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April 25, 2005

DRI Insurance Law Committee—Chair's Message

Below is an adaptation of the Chair's column I authored to lead off the DRI Insurance Law Committee's collection of articles for the May 2005 issue of *For The Defense*. I thought it would appropriate to include it in the inaugural *Carrier Chronicle* in order to provide the Insurance Industry with a glimpse of the many ways that DRI and our Committee are pouring our efforts into projects that will benefit us all. When I look at how much we're involved, I'm often amazed at how well it's all coming together. Our Committee has a remarkably strong base of leadership, and the hard work of many is responsible for the results we've seen. Further, response from the Insurance Industry to these projects has been incredibly positive. I've been stopped several times at seminars and even received calls and e-mails about the "cutting edge" sensibilities that DRI has exhibited by being involved in these projects. I'd love more input from the insurers on how we can help them identify and respond to the issues that are important to them. Please feel free to contact me at pwhite@tsmp.com.

An Ambitious and Responsive Committee

The mission of the Insurance Law Committee ("ILC") is to stay current on insurance coverage issues, identify evolving theories confronting insurers, and identify the defenses and strategies for responding to such theories. Reports of DRI papers being referred to in judicial decisions, news reports, and in Congress are frequent, and are a tribute to the hard work and work product of our membership. Highlights of activities over the last several months include:

DRI Insurance Roundtable: From April 13–15, 2005, members of the ILC participated in the DRI Insurance Roundtable—a gathering of senior officers from several insurers throughout the country. The Roundtable allows those in attendance to hear about the latest developments and issues confronting insurers. Issues this year included, among others, the use of Metrics in evaluating attorney performance, where trial lawyers of the future will come from, discovery issues, investigations into insurance industry commission and bidding practices, and punitive damages after *State Farm v. Campbell*.

Insurance Coverage & Practice Symposium: Our annual Insurance Coverage & Practice ("ICP") Symposium closed out 2004 with a bang in New York City. We had almost 500 people in attendance. This seminar has become the benchmark for presentations on current insurance coverage issues. This seminar will once again be held in New York City in December 2005.

Insurance Coverage & Claims Institute: From April 6–8 the ILC presented the annual Insurance Coverage and Claims Institute in Chicago. The seminar attracted record attendance (almost 400 people) and provided an opportunity for attorneys and insurance professionals to educate themselves on current developments and to network with each other. On April 7, a plenary session was held that covered numerous current issues confronting insurers. On April 8, breakout sessions were held to address the latest issues regarding property insurance, commercial liability insurance, and bad faith issues.

Specialized Litigation Group Subcommittees: Our ILC is currently working on the reorganization of its SLG (Specialized Litigation Group) subcommittees. The current subcommittees are: Advertising Liability, Automobile Liability, Bad Faith, Construction Law, Directors and Officers, Employment Law, Environmental Law, Excess and Reinsurance, First-Party Property, Homeowners Insurance, Professional Liability, Mold and Toxic Torts, and Staff Counsel. We are seeking Chair and Vice Chair positions for each SLG, and are also seeking recommendations for any other SLGs that we should establish. If you are interested, please send an e-mail to julia.molander@sdma.com.

Insurance Industry Investigation: On February 1, we sponsored a teleconference on issues arising from the investigation into insurer and broker sales and commission practices. Patrick Maloney, a former DRI President, and Robert Mahler, an attorney with substantial experience in white-collar defense work, spoke and presented papers on the theories of liability facing the insurance industry and the most likely defenses to those theories. We have also initiated a separate subcommittee to help us monitor these investigations. Jeanne Unger, a former ILC chair is spearheading this project, which will include publishing of papers and conferences on issues arising from these investigations.

Annual Meeting: The Committee is currently planning for the DRI Annual Meeting, which will be held in Chicago in October. There will be a panel discussion on the recent investigations into the insurance industry during the general session and a CLE on trial tactics in bad faith cases for the ILC meeting.
Auto Insurance and Coverage Seminar: DRI's first automobile liability insurance coverage seminar is

scheduled for November 2005. Jay Harris will chair this seminar. You can contact Jay at jharris@finemanlawfirm.com.

Bad Faith Teleconference: A teleconference highlighting bad faith issues and litigation will commence in May 2005. Tony Zelle, who chaired our preparation of a bad faith compendium, has taken on the role of chair/speaker for this teleconference, along with Daina Kojelis of Zurich Insurance Company.

Hurricane Teleconference: Within a few weeks of the devastating hurricanes that struck Florida this last fall, the ILC—led by Lee Craig—presented a two-hour telephone conference on the legal and coverage issues confronting insurers responding to hurricane claims. Hundreds of people participated in the teleconference, which helped to educate insurers and served the interests of both policyholders and insurers in identifying coverage issues and solutions related to these catastrophes.

For The Defense: The May 2005 issue of *For The Defense* will include substantive articles addressing insurance issues surrounding insurers' use of Metrics in evaluating counsel performance and issues regarding the tripartite relationship.

Covered Events: This monthly electronic newsletter continues to highlight new appellate decisions and present timely articles on insurance coverage issues.

Terrorism Risk Insurance Act ("TRIA"): April 2005 also saw the completion of the *Terrorism Risk Insurance Act ("TRIA") Compendium*. Ronald Robinson, Chair of our TRIA subcommittee (and recipient of DRI's 2004 Community Service Award), oversaw this comprehensive analysis of one of the most pressing insurance issues. Ron and members of his subcommittee have also been active in educating Congress on TRIA-related issues and have spoken or been asked to speak on terrorism insurance issues on programs both in the United States and abroad.

Miscellaneous Projects: We also have several other projects underway regarding the duty to defend, discovery, UM/UIM issues, and attorneys' fees. In sum, we are compiling law on these issues and working to create compendiums, White Papers, and other compilations that will benefit DRI, its members and their clients.

We hope to see many of you at our upcoming seminars and to hear about how the ILC can be of further assistance to you.

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April 25, 2005

The Insurance Industry Under Investigation: Investigations and Their Aftermath

Background of Investigations

In February 2004, the Washington Legal Foundation wrote to the Attorney General and Insurance Commissioners of the States of New York and California urging them to investigate the practices of various insurance brokers. In May of 2004, New York Attorney General Spitzer's office was reported to have issued subpoenas to several major brokers and insurance companies requesting information on commission agreements, also known as broker contingent agreements, placement service agreements (PSA's), or market service agreements (MSA's).

On October 14, 2004, the New York Attorney General's office filed a civil suit in Manhattan bringing charges of fraud and anti-trust violations against Marsh & McLennan Cos. The lawsuit alleges that Marsh illegally steered clients to insurers that paid the highest commissions and that Marsh solicited rigged bids for insurance contracts. In addition, the lawsuit alleged undisclosed and illegal compensation arrangements between Marsh and various insurance companies primarily through the use of "contingent commissions." Several major insurance companies are named in the lawsuit as participants.

The investigation has spread into other areas of the insurance industry including employee benefits as well as life, health and disability insurance. On November 12, 2004, the New York AG's office filed a lawsuit in Manhattan bringing charges of fraud against life and disability insurance broker Universal Life Resources.

In addition, the New York Attorney General's office has undertaken investigation of another industry practice referred to as "tying" whereby certain brokers are alleged to have steered business to insurance companies in return for arranging the insurers' reinsurance program. In December of 2004, the investigation again widened into the sale of professional malpractice insurance to law firms. Finally, this office has also subpoenaed documents from numerous insurance companies for information related to non-traditional insurance products such as finite risk insurance and reinsurance policies.

Insurance-Brokerage Business

The insurance brokerage business operates on a multi-national level and is pivotal to the insurance community. Noticeably, the insurance brokerage industry has become much more concentrated in the last ten or fifteen years based upon a series of mergers and acquisitions. Large brokers provide a broad range of services to insurance companies in addition to simply placing and evaluating insurance risk. It is important to distinguish between insurance agents and insurance brokers. Generally, brokers purchase insurance on behalf of their clients in exchange for a commission which is determined as a percentage of the premium. Insurance agents, on the other hand, are generally appointed by insurance companies to offer their products for sale.

Significance of Contingent Commissions

Agents and brokers have traditionally been paid in the form of commissions for the services they render to their clients. In addition to being paid commissions, brokers oftentimes are paid additional fees by their clients for representing them in the purchase of insurance and for other services such as risk analysis and loss control. In addition, there are agreements that provide compensation to brokers over and above commission payments and these are commonly referred to as contingent commissions, placement service agreements, or market service agreements. This is not something new to the insurance industry. They have been used throughout the world and in the United States for decades. The use of such commissions is well known among corporate buyers of insurance, risk managers, the insurance trade associations, the insurance commissioners of the various states, and others. It is important to distinguish between allegations of anti-competitive practices (including bid-rigging and market manipulation) and contingent commissions. Contingent commissions are not generally linked to specific policies, but are based on the overall relationship between brokers and carriers and the specific services that the broker provides.

The Civil Suit Theories:

• "Steering"

Unjust enrichment from use of contingent commission agreements, i.e., receiving undisclosed additional payments from insurance companies based upon volume of insurance placed with those particular companies

• "Bid-Rigging"

Persuading insurance companies to submit false, high bids in order to inflate amount of actual bid—companies later rewarded for inflated bids; or, price-fixing through manipulation of insurance procurement process.

• "Tying" or "Leveraging"

Anti-trust violation through unlawful tying arrangements by using market power to tie the purchase of one product to purchase of a second product

• "Breach of Fiduciary Duty"

Illegal schemes breach relationship of trust and confidence owed to clients; or not acting in good faith—not serving clients' best interests.

Defenses

- Utilization of contingency fee agreement had been disclosed to client;
- The use of contingency fee agreements is not illegal;
- Insurance commissioners, risk managers, and professionals in the industry have been aware of the use of contingency fee agreements, and have approved them for decades;
- An insurance company does not have a direct relationship with the insurance purchaser and is not obligated to disclose any contingent fee agreements to the purchaser;
- The insurance broker represents the purchaser of insurance and it is their obligation, if any, to disclose the existence of any contingent fee agreement;
- If an insurance agent represents the insurance company alone, that agent has no direct relationship with the insurance purchaser and has no obligation to disclose the existence of any contingent fee agreement;
- An insurance company is not vicariously responsible for the conduct of an insurance broker. In fact, an insurance company may sue an insurance broker for any fraudulent acts of the broker related to the purchase of insurance from that insurance carrier;
- An insurance company is not responsible for the acts of any of its employees committed outside the scope of their employment;
- An insurance company may not be vicariously liable for the criminal acts of any of its employees;
- Statutes of limitations may apply;
- Estoppel may apply.

Impact on Insurance Companies—Considerations

Almost immediately following the filing of the lawsuit against Marsh, several leading brokers, including Marsh, announced that they would eliminate contingent fee commissions. In addition, several insurers have announced that they will not be making contingent fee commission payments going forward. Although many insurance carriers have received subpoenas related to the issues raised in the Marsh litigation, few of those carriers have yet been required to speak publicly. There is a general consensus in the industry that the terms

of any contingent compensation system for brokers should be transparent and disclosed in the most highly desirable way. There is a dispute and disagreement in the industry as to exactly how the transparency and disclosure goals should be reached. Should there be uniform disclosure standards? Should there be a federal regulatory reform statute? Should the various insurance commissioners in different states develop a model that would contain common requirements for disclosure by brokers?

All carriers should be prepared to respond to any subpoena issued by the regulators seeking documentation related to the method of payments to brokers and agents. An internal review of documents should be done under the close supervision of legal counsel with an eye toward identifying all types of documentation related to contingent commission arrangements.

Policyholders—Possible Damages

- Difference between inflated premiums and their reasonable market price:

If a policyholder purchased insurance through a broker using an undisclosed contingent commission arrangement, they may have paid an artificially high premium.

- Damages resulting from illegal steering:

If a policyholder can demonstrate it received less than desired insurance program due to “steering,” it may be able to recover against the broker that improperly steered them away from otherwise available coverage.

- Other avenues for recovery:

Claims for restitution, unjust enrichment, unfair business practices, fraud, misrepresentation, antitrust violations, and RICO.

Websites and databases tracking insurance broker litigation:

a. Insurance Journal

i. <http://www.insurancejournal.com>

1. Perform “Site Search” of key terms “Spitzer,” “bid-rigging,” “contingent commissions”

b. Insurance Information Institute

i. <http://www.iii.org>

1. Under “Media” click “hot topics”

2. Under “hot topics” click “Broker/Agent Compensation”

c. Insurance News Net

i. <http://www.insuranceneWSnet.com>

1. Skim headlines under “Today on INN...” and “Top Insurance News”

d. The National Underwriter Company

i. <http://www.nationalunderwriter.com>

1. Perform “Search” of key terms “Spitzer,” “bid-rigging,” “contingent commissions”

e. Insurance Newscast

i. <http://www.insurancebroadcasting.com/today.htm>

1. Scroll down, skim headlines

ii. <http://www.businessinsurance.com>

1. Scroll down, skim headlines

f. RiskVue – Risk Management Professionals

i. <http://www.riskvue.com>

Scroll down, skim headlines

g. RiskVue – Risk Management Professionals

i. <http://www.riskvue.com>

1. Scroll down, skim headlines

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“Total Loss” Storm Claims in Florida

From August 13 to September 25, 2004, four hurricanes—Charley, Frances, Ivan and Jeanne—came ashore in the Sunshine State. As these events unfolded, catastrophe after catastrophe, it is unlikely that anyone was thinking about an appellate decision just two months old—*Mierzwa v. Florida Windstorm Underwriting Ass'n*, 877 So.2d 774 (Fla. 4th DCA. 2004). But as we see now, that

decision hardly could have been more timely, more troublesome, or more unwelcome for claims arising from the 2004 hurricanes. Taken together with the so-called 50 percent rule of the Federal Emergency Management Agency (“FEMA”), and Florida’s “valued policy” law, the *Mierzwa* case created massive claims exposure in the wake of the storms. The conjunction of these three laws has given birth to “total losses” undreamed of by underwriters. To understand why, one must look first at each of the three laws.

50 Percent Rule

The 50 percent rule determines when a partially damaged building that does not conform to then existing building codes must be brought into full compliance with such codes. The rule has many sources. In Florida, it is embodied in the Florida Building Code and, with respect to FEMA, in the Code of Federal Regulations at 44 C.F.R. §59.1. Basically, the rule takes effect when a building is “substantially damaged,” meaning the “cost of restoring” it equals or exceeds 50 percent of the “market value” before the damage. In that case, the building must be brought “up to code.”

The 50 percent rule can have profound consequences. If the damaged building is located in a designated flood plain, bringing it “up to code” can mean, at a minimum, it must then be elevated above the 100-year “base flood elevation.” In other words, the building cannot be merely repaired. It must be knocked down and rebuilt, if at all, on some kind of supporting structure. Unfortunately, under Florida law, when an ordinance, regulation or governmental entity forbids mere repair, the building may be deemed a “constructive total loss.” *Reliance Ins. Co. v. Harris*, 503 So.2d 1321 (Fla. 1st DCA 1987); *Regency Baptist Temple v. Ins. Co. of North America*, 352 So.2d 1242 (Fla. 1st DCA 1977); *Netherlands Ins. Co. v. Fowler*, 181 So.2d 692 (Fla. 2d DCA 1966).

Valued Policy Law

This brings us to the second of the three laws under consideration—the “valued policy” law. The crux of the pertinent part of the Florida valued policy law, §627.702 Florida Statutes, is that, in case of a total loss, the amount owed under the policy is the limit for the structure. In other words, it is prohibited to depreciate or assign an alternate value for a total loss. The contract damages are liquidated in the face amount of the policy for that coverage.

The Valued Policy Law is part of every insurance policy written on property in Florida. *Citizens Ins. Co. v. Barnes*, 124 So. 722 (Fla. 1929); *Regency Baptist Temple v. Ins. Co. of N. Am.*, 352 So. 2d 1242 (Fla. 1st DCA 1977).

There are two essentials in the statute. The first is that the building be “insured by [an] insurer as to a covered peril.” The second is that the building be a total loss. If these two facts exist, the Valued Policy Law mandates that the carrier, who chooses not to elect to repair, is liable for the face amount. The rationale, of course, is that the insured paid a premium to insure the building for a certain total amount. It would be inequitable for the law to allow depreciation of that amount when there is a total loss.

Mierzwa, 877 So.2d at 775.

Thus, we can see that a building that cannot be repaired, because of the invocation of the 50 percent rule, but must be demolished, is a constructive total loss. Accordingly, the valued policy law dictates the amount owed is the “face amount” of the policy even though the actual direct physical loss is far less than the limits. This consequence alone was probably not fully appreciated in the underwriting of property insurance in Florida. But it gets worse.

The *Mierzwa* Decision

What if the building is damaged say, 51 percent of its market value? And what if that damage resulted from more than one cause of loss? And what if a particular policy on that building provides coverage for only one of the operative causes of the loss? How is the valued policy law applied in such circumstances?

In *Mierzwa v. Florida Windstorm Underwriting Ass’n*, 877 So.2d 774 (Fla. 4th DCA. 2004), decided June 23, 2004, the Florida Fourth District Court of Appeals addressed the application of the valued policy law in a case involving two carriers insuring the same house for different perils. The homeowner had wind insurance with one carrier and flood insurance with another. The wind insurer’s policy contained an anti-concurrent cause clause excluding coverage for damage other than by wind. The house was damaged by both wind and flood. There was no dispute that the windstorm caused 57 percent of the damage and flood caused the other 43 percent.

A city ordinance (patterned after FEMA guidelines) contained a 50 percent rule. The local building official determined, the dollar amount of the damage was more than 50 percent of the market value. (The dollar amount of the damage, by the way, was less than 50 percent of the policy limit for windstorm.) Because the house was located in a flood area, the building code required that the site be elevated and this could not be

done without demolishing the structure.

The insured claimed that the valued policy law required the wind insurer to pay the face amount of the policy because the building was a total loss. The insured also contended he was due an additional 25 percent in benefits under the ordinance or law coverage. The wind insurer, on the other hand, contended it was liable only for its *pro rata* share of the total loss, not the face amount of the policy.

The trial court agreed with the insurance company. The trial court also refused also to award any additional sum for "law and ordinance" coverage. The damage by windstorm alone, said the trial court, had not exceeded 50 percent of the structure's value and thus had not resulted in the application of the ordinance.

The Fourth Circuit Court of Appeal reversed, holding that the insurer was liable for both the face value of the policy and the full ordinance or law coverage. The court found that the meaning of the Valued Policy Law was "simple and straightforward." If the building is insured by an insurer for a covered peril and the building is determined to be a total loss, the Valued Policy Law mandates that the carrier is liable to the owner for the face amount of the policy, no matter what other facts are involved as to the cost of repairs or replacement.

According to the *Mierzwa* court, then, once there is a determination that there has been a total loss, the value of damage actually caused by individual perils is simply not relevant. It did not matter, in that case, that the total damage was less than half the limit on the windstorm policy. It did not matter that wind caused only 57 percent of that damage, such as it was. It did not matter even that there was an anti-concurrent causation clause in the windstorm policy. The windstorm carrier owed the face amount of the policy.

The court also rejected the argument that the law and ordinance coverage should depend on whether the damage caused by the covered peril actually resulted in the application of the law or ordinance. If the building is deemed a total loss for the purpose of the Valued Policy Law, "it should certainly be deemed a total loss for purposes of ordinance or law coverage." 877 So.2d at 879.

This case is precedent in the trial courts of Florida. The Florida Supreme Court proclaimed, in *Gore v. Harris*, 772 So.2d 1243, 1258 (Fla. 2000), that "[t]he decisions of the district courts of appeal represent the law of this State unless and until they are overruled by this Court, and therefore, in the absence of interdistrict conflict, district court decisions bind all Florida trial courts." Thus, *Mierzwa* is the law of Florida until there is a different rule by another district court, or the Florida Supreme Court.

Is Relief in Sight?

Is anybody doing anything about this? The Florida legislature has House Bill 1937 under consideration. One part of that bill included a prospective amendment to the valued policy law.

The legislative intent of this subsection is not to require an insurer to pay for a loss caused by a peril other than the covered peril. In furtherance of such legislative intent, when a loss was caused in part by a covered peril and in part by a non-covered peril, the insurer's liability under this section shall be limited to the amount of the loss caused by the covered peril.

At the time of this writing, the above language, clearly intended to negate the harsh effect of *Mierzwa*, has been removed from the bill. It appears that there will be no immediate relief from the legislature.

Also there are several class actions that may frame the issues, e.g., *Mineo vs. USAA Casualty Insurance Co.*, Case No. 05000156CA, in the Circuit Court for Santa Rosa County. But, of course, litigation moves slowly, and class actions slowest of all. And the outcome is uncertain in any event. It appears there will be no immediate relief from the courts.

Conclusion

It is no understatement that there is a property insurance crisis in the offing. Some carriers simply cannot follow the law outlined above and remain solvent. Others, in grim recognition of the unjustness of *Mierzwa*, have elected to ignore it in hopes of creating judicial conflict through litigation. Others, resigned to the bitter consequences of the conjunction of the 50 percent rule, the valued policy law, and the decision in *Mierzwa*, plan to apply for a rate increase, or stop issuing new policies.

This brief article contains several generalizations. It glosses over, or skips, a number of deep and complex matters. Indeed, many questions will arise for even the casual reader. What, if anything, can the insurance company do to influence the underlying determination that a building is, or is not, damaged more than 50 percent of its market value? Can the insurance company avoid the valued policy law by electing to repair, as mentioned in the *Regency Baptist* case? Does the above analysis apply to any causes of loss in any combination? The answers to these questions, and many others, are beyond the scope of this article.

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April 25, 2005

What Insurers Can Do to Secure Reasonable Rates from Conflict Counsel

Containing defense costs begins by establishing a reasonable rate for the legal services to be provided by defense counsel. Even in situations where a liability insurer does not have an unrestricted right to select defense counsel or control how the case is defended, the insurer is not powerless to secure reasonable rates from the defense attorneys. This article describes what liability insurers can do to obtain reasonable rates when the selection of conflict counsel does not depend entirely upon the choice of the insurer. As discussed, *infra*, some states have enacted statutes that provide a framework for challenging the reasonableness of fees submitted by independent or conflict counsel. See Cal. Civ. Code §2860 (2001).

How the Right to Select Defense Counsel Affects the Rate Question

One of the basic obligations under general liability policies is the duty to defend the insured for potentially covered suits. The insurer's obligation to defend potentially covered claims is generally accompanied by the contractual right to select defense counsel. However, when a suit against an insured does not fall clearly and certainly within the insuring agreements of the policy, a liability insurer may reserve its right to deny coverage. A conflict of interest between the insurer and its insured can arise when a reservation of rights is asserted. When a conflict does exist, it eliminates or at least limits the insurer's right to select defense counsel.

Depending upon the laws of the particular jurisdiction, a liability insurer finding itself in such a conflict situation may have little or no control over the selection of defense counsel. When a conflict of interest exists, the insurer typically is not allowed to control the defense of the insured, but must discharge its duty to defend by reimbursing the insured for the reasonable costs of the defense. This includes the "reasonable fees" incurred by defense attorneys selected by the insured.

The practical problem is that in circumstances where a conflict of interest deprives an insurer of the right to select defense counsel, the insurer's ability to negotiate fair rates with the lawyers is greatly diminished. Yet, even when the insurer has no say in the selection of counsel, the "reasonable fee" standard represents a significant limitation on the defense costs that conflict counsel can demand of the insurer.

Conflicts of Interest and the Right to Choose Defense Counsel

In circumstances where a conflict of interest exists, state law determines the extent to which the insurer may participate in the selection of defense counsel. This is pivotal with respect to an insurer's efforts to secure a fair and reasonable rate from defense counsel, because the more control the insurer retains over the selection of defense counsel, the better able the insurer will be to negotiate rates with the attorneys who seek the assignment. Thus, the conflict rules of the governing jurisdiction largely define how much leverage an insurer will have to determine the rates that can be charged by conflict counsel.

Some jurisdictions grant the *insured* sole discretion in the selection of conflict counsel, without any consideration for the insurer's preferences. Insureds in several states enjoy relatively unfettered discretion in assigning independent defense counsel to represent them in conflict situations, including: Arkansas: *Northland Ins. Co. v. Heck's Service Co.*, 620 F. Supp. 107 (D. Ark. 1985); Illinois: *Maryland Casualty Co. v. Peppers*, 355 N.E.2d 24 (Ill. 1976); New York: *Nelson Electrical Contracting Corp. v. Transcontinental Ins. Co.*, 660 N.Y.S.2d 220 (3d Dep't 1997); Mississippi: *Moeller v. Amer. Guar. And Liability Ins. Co.*, 707 So.2d 1062 (Miss. 1986); Louisiana: *Belangerr v. Gabriel Chemicals, Inc.*, 787 So.2d 559 (La. Ct. App. 2001); New Jersey: *Merchants Indem. Corp. v. Eggleston*, 179 A.2d 505 (N.J. 1962); Maryland: *Roossos v. Allstate Ins. Co.*, 655 A.2d 40 (Md. App. 1995); Utah: *Lima v. Chambers*, 657 P.2d 279 (Utah 1988). Courts in these jurisdictions preclude an insurer from having any role in the selection of counsel to ensure that the insurer exerts no influence on the way the defense is conducted in the underlying litigation. However, even in these jurisdictions, the insured is required to exercise good faith and act reasonably when selecting its defense counsel, which includes the retention of counsel who use ethical billing practices and are competent to represent the insured's interests in the litigation. *Center Foundation v. Chicago Ins. Co.*, 278 Cal. Rptr. 13 (Ct. App. 1991).

At the opposite end of the spectrum, some jurisdictions allow the insurer to select conflict counsel when a conflict exists. However, these courts typically impose special requirements on insurers to prevent abuse of this right to select defense counsel. For example, the insurer selecting the counsel may be precluded from raising collateral estoppel against the insured concerning coverage issues remaining after the resolution of the underlying action; the insurer may be required to select counsel for the insured who are not the insurer's usual "panel counsel;" and the insurer may have a heightened obligation to report to the insured of the progress and status of the defense, including settlement demands and other issues. See, e.g., *Tank v. State*

Farm Fire & Cas. Co., 715 P.2d 1133 (Wash.) (providing these and other requirements on the insurer); *Twin City Fire Ins. Co. v. Colonial Life & Ass.*, 839 So.2d 614 (Ala. 2002); *Federal Ins. Co. v. X-Rite, Inc.*, 748 F. Supp. 1223 (E.D. Mich. 1990).

Other jurisdictions permit the insurer and insured to *share* in the selection of conflict counsel. See *Employers Fire Ins. Co. v. Beals*, 240 A.2d 397 (R.I. 1968) (insurer provided with the right to approve the insured's selected independent counsel). By allowing the insurer a voice in the selection of the independent counsel, these jurisdictions attempt to minimize the abuses that may occur when an insured is given sole discretion to select its own counsel. Some jurisdictions define the insurer's and insured's respective roles in the selection of counsel through statutory guidelines. Cal. Civ. Code §2680 (2001); Fla. St. §627.426 (2000); Alas. St. §21.89.100 (1999). These statutes typically provide objective descriptions of the insured's and insurer's respective roles in the selection of conflict counsel. Cal. Civ. Code §2860 provides that an insurer has the right to require the counsel selected by the insured to have at least four years of experience; Fla. St. §627.426 provides that in a conflict situation, the insurer is entitled to retain independent counsel which is mutually agreeable to both the insurer and the insured; and Alaska St. §21.89.100 provides that if the insured selects counsel, the insurer may require the defense counsel to have 4 or more years experience. Courts in these jurisdictions have recognized that insurers have a legitimate interest in controlling the total costs of the litigation, so they require that the insured's selection of conflict counsel must be approved by the insurer, provided that approval is not unreasonably withheld. See *Beals, supra.*; see also *Hartford Ins. Co. v. A&M Associates, Ltd.*, 200 F. Supp. 2d 84 (D. R.I. 2000).

Determining a fair and reasonable rate for conflict counsel can be resolved through arm's length negotiations, to the extent that the insurer is permitted to select or provide input into the selection of conflict counsel. However, when an insurer is excluded from participation in that selection process, the question of a reasonable rate becomes much more difficult to resolve. Consequently, securing a reasonable rate from conflict counsel is intrinsically more difficult in some jurisdictions than it is in others.

Legal Standards Defining the Duty to Defend

Regardless of who selects the defense attorney, an insurer is responsible for reimbursing only the *reasonable* attorneys' fees and costs that are actually incurred in the underlying defense. *First Jefferson Associates v. Ins. Co. of N. America*, 691 N.Y.S.2d 506 (1st Dep't 1999); *Chicago Title Ins. Co. v. F.D.I.C.*, 172 F.3d 601 (8th Cir. 1999) (interpreting Minnesota law and recognizing a duty to reimburse reasonable fees); *Aetna Cas. & Sur. Co. v. Dow Chemical Co.*, 44 F. Supp.2d 847 (E.D. Mich. 1997); *Chatterson v. Walker*, 938 P.2d 255 (Utah 1997); *Nisson v. Amer. Home Assur. Co.*, 917 P.2d 488 (Okla. Civ. App. 1996); *Northern Ins. Co. of N. Y. v. Allied Mut. Ins. Co.*, 955 F.2d 1353 (9th Cir. 1992); *Maryland Casualty Co. v. Peppers*, 355 N.E.2d 24 (Ill. 1976). This is a substantive standard of limitation on the rates that conflict counsel can charge and on the rates that the insurer may be expected to pay. This standard binds insurers, the defense attorneys who seek payment from the insurers, and the insureds who have selected the defense attorneys. The "reasonable fee" standard arises from state insurance law, and it is also a central tenet of the rules of professional responsibility that bind defense lawyers throughout the country. On one side of the coin, state insurance law principles provide that an insurer is not required to pay rates in excess of what is reasonable; on the other side of the coin, the rules of professional responsibility prohibit an attorney from attempting to charge and collect more than a reasonable fee.

A related rule is that an attorney may not unilaterally raise his or her rates during the course of litigation. See, e.g., *Perez v. Pappas*, 659 P.2d 475 (Wash. 1983) (modified fee agreement to increase attorney's compensation during course of representation is unenforceable unless attorney demonstrates new consideration to support the increase). This rule of professional responsibility is based on the concern that a lawyer seeking a rate increase in the midst of litigation would have an unfair advantage over the client in negotiating a rate increase, inasmuch as it may be difficult and expensive for a litigant to change defense counsel during the course of litigation.

Because disputes often arise concerning what constitutes a reasonable rate for a given case, the burden of proof can be critical. Ordinarily, insurers do not have the burden of proof on the reasonable rate issue. Under state insurance laws, the insured has the initial burden of establishing the reasonableness of the fee for which reimbursement is sought, as the insurer's obligation to reimburse incurred defense costs is limited and defined by the reasonable fee. *International Ins. Co. v. City of Chicago Heights*, 643 N.E.2d 1305 (Ill. Ct. App. 1994) (initial burden of demonstrating reasonableness of fees is on the party seeking recovery of the fees). As explained in *City of Chicago Heights*, the burden shifts if the party seeking reimbursement shows (1) the services performed, (2) who performed each service, (3) the time spent, and (4) the hourly rate. See also *Curtis v. Nutmeg Ins. Co.*, 681 N.Y.S.2d 620 (3d Dep't 1998) (burden is on the insured to demonstrate reasonableness of the fees); *Benoit v. Fuselier*, 195 So.2d 679-83 (La. Ct. App. 1967) (same). Under the rules of professional responsibility, the burden of establishing the reasonableness of the fee rests upon the attorneys who charge the fee. Rule 1.5 of the ABA Model Rules for Professional Conduct provides that "a lawyer's fee must be reasonable." The ABA Formal Opinion 1993-379 explains that it is the attorney's responsibility to explain any changes to the client and convey the content of the legal invoice in a meaningful manner.

How to Determine a Reasonable Rate

The "reasonable fee" standard is a flexible standard. Because the standard is flexible, it is often misunderstood as a subjective measure lacking substance and vitality. To the contrary, the "reasonable fee" standard is actually a composite of several discrete objective criteria. It is a flexible standard, because it requires analysis of several factors that vary with the circumstances of each particular case. However, the criteria of the standard themselves are clear and objective.

- A check list of the criteria relevant to determining a reasonable rate for conflict counsel include the following:
- a. the experience, reputation and ability of the particular defense attorneys;
 - b. the undesirability of the case;
 - c. the hourly rates of other attorneys doing similar work in the same or a comparable venue;
 - d. the nature and length of the attorney's professional relationship with the client and rates customarily paid by that client;
 - e. the preclusion of other employment by the attorney due to acceptance of the particular case;
 - f. the skill required by the defense attorney to properly perform the requested legal services;
 - g. the attorneys' customary fees charged to other clients;
 - h. the time limitations imposed by the client or by the circumstances;
 - i. the amount in controversy and the results obtained;
 - j. the novelty and difficulty of the questions involved in the litigation;
 - k. the time and labor required of the defense attorney;
 - l. fee awards in similar cases; and
 - m. the importance of the litigation to the client.

See Patrick v. Head of the Lakes Cooperative Electric Association, 295 N.W.2d 205 (Wis. Ct. App. 1980); *Baghrain v. MFA Mutual Ins. Co.*, 315 So.2d 849 (La. Ct. App. 1975); *Ripepi v. American Insurance Companies*, 234 F. Supp. 156 (W.D. Penn. 1964).

Implementing the "Reasonable Fee" Standard

When the party who selects defense counsel is also the party who will pay for the services of the attorney, the market largely determines the reasonable rate through arm's length negotiations. *See Vanguard Ins. Co. v. Guagenti*, 599 N.Y.S.2d 215 (N.Y. Sup. Ct. 1993) (finding the insured is entitled to select its own independent counsel to be paid only at the standard insurance defense rates). Absent a conflict of interest, if the insurer and the attorney seeking the assignment cannot agree on a rate, the insurer can simply find another attorney who shares the insurer's views on the appropriate rate. However, in instances where local law permits the insured to select defense counsel at the insurer's expense, this market influence is not active.

In situations in which the insured selects defense counsel but the insurer pays, the insured has virtually no interest in conserving defense expense. Instead, the insured's interest is in getting the best defense that money can buy, because he wants to be well represented and does not have to worry about paying the defense bills. This dynamic is even more pronounced where the party who demands a defense is not a named insured on the policy issued by the insurer, but an additional insured or a defined insured who is unconcerned about whether a big defense bill might increase future policy premiums.

Unfortunately (from the insurer's perspective), the defense attorney who is selected by the insured also has little interest in charging a conservative rate, because his or her loyalties run to the insured and he or she may have no preexisting relationship with the insurer. Conflict counsel stands to gain most by imposing an aggressive rate upon his or her client's insurer. It is more costly for an insurer to hire conflict counsel than to retain its own panel counsel because insurers have less ability to negotiate the rates of conflict counsel.

Yet, even against this backdrop, a liability insurer with a recognized duty to defend can gain bargaining power by enforcing the "reasonable fee" standard. Under the "reasonable fee" standard, an insurer should never be at the mercy of the insured's conflict counsel to pay whatever rate the defense attorney chooses to impose. A liability insurer's right and duty is to pay only the reasonable costs of the defense, which means that only a reasonable rate need be paid for defense counsel. Success in this effort requires a familiarity with the applicable standards. It also requires early action on the part of the insurer to insist that the insured and defense counsel sustain their respective burdens to establish the objective reasonableness of the attorney's rates.

As soon as the insured makes its selection of conflict counsel known, the insurer should begin the process of establishing a reasonable and acceptable rate. The first step is to make prompt and direct inquiry into the proposed rate to be charged by the insured's chosen defense attorney. If the quoted rate appears suspect in light of the nature of the case and qualifications of defense counsel, the insurer should immediately advise the insured that the rate is being questioned. The insurer should remind the insured that under the terms of the insurance policy, the jurisdiction's insurance law and applicable rules of professional responsibility, the insurer has no obligation to pay more than a reasonable fee. The best practice is to state this in writing, as a reservation of rights.

The second step is to ask the insured and defense counsel for information supporting the objective reasonableness of the proposed rate. Neither the insured nor the insured's chosen counsel is entitled to impose a suspect rate or unreasonable fee upon an insurer by fiat. The insured and its counsel have the initial burden of showing the reasonableness of the rates, and, upon proper inquiry, can be required to answer appropriate questions concerning the foundation for the rates to be charged to the insurer. A general inquiry will most likely elicit a general response, which will probably be of little assistance in the insurer's efforts to secure a reasonable rate. The better practice is for the insurer to ask the insured to identify the attorneys who are being retained for the work, and then to request the insured and defense counsel to justify the proposed rate in terms of specific criteria, including the following factors:

- The particular defense attorneys' experience, reputation and ability. Specific request may be made for each attorney's professional resume, jury verdict reports and a description of the attorney's experience in handling the particular type of case at issue ;
- The rates of other attorneys for similar work in the same or comparable venues;
- The rates charged by each retained attorney to other clients for similar work in the same or comparable venues;
- The nature and length of the attorneys' professional relationship with the client and the rate paid to the attorneys by that client in the past;
- The level of skill required by the defense attorneys to adequately perform the requested legal services;
- Any notable time limitations imposed by the circumstances;
- The amount in controversy;
- The novelty and difficulty of the questions involved in the litigation;
- The time and labor that will be required of the defense attorneys; and
- The amount of time the proposed rate will remain in effect.

The third step depends upon the response that the insurer receives to its rate information request. If the insured and/or its chosen defense counsel respond to the information request, the insurer should evaluate the substance of the response to determine whether the provided information fairly and objectively supports the proposed defense counsel rate. If the response to the information request supports the proposed rate, the inquiry will end and the insurer should advise the insured and its counsel that there is agreement as to the proposed rates.

If the response to the rate information request does not appear to justify the proposed rate, the insurer should propose an alternative rate and provide its rationale. This process is best started by informing the insured and its chosen defense counsel of the rate that the insurer typically pays to attorneys in the ordinary course of business to defend similar actions in the same venue. Comparison of the market rate to the conflict counsel's proposed rate is one widely recognized objective measure to determine the reasonableness of the proposed rate. Cal. Civ. Code §2860 provides that "the insurer's obligation to pay fees to the independent counsel selected by the insured is limited to the rates which are actually paid by the insurer to attorneys retained by it in the ordinary course of business in the defense of similar actions in the community where the claim arose or is being defended." *Id.* Additionally, several cases, outside of the insurance context, have discussed the impact of the "market rate" for the hourly rate, including *Moriarty v. Svec*, 233 F.3d 955 (7th Cir. 2000) (finding that the lawyer's regular rate is strongly presumed to be the market rate for his or her services); *Arquest Inc. v. Tracy*, 2003 WL 22012688 (N.D. Ill. 2003) (discusses elements involved in analysis of hourly rate and fees); *Glover v. Johnson*, 934 F.2d 703, 716 (6th Cir. 1991) (hourly rate can be established by proving that the rates sought are rates charged for similar services by lawyers of comparable skill, experience and reputation); *Blum v. Stenson*, 465 U.S. 886 (1984) (establishing that market rates are the appropriate basis for determining appropriate hourly rates). Under the California statute, this is the ultimate measure of the rate applicable to conflict counsel, but in most jurisdictions it is the only beginning point for the determination of an appropriate rate.

Beyond reference to the market rate, the insurer should attempt to use the information provided by the insured in response to the rate justification request as the substantive basis for negotiating an acceptable rate. Absent bargaining power in a conflict situation, an insurer's primary tool in rate negotiations is information. For every point offered by the insured and its conflict counsel in support of a proposed rate, the insurer may develop a counterpoint as grist for the negotiation. If reasonable counterpoints cannot be developed, the insurer should carefully consider whether any objective reason exists for declining to accept at the proposed rates of conflict counsel.

A more challenging situation is presented if the insured and its defense counsel fail to respond to the insurer's rate information request. The insurer should inform the insured that its failure to provide a response will be considered to be a waiver of any right to reimbursement for defense counsel fees under the insurance policy. This done, the insurer has essentially three options: (1) to abandon efforts to secure a reasonable rate and simply pay the proposed rate; (2) to pay the proposed rate under a reservation of rights, including the right to seek a refund of the amount of fees paid in excess of the reasonable rate; or (3) to file a declaratory judgment action to resolve the rate question as a component of the broader duty to defend issue. How an insurer should proceed depends upon a number of case-specific variables, including the disparity between the proposed rate and a reasonable rate, the anticipated amount of defense counsel's time and labor, the other grounds on which the insurer has reserved its rights, and the degree to which the particular jurisdiction enforces the "reasonable fee" standard.

If the insured has overreached in proposing a rate for defense counsel, the insurer's reservation of rights or filing of a declaratory judgment action on the "reasonable fee" issue may influence the insured to compromise rather than contest the issue. The primary concern of the insured should be to obtain effective assistance of defense counsel, not to enrich its defense lawyers. Thus, the insured may be interested in finding alternatives to the risk and cost associated with a prolonged dispute on the rate issue, such as selecting less expensive defense counsel, or negotiating a better rate with its chosen defense counsel, or reaching a compromise on the rate to be paid by the insurer. In the absence of some early resolution of the issue, the rate issue will remain an unwanted cost and distraction for the insured, when its primary attention is upon achieving success in the underlying litigation.

Conclusion

While the particulars differ from case to case, the important thing is for the insurer to take early steps to affirmatively assert its expectation that the rate charged by conflict counsel must be an objectively reasonable

rate. If the insurer fails to clearly assert this expectation and demand, by default the determination of the applicable rate will be left entirely to the insured and its counsel, neither of who have any interest in establishing a conservative rate. Insurers are not powerless to secure reasonable rates from conflict counsel. The duty to defend arising under public liability policies encompasses rights as well as obligations.

It is the right of a liability insurer to defend its insured under reservation, if the insurer believes there are genuine questions concerning coverage. It is also the right of a liability insurer to pay no more than a reasonable fee for the defense of its insureds. While the insurer's assertion of a reservation of rights may affect its right to select defense counsel, it does not diminish its right to demand a reasonable rate. Yet, the right to pay only a reasonable rate is not self-executing. It is a right that is lost unless asserted promptly.

Contrary to common belief, there is a lot that insurers can do to ensure reasonable rates from conflict counsel. If the insurer seeks a reasonable rate, the law is emphatically in support. All that is required is that the insurer be prepared to do what is necessary to enforce its rights.

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April 25, 2005

ARIZONA - Bad Faith/Consent Judgments

<http://www.supreme.state.az.us/opin/pdf2005/CV040146PR.pdf>

In *Safeway Ins. Co. v. Gerrero, No. 04-0146* (Ariz. February 24, 2005), the Arizona Supreme Court ruled that a lawyer who negotiated a *Morris* settlement agreement, whereby a policyholder consented to a judgment against it and assigned all of its coverage rights to the tort claimant, could not be sued by the defendant's insurer for intentional interference with contractual relations despite the insurer's argument that counsel had induced its policyholder to admit liability by threatening him with a multi-million dollar judgment and had then manufactured a bad faith claim against the insurer to obtain a bigger fee. The Supreme Court held that the mere fact that the insurer might not have acted in bad faith in refusing to accept a policy limits demand did not in and of itself established that the plaintiff's lawyer had engaged in "improper conduct."

April 25, 2005

CALIFORNIA – Total Pollution Exclusion

<http://fsnews.findlaw.com/cases/ca/caapp4th/slip/2005/a104076.html>

In *Garamendi v. Golden Eagle Ins. Co.* (2005) ___ Cal.App.4th ___, 05 C.D.O.S. 2096, the California Court of Appeal for the First Appellate District affirmed the judgment of the trial court in favor of Golden Eagle concluding that its denial of coverage for claims asserted by workers for "silica-related injuries and damages" was proper based on the total pollution exclusion contained in its CGL policy.

The underlying complaints were filed by workers that sustained bodily injury allegedly caused by exposure to silica-containing dust and the use of defective respiratory and sandblasting equipment. Golden Eagle insured Pauli Systems ("Pauli"), which was one of many defendants. Pauli's policy included a total pollution exclusion which precluded coverage for "'bodily injury' ... which would not have occurred in whole or in part but for the actual, alleged or threatened discharge, dispersal, seepage, migration, release or escape of pollutants at any time." The term "pollutants" was defined as "any solid, liquid, gaseous, or thermal irritant or containment including smoke, vapor, soot, fumes, acid, alkalis, chemicals and waste...."

Pauli tendered the complaints to Golden Eagle after liquidation proceedings against the insurer had begun. Golden Eagle denied coverage based on the pollution exclusion. Pauli filed applications for orders to show cause why the claims should not be allowed. The trial court denied the applications and Pauli appealed. Because Golden Eagle was in liquidation, the court of appeal determined that its review of the factual and legal determinations of the liquidation and trial courts was under an abuse of discretion standard. The court of appeal rejected each of Pauli's arguments.

The court found that Pauli's reliance on the California Supreme Court's decision in *MacKinnon v. Truck Ins. Exch.* (2004) 31 Cal.4th 635, was not helpful. The MacKinnon Court limited the scope of pollution exclusions "to injuries arising from events commonly thought of as pollution, i.e., environmental pollution" and held, under this standard, that an absolute pollution exclusion did not preclude coverage for a claim against an insured-landlord arising out of a tenant's death allegedly due to the spraying of pesticide at the insured's apartment building. The court of appeal distinguished the spraying of pesticide at issue in MacKinnon from the

facts before it finding that “the widespread dissemination of silica dust as an incidental by-product of industrial sandblasting operations most assuredly is what is ‘commonly thought of as pollution’ and ‘environmental pollution’.”

The court also rejected Pauli’s arguments that (1) the underlying defective product claims fell outside the scope of Golden Eagle’s total pollution exclusion; (2) if Golden Eagle wanted to exclude coverage for silica claims, its should have included a specific silica exclusion; (3) the underlying complaints could be amended, or discovery propounded, to establish a potential for coverage; and (4) the trial court erred in refusing to permit discovery before issuing its ruling.

CALIFORNIA – Contribution / Excess Insurance / “Other Insurance” Clauses

<http://fsnews.findlaw.com/cases/ca/caapp4th/slip/2005/h026360.html>

In *Carmel Development Co. v. RLI Ins. Co.* ___ Cal.App.4th ___, 05 C.D.O.S. 1100, the California Court of Appeal for the Sixth Appellate District reversed the trial court and held that a contribution claim did not exist between an excess and umbrella insurer for a common insured because the insurers did not provide the same level of coverage.

Carmel was the general contractor on a project. Carmel contracted work to Largo, which in turn contracted with CAB. Vargas, a CAB employee, was injured on the job site and sued Carmel and Largo. Largo settled, but Carmel proceeded to trial. A jury awarded over \$10 million in damages.

Carmel had a CGL policy with Reliance and a \$10 million excess policy with Fireman’s Fund Insurance Company (“FFIC”). Largo had a primary policy with Acceptance and an umbrella policy with RLI. Reliance and FFIC settled the Vargas action for \$7.25 million, with Reliance paying out its policy limits of \$1 million and FFIC paying \$6.25 million. Carmel then sued Acceptance and RLI seeking a judicial determination that it was an additional insured under the Acceptance policy and that RLI, as its excess insurer, was obligated to contribute to the Vargas settlement after the Acceptance policy limits were exhausted. FFIC intervened.

The trial court held that Carmel was an additional insured under both the Acceptance and Reliance policies issued to Largo. FFIC and RLI, as excess insurers, were obligated to provide coverage when their underlying carriers had exhausted their limits. Because of irreconcilable “other insurance” clauses in the FFIC and RLI policies, the trial court found it appropriate to require both FFIC and RLI to contribute to the settlement in proportion to their policy limits, resulting in a judgment against RLI. RLI appealed.

RLI argued that the trial court incorrectly required it to contribute to the settlement because the insuring agreement contained in its policy made it excess to the FFIC policy. The court of appeal agreed. It recognized that a claim for equitable contribution exists between two or more insurers that issued policies covering the same insured at the same level for the same risk. It found that FFIC and RLI did not provide the same level of coverage with the FFIC policy providing coverage specifically in excess of the underlying policy while the RLI policy was liable for claims in excess of any other insurance. It determined that because the FFIC and RLI policies did not operate at the same level of coverage, it was irrelevant that the two policies contained conflicting excess-only “other insurance” clauses.

CALIFORNIA – **CASE UPDATE - Auto Insurance / Exhaustion**

On February 16, 2005, the California Supreme Court granted Allstate Insurance Company’s (“Allstate”) request for depublication and withdrew from publication the decision in *Mercury Ins. Co. v. Allstate Ins. Co.* ___ Cal.App.4th ___, 04 C.D.O.S. 10074, which held that a personal umbrella insurer is obligated to contribute to the defense of an auto accident case where the settlement exceeds the primary policy limits.

CALIFORNIA – Northridge Earthquake

<http://fsnews.findlaw.com/cases/ca/caapp4th/slip/2005/b172406.html>

In *Rosenblum v. Safeco Ins. Co.* (2004) ___ Cal.App.4th ___, 05 C.D.O.S. 1244, the California Court of Appeal for the Second Appellate District affirmed a trial court order granting Safeco Insurance Company’s (“Safeco”) motion for summary judgment against insured Thelma Rosenblum. After negotiating a settlement of her Northridge earthquake claim with Safeco and executing a full release, Rosenblum sued Safeco alleging that in spite of the settlement, her claim had been revived by California Code of Civil Procedure § 340.9 (“Section 340.9”). The appellate court affirmed the trial court’s granting of Safeco’s motion for summary judgment on the ground that Section 340.9 was a revivor statute that served only to overcome any time limitations defense Safeco might have had, but did not operate to revive a claim that had been extinguished by a validly executed release.

CONNECTICUT – Attorney Client Privilege in Bad Faith Cases

In *Marie J. Hutchinson, Administratrix et al. v. Farm Family Casualty Insurance Company*, 2005 WL 418605, ___ A.2d ___ (Conn. March 1, 2005), the Connecticut Supreme Court limited the right of an insured who makes allegations of bad faith against an insurer arising from a first-party insurance claim for benefits under a policy to obtain discovery from the insurer of materials protected by the attorney-client privilege. The court held that the mere allegation of bad faith by itself does not give rise to a need for disclosure of relevant materials that are otherwise protected by the attorney-client privilege. Instead, to overcome the attorney-client privilege and obtain an in camera review by the court of the privileged materials, an insured who alleges bad faith against his insurer must establish, on the basis of nonprivileged materials, probable cause to believe that: (1) the insurer acted in bad faith and (2) the insurer sought the advice of counsel in order to conceal or facilitate its bad faith conduct.

This case arose from the plaintiff's claim for underinsured motorist benefits from the defendant insurer after plaintiff's decedent was killed in an automobile collision with an underinsured motorist. Plaintiff alleged that her insurer engaged in bad faith when it failed to pay the full policy limits of the underinsured motorist benefits after the defendant's claims representative represented that the defendant would pay the limits of the policy and that the defendant would only deduct the tortfeasor's policy limits plaintiff received, not any amounts plaintiff recovered from the tortfeasor's personal assets, from the payment of underinsured motorist benefits.

The Connecticut Supreme Court overturned the trial court's judgment that the plaintiff was entitled to discovery of materials otherwise protected by the attorney-client privilege because the privileged materials were relevant to the plaintiff's claims of bad faith. In doing so, the court reaffirmed that an insurer may waive the attorney-client privilege by placing the attorney-client privilege at issue, such as when the insurer pleads that it relied on an attorney's advice as an element of a claim or defense, the insurer voluntarily testifies regarding portions of the attorney-client communication, or the insurer specifically places at issue, in some other manner, the attorney-client relationship. The court also recognized that the civil fraud exception to the attorney-client privilege should be extended to claims by an insured of bad faith against an insurer. The court ruled that the attorney-client privilege does not apply when an otherwise privileged communication was made for the purpose of evading a legal or contractual obligation to an insured without reasonable justification. The court held, however, that the plaintiff was not entitled to discovery of the privileged materials because the plaintiff failed to establish, through non-privileged materials, probable cause to believe that the insurer acted in bad faith and that the insurer sought the advice of its attorneys in order to conceal or facilitate its bad faith conduct.

April 25, 2005

NEBRASKA

- Auto/UIM/Jurisdiction

<http://court.nol.org/opinions/2005/january/jan28/s03-1087.pdf>

In *Brunkhard v. Mountain West Farm Bureau Mut. Ins. Co.*, No. S-03-1087 (Neb. January 28, 2005), the Nebraska Supreme Court ruled that a Wyoming auto insurer could not be sued in Nebraska since it did not do business there. Even though Mountain West knew that its policyholder worked in Nebraska and regularly commuted there, the court refused to find that the act of insuring a person who might travel to a nearby state was sufficient to find that the insurer purposely directed its activities there

April 25, 2005

NEW JERSEY

•Bad Faith

In American Hardware Mutual Insurance Company v. Harley Davidson of Trenton, Inc. (3rd Cir. (N.J.) Feb. 22, 2005), the district court held that bad faith results from failure to actively negotiate a claim. An Insurer was liable for bad faith where defense counsel opined that chances of prevailing at trial were 30–40 percent, that the plaintiff would likely settle for \$250,000 - 350,000, the policy limits were \$500,000, plaintiff had demanded \$497,000, insurer never attempted to enter into settlement negotiations, and insurer never offered more than \$100,000 to settle the claim. The jury returned a verdict of \$1.4 million. The Court found the insurer acted in bad faith because it failed to “actively negotiate” the underlying claim, particularly where it received information that plaintiff was likely to settle for \$250,000 and counsel had advised the value of the case was in excess of the \$100,000 offer.

April 25, 2005

NEW YORK - Additional Insured

In HRH Construction Interiors, Inc. v. Royal Surplus Lines Insurance Company, (N.Y. App., 1st Dept., March 1, 2005), the court held that specific and blanket Additional Insured Endorsements on the same policy should be read together, and that defense obligation is triggered from the date of suit, not Tender. This coverage dispute arose from an underlying action alleging a fatal fall at a construction site. HRH was the general contractor; the worker was employed by a subcontractor; National was HRH's general liability insurer; and Royal was the subcontractor's general liability insurer. The contract between HRH and the subcontractor required the subcontractor to indemnify and hold HRH harmless from all losses arising out the subcontractor's work, and also required the subcontractor to procure primary insurance naming HRH as an additional insured. National's policy with HRH and Royal's policy procured by the subcontractor contain identical “Other Insurance” clauses to the effect that the policy was primary, unless there was other insurance that was also primary, in which event the insurer would share the loss equally. Royal's policy with the subcontractor also contained a blanket additional insured endorsement including as an insured any organization for which the subcontractor was obligated to provide insurance by written contract, and providing that if such contract required such insurance to be primary, then Royal's policy “shall be primary as respects [the subcontractor's] negligence.... Other insurance does not apply, but only with respect to coverage provided by this policy.” Also part of Royal's policy was an endorsement that was labeled a “Schedule” of “Additional Insureds,” which specifically listed HRH. Thus HRH was an insured by virtue of both the blanket and scheduled additional insured endorsements. Royal argued that the specific endorsement superceded the blanket additional insured endorsement, and that because the specific endorsement did not contain any language pertaining to other insurance; National and Royal were co-primary insurers equally responsible for HRH's defense. The court disagreed, concluding that the specific endorsement was meant to be read in addition to the blanket endorsement, and not to replace it. The court also concluded that, since Royal's duty to defend is triggered by a “suit” against an insured, such duty arose upon the commencement of the underlying action against HRH, not upon National's notice to Royal of the accident and initial tender of the defense.

NEW YORK – Auto Med Pay

In Mount Sinai Hospital v. Zurich American Insurance Company (N.Y. App., 2nd Dept., Feb. 22, 2005), the court held that a carrier not required to pay a claim where limits were exhausted. In an action to recover no-fault insurance medical payments, the court held that plaintiff Mount Sinai Hospital's motion for summary judgment was properly denied. Plaintiff demonstrated its entitlement to judgment as a matter of law by establishing that it submitted the requisite documents to recover payment for medical services, but Zurich neither paid nor denied the claims. The court concluded, however, that an insurer is not required to pay a claim where the policy limits have been exhausted. Zurich demonstrated that there were issues of fact as to whether it exhausted the coverage limits of the policy by other “no-fault” payments and whether such payments were in compliance with 11 NYCRR 65.15(n).

NEW YORK - Fraud and Misrepresentation

In Pipo Bar and Restaurant, Inc. v. Certain Underwriters at Lloyd's at London(N.Y. App., 2nd Dept., Feb. 22, 2005), the court held that plaintiff's fraudulent misrepresentations regarding the total loss of two pool tables following a fire vitiated the policy in accordance with its terms, and the insurers properly disclaimed coverage. The policy is rendered void where the plaintiff has “willfully and fraudulently placed in the proofs of loss a statement of property lost which [it] did not possess, or has placed a false and fraudulent value upon the

articles which [it] did own.”

NEW YORK - Reservation of Rights

In *Royal Sun Alliance Insurance Company v. Travelers Insurance Company* (N.Y. App., 2nd Dept., Feb. 22, 2005), an action for a judgment declaring that Travelers was obligated to indemnify Structure Tone, Inc., after the plaintiff's primary policy was exhausted and before the plaintiff's excess policy was applied, the court held that Travelers was not so obligated until after both of the plaintiff's policies were exhausted. The plaintiff had expressly agreed to “fully defend [Travelers Insurance Company's insured] and to fully indemnify [it] without any reservation, to the limit of the applicable insurance coverage” in connection with the underlying personal injury action. The plaintiff had issued a general liability policy and an umbrella policy, both of which were applicable to the underlying action. The unambiguous terms of the agreement indicated that the plaintiff intended to have its policies exhausted before resorting to the policy issued by Travelers.

April 25, 2005

PENNSYLVANIA - Bad Faith

In *Brickman Group, Ltd. v. CGU Ins. Co.*, 865 A.2d 918 (Pa. Super. Ct. 2004) the Pennsylvania Superior Court affirmed a trial court decision granting summary judgment in favor of CGU Insurance on all of the plaintiff's claims, including breach of contract and violation of Pennsylvania's insurance bad faith statute, 42 Pa. C.S.A. § 8371. Section 8371 authorizes the award of punitive damages and attorneys fees if an insurer is found to have acted in bad faith towards its insured.

In 1997 Brickman purchased certain insurance policies from CGU which contained standard provisions regarding premium increases, policy nonrenewal and policy cancellation. Brickman also alleged that CGU made oral and written promises to Brickman as part of an “Insurance Program Guarantee” to freeze rates for six years if Brickman purchased coverage from CGU, although these representations were not contained in the policies. After Brickman refused to pay increased premiums to renew its policies, CGU nonrenewed the policies. Brickman then sued CGU for breach of contract and bad faith.

The trial court granted summary judgment in favor of CGU on the breach of contract claim, ruling that the purported Insurance Program Guarantee was not part of the insurance policies which formed the contract. The trial court ruled, and the Superior Court affirmed, that an alleged contract to cap rates outside of the policies would be an illegal inducement. See 40 P.S. §§ 275, 471. Summary judgment was also affirmed on Brickman's claim for bad faith. The Superior Court reasoned that the protections afforded by Section 8371 do not extend “to conduct preceding the execution of insurance coverage.”

PENNSYLVANIA - Intentional Act Exclusion/Duty to Defend

<http://www.paed.uscourts.gov/documents/opinions/05D0239P.pdf>

In *Strouss v. Fireman's Fund Ins. Co.*, No. 03-5718 (E.D. Pa. February 22, 2005), a federal district court held that a homeowner's insurer had a duty to defend claims involving shots fired by the insured's son who was psychotic and suffered from paranoid schizophrenia. The district court relied on the fact that the underlying complaint alleged that the son was incapable of forming an intent to cause injury given his delusional state. The court also questioned whether the son was an “insured” under the policy since the underlying complaint failed to allege that he was a resident of the named insured's household. The court declined to address indemnity issues at this time.

April 25, 2005

•Auto UM/UIM

In *Gloe v. Union Insurance Company* (S.D. March 2, 2005), the South Dakota high court resolves how to calculate UIM liability. The court held that a UM carrier's limit of liability was not to be determined by subtracting the amount of liability insurance proceeds received by claimant after allocation among all wrongful death beneficiaries, rather it is determined by the entire amount paid by the liability carriers on behalf of the tortfeasor.

April 25, 2005

TEXAS - Application of Business Pursuits Exclusion in Homeowners Policy

In *Allstate Ins. Co. v. Hallman*, No. 03-0957, 2005 WL 563110, 48 Tex. Sup. Ct. J. 474, (March 11, 2005), the Texas Supreme Court addressed for the first time the application of the business pursuits exclusion in a homeowners insurance policy. In *Allstate*, the Court determined whether, under the terms of a homeowners insurance policy, an insurer has a duty to defend and indemnify an insured's liability for damages resulting from limestone mining operations on the insured's property. Hallman had a homeowners policy of insurance covering her home that was issued by Allstate. Hallman leased out the property on which her home was located to a company for limestone mining in 1995. The mining was continuing at the time of this lawsuit. The dynamite blasting from the limestone mining allegedly caused property damage and health related damage to neighboring property owners. As a result of these alleged damages, Hallman was sued by her neighbors. Hallman sought coverage under her homeowner's policy and requested that Allstate defend and indemnify her. Allstate agreed to defend Hallman under a reservations of rights and thereafter cross-declaratory judgment actions were filed by Allstate and Hallman. Hallman received a jury verdict while being defended by Allstate. Although Allstate did not seek reimbursement of its defense costs, the parties argued that the appeal to the Texas Supreme Court was not moot because Hallman still sought her attorneys fees in defending and pursuing the cross-declaratory judgment actions. Allstate argued that the alleged injuries and damages relating to the mining did not constitute an occurrence. Allstate also argued that the policy business pursuits exclusion excluded bodily injury or property damage arising out of or in connection with a business engaged in by an insured. The Court determined that this exclusion does not apply to activities that are ordinarily incidental to non-business pursuits. Under the policy, "business" is defined as "including trade, profession or occupation." Reviewing the common meanings of "trade", "profession" and "occupation" from a previous court of appeals decision, the Court held that the business pursuits inquiry involves two elements: (1) continuity or regularity of the activity, and (2) a profit motive, usually as a means of livelihood, gainful employment, earning a living, procuring subsistence or financial gain, a commercial transaction or engagement. Regarding the second element, the Court noted that the profit need not be realized; rather, the issue is the expectation or anticipation for profit in the future. Even though there was only one lease, the Court found the mining on Hallman's land to be continuous because the 1995 mining lease had not expired. Also, the Court concluded that a profit could be inferred from the nature of the activity because one generally does not allow dynamite blasting on one's property without some expectation of monetary gain. The Court held that commercial limestone mining is not an activity typically associated with owning and maintaining a home and therefore damages to neighbors caused by the commercial limestone mining fell within the homeowners insurance policy's business pursuits exclusion.

TEXAS – Additional Named Insureds and the “Known Loss” Doctrine

In *United States Fire Ins. Co. v. Gnade*, 2005 WL 552473 (Tex.App.–Waco 2005, no pet. hist.), the Texas Department of Transportation (TXDOT) contracted with Champagne-Webber ("Champagne") to repave the shoulders on Interstate Highway I-35W in Tarrant County, Texas. In turn, Champagne subcontracted with Dustrol, Inc. ("Dustrol") to remove the shoulders. Pursuant to its subcontract with Champagne, Dustrol milled away the shoulders between April 23, 1998, and May 22, 1998. Between May 30, 1998 (after Dustrol finished its work), and August 15, 1998, at least nine auto accidents occurred along the work site. These accidents resulted in lawsuits against Dustrol, Champagne, TXDOT, and also TXDOT's engineers. TXDOT made a demand upon U.S. Fire Insurance Company ("US Fire") for defense and indemnity in the underlying lawsuits. US Fire refused the demand, and TXDOT settled five of the underlying lawsuits for \$1,250,000. TXDOT and its engineers sued US Fire, seeking a declaration that US Fire had a duty to defend TXDOT and the engineers in two ongoing lawsuits and seeking to recover the defense costs already incurred and the \$1,250,000 that TXDOT had paid to settle five of the lawsuits. Judgment was entered for TXDOT, and US Fire appealed.

US Fire argued that it had no duty to defend or indemnify because TXDOT and its employees were not "named insureds" on the declarations pages of the relevant insurance policies. The court of appeals noted that the trial court had found that TXDOT was an "additional named insured" under one of the policies' endorsements. One endorsement was a blanket "additional insured" endorsement that included as an insured

the persons and organizations whom Dustrol had agreed to insure. The second endorsement was a similar blanket "additional insured" endorsement, but it specifically listed "Texas Dept. of Transportation (State of Texas)" as an insured. The court of appeals agreed with the trial court that the second endorsement added TXDOT as an additional named insured under the policy. Furthermore, the court of appeals agreed with the trial court's conclusion that TXDOT's engineers (i.e., TXDOT's employees) qualified as insureds under section II (2) of the policy.

US Fire also argued that the "known loss" or "fortuity" doctrine precluded coverage for TXDOT because the second additional insured endorsement was added to the policy after all of the accidents had occurred. The trial court had found that there was no evidence of what Dustrol or TXDOT knew about the accidents, and no evidence that Dustrol or TXDOT made any misrepresentations or concealed any information from the insurers. As a result, the court of appeals found the "known loss" doctrine to be inapplicable.

TEXAS – Misrepresentation in Sale of Home

In the recent case of *Allstate Texas Lloyd's v. Meyers, et al*, 2005 WL 33112 (N.D. Tex. 2005), Defendants Heath and Cynthia Meyers purchased a home from Defendants Brett and Linda Dubay who were covered by an Allstate homeowner's insurance policy. The Meyers claim they purchased the home because the Dubays represented that the home was in good condition and of high quality; however, the Meyers later learned that the house, pool and deck had various defects and that the Dubays had known of and concealed the defects from the Meyers. The Meyers claim they would not have purchased the home had they known of the defects and sued the Dubays and several other parties in Texas state court, claiming fraud, negligent misrepresentation, damages for mental anguish and economic damages associated with the cost of purchasing the home and for repair of the property. Allstate brought this declaratory judgment action against both the Meyers and the Dubays asking the Court to declare that Allstate had no duty to defend or indemnify its insureds, the Dubays, and moved for summary judgment, claiming that the Dubays' homeowner's policy did not cover the Meyers' lawsuit.

Under the Liability Coverage portion of the Allstate policy at issue, Allstate agreed to defend and indemnify the Dubays against claims "for damages because of bodily injury or property damage caused by an occurrence to which coverage applies." In the underlying action, the Meyers specifically alleged that the Dubays knew that their representations about the condition of the property were false and that the Dubays knowingly concealed the true condition of the property. In determining whether the Dubays' alleged negligent misrepresentations were covered "occurrences" under the policy, the court stated that it was required by Texas law to focus on the factual allegations showing the origin of the damages rather than the legal theories alleged and, accordingly, held that the Meyers' claims were for intentional conduct rather than an "occurrence" as defined by the policy, despite the fact that an alternative claim of negligence was alleged. Furthermore, in deciding whether there were any covered damages as defined by the policy, the court stated that it must focus on the causal relationship between the operative conduct alleged and the claimed damages and held that damages resulting from a sellers' misrepresentations to purchasers amount to economic damages, which are not covered property damage under homeowners' insurance policies in Texas. In addition, the court held that the Meyers' claim for mental anguish damages were not covered damages, stating that even mental anguish damages resulting from negligent conduct are not covered damages under the standard form homeowner's insurance policy. Accordingly, the court held that neither the alleged conduct nor the alleged damages implicated Allstate's duty to defend or indemnify the Dubays and granted Allstate's Motion for Summary Judgment.

April 25, 2005

WISCONSIN

•Reformation

<http://www.wisbar.org/res/capp/2005/04-1679.htm>

In *Bartelt v. State Farm Mut. Auto. Ins. Co.*, No. 04-1679 (Wis. App. February 1, 2005), the Wisconsin Court of Appeals held that a trial court erred in reforming a homeowner's policy to provide coverage for the insured's car where, in fact, the evidence was that the insured had understood and intended at the outset of the policy that it would not cover its automobiles and where the policy itself expressly precluded oral modification. As a result, the court concluded that the agent's statements could not have created an oral contract to expand the scope of coverage nor was waiver or estoppel a basis for extending coverage under the circumstances.

April 26, 2005

Special thanks to Matthew S. Foy, Mary Reyes and Michael A. Hamilton, co-editors of DRI's Insurance Law Committee Newsletter, *Covered Events*, for their efforts in assembling the following "Recent Cases of Interest."

April 25, 2005

xml:namespace prefix = st1 />**Arizona**

AR SB 233: Comprehensive and Uniform Insurance Reform.

- An Act to provide comprehensive and uniform insurance reform, and for other purposes.
- 04/05/2005 – Adopted.

Colorado

CO HB 1312: Small Group Health Uniform Act.

- An Act that would require the insurance commissioner to develop a uniform employee application form for health coverage and to require each small group carrier to exclusively use the form for the conduct of business in the state.
- 03/21/2005 – Introduced.

Connecticut

CT SB 27: Concerning captive insurers.

- To allow captive insurers to be licensed and domiciled in this state.
- 04/07/2005 – Favorably reported out of Legislative Commissioners' Office; tabled for Senate calendar.

Delaware

DE HB 75: An Act to amend the Delaware Code relating to the Medical Practices Act.

- This bill reorganizes and revises the Medical Practices Act pursuant to the recommendations of the Joint Sunset Committee, providing: purposes of the Act; definitions; rules for the Board of Medical Practice; regulations for certification to practice medicine; disciplinary regulation; requirements of malpractice insurance carriers and insured physicians to inform Board of final judgments, settlements, or awards against insured physicians; and for other purposes.
- 03/16/2005 – Introduced.

DE HB 90: An Act to amend the Delaware Code relating to unfair insurance business practices and applicable penalties.

- This legislation updates and strengthens the unfair business practices section of the Delaware Insurance Code, in three ways: 1. Heightening the financial penalties associated with unfair business practices, in order to reflect inflation and the level of penalties necessary to deter unfair practices by large business entities. 2. Requiring insurance carriers to respond to the Department in a timely fashion when the Department makes inquiries on behalf of Delaware consumers. 3. Preventing health insurance carriers from imposing bad faith documentation requirements upon health care providers seeking to be reimbursed for their services.
- 03/17/2005 – Introduced.

Florida

FL HB 1937: An act relating to property insurance.

- limiting an insurer's recoupment of reimbursement premium; providing limitations limiting use of certain methodologies in determining hurricane loss factors for reimbursement determining hurricane loss factors for reimbursement premium rates in certain rate filings requiring certain insurers and organizations to develop, maintain, and update a public hurricane loss projection model; providing reporting requirements for insurers; protecting trade secret information; amending s. 627.0629, F.S.; tightening a limitation on rate filings based on computer models under certain circumstances; and for other purposes.
- 04/13/2005 – Amended/Substituted.

FL SB 1488: Property insurance.

- revises retention of losses for which insurer is not entitled to reimbursement from Fla. Hurricane Catastrophe Fund; requires residential property insurance & rating & advisory organizations to report hurricane loss data for development of public hurricane model for said loss projections; prohibits insurers from canceling or nonrenewing residential property insurance policies under certain emergency circumstances, etc.
- 04/07/2005 – In general Governmental Appropriations.

FL HB 1601: Attorney's fees/vehicle no-fault law.

- Attorney's Fees/Vehicle No-Fault Law; prohibits application of contingency risk multiplier in award of attorney's fees in suits based on claims arising under Fla. Motor Vehicle No-Fault Law except in certain circumstances.
- 04/11/2005 – Pending review of Judiciary Committee substitute.

Georgia

GA SB 217: Life Settlements Act.

- To amend Title 33 of the Official Code of Georgia Annotated, relating to insurance, so as to enact the "Life Settlements Act"; to provide a short title; to provide definitions; to provide for the protection of contractual and property rights of a life insurance policy owner to seek a life settlement; to establish consumer protections by providing for the regulation of a life settlement transaction; to provide for the licensing and regulation of a life settlement provider and others involved in a life settlement transaction; to provide for antifraud measures; to provide penalties for certain violations; to provide for related matters; to provide for severability; to provide an effective date; to repeal conflicting laws; and for other purposes.
- 04/14/2005 – Enrolled.

GA HB 407: Insurance; administrators; agents; insolvency pool; definitions and provisions.

- relating to insurance, so as to authorize the Commissioner to place administrators on probation and to provide penalties against administrators for certain violations; to provide for certain additional regulations of nonresident representatives who represent life insurers in certain military installations; to provide certain definitions; to provide for certain disclosures by counselors; to provide for certain exceptions; to provide for certain licensing for third party administrators; to provide certain procedures and standards for approval or rejection of such licenses; to provide for probationary licenses; to provide for certain bonds and insurance for administrators; to require administrators to be subject to certain examinations; to revise the provisions of law concerning the Georgia Insurers Insolvency Pool; and for other purposes.
- 04/05/2005 – Sent to Governor.

Iowa

IA HB 854: Relating to various provisions.

- An Act relating to various provisions administered by the insurance division of the department of commerce concerning premium tax refunds, the interstate insurance compact, insurer insolvency proceedings, individual health insurance, the small employer carrier reinsurance program, insurance applications, etc.
- 04/13/2005 – Introduced.

Maine

ME HB 1038: An Act to establish a simplified package of health care insurance affordable by all.

- The purpose of this bill is to allow health insurance carriers to offer a simple package of basic health care insurance that is affordable for more of the citizens of the State. The bill repeals existing state-mandated benefits, mandated health insurance coverage and mandated offerings of health benefits. This bill also makes cross-reference corrections necessitated by the repeal of various provisions of law.
- 03/28/2005 – Introduced.

ME HB 1038: An Act to reduce Maine's health insurance rates and expand consumer choice.

- This bill: repeals the guaranteed issuance and community rating law for individual health plans effective April 1, 2006 and allows carriers to treat their pre-2006 book of business separately from their post-2006 book of business; makes changes to the continuity of coverage laws to allow underwriting when someone switches carriers in the individual market; creates the Comprehensive Health Insurance Risk Pool Association to spread the cost of high-risk individuals among all health insurers; funds the high-risk pool through an assessment on insurers; allows a carrier to offer health plans that do not comply with geographic access standards if the carrier also offers health plans that comply with those access standards or offers a fee-for-service health plan; imposes a \$250,000 cap on noneconomic damages awarded in medical malpractice cases; among other purposes.

- 03/28/2005 – Introduced.

ME HB 1070: An Act to create lower-cost health insurance options.

- An Act that requires health insurance carriers to offer a catastrophic health plan as alternative coverage for each of its group health coverage plans. The bill requires the Superintendent of Insurance to define, by rule, the requirements of the catastrophic plan. The bill also requires that employers providing health insurance coverage to their employees offer their employees the option of choosing the catastrophic plan. To the extent allowed by federal and state law, the bill allows carriers and employers to establish health savings accounts in conjunction with the catastrophic plan. Part B requires the State Employee Health Insurance Program to offer a high-deductible health plan option compatible with health savings accounts.

- 04/04/2005 – Introduced.

Massachusetts

MA SB 612: Retroactive termination of coverage.

- An Act to prohibit carriers from retroactively terminating a consumer's health insurance coverage.
- Introduced March 16, 2005.

Montana

MT SB 134: Revise captive insurance company laws.

- An Act clarifying application of Title 33, MCA, statutes to captive insurance companies regarding voluntary dissolutions and limits on aggregate premium taxes and certain other taxes; clarifying that risk retention group statutes apply to certain captive insurers; and for other purposes.

- 04/08/2005 – Signed by Governor.

Nevada

NV HB 338: Makes various changes relating to insurance.

- An Act relating to insurance; providing for the regulation of discount health plans; providing the tax rate on premiums for risk retention groups; decreasing certain fees for risk retention groups; authorizing an insurer to invest in bonds or notes secured by second liens upon real property under certain circumstances; setting forth the circumstances under which a producer of insurance may pay a commission for selling, soliciting or negotiating insurance in this State; and for other purposes.
- 03/21/2005 – Introduced.

New York

NY HB 6703: Assessments of self-insurers for the special disability fund.

- Provides that assessments of self-insurers, the state insurance fund, and all insurance carriers for the workers' compensation special disability fund shall be based on 110 percent, rather than 150 percent, of total disbursements from the fund during the preceding calendar year, less the amount of the fund's net assets as of December 31st of such preceding calendar year.
- 03/18/2005 – Introduced.

NY SB 4312: Notices pertaining to commercial insurance policies.

- An act to amend the insurance law, in relation to requiring certain notices pertaining to commercial insurance policies to include the annual premium and loss information. To require insurers, when they cancel or nonrenew, or significantly raise premiums or change insurance coverage, to provide commercial insurance policyholders with loss histories and premium information.
- 04/13/2005 – Introduced; referred to Committee on Insurance.

Oklahoma

OK HB 1566: Extending moratorium on applicability of reserve and surplus requirements.

- An Act relating to insurance; amending 36 O.S. 2001, Section 1509, as amended by Section 56, Chapter 368, O.S.L. 2004 (36 O.S. Supp. 2004, Section 1509), which relates to assets and liabilities of insurers; extending moratorium on applicability of certain reserve requirements; amending 36 O.S. 2001, Section 1530, as amended by Section 57, Chapter 368, O.S.L. 2004 (36 O.S. Supp. 2004, Section 1530), which relates to risk-based capital for insurers; extending time insurer is exempt from certain surplus requirements; and providing an effective date.
- 04/14/2005 – Adopted.

Pennsylvania

PA HB 1060: Use of credit information.

- An Act relating to the use of credit information by carriers of personal lines insurance.
- 03/21/2005 – Introduced.

Rhode Island

RI HB 158: UIM coverage.

- This act would require insurance carriers to respond to a request to settle with a tortfeasor within 60 days of such request; if not responded to within 60 days then said consent would be deemed granted.
- 04/14/2005 – Amended/Substituted.

Tennessee

TN SB 154: Judgments.

- Established presumption of damages for default judgments in subrogation actions.
- 04/05/2005 – Adopted.

Texas

TX SB 1697: Eligible surplus lines insurers.

- Eligible surplus lines insurers are companies that are not licensed to sell insurance in the state, but are allowed to sell a particular type of insurance if it cannot be obtained from a licensed insurer within the state. To become eligible, a surplus lines insurer must meet minimum capital and surplus requirements, hold a license in the state in which they are located, and be authorized to write the same coverage in the state in which they are licensed that they seek to write in Texas.
- 04/19/2005 – Scheduled for public hearing.

Washington

WA HB 1418: Regulating insurance overpayment recovery practices.

- Except in the case of fraud, a carrier may not: (a) request a refund from a health care provider of a payment previously made to satisfy a claim unless it does so in writing to the provider within 24 months after the date that the payment was made; or (b) request that a contested refund be paid any sooner than six months after receipt of the request. Any such request must specify why the carrier believes the provider owes the refund. If a provider fails to contest the request in writing to the carrier within thirty days of its receipt, the request is deemed accepted and the refund must be paid.

- 04/19/2005 – Passed House.