eleven-figure underlying losses spanning the globe.

He has had direct responsibility for the hands-on management of many international and multi-jurisdictional arbitrations in England, Bermuda, and the United States, at least twenty of which went to an Award.

Lenzen also has extensive experience personally resolving many complex, nine-figure disputes through mediation and principal-to-principal discussions, and successfully employing creative negotiating strategies for challenging multi-party disputes implicating up to ten figures and involving numerous counsel and perspectives, and dozens of parties.

With this background, a large part of his career has been devoted to counseling executives, underwriters, and claims professionals on best practices, likely outcomes, and unconventional approaches to achieve exceptional resolutions.

New Certified Neutral Arbitrator

Peter Scarpato is an experienced alternative dispute resolution professional, who has served in hundreds of cases as either arbitrator or mediator. He began his career as a lawyer licensed to practice in New Jersey and New York, and moved into the corporate sector, where he negotiated hundreds of commercial disputes and settlements involving insurance and reinsurance matters. His career ADR practice covers all forms of civil, commercial, contract, construction, and insurance disputes, with a specific expertise in property/casualty/life insurance and reinsurance, run-off (legacy) business, FINRA securities claims, surety, and automobile and other types of warranties. In his 40-plus year career, Peter served as outside and in-house counsel, senior profit center executive managing business and related litigation, senior executive for the collection and negotiation of reinsurance balances, and arbitrator or mediator successfully resolving disputes. With five decades of experience, Peter is qualified to offer a comprehensive perspective on the proper and reasonable resolution of all types of disputes. In his free time, Peter enjoys writing (he's currently co-authoring a book), reading, singing choral music, and spending quality time with his wife, Paula Weiss; children Rachel (and her wife, Jenna) and Aaron; grandson Adrian; and dog Millie.

New Certified Umpire

John Chaplin has been employed as a transactor of reinsurance (broker, underwriter) in the insurance and reinsurance field for 45 years, and thus has first-hand experience in the turmoil of the US and London reinsurance markets during the liability crisis of the 1970's and 1980's along with the subsequent market recoveries; the meltdowns in the Workers Compensation field that followed in the 1990's and the boom in the natural disasters of the early 2000's. His experience in those years was as an intermediary at Guy Carpenter and later as a direct writing reinsurer at North American Re (now, Swiss Re America).

He has performed several roles within the field of alternative dispute resolution under the aegis of ARIAS-US: arbitrator, umpire, mediator, advisor and expert witness. Chaplin's long experience in broking and underwriting has made him conversant in virtually all of the insurance and reinsurance disciplines of underwriting, intermediation, accounting, finance, and claims.

In addition, Chaplin has served as a lecturer, trainer and panel member typically in the field of reinsurance, providing education to insurers, reinsurers and intermediaries on a variety of subjects. Chaplin's training activities outside of ARIAS-US include seminars for the Reinsurance Association of America, the Intermediaries and Reinsurance Underwriters Association and the Insurance Library Association of Boston.

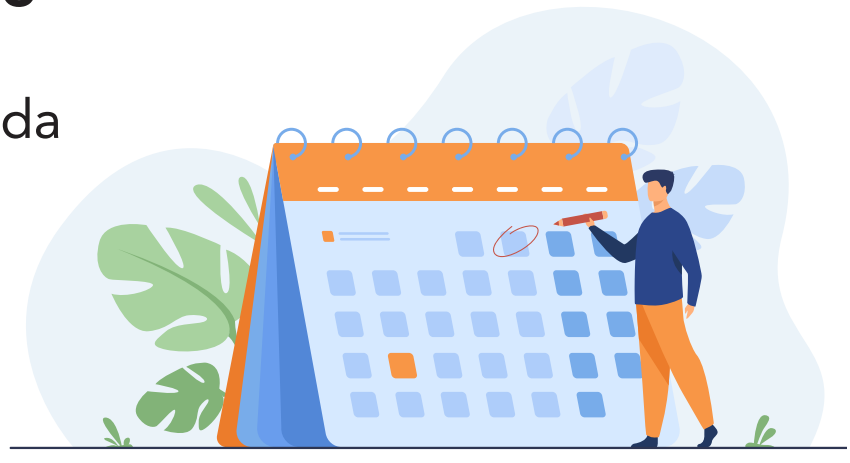
While Chaplin's major focus over time has been property and casualty insurance, he is experienced in certain specialty lines of business such as life and health insurance, professional liability, cyber and aviation.

UPCOMING EVENTS

Spring Conference

May 17-19, 2023

Ritz-Carlton on
Amelia Island, Florida



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