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For subscription information call: (800) 221-9428

Editor-in-Chief: John K. DiMugno, Esq.

Editorial Board Director and Senior Contributing Editor: William T. Barker

Senior Contributing Editor: Stephen S. Ashley

Contributing Editors: Robert D. Phillips Jr., Michael Sean Quinn, John Torigian, Dennis J. Wall

Editorial Offices: Litigation Research Group, 3450 Palmer Dr., Cameron Park, CA 95682

Telephone: (530) 344-0239 Facsimile: (530) 344-0189 E-Mail dimugno@pacbell.net

Editorial Board

Stephen S. Ashley
Stratton Press
1255 37th Avenue
San Francisco, CA 94122
(P) 415-759-5270
sashley@strattonpress.com

Elizabeth E. Bader
50 California Street, Suite 1500
San Francisco, CA 94111
(415) 391-7272
eebader@att.net

Michael Barnes
Sonnenschein Nath & Rosenthal, LLP
525 Market Street, 26th Floor
San Francisco, CA 94105
(P) 415-882-5007
(F) 415-882-0300
mbarnes@sonnenschein.com

William T. Barker
Sonnenschein Nath & Rosenthal, LLP
8000 Sears Tower
Chicago, IL 60606
(P) 312-876-8140
(F) 312-876-7934
wtb@sonnenschein.com

Ruben A. Castellon
Stanzler Funderburk & Castellon
180 Montgomery Street, Suite 1700
San Francisco, CA 94103
(P) 415-677-1450
(F) 415-677-1476
rcastellon@sfcfirm.com

Andrew B. Downs
Bullivant Houser Bailey PC
601 California Street, Suite 1800
San Francisco, CA 94108-2823
(P) 415-352-2716
(F) 415-352-2701
andy.downs@bullivant.com

Paul E.B. Glad
Sonnenschein Nath & Rosenthal, LLP
525 Market Street, 26th Floor
San Francisco, CA 94105
415-882-5001
pglad@sonnenschein.com

Roland C. Goss
Jorden Burt LLP
1025 Thomas Jefferson St., NW
Washington, DC 20007
(P) 202-965-8148
(F) 202-965-8104
rcg@jordenusa.com

Todd C. Hayes
Harper Hayes PLLC
600 University Street, Suite 2420
Seattle WA 98101
206-340-8010
todd@harperhayes.com

Susan S. Hayes
Quinn Hayes & Quinn
PO Box 26406
Birmingham, AL 355260
(P) 205-824-2958
shayes@qhq-law.com

Pamella A. Hopper
Nickens Keeton Lawless Farrell Flack,
327 Congress Avenue, Suite 490
Austin, TX 78701
512.472.3067
512.472.3068 (Fax)
phopper@nickenskeeton.com

Peter J. Laufenberg
Wendel Rosen Black & Dean, L.L.P.
1111 Broadway, 24th Floor
Oakland, CA
(P) 510-834-6600
(F) 510-588-4974

Linda Oliver
Reed Smith LLP
1999 Harrison St., Suite 2400
Oakland, CA 94612
(P) 510-466-6729
(F) 510-273-8832
loliver@reedsmith.com

Vincent E. Morgan
Pillsbury Winthrop LLP
909 Fannin, Suite 2200
Houston, Tx 77010
(P) 713-425-7325
vmorgan@pillsburywinthrop.com

Steven Plitt
Kunz Plitt Hyland Demlong & Kleifield
3838 North Central Avenue, 15th Floor
Phoenix, AR 85012
(P) 602-331-4600
(F) 602-331-8600
sp@kunzlegal.com

Robert D. Phillips Jr.
Reed Smith LLP
Two Embarcadero Center, Suite 2000
San Francisco, CA 94111
(P) 415-659-5965
rphillips@reedsmith.com

Charles Platto
Law Offices of Charles Platto
1020 Park Ave., Suite 6B
New York, New York 10028
212-423-0579
cplatto@plattolaw.com

Michael Sean Quinn
Quinn Hayes & Quinn
5511 Parkcrest Dr., #107
Austin, TX 78731
(P) 512-542-9243
mquinn@@qhq-law.com

Douglas R. Richmond
Aon Risk Services
200 East Randolph, 12th Floor
Chicago, IL 60601
(P) 312-381-4000

Matthew J. Sekits
Bullivant Houser Bailey PC
1601 Fifth Ave., Suite 2300
Seattle, WA 98101
206-521-6452
matthew.sekits@bullivant.com

Dan Syhre
Betts, Patterson & Mines, P.S.
1 Convention Place, Suite 1400
701 Pike Street
Seattle, WA 98101
(P) 206-292-9988

John S. Torigian
Krell & Torigian
1600 Smith Street
Suite 3885
Houston, TX 77002
(P) 713-951-7603
jtorigian@msn.com

Christopher L. Troy
The Chartwell Law Offices, LLP
Valley Forge Corporate Center
970 Rittenhouse Road, Suite 300
Eagleville, PA 194203
(P) 610-666-7700

Jason Vacha
Reed McClure, Attorneys at Law
601 Union Street, Suite 1500
Seattle, WA 98101-1363
(206) 292-4900 main office line
(206) 386-7017 direct dial
jvacha@rmlaw.com

Dennis J. Wall
Dennis J. Wall & Associates
3452 Lake Lynda Drive, Suite 170
Orlando, FL 32817-1472
(P) 407-381-5887
(F) 407-381-8199
walldjatty@aol.com

Janice Wang
Gordon & Polscer
1000 Second Avenue
Seattle, WA 98104
(P) 206-223-4226
(F) 206-223-5459
jwang@gordon-polscer.com

Market Conduct Examinations: The Past Decade and Future Trends—Good News; Bad News

By Gary Hernandez,* Kara Baysinger,** and Elizabeth Tosaris***
Sonnenschein Nath & Rosenthal LLP

While much discussion and activity is occurring on the national stage relating to insurance, much of the regulation of insurance companies will remain within the jurisdiction of the state Departments of Insurance (DOI). Over the past five years, state DOIs have moved toward a focus on more targeted market conduct examinations as a way to focus resources on areas or practices of particular concern.

The move toward fewer, more targeted examinations is borne out by the numbers. There were 979 completed market conduct examinations in 1999 (393 domestic and 586 foreign) versus 735 completed market conduct examinations in 2009 (256 domestic and 479 foreign), according to the 1999 and 2009 NAIC Insurance Department Resources Reports.¹

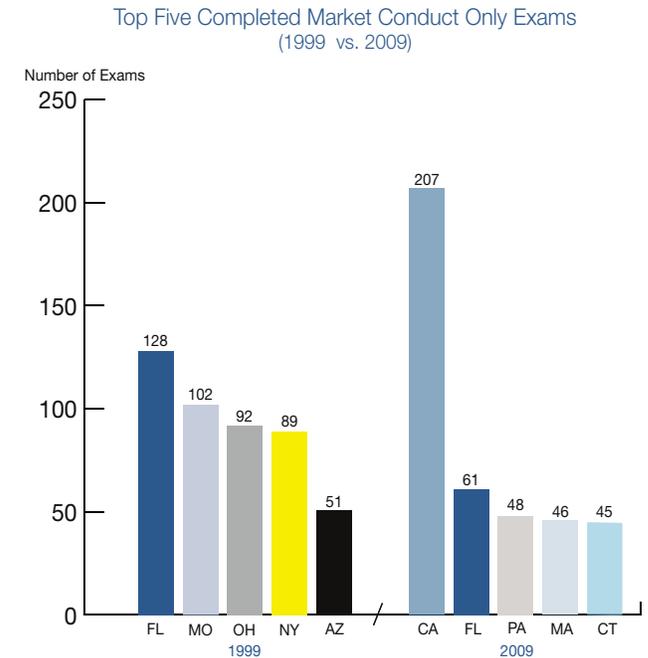
Despite the reduction in the number of examinations annually, for those insurance companies that are examined, our experience is that the costs to address the issues raised in the examinations have risen dramatically. One reason for this increased cost is that regulators are more likely than in years past to require the implementation of long term and comprehensive corrective action plans. These plans are correspondingly more expensive for companies to implement. In addition, in the last few years, regulators have worked together through the NAIC to target carriers for examinations that are likely to have larger or more serious compliance issues. As a result, those carriers that are examined are more likely to be carriers where the regulators will seek more sweeping changes and higher penalties.

While there appears to be some correlation between the number of market conduct examinations a state completes in a year and the number of market conduct examiners and/or analysts on its staff, the

growing use of contract examiners allows DOIs with fewer market regulation personnel to perform a significant number of examinations. The following data may help companies focus their attention on states more likely to examine them with either DOI staff or contract examiners.

Top States Completing Market Conduct Examinations

In 1999, the top five state DOIs that completed market conduct only examinations were Florida (FL), Missouri (MO), Ohio (OH), New York (NY), and Arizona (AZ). In 2009, the top states were California (CA), Florida (FL), Pennsylvania (PA), Massachusetts (MA), and Connecticut (CT). A comparison chart follows:



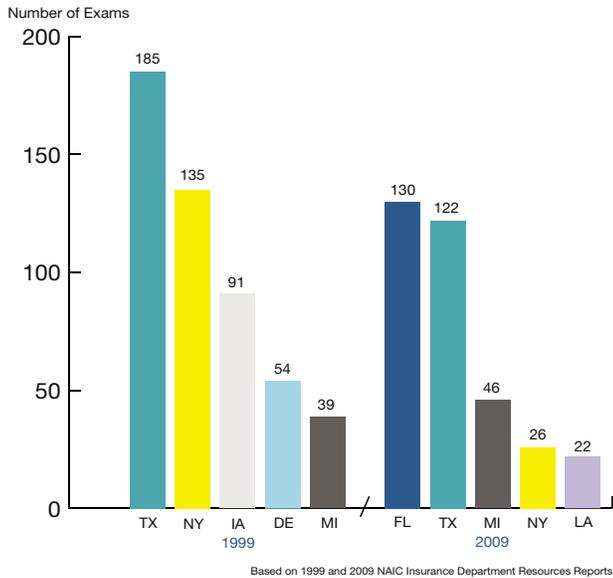
Based on 1999 and 2009 NAIC Insurance Department Resources Reports

1. This is market conduct only, not financial.

Top States Completing Financial Market Conduct Examinations

Some states combine their market conduct examinations with financial examinations. Here is a comparison of the top five DOIs who perform audits in that manner for 1999 versus 2009:

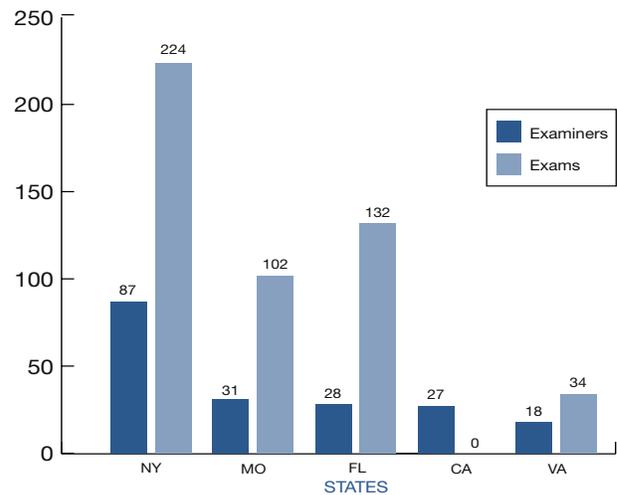
Top Five Completed Financial/Market Conduct Exams (1999 vs. 2009)



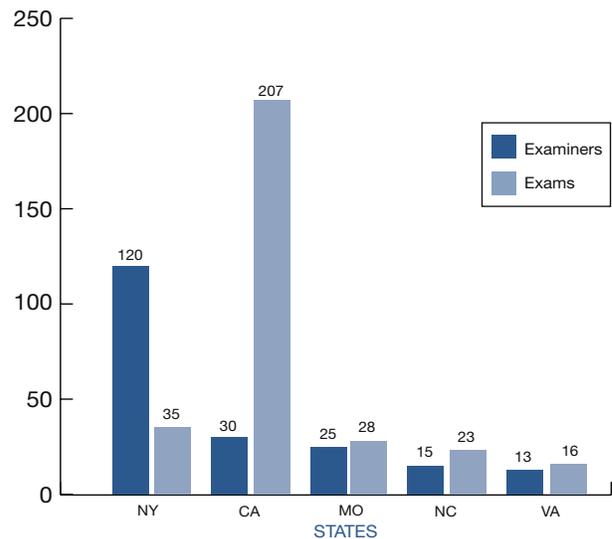
States with Largest Number of Market Conduct Department of Insurance (DOI) Staff

The following charts compare the 1999 versus 2009 top five states with the largest number of market conduct examiners on DOI staffs (not including market conduct analysts or contract examiners) and the total number of market conduct only and combined financial/market conduct examinations completed for that year.

Examiners and Exams in the Top Five States (1999)



Examiners and Exams in the Top Five States (2009)



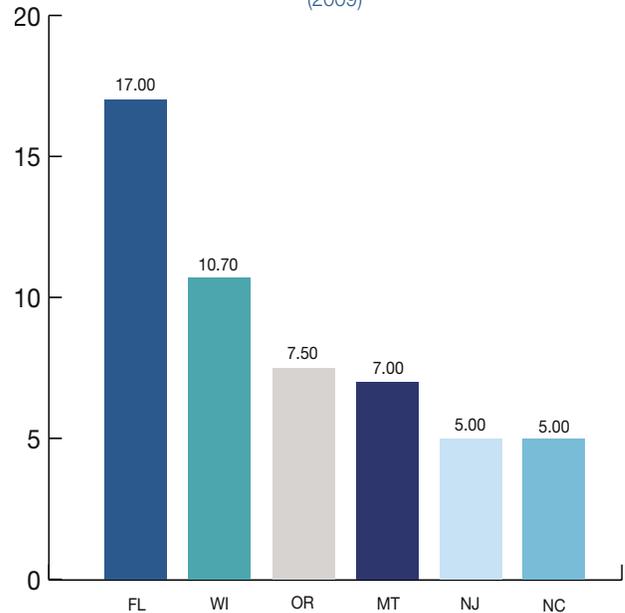
States with Largest Number of Market Conduct Analysts on Staff

State DOIs are moving toward implementation of a market analysis model that allows the state to consider data, information, and statistics on each company. This market analysis is used to identify emerging market conduct issues and to target companies and/or issues for examinations. Market conduct analysts review data on insurance companies and provide DOI Market Regulation Chiefs with recommendations on significant issues arising in the market and companies to examine in more detail, based on the initial review of the data.

The NAIC did not track the number of market analysts on DOI staffs in 1999, because this role is one of more recent creation. The following chart lists the top states with the largest number of market conduct analysts on staff in 2009, illustrating the growth in this role and indicating increased reliance on this position and the results of the analysts' efforts.

Market analysis is increasingly important, because it is the basis for determining what issues the DOIs track, the examinations called, and is an influence on the focus of regulator scrutiny. Of course, these focused examination and investigation practices may result in fines and/or other regulatory action against companies for non-compliance.

Top State DOIs With Most Number of Market Conduct Analysts on Staff (2009)



Based on 2009 NAIC Insurance Department Resources Report

* Mr. Hernandez practices insurance regulatory and administrative law. Formerly, he served as a deputy insurance commissioner and chief of enforcement in charge of insurer enforcement and market conduct, fraud investigations and management of all failed insurers in California. Prior to that, he served as deputy city attorney for the City and County of San Francisco. Mr. Hernandez is the founding Partner of Sonnenschein's Insurance Regulatory Practice. He is a managing partner of the Firm's 450 attorney Business and Regulation Department. Mr. Hernandez has extensive experience advising insurers facing multi-state market conduct examination and enforcement actions. For contact information, see <http://www.sonnenschein.com/attorneys/gary-a-hernandez>

** Ms. Baysinger is a Partner in Sonnenschein's Insurance Regulatory and E-business Practices, Vice Chair of the firm's Insurance Practice, Lateral Acquisition Partner, and a member of the firm's Management Team, Policy and Planning Committee and Women's Business Development Group. Ms. Baysinger has extensive national experience in reinsurance, market conduct and sales practices (including multi-state examinations and investigations), licensing, regulatory approvals, electronic commerce, transactional matters (including acquisitions, mergers and divestitures of insurance and non insurance entities), as well as product and market development issues. For contact information, see <http://www.sonnenschein.com/attorneys/kara-baysinger>

*** Ms. Tosaris is a member of Sonnenschein's Insurance Practice with nearly 20 years of insurance regulatory and insurance litigation experience. Ms. Tosaris has particular expertise in responding to market regulation examinations including resolving issues arising out of those exams. She regularly advises major insurers who are the target of multi-state market conduct exams across the country. For contact information, see <http://www.sonnenschein.com/attorneys/elizabeth-a-tosaris>

Gulf Oil Catastrophe Insurance Coverage Claims – Update

BP Counterclaims against Transocean's Excess Insurers

By Charles Platto* and Joseph G. Grasso**

In an article in the June 18, 2010 issue of *Insurance Litigation Reporter* entitled “Gulf Oil Catastrophe—Round 1 Transocean Insurers v. BP Additional Insured Claim” (*Insurance Litigation Reporter*, vol. 32, no. 9), we reported that Transocean's excess liability insurers (who provided \$700 million excess of \$50 million of coverage to Transocean under marine liability policies), filed a declaratory judgment action in federal court in Texas on May 21, 2010, challenging a notice of claim by various BP entities as additional insureds under the Transocean policies. *Certain Underwriters at Lloyd's and Various Insurance Companies vs. BP Exploration & Production Inc. (and other BP entities)*, Civil Action No. 10-01823 (SD Tex.) The insurers acknowledged in the complaint that BP was an additional insured under the policies, but they asserted that Transocean and its insurers were not responsible for damage relating to the pollution from BP's well.

On August 6, 2010, BP, represented by Covington & Burling LLP, a leading policyholder firm, filed an answer and counterclaims. Not surprisingly, the counterclaims included as counts One and Two declaratory judgment and breach of contract assertions for coverage by BP. But what was most interesting and somewhat unexpected, was a Third count for Subrogation, Contribution, or Indemnity. That count disclosed that BP had a \$300 million liability policy with National Union Fire Insurance Company of Pittsburgh, PA (an AIG entity), coverage that has not previously been generally reported. The count further reveals that National Union has

tendered its full policy limits to BP and assigned its rights to contribution, indemnity or subrogation to BP. Accordingly, BP is pursuing National Union's (AIG's) claims against Transocean (and its insurers) as assignee.

As previously reported, according to the Court's docket, a status conference is scheduled for September. We will continue to keep you posted as developments unfold.

* Mr. Platto is Adjunct Professor of Insurance Law and Litigation at Fordham Law School, a Vice Chair of the ABA Insurance Coverage Litigation Committee and a Member of the Editorial Board of the *Insurance Litigation Reporter*. He was formerly Chair of the Insurance Practice Group at Wiggin and Dana LLP, and previously a partner at Cahill Gordon & Reindel, and is now an independent arbitrator and mediator in domestic and international commercial and insurance matters.

** Mr. Grasso is the current Co-Chair of the Insurance Practice Group of Wiggin and Dana LLP and Chair of the Committee on marine insurance and General Average of the U.S. Maritime Law Association. He is counsel to the American Institute of Marine Underwriters and wrote the Institute's amicus brief to the United States Supreme Court in the Exxon Valdez case. Mr. Platto and Mr. Grasso have been appointed as co-editors of the *Additional Insured Handbook*, to be published by the American Bar Association in 2011.

Agents & Brokers

Broker had No Duty to Advise Client about Amount of Insurance Coverage to Obtain

Insured Was Deemed to Know Policy's Contents

Isidore Newman School v. J. Everett Eaves, Inc., ___ So.2d ___, 2010 WL2723704 (La. July 6, 2010)

Case at a Glance

Damages award against broker for breaching duty of care to explain coverage components and for failing to make coverage suggestions concerning tuition/income loss of a private school was reversed. An insurance broker or agent did not owe a duty to advise the client as to the amount of insurance to obtain. It was not the agent's obligation to affirmatively identify the scope or amount of insurance coverage the client needed. Rather it was the insured's obligation to read the policy and the insured was deemed to know its contents.

Summary of Decision

Defendant, an insurance broker, sold property and casualty insurance to the plaintiff, Isidore Newman School. From 1989 until 1999 Newman purchased \$250,000 "Extra Expense Coverage" through defendant. In 1999, the coverage was renamed "Business Income & Extra Expense Coverage" (BI & EE). In 2003, the policy coverage was increased from \$250,000 to \$350,000. According to Newman, defendant explained that the coverage protected the school against the extra expenses the school would incur while repairing physical damages to the school building.

Following Hurricane Katrina in 2005, Newman School suffered major damage to its physical structure that caused the school to be closed for over two months. As a result Newman suffered loss of tuition revenue and income totaling \$3,166,606. Newman filed suit against defendant alleging that defendant was negligent in failing to advise the school

the BI & EE coverage covered income/tuition losses and that the amount of coverage was not sufficient to cover tuition losses, and in misleading the school into believing that BI & EE coverage was limited to physical damages to building. Newman argued that defendant had a duty to exercise reasonable skill, care, and diligence in evaluating Newman's insurance needs, advising Newman as to level of insurance coverage it required, and procuring that coverage. Newman also argued that defendant had a duty to inform Newman of available coverage options and to explain the costs and potential benefits of those coverages.

Defendant moved for summary judgment, arguing that Newman had a legal duty to be aware of the amount of coverage, and an obligation to adjust the limits to meet the school's needs. Defendant asserted that the amount of coverage was plainly listed on both the written proposals and the policy of insurance presented annually. The trial court denied defendant's motion for summary judgment, finding that there was an issue of material fact as to whether defendant failed to properly advise Newman regarding coverage options and the amount of coverage needed. After a trial, the court found that defendant breached the duty of care required of an insurance broker by not explaining the components of the BI & EE coverage so that Newman could make an informed choice concerning coverage, and by not including in the annual recommendations of suggested coverage a sum to cover the loss of tuition. The trial court further found that Newman was not justified in relying solely on defendant's advice and failed to uphold its duty to read or review the policy. The court awarded damages of \$3,166,606, but determined that Newman was 70% at fault, comparatively. The court of appeal affirmed.

The Louisiana Supreme Court reversed, concluding that the lower courts erred in holding that the insurance broker or agent owed a duty to advise the client as to the amount of insurance coverage to obtain. An agent has a duty of "reasonable diligence" to advise the client, but this duty has not been expanded to include the obligation to advise whether the client has procured the correct amount or type of insurance coverage, and the amount of coverage needed. Thus, it was not the agent's obligation to spontaneously or affirmatively identify the scope or the amount of insurance coverage the client needed. It was also well settled that it was the insured's

obligation to read the policy when received, as the insured was deemed to know the policy contents, the court concluded.

One justice concurred because coverage for tuition loss was never requested by the insured despite the fact that Newman, a sophisticated client, was informed by the policy as well as the insurance proposal that BI & EE coverage included coverage for tuition loss. // Holt

Automobile Insurance/ Policy Limits

Collision Involving Four Trucks and Drivers Was One “Occurrence” for Coverage Limit Purposes

Injuries Arose from Single Force and Uninterrupted Chain Reaction

Auto-Owners Insurance Co. v. Munroe, ___ F.3d ___, 2010 WL 2852611 (7th Cir. (Ill.) July 22, 2010)

Case at a Glance

Insurance coverage for a truck driver injured when his vehicle was involved in a collision with three trucks traveling in a convoy that were owned by a single company and insured under a single policy was subject to the policy’s \$1 million per occurrence liability limit. The plaintiff’s injuries resulted from a single force and an uninterrupted chain reaction involving several vehicles, and thus a single continuous occurrence. The single injury did not give rise to multiple occurrences merely because several acts of negligence combined to produce a single result. A federal requirement of \$750,000 minimum coverage per truck was inapplicable when there was no final judgment in the plaintiff’s case.

Summary of Decision

Joshua Munroe sustained severe injuries when the tractor-trailer he was driving northbound on a highway struck the rear of a southbound tractor-trailer and then careened into a head-on collision with

another tractor-trailer that was following the first southbound tractor-trailer and attempting to pass yet another tractor-trailer. Munroe incurred medical expenses in excess of \$474,000 as a result of his injuries. All three southbound trucks were owned and operated by Wayne Wilkens Trucking and had been traveling in convoy. All were covered under a single insurance policy issued by Auto-Owners Insurance. The policy declarations specified a \$1 million limit for each occurrence and listed all three Wilkens trucks involved in the incident, as well as other Wilkens trucks. The policy also contained a combined limit of liability provision which stated that the maximum total coverage was the \$1 million limit, regardless of how many automobiles were listed in the declarations or involved in the accident.

Munroe and his wife sued the drivers of the Wilkens trucks, alleging that they acted negligently, one by failing to yield and letting the second pass at a safe time and place, the second by passing when unsafe, and the third by following too closely and failing to avoid the head-on collision. Plaintiffs also alleged that the three trucks were exceeding the speed limit, and that Wilkens was negligent in hiring and training the drivers.

The Munroes entered a partial settlement agreement in which they agreed to release the Wilkens and the drivers from any individual liability above their liability insurance in exchange for \$903,449, the remainder of the \$1 million coverage limit after property damage was paid to the owner of Munroe’s tractor-trailer. Auto-Owners brought a suit for a declaratory judgment that the limit of the liability insurance coverage under the policy was in fact \$1 million. The trial court granted summary judgment to Auto-Owners, holding that the insurance policy unambiguously limited coverage to \$1 million for each occurrence, and dismissing the Munroes’ additional argument that the federal Motor Carriers Act mandated at least \$2.25 million insurance under an MCS-90 endorsement required for the policy.

The Seventh Circuit affirmed, determining that the insurance policy unambiguously limited coverage to \$1 million per occurrence, and that there was a single occurrence in this case because there was a single continuous event. The court further determined that inclusion in the policy of the MCS-90 endorsement did not affect Auto-Owners’ liability because it applied only if triggered by an unpaid final

judgment against Wilkens. With respect to the “per occurrence” policy limitation, the court noted that Illinois had adopted the “cause theory” to determine the number of occurrences under a policy for purposes of coverage limitations. Under the cause theory, the number of occurrences was determined according to the number of separate and intervening human acts giving rise to the claims under the policy. The court distinguished *Illinois Nat’l Ins. Co. v. Szczepkowitz*, 542 N.E.2d 90 (Ill. App. 1989), in which a single trucker caused two occurrences when his separate acts of negligence following an initial collision caused a second collision five minutes later. In *Szczepkowitz* the two collisions were not the result of a single force or unbroken or uninterrupted continuum. Unlike *Szczepkowitz* the Munroes case involved a single force and an uninterrupted chain reaction involving several vehicles, and thus a single continuous occurrence. The court noted that no Illinois court had held that a single claim or injury could give rise to multiple occurrences merely because several acts of negligence combined to produce a single result.

Addressing the MCS-90 endorsement, the court acknowledged that the minimum coverage required by the endorsement was \$750,000 for a vehicle. The court was skeptical of the Munroe’s claim that the MCS-90 minimum applied on a per-vehicle as well as per-accident basis, however, but found it unnecessary to answer the question because the MCS-90 was inapplicable for a more fundamental reason—it applied only to a final judgment and there was no final judgment in the Munroes’ case. // Holt

Automobile Insurance/Use

Catering Truck Fire Covered in Texas under Commercial Auto Policy

Insurer Was Charged with Knowledge of Special Vehicle’s Usage

Employers Mut. Cas. Co. v. Bonilla, ___ F.3d ___, 2010 WL 2946856 (5th Cir. [Tex.] July 29, 2010)

Case at a Glance

In a highly unusual case from Texas, the Fifth Circuit Court of Appeals has found that a kitchen fire in a catering truck arose from the “use” of the vehicle, although it was not being operated at the time. Because the insurer knew the vehicle had a special purpose, it could not claim the routine use of the truck as a mobile kitchen was an unanticipated loss.

Summary of Decision

The *Bonilla* case arose from an unusual fact pattern. Employers Mutual insured Jolly Chef Express, a Texas company that leased catering trucks to individuals. One of them, Juan Bonilla, leased such a truck and hired Isabel Molina as his cook. In 2002, while cleaning grease from the truck’s floor, Molina was badly burned in a fire that started when the stove’s pilot light ignited the cleaning fluid. The district court held Molina’s injury failed to arise from the use of the vehicle “qua vehicle,” but the Court of Appeals reversed.

After an interesting but seemingly pointless discussion of the relationship between auto and general liability policies, the appellate court squarely addressed whether a kitchen fire resulted from the “use” of a motor vehicle, when the vehicle was not in motion at the time. Acknowledging that the operation of a passenger vehicle as a portable kitchen might not be a traditional “use” of a motor vehicle, the court pointed out that *this* vehicle was specifically designed as a catering truck, a fact that was well known to the insurer because it said so in the policy declarations.

As such, the truck was a “special purpose” vehicle and the insurer should be charged with knowledge of the risks inherent in a vehicle of that nature—in particular, risks associated with cooking and maintaining a clean food preparation space. The court remanded the case to the district court, however, to determine whether the “employee exclusion” barred coverage.

Comment

Although one can argue that Bonilla should have purchased CGL insurance to cover his cooking operations—cooking is not, after all, a risk traditionally associated with motor vehicle policies—it is difficult to argue with the result on equitable grounds. Employers insured a mobile catering truck that was designated as such on the policy—just as another type of policy might cover a private security force, an off-road logging operation, or an amphibious sightseeing vehicle. An insurer in that circumstance presumably can exclude the use of the vehicle for other than transportation purposes without running afoul of regulators. Having written broad liability coverage for the “use” of a kitchen on wheels, Employers was not in a strong position to contend it never intended to cover cooking operations as opposed to car accidents. Of course, if the next case addresses food poisoning originating in a catering truck insured by Employers, the result is anyone’s guess. // Barnes

Bad Faith

Evidence of Underinsured Motorist Carrier’s Unreasonable Delay in Proceeding to Arbitration Exposes Insurer to Liability for Extra-contractual and Punitive Damages

Insurer’s Summary Judgment Motion Denied

Gentry v. State Farm Automobile Insurance Co., __ F.Supp.2d __, 2010 WL 2903952 (E.D.Cal., July 26, 2010)

Case at a Glance

A jury could decide whether the insured under an underinsured motorist policy was entitled to recover tort damages and punitive damages from the insurer, even though the insurer eventually paid its policy limits, based on evidence that the insurer unreasonably delayed in making payment by not conducting a timely investigation of the claim and delaying arbitration and settlement of the claim.

Summary of Decision

After an arbitrator awarded essentially the amount plaintiff demanded from his underinsured motorist insurer approximately two-years earlier, and the insurer paid the arbitration award in full, plaintiff sued the insurer for bad faith. The gravamen of plaintiff’s complaint was the insurer’s unreasonable delay in paying his claim. The insurer moved for summary judgment, arguing that the existence of a “genuine dispute” about the amount of plaintiff’s damages precluded recovery of extra-contractual and punitive damages as a matter of law. The insurer’s motion relied heavily on the fact that plaintiff’s only injuries were to his knees on which plaintiff had undergone arthroscopic surgery prior to the accident, making determination of causation difficult.

In opposing the motion, plaintiff proffered his treating physician’s testimony that the arthroscopic surgery performed on plaintiff’s knee after the surgery would likely not have been required if plaintiff’s knee had not been injured in the accident,

a conclusion the physician hired by the insurer to perform an independent medical examination (IME) later confirmed. Moreover, plaintiff argued that the insurer took far too long to make its causation determination. Plaintiff pointed out that the insurer did not schedule the IME until nearly two-years after plaintiff had formally demanded UIM benefits and three and one-half years after the accident. Plaintiff further noted that in the months following his demand, the insurer made two low ball offers of \$4,886.20, once by the insurer's adjuster without reviewing the medical records and once by the insurer's outside counsel after reviewing the medical records. The insurer's identical offers were in response to a letter from plaintiff's counsel in which he identified medical specials totaling \$27,476.50 and demanded the \$75,000 remaining on plaintiff's underinsured motorist limits of \$100,000 after he settled with the adverse driver's insurer for driver's \$25,000 policy limit. Finally, plaintiff noted that the insurer did not agree to set his claim for arbitration until over six months after plaintiff's initial demand for arbitration.

The district court denied the insurer's motion. Quoting the California Supreme Court's decision in *Wilson v. 21st Century Ins. Co.*, 42 Cal.4th 713, 720, 68 Cal.Rptr.3d 746, 171 P.3d 1082 (2007), the district court explained that the genuine dispute rule "does not relieve an insurer from its obligation to thoroughly and fairly investigate, process and evaluate the insured's claim. A *genuine* dispute exists only where the insurer's position is maintained in good faith and on reasonable grounds." The court further noted that the questions of whether an investigation was reasonable and whether a genuine dispute existed are ordinarily questions for the trier of fact. The genuine dispute rule does not alter the standards for deciding and reviewing summary judgment.

The court found that the insurer had failed to establish the reasonableness of its investigation and coverage position as a matter of law. A jury could reasonably conclude that the insurer failed to conduct an adequate investigation based on evidence that the insurer failed to obtain plaintiff's medical records or schedule an IME in a timely fashion, and on evidence that the insurer's attorney reduced plaintiff's medical specials without explanation. In light of *Wilson*, triable issues of fact regarding the adequacy of the insurer's

investigation precluded the insurer from establishing that its valuation of plaintiff's claim was reasonable. Moreover, the court noted that even assuming the adequacy of the insurer's investigation, IME physician's agreement with plaintiff's treating physician raised a triable issue of fact regarding the reasonableness of the insurer's valuation.

The court categorically rejected the insurer's contention that its reliance on the advice counsel entitled it to summary judgment. Reliance on the advice of counsel, the court explained, is just one piece of evidence in the "totality of circumstances" the trier of fact must consider in determining the reasonableness of the insurer's position. Here, the discrepancy between counsel's assessment of plaintiff's medical specials and plaintiff's claimed specials cast doubt on the reasonableness of the insurer's reliance.

Finally, the court found triable issues of fact regarding whether the insurer was guilty of "oppression"—defined as a "conscious disregard" of plaintiff's rights—for purposes of awarding punitive damages under California Civil Code § 3291. In so doing, the court placed particular emphasis on the insurer's six-month delay in agreeing to arbitration.
// DiMugno

Bad Faith/Standing

Third-Party Had No Bad Faith Cause of Action against Excess Liability Insurer

*Plaintiff Was Not Beneficiary of
Mandatory Coverage Such As
Statutorily Mandated Auto Liability Insurance*

Jolley v. Associated Electric & Gas Insurance Services Limited, ___ P.3d ___, 2010 WL 2871627 (N.M. June 17, 2010)

Case at a Glance

A third-party plaintiff who sued a natural gas company for a motorist's death from a wellhead explosion had no statutory bad faith cause of action against the gas company's excess liability insurer.

Third-party claimants may have a private action against insurers where specific legislation indicated that the legislature contemplated classes of person to be protected under the New Mexico Insurance Code. The state supreme court has held, in the context of statutorily mandated automobile liability insurance, that the legislature intended to provide a statutory cause of action to third-party claimants. This right of action does not apply against an excess liability insurer whose coverage was not required by any New Mexico law.

Summary of Decision

Plaintiff represented the estate of a motorist who backed over and damaged an unprotected natural gas wellhead, resulting in an explosion and fire that killed him and his passenger. Plaintiff sued Energen Resources Corporation, the well operator, for wrongful death. Energen had an excess reimbursement insurance policy with Associated Electric and Gas Insurance Services Limited (AEGIS). Under the policy AEGIS agreed to reimburse Energen for incurred damages and defense costs exceeding Energen's self-insured retention of \$500,000. The parties did not settle before trial. Plaintiff made a settlement demand of \$2 million that Energen rejected. Energen settled with the passenger's estate for \$2 million, however, and that sum was reimbursed by AEGIS. Plaintiff's wrongful death suit went to trial. The jury found compensatory damages of \$2,957,000, reduced by the decedent's negligence to \$1,922,050. The jury also awarded \$13 million in punitive damages. After unsuccessful appeals Energen paid \$20,610,413 on plaintiff's verdict and was reimbursed by AEGIS.

Plaintiff then brought suit against AEGIS pursuant to the Trade Practices and Frauds Article of the New Mexico Insurance Code, alleging that AEGIS failed to make a good faith effort to settle plaintiff's wrongful death lawsuit. AEGIS removed the matter to federal district court and filed a motion to dismiss. The district court certified two questions to the New Mexico supreme court:

(1) Whether Plaintiff, a third-party claimant, has a statutory bad faith cause of action against AEGIS, an excess liability insurer, for failure to settle an underlying lawsuit,

pursuant to the New Mexico Insurance Code and as recognized by this Court in *Hovet* [*Hovet v. Allstate Insurance Co.*, 89 P.3d 69 (N.M. 2004)], where the excess liability insurance policy between AEGIS and the insured was not mandated by any state law.

(2) If such a cause of action exists, whether the third party can recover as damages the costs and contingency attorney's fees incurred by the third party in an underlying action where the third party was awarded at trial an amount far in excess of the third party's highest pretrial settlement offer.

The New Mexico Supreme Court accepted certification and answered the first question in the negative, determining that plaintiff had no statutory bad faith action against the excess liability insurer. The court found it unnecessary to reach the second question. The court observed that its precedents recognized that third-party claimants may have a private action against insurers in certain circumstances, but only where specific legislation indicated that the New Mexico legislature contemplated classes of person to be protected under the Insurance Code. In *Hovet*, the court held that, in the context of statutorily mandated automobile liability insurance, the legislature intended to provide a statutory cause of action under the Insurance Code to third-party claimants. The court declined to extend *Hovet* to plaintiff's case, noting that the case had nothing to do with the decedent's operation of an automobile. The AEGIS excess liability policy was not mandated by the New Mexico Mandatory Financial Responsibility Act and was not a policy required by any New Mexico law.

The court reasoned that the purpose of the excess coverage insurance was different from that of compulsory automobile liability insurance because it was intended for the financial protection of the insured, not for the protection of members of the public who may be injured by the insured's operation of an automobile. Accordingly, the precedent and public policy considerations that dictated the result in *Hovet* neither compelled nor support a private right of action for the plaintiff in this case. Although AEGIS owed Energen, as its insured, a duty to engage in fair claims practices, neither the Insurance Code nor any other statute imposed any such obligation on

AEGIS with regard to the plaintiff. The court found nothing indicating that the legislature intended to extend a private action to claimants who were neither parties to the insurance contract nor special beneficiaries of a statutory scheme requiring mandatory insurance for the benefit of third parties.
// Holt

Health Insurance

Insurer's Exclusion of Maternity Services for Surrogate Mothers Violated Statute

Law Barred Making Maternity Services Unavailable to Subgroup Based on Reasons for Becoming Pregnant or Method Used to Achieve Pregnancy

MercyCare Insurance Co. v. Wisconsin Commissioner of Insurance, __ N.W.2d __, 2010 WL 2791999 (Wis. July 16, 2010)

Case at a Glance

An insurer's exclusion of maternity coverage for surrogate mother services was properly disapproved by the Insurance Commissioner. Under a Wisconsin statute, an insurer may not make routine maternity services that are generally covered under the policy unavailable to a specific subgroup of insureds, surrogate mothers, based solely on the insured's reasons for becoming pregnant or the method used to achieve pregnancy. Further, the definition of "surrogate mother" in an insurance contract was misleading because the benefits were too restricted to serve the purposes for which the policy was sold.

Summary of Decision

MercyCare offered a 2002 group disability insurance policy that provided maternity coverage for eligible persons covered under the policies. MercyCare denied coverage for maternity services received by persons who acted as gestational carriers by carrying a child for other parents, stating that the policy did not cover "surrogate mother services." The 2002 contract identified surrogate mother services as

a non-covered services, but "surrogate mother services" was not defined in the 2002 contract.

The Wisconsin Office of the Commissioner of Insurance (OCI) reviewed MercyCare's denial of coverage. During the review MercyCare filed its new 2005 group disability policy insurance contract with OCI for approval. The 2005 contract revised the exclusion to provide that treatment, services or supplies for a surrogate mother or any pregnancy resulting from "your" services as a surrogate mother were non-covered services. The contract defined a surrogate mother as "a woman who, through in vitro fertilization or any other means of fertilization, gives birth to a child which she may or may not have genetic relationship to, or an individual who provides a uterus for the gestation of a fertilized ovum obtained from a donor when the child will be parented by someone other than the woman who gives birth."

OIC disapproved the 2005 contract, explaining that a policy that provides maternity coverage may not limit the coverage based on method of conception, as such a limitation is unfairly restrictive and discriminatory. After MercyCare requested a hearing the Insurance Commissioner issued a decision concluding that, under the mandate of Wis. Stat. § 632.895(7), (1) MercyCare could not exclude maternity coverage of otherwise covered persons based on their status as surrogate mothers, (2) the language of the 2002 contract was ambiguous; and (3) OCI appropriately disapproved the 2005 contract because the exclusion was contrary to section 632.895(7) and the 2005 contract was misleading because its benefits were too restricted to achieve the purposes for which the policy was sold.

MercyCare filed for judicial review. The trial court determined that the Commissioner exceeded his authority in disapproving the 2005 contract, reasoning that section 632.895(7) unambiguously permitted MercyCare to exclude maternity coverage for otherwise covered persons who were serving as surrogate mothers, and that the statute required only that any exclusions or limitations must be applied uniformly to all covered persons.

The Wisconsin Supreme Court reversed the trial court, applying due weight deference to the Commissioner's decision to conclude that an insurer may not make routine maternity services that are generally covered under the policy unavailable to a specific subgroup of insureds, surrogate mothers,

based solely on the insured's reasons for becoming pregnant or the method used to achieve pregnancy. The court accordingly determined that MercyCare's 2002 contract exclusion of coverage contravened section 632.895(7). The court also determined that the Commissioner appropriately disapproved MercyCare's 2005 contract because it, too, was contrary to section 632.895(7). Further the definition of "surrogate mother" in the 2005 contract was misleading because the benefits were too restricted to serve the purposes for which the policy was sold.

In reviewing the Commissioner's decision, the court observed that due deference may be warranted when an agency has specialized experience with the issues regulated by the statute, but had not yet interpreted the specific statutory language at issue. The Legislature had charged the Commissioner with approving group disability forms, and the Commissioner had substantial experience interpreting mandatory coverage provision, although not this particular exclusion. Accordingly, the Commissioner's statutory interpretation was entitled to due deference and would be sustained if it was not contrary to the clear meaning of the statute and no more reasonable interpretation existed. Section 632.895(7) provided that every group disability insurance policy which provided maternity coverage must provide maternity coverage for all persons covered under the policy. Required coverage could not "be subject to exclusions or limitations which are not applied to other maternity coverage under the policy." The court determined that the meaning of the statute and its application to the surrogate mother services exclusion was not readily apparent from the statutory text, and the court therefore could not conclude that the Commissioner's interpretation was contrary to the statute's clear meaning. The court rejected MercyCare's argument that it was more reasonable to interpret the statute to allow the exclusion if it was applied uniformly, reasoning that such an interpretation would produce unreasonable results by allowing an insurer to discriminate against any number of subgroups, providing the discrimination was uniform. The court also rejected an alternative interpretation suggested in the concurring opinion, that the statute allowed exclusion of coverage for "gestational carrier services." That concept was not found in the statute, the court pointed out, and the definition of gestational carrier services made no reference to the

existence of a contract. Further, the interpretation did not appear to yield a predictable result, because the exclusion could apply even if there was no surrogacy contract.

The 2005 contract defined "surrogate mother" as a woman who, through in vitro fertilization or any other means of fertilization, gives birth to a child which she may or may not have a genetic relationship to, or an individual who provides a uterus for the gestation of a fertilized ovum obtained from a donor when the child will be parented by someone other than the woman who gives birth. The Commissioner concluded that this definition was misleading because its benefits were too restricted to achieve the purposes for which the policy was sold. Aside from being contrary to the statutory mandate, MercyCare's definition was overly broad and would have the unintended effect of excluding coverage for some insureds that MercyCare may not have intended to exclude. The first part of the definition encompassed an insured who through in vitro or any other means of fertilization gave birth to a child, which appeared to exclude all pregnancies. The definition was overbroad because it appeared the insurer could invoke the exclusion and deny coverage in any situation "when the child will be parented by someone other than the woman who gives birth" regardless of when that decision was made. // Holt

Insurance Counsel

Insurer Not Prohibited from Employing Staff Attorneys to Represent Insureds

*Rules against Corporate Practice of Law
Did Not Invalidate Law Allowing
Employment of Staff Attorneys*

Bowers v. State Farm Mutual Automobile Insurance Agency, ___ N.E.2d ___, 2010 WL 2744634 (Ill. App., 1st Dist. July 9, 2010)

Case at a Glance

An automobile insurer's employment of staff counsel to represent its policy holders was permitted

under Illinois law, and a trial court properly dismissed a policyholder's claims of unlawful practice of law by the insurer. The Illinois Corporation Practice of Law Prohibition Act prohibited insurance carriers from practicing law in Illinois, but section 5 of the Act provided an exception that permitted an insurance carrier to employ attorneys in and about its own immediate affairs or in any litigation in which the corporation might be interested by reason of an insurance policy.

Summary of Decision

Plaintiff sued State Farm Mutual Automobile Insurance Agency individually and as a purported class representative alleging that he was insured by State Farm under an automobile policy that included general liability insurance coverage, and that State Farm provided staff counsel to represent him in connection with an unrelated claim against him. One count of plaintiff's claim alleged the unauthorized practice of law where State Farm used employee attorneys on staff to represent State Farm's insureds. The trial court consolidated two other similar challenges to State Farm's counsel arrangements.

State Farm moved to dismiss plaintiff's unauthorized practice of law claim. While the motion was pending, the court of appeals issued a ruling in one of the consolidated cases, *Jacobs v. State Farm*, No. 03L014178, rejecting the assertion that State Farm's staff counsel arrangement violated the prohibition against unauthorized practice of law. The trial court subsequently dismissed plaintiff's claim with prejudice, determining that State Farm's representation was legal and permitted under Illinois law and that State Farm's use of staff attorneys fell under the exception provided by section 5 of the Corporation Practice of Law Prohibition Act, 705 ILCSA 220/5, and *Kittay v. Allstate Insurance Co.*, 397 N.E.2d 200 (Ill. 1979). The court concluded that the Act and *Kittay* clearly and unequivocally authorized the staff counsel arrangement, compelling the granting of State Farm's motion to dismiss. The court also noted that the

appeals court ruling in *Jacobs* was the "final nail in the coffin" of plaintiff's claim and constituted the law of the case.

The court of appeals affirmed the dismissal, concluding that based on Illinois law and the record on appeal it was clear that State Farm's employment of staff counsel to represent its policy holders was permitted. The court rejected plaintiff's contention that the trial court erroneously relied on *Jacobs* as the law of the case, finding no need to reach the merits of that argument because both the trial court and the court of appeals resolved the unauthorized practice of law issue without reliance on *Jacobs*.

The court acknowledged that the Act prohibited insurance carriers from practicing law in Illinois. Section 5 of the Act, however, provided an exception to this rule by permitting an insurance carrier to employ attorneys in and about its own immediate affairs or in any litigation in which the corporation might be interested by reason of an insurance policy. The court of appeals concluded that because Section 5 plainly stated that a corporation could employ an attorney in any litigation in which the corporation was interested by reason of the issuance of a policy of insurance, it was lawful for insurance carriers such as State Farm to employ attorneys or a law firm to defend their policyholders.

The court of appeals also found *Kittay* directly on point with plaintiff's case, observing that in *Kittay* it had recognized that the Illinois statute prohibiting corporations from practicing law contained an express exception for litigation in which the corporation might be interested by reason of the issuance of any policy of insurance. The court of appeal rejected the argument that *Kittay* was implicitly overruled by rules of professional conduct prohibiting certain conduct by attorneys, reasoning that those prohibitions applied to lawyers but did not impose obligations or restrictions on a corporation, and therefore did not conflict with the statutory and judicial authorization of conduct by a corporation found in section 5 and *Kittay*. // Holt

Liability Insurance/ Misrepresentation

South Dakota High Court Rejects Coverage For Home Sale Fraud

Insured's Knowledge of Previous Problems Prevented Finding of "Accidental" Loss

Am. Family Ins. Group v. Robnik, ___ N.W.2d ___, 2010 WL 3172184 (S.D., Aug. 11, 2010)

Case at a Glance

In a case of first impression, the South Dakota Supreme Court has held that an insured's failure to disclose defects in the sale of a home was not an "occurrence." Because the insured was aware of previous plumbing problems, she could not claim the buyer's subsequent property damage was "accidental."

Summary of Decision

When Shirley Hunter sold her Rapid City home to Heather Robnik, she knew there had been some prior plumbing problems, but failed to disclose them to Robnik. After moving in, Robnik experienced serious sewer backups, and sued Hunter for failing to disclose that she had capped the sewer lines in the past because of ongoing problems. The trial court held the nondisclosure suit was not covered, and the Supreme Court affirmed.

The high court first considered whether the failure to mention the prior plumbing problems was "accidental," which was an issue of first impression. After reviewing case law from other jurisdictions, the court concluded it was not—at least not on the facts before it. Rather, Hunter had experienced plumbing problems in the past and had capped the defective line, and therefore would have expected that the

purchaser would uncapped the line and try to use it. Although the result might have been different had the insured never had a prior plumbing problem, Hunter could not claim her nondisclosure was completely innocent.

The court also rejected the argument that American Family was collaterally estopped from claiming Hunter acted intentionally, given that there was no such finding in the underlying action. Apart from the fact that the two cases did not involve the same issue, the court held, it would have violated American Family's duty to its insured to argue in the underlying action that she had intentionally defrauded Robnik. Because American Family had only agreed to defend Hunter, and not to indemnify her, it was not bound by the factual determinations in the suit between Robnik and Hunter. Two dissenting justices would have required American Family to show Robnik's injury was not just foreseeable but "substantially probable" to result from the insured's acts.

Comment

The *Robnik* case might have been fairly adjudicated, and might even be a correct statement of South Dakota law, but it dodged two of the most important coverage arguments raised in "failure to disclose" cases. First, irrespective of Hunter's state of mind, the court never addressed how she could have "accidentally" concealed the prior plumbing problems. Other cases—some cited without comment in *Robnik* itself—have held that a misrepresentation cannot be "accidental" in *any* circumstances. The *Robnik* court also failed to address whether Robnik was suing over "property damage" as opposed to an economic loss—that is, the purchase of a house that was worth less than she paid for it. After all, Hunter did not cause the capped line to leak, but merely caused Robnik to buy the house. Thus, by taking a narrow view of the issue before it and deciding the case on factual grounds, the court reached a decision that bound the parties but provided little in the way of guidance for future cases. // Barnes

Lloyd's London/ Diversity Jurisdiction

A Lloyd's Syndicate, as an Unincorporated Association, must Plead the Citizenship of Every Member of the Syndicate to Allege the Factual Basis for Diversity Jurisdiction

Question of First Impression in Eleventh Circuit

Underwriters at Lloyd's, London v. Osting-Schwinn, ___ F.3d ___, 2010 WL 3056606 (11th Cir. August 5, 2010)

Case at a Glance

When a dispute arose as to a claim on an insurance policy issued through a Lloyd's syndicate, the syndicate filed a declaratory judgment action in United States District Court. The issue in this case was what citizenship allegations were required to support diversity jurisdiction. The district court allowed the lead underwriter to be the sole plaintiff, not requiring jurisdictional allegations as to any other Name who was contractually obligated on the insured risk. The United States Court of Appeals for the Eleventh Circuit disagreed, vacated, and remanded, finding that since the syndicate was an unincorporated association, it was required to allege the citizenship of every Name who was potentially liable on the policy.

Summary of Decision

A Lloyd's syndicate insured the owner of an all-terrain vehicle that collided with a dirt bike, injuring a minor child. When the injured child's mother submitted a claim, the syndicate offered to pay its policy limits in exchange for a full release, but the tender was declined due to a dispute as to the sufficiency of the syndicate's proposed compliance with the requirements of Florida Statutes § 627.4137, which requires the disclosure of certain information regarding other insurers and the provision of a complete copy of insurance policies. The claimant returned the settlement checks and filed a negligence action in Florida state court against the insured.

The syndicate filed a declaratory judgment action in federal court, alleging diversity jurisdiction, seeking a declaration that the parties had reached a valid settlement of the insurance claim. The complaint was amended twice to address issues of citizenship for purposes of diversity jurisdiction. The syndicate alleged only the citizenship of its lead underwriter.

The opinion contains a fairly extensive description of the history of the Lloyd's market, the organization of the underwriting syndicates and the role of the individual underwriters, who are known as "Names," in each syndicate. For purposes of diversity jurisdiction, the most important facts are that the underwriting syndicates are unincorporated associations, not corporations, and that the individual members of each syndicate are severally, but not jointly, liable on each contract of insurance agreed to by a syndicate, in accordance with their individual subscriptions to each policy.

The district court denied the defendant's motion to dismiss for lack of subject matter jurisdiction and granted summary judgment to the plaintiff syndicate, holding that the parties had reached a valid settlement of the insurance claim. The district court found it sufficient that the Complaint alleged that the underwriters were citizens of the United Kingdom, and that the lead underwriter was a UK-domiciled corporation. It rejected the argument that the syndicate had to plead the citizenship of each Name, i.e., each individual who had subscribed to the insurance policy at issue. The district court relied upon a Sixth Circuit opinion for the proposition that the lead underwriter was an agent for undisclosed principals, was the real party in interest, and therefore could establish diversity jurisdiction on the basis of its citizenship alone.

The Eleventh Circuit did not reach the merits issue, because it found the jurisdictional issue to be dispositive. It found that there was "a wealth" of relevant Supreme Court precedent. Starting with the basic proposition that there had to be complete diversity among the parties, the court recognized that only corporations have a special legal status for purposes of 28 U.S.C. §1332. All other entities, including partnerships and unincorporated associations, have to allege the citizenship of every member to invoke diversity jurisdiction. The court rejected the invitation to find that the syndicate had sufficient "entity characteristics" such that it should be treated

as a corporation for purposes of diversity jurisdiction. The court instead preferred to draw a bright line at corporate status.

The court therefore concluded that whatever the syndicate's "peculiar characteristics," Supreme Court precedent requires that they plead the citizenship of each of their member Names to establish diversity jurisdiction. It noted that its conclusion was in accord with the conclusions of the Second and Seventh Circuits on the issue. The court rejected the Sixth Circuit's approach, finding that the real party in interest theory had been rejected by the Supreme Court, and could not be used to circumvent the requirement for complete diversity of citizenship. The court vacated and remanded, directing the district court to permit the plaintiff to amend to attempt to allege the citizenship of all of the Names of the syndicate. // Goss

Property Insurance

Policyholder's Failure to Proffer Evidence That Covered Peril, Wind, Caused Uncompensated or Undercompensated Loss in Opposing Insurer's Motion for Summary Judgment Results in Summary Judgment for Insurer

Insurer Made Prima Facie Case that Excluded Peril, Flooding, Was Cause of Loss

Bayle v. Allstate Insurance Company, ___F.3d ___, 2010 WL 3155921 (5th Cir. (La.) Aug. 11, 2010)

Case at a Glance

Under Louisiana law, the burden of proving a loss is covered rests with the insured and the burden of proving a loss is excluded rests with the insurer. An insurer moving for summary judgment based on its policy's flood exclusion has the burden of producing evidence sufficient to make a prima facie case that the loss was caused by flooding. The burden of production then shifts to the insured to present evidence showing a material issue of fact regarding whether the loss was caused by a covered or an

excluded peril. Thus, when an insurer in a Hurricane Katrina coverage dispute moved for summary judgment on the ground that an excluded peril, flooding, caused all remaining uncompensated or undercompensated damage, and supported its motion with evidence of specifically itemized and quantified damage caused by wind, and demonstrated that the amounts paid under the policy for wind damage exceeded such specified wind damage, the burden shifted to the insureds to produce evidence sufficient to raise a material issue of fact about the amount of wind damage their property sustained in the hurricane. Their failure to do so entitled the insurer to summary judgment.

Summary of Decision

A recurring question in Hurricane-related property insurance disputes is whether wind, a covered peril, or flooding, an excluded peril, caused the insured's loss. The conditions following a Hurricane can make identifying and segregating discrete items of water-damage and wind-damaged property difficult, and sometimes impossible. In partial loss situations, adjusters and consulting engineers can examine what remains of the structure to estimate how much of the damage was caused by wind and how much by flood water. When only a slab remains, direct evidence needed to allocate between covered and excluded damage often no longer exists. In either circumstance, the allocation of the burden of proof between the insured and the insurer can dramatically effect the amount of coverage available

Bayle v. Allstate Insurance Company illustrates how the parties' respective burdens of proof at trial can affect the burden of demonstrating the absence or existence of a material issue of triable fact at the summary judgment stage. The Bayles' one-story home suffered extensive damage in Hurricane Katrina. The damage was so severe that the Bayles elected not to repair their property. Much of the damage occurred when eight to ten feet of water (mixed with oil from a nearby storage tank) flooded the property. Aside from a couple of broken windows and missing roof shingles, there was no evidence that Hurricane Katrina's 115-120 mile/hour Category 3 winds caused significant damage to the Bayles' home.

At the time of the hurricane, the Bayles had homeowners insurance through Allstate Insurance

Company and flood insurance through the National Flood Insurance Program under a policy administered by Allstate. The homeowners policy excluded coverage for flood damage and provided that if the insureds do not repair their damaged property, payment under the policy for covered wind damage “will be on an actual cash value basis.” Allstate authorized payment of the full policy limits of \$75,000 for structural damage and \$30,000 for contents under the flood insurance policy, which was funded by the federal government. Allstate and the Bayles, however, disputed the amount of wind damage covered under the homeowners policy. Allstate paid the Bayles \$3,628.87 for damage to the roof, \$8,804.22 for personal property, and \$5,127.64 in additional living expenses, for a total of \$17,560.73 in wind damage.

The Bayles sued Allstate to recover the balance of their claimed wind damage. Allstate moved for summary judgment, supporting their motion with the Bayles’ own deposition testimony and expert reports and testimony which specifically itemized and quantified the damage caused by wind as opposed to flood. In opposing the motion, the Bayles offered a line-item listing of the materials and labor needed to restore the entire property, irrespective of whether the cause of the damage was wind or flood, or a combination of both. The Bayles did not attempt to identify which particular wind-damaged items had gone uncompensated or undercompensated under their homeowners policy. The district court granted summary judgment for Allstate, and the Fifth Circuit, applying Louisiana law, affirmed.

On appeal, the Bayles argued that Allstate was not entitled to summary judgment because it failed to meet its evidentiary burden under Louisiana law of allocating the loss between covered wind damage and excluded water damage. The Bayles based their argument on the Fifth Circuit’s recent decision in *Dickerson v. Lexington Insurance Company*, 556 F.3d 290 (5th Cir. 2009), another Hurricane Katrina case decided under Louisiana law in which the court was asked to address how much of the insured’s damage resulted from wind and how much from flood. Unlike the present case, *Dickerson* went to the Fifth Circuit after a full trial. The Dickersons’ expert, a New Orleans general contractor, testified that wind and rain from Hurricane Katrina caused approximately 70 percent of the damage. Lexington did not submit a competing percentage. Instead, it offered the

testimony of its own adjuster who provided the court with estimates of rebuilding costs. Lexington also attempted to deconstruct Dickerson’s expert’s estimate by identifying individual components of the damage and assigning their cause to either flood or wind. For example, because flooding damaged the electrical wiring, Lexington maintained that the entire replacement cost of the wiring system throughout the house could be attributed to flooding. Dickerson’s expert conceded that some of the figures in his estimate could be attributed entirely to flood damage, but insisted that he had accounted for that in calculating the 70-30 ratio.

Based on this evidence, the district judge, sitting as a trier of fact, found that 70 percent of the damage to the Dickersons’ home was caused by wind. Lexington appealed, arguing that there was insufficient evidence for a fact-finder to conclude that wind, rather than flooding, caused 70 percent of the damage to the Dickersons’ home. The Fifth Circuit disagreed, reiterating its position that the insurer has the burden of apportioning damage between covered and excluded perils under an all risk policy:

[O]nce Dickerson proved his home was damaged by wind, the burden shifted to Lexington to prove that flooding caused the damage at issue, thereby excluding coverage under the homeowner's policy. As no one disputes that at least some of the damage to the Dickerson home was covered by the homeowner's policy, *Lexington had to prove how much of that damage was caused by flooding and was thus excluded from coverage under its policy.* (Emphasis added).

Given this burden of allocation, the court concluded that the Dickersons had sustained their evidentiary burden.

The Fifth Circuit in the present case distinguished *Dickerson* based on the procedural posture of the case:

Dickerson [does not] stand for the proposition advanced by the Bayles that the insurer alone must bear the burden of producing evidence to segregate covered losses from excluded losses, *at least not at the summary judgment stage*

(Emphasis in original.) The court explained that both the Bayles and Allstate confused the burden of persuasion at trial with the burden of production on summary judgment:

As the Louisiana Supreme Court made clear in *Jones v. Estate of Santiago*, 870 So.2d 1002, 1010 (La.2004)] and as our reasoning in *Dickerson* reflects, the insured must carry the burden of persuasion to establish that any uncompensated (or under-compensated) damage was caused by a covered peril. Simply put, this is what is meant by the rule that the insured must prove *coverage* under the policy. [Citations] Then, if the defendant-insurer wishes to avoid liability by relying on a policy exclusion from coverage, *it* has the burden of persuasion to establish that the uncompensated or under-compensated damage is subject to an exclusion. Contrary to Allstate's second contention, we have found nothing in Louisiana law to suggest that these respective burdens of *persuasion* shift between the parties. What *does* shift—but only during the summary judgment stage—is the burden of *production*. Because *at trial* the defendant-insurer has the ultimate burden of persuasion that the exclusion is applicable, a defendant-insurer that moves *for summary judgment* must bear the burden of producing evidence to make out a “prima facie” case that the cause of the uncompensated or under-compensated damage was excluded from coverage. If the defendant-insurer does so, “the burden shift[s] to the [insured] to present evidence demonstrating there remain[s] a material issue of fact.” [Citations]

As *Jones* makes clear, this simple, burden-shifting minuet arises from the effect of summary judgment on the burdens of production and not any shift between the parties' respective burdens of persuasion. [Citations] Because *Dickerson* addressed the sufficiency of the evidence adduced *at trial*, it was not concerned with the shifting of the burdens of production that characterizes summary judgment.

In this light, the circuit court had little difficulty concluding that the Bayles had failed to carry their burden of *production* on summary judgment. Allstate had met its burden of making a prima facie case that it had already fully compensated the Bayles for wind damage by specifically itemizing and quantifying the damage caused by wind as opposed to flood. The burden then shifted to Bayles to offer rebuttal evidence sufficient to create a genuine issue of material fact as to which, if any, uncompensated items of damage were caused by wind, which they did not do. They simply presented the court with a line-item cost estimate to repair *all* the damage to their property, without even attempting to explain which portion or portions of those costs were attributable to wind-caused damage.

Comment

It is important to note that the Bayles' home remained standing and that most of the structural damage was clearly flood-related. When only a slab remains, direct evidence needed to allocate between covered and excluded damage often no longer exists and insurers face a much more difficult task of segregating wind from flood damage. In such circumstances, insureds are more likely to be able to raise triable issues of material fact.

Although the *Dickerson* and *Bayle* cases were decided under Louisiana law, Mississippi law appears to take the same approach to allocating burdens of proof in insurance coverage cases, at least according to the Fifth Circuit. Burden of proof issues were at the heart of the Fifth Circuit's recent decision in *Broussard v. State Farm Fire and Casualty Co.*, 523 F.3d 618 (5th Cir. 2008). Although the circuit court reversed a judgment in favor of the policyholder because the district judge had improperly resolved factual questions as a matter of law, the court's analysis of the parties' respective burdens would prove helpful to policyholders in later cases. The circuit court held that when a hurricane totally destroys an insured's property, leaving only the foundation slab, and evidence suggests that the loss resulted from both a covered peril—wind—and an excluded peril—water—the question of causation is for the jury to decide. In so ruling, the court discussed the respective burdens of proof of the Broussards and State Farm. The court first reiterated long standing

insurance law principles known to insurance lawyers and most adjusters. Under an open peril or all risk policy, the policyholder need only show that physical loss occurred and the dollar amount of the damage. Unless the insurer can prove the loss resulted from an excluded peril—such as flooding—the policyholder is entitled to coverage. Under a named peril policy, by contrast, the policyholder must prove that the physical loss was covered by a named peril. The burden then shifts to the insurer to prove the loss was excluded.

Suppose the Broussards carry their burden—proving an accidental physical loss in the case of their open peril dwelling coverage and wind caused personal property damage in the case of their named peril personal property coverage—and then State Farm introduces evidence that water also contributed to their loss. Who has the burden of allocating the loss between covered wind damage and excluded water damage? State Farm argued that once it establishes that some of the damage is excluded, the burden shifts back to the insured to segregate covered from non-covered damages. The Fifth Circuit, however, thought otherwise. The Mississippi Supreme Court previously had rejected attempts to shift the burden of allocation back to the insured in Hurricane Camille slab cases. See *Lititz Mut. Ins. Co. v. Boatner*, 254 So.2d 765, 766 (Miss.1971); *Grace v. Lititz Mutual Insurance Co.*, 257 So.2d 217, 219, 224-25 (Miss.1972). Although the Mississippi high court had not addressed the insurance industry’s “shifting back” theory under open peril policies, the circuit court saw no reason why the supreme court would adopt a different approach under open peril or all risk policies. In *Grace*, the supreme court had emphasized that causation is a fact question for the jury “independent of the explicit application of any rule of law.” *Grace*, 257 So.2d at 224, quoting *Commercial Union Ins. Co. v. Byrne*, 248 So.2d 777, 781 (Miss. 1971). The circuit court characterized State Farm’s “shifting back” theory as “the sort of ‘rule of law’ which would operate in many cases to take the issue of causation away from the jury.” 523 F.3d at 627 Thus, on remand, the ultimate allocation of the Broussards’ wind and water damage is a question of fact for the jury. // DiMugno

Sales Practices/Remedies

California Supreme Court Reverses Decision Trebling Restitution Award against Life Insurer under State Unfair Competition Law

Civil Code § 3345 Permits Treble Damages Only If Purpose of Remedy Is Punishment

Clark v. Superior Court (National Western Life Insurance Co.), __ Cal.4th __, 112 Cal.Rptr.3d 876, 235 P.3d 171 (Cal. Aug. 9, 2010)

Case at a Glance

California Civil Code § 3345, which permits treble damages “in actions brought by, on behalf of, or for the benefit of senior citizens or disabled persons . . . to redress unfair or deceptive acts or practices or unfair methods of competition” if the “trier of fact is authorized by a statute to impose either a fine, or a civil penalty or other penalty, or any other remedy the purpose of which is to punish or deter,” does not permit trebling of restitution awards under the California’s Unfair Competition Law (“UCL”), Business & Professions Code § 17200. Treble damages may be awarded under § 3345 only if the statute under which recovery is sought provides a remedy that is in the nature of a penalty. The only remedy available in a private action under the UCL is an award of restitution, which is not a penalty; thus, § 3345 does not apply to UCL actions.

Summary of Decision

Plaintiffs alleged that defendant National Western Life Insurance Company violated the UCL by using deceptive business practices to induce senior citizens to buy high-commission annuity contracts with large penalties for early surrender. Plaintiff’s sought an injunction and restitution under the UCL and treble damages under Civil Code § 3345. Subdivision (b) of section 3345 allows for a damages award to be trebled only if the “trier of fact is authorized by a statute to impose either a fine, or a civil penalty or other penalty, or any other remedy the purpose of which is to punish or deter.” In a private action under the UCL, remedies

are generally limited to injunctive relief and restitution, and punitive and increased or enhanced damages are not recoverable. Accordingly, the trial court ruled as a matter of law that § 3345's trebled recovery provision does not apply to private actions brought under the UCL.

The California Court of Appeal, Second District, granted Plaintiff's petition for writ of mandate and directed the trial court to enter an order denying National Western's motion for judgment on the pleadings. In so ruling, the court of appeal focused on language in § 3345(b) making the treble damage provision applicable to a remedy "the purpose or effect of which is to ... deter." The court determined that an award of restitution—the only monetary remedy available in a private action brought under the UCL—has a deterrent purpose and effect within the meaning of § 3345. The California Supreme Court granted review.

National Western raised two arguments before the supreme court. The court rejected the first but agreed with the second, and therefore reversed the court of appeal. The court rejected National Western's argument that § 3345's trebling provision applies only to actions brought under the Consumer Legal Remedies Act, California Civil Code, § 1750 et seq.) ("CLRA"). National Western had argued the use of identical phrases such as "unfair or deceptive acts" and "unfair methods of competition" which are found in both § 3345 and the CLRA, but not found in the UCL, evidenced a legislative intent to limit § 3345 to CLRA claims. The supreme court, however, found that both the plain language of Civil Code § 3345, and the circumstances surrounding its enactment, makes the treble damages provision applicable to actions

brought to redress unfair or deceptive acts or practices or unfair methods of competition, not just actions under the CLRA.

The supreme court agreed with National Western's second argument that the court of appeal erroneously concluded that any remedy with a deterrent effect, including restitution under the UCL, falls within subdivision (b) of § 3345. The court reasoned that the court of appeal improperly interpreted the phrase "the purpose or effect of which is to . . . deter" in isolation, rather than in context with the immediately preceding language which restricts trebled recovery to a statutorily authorized "fine, or a civil penalty or other penalty." Relying on the canon of statutory construction that generally provides "if a statute contains a list of specified items followed by more general words, the general words are limited to those items that are similar to those specifically listed," the supreme court reasoned that making § 3345 applicable to any remedy with a deterrent effect or purpose would render the immediately preceding statutory language referring to a "fine, or a civil penalty or other penalty" meaningless surplusage. Thus, the supreme court held that treble recovery may be awarded under § 3345 only if the statute under which recovery is sought permits a remedy that is in the nature of a penalty. In finding that the UCL's remedies are not punitive in nature, the court distinguished restitution (which is the return of money or property obtained through an improper means to the person from whom the property is taken and is not punitive in nature) from a penalty (which is recovery without reference to the actual damage sustained). // DiMugno

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