JAZZING IT UP IN KANSAS CITY

Turning Your Claims Handling Into Beautiful Music

KANSAS CITY 2025

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EAGLE INTERNATIONAL ASSOCIATES

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Eagle International Associates is an international network of independent law firms, adjusters and claims related service providers throughout the United States and Canada. Eagle members are dedicated to providing insurance companies and self-insureds with the highest quality legal and adjusting services for competitive and fair compensation. As members, we are committed to the highest ethical standards and act with professionalism and civility in all our endeavors. Eagle members exceed their clients' expectations for quality and service. At every opportunity, we promote the use of Eagle and its members and refer existing relationships through active participation in Eagle's meetings, programs and seminars.

DIVERSITY POLICY

Eagle International Associates, Inc. is of the strong belief that our organization is stronger, more valuable, and more effective through the inclusion of adjustors and attorneys of diverse gender, sexual orientation, racial, ethnic, cultural backgrounds, and all religious or non-religious affiliations. Eagle recognizes that the inclusion of such diversity is vital in order to achieve excellence and to serve its clientele effectively. Eagle is committed to a further understanding of its cultural filters and the absolute need to accept each person as a valued, talented, unique individual, which, when working with other Eagle members, will bring the organization and all its members genuine benefits and competitive advantage in the marketplace.

JAZZING IT UP IN KANSAS CITY
Turning Your Claims Handling into Beautiful Music
March 12, 2025

PROGRAM

3rd Floor
Library/President's Room

11:30 am **Registration and Lunch**

12:30 pm **Welcoming Remarks**

Stephen Fields, Esq., Brinker & Doyen LLP, Eagle Chair
Program Introduction
Sean Sturdivan, Esq., Sanders Warrant & Russell, LLP

12:40 pm **Best Practices for Claims Handling: Steering Clear of Bad Faith Hazards**

Moderators:

John Bordeau, Esq., Sanders Warren & Russell, LLP
Jennifer Howell, Esq., Brinker & Doyen, LLP

Panelists:

Cindy Khin, Casualty Resolution Director, Berkley Life Sciences
Shannon Smith, Eastern Litigation Consultant-Casualty Claims, The Hartford
Gavin Fritton, Complex Specialty Claims Analyst, AmTrust Financial Services

1:40 pm **Reworking the Score with Professionals Who Want to Sing the Blues During a Jazz Festival**

Moderators:

Paul Finamore, Esq., Pessin Katz Law Firm
Tara Perkinson, Esq., Secrest, Hill & Butler, PC

Panelists:

Mark Berry, JD, ARM, Kaestner & Berry Professional Insurance Services, LLC
Konrad Hendrickson, Consultant
Sharon Spiegel, Senior Counsel of EPL Claims, Bowhead Specialty

2:40 pm **BREAK**

3:00 pm **"Birdman," "Satchmo" and "Lady Day" walk into a bar… Jazzing up Premises liability defense strategies to prevent the courtroom blues.**

Moderators:

Jason J. Campbell, Esq., Gill, Ragon & Owen, PA
Daniel J. Ripper, Esq., Luther-Anderson, PLLP

Panelists:

Phyllis Conley, Senior Litigation Manager, Sedgwick Claims Management
John Leffler, PE, Senior Managing Engineer, YA Engineering Services
Kevin Prophet, Claims Supervisor, H&W Risk Management

4:00 pm **What Should be Your Best Play in the 'Super Bowl' of Catastrophic BI Claims?**

Moderators:

Megan Cook, Esq., Bullivant Houser Bailey PC
Elizabeth Evers Guerra, Esq., Sanders Warren & Russell, LLP

Panelists:

Andrew Ambrose, Senior Claims Adjuster, Brotherhood Mutual Insurance Company
Kelly Bradley, Claims Specialist, Major Case Unit, West Bend Insurance
Doug Powell, Senior Biomechanist, YA Engineering Services

5:00pm **Cocktail Reception**

6:00 pm **Shuttle Bus to American Jazz Museum**

6:15 pm **An Evening of Dinner, Live Jazz, Camaraderie, and Exhibit Exploration**

APPROVED CE / CLE CREDIT HOURS

General Adjuster - Florida (4.0) and Texas (4.0)
Producer/Agent – Missouri (4.0)
Legal – Illinois (4.0), Kansas (4.5), Missouri (4.8) and Wisconsin (4.5)

THE OPINIONS AND VIEWS OF THE PANELISTS ARE THOSE OF THE PANELISTS ONLY, AND NOT THOSE OF THE PANELISTS' EMPLOYERS

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Andy Ambrose is a Senior Claims Adjuster at Brotherhood Mutual Insurance Company, handling complex litigation claims, along with potential large loss exposures. Brotherhood Mutual's niche market of churches and related ministries across the country has given Andy significant exposure in a variety of jurisdictions regarding an even wider variety of claims. Andy takes great pride in being able to provide expert guidance and support to the organizations covered by Brotherhood Mutual. Andy's goal is to resolve the claims in his care efficiently and effectively to allow the ministries to continue their important work with confidence that he is there to protect and advise them.

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Mark Berry is a 1984 graduate of St. Louis University School of Law. He has over thirty-five years of experience in the insurance industry. From 1987 to 2006 he was in charge of Professional Liability Claims at The Bar Plan Mutual Insurance Company. He has obtained certifications from the Insurance Institute of America as an Associate in Risk Management (ARM), Associate in Management (AIM), and Associate in Claims (Ale}.

Mark has co-authored chapters on "Professional Liability Insurance" for the Missouri Bar CLE books on "Insurance Law" and on "Professional Liability". He has also authored two Missouri Bar articles on claim prevention. Additionally, he has drafted articles for the MO Bar on claim prevention.

Since 2007 Mark has been a Partner in Kaestner & Berry Professional Insurance Services. Kaestner & Berry is an independent insurance agency dedicated to insurance coverage for law firms in Missouri, Kansas, Southern Illinois, Tennessee and Texas.

Mark has been a speaker on Risk Management and Claim Prevention topics for The Missouri Bar, St. Louis County Lawyer's Association, Missouri Organization of Defense Lawyers, The Bar Association of Metropolitan St. Louis, The Bar Plan Mutual Insurance Company, University of Missouri-Kansas City and Saint Louis University School of Law.

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John E. Bordeau is a partner on the management committee at Sanders Warren & Russell and has been with the firm since its doors opened in 1999. John is licensed in state and federal courts in Kansas and Missouri. His law degree is from the University of Kansas. His undergraduate degree is from Sacred Heart University in Fairfield, Connecticut. John has 27 years of litigation and arbitration experience. His practice focuses on professional liability, construction litigation, products, and complex personal injury litigation. John is an active member of CLM and DRI. John has been named a Super Lawyer every year since 2013. He is a certified instructor with CLM's continuing education program and presents regularly on claims handling and legal topics.

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Kelly Bradley is a Claims Specialist with the Major Case Unit for West Bend Insurance. She manages large exposure and specialty coverage claims. Kelly has 25 years of experience as an insurance professional which includes personal lines, commercial, and excess surplus specialty carriers. Beginning with managing simple auto PD claims, liability disputes, total loss teams and subrogation teams she eventually transitioned into a large trucking with general liability specialist, construction defects, specializing in EPL and child daycare matters. Kelly participated in the Arbitration Forum as a panelist and as a trainer. As a specialist, Kelly consulted with the Arizona Department of Insurance to rewrite and design the adjuster licensing test. She strives for reasonable evaluations and resolution, with a strong passion for virtuous ethics. Kelly enjoys her family, grandchildren, traveling and giving back to her community.

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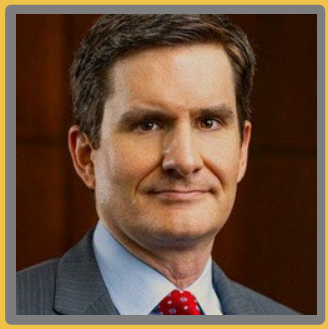

Jason Campbell is a shareholder and director at Gill Ragon & Owen P.A. in Little Rock, Arkansas. His practice over the past 23 years has been primarily concentrated towards representation of professionals, premises owners, trucking carriers and non-profit entities including POA's, schools, and religious organizations. Jason also serves as regional and local counsel to various lending institutions, government entities, and property developers in commercial litigation matters.

Jason has been recognized by Best Lawyers in America since 2011 and Mid-South Super Lawyers. He holds a Certified Claims and Litigation Management Professional (CLMP) certification. He is a graduate of the Litigation Management Institute held at Columbia University; the IADC trial academy; and the ABA Construction Forum Trial Academy. Jason has completed 40 hours of mediation training through the Arkansas Alternative Dispute Resolution Commission. He has taken over 50 cases to jury verdict and arbitration decision. He has successfully resolved over 350 cases through mediation. He is licensed to practice in all state and federal courts in Arkansas, the 8th Circuit Court of Appeals and the U.S. Supreme Court. He holds an "AV-Preeminent" rating from Martindale Hubbell.

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Phyllis Conley is a Senior Litigation Manager for Sedgwick Claims Management Services of Houston, Texas who entered the Insurance Industry via the North Carolina Baking Commission as an examiner in 1992 and relocated to Texas and accepted a position handling Fatality Losses for American Eagle Airlines handling claims and property damages related to large losses. Prior employment with many of the major insurance carriers Allstate, Encompass Insurance, Horace Mann and AAA of Texas gaining a wealth of knowledge handling bodily injury, auto, personal property losses as well as minor injury soft tissue claims and fatality losses.

Phyllis is a former Member of the Dallas Claims Association and a Sedgwick Brand Ambassador. She has lived and traveled the length and breathe of the world sharing her knowledge and experience of claims, fraud investigation and litigation process for newly designated claim representatives and colleagues in the Insurance Industry.

Phyllis strives to build relationships with Insurers, Third Party carriers and vendors to reach amicable solutions to losses, growth and amicable settlements.

Phyllis has a love for reading and roller skating and is the mother of six adult children and the grandmother of seven, five boys and two girls. She has been a devoted wife to Milton Conley Sr. for over thirty-five years.

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Megan Cook's Oregon and Washington litigation practice focuses on defending personal and catastrophic injury claims in state and federal court. She has defended a wide variety of businesses and individuals in personal injury, construction defect, product liability and professional liability cases. In addition, she has experience in environmental, insurance, business, real estate, and land use law. She enjoys working with each client to develop a defense strategy that reflects their individual needs and goals and move a matter toward resolution as efficiently as possible.

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Beth Evers Guerra is a partner at Sanders Warren & Russell, LLP. She routinely handles matters involving personal injury and wrongful death, mass tort, and professional liability. She practices in Kansas and Missouri state and federal courts. Prior to joining the firm many years ago, Beth started her career in criminal prosecution. In that role, she successfully tried over 20 jury trials, and routinely secured guilty verdicts for a wide range of criminal offenses. Beth also has experience practicing before the Kansas Court of Appeals and Kansas Supreme Court, having successfully briefed and argued cases before both courts. Beth brings the same zeal and dedication to her civil practice as she did to her prosecution of violent crimes. Beth is a graduate of Truman State University, summa cum laude, 2003 and earned her J.D. from the University of Kansas School of Law, 2006.

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Steve Fields is a partner in the law firm of Brinker & Doyen, L.L.P. He is a graduate of the University of Illinois at Champaign-Urbana and The John Marshall Law School. He is licensed to practice law in Missouri and Illinois. He practices in the areas of personal injury defense, professional liability, restaurant liability, medical malpractice, products liability, securities liability and insurance fraud. He has tried cases in Missouri and Illinois. He has completed several arbitrations in various matters. He has provided numerous presentations to clients and industry professionals on a variety of topics. He is a member of the Missouri Bar Association, the Illinois State Bar Association, the Bar Association of Metropolitan St. Louis, Defense Research Institute, Claims Litigation Management (board member), The Risk and Insurance Management Society, Inc., and the Missouri Organization of Defense Lawyers (board member). Steve is the current Chair of Eagle International Associates. When he is not working, Steve enjoys spending time with his wife and two boys riding bikes, hiking, and golfing.

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Paul Finamore is a member of the Maryland firm, Pessin Katz Law, P.A. He is an experienced trial lawyer who has practiced in state and federal courts throughout Maryland and the District of Columbia for over 30 years. His experience includes litigation of general and professional liability matters, including first and third party claims, as well as employment law.

Mr. Finamore has been recognized in Best Lawyers in America in the areas of Insurance Law as well as in Litigation – Insurance. He has an AV- preeminent peer rating in Litigation, Insurance, and Labor and Employment. He has also been recognized as a top attorney by Maryland SuperLawyers magazine annually from 2008 through the present. He is a three-time recipient of the Golden Gavel Award from the Westfield Group of Insurance Companies. He is also a member of the Federation of Defense and Corporate Counsel.

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Gavin Fritton is an experienced claims professional, having handled claims in multiple lines for six different carriers as well as serving as a Claims Consultant for one major brokerage. Prior to entering the insurance industry, Gavin practiced law representing both plaintiffs and defendants. In Gavin's 30-year career as an insurance claims professional, he has handled claims in numerous professional lines including medical malpractice, legal malpractice, real estate agents, accountants, insurance agents, and architects and engineers errors and omissions. He has also handled EPL and municipal liability claims. In his current position, Gavin handles financial institution bond and liability claims, including claims against directors & officers, employment practices liability, management liability, professional liability, lender liability and various other miscellaneous claims. He obtained his Bachelor of Arts and his Juris Doctor degrees from the University of Kansas. On weekends, you are likely to find him screaming at a television broadcasting whatever game his favored teams are playing.

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Konrad Hendrickson is a seasoned legal and insurance expert specializing in coverage analysis, professional liability claims, and risk management. With over 20 years of experience advising insurers on negotiation strategy, complex coverage matters, time-limit demands, and reservation of rights, he has provided counsel on countless opinions, coverage letters, high severity claims and complex litigation. His expertise extends to managing high-exposure professional liability claims, including Errors and Omissions (E&O), Lawyers Professional Liability (LPL), Insurance Company Professional Liability (ICPL) and Accounting Liability, at both primary and excess levels.

Konrad previously served as Chair of the APCIA Liability Claims Committee and Co-Chair of the APCIA Claims committee. He also served as Vice President of Claims, Head of Commercial Claims, and Associate General Counsel at American National where he played key roles in catastrophe management, litigation management, regulatory compliance, and corporate risk mitigation. He now serves in a freelance capacity as Litigation and Claims Counsel at Innocuous AI, a pre-seed startup, voted as #7 Generative AI company (1.7M companies reviewed) by F6S. There he collaborates on AI-driven compliance solutions for the insurance industry. Additionally, he serves as an active advisor in the insurtech ecosystem, including mentoring startups through the Global Insurance Accelerator (GIA).

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Cynthia Khin is the Life Sciences Casualty Resolution Director for Berkley Life Sciences. She is also a claims and litigation management expert with substantial experience managing and directing high exposure litigation, coverage litigation, pharmaceutical and medical device product liability litigation, litigation management for mass torts and class actions and professional liability (e.g. LPL & E&O) litigation. Ms. Khin is responsible for pharmaceutical and medical device claim investigation and settlement oversight, defense counsel selection, litigation management, trial preparation/supervision, claim reserve audits and assessments.

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Tara Perkinson joined Secrest, Hill and Butler in 2005, and has served as a partner since 2010. Prior to joining the firm, she served as a felony prosecutor for the Tulsa County District Attorney's Office. As an Assistant District Attorney, she tried numerous felony cases and prosecuted hundreds of offenders. Her current work focuses on the area of Medical Malpractice Defense, representing hospitals, physicians, nurses, skilled facilities, long term acute care facilities, and staffing companies. She was named a Super Lawyers Rising Star in 2011, 2012, 2013, 2014, and 2015. Tara is a member of the Oklahoma Bar Association and is admitted to practice before the United States District Courts for the Northern, Eastern and Western Districts of Oklahoma. Tara is a native of Dallas, Texas and attended the University of Arkansas at Fayetteville. She graduated in 1998 with a Bachelor's Degree in Broadcast Journalism and earned her Juris Doctorate from the University of Arkansas College of Law in 2001.

In her free time, Tara is an avid equestrian and passionate foster parent for rescue dogs in addition to her own pack of four.

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Doug Powell joined the YA Engineering team in 2024. He earned a Bachelor of Science degree in Exercise Physiology and a Master of Arts degree in Biomechanics from East Carolina University. He then earned a PhD in Biomechanics and Sports Medicine from the University of Tennessee (Knoxville) and a Master of Science in Biomedical Engineering from the University of Memphis. Dr. Powell also had a Research Fellowship at Creighton University in the Department of Physical Therapy with a focus in neurophysiology and biomechanics.

Dr. Powell has extensive experience in the area of injury biomechanics, treatment and rehabilitation. His experience includes sport-related injury, motor vehicle collisions, slip/trip and fall events, traumatic brain injury, spine injury and fixation, and injuries to infants (such as shaken baby syndrome). Dr. Powell has provided written and oral testimony in both civil and criminal cases.

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Kevin Prophet has spent the last 26-years of his 38-year insurance claims career resolving general liability and commercial auto claims in the niche leisure and entertainment industries throughout the country and internationally. He is currently the Claims Supervisor for H&W Risk Management, a Division of Haas & Wilkerson Insurance, nationally recognized as the claims, litigation, and risk management authority and service provider to the amusement industry, extending to fairs, festivals, family entertainment centers, rodeo events, trampoline parks, and water attractions, and more. Previous experience includes professional and amateur sports, major event arenas and stadiums. He is well versed in coverage, waivers, risk transfer, and litigation, and has overseen claims setting favorable State Supreme Court case law. He holds his BSB and MBA from Emporia State University, earned the Associate in Claims designation, and has received certification from the National Association of Amusement Ride Safety Officials.

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Shannon Smith is a Litigation Claims Consultant for The Hartford handling litigated and non-litigated liability claims on the East Coast. Prior to commencing her insurance career, Shannon worked as a litigation legal assistant for law firms handling a variety of cases including medical malpractice defense, employment law, real estate, oil and gas taxation, and eminent domain. Shannon began her insurance career in 2001 handling claims for a medical professional liability carrier. In 2012 Shannon joined Meadowbrook Insurance Group/AmeriTrust Group as an adjuster handling litigated and non-litigated claims for their Educators Professional Liability Program. Shannon expanded her role with the company and started handling litigated commercial general liability claims. In 2022 Shannon joined a large international third-party administrator as a team lead overseeing a team of 6 remote adjusters handling auto and general liability claims for 13 clients across the United States. Shannon completed her Associates degree and the Legal Assistant Program at Hutchinson Community College. She completed her Bachelor in Business Administration/Business Management degree at Friends University, Wichita, Kansas. She has completed her Associate In Claim Management and AINS certifications through The Institutes and is currently working on completing her CPCU designation.

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Sharon Spiegel is the Senior Counsel for EPL Claims at Bowhead Specialty, where she oversees all private company management liability matters, including EPL, Crime, and private company D&O claims. Prior to joining Bowhead, Sharon was a Manager of Unit & Management Liability Professional at RiverStone Group, where she led a team of analysts managing claims for multiple carriers acting as third-party administrators (TPAs). While at Riverstone, Sharon also handled public company D&O matters, as well as private company management liability matters.

Sharon earned her J.D. from Hofstra University School of Law and spent five years in private practice before transitioning to the insurance industry. She began her insurance career as a Financial Lines Claims Analyst at AIG. With nearly a decade of experience in the insurance field, Sharon has built strong professional relationships with analysts, defense counsel, coverage counsel, and brokers. She holds a Bachelor of Arts in Political Science from the University at Buffalo.

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Sean M. Sturdivan is a partner at Sanders Warren & Russell LLP, an insurance defense firm with offices in Kansas City, Missouri; Overland Park, Kansas; and Springfield, Missouri. Sean is licensed in the state and federal courts for Kansas, Missouri, Iowa, and California. He received his B.S. in International Business from Baker University, a small liberal arts college in Kansas, and his J.D. from the University of Oregon. Since graduating from law school, Sean has represented businesses and individuals in a wide variety of civil claims. His current practice focuses mainly on the defense of insureds in employment, professional liability, product liability, and personal injury claims. Sean is a member of CLM, Defense Research Institute, Missouri Organization of Defense Lawyers, and the state bar associations for Kansas and Missouri. Sean has been rated AV Preeminent by the Martindale Hubbell Law Directory and named as a Kansas Super Lawyers Rising Star (2011-2017), Super Lawyer (2020), and selected as one of the Best Lawyers in America (2024). Outside his practice, Sean enjoys spending time with his wife and 5 kids.

BEST PRACTICES FOR CLAIMS HANDLING:

Steering Clear of Bad Faith Hazards

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Best Practices for Claims Handling:
Steering Clear of Bad Faith Hazards[1]

I. INTRODUCTION

Ohio State University's former football coach Woody Hayes was famous for his quotes; including: "we hate to lose, but when we do, rest assured we'll be back, and someone will pay the price." In the world of handling claims, insurers do not want to be the ones to "pay the price" when there is a loss.

Like all football teams having a playbook, almost all states have statutory or regulatory provisions governing fair claims handling. These laws are mostly a product of the model legislation drafted by the National Association of Insurance Commissioners ("NAIC"). "The purpose of this [Model Act] is to set forth standards for the investigation and disposition of claims arising under policies or certificates of insurances." UNFAIR CLAIMS SETTLEMENT PRACTICES ACT § 1 (1997). The Model Act was not drafted to be construed to create a private cause of action; instead, the Model Act includes proposed language providing for state insurance commissioners to investigate conduct of insurance carriers and issue sanctions if warranted. While most states have adopted the Model Act, there is a split between the states as to whether a particular state's laws permit a private cause of action as opposed to simply implementing administrative penalties. Insurer liability also exits under common law; to which, insured can pursue claims for breach of the insurance contract, breach of good faith duty, breach of fiduciary duty, or negligence arising out of improper claims handling.

This paper will focus primarily on statutory and extra-contractual liability; specifically, addressing extra-contractual liability for failing to defend an insured when there is no bad faith. It will also address when independent counsel is required and provide some best practices.

[1] This paper consists of written materials previously prepared for an Eagle Seminar held in Philadelphia, PA and drafted by Shea Backus, Esq. of the law firm Backus, Carranza & Burden and Lindsay J. Woodrow Esq. of the law firm Waldeck Law Firm, P.A., both individuals have given permission to update this paper.

II. PAYING THE PRICE – FAILING TO ADHERE TO STATUTORY OR REGULATORY PROVISIONS GOVERNING FAIR CLAIMS HANDLING

The Model Act provides the following unfair claims practices when such is committed "flagrantly and in conscious disregard of [the Act] or any rules promulgated hereunder" or "with such frequency to indicate a general business practice to engage in that type of conduct":

A. Knowingly misrepresenting to claimants and insureds relevant facts or policy provisions relating to coverage at issue;
B. Failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under its policies;
C. Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies;
D. Not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear;
E. Compelling insureds or beneficiaries to institute suits to recover amounts due under its policies by offering substantially less than the amounts ultimately recovered in suits brought by them;
F. Refusing to pay claims without conducting a reasonable investigation;
G. Failing to affirm or deny coverage of claims within a reasonable time after having completed its investigation related to such claim or claims;
H. Attempting to settle or settling claims for less than the amount that is reasonable person would believe the insured or beneficiary was entitled by reference to written or printed advertising material accompanying or made part of an application;
I. Attempting to settle or settling claims on the basis of an application that was materially altered without notice to, or knowledge or consent of, the insured;
J. Making claims payments to an insured or beneficiary without indicating the coverage under which each payment is being made;
K. Unreasonably delaying the investigation or payment of claims by requiring both a formal proof of loss form and subsequent verification that would result in duplication of information and verification appearing in the formal proof of loss form;
L. Failing in the case of claims denials or offers of compromise settlement to promptly provide a reasonable and accurate explanation of the basis for such actions;
M. Failing to provide forms necessary to present claims within fifteen (15) calendar days of a request with reasonable explanations regarding their use;
N. Failing to adopt and implement reasonable standards to assure that the repairs of a repairer owned by or required to be used by the insurer are performed in a workmanlike manner.

UNFAIR CLAIMS SETTLEMENT PRACTICES ACT at §§ 3-4. While the Model Act explicitly provides that it is not intended to create a private cause of action, it provides

administrative procedures for the insurance commissioner to determine whether the insurance carrier has engaged in unfair claims practices and sets penalties varying from $1,000 for each violation to revocation of the insurer's license. *Id*. at § 5-7.

Although most states have adopted the Unfair Claims Settlement Practices Act, many states have varying statutory and regulatory laws to govern fair claims practices. *See* EAGLE INT'L ASSOC., INC., FAIR CLAIMS HANDLING STATUTES A 50 STATE SURVEY (Sept. 2015). The following states and territories have adopted the most recent version of the NAIC Model Act in a substantially similar manner: Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Northern Marianas, Ohio, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming. While District of Columbia, Iowa, Nevada and Oklahoma have not adopted the Model Code, these states and territories have enacted statutory and regulatory provisions to govern unfair practices. *See* D.C. ST. § 31-2231.17; IOWA CODE § 507B.4(9) (Am. 2018); N.R.S. 686A.310 (Am. 1991); NAC 686A.600-690; 36 O.S. §§ 1250.1 et. seq.; OKLA. ADMIN. CODE 365:15-3-5, -7. While Alabama has not adopted any statutory law, it has regulatory law providing for fair claims practices. *See* ALA. ADMIN. CODE. r. 482-1-124-482-1-125 (2003/2014); 482-12-24 (1971). The only state that does not have any statutory or regulatory provisions governing fair claims handling is Mississippi. Mississippi has, however, codified certain guidelines for insurers. *See* MISS. CODE ANN. § 83-9-5.

A. AVOID THE LOSS: KNOW HOW TO HANDLE FIRST PARTY CLAIMS

A first party insurance claim is one where the policyholder makes a claim to its insurance company for damages that are covered by the insurance company's policy. An example of such first party claim would be where a homeowner suffers from a fire at his residence and submits a claim for the fire damage to its carrier under his homeowner's insurance policy. In responding to such first party claim, the carrier should be cognizant of the governing state's laws and regulations in handling the claim and investigation and any pertinent timeframes that must be complied with.

The clock starts ticking when the carrier gets notice of the claim. It is key for the adjuster handling the claim to be aware of any deadlines set by the governing state laws. The following provides a chart summarizing each state's timeframes for initial response to the claim and issuance of any disclaimer of coverage or reservation of rights:

State (Statute/ Regulation)	**Contacting Insured Upon Initial Receipt of Claim**	**Issuing Disclaimer of Coverage from Proof of Loss**	**Issuing Reservation of Rights from Proof of Loss**
Alabama (ALA. ADMIN. CODE r. 482-1-125)	15 days, unless payment is made prior	30 days or number of days set forth in policy	30 days or number of days set forth in policy
Alaska (ALASKA STAT. § 21.36.125; ALASKA ADMIN. CODE tit. 3 § 26.040, § 26.070)	10 working days	15 working days	15 working days
Arizona (ARIZ. REV. STAT. § 20-461, ARIZ. ADMIN. CODE R20-6-801)	10 working days	15 working days	15 working days
Arkansas (ARK. CODE ANN. § 23-66-201; 054-00-043 Ark. Reg. § 1)	15 working days	15 working days	15 working days
California (CAL. INS. CODE § 790.03(h); CAL. CODE REGS. tit. 10, § 2695)	15 calendar days unless suit has already been filed	40 calendar days; 80 days if fraud suspected; N/A for certain policies	40 calendar days
Colorado (C.R.S. §§ 10-3-1101 to 10-3-1116)	Reasonably promptly	60 days	60 days
Connecticut (CONN. GEN. STAT. ANN. §§ 38a-815 to 38a-832)	Reasonable time	Reasonable time	Reasonable time
Delaware (DEL. CODE ANN. Tit. 18, § 2304, 18-900-902 DEL. CODE REGS. 1.2.1.2-1.2.1.5)	15 days; Must investigate claim within 10 days of notice of loss	30 days	30 days

State (Statute/ Regulation)	**Contacting Insured Upon Initial Receipt of Claim**	**Issuing Disclaimer of Coverage from Proof of Loss**	**Issuing Reservation of Rights from Proof of Loss**
District of Columbia (D.C. ST § 31-2231.17)	Reasonably Promptly	Reasonable Time	
Florida (F.S. 624.155, 627.426 & 626.9541; FLA. ADMIN. CODE ANN. r. 690-166.024)	14 calendar days; Must investigate claim within 10 working days of proof of loss	60 days of giving reservation of rights or of receipt of summons & complaint	30 days from knowing or should have known of coverage defense
Georgia (GA. CODE ANN. 33-6-34, GA. COMP. R. & REGS. r. 120-2-52-.03)	15 days	15 days; 30 days after receiving notice if proof of loss form not required	Timely notice
Hawaii (HAW. REV. STAT. § 431:13-103(11))	15 days	Reasonable time after investigation completed	Reasonable time after investigation completed
Idaho (IDAHO CODE § 41-1329)	Promptly	None	None
Illinois (215 ILL. COMP. STAT. ANN. 5/154.6; ILL. ADMIN. CODE tit. 50, § 919.50)	Reasonable promptness	Reasonable time to determine coverage and notify insured within 30 days of determination	Reasonable time to determine coverage and notify insured within 30 days of determination
Indiana (IND. CODE § 27-4-1-4.5)	Reasonable promptness	Promptly	Promptly
Iowa (IOWA CODE § 507B.4; IOWA ADMIN. CODE 191 – Ch. 15)	15 days	30 days	30 days
Kansas (KAN. STAT. ANN. § 40-2404)	Reasonably promptly	Promptly	Promptly
Kentucky (K.R.S. 304-12-230; 806 KY. ADMIN. REGS. 12:095)	15 working days	Reasonable time; If more time is needed to investigate, must notify within 30 calendar days	30 calendar days; update every 45 calendar days thereafter until investigation is complete

State (Statute/ Regulation)	**Contacting Insured Upon Initial Receipt of Claim**	**Issuing Disclaimer of Coverage from Proof of Loss**	**Issuing Reservation of Rights from Proof of Loss**
Louisiana (LA. REV. STAT. ANN. § 22:1892)	Initiate loss adjustment within 14 days after notification; 30 days for catastrophic losses	30 days (*lawsuit can be considered a proof of loss*)	30 days
Maine (ME. REV. STAT. 24-A, §2164-D)	Reasonably promptly	Reasonable time after investigation completed	Reasonable time after investigation completed
Maryland (MD. CODE ANN. §27-303, § 27-1001; MD. CODE REGS. 31.15.07.03, .04)	15 working days	15 working days or policy	15 working days or policy
Massachusetts (MASS. GEN. LAWS ch. 176D)	Reasonably promptly	Reasonable time; Promptly	Reasonably promptly
Michigan (Michigan's Uniform Trade Practices Act, MCL 500.2001, et. seq.)	30 days to provide materials that constitute a satisfactory proof of loss	None.	Reasonable time. ***Caution*** of waiving disclaimer of coverage when defending without ROR within reasonable time.
Minnesota (MINN. STAT. § 72A.201)	10 business days	60 days; 30 days after investigation is completed	60 days; 30 days after investigation is completed
Mississippi (None)			
Missouri (MO. ANN. STAT. § 375.1000; MO. CODE REGS. ANN. tit. 20, §100-1.030, 1.050)	10 working days	15 working days following all necessary forms	15 working days following all necessary forms
Montana (MONT. CODE ANN. § 33-18-101, et. seq.)	Reasonably promptly	30 days unless request add'l info, then 60 days to pay or deny	None

State (Statute/ Regulation)	**Contacting Insured Upon Initial Receipt of Claim**	**Issuing Disclaimer of Coverage from Proof of Loss**	**Issuing Reservation of Rights from Proof of Loss**
Nebraska (NEB. REV. STAT. ANN. § 44-1540; NEB. ADMIN. CODE tit. 210, ch. 60 §6-006 to -008)	15 days	15 days	15 days
Nevada (N.R.S. 686A.310; NAC 686A.600-690)	20 working days	30 working days	30 working days
New Hampshire (N.H. REV. STAT. ANN. 417:4 XV; N.H. ADMIN. RULES, Ins. §1001.01)	10 working days	10 working days; 30 days for health insurance claims	10 working days
New Jersey (NJSA 17:29B-4; NJSA 17B:30-13.1; NJ ADMIN CODE 11:2-17)	10 working days	Reasonable period of time	Reasonable period of time
New Mexico (N.M. STAT. ANN. §59A-16-20)	Reasonably promptly	Reasonable time	Reasonable time
New York (N.Y. INS. § 3420; N.Y. COMP. CODES R. & REGS. tit. 11,§ 216)	15 business days	15 business days	15 business days
North Carolina (N.C. GEN. STAT. ANN. § 58-63 et. seq.)	Reasonably promptly	Reasonable time	Reasonable time
North Dakota (ND CENT. CODE. § 26.1-04-03)	Reasonable time	Reasonable time	Reasonable time
Ohio (OHIO ADMIN. CODE § 3901-1-54, OHIO REV. CODE §§ 3901.19-3901.26)	15 days, but no time limit if suit is filed	21 days	21 days
Oklahoma (36 O.S. §§ 1250.1 et. seq.; OKLA. ADMIN. CODE 365:15-3-5, -7)	30 business days	45 days; 60 days for investigation for property & casualty to be completed	45 days
Oregon (OR. REV. STAT. § 746.230; OR. ADMIN. R. § 836-080-0225 to 235)	30 days	30 days	30 days

State (Statute/ Regulation)	Contacting Insured Upon Initial Receipt of Claim	Issuing Disclaimer of Coverage from Proof of Loss	Issuing Reservation of Rights from Proof of Loss
Pennsylvania (40 PA. STAT. ANN. § 1171.5; 31 PA. CODE §§ 146.1-146.9)	10 working days	15 working days	15 working days
Rhode Island (R.I. GEN. LAWS §§ 27-9.1-1 et. seq.; 230-RICR-20-40-1.4 (life, accident & health); 230-RICR-20-40-2.6 to 2.7 (property & casualty)	15 days (property/ casualty); 15 days (accident, health & life)	21 days (property / casualty); Reasonable Time (accident, health & life)	21 days (property / casualty) Reasonable Time (accident, health & life)
South Carolina (S.C. CODE ANN. § 38-59-20)	Reasonable promptness	Prompt investigation	Prompt investigation
South Dakota (S.D.C.L. § 58-33 et. seq.)	At least 30 days	30 days	Not specific, but 30 days could be interpreted from statute
Tennessee (TENN. CODE ANN § 56-8-105)	Reasonably promptly	Reasonable time	Reasonable time
Texas (TEX. INS. CODE Chs. 541, 542)	15 days; 30 days if insurer is an eligible surplus-lines insurer	15 days	Reasonable time
Utah (UTAH ADMIN. CODE R590-190-9 & 10; UCA 31A-26-303)	Promptly acknowledge – within 15 calendar days	Promptly – 30 calendar days	Promptly – 30 calendar days
Vermont (8 V.S.A. § 4724; 21-020-008 VT. CODE R. §§ 5-6)	10 working days	15 working days	15 working days[2]
Virginia (VA. CODE ANN. § 38.2-510; 14 VA. ADMIN. CODE § 5-400-50, -60, -70)	15 calendar days	15 calendar days	15 calendar days; Every 45 days thereafter until investigation is complete

[2] Insurer must obtain its insured's consent when reserving its rights. *American Fiduciary Co. v. Kerr*, 416 A.2d 163 (Vt. 1980) (providing that insurer controlling the defense of the case with knowledge of the facts and without consent of the insured constitutes an election to stand by the terms of the policy).

State (Statute/ Regulation)	Contacting Insured Upon Initial Receipt of Claim	Issuing Disclaimer of Coverage from Proof of Loss	Issuing Reservation of Rights from Proof of Loss
Washington (WASH. REV. CODE § 48.30.010 et. seq.; WASH. ADMIN. CODE § 284-30-360, -380)	10 working days; 15 days (group insurance)	15 working days from proof of loss	15 days
West Virginia (W. VA. CODE § 33-11-1, et. seq.; W. VA. CODE R. § 114- 14-5, -6)	15 working days	10 working days after completion of investigation; investigation to be commenced within 15 days of claim; reasonable time to complete investigation	10 working days after completion of investigation; investigation to be commenced within 15 days of claim; reasonable time to complete investigation
Wisconsin (WIS. ADMIN. CODE INS. § 6.11)	10 consecutive days	Reasonable time	Reasonable time
Wyoming (WYO. STAT. 26-13-124, 26-25-124)	Reasonably promptly	Reasonable time; 45 days (UIM, property, casualty, life, accident or health)	Reasonable time

While the above chart is intended to provide a quick resource,[3] it is strongly recommended that the policy and the governing state's statutes and regulations are reviewed for more information pertaining to these timeframes, as well as other pertinent timelines (e.g. providing response to written request, providing forms, tendering payment), and case law for any other mandates.

Various states provide differing timeframes to communicate with the insured when additional time is needed to investigate the claim. These timeframes vary from 15 days to 45 days, with specific timeframes for additional communications to be sent setting forth that there is an ongoing investigation and justification for the additional time needed to evaluate the claim. *See* EAGLE INT'L ASSOC., INC., FAIR CLAIMS HANDLING STATUTES A 50

[3] The cited statutes and regulations have been reviewed as of February 12, 2020.

STATE SURVEY (Sept. 2015).

Numerous states have statutory provisions setting forth timelines that are "reasonable" or "prompt" for the insurer to communicate to the insured. Some states provide regulations to define a period of time that is "reasonable" or "prompt." The Model Act provides the following unfair claims practice: "Failing to acknowledge with ***reasonable promptness*** pertinent communications with respect to claims arising under its policies" when done so "flagrantly and in conscious disregard of [the Act] or any rules promulgated [thereunder]" or "with such frequency to indicate a general business practice to engage in that type of conduct." (emphasis supplied). Since "reasonable promptness" was not defined in the Model Act, New Jersey promulgated regulations setting forth a specific timeframe for the insurer to respond. S*ee* N.J.S.A. 17B:30-13.1(b) (2013). Specifically, "[e]very insurer, upon receiving notification of claim shall, ***within 10 working days***, acknowledge receipt of such notice unless payment is made within such period of time." N.J.A.C. 11:2-17.6(b) (emphasis supplied). Several states have similar regulations that provide specific timeframes to comport with the terminology of the adopted Model Act's defined unfair claims practices: "reasonable time" or "reasonable promptness." *See e.g*. ALASKA STAT. § 21.36.125; ALASKA ADMIN. CODE tit. 3 § 26.040, § 26.070; ARIZ. REV. STAT. § 20-461; ARIZ. ADMIN. CODE R20-6-801; GA. CODE ANN. 33-6-34; GA. COMP. R. & REGS. r. 120-2-52-.03(2)-(3); UCA 31A-26-303; UAC r. 590-190-9 and -10.

Michigan's adoption of the Model Act does not provide for any regulatory framework for specified time periods for the insurance carriers to provide denial of coverage or to provide the insured with a letter setting forth its reservation of rights. The Michigan Supreme Court has held that an insurer who has knowledge of facts which may preclude coverage must give notice of potential defenses within a "reasonable time;" otherwise, the insurer may be estopped from later denying coverage. *Kirschner v. Process Design Assoc., Inc*., 592 N.W.2d 707 (Mich. 1999). In determining what constitutes "reasonable time", the Michigan courts have held that waiting two years to issue a reservation of rights letter is unreasonable, while a reservation of rights letter issued four months after the carrier has provided a defense to the insured is reasonable. *See Meirthew v. Last*, 135 N.W.2d 353 (Mich. 1965); *Fire Insurance Exchange v. Fox*., 423 N.W.2d 325 (Mich. App. 1988).

Flagrant or repetitive failure of the insurer to meet the statutory or regulatory deadlines or to properly handle claims could constitute in (1) administrative penalties and (2) private cause of action.

1. PENALTIES FOR FLAGRANT FIRST PARTY CLAIM HANDLING

Most states adopting the Model Act have adopted substantially similar procedures for the state administrative agency overseeing insurance carriers in enforcing the Act through administrative penalties. *See* UNFAIR CLAIMS SETTLEMENT PRACTICES ACT §§ 5-7. Like the Model Act, the adopted statutory or regulatory law provides for notice of a hearing, a hearing, and a ruling. *See e.g.* CAL. INS. CODE § 790.04-.06; S.D.C.L. §§ 5812-35, -36 (2014). In addition to the issuance of an order for the carrier to cease and desist from engaging in conduct that violates the unfair claims act, states have set forth varying penalties beyond those specified in the Model Act (e.g. revocation of license or imposition of fines). *See e.g.* CAL. INS. CODE § 790.035(a), §790.08; S.D.C.L. §§ 58-1236. Virginia, for example, has adopted the following penalties for violation of its Unfair and Deceptive Acts or Practices in Business of Insurance:

> A. Any person who knowingly or willfully violates any provision of this title or any regulation issued pursuant to this title shall be punished for each violation by a penalty of not more than $5,000.
> B. Any person who violates without knowledge or intent any provision of this title or any rule, regulation, or order issued pursuant to this title may be punished for each violation by a penalty of not more than $1,000. For the purpose of this subsection, a series of similar violations resulting from the same act shall be limited to a penalty in the aggregate of not more than $10,000.
> C. Any violation resulting solely from a malfunction of mechanical or electronic equipment shall not be subject to a penalty.
> D. 1. The Commission may require a person to make restitution in the amount of the direct actual financial loss:
> a. For charging a rate in excess of that provided by statute or by the rates filed with the Commission by the insurer;
> b. For charging a premium that is determined by the Commission to be unfairly discriminatory, such restitution being limited to a period of one year from the date of determination;
> c. For failing to pay amounts explicitly required by the terms of the insurance contract where no aspect of the claim is disputed by the insurer; and
> d. For improperly withholding, misappropriating, or converting any money or property received in the course of doing business.

> 2. The Commission shall have no jurisdiction to adjudicate controversies growing out of this subsection regarding restitution among insurers, insureds, agents, claimants and beneficiaries.
> E. The provisions provided under this section may be imposed in addition to or without imposing any other penalties or actions provided by law.

VA. CODE ANN. § 38.2-218 (2010). What is interesting about the Virginia penalties is that any violation resulting solely from a malfunction of mechanical or electronic equipment shall not be subject to penalty. *Id*. at (C).

2. IS THERE A PRIVATE CAUSE OF ACTION FOR FIRST PARTY CLAIMS HANDLING?

While the Model Act explicitly provides that it is not intended to create a private cause of action, some states have either statutorily provided for a private cause of action or the state courts have interpreted the act to provide for a private cause of action. Nevada's unfair practices in settling claims act explicitly provides for a private cause of action by providing:

> In addition to any rights or remedies available to the Commissioner, an insurer is liable to its insured for any damages sustained by the insured as a result of the commission of any act set forth in subsection 1 as an unfair practice.

NRS 686A.310(2) (1991). *See also*, *Pioneer Chlor Alkali Co., Inc. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Penn.*, 863 F. Supp. 1237 (D. Nev. 1994) (recognizing two different causes of action for actions arising under NRS 686A.310 and for bad faith). The Arizona Supreme Court has concluded that ARS § 20-443(C), which provides that "no order of the director pursuant to this section or order of court to enforce it, or holding of a hearing, may in any manner relieve or absolve any person affected by the order or hearing from any other liability, penalty or forfeiture under law," "contemplates a private suit to impose civil liability irrespective of governmental action against the insurer." *Sparks v. Republic Nat. Life Ins. Co*., 647 P.2d 1127, 1139 (Ariz. 1982). *See also, Farmer's Union Cent. Exch. v. Reliance Ins. Co*., 626 F. Supp. 583, 590 (D.N.D. 1985) (providing that N.D. Cent. Code § 26.1-04 may be the basis for an action sounding in tort); *Jenkins v. J.C. Penney Casualty Ins. Co*., 280 S.E.2d 252, 255-56, (W.Va. 1981), *overruled on other grounds by State ex. rel. State Farm Fire & Cas. Co. v. Madden*, 451 S.E.2d 721, 724-25 (W. Va.

1994). On the other hand, California overturned prior case law finding a private cause of action arising under CAL. INS. CODE §§ 790.03(h) and 790.09 in favor of the insured by following the majority approach holding that the Model Act does not provide a private cause of action. *See Moradi-Shalal v. Fireman's Fund Ins. Companies*, 758 P.2d 58, 64 (Cal. 1988) (providing that 17 out of 19 states having been faced with the issue of whether the Model Act created a private cause of action rejected such interpretation).

Although Mississippi has not adopted the Model Act, it allows first-party claimants to sue insurers for bad faith. *See Chapman v. Coca-Cola Bottling Co*., 180 So. 3d 676, 681 (Miss. Ct. App. 2015). The Mississippi Court of Appeals provided that for an insured to prevail on its claim for bad faith, it must prove any of the following: (1) insurer lacked an arguable or legitimate basis for denying the claim; (2) insurer committed a willful or malicious wrong; or (3) insurer acted with gross and reckless disregard for insured's rights. *Id*. The carrier is not in bad faith for denying or delaying payment of a valid claim if there is reasonable cause. *Id*. Under Mississippi law, coverage must be proved to predicate bringing a bad faith claim. *See Sobley v. S. Nat. Gas Co.*, 210 F.3d 561, 564 (5th Cir. (Miss.) 2000).

While some states' laws provide for a private right of action for an insurance carrier's violation of the Act, numerous states that have adopted the Model Act do not provide for such private cause of action. *Compare* 215 ILL. COMP. STAT. ANN. 5/155 (providing that an insured may recover damages, including extracontractual damages and attorney's fees, for the insurer's unreasonable and vexatious delay in the handling and settling a claim); MASS. GEN. LAWS. Ch. 93A, § 9(1) (providing that any person whose rights are affected by another person violating Ch. 176D, §3(9) governing unfair claim settlement practices may bring an action for damages and such equitable relief) *with* GA. CODE. ANN. § 33-6-37 (providing for no private cause of action for violation of the Fair Claims Settlement Act); *Bates v. Allied Mut. Ins. Co*., 467 N.W.2d 255, 259-60 (Iowa 1991) (Iowa does not recognize private cause of action under its statute governing fair claims practices). Some states do allow violations of the Act to be admissible in insurance bad faith cases. *See e.g. Weinstein v. Prudential Property and Cas. Ins. Co.*, 149 Idaho 299, 233 P.3d 1221 (2010). For those states where the Act does not provide for a private cause of action, the insured still may maintain a cause of action for bad faith against the

carrier for failing to treat its policyholders fairly during its investigation of the claim. *See e.g*. *Klepper v. ACE American Ins. Co*., 999 N.E.2d 86 (Ind. Ct. App. 2013). *See also*, Hamilton Mut. Ins. Co. of Cincinnati v. Buttery, 220 S.W.3d 287, (Ken. Ct. App. 2007) (providing that "a cause of action for violation of [Kentucky's Unfair Claims Settlement Practices Act] may be maintained only where there is proof of bad faith of an outrageous nature").

B. GO FOR THE WIN: PROPERLY HANDLE THIRD PARTY CLAIMS

A third party insurance claim is made by a person who is not the policyholder. The most common example of a third party claim would be a car accident caused by the policyholder; whereby, the third party suffered damages as a result of the accident.

Similar to first party claims, adjusters should be aware of pertinent timeframes surrounding the investigation and handling of the claim. The following chart provides a summary of deadlines for initial response, denial of coverage and reservations of rights for third party claims:

State (Unfair Claims Statute/ Regulation)	**Contacting Insured Upon Initial Receipt of Claim**	**Issuing Disclaimer of Coverage from Proof of Loss**	**Issuing Reservation of Rights from Proof of Loss**
Alabama (ALA. ADMIN. CODE r. 482-1-125)	No time limit	No time limit	No time limit
Alaska (ALASKA STAT. § 21.36.125; ALASKA ADMIN. CODE tit. 3 § 26.040)	10 days	15 days	15 days
Arizona (ARIZ. REV. STAT. § 20-461)	N/A	N/A	N/A
Arkansas (ARK. CODE ANN. § 23-66-201; 054-00-043 Ark. Reg. § 1)	N/A	N/A	N/A
California (CAL. INS. CODE § 790.03(h); CAL. CODE REGS. tit. 10, § 2695)	15 days	40 days; 80 days if fraud; N/A for certain policies	40 days
Colorado (C.R.S. § 10-3-1101-1116)	Reasonably promptly	60 days after a valid & complete claim	Reasonably promptly

State (Unfair Claims Statute/ Regulation)	**Contacting Insured Upon Initial Receipt of Claim**	**Issuing Disclaimer of Coverage from Proof of Loss**	**Issuing Reservation of Rights from Proof of Loss**
Connecticut (CONN. GEN. STAT. ANN. §§ 38a-815 to 38a-832)	Reasonable time	Reasonable time	Reasonable time
Delaware (DEL. CODE ANN. Tit. 18, § 2304, 18-900-902 DEL. CODE REGS. 1.2.1.2-1.2.1.5)	15 days; Must investigate claims within 10 days of notice of loss	30 days	30 days
District of Columbia (D.C. ST § 31-2231.17)	Reasonably promptly	Reasonable time	
Florida (F.S. 624.155, 627.426 & 626.9541; FLA. ADMIN. CODE ANN. r. 690-166.024)	14 calendar days; Must begin investigation within 10 working days of proof of loss	60 days of giving reservation of rights or of receipt of summons & complaint	30 days from knowing or should have known of coverage defense
Georgia (GA. CODE ANN. 33-6-34, 33-4-7; GA. COMP. R. & REGS. r. 120-2-52-.03)	60 days of receiving written request	None	None but must give its insured timely notice
Hawaii (HAW. REV. STAT. § 431:13-103(11))	15 days	Reasonable time after investigation completed	Reasonable time after investigation completed
Idaho (IDAHO CODE § 41-1329)	None	None	None
Illinois (215 ILL. COMP. STAT. ANN. 5/154.6; ILL. ADMIN. CODE tit. 50, § 919.50)	Reasonable promptness	Reasonable time	Reasonable time
Indiana (IND. CODE § 27-4-1-4.5)	Reasonable promptness	Promptly	Promptly
Iowa (IOWA CODE § 507B.4)	Reasonably promptly	Reasonable time	Reasonable time
Kansas (KAN. STAT. ANN. § 40-2404)	Reasonably promptly	Promptly	Promptly

State (Unfair Claims Statute/ Regulation)	**Contacting Insured Upon Initial Receipt of Claim**	**Issuing Disclaimer of Coverage from Proof of Loss**	**Issuing Reservation of Rights from Proof of Loss**
Kentucky (K.R.S. 304-12-230; 806 KY. ADMIN. REGS. 12:095)	15 working days	Reasonable time; If more time is needed to investigate, must notify within 30 calendar days	30 calendar days; update every 45 calendar days thereafter until investigation is complete
Louisiana (LA. REV. STAT. ANN. § 22:1892)	None, 30 days suggested	30 days to settle property damage claim	30 days recommended
Maine (ME. REV. STAT. 24-A, §2164-D)	Reasonably Promptly	Promptly	Reasonable time after investigation complete
Maryland (MD. CODE ANN. §27-303; MD. CODE REGS. 31.15.07.03, .04)	15 working days	15 working days or policy	15 working days or policy
Massachusetts (MASS. GEN. LAWS ch. 176D)	Reasonably promptly	Reasonable time; Promptly	Reasonably promptly; Reasonable time; Promptly; Reasonable time after completion of investigation
Michigan (Michigan's Uniform Trade Practices Act, MCL 500.2001, et. seq.)	30 days to provide materials that constitute a satisfactory proof of loss	None.	Reasonable time to policyholder and not to claimant. ***Caution*** of waiving disclaimer of coverage when defending without ROR within reasonable time
Minnesota (MINN. STAT. § 72A.201)	10 business days	60 days; 30 days after investigation is completed	60 days; 30 days after investigation is completed

State (Unfair Claims Statute/ Regulation)	**Contacting Insured Upon Initial Receipt of Claim**	**Issuing Disclaimer of Coverage from Proof of Loss**	**Issuing Reservation of Rights from Proof of Loss**
Mississippi (None)	N/A	N/A	N/A
Missouri (MO. ANN. STAT. § 375.1000; MO. CODE REGS. ANN. tit. 20, §100-1.030, 1.050)	10 working days	15 working days following all necessary forms	15 working days following all necessary forms
Montana (MONT. CODE ANN. § 33-18-101, et. seq.)	Reasonable promptly	Reasonable time	Reasonable time
Nebraska (NEB. REV. STAT. ANN. § 44-1540; NEB. ADMIN. CODE tit. 210, ch. 60 §6-006 to -008)	15 days	15 days	15 days
Nevada (N.R.S. 686A.310; NAC 686A.600-690)	20 working days	30 working days	30 working days
New Hampshire (N.H. REV. STAT. ANN. 417:4 XV; N.H. ADMIN. RULES, INS. §1001.01)	10 working days	10 working days	10 working days
New Jersey (NJSA 17:29B-4; NJSA 17B:30-13.1; NJ ADMIN CODE 11:2-17)	10 working days	Reasonable period of time	Reasonable period of time; ***Caution*** waives coverage defense if defend lawsuit without ROR
New Mexico (N.M. STAT. ANN. §59A-16-20)	Reasonably promptly	Reasonable time	Reasonable time
New York (N.Y. COMP. CODES R. & REGS. tit. 11,§ 216; N.Y. INS. § 3420)	15 days	15 days	15 days
North Carolina (N.C. GEN. STAT. ANN. § 58-63 et. seq.)	Reasonably promptly	Reasonable time	Reasonable time
North Dakota (ND CENT. CODE. § 26.1-04-03)	Reasonable promptness	Reasonable time	Reasonable time

State (Unfair Claims Statute/ Regulation)	**Contacting Insured Upon Initial Receipt of Claim**	**Issuing Disclaimer of Coverage from Proof of Loss**	**Issuing Reservation of Rights from Proof of Loss**
Ohio (OHIO ADMIN. CODE § 3901-1-54; OHIO REV. CODE §§ 3901.19-3901.26)	15 days, but no time limit if suit is filed	21 days	21 days
Oklahoma (36 O.S. §§ 1250.1 et. seq.; OKLA. ADMIN. CODE 365:15-3-5, -7)	30 days	45 days; 60 days for investigation for property & casualty to be completed	No specific time, but presumed 45 days
Oregon (OR. REV. STAT. § 746.230; OR. ADMIN. R. § 836-080-0225 to 235)	30 days	30 days	30 days
Pennsylvania (40 PA. STAT. ANN. § 1171.5; 31 PA. CODE §§ 146.1-146.9)	10 days	15 days	15 days
Rhode Island (R.I. GEN. LAWS §§ 27-9.1-1 et. seq.; 230-RICR-20-40-1.4 (life, accident & health); 230-RICR-20-40-2.6 to 2.7 (property & casualty)	15 days (property/ casualty); 15 days (accident, health & life)	21 days (property / casualty); Reasonable Time (accident, health & life)	21 days (property / casualty) Reasonable Time (accident, health & life)
South Carolina (S.C. CODE ANN. § 38-59-20)	Reasonable promptness	Prompt investigation	Prompt investigation
South Dakota (S.D.C.L. § 58-33 et. seq.)	None specified, but 30 days per S.D.C.L. would be appropriate	None specified, but 30 days per S.D.C.L. would be appropriate	None specified, but 30 days per S.D.C.L. would be appropriate
Tennessee (TENN. CODE ANN § 56-8-105)	Reasonably promptly	Reasonable time	Reasonable time
Texas (TEX. INS. CODE Chs. 541)	Reasonable promptly	Reasonable time	Reasonable time
Utah (UTAH ADMIN. CODE R590-190-9 & 10; UCA 31A-26-303)	Promptly acknowledge – within 15 calendar days	Promptly – 30 calendar days	Promptly – 30 calendar days

State (Unfair Claims Statute/ Regulation)	**Contacting Insured Upon Initial Receipt of Claim**	**Issuing Disclaimer of Coverage from Proof of Loss**	**Issuing Reservation of Rights from Proof of Loss**
Vermont (8 V.S.A. § 4724; 21-020-008 VT. CODE R. §§ 5-6)	10 days	30 days	30 days
Virginia (VA. CODE ANN. § 38.2-510; 14 VA. ADMIN. CODE § 5-400-50, -60, -70)	15 calendar days	15 calendar days	15 calendar days; Every 45 days thereafter until investigation is complete
Washington (WASH. REV. CODE § 48.30.010 et. seq.; WASH. ADMIN. CODE § 284-30-360, -380)	10 days	15 days	15 days
West Virginia (W. VA. CODE § 33-11-1, et. seq.; W. VA. CODE R. § 114-14-5, -6)	15 days	10 days after completion of investigation; investigation to be commenced within 15 days of claim; reasonable time to complete investigation	10 days after completion of investigation; investigation to be commenced within 15 days of claim; reasonable time to complete investigation
Wisconsin (WIS. ADMIN. CODE INS. § 6.11)	10 consecutive days	Reasonable time	Reasonable time
Wyoming (WYO. STAT. 26-13-124, 26-25-124)	Reasonably promptly	Reasonable time	Reasonable time

See EAGLE INT'L ASSOC., INC., FAIR CLAIMS HANDLING STATUTES A 50 STATE SURVEY (Sept. 2015) [4]. While this chart is intended to provide a quick resource, and for the most party mirrors first party claims, it is strongly recommended that the policy and the governing state's statutes, regulations and case law are reviewed for more information pertaining to these timeframes, as well as other pertinent timelines (e.g. providing response to written request, providing forms, tendering payment, communicating about ongoing investigation).

[4] The cited statutes and regulations have been reviewed as of February 12, 2020.

Similar to first party claims, a carrier's frequent or flagrant failure to timely and properly handle claims could constitute in (1) administrative penalties, (2) private cause of action or (3) waiver of disclaimer of coverage.

1. WHEN DO PRIVATE CAUSES OF ACTION EXIST FOR THIRD PARTY CLAIMS HANDLING?

Most states do not recognize a third party claimants' private cause of action arising under governing unfair claims acts; however, some states do. *See e.g.* W. VA. CODE ANN. § 33-11-4a(a), 33-11-4a(b) (prohibiting a third party claimant from pursuing a private cause of action and only permitting a third party claimant to file an administrative complaint). *But see*, *Goff v. Penn. Mut. Life Ins. Co.*, 729 S.E.2d 890 (W.Va. 2012) (holding that upon the death of the insured, a primary beneficiary to a life insurance policy has standing to bring a statutory bad faith claim against the insurer pursuant to the unfair claim settlement practices section). Massachusetts has enacted legislation specifically providing a private cause of action by third party claimants. *See* MASS. GEN. LAWS. Ch. 93A, § 9(1) (providing that any person whose rights are affected by another person violating Ch. 176D, §3(9), governing unfair claim settlement practices, may bring an action for damages and such equitable relief). In New Mexico, a private cause of action against an insurer for unfair and deceptive practices is available to third party claimants in some circumstances (e.g. failure to settle) but not in other circumstances (e.g. declination of providing non-mandatory excess liability insurance coverage). *Hovet v. Allstate Ins. Co.*, 89 P.3d 69, 73 (N.M. 2004); *Jolley v. Associated Elec. & Gas Ins. Servs.*, 237 P.3d 738, 739 (N.M. 2010). However, the third-party claimant cannot bring an action against the insurance carrier until the underlying action between the claimant and the insured is concluded. *Hovet*, 89 P.3d at 76-77. The Kentucky Supreme Court has concluded that its unfair claims provision provides for a private cause of action by third party claimants by reasoning that "KRS 446.070 and KRS 304.12–230 read together create a statutory bad faith cause of action" and "that private citizens are not specifically excluded by the statute from maintaining a private right of action against an insurer by third party claimants." *State Farm Mutual Automobile Insurance Company v. Reeder*, 763 S.W.2d 116, 118 (Ky. 1988).

Delays in informing the insured that there may be no coverage under the policy

while providing a defense may later result in waiver of the carrier's right to disclaim coverage under the policy. *See Centennial Ins. Co. v. Tom Gustafson Industries, Inc*., 401 So.2d 1143, 1144 (Fl. Ct. App. 4th dist. 1981) (providing that "a delay in informing the insured of a dispute as to coverage may result in estoppels of the insurer from contesting coverage if the insured can show that he has been prejudiced"); *Merchants Indemnity Corp. of New York v. Eggleston*, 179 A.2d 5050 (N.J. 1962) (holding that an insurer waiting nine months to issue a reservation of rights after having knowledge of all facts giving rise to possible right of disclaimer after defending the insured constituted a waiver of its right to disclaim). *See also*, *World Harvest Church, Inc. v. GuideOne Mut. Ins. Co.*, 695 S.E.2d 6 (Ga. 2010) (holding that insurer was estopped from asserting defense of noncoverage regardless of whether insured could show prejudice).

C. TIPS TO AVOID FOULS FOR VIOLATIONS OF THE UNFAIR CLAIMS SETTLEMENT PRACTICES ACT

The following highlights some pointers that adjusters can do to avoid violating the Unfair Claims Settlement Practices Act:

- v' Understand the governing law's requirements for investigating and handling claims
- v' Maintain diligent log notes
- v' Manage the massive onslaught of daily activities
- v' Accurately represent relevant facts and policy provisions
- v' Timely affirm or deny coverage
  - > Provide adequate explanations for claim denials
- v' Review of Settlement Values
- v' Update evaluations regularly
- v' Monitor cases appropriately
- v' Single point of contact with the State Agency

III. PAYING THE PRICE – EXTRA-CONTRACTUAL LIABILITY WHEN INSURER BREACHES DUTY TO DEFEND ABSENT BAD FAITH

Recently, Nevada Supreme Court considered whether an insurer could be liable for damages in excess of the policy limit plus defense costs when the carrier has not

acted in bad faith. The court answered affirmatively that the insurer may be liable for any consequential damages caused by the breach of the insurance contract for failing to defend its insured. *Century Surety Co. v. Andrew*, 432 P.3d 180, 182 (Nev. 2018).

The underlying pertinent facts in *Century Surety Co. v. Andrew* include an insured who had automobile coverage under a personal policy and a commercial general liability policy for business use. When the matter was initially tendered to the CGL carrier, the insurer determined that the automobile was not being used in the scope of insured's business and denied coverage. After the denial of coverage, the insured notified the insurer of the filing of a complaint that alleged that the insured was within the scope of his employment at the time of the accident. Since an answer was not filed, a default was taken against the insured. Default judgment was entered in the sum of $18,050,183 as the plaintiff suffered significant brain injuries as result of the accident. Insured entered an agreement with plaintiff that judgement would not be executed in exchange for an assignment of rights against the insurance carrier. Nevada law does provide that the duty to defend arises "if facts [in a lawsuit] are alleged which if proved would give rise to the duty to indemnify," which then "the insurer must defend." *Id*. at 184 (citing *Rockwood Ins. Co. v. Federated Capital Corp.,* 694 F.Supp. 772, 776 (D. Nev. 1988)).

Jurisdictions are split as to whether or not an insured can recover in excess of the policy limits when an insurer fails to defend absent bad faith. The majority view limits the liability of the insurer to the amount of the policy plus attorneys' fees and costs when the carrier fails to provide a defense and there is no opportunity to compromise the claim. *See e.g. Afcan v. Mutual Fire, Marine and Inland Ins. Co*., 595 P.2d 638, 647 (Alaska 1979); *Alabama Farm Bureau Mut. Cas. Ins. Co., Inc. v. Moore*, 349 So.2d 1113 (Ala.

1977*); Allen v. Bryers*, 512 S.W.3d 17, 38-39 (Mo. 2016); *Comunale v. Traders & Gen. Ins. Co.,* 328 P.2d 198, 201 (Ca. 1958); *Emp'rs Nat'l Ins. Corp. v. Zurich Am. Ins. Co. of Ill.,* 792 F.2d 517, 520 (5th Cir. (Texas) 1986); *George R. Winchell, Inc. v. Norris,* 633 P.2d 1174, 1177 (Kan. App. 1981); *Hirst v. St. Paul Fire & Marine Ins. Co*., 683 P.2d 440, 447 (Idaho 1984). The minority view does not limit damages to policy limits plus the cost of defense. See *Delatorre v. Safeway Ins. Co*., 989 N.W.2d 268, 274 (Ill. 2013); *Khan v. Landmark American Ins. Co.,* 757 S.E.2d 151 (Ga. App. 2014); *Newhouse v. Citizens Security Mut. Ins., Co*., 501 N.W.2d 1 (Wisc. 1993).

For those jurisdictions following the minority view, the best practice is to defend the insured under a reservation of rights that it is not waiving any right to later deny coverage based on the terms of the insurance policy and to seek declaratory judgment as to coverage. *See e.g. Woo v. Fireman's Fund Ins. Co.*, 164 P.3d 454, 460 (Wa. 2007).

IV. KNOW WHEN TO RETAIN INDEPENDENT COUNSEL

The jurisdictions are split as to whether a carrier has to retain independent counsel for the insured when coverage is at issue.

The *Cumis* counsel originated from the California Court of Appeals' holding that when there is a potential conflict of interest between an insurer and its insured requiring the insured to retain independent counsel, the insurer is to pay for the independent counsel. *See San Diego Navy Federal Credit Union v. Cumis Ins. Society, Inc.,* 162 Cal.App.3d 358, 208 Cal. Rptr. 494, 50 A.L.R.4th 913 (Ct. App. 1984), *superseded by* CAL. CIV. CODE § 2860. *See also, Nandorf, Inc. v. CNA Ins. Companies*, 479 N.E.2d 988 (Ill. App. 1985); *Belanger v. Gabriel Chemicals, Inc*., 787 So.2d 559 (La.App. 1 Cir. 2001); *Parker v. Agric. Ins. Co.* 109 Misc.2d 678, 440 N.Y.S.2d 964 (Sup. Ct. 1981).

Several states have adopted or modified California's *Cumis* counsel rule. Nevada held that an insurer was required to satisfy its duty to defend by permitting insured to select and pay reasonable costs for independent counsel when an actual conflict of interest exists; however, the court noted that an insurer sending its insured a reservation

of rights letter did not create a per se conflict of interest. *State Farm Mutual Automobile Insurance Company v. Hansen*, 357 P.3d 338 (Nev. 2015). Consistent with Nevada, Minnesota has made it clear that there must be an actual conflict of interest as opposed to an appearance of a conflict, including an insured requesting to be informed of the insured's litigation while maintaining a declaratory judgment action against the insured. *See Mutual Service Cas. Ins. Co. v. Luetmer*, 474 N.W.2d 365, 368-69 (Minn. App. 1991). Other jurisdictions have applied a per se rule that defending under a reservation of rights is a conflict of interest. *See* ALASKA STAT. ANN. § 21.96.100(c) (2014); *Armstrong Cleaners, Inc. v. Erie Ins. Exchange*, 364 F. Supp. 2d 797, 806 (S.D. Ind. 2005); *Pueblo Santa Fe Townhomes Owners' Ass'n v. Transcon. Ins. Co.,* 178 P.3d 485, 491 (Ariz. App.2008); *Herbert A. Sullivan, Inc. v. Utica Mut. Ins. Co.,* 788 N.E.2d 522, 539 (Mass. 2003); *Patrons Oxford Ins. Co. v. Harris,* 905 A.2d 819, 825–26 (Me. 2006).

Other states have rejected the *Cumis* rule by reasoning that the insured is the sole client. *See e.g. Point Pleasant Canoe Rental Inc. v. Tinicum Twp*., 110 F.R.D. 166, 170 (E.D. Pa. 1986); *L & S Roofing Supply Co. v. St. Paul Fire & Marine Ins. Co.,* 521 So.2d 1298, 1303–04 (Ala.1987); *Higgins v. Karp,* 687 A.2d 539, 543 (Conn. 1997); *Finley v. Home Ins. Co*., 975 P.2d 1145, 1152-53 (Haw. 1998); *In re Youngblood,* 895 S.W.2d 322, 328 (Tenn.1995); *Tank v. State Farm Fire & Cas. Co.,* 715 P.2d 1133, 1137 (Wash. 1986).

The California Supreme Court recently ruled that an insurance carrier could bring an action against its insured's independent counsel under unjust enrichment for reimbursement of unreasonable and unnecessary fees that it had paid to the *Cumis* counsel. *Hartford Casualty Ins. Co. v. J.R. Marketing, L.L.C.*, 353 P.3d 319 (Cal. 2015). In *Hartford Casualty Ins. Co*., the trial court issued an order, which was drafted by *Cumis* counsel, requiring "the insurer to pay all 'reasonable and necessary defense costs,' but expressly preserved the insurer's right to later challenge and recover payments for 'unreasonable and unnecessary' charges by counsel" in a case where Hartford was defending the insured against covered and non-covered claims. *Id*. at 321-22. Due to Hartford being in breach of its duty to defend prior to this court order, Hartford was not able to benefit from California Civil Code limiting the rates charged by independent counsel to be limited to that actually paid by the insurer to attorneys retained in the defense of similar suits. *Id*. at 323 (citing CAL. CIV. CODE § 2860). Hartford incurred $15

million in defense fees and costs. *Id*. In California, where the doctrine of unjust enrichment applies, "the law implies a restitutionary obligation, even if no contract between the parties itself expresses or implies such duty." *Id*. at 326 (citation omitted). In prior case law, the California Supreme Court allowed a carrier to restitution from the insurer for fees paid to independent counsel to defend non-covered claims. *Id*. While the California Supreme Court "emphasiz[ed] that [its] conclusion hinges on the particular facts and procedural history of [the underlying litigation]," including the order providing that Hartford could pursue anyone for the overpayments, the Court held that the carrier was entitled to seek reimbursement directly from *cumis* counsel. *Id*. at 327, 331-32.

V. BEST SETTLEMENT PRACTICES

Most states require that insurers "devise a litigation strategy (and make settlement offers within the policy limits) as if the insurer bore the full exposure." *Transport Ins. Co. v. Post Express Co.,* 138 F.3d 1189, 1192 (7th Cir. (Ill.) 1998). An insurer must give its insured's interests "at least equal consideration with its own when the insured is a defendant in a suit in which the recovery may exceed the policy limits." *See Adduci v. Vigilant Ins. Co.,* 424 N.E.2d 645, 648 (Ill. App. 1981); *Kavanaugh v. Interstate Fire & Casualty Co.,* 342 N.E.2d 116, 120 (Ill. App. 1975); *McKinley v. Guar. Nat'l Ins. Co.,* 159 P.3d 884 (Idaho 2007). Negligent failure to settle typically requires the insured establish (1) the claim is within the scope of coverage, (2) a demand was made that was within policy limits, and (3) the demand was such that an ordinary prudent insurer would have accepted it, considering the likelihood and degree of the insured's potential exposure. *See Twin City Fire Ins. Co. v. Country Mut'l Ins. Co.,* 23 F.3d 1175 (7th Cir. (Ill.) 1994); *Yorkshire Ins. Co. v. Seger,* 279 S.W.3d 755, 768 (Tex. App. 2007); *G.A. Stowers Furniture Co. v. Am. Indem. Co.,* 15 S.W.2d 544, 547 (Tex. Comm'n App. 1929). An insurer must settle, if possible, "where a reasonably prudent person faced with the prospect of paying the total recovery would do so." *Robinson v. State Farm Fire & Casualty Co.,* 583 So.2d 1063, 1067 (Fla. App. 1991).

Various factors are considered in determining whether a failure to settle a case was "reasonable." *Brown v. Guarantee Insurance Co.,* 319 P.2d 69 (Cal. App. 1958), *Commercial Union Insurance Co. v. Liberty Mutual Insurance Co.,* 393 N.W.2d 161 (Mich. 1986). California courts have weighed the following: (1) the strength of the claimant's

case on both liability and damages; (2) the attempts by the insurer to induce the insured to contribute to the settlement (in third party claims); (3) the failure of the insurer to properly investigate so as to fully consider the evidence that exists against the insured; (4) any rejection of settlement advice from the insurer's own attorney or agent; (5) the failure of an insurer to inform its insured of a demand or offer; (6) a failure to consider the amount of financial risk to which each party is exposed if there is a refusal to settle; (7) the fault of the insured in inducing the insurer to reject a demand by misleading the insurer as to the facts; and (8) other evidence that would establish or negate bad faith on the part of the insurer. *Brown*, 319 P.2d at 74. Michigan considers additional procedural items such as: (1) a failure to inform the insured of any relevant litigation developments; (2) a failure to keep the insured informed of all demands outside of policy limits; (3) a failure to solicit a demand or extend an offer when the facts warrant; (4) a failure to accept a reasonable compromise when the liability is evident and the damages are high; (5) a rejection of a reasonable settlement offer that is within policy limits; (6) an attempt to coerce the insured into contributing to a settlement that is within policy limits; and (7) creating undue delay in accepting a settlement demand that is within policy limits where a potential verdict is high. *Commercial Union Insurance Co.,* 393 N.W.2d at 165. Failing to inexcusably meet a deadline placed on a policy limit demand or failing to timely pay policy limits where liability is extreme and damages are high may also result in a finding of bad faith. *Berges v. Infinity Ins. Co.,* 896 So.2d 665 (Fla. 2004).

A claim for bad faith based on an alleged wrongful refusal to settle for an amount within policy limits generally requires a reasonable offer where (1) the terms have been made clear enough to have created an enforceable contract resolving all claims at issue; (2) all third party claimants (if any) have joined in the demand; (3) the demand provides for a complete release of all insureds; and (4) and the time provided for acceptance did not deprive the insurer of an adequate opportunity to investigate and evaluate the insured's exposure. *Critz v. Farmers Ins. Group*, 230 Cal.App.2d 788, 798 (1964) (citations omitted).

In handling demands, whether within policy limits or above, the insurer must do more than just act reasonably—it must be able to prove that all steps taken in either negotiating a settlement or denying settlement was done reasonably. Documenting the

claim file and keeping accurate and complete records of all communications and decisions within the claim analysis is essential. All materials should be date stamped in order for the file to be reconstructed at a later date. Bad faith claims with regard to settlement decisions are often determined by looking at all of the evidence and conducting an analysis of what was available at the time the settlement decisions were made. In addition to file stamping documents, all phone communications should be documented in writing and in as much detail as possible, including attempts to contact an insured or others integral to an investigation, even where the person called is not reached. All activity including investigations in to damages should be noted by date within the file. Dilatory behavior on behalf of an insurer can be the foundation upon which a bad faith claim is structured.

Notwithstanding the requirement to fully and completely document the claim file, the insurer must assume that everything within that file will be discovered by the party making a bad faith claim. *Brown v. Superior Court In and For Maricopa County,* 670 P.2d 725, 734 (Ariz. 1983). Gratuitous comments in correspondence or memoranda should be avoided. This is true for both those handling the claim on behalf of the insurance company as well as any counsel or experts retained by the insurance company. Comments such as “this lady is such a liar” or “I’m sick of this guy” should never be included in any portion of the claim file. However, it is important to document any difficulties that arise in dealing with the insured or claimant. For example, an insured’s failure to timely respond to a demand for proof of loss, an unreasonable restriction on medical authorizations or failure to timely provide medical authorizations, a claimant or insured’s dishonesty relaying essential facts or where the claimant has otherwise delayed the investigation should all be things noted in detail within the file.

VI. CONCLUSION

In conclusion, Coach Hayes said: “Paralyze resistance with persistence.” Instead of standing on the defense in claims handling, understand the governing law and persist with successful and prompt claims handling.

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TIPS ON VALUING THOSE CHALLENGING CASES WHILE ASSESSING LIABILITY EXPOSURE

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`Tips on valuing those challenging cases while assessing liability exposure.

This paper discusses four key areas of assessing liability exposure: considerations for settling cases, exposure versus liability, assessing the potential values of a claim and the timing of settlement.

Initial Considerations

Of primary importance is the protection of the insured. As a practical matter, considering the available policy limit, the costs of defense and the overall liability exposure will often result in a prompt settlement.

However, there are several other factors that may come into play. First, is there a deductible? Does the policy have a loss only deductible that provides for a "dollar one defense," or are defense costs included within the deductible? Is an insured willing to pay the total amount of the deductible in a situation where it is perceived that the insured has very limited or no liability; this may have a significant impact on how the claim is viewed. A professional sued for malpractice often feels strongly about the claims that are being made against them, which at times impacts their willingness to contribute toward any settlement, and it is not uncommon for an insured to request the carrier to waive a deductible.

Second, the identity of the insured may be another important consideration. Is the insured an individual? Does the insured have a "high profile" in the community? Is the insured a celebrity? Alternatively, is the insured a small family company or, perhaps, a national or multi-national corporation? If the insured is a large corporation, does it pay significant premiums, does it have a large self-insured retention, had it retained the right to select counsel and control the defense? All of these factors should be considered during an initial valuation of a claim.

Third, the decision to settle might be influenced by the availability of other insurance. Assuming there are two primary policies, the first question might be whether the coverage of the other policy is "pro rata" or whether it is excess over the first layer of coverage. Check the "other insurance" clause. What is the actual exposure to the company?

There might also be excess or umbrella insurance available. Both policies would provide additional coverage to the insured beyond the limits of coverage available on the primary policy. Generally speaking, excess policies are more restrictive than umbrella policies, and routinely provide coverage above the limit of the underlying policy, but not broader coverage. Many excess policies "follow-the-form" of the primary policy. When an insured has an excess follow-form policy, the excess coverage is subject to all of the terms and conditions of the underlying policy. An umbrella policy, on the other hand, might provide broader coverage than the underlying policy. It is important to consider the duties owed by primary insurers to excess or umbrella insurers.

Finally, consideration must be given to the possibility that a settlement might spawn further litigation. A decision not to settle quickly might result in bad publicity that causes other claims to be filed. Alternatively, if some type of serial litigation is a possibility, consideration might be given to a global resolution, such as a settlement class action. Another possibility is existing multi-district litigation that covers the subject of the dispute. Prior to considering any settlement, removal and referral might be a viable option.

It should not be overlooked that the decision to settle may also affect future underwriting. (This might depend, in part, upon whether the policy is an occurrence or claims made-type policy.) The bottom line is that all of these factors, including others, may come into play.

Exposure Versus Liability

Especially when dealing with the potential high exposure claim, it is imperative to immediately start an investigation and assessment of that claim. This is particularly important when no lawsuit has yet been filed. Local adjusters or investigators can provide a great resource for obtaining a good "feel for the facts" of the case and impressions of the claimant, any witnesses and your insured.

Early retention of experts is another way in which an adjuster can undertake an initial liability assessment in high exposure cases. Finding local and reputable accident reconstructionists, engineers, architects, medical professional and damage experts can provide a competent evaluation of both exposure and liability. In personal injury cases, if available, obtain all of the claimant's medical records immediately and arrange for a records review. A surgery that might take place three years after an accident may be easily discredited by a timely records review -- cutting exposure on the file even without physically seeing the claimant for an examination.

On the liability side, an early accident reconstruction can provide critical analysis and opinion shoring up the lack of liability, or perhaps, the questionable liability of the insured. By way of example, tire skid and scuff marks may disappear, vehicles may be repaired or destroyed, the scene of the accident might change (for example, guard rails might be replaced following an accident), all making it more difficult to assess liability. While early opinions in a catastrophic loss case finding that the insured has little or no liability may not preclude a lawsuit from being filed, it may give great assistance in obtaining a relatively low settlement in subsequent settlement negotiations or at a mediation. Saying "It's not my insured's fault" is much more clearly done through an expert, and it also sets the frame of mind of the claimant's counsel to know that this is a claim the carrier is willing and ready to fight.

Do not forget to consider the "next level up expert." If your claimant is treating with a chiropractor, look at retaining an orthopedic surgeon or, perhaps, a neurologist or neurosurgeon, if there are radiating symptoms, to perform an evaluation. If the claimant has suggested that his lawyer retained a local construction company to do an evaluation and bid on a defect claim, consider retaining an engineer or an architect. These advanced experts may come with higher fees, but they also come with a certain amount of additional expertise in assisting with the assessment of the file. With their additional credibility, they can also have an impact on how a jury would subsequently view any of the liability issues.

An attorney may be a great asset to help in assessing exposure and performing a complete legal analysis. Local defense counsel can also aid in finding those important and reputable experts and get investigators as described above. Counsel can also be useful in providing legal analysis and supporting case law early in the analysis, so that an adjuster can complete a full investigation on all of the facts relevant to the legal theory portion of the claim. An attorney can also ensure the interests of the insured are protected, and provide additional work product and attorney-client privilege protection to any facts and opinions learned, discovered and obtained through an early investigation.

On high exposure cases, the likelihood and effect of media coverage should be a consideration. Attorneys can help frame media scrutiny and coverage in those high profile cases, and can limit access to the insured. They can also assist in the retention of publicist to deal with the media.

Once the preliminary investigation is complete, weigh the potential of a Rule 12 Motion to Dismiss or Summary Judgment Motion should litigation ensue. If a full investigation was completed prior to the commencement of litigation, an early Motion to Dismiss may be feasible, thereby limiting the cost of defense, including the taking of depositions and the retention of damages experts. Even if the motion is unsuccessful, the filing of the motion or even the threat of filing can play a large role in settlement discussions. The motion and arguments of counsel on the issues a jury will someday be asked to determine, especially if they are made in the presence of the plaintiff, can go a long way to reducing the settlement value of the case.

In those cases, where an insured is going to share some portion of the liability, determine what the comparative fault structure is in the relevant jurisdiction. Cases with multiple potentially liable parties can also limit or even negate liability of the insured. Likewise, when investigating the matter, make certain that all potentially liable parties are put on notice of the claim, that proper tenders are made where applicable, and that the investigation includes an analysis on how much of the overall liability can be attributed to another party rather than the insured.

As a final note on this topic, reviewing jury instructions and verdict forms can be a useful tool in evaluating claims, even pre-suit. Knowing what a juror will be asked to decide, the questions jurors will need to answer, such as the interrogatories regarding future damages and life expectancy tables (if applicable), can prove to be beneficial in understanding the liability defenses and issues.

What are the Potential Values of the Claim?

In high exposure cases especially, often times the first valuation that comes from the claimant's counsel will be inflated. In evaluating the value that the claimant's counsel assigns to a case versus what the actual exposure of settlement value should be an important aspect of the early investigation process, but should also be done on a regular basis throughout the course of the file. As is well known, any evidence or information learned through the adjuster's investigation, defense counsel's investigation, or even provided by plaintiff's counsel or the insured can change the value of the case at any time. It is not wrong to stick to an evaluation; however, you must make sure that consideration is given to all additional information that may be provided -- regardless of the source.

When assessing either the exposure or settlement value, identify whether the exposure is contained. Is this a case that will have future damages, or is there a finite value to it? Consider the bodily injury case that transforms from a basic soft tissue neck/back injury to a case involving fusion surgery or claims of a traumatic brain injury. Also consider construction defect cases; the longer the claim exists, often times the more "defects" are identified. Repair costs can mushroom from replacing some roofing to repairing the complete building envelope. Knowing if the exposure is contained, or if it can be locked-in early on is an important consideration to be given when valuing the file.

A claim cannot be properly valued without knowing what the costs are. For example, are the special damages known, are the subrogation liens and offsets identified, is there a Medicare lien, is there sufficient documentation of a loss of earnings claim, have repair estimates been provided, has

there been a competitive estimate completed - - all of these need to be understood. In some cases, the less tangible damages can have the greatest impact on how a claim is valued. Future medical expenses, pain and suffering, future losses of earning and punitive or exemplary damages should all be evaluated as part of the process.

On assessing the exposure on these less tangible aspects of the claim, do not discount who your claimant or plaintiff is. What is the age of the person? Are they likeable? What is their educational background, religion, socio-economic status, nationality or culture? Someone who has met the claimant in person, someone like a local adjuster/investigator or defense counsel, can greatly assist in obtaining answers to these questions. A jury is going to consider all of these factors, and so should you! Obviously, a more likeable plaintiff can lead to a higher exposure which, in turn, can lead to a higher settlement value of the case. Conversely, an unlikeable plaintiff, regardless of the facts of the case, can turn off a jury and significantly lower or even extinguish the value of the plaintiff's claim.

Timing of A Settlement Can Really Matter

Early settlement can provide benefits in cases where pubic exposure plays a role in the case, including the negotiation of terms and conditions within a settlement agreement such as a non-disparagement clause or a confidentiality clause. Control over timing and substance of the information that is disclosed can also be of benefit to an early settlement, especially in highly visible cases or, perhaps, professional liability cases where there is a concern that sensitive matters need to be protected and contained.

Early settlement can offer both parties the ability to exercise some control over the expense of litigation. It can also provide a benefit to the plaintiff and the insured by avoiding the time and effort it takes on their respective part to participate in the litigation process. This can and does have an impact on how the insurer is viewed within the industry as well
Early settlement is, of course, not appropriate in all cases. Delaying settlement talks until the full investigation into the matter on both liability and damages to discover any latent favorable or unfavorable facts can be critical.

Whether early in the process or at the eve of trial, in a low liability high exposure case, do not forget to consider the option of serving an Offer of Judgment or Proposal for Settlement if that tool is available in your jurisdiction. A formal offer is sometimes viewed differently by a plaintiff as a "last offer" by a defendant and taken more seriously. Often it also includes some penalty such as the requirement to pay attorney's fees at the close of the litigation. Obviously, it is imperative to make sure that the amount offered is an amount that the insurer is willing to pay if accepted. Once offered, there may be a limitation on the ability to withdraw the offer if it is in the form of an Offer of Judgment or Proposal for Settlement.

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“Birdman,” “Satchmo” and “Lady Day” walk into a bar… Jazzing up premises liability defense strategies to prevent the courtroom blues

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"Birdman," "Satchmo" and "Lady Day" walk into a bar… Jazzing up premises liability defense strategies to prevent the courtroom blues

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By: Jason J. Campbell (Arkansas)

1. Determining the Duty Owed, Burden of Proof, and Legal Defenses

The status or classification of the injured person is generally determined by the benefit that person provides to the property owner. Most states have pattern jury instructions for premises liability actions. Defense counsel should consult those instructions at the inception of case to determine initial investigation strategies and defense themes. Likewise, at the inception of the claim, the claims adjuster who is conversant with the applicable instructions will have instant credibility and enhanced bargaining power with plaintiff's counsel.

A) Invitee- Public/Business Invitee- Highest Degree of Care
Generally, those who have come upon the property at the express or implied invitation of a possessor for the purpose of transacting business within the scope of the invitation.

a. Examples:

i. Restaurant patrons
ii. Store customers
iii. Amusement park guests
iv. Hotel guests
v. Apartment building tenants
vi. Hospital patients
vii. Business clients

b. Duty owed:
state specific but generally reasonable care in maintaining the property in a reasonably safe condition.
The duty to warn of dangers of which the owner has or should have knowledge and which are unknown to the invitee and cannot be discovered by the invitee through the exercise of reasonable care.
Foreseeability is Key.

c. Examples and Common Fact patterns: keeping floors dry, warning customers of potentially dangerous conditions, warning of trip hazards, steep steps or drop offs, preventing falling items from shelves

A) Licensee- Intermediate Degree of Care

Generally, social guests who have been granted permission to visit and/or stay on a property for purposes unrelated to business or commerce.

a. Examples:

i. Friends and family
ii. Neighbors
iii. Unsolicited door-to-door salesman
iv. Why is there a Mormon missionary at my keg party?

b. Duty owed:

state specific but generally just as for licensees, property owners must warn invitees of known dangers. If there is an apparent hazardous condition on the property, licensees must take care to avoid it.

B) Trespasser- Lowest Degree of Care

Generally, an individual who enters the property of another without any legal right, express or implied.

a. Examples:

i. Private pools
ii. Posted property
iii. Exception for attractive nuisance/children.

b. Duty owed:

State specific but generally, there is no duty owed to unknown trespassers other than refraining from causing intentional injury.

i. Exceptions may exist where the owner is aware of trespassers who frequent his property,
ii. Attractive nuisance exception/ minors.

Defense counsel should be proficient as to the common law or statutory legal defenses/affirmative defenses applicable to premises liability actions. Affirmative defenses should be raised in any initial answer or responsive pleading and developed from evidence gathered from the initial investigation and discovery phase of the case to support future dispositive motions. Common legal defenses in premises liability cases include: the “open and obvious” defense; the “step in the dark” defense; assumption of risk; the accumulation rule or “ongoing storm” doctrine; and release and waiver of liability.

It is often crucial for defense counsel to issue early, targeted written discovery to plaintiff in the early stages of the case to develop a timeline of plaintiff's activities, whereabouts and communications leading up to and during the alleged event. Defense counsel should obtain pertinent social media postings, phone records and text communications from the plaintiff when appropriate.

Defense counsel should engage in calculated planning and outlining of key defense elements to obtain necessary concessions during plaintiff's deposition to support dispositive motions in premises liability actions. For example, many states strictly construe activity waivers of liability/exculpatory agreements and appellate courts are often reluctant to enforce such agreements where any ambiguous language exists. In a case in which an executed exculpatory agreement exists, defense counsel should be prepared to address and reconcile the pertinent provisions of the agreement with plaintiff using casual or common language and analogies to everyday life or situations. This technique is often effective in demonstrating plaintiff's understanding of the risks undertaken by engaging in the activity and a knowing waiver of those risks as required in many states. *See Kotcherquina v. Fitness Premier Management, LLC*. 2012 WL 682733 (E.D. Arkansas 2012) (summary judgment granted against Arkansas symphony concert violinist who broke both wrists ending her career. District Court found plaintiff's testimony demonstrated a knowledgeable waiver of fitness center's liability).

2) Using Standards or Codes

In most *static* condition premises liability cases, safety standards and codes will become significant, and often controlling, in determining liability. Since they are in and of themselves party neutral (i.e. standards do not favor plaintiffs or defendants as a class) a party's use of such neutral evidence in support of its position can be powerful. It is only when the standards are applied to a specific factual situation that the evidence derived from the standards favors one party or the other.

Standards and codes can be found through various sources. Specific statutes may directly set forth a standard or incorporate one by reference. Standards are also issued by standards organizations (ANSI), trade associations, and industry groups.

Common premises liability "standards" sources include:

1. OSHA (Occupational Safety and Health Administration)
2. UBC (Uniform Building Code)
3. ANSI (American National Standards Institute)
4. ASTM (American Society of Testing Materials)
5. ADA (Americans with Disability Act)
6. NAARSO (National Association of Amusement Ride Safety Officials)
7. ServeSafe

The insured/defendant may have its own internal safety standards and policies. Standards may also be found in “specifications” sections of contract documents. Defendant’s internal safety policies and procedures, employment manuals, and contract documents should be thoroughly examined by defense counsel and discussed with defendant’s employees and corporate representatives prior to defense depositions to defend against “reptile theory” strategies and questioning by plaintiff’s counsel.

3) Retention and Use of Experts

The initial question is whether an outside liability expert is necessary. Retention of an expert in large part depends on the answers to the following questions:

1. *Is the alleged dangerous condition static or transitory?*

A *transitory* condition (i.e. a spilled substance) of short temporal duration as to which there is a lack of notice argument normally may not require an expert because the factual question of notice is likely to control the determination of liability.

A *static* condition (i.e. an unlevel walkway) almost always requires an expert to establish whether the condition is unreasonably dangerous and/or that the defendant’s conduct (attempts to safeguard, remedy or warn) met the applicable standards and codes.

2. *Is the insured familiar with the applicable codes?*

When the insured does not have an in-house expert, an “independent” expert may be necessary to educate the adjuster or attorney as to what is or is not significant about the condition, whether there is a standard that applies, or to determine what needs to be done to establish proof of compliance with a standard (i.e. photographic evidence vs. testing).

3. *Is the alleged condition open and obvious?*

Typically, a plaintiff will hire a human factors expert to defend this claim. Depending on the circumstances and the opinions of plaintiff’s expert, defendant may want to also retain an expert with similar qualifications to rebut those opinions.

4. *Will testing be necessary or desirable?*

“Slippery” or “Sticky” are relative terms. Typically, a plaintiff will hire an expert to calibrate or quantify the characteristics of a surface through testing. Again, depending on the circumstances and the findings of plaintiff’s expert, defendant may need to retain an expert to analyze the validity of the equipment used to conduct the testing, testing methods and test results.

1. *Is the design or as built nature of the condition being challenged?*

If plaintiff's argument is that an alternate design should have been utilized or that the existing conditions were different from the design, an expert will be required to validate the design and/or as built condition.

2. *Do the economic damages justify an expert?*

Before the expert begins his or her work, defense counsel and claims adjustors should set clear expectations as to the scope of services required and estimated costs to complete the work (i.e. the document review, testing, development of opinions and/or reports, etc.).

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United States District Court,
E.D. **Arkansas**,
Western Division.

Tatiana **KOTCHERQUINA**, Plaintiff
v.
FITNESS PREMIER MANAGEMENT, LLC d/b/
a Fitness Premiere of Little Rock, et al., Defendants.

No. 4:11CV00342 JMM.
|
March 2, 2012.

Attorneys and Law Firms

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ORDER

JAMES M. MOODY, District Judge.

***1** Pending before the Court is Defendant's Motion for Summary Judgment to which Plaintiff has responded. For the reasons stated below, the motion is granted (# 21).

Plaintiff brings a claim of negligence based upon an injury she suffered on August 31, 2010, at Defendant Fitness Premier Management, LLC, d/b/a Fitness Premiere's gym ("Fitness Premiere") while under the supervision of a Fitness Premiere personal trainer, Defendant Raymond "Trey" Gruver. Plaintiff alleges that Fitness Premiere failed to provide Plaintiff with a qualified or certified personal trainer and that both Defendants failed to use ordinary care under the circumstances.

Defendants contend that Plaintiff signed exculpatory agreements with each of them prior to the August 31, 2010 incident which caused her injury and that these exculpatory agreements released them from any liability for injuries or damages resulting from exercising at Fitness Premiere with or without a Fitness Premiere trainer.

I. *Facts*

Defendant Fitness Premiere is a private fitness center located in Little Rock, **Arkansas**. On September 15, 2007, Plaintiff signed a fitness Membership Agreement with Fitness Premiere, which for a monthly fee, allowed her to use the exercise equipment, personal training services, and other facilities offered by Fitness Premiere. The Membership Agreement contained a exculpatory provision entitled "Waiver and Release."

The exculpatory provision stated:

> **Waiver and Release:** I am aware that physical exercise is a calculated risk activity and that using the Club's exercise machines, free weights, tanning, personal training services, and any other facilities and related services offered by the Club involves inherent risks and dangers, including loss of or damage to personal property and serious personal injury or death. I am aware of and understand the scope, nature, and extent of the risks involved in the activities contemplated by this Release and Waiver. I voluntarily assume and freely choose to incur any and all such risks of loss, damage, or injury, including death, including, but not limited to, the risk of harms caused in whole or in part by the unintended conduct of the Club.

On July 19, 2010, Plaintiff signed a one-page Personal Training Agreement which stated:

> I am aware that weight training is a calculated risk activity and that working with a Fitness Premier/ Personalized Training Inc. Personal Trainer involves inherent risks and dangers, including loss or damage of personal property, serious personal injury and/or death. I am aware of and understand the scope, nature and extent of the risks involved in the activities contemplated by this Release and Waiver. I voluntarily assume and freely chose (sic) to incur any and all such risks of loss, damage or injury, including death, but not limited to, the risk of harms caused while or part of by

> the unintentional conduct of a Fitness Premier/Personalized Training Inc. Personal Trainer. I agree to indemnify and hold harmless Fitness Premier/ Personalized Training Inc. Personal Trainer and Fitness Premier against any and all loss, damage, cost and expense which may result to me as a result of my training.

***2** This latter document was also signed by Defendant Gruver on that same date. Plaintiff understood the Membership Agreement and the Personal Training Agreements to be legal contracts and understood the meaning of "waiver."

II. *Discussion*

An exculpatory contract is one where a party seeks to absolve himself in advance of the consequences of his own negligence. *Finagin v. Ark. Dev. Fin. Auth.*, 355 **Ark**. 440, 455, 139 S.W.3d 797, 806 (2003). Contracts that exempt a party from liability for negligence are not favored by the law. *Plant v. Wilbur,* 345 **Ark**. 487, 493, 47 S.W.3d 889, 893 (2001). However, exculpatory contracts are not invalid *per se*. *See Id.* They are strictly construed against the party relying on them, and the to be valid the contract must clearly set out what negligent liability is to be avoided. *See Finagin v. Ark. Dev. Fin. Auth.*, 355 **Ark**. at 455, 139 S.W.3d at 806.

In addition to these two rules of construction, **Arkansas** courts have stated that they are not restricted to the literal language of the contract but "will also consider the facts and circumstances surrounding the execution of the release in order to determine the intent of the parties." *Id.* **Arkansas** courts, in deciding the validity of exculpatory clauses, consider three factors: (1) whether the party is knowledgeable of the potential liability that is being released; (2) whether the party is benefitting from the activity which may lead to the potential liability that is being released; and (3) whether the contract that contains the clause was fairly entered into. *Id.* at 458, 139 S.W.3d at 808.

The Court finds that the agreements signed by Plaintiff are clear and unambiguous. Moreover, Plaintiff's testified that in 2004 or 2005 she had a membership and the services of a fitness trainer in another gym prior to joining Fitness Premiere in 2007. Based upon this testimony Plaintiff clearly knew the risks associated with working out in a gym and working with a fitness trainer in 2007 and 2010 when she signed agreements with Fitness Premiere and Gruver. Moreover, there is evidence that Plaintiff benefitted from the activity as she stated that she was happier and had more energy when she exercised.

Plaintiff's testified that she signed her Membership Agreement, and signed and read her Personal Training Agreement. She also testified that she understood the meaning of the word "waiver." *See Hipp v. Vernon L. Smith And Associates, Inc.*, 2011 Ark.App. 611 at 6, 2011 WL 4824296 (2011) (the general rule is that a person who signs a document is bound under the law to know the contents unless signature is procured by fraudulent representations of what a document contains). There is no evidence that either of the Defendants made any fraudulent representations concerning the contents of their contracts to Plaintiff.

The September 15, 2007 contract between Plaintiff and Fitness Premiere and the July 19, 2010 contract between Plaintiff and Defendant Gruver are valid contracts signed by Plaintiff which released each of these Defendants from liability.

***3** Plaintiff's contends that Fitness Premiere cannot benefit from the July 19, 2010 contract because its agent did not sign the contract, or alternatively because of Gruver's alleged status as an independent contractor. These arguments are without merit because regardless of whether Fitness Premiere's agent signed the July contract or regardless of whether Gruver is an employee or an independent contractor, the September 15, 2007 contract between Plaintiff and Fitness Premiere specifically releases Fitness Premiere from liability including liability associated with personal training services.

The Court has taken into account that the Plaintiff is a resident alien for whom English is a second language. However, Plaintiff has been living in the United States since 1999 and her testimony clearly reflects than she understands English and understood the consequences of her actions in signing these two contracts.

After considering all the facts and circumstances surrounding the execution of the release, the Court finds that these exculpatory agreements are valid and a complete defense to Plaintiff's claims for damages.

IT IS SO ORDERED.

All Citations

Not Reported in F.Supp.2d, 2012 WL 682733

End of Document

ERODING LIMITS POLICIES:

Explanation and Considerations for Claims Handling

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A) Eroding Limits Policies: Explanation and Considerations for Claims Handling

I. What are Eroding or Diminishing Limits Policies

Eroding limits policies represent a fundamental shift in the nature of insurance purchased. Your own Errors and Omissions policy may include such a clause. Insurers commonly refer to these as "Defense Within Limits" policies, however, more descriptive labels include: "cannibalizing limits," "wasting limits," "burning limits," "reducing limits," "Pac-man," "self-consuming" and "self- liquidating" policies. The policies gained popularity in the 1980s and remain in use and common today.

Specifically, in 1986, the Insurance Services Office (ISO) proposed comprehensive general liability policies be offered on a "claims made" basis and include a "diminishing limits" clause. Under this clause claims expenses, including attorney fees incurred in defending a claim or lawsuit, reduce the limits of the policy otherwise available for indemnifying the insured. Around that time, the author, in an article published by the American Bar Association's Tort and Insurance Practice Section (TIPS),1 wrote:

> Because every defense dollar spent brings the insured closer to having his aggregate reduced, that inured would seem to have a clear financial interest in the costs of defense. Given [case law's] clear concern with the competing financial interests of insurer and insured, an argument can be made that, by applying defense costs so as to reduce an insured's available policy limits, insurance companies will completely forfeit the right to control the defense of that insured. . .This possibility is something which insurers should study carefully before blindly accepting the ISO defense cost provisions as a panacea for their legal expense dilemma. Adopting such provisions may cost them more in the short and long term than does any lawyer under the current system.[1]

During this same time period, diminishing limits policies were already being utilized in professional liability policies. The effort to expand their use into the CGL arena has not been as successful or well received as was likely anticipated by ISO, yet they are still frequently utilized to limit exposures of insurers in professional liability and other niche markets.

The issues raised and the conflicts created between insurers and insureds in the eroding limits arena brings with it concerns that a court, at any time, could interpret these policies and issue a ruling that would dramatically alter the landscape for how such policies are enforced. If, for instance, it were determined diminishing limits policies are against public policy or create an inherent conflict of interest that cannot be waived, the potential consequences for insurers and for the attorneys retained by insurers to represent insureds would be far reaching and profound.

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[1] "Controlling the Defense: The Insurer's Hollow Crown" (1986). TIPS is now known as the Tort Trial and Insurance Practice Section

I. Eroding Limits Provisions & Public Policy

The "Hollow Crown" is not the only source to question whether policies with eroding limits create an inherent conflict of interest between insurer and insured and between insurer-retained defense counsel and insured. At least one commentator noted:

> There is an inherent conflict between the insured and the insurer in every case where payment of loss plus payment of defense costs could exceed the limits of liability, since every dollar spent on defense of the claim is a dollar that will not be available for settlement or satisfaction of judgment. This is no problem as long as the insured and insurer are fully agreed (and continue to agree) on the merits of settling versus defending including issues of timing and resources invested in the process.[2]

Courts have also addressed this same concern, some even going so far as to consider whether eroding limits policies might be against public policy altogether. The Supreme Court of Appeals of West Virginia considered the question. The decision was ultimately limited to policies issued pursuant to a statute specifically governing liability policies issued to municipalities.

In *Gibson v. Northfield Ins. Co.,* 219 W.Va. 40, 631 S.E.2d 598 (2005), the estate of someone killed by a city-owned vehicle brought a lawsuit against the insurer of the City after taking an assignment of the City's rights to coverage. The estate claimed that the insurance policy in question was void as against public policy to the extent that it held defense costs to be part of the limits of the policy. The court considered the provision in light of a governing statute and held it was contrary to the legislative intent. The court limited its ruling to policies of insurance issued to municipalities, stating:

> [O]n a more general note, we believe that the inclusion of a defense within limits provision in a governmental entity's insurance policy offends traditional notions of fairness. Governmental entities purchase liability insurance to protect their employees and to protect [public funds]. The quiet inclusion of a defense within limits provision into a governmental entity's liability policy subverts that intent by using the liability coverage to pay the insurance company's litigation expenses and attorney fees, rather than protecting the governmental entity and its employees and making injured third parties whole against their losses.

Despite the narrow scope of this particular decision, the court's analysis is not unique to municipal insureds and could easily be expanded to insureds under professional liability policies or even insureds generally.

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[2] Munro, Defense within Limits: The Conflicts of "Wasting" or "Cannibalizing" Insurance Policies, 62 Mont.L.Rev. 131, 148 (2001).

In *Illinois Union Insurance Co. v. North County Ob-Gyn Medical Group,* S.D. California, 2010 U.S. Dist. Lexis 50095, at *6 (S.D. Cal. May 18, 2010), the court held policy language attempting to reduce coverage limits by defense expenses could not be enforced because the insured could not have known that its policy limits would be eroded by defense costs. There are, however, many policy provisions reducing coverage limits that have been upheld by various courts.[3]

One of the most instructive decisions on this issue came in the federal district court in *NIC Ins. Co. v. PFP Consulting, LLC*, CIV.A. 09-0877, 2010 WL 4181767 (E.D. Pa. Oct. 22, 2010), which held that the determination of whether an eroding limits clause in an insurance policy is against public policy is a matter better addressed and resolved by the Pennsylvania state courts and not the federal courts. Attorneys and insurers alike should remain cautious when making general and overly broad pronouncements about the enforceability of eroding limits in policies of insurance. Indeed, it appears a state specific analysis of the issue is required when examining the enforceability of these policies from a public policy standpoint.

I. Reservation of Rights Letters

Insurers should exercise extreme caution when communicating with their Insureds about the terms, conditions and effects of an eroding limits policy. As a lawsuit proceeds and coverage dollars erode, the timing of the reservation of rights letter is critical. In *Lexington Ins. Co. v. Swanson*, 2007 WL 1585099 (W.D.Wash. 2007), an insured sought to invalidate the insurer's coverage defenses based, in part, on the claim the insurer's control of the defense under an eroding limits policy created a conflict of interest. The argument presented was that a conflict arose because, while the insured would likely wish to settle the claim in order to avoid the potential excess and personal exposure, the insurer's interest would be to defend the lawsuit in order to avoid liability entirely, without having to face any exposure beyond its policy limits, thereby paying the same amount whether or not the settlement offer was accepted but saving money if settlement were rejected and the case successfully defended.

The district court agreed with argument and issues a ruling in favor of the moving party based on the fact that the insurer had controlled the defense of the litigation for nearly two years before issuing a reservation of rights. In the eyes of the court, this raised a presumption that the insured was prejudiced. The insurer was therefore precluded from asserting contract defenses to coverage. The court did, however, note that this ruling applied to coverage defenses, not to the limits themselves. Consequently, the insurer was

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[3] See, e.g., Continental Ins. Co. v. Bangerter, 37 Cal. App. 4th 69 (Cal. App. 1995); California Dairies, Inc. v. RSUI Indemnity Co., 2010 U.S. Dist. Lexis 64049 (E.D. Cal., June 25, 2010) (Loss means damages, settlements, judgments, and defense expenses); Weber v. Indemnity Insurance Co. of North America, 345 F. Supp. 2d 1139 (D. Haw. 2004) (Defense expenses include the attorney's fees, legal costs, and expenses spent to defend the underlying suit).

barred from litigating its defenses to coverage, but could still rely on the policy's spend-down provision to dispute the applicable policy limit without a timely reservation of rights.

While the *Swanson* court was willing to enforce the policy's maximum limits as written, insurers face two essential roadblocks when litigating eroding limits clauses. First, they must combat the argument that the clause violates public policy, is ambiguous or otherwise unenforceable. Second, they must address the claim that the insurer, because of its conduct in the face of conflicts of interest created by the eroding nature of its policy, is or should be estopped from contesting coverage in any manner. In the face of these threats, a third possibility, rejected by *Swanson* but easily imagined, is because of the conflict of interest and the conduct of the insurer, the insurer will remain liable for defense fees and expenses in addition to indemnity limits. This is particularly foreseeable where an insured claims that it should be entitled to extra- contractual damages due to a failure to settle and/or an excess verdict.

I. Settlement Demands and Responses

Public policy leans heavily in favor of resolving cases through settlement. Courts routinely grant motions to approve settlement agreements in cases involving burning limits policies. Cases in which a settlement is threatened or an insured is confronted with personal exposure due to a refusal of an insurer to settle, present a significant incentive for a court to issue a broad ruling against the enforceability of eroding limits clauses generally. These cases would also severely restrict the control an eroding limits insurer may exercise in defending a lawsuit. Moreover, it is just these kinds of claims that make for tempting targets for extra-contractual claims and extra-contractual rulings. Thus, in a decision upholding the Depositors Economic Protection Corporation Act against an equal protection challenge, the Rhode Island Supreme Court noted the likely impact that "defense within limits" policies would have in the absence of settlement given the alternative would allow the policies to deplete by payment of attorney's fees and litigation expenses, thereby leaving no limits left to satisfy a judgment. *Rhode Island Depositors Economic Protection Corp. v. Brown*, 659 A.2d 95 (1995).

A similar decision was reached in a case approving the settlement of a class action alleging fraud, where the court expressly considered the fact that the applicable insurance policy was "self-consuming" and, therefore, defense costs and expenses would continue to reduce the amount of coverage available to satisfy any judgment. *Scholes v. Stone, McGuire & Benjamin*, 839 F. Supp. 1314 (N.D. Ill. 1993). These issues are legitimately seen as real and not merely vague and horrible hypotheticals. Courts recognize that, when an insurer believes that a claim has little merit, it may wish to defend the claim through trial and, in doing so, the insured's coverage limits will be completely or significantly eroded. The courts further recognize that, in contrast, the insured will want its insurer to make a substantial and early offer to a claimant in order to obtain a dismissal and protected them from an uninsured excess verdict liability.

In *Biomass One, L.P. v. Imperial Casualty & Indemnity Co*., 968 F.2d 1220 (9th Cir.

1992), an insurer paid $1.9 million in legal fees and costs defending a professional liability claim under a $2 million policy. In that case the court found the policy language of an eroding limits policy to be ambiguous and therefore the legal fees did not erode the available indemnity limits. The decision, however, would not appear to be a significant threat to well-written eroding limits policies. As the *Biomass One* court noted, the policy in question did not contain any single and unambiguous statement that the limits of coverage were subject to defense fees and expenses. The lesson of the decision is that any eroding limits policy must be carefully and precisely drafted to avoid any potential for ambiguity upon review.

IV. Defense Counsel Considerations

All defense lawyers representing insureds will remember that they represent and owe a duty of utmost loyalty to that insured. Accordingly, there are a number of challenges that defense counsel face when presented with an eroding limits policy.

For instance, while defense counsel cannot get involved in a coverage dispute with the insurer they must nevertheless remain attentive to the existence and implications of an eroding limits policy on the defense of their client. An eroding limits policy puts the burden on defense counsel to make certain they communicate early and often with the insured regarding specifically the cost of defense and the impact on the available insurance limits. These issues are readily apparent in cases involving policies where the insured has the right to consent to any settlement. Early and thorough communication should include developing a budget and comprehensive case evaluation at the onset.

Discovery disclosure issues also present unique challenges for defense counsel in the eroding policy limits arena. For example, when preparing answers to interrogatories and initial case disclosures pertaining to applicable insurance, defense counsel must determine how to handle disclosure of available insurance and the potential impact such a disclosure could have on the posturing of the defense.

Furthermore, defense counsel should be aware that governing rules of professional responsibility might require them to continue representing an insured even after the exhaustion of liability insurance limits. In most states, when an attorney seeks to terminate the representation of a client in litigation, that attorney may only do so after taking reasonable steps to avoid foreseeable prejudice to the client. Further, an attorney, after having appeared for a client in court, may only withdraw from such representation in compliance with the applicable rules of that particular court. These ethical obligations apply regardless of who was paying for the defense prior to exhaustion of the policy limits. As such, when the insurance company retaining the defense counsel claims that its policy limits have been exhausted under an eroding limits provision and stops paying for the insured's defense, the defense counsel may find themselves unwittingly providing pro bono services to the insured.

Defense counsel must also consider the inherent conflict of interest that could be found between the attorney and the insured when it comes to the financial self-interest of the

attorney. Specifically, an attorney may desire to be paid as much as possible for representation of the insured, while the insured will likely desire maximum insurance protection at all times. Not disclosing this potential conflict and discussing it with the insured from the outset of a claim can put defense counsel at risk.

IV. Issues for the Insurer

Insurers issuing eroding limits policies should be careful to make sure their insured are fully appraised of the existence of such provisions and their effect. Identifying the risk as a potential conflict of interest is likely the clearest way to avoid a problem later on. It is important to remember that the duty of the insurer to address this issue is separate and distinct from the obligation of the attorney and therefore the insurer cannot depend on the attorney to explain this potential conflict.
In addition, insurers should communicate with the insured regarding the potential for an excess verdict and the impact that will have on the insured. Because every defense dollar diminishes the insured's protection, the insurer issuing eroding limits policies should make certain that a system is in place both to control litigation costs and the costs incurred by attorneys representing their insureds. Such policies further emphasize the need to keep the insured current on up to date defense costs and the amount of remaining coverage.

A) Consent-to- Settlement Clauses

I. What is the Purpose of a Consent-to- Settlement Clause

A consent- to- settlement clause is a provision found in many professional liability and E&O insurance policies that require an insurer to seek an insured's approval prior to settling a claim. Consent- to- settlement clauses stem from a recognition of the potential harm to the insured professional's reputation in the event of a settlement payment. Professionals may be required to disclose settled claims to professional licensing boards or data banks. Medical Malpractice insurers, hospitals and self- insured health care providers for example must report medical malpractice claim settlements to the National Practitioner Data Bank (NPDB) in accordance with Title IV and Section 60.7(d) of the NPDB regulations.

Consent to settlement clauses have generally been

While some professional liability policies contain consent-to-settle provisions carrying no repercussions for the insured in the event settlement consent is withheld, many policies contain variations of a "hammer clause" with significant impact to the insured.

II. Examples of Consent-to- Settlement Clauses

A traditional consent provision may read as follows: "[Insurer] will not settle any claim without your written consent, which shall not be unreasonably withheld." A "full

hammer" clause however may provide that in the event the insured refuses to consent to a settlement endorsed by the insurer, the insurer's liability for the cost of defense and indemnity is capped at the amount of the endorsed settlement. The insured is then responsible for any attorney's fees and judgment in excess of the endorsed settlement amount. A typical "full hammer" provision may read as follows:

> "[Insurer] shall … not settle any claim without the written consent of the named insured, which consent shall not be unreasonably withheld. If, however, the named insured refuses to consent to a settlement recommended by the [Insurer] and elects to contest the claim or continue legal proceedings in connection with such claim, the [Insurer's] liability for the claim shall not exceed the amount for which the claim could have been settled, including claims expenses up to the date of such refusal, or the applicable limits of liability, whichever is less."

Similarly, certain policies may contain a modified-hammer provision, which operates similar to the classic hammer provision, yet the insured is liable only for a percentage of any judgment in excess of the endorsed settlement.

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