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## Subprime and Credit Crisis Investigations: What Constitutes a Claim for the Purposes of Professional Liability Insurance

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## THE FILED RATE DOCTRINE AND THE INSURANCE ARENA

VONDA MALLICOAT LAUGHLIN\*

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*The article discusses the modern application and jurisprudential background of the “filed rate doctrine.” The filed rate doctrine is used by courts to uphold the validity of rates approved by regulatory agencies and as a bar to claims implicating those rates. The doctrine has enduring relevance to the field of insurance litigation and overrides certain common legal principles. The article focuses on the broad applicability of the doctrine and gives a comprehensive overview of the myriad issues impacting its usage.*

*The article discusses early cases establishing the doctrine decided earlier than the United Supreme Court’s decision in *Keogh v. Chicago & Northwestern Railway Co.*, which is often referenced in connection with the doctrine’s origination. Based on grounds of legislative intent and the perceived unfairness of allowing certain plaintiffs to escape from a legislative scheme applicable to others, the article shows how the doctrine emerged from judicial deference to federal railroad rate regulations enacted by the Interstate Commerce Commission. The filed rate doctrine was later expanded to other federally regulated industries including energy and telecommunications.*

*The applicability of the filed rate doctrine to litigation impacting the insurance industry emerged in the mid-1980s. The article highlights a number of recent cases showing how various courts have applied the doctrine to the insurance industry and how various litigants have attempted to avoid the application of it.*

*The article delves into a number of issues regarding the filed rate doctrine that are specific to the insurance industry and conflicting authority regarding application of the doctrine in the insurance arena. The*

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*article also discusses the various ways the filed rate doctrine has been applied to claims for equitable relief. The article discusses the inapplicability of the filed rate doctrine to various claims, including claims that an insurer violated insurance regulations. The article also examines other typical claims including fraud, charges outside of the basic rate, antitrust claims, discrimination claims, Racketeer Influenced and Corrupt Organizations Act claims, breach of contract claims, and claims alleging the wrongful receipt of kickbacks. The article further discusses the issue of administrative review.*

*The article concludes by considering the future of the filed rate doctrine and predicts its future importance to insurance litigation.*

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The filed rate doctrine upholds the validity of rates approved by a regulatory authority and is often applied to bar claims implicating authorized rates. The breadth of the doctrine is in hot dispute, and insurance cases address it with increasing frequency.<sup>1</sup> Cases interpreting the filed rate doctrine confront questions such as the following:

- An insurer refuses to honor a promise to charge a policyholder a lower rate than the filed rate charged to other policyholders. Will a court enforce the promise?
- An insurer promises a policyholder additional services without an increase in the filed rate? Is that promise enforceable?
- Will a state court consider the filed rate doctrine, or is it just a federal issue? Is the McCarran-Ferguson Act<sup>2</sup>

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<sup>1</sup> See, e.g., Saunders v. Farmers Ins. Exch., 440 F.3d 940, 943-46 (8th Cir. 2006); Arroyo-Melecio v. P.R. Am. Ins. Co., 398 F.3d 56, 73 (1st Cir. 2005); Allen v. State Farm Fire & Cas. Co., 59 F. Supp. 2d 1217, 1227-30 (S.D. Ala. 1999); Schilke v. Wachovia Mortg., No. 09-CV-1363, 2011 WL 4501381, at \*8 (N.D. Ill. Sept. 28, 2011); Rios v. State Farm Fire & Cas. Co., 469 F. Supp. 2d 727, 734-40 (S.D. Iowa 2007); Schermer v. State Farm Fire & Cas. Co., 721 N.W.2d 307 (Minn. 2006). Compare MacKay v. Superior Court, 115 Cal. Rptr. 3d 893, 910 (Cal. Ct. App. 2010) (approving application of the doctrine to property and casualty insurance), with Fogel v. Farmers Grp., Inc., 74 Cal. Rptr. 3d 61, 74 (Cal. Ct. App. 2008) (rejecting the doctrine's application to property and casualty insurance). See also Alexander v. Wash. Mut. Inc., No. 07-4425, 2008 WL 2600323, at \*2-3 (E.D. Pa. June 30, 2008).

<sup>2</sup> 15 U.S.C. §§ 1011-15 (2006).

a consideration in relation to the doctrine?

- Can injunctive relief regulating future rate charges be obtained against an insurer?
- Will the doctrine be applied to bar enforcement actions by the government?
- Can an insurer take advantage of the filed rate doctrine if the regulatory agency is merely a “rubber stamp” performing an inadequate review of rates?
- An insurer wrongfully classifies an insured and charges an excessive premium. Is the policyholder entitled to a refund?
- Do policyholders have the right to sue for damages if an insurer defrauds a state regulatory agency in order to obtain favorable rates?
- What if the regulatory agency itself is involved in accepting bribes from an insurer pertaining to rates? Can policyholders go to court, obtain damages from the insurer, and have those rates rescinded?
- What if administrative charges are added in addition to a filed rate? Can policyholders use the filed rate doctrine to avoid such charges?
- What if insurers engage in wrongful price fixing? Will a court order refunds of illegally charged premiums?
- Will a court order a refund of excessive premiums wrongfully charged to a policyholder who is discriminated against on an illegal basis such as race?
- What about entities other than insurers? Does the doctrine, for example, affect suits against mortgage lenders who illegally accept kickbacks from property insurers?

Understanding the implications of the filed rate doctrine, which is also occasionally referenced as the filed tariff doctrine<sup>3</sup> or the *Keogh* doctrine,<sup>4</sup> is of crucial importance to attorneys confronted with issues such

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<sup>3</sup> *McCray v. Fid. Nat'l Title Ins. Co.*, 636 F. Supp. 2d 322, 326 (D. Del. 2009).

<sup>4</sup> The Supreme Court first applied the filed rate doctrine to the antitrust area in *Keogh v. Chicago & Northwestern Railway Co.*, 260 U.S. 156 (1922), and some cases refer to the doctrine by that name. *E.g.*, *Blaylock v. First Am. Title Ins. Co.*, 504 F. Supp. 2d 1091, 1099 n.6 (W.D. Wash. 2007); *Amundson & Assoc's. Art*

as those set forth above. The doctrine alters the application of many commonly accepted legal principles and must be considered in devising litigation strategy in any case implicating an insurer's approved rating structure. Establishing that the filed rate doctrine is not an antiquated relic living only to a limited extent as some contend,<sup>5</sup> this article discusses the background of the filed rate doctrine, case law interpreting it, and its modern application in the insurance arena.

Although separation of powers, comity, and legislative intent have all been referenced in support of the filed rate doctrine,<sup>6</sup> it is most often expressed as serving two interests: (1) the prevention of price discrimination that is threatened by a judicial determination of rates for litigants but not for other policyholders and (2) the preservation of the role of agencies in setting rates, often referred to as the "nonjusticiability" strand of the doctrine.<sup>7</sup> While judicial interest in fairness and nondiscrimination in relation to the application of rates is self-evident,<sup>8</sup> the "nonjusticiability" strand of the doctrine is conceptually more challenging. *Black's Law Dictionary* defines the term "justiciability" as "[t]he quality or state of being appropriate or suitable for adjudication by a court."<sup>9</sup> In accord with that definition, courts typically reference the concept in connection with avoiding the enmeshment of courts in the rate-making process.<sup>10</sup> For example, according to the Minnesota Supreme Court in *Schermer v. State Farm Fire & Casualty Company*, justiciability concerns establish that a court is not well-suited to retroactively reallocate rates and

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Studio, Ltd. v. Nat'l Council on Comp. Ins., Inc., 988 P.2d 1208 (Kan. Ct. App. 1999).

<sup>5</sup> See, e.g., Amundson, 988 P.2d 1208 at 1213-16 (disagreeing with the position that the doctrine is weak and discredited); Richardson v. Standard Guar. Ins. Co., 853 A.2d 955, 963 (N.J. Super. Ct. App. Div. 2004) (disagreeing with the contention that the filed rate doctrine is a bankrupt theory inapplicable to the insurance industry).

<sup>6</sup> *Schermer*, 721 N.W.2d at 307-08.

<sup>7</sup> *Wegoland Ltd. v. NYNEX Corp.*, 27 F.3d 17, 19 (2d Cir. 1994); *Schilke v. Wachovia Mortg.*, 705 F. Supp. 2d 932, 942-43 (N.D. Ill. 2010), *rev'd on other grounds*, 758 F. Supp. 2d 542 (N.D. Ill. 2010); *Morales v. Attorneys' Title Ins. Fund, Inc.*, 983 F. Supp. 1418, 1428 (S.D. Fla. 1997).

<sup>8</sup> In *Maislin Industries, U.S., Inc. v. Primary Steel, Inc.*, 493 U.S. 116 (1990), the U.S. Supreme Court, for example, emphasized the nondiscriminatory strand of the doctrine, rejecting the application of rates obtained by secret negotiation and requiring the application of rates duly published and known to all. *Id.* at 130-31.

<sup>9</sup> BLACK'S LAW DICTIONARY 943 (9th ed. 2009).

<sup>10</sup> E.g., *Wegoland Ltd.*, 27 F.3d at 19; *Clark v. Prudential Ins. Co. of Am.*, 736 F. Supp. 2d 902, 913 (D.N.J. 2010).



determine what rate an agency would find appropriate in place of an unlawful rate.<sup>11</sup> According to the court in *Schermer*, rate regulation is an “intricate ongoing process,” and judicial interference “may set in motion an ever-widening set of consequences and adjustments” that courts are powerless to address.<sup>12</sup> Similarly, relying on Supreme Court precedent and emphasizing the difficulty the judiciary would encounter in attempting to determine what reasonable rates in the past should have been, the court in *Wegoland Ltd. v. NYNEX Corp.* stated that “abstract” notions of reasonableness are best left for agency determination.<sup>13</sup>

The concept of nonjusticiability also encompasses the idea that filed rates are available to those affected by them, and that consumers are charged with knowledge of those rates. For example, in discussing the principle of nonjusticiability, the court in *Richardson v. Standard Guarantee Insurance Co.* stated that the principle “operates on the presumption that the plaintiff had knowledge of the filed rates and, thus, could not reasonably rely upon the regulated entity's misrepresentations or omissions of material facts.”<sup>14</sup>

## I. THE GENESIS OF THE FILED RATE DOCTRINE

Many authorities trace the origination of the filed rate doctrine to the United States Supreme Court decision of *Keogh v. Chicago & Northwestern Railway Co.*, in which the Supreme Court upheld rates duly filed and approved by the now abolished Interstate Commerce Commission (the “ICC”)<sup>15</sup> against challenges under antitrust laws.<sup>16</sup> Case law prior to

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<sup>11</sup> *Schermer*, 721 N.W.2d at 311-12, (citing *Keogh v. Chi. & Nw. Ry.*, 260 U.S. 156, 164-65 (1922)).

<sup>12</sup> *Id.* at 315 (quoting *Peoples Natural Gas Co. v. Minn. Pub. Utils. Comm'n*, 369 N.W.2d 530, 535 (Minn. 1985)).

<sup>13</sup> *Wegoland Ltd.*, 27 F.3d at 19 (quoting *Mont.-Dakota Utils. Co. v. Nw. Pub. Serv. Co.*, 341 U.S. 246, 251 (1951)).

<sup>14</sup> *Richardson v. Standard Guar. Ins. Co.*, 853 A.2d 955, 962 (N.J. Super. Ct. App. Div. 2004) (citing *Weinberg v. Sprint Corp.*, 801 A.2d 281, 287-88 (N.J. 2002)).

<sup>15</sup> The Interstate Commerce Commission Termination Act of 1995, Pub. L. No. 104-88, 109 Stat. 803 (1995) (codified in scattered sections of 49 U.S.C.), abolished the ICC and created the Surface Transportation Board to perform many of the regulatory functions formerly performed by the ICC. See *Friberg v. Kansas City S. Ry. Co.*, 267 F.3d 439, 442 (5th Cir. 2001).

<sup>16</sup> *E.g.*, *Knevelbaard Dairies v. Kraft Foods, Inc.*, 232 F.3d 979, 992 (9th Cir. 2000); *In re N.J. Title Ins. Litig.*, No. 08-1425, 2009 WL 3233529, at \*2 (D.N.J.

*Keogh*, however, establishes that the doctrine had its genesis in much earlier cases addressing the role of the ICC following its creation by the Interstate Commerce Act of 1887, also referred to as the Act to Regulate Commerce.<sup>17</sup> For example, the Eleventh Circuit in *Taffet v. Southern Co.*<sup>18</sup> and the federal district court in *McCray v. Fidelity National Title Insurance Co.*<sup>19</sup> trace the doctrine back as far as the 1907 Supreme Court case of *Texas & Pacific Railway Co. v. Abilene Cotton Oil Co.*,<sup>20</sup> in which the rating system of the railway involved was challenged as being preferential, unjust, and unreasonable.<sup>21</sup> The railway in *Texas & Pacific Railway Co.* defended on the basis that the rates at issue had been approved by the ICC. In ruling in favor of the railway, although not referencing the filed rate doctrine by name, the Court applied its underlying principles noting the chaotic effect that would result if both the judiciary and the ICC were allowed to address rate disputes.<sup>22</sup>

The U.S. Supreme Court in *Arkansas Louisiana Gas Co. v. Hall*,<sup>23</sup> further referenced the 1913 case *Pennsylvania Railroad Co. v. International Coal Co.*,<sup>24</sup> as an early filed-rate case. The coal company in *Pennsylvania Railroad* sued the defending railway complaining that it wrongfully denied the coal company certain rebates granted to other shippers. The Supreme Court agreed that the railroad was bound by the filed rate and illegally deviated from it by granting rebates to some.<sup>25</sup> Nevertheless, the plaintiff was unable to adduce proof of damages based on the rate differential because, as the Court reasoned, the plaintiff “[h]aving paid only the lawful rate . . . was not overcharged, though the favored

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Oct. 5, 2009); *Munoz v. PHH Corp.*, 659 F. Supp. 2d 1094, 1099 (E.D. Cal. 2009); *In re Se. Milk Antitrust Litig.*, No. 2:08-MD-1000, MDL 1899, 2008 WL 2368212, at \*3-4 (E.D. Tenn. June 06, 2008); *Schermer*, 721 N.W.2d at 311.

<sup>17</sup> Interstate Commerce Act of Feb. 4, 1887, Ch. 104, 24 Stat. 379 (codified as amended in scattered sections of 49 U.S.C.). See Kevin M. Decker, *The Filed-Rate Doctrine: Leaving Regulation to the Regulators*, 34 WM. MITCHELL L. REV. 1351, 1353-56 (2008) (referencing cases predating *Keogh* involving the filed rate doctrine).

<sup>18</sup> *Taffet v. S. Co.*, 967 F.2d 1483, 1488 (11th Cir. 1992).

<sup>19</sup> *McCray v. Fid. Nat'l Title Ins. Co.*, 636 F. Supp. 2d 322, 326 (D. Del. 2009).

<sup>20</sup> *Tex. & Pac. Ry. Co. v. Abilene Cotton Oil Co.*, 204 U.S. 426, 436 (1907).

<sup>21</sup> *Id.* at 430.

<sup>22</sup> *Id.* at 441.

<sup>23</sup> *Ark. La. Gas Co. v. Hall*, 453 U.S. 571, 577 (1981).

<sup>24</sup> *Penn. R.R. Co. v. Int'l Mining Co.*, 230 U.S. 184 (1913).

<sup>25</sup> *Id.* at 197.

shipper was illegally undercharged.”<sup>26</sup>

Other early Supreme Court decisions, such as *Chicago & Alton Railroad Co. v. Kirby*,<sup>27</sup> further laid the groundwork for the modern filed rate doctrine.<sup>28</sup> *Kirby* demonstrates that the filed-rate doctrine may apply to complaints involving the provision of services, not just to the rates themselves.<sup>29</sup> *Kirby* involved a dispute between a shipper and a railroad arising after horses failed to arrive as scheduled by expedited delivery via a particular train. A railroad representative had promised the shipper a deviation from regularly published rates that did not provide for that expedited service. Even though upon contracting the shipper did not know of the deviation, the Supreme Court refused to enforce the agreement, stating that “[t]o guarantee a particular connection and transportation by a particular train was to give an advantage or preference not open to all, and not provided for in the published tariffs.”<sup>30</sup>

## II. THE CONTINUING VALIDITY OF THE *KEOGH* DECISION

Of course, not to be overlooked is the often cited *Keogh*<sup>31</sup> decision, which first applied the filed-rate doctrine in the context of antitrust.<sup>32</sup> The alleged antitrust violation in *Keogh* was that the defending railways had illegally agreed upon shipping rates for excelsior and tow.<sup>33</sup> The sole

<sup>26</sup> *Id.* at 202.

<sup>27</sup> *Chi. & Alton R.R. Co. v. Kirby*, 225 U.S. 155 (1912).

<sup>28</sup> The U.S. Supreme Court also referenced *Louisville & Nashville Railroad Co. v. Maxwell*, 237 U.S. 94 (1915) as an early case applying the principles later to become known as the “filed rate doctrine.” See *Am. Tel. & Tel. Co. v. Cent. Office Tel., Inc.*, 524 U.S. 214, 222 (1998); *Ark. La. Gas Co.*, 453 U.S. at 582 (1981). The term “doctrine” was first used in conjunction with principles construing the effect of filed rates in *George N. Pierce Co. v. Wells Fargo & Co.*, 236 U.S. 278, 286 (1915).

<sup>29</sup> See *Kirby*, 225 U.S. at 166; see also *Am. Tel. & Tel. Co.*, 524 U.S. at 223 (“Any claim for excessive rates can be couched as a claim for inadequate services and vice versa.”).

<sup>30</sup> *Kirby*, 225 U.S. at 166.

<sup>31</sup> *Keogh v. Chicago & Nw. Ry.*, 260 U.S. 156 (1922).

<sup>32</sup> See *Prentice v. Title Ins. Co. of Minn.*, 500 N.W.2d 658, 661 (Wis. 1993) (recognizing that *Keogh* first applied the filed rate doctrine in the antitrust context).

<sup>33</sup> *Keogh*, 260 U.S. at 160. In the context of this case, “excelsior” is used to mean a “fine curled wood shavings, used esp. for packing fragile items”. MERRIAM WEBSTER’S COLLEGIATE DICTIONARY 403 (Merriam Webster’s, Inc., 10th ed. 1994). “Tow” is used in this context to mean a “short or broken fiber...that is used esp. for yarn, twine, or stuffing.” *Id.* at 1248.

defense was that the rates had been filed with and approved by the Interstate Commerce Commission.<sup>34</sup> The Supreme Court acknowledged that the fact that the rates had been filed would not bar proceedings brought by the federal government against the carriers.<sup>35</sup> Expressing its concern as follows, the Court, however, refused to allow the plaintiff to proceed with an antitrust action for price fixing because allowing such actions would result in unfairness and discrimination:

If a shipper could recover under section 7 of the Antitrust Act for damages resulting from the exaction of a rate higher than that which would otherwise have prevailed, the amount recovered might, like a rebate, operate to give him a preference over his trade competitors. It is no answer to say that each of these might bring a similar action under section 7. Uniform treatment would not result, even if all sued, unless the highly improbable happened, and the several juries and courts gave to each the same measure of relief.<sup>36</sup>

Another factor influencing the Court involved the responsibility of the ICC to address rates in the first instance. The Court rejected as unworkable the suggestion that it suspend proceedings pending a later determination of the discrimination issue by the ICC:

The powers conferred upon the Commission are broad. It may investigate and decide whether a rate has been, whether it is, or whether it would be, discriminatory. But by no conceivable proceeding could the question whether a hypothetical lower rate would under conceivable conditions have been discriminatory, be submitted to the Commission for determination. And that hypothetical question is one with which plaintiff would necessarily be confronted at a trial.<sup>37</sup>

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<sup>34</sup> *Keogh*, 260 U.S. at 160.

<sup>35</sup> *Id.* at 162.

<sup>36</sup> *Id.* at 163.

<sup>37</sup> *Id.* at 164.

The final factor addressed by the *Keogh* Court was the likely impossibility of computing damages with any amount of accuracy.<sup>38</sup> Since the carriers were charging the legal rate, damages could not flow from the amount the charges exceeded the legal rate.<sup>39</sup> Additionally, had charges been lowered, all competitors would have been entitled to have been put on a parity with *Keogh* rendering speculative whether *Keogh*'s business would have benefited at all by the lowering of rates.<sup>40</sup>

Over the years, acceptance of the *Keogh* decision diminished.<sup>41</sup> Following the Second Circuit's criticism of the filed-rate doctrine in *Square D Co. v. Niagara Frontier Tariff*,<sup>42</sup> an opinion authored by Judge Henry J. Friendly, the Supreme Court granted *certiorari* in order to address the doctrine's continuing validity.<sup>43</sup> The petitioners in *Square D* claimed that the defending motor carriers and a rating bureau engaged in illegal price fixing and other activities in violation of section one of the Sherman Act.<sup>44</sup> The Supreme Court addressed the argument that developments in the law undermined *Keogh*, including the rise of class actions, which arguably relieved some concern regarding unfair rebates; the emergence of support for treble damages; greater sophistication in evaluating damages; and the development of procedures to stay judicial proceedings pending regulatory action.<sup>45</sup> Nevertheless, the Court refused to overrule *Keogh* finding pertinent Congress' failure to disturb the principles set forth in *Keogh* during the intervening sixty-five years.<sup>46</sup> The Court relied heavily upon the fact that while Congress was clearly aware of the *Keogh* rule when it passed the Reed-Bulwinkle Act,<sup>47</sup> addressing rating systems of rail carriers, and enacted the Motor Carrier Act of 1980,<sup>48</sup> Congress did not overturn the

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<sup>38</sup> *Id.* at 164-65.

<sup>39</sup> *Id.* at 165.

<sup>40</sup> *Keogh*, 260 U.S. at 165.

<sup>41</sup> See generally *McCray v. Fid. Nat'l Title Ins. Co.*, 636 F. Supp. 2d 322, 326-27 (D. Del. 2009) (discussing the history of the doctrine and questions regarding its continued validity).

<sup>42</sup> *Square D Co. v. Niagara Frontier Tariff Bureau, Inc.*, 760 F.2d 1347, 1352-54 (2d Cir. 1985), *aff'd*, 476 U.S. 409 (1986).

<sup>43</sup> *Square D Co.*, 476 U.S. at 417.

<sup>44</sup> 15 U.S.C. § 1 (1994) (current version at 15 U.S.C. § 1 (2006)).

<sup>45</sup> *Square D Co.*, 476 U.S. at 423.

<sup>46</sup> *Id.*

<sup>47</sup> Reed-Bulwinkle Act, Pub. L. No. 80-662, 62 Stat. 472 (1948) (codified as amended at 49 U.S.C. § 10706 (2006)).

<sup>48</sup> Motor Carrier Act of 1980, Pub. L. No. 96-296, 94 Stat. 793 (codified as amended in scattered sections of 49 U.S.C.).

principles set forth in *Keogh*.<sup>49</sup> According to the Supreme Court, “[i]f there is to be an overruling of the *Keogh* rule, it must come from Congress, rather than from this Court.”<sup>50</sup>

### III. EXTENSION OF THE FILED RATE DOCTRINE TO THE ENERGY AND TELECOMMUNICATIONS INDUSTRIES

The principles underlying the filed rate doctrine, first spawned in disputes involving the ICC, were well established in other utilities prior to general recognition in the insurance industry. Courts addressing the role of the filed rate doctrine in insurance disputes often glean guiding principles from decisions involving other regulated industries.

The Supreme Court first applied the filed rate doctrine to the electrical industry in *Montana-Dakota Utilities Co. v. Northwestern Public Service Co.*,<sup>51</sup> a case in which the plaintiff alleged that the defendant’s fraudulent acts led to the imposition of excessive rates in violation of the Federal Power Act.<sup>52</sup> Although the rates involved had been approved by the Federal Power Commission, the plaintiff claimed that through a system of an interlocking directorate and joint officers, its predecessor was overcharged by the defendant. Refusing to accept that position and upholding the authority of the Commission, the Supreme Court stated that the complainant could claim “no rate as a legal right that is other than the filed rate, whether fixed or merely accepted by the Commission, and not even a court can authorize commerce in the commodity on other terms.”<sup>53</sup>

In rejection of a gas supplier’s breach of contract claim, the filed rate doctrine was first applied by the Supreme Court in the natural gas arena in *Arkansas Louisiana Gas Co. v. Hall*.<sup>54</sup> The Supreme Court recognized that pursuant to the filed rate doctrine, the supplier was

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<sup>49</sup> *Square D Co.*, 476 U.S. at 418-20.

<sup>50</sup> *Id.* at 424.

<sup>51</sup> *Mont.-Dakota Utils. Co. v. Nw. Pub. Serv. Co.*, 341 U.S. 246 (1951).

<sup>52</sup> *Id.* at 250 n.6 (The plaintiff relied on a provision of the act requiring that rates be “just and reasonable.”).

<sup>53</sup> *Id.*

<sup>54</sup> *Ark. La. Gas Co. v. Hall*, 453 U.S. 571, 599 (1981). According to the Justice Steven’s dissent, although earlier cases had marked the contours of the doctrine, the case marked the first time the term “filed rate doctrine” had been used by the Supreme Court. *Id.* at 599 (Stevens, J., dissenting). No mention was made of the earlier case of *George N. Pierce Co. v. Wells Fargo & Co.*, 236 U.S. 278 (1915), cited in footnote 28, referencing “the doctrine of the conclusiveness of the filed rates.” *Id.* at 286.

forbidden to charge rates for its services other than those properly filed with the appropriate regulatory authority and that the judiciary lacked authority to impose a different rate.<sup>55</sup> According to the Court, “under the filed rate doctrine, when there is a conflict between the filed rate and the contract rate, the file rate controls.”<sup>56</sup>

In *American Telephone and Telegraph Co. v. Central Office Telephone, Inc.*, a case often cited in disputes involving insurance, the Supreme Court applied the filed rate doctrine in the telecommunications context.<sup>57</sup> The case originated when Central Office Telephone, Inc. (“COT”), sued American Telephone and Telegraph Co. (“AT&T”) for breach of contract and tortious interference with contract following problems encountered with AT&T’s provision of communication services for resale. Among the allegations were that AT&T failed to deliver various promised services and billing options in addition to those set forth in its filed rates.<sup>58</sup> AT&T defended on the basis that it was required by the Communications Act to file tariffs containing all charges and classifications and that COT’s lawsuit seeking damages based upon unfiled criteria was barred by the filed rate doctrine.<sup>59</sup> Recognizing the importance of preventing unreasonable and discriminatory charges, the Supreme Court applied the filed rate doctrine and dismissed the claims.<sup>60</sup> The Court recognized that discrimination may exist in the form of a lower price for a service offered to some but not all, or in the form of enhanced services at a price not offered to all.<sup>61</sup> Supporting its decision, the Court cited cases arising under the Interstate Commerce Act, including *Chicago & Alton Railroad Co. v. Kirby*,<sup>62</sup> referenced above, in which the Court refused to enforce a shipper’s contract promising a service not contained in the railroad’s filed tariffs.

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<sup>55</sup> *Ark. La. Gas Co.*, 453 U.S. at 577-78 (majority opinion).

<sup>56</sup> *Id.* at 582.

<sup>57</sup> *Am. Tel. & Tel. Co. v. Cent. Office Tel. Inc.*, 524 U.S. 214 (1998). This case is often cited in disputes involving insurance. *See, e.g., In re Title Ins. Antitrust Cases*, 702 F. Supp. 2d 840 (N.D. Ohio 2010); *Rios v. State Farm Fire and Cas. Co.*, 469 F. Supp. 2d 727, 735 (S.D. Iowa 2007); *Lumpkin v. Farmers Grp., Inc.*, No. 05-2868 MA/V, 2007 WL 6996584 (W.D. Tenn. Apr 26, 2007); *Allen v. State Farm Fire & Cas. Co.*, 59 F. Supp. 2d 1217 (S.D. Ala. 1999).

<sup>58</sup> *Am. Tel. & Tel. Co.*, 524 U.S. at 220.

<sup>59</sup> *Id.* at 221.

<sup>60</sup> *Id.* at 223.

<sup>61</sup> *Id.*

<sup>62</sup> *Id.* at 224 (citing *Chi. & Alton R.R. Co. v. Kirby*, 225 U.S. 155, 163, 165 (1912)).

## IV. EXTENSION OF THE FILED RATE DOCTRINE TO THE INSURANCE INDUSTRY

The first insurance cases addressing the application of the filed rate doctrine occurred in the latter 1980's and 1990's, with the majority decided within the last decade. This seems rather late in view of the fact that the doctrine had been applied for many years in other regulated areas. The 1986 decision of the Supreme Court in *Square D Co. v. Niagara Frontier Tariff*,<sup>63</sup> reaffirming the validity of the doctrine, may have resulted in increased attention to its applicability.

Although not referencing the term "filed rate doctrine," the 1986 decision of *Anzinger v. Illinois State Medical Inter-Insurance Exchange*,<sup>64</sup> was one of the first cases to apply the concepts underlying the filed rate doctrine in the context of insurance. The plaintiff physicians in *Anzinger* sought a refund of malpractice premiums collected pursuant to a rate schedule approved by the Illinois Director of Insurance but found to be excessive and unfairly discriminatory upon later judicial review.<sup>65</sup> The court refused to order a refund of the premiums believing that recognition of a private right of action would interfere with authority granted to the state's department of insurance.<sup>66</sup> The court recognized as follows that the filed rates were the only rates that could be charged at the time the premiums were paid:

[W]hen the agency or body sets the rates, these then are the only lawful rates that can be charged and remain such until overturned or set aside by a court . . . [T]here is no basis

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<sup>63</sup> *Square D Co. v. Niagara Frontier Tariff Bureau*, 476 U.S. 409, 424 (1986).

<sup>64</sup> *Anzinger v. Ill. State Med. Inter-Ins. Exch.*, 494 N.E.2d 655, 657 (Ill. App. 1986). Interestingly, the decision in *Anzinger* was issued on May 27, 1986, the same day as the decision in *Square D Co. v. Niagara Frontier Tariff*. See also *Prentice v. Title Ins. Co. of Minn.*, 500 N.W.2d 658, 663 (Wis. 1993) (applying the doctrine to state antitrust claims against insurers); *In re Empire Blue Cross & Blue Shield Customer Litig. v. Weissman*, 622 N.Y.S.2d 843 (N.Y. Sup. Ct. 1994), *aff'd sub nom. Minihane v. Weissman*, 226 A.D.2d 152 (N.Y. 1996) (applying the doctrine to bar claims of fraud and breach of contract); *Calico Trailer Mfg. Co. v. Ins. Co. of N. Am.*, No. LR-C-93-717, 1994 WL 823554, at \*3 (E.D. Ark. Oct. 12, 1994) (applying the doctrine to bar allegations of antitrust violations and other state law claims). Courts in these insurance cases relied heavily on cases from other industries approving application of the doctrine.

<sup>65</sup> *Anzinger*, 494 N.E.2d at 656.

<sup>66</sup> *Id.* at 658.



for a refund under such circumstances if a rate was subsequently set aside because the government agency had determined that the initial rate was reasonable and that only this rate could be charged.<sup>67</sup>

In attempting to avoid the effects of the filed rate doctrine, plaintiffs may attempt to distinguish the insurance industry from other regulated industries. For example, the plaintiff in *Horwitz ex rel. Gilbert v. Bankers Life and Casualty Co.* argued against extending the filed rate doctrine to insurance disputes claiming that it was only appropriate in areas involving highly regulated and monopolistic activities, namely the shipping and power industries.<sup>68</sup> Recognizing, however, the lack of authority supporting the plaintiff's position, the court proceeded to apply the doctrine.<sup>69</sup> Similarly, in rejecting the plaintiff's position that the filed rate doctrine should be applied only to areas traditionally thought of as utilities, the federal district court in *Korte v. Allstate Insurance Co.* stated that the doctrine was "equally applicable to the insurance industry as to other industries where a state agency determines reasonable rates pursuant to a statutory scheme."<sup>70</sup>

In applying the doctrine to a controversy involving homeowner's insurance, the court in *Rios v. State Farm Fire and Casualty Co.* noted that while the doctrine's roots lie in cases decided under the Interstate Commerce Act, it has spread "across the spectrum of regulated utilities."<sup>71</sup> The following factors were referenced by the court as pertinent in determining the filed rate doctrine's application to a new area:

(1) the impact the court's decision will have on agency procedures and rate determinations; (2) whether there is an administrative agency to review the claim and provide a remedy; (3) whether there is meaningful review of rate increases; and (4) whether the damages are based upon the difference between the filed rate and the rate that would have been charged absent some alleged wrongdoing.<sup>72</sup>

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<sup>67</sup> *Id.* at 657.

<sup>68</sup> *Horwitz v. Bankers Life & Cas. Co.*, 745 N.E.2d 591, 601 (Ill. App. 2001).

<sup>69</sup> *Id.* at 604.

<sup>70</sup> *Korte v. Allstate Ins. Co.*, 48 F. Supp. 2d 647, 651 (E.D. Tex. 1999).

<sup>71</sup> *Rios v. State Farm Fire & Cas. Co.*, 469 F. Supp. 2d 727, 734 (S.D. Iowa 2007) (quoting *Ark. La. Gas Co. v. Hall*, 453 U.S. 571, 577 (1981)).

<sup>72</sup> *Rios*, 469 F. Supp. 2d at 736 (citing Allan Kanner, *The Filed Rate Doctrine and Insurance Fraud Litigation*, 76 N.D. L. REV. 1, 3 (2000)).

In ruling that the doctrine should be applied in the insurance industry, the South Carolina Supreme Court in *Edge v. State Farm Mutual Automobile Insurance Co.*, further discussed rationale supporting the doctrine as follows:

Courts which have adopted the filed rate doctrine have given several reasons for doing so, including: (1) preserving the agency's authority to determine the reasonableness of rates; (2) recognizing the agency's expertise with regard to that industry, whereas courts do not; (3) allowing an action would undermine the regulatory scheme because the statute allows for enforcement by the appropriate state officers; and (4) allowing an action may result in different prices being paid by victorious plaintiffs than non-suing ratepayers, which violates the statutory scheme of uniform rates.<sup>73</sup>

As case law has developed, acceptance of the filed rate doctrine in the insurance arena is the norm rather than the exception. For example, recognizing the number of cases supporting the doctrine, the court in *Richardson v. Standard Guaranty Insurance Co.*, stated that “[w]e, thus, align our decision with the considerable weight of authority from other jurisdictions that have applied the filed rate doctrine to ratemaking in the insurance industry.”<sup>74</sup> In support of its decision, the court relied on the extensive regulation of the insurance industry and its perception that courts are not institutionally suited to regulate insurance premium and benefit rates.<sup>75</sup> Similarly, in applying the filed rate doctrine in the context of property insurance, the court in the recent case of *Schilke v. Wachovia Mortg.* stated that “[n]umerous courts have held, contrary to Plaintiff's contention, that the filed rate doctrine applies to the insurance industry.”<sup>76</sup>

Nevertheless, controversy regarding the application of the filed rate

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<sup>73</sup> *Edge v. State Farm Mut. Auto. Ins. Co.*, 623 S.E.2d 387, 391-92 (S.C. 2005).

<sup>74</sup> *Richardson v. Standard Guar. Ins. Co.*, 853 A.2d 955, 963 (N.J. Super. Ct. App. Div. 2004).

<sup>75</sup> *Id.*

<sup>76</sup> *Schilke v. Wachovia Mortg.*, No. 09-CV-1363, 2011 WL 4501381, at \*8 (N.D. Ill. Sep. 28, 2011) (citing *Schermer v. State Farm Fire & Cas. Co.*, 702 N.W.2d 898, 907 (Minn. Ct. App. 2005); *Richardson*, 853 A.2d at 964; *Horwitz v. Bankers Life & Cas. Co.*, 745 N.E.2d 591 (Ill. App. Ct. 2001); *Anzinger v. Ill. State Med. Inter-Ins. Exch.*, 494 N.E.2d 655 (Ill. App. Ct. 1986)).

doctrine in insurance cases continues. For example, in *In re Title Insurance Antitrust Cases*, when confronted with a lack of case law on the subject in that jurisdiction, the federal district court for the Northern District of Ohio ruled that the filed rate doctrine should be applied in the insurance context to bar claims for damages arising under Ohio state, as well as federal, antitrust laws.<sup>77</sup> On the other hand, a year later, in *Clark v. Prudential Insurance Co. of America*, a federal district court in New Jersey recently disagreed and ruled that Ohio courts would not apply the filed rate doctrine to insurance disputes arising under Ohio law.<sup>78</sup> Controversy regarding the doctrine's application is further illustrated by the recent conflicting decisions of *MacKay v. Superior Court*<sup>79</sup> and *Fogel v. Farmers Group, Inc.*,<sup>80</sup> involving application of the doctrine to property and casualty insurance in California.

As discussed further in specific topics in this article, courts refusing to apply the doctrine in the insurance context reference reasons including concerns with federalism<sup>81</sup> and perceived insufficiency of administrative review.<sup>82</sup> The court in *Hanson v. Acceleration Life Insurance Co.* also raised the lack of opportunity for public input into rate determinations in support of its decision rejecting application of the doctrine to an insurance dispute.<sup>83</sup>

Furthermore, even after the doctrine is accepted in a jurisdiction in one area of insurance, opponents may resist its extension into other areas. For example, as set forth above, the *Anzinger* decision, arising in state court in Illinois, applied the principles underlying the filed rate doctrine to deny recovery to physicians who were overcharged for insurance. Later, in *Schilke v. Wachovia Mortgage, FSB*,<sup>84</sup> a case based on diversity jurisdiction and construing Illinois law, the plaintiff claimed that the doctrine should not be extended to insurance disputes involving property.

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<sup>77</sup> *In re Title Ins. Antitrust Cases*, 702 F. Supp. 2d 840, 861-64 (N.D. Ohio 2010).

<sup>78</sup> *Clark v. Prudential Ins. Co. of Am.*, No. Civ. 08-6197 (DRD), 2011 WL 940729, at \*12-14 (D.N.J. Mar. 15, 2011).

<sup>79</sup> *MacKay v. Superior Ct.*, 115 Cal. Rptr. 3d 893 (Cal. Ct. App. 2010).

<sup>80</sup> *Fogel v. Farmers Grp., Inc.*, 74 Cal. Rptr. 3d 61 (Cal. Ct. App. 2008).

<sup>81</sup> *See Saunders v. Farmers Ins. Exch.*, 440 F.3d 940, 945 (8th Cir. 2006).

<sup>82</sup> *See, e.g., Brown v. Ticor Title Ins. Co.*, 982 F.2d 386 (9th Cir. 1992); *Blaylock v. First Am. Title Ins. Co.*, 504 F. Supp. 2d 1091 (W.D. Wash. 2007).

<sup>83</sup> *Hanson v. Acceleration Life Ins. Co.*, No. CIV A3-97-152, 1999 WL 33283345, at \*4 (D. N.D. Mar. 16, 1999).

<sup>84</sup> *Schilke v. Wachovia Mortg.*, 705 F. Supp. 2d 932 (N.D. Ill. 2010), *vacated on other grounds*, 758 F. Supp. 2d 549 (N.D. Ill. 2010).

Citing a number of cases in support, the court recognized, however, that application of the doctrine in the context of property insurance was consistent with the weight of authority.<sup>85</sup> In support of its decision, the court cited the goal of preventing discrimination among policyholders and also the nonjusticiability strand of the doctrine placing authority for rates with the department of insurance, not the court system.<sup>86</sup>

#### V. THE RELATION OF THE FILED RATE DOCTRINE TO THE MCCARRAN-FERGUSON ACT

When considering claims against insurers, examination of the interplay between the filed rate doctrine and the McCarran-Ferguson Act<sup>87</sup> may be helpful. The McCarran-Ferguson Act provides in pertinent part that “[n]o Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance...unless the Act specifically relates to the business of insurance.”<sup>88</sup> Certain exceptions involve the Sherman Act, the Clayton Act, and the Federal Trade Commission Act to the extent that state law fails to regulate the business of insurance.<sup>89</sup>

An example of the interplay between the two defenses is illustrated in the case of *Saunders v. Farmers Insurance Exchange* involving alleged discrimination in the provision of homeowners’ insurance.<sup>90</sup> The court in *Saunders* declined to apply the filed rate doctrine to the claims of discrimination at issue but remanded the case for further consideration on the basis that it could not be determined on the record presented whether application of the federal anti-discrimination laws involved would impair the state’s system of insurance rate regulation in violation of the McCarran-Ferguson Act.<sup>91</sup>

The defendants in *Sandwich Chef of Texas, Inc. v. Reliance*

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<sup>85</sup> *Id.* at 942 (citing *Richardson v. Standard Guar. Ins. Co.*, 853 A.2d 955, 964 (N.J. Super. App. Div. 2004); *Schermer v. State Farm Fire and Cas. Co.*, 702 N.W.2d 898, 907 (Minn. App. Ct. 2005); *Horwitz v. Bankers Life & Cas. Co.*, 745 N.E.2d 591 (Ill. App. 2001); *Anzinger v. Ill. State Med. Inter-Ins. Exch.*, 494 N.E.2d 655 (Ill. App. 1986)).

<sup>86</sup> *Schilke*, 705 F. Supp. 2d at 942-43.

<sup>87</sup> 15 U.S.C. §§ 1011-15 (2006).

<sup>88</sup> *Id.* at § 1012(b).

<sup>89</sup> *Id.*

<sup>90</sup> *Saunders v. Farmers Ins. Exch.*, 440 F.3d 940 (8th Cir. 2006).

<sup>91</sup> *Id.* at 945-46. The ruling of the court in *Saunders* on the filed rate doctrine is discussed further in Section XVII, B, *infra*.

*National Indemnity Insurance Co.* also raised both the filed rate doctrine and the McCarran-Ferguson Act as defenses.<sup>92</sup> On the basis that the plaintiffs sought to apply, not avoid, the filed rate, the court refused to find that the filed rate doctrine barred the plaintiffs' RICO claims involving alleged overcharges for worker's compensation insurance.<sup>93</sup> In regard to the McCarran-Ferguson Act, the defendants claimed that awarding the plaintiffs treble damages under RICO for fraudulent departures from the filed rates would "frustrate non-discrimination policies declared in state insurance laws requiring insurers to collect the full amount of any applicable filed rate."<sup>94</sup> The court, however, disagreed ruling that the remedies available for fraud under RICO complemented, rather than conflicted, with state regulations.<sup>95</sup>

Another case highlighting the fact that both the filed rate doctrine and the McCarran-Ferguson Act should be considered as defenses in insurance cases is *In re Title Insurance Antitrust Cases*.<sup>96</sup> The court in that case ruled that the McCarran-Ferguson Act completely barred plaintiff's claims for both damages and injunctive relief although the court believed that the filed rate doctrine standing alone would have allowed claims for injunctive relief.<sup>97</sup>

Litigants in insurance cases involving interplay between federal and state law should consider both the filed rate doctrine and the McCarran-Ferguson Act, as either could provide grounds for dismissal. Although both may involve the regulatory processes involved in the setting of rates, the legal theories underlying the two defenses are distinct and separate.

## VI. THE RELATION OF THE FILED RATE DOCTRINE TO THE STATE ACTION DOCTRINE

A theory referred to as the "state action doctrine" may bar an antitrust claim if the defense can establish the state's intent to replace competition with state regulation and the state's active supervision of the

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<sup>92</sup> *Sandwich Chef of Tex. v. Reliance Nat'l Indem. Ins. Co.*, 111 F. Supp. 2d 867, 874-77 (S.D. Tex. 2000).

<sup>93</sup> *Id.* at 874-75.

<sup>94</sup> *Id.* at 872.

<sup>95</sup> *Id.* at 877.

<sup>96</sup> *In re Title Ins. Antitrust Cases*, 702 F. Supp. 2d 840 (N.D. Ohio 2010).

<sup>97</sup> *Id.* at 877-78.

conduct at issue.<sup>98</sup> As recognized in *Arroyo-Melecio v. Puerto Rican American Insurance Co.*,<sup>99</sup> in order to justify state action immunity, “[t]he state must manifest intent to intervene in the market, displacing antitrust laws and must engage in active supervision of the challenged conduct.”<sup>100</sup> The doctrine requires first that the challenged restraint on trade “be one clearly articulated and affirmatively expressed as state policy” and second that the policy “be actively supervised by the State itself.”<sup>101</sup>

The court in *In re Pennsylvania Title Insurance Antitrust Litigation* recognized that the filed rate doctrine and the state action doctrine constitute two independent bases for antitrust immunity.<sup>102</sup> A significantly lower standard of administrative review, however, is required in regard to the filed rate doctrine as compared to the state action doctrine.<sup>103</sup> Because the standard of administrative supervision required for application of the state action doctrine is higher, the filed rate doctrine would likely result in a viable defense in a larger number of cases.

The plaintiffs in *N.C. Steel, Inc. v. National Council on Compensation Insurance* presented a novel theory to the effect that the filed rate doctrine was subsumed and made inapplicable by the state action doctrine; that the second prong of the state action doctrine requiring active state regulation was not met under the circumstances of that case; and that their lawsuit was, therefore, viable.<sup>104</sup> The court, however, refused to follow the plaintiffs’ reasoning and instead applied the filed rate doctrine to dismiss the claims.<sup>105</sup> No cases were cited in support of the plaintiffs’

<sup>98</sup> See *N.C. Steel, Inc. v. Nat’l Council on Comp. Ins.*, 496 S.E.2d 369, 374 (N.C. 1998).

<sup>99</sup> *Arroyo-Melecio v. P.R. Am. Ins. Co.*, 398 F.3d 56 (1st Cir. 2005).

<sup>100</sup> *Id.* at 71 (citing I AREEDA AND HOVENKAMP, *ANTITRUST LAW*, ¶ 221c (2d ed. 2000)).

<sup>101</sup> *Id.* at 71 (quoting *Cal. Retail Liquor Dealers Ass’n v. Midcal Aluminum, Inc.*, 445 U.S. 97, 105 (1980)).

<sup>102</sup> *In re Pa. Title Ins. Antitrust Litig.*, 648 F. Supp. 2d 663, 677 n.10 (E.D. Pa. 2009).

<sup>103</sup> *Arroyo-Melecio*, 398 F.3d at 71; *In re Pa. Title Ins. Antitrust Litig.*, 648 F. Supp. 2d at 677 n.10; *In re N.J. Title Ins. Litig.*, No. CIV.A. 08-1425, 2009 WL 3233529, at \*3 (D.N.J. Oct. 05, 2009).

<sup>104</sup> *N.C. Steel, Inc. v. Nat’l Council on Comp. Ins.*, 496 S.E.2d 369, 374 (N.C. 1998).

<sup>105</sup> *Id.* On the basis that neither prong of the defense was met, another case refusing to apply the state action doctrine to bar claims of anti-competitive activity is *State ex rel. Cooper v. McClure*, No. 03-CVS-005617, 2004 WL 2965983, at \*10-11 (N.C. Super. Dec. 14, 2004), *rev’d on other grounds*, No. 03-CVS-005617, 2005 WL 3018635 (N.C. Oct. 28, 2005).

position that the state action subsumed the filed rate doctrine, and other cases do not hold as such.

## VII. FILED RATES V. FILED FORMS

The filed rate doctrine is more appropriately viewed as applying to insurance rates, not insurance forms. For example, in *Peachtree Casualty Insurance Co., v. Sharpton*, the Supreme Court of Alabama rejected the insurer's position that based on regulatory approval of its policy provisions, the filed rate doctrine barred claims against it for uninsured motorist protection.<sup>106</sup> The insurer had issued a policy excluding uninsured motorist coverage for injuries incurred during the use of certain vehicles such as motorcycles. The problem for the insurer was that the exclusion conflicted with the Alabama statutory requirements for uninsured motorist protection.<sup>107</sup> Stating that no rate case was involved, the court refused to apply the filed rate doctrine to bar the claims for uninsured motorist protection.<sup>108</sup> Similarly, in rejecting a "filed form doctrine" defense, the court in *Southern Farm Bureau Life Insurance Co. v. Banko* observed that no cases were cited indicating that regulatory approval of a form barred a lawsuit over policy language.<sup>109</sup>

The background and history of the filed rate doctrine uphold the position that it fails to bar complaints implicating forms. The justiciability strand of the doctrine supports the belief that courts should not become enmeshed in the rate-making process through attempting to retroactively reallocate rates and determine what rate an agency would find appropriate in place of an unlawful rate in relation to all interested parties.<sup>110</sup> Complaints regarding forms are on a different footing and do not implicate the same concerns.

The existence of at least one case supporting a filed form type of doctrine, however, should be noted. In *AMEX Assurance Co. v. Caripides*,<sup>111</sup> the court upheld policy language contained in an insurance

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<sup>106</sup> *Peachtree Casualty Ins. Co. v. Sharpton*, 768 So. 2d 368, 373 (Ala. 2000).

<sup>107</sup> *Id.* at 372.

<sup>108</sup> *Id.* at 373.

<sup>109</sup> *S. Farm Bureau Life Ins. Co. v. Banko*, No. 8:06CV840T27EAJ, 2006 WL 2935281, at \*2 (M.D. Fla. Oct. 13, 2006).

<sup>110</sup> *See Wegoland Ltd. v. NYNEX Corp.*, 27 F.3d 17, 19 (2nd Cir. 1994); *Schermer v. State Farm Fire & Cas. Co.*, 721 N.W.2d 307, 312 (Minn. 2006) (citing *Keogh v. Chi. & Nw. Ry. Co.*, 260 U.S. 156, 164-65 (1922)).

<sup>111</sup> *AMEX Assur. Co. v. Caripides*, 179 F. Supp. 2d 309 (S.D.N.Y. 2002), *aff'd*, *AMEX Assur. Co. v. Caripides*, 316 F.3d 154 (2d Cir. 2003).

policy against a claim that the policy violated state statutory requirements. In addition to finding no conflict with the statute involved, the court noted that “[a] line of cases on the ‘filed rate doctrine’ suggests that the Insurance Department’s review and approval of a policy is presumptively valid and cannot be subsequently judicially challenged as unfair or violative of public policy.”<sup>112</sup> Both cases cited in support of the court’s statement, *City of New York v. Aetna Casualty & Surety Co.*,<sup>113</sup> and *Byan v. Prudential Insurance Co. of America*,<sup>114</sup> however, addressed filed rates, not filed forms.<sup>115</sup>

### VIII. THE RELATION BETWEEN STATE AND FEDERAL LAW

During the evolution of the filed rate doctrine, issues involving the interplay between federal and state law have surfaced. One such area examined below involves the application of the doctrine to administrative review performed by state, as opposed to federal, agencies. This is a significant issue in the insurance area since the filing of insurance rates with state agencies is the norm. Other issues involve the application of the doctrine to claims based solely on state law, and the interplay between state and federal law as applied to disputes.

#### A. APPLICATION OF THE FILED RATE DOCTRINE TO RATES REGULATED BY STATE AGENCIES

There is authority that the filed rate doctrine should only be applied when rates are reviewed in conjunction with a federal regulatory system as opposed to a state regulatory system. For example, the Montana Supreme Court in *Williams v. Union Fidelity Life Insurance Co.*,<sup>116</sup> refused to apply the doctrine to an insurance dispute because the rates at issue were not set, reviewed, or filed with a federal regulatory authority.<sup>117</sup> Similarly, in

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<sup>112</sup> *Id.* at 319 n.5 (citing *City of N.Y. v. Aetna Cas. & Sur. Co.*, 693 N.Y.S.2d 139 (N.Y. App. Div. 1999); *Byan v. Prudential Ins. Co. of Am.*, 662 N.Y.S.2d 44, 45 (N.Y. App. Div. 1997)).

<sup>113</sup> *City of N.Y. v. Aetna Cas. & Sur. Co.*, 693 N.Y.S.2d 139 (N.Y. App. Div. 1999).

<sup>114</sup> *Byan v. Prudential Ins. Co. of Am.*, 662 N.Y.S.2d 44, 45 (N.Y. App. Div. 1997).

<sup>115</sup> *Aetna Cas. & Sur. Co.*, 693 N.Y.S.2d at 140; *Byan*, 662 N.Y.S.2d at 45.

<sup>116</sup> *Williams v. Union Fid. Life Ins. Co.*, 123 P.3d 213 (Mont. 2005).

<sup>117</sup> *Id.* at 219.



*Miletak v. Allstate Insurance Co.*,<sup>118</sup> a case involving an insurance premium dispute, the court stated that “the doctrine does not directly apply to a situation, as here, involving potential interference with rates set by a state agency rather than a federal agency.”<sup>119</sup>

As discussed below, the better and more prevailing view, however, is that the doctrine applies to rates reviewed by state insurance departments. There seems to be no logical reason to limit application of the doctrine to federal agency review only. In applying the filed rate doctrine to state agency review, the court in *Taffet v. Southern Co.*,<sup>120</sup> stated that “where the legislature has conferred power upon an administrative agency to determine the reasonableness of a rate, the rate-payer ‘can claim no rate as a legal right that is other than the filed rate’.”<sup>121</sup> According to the *Taffet* court, that central principle of the filed rate doctrine “applies with equal force” regardless of whether rate setting is done by a state or federal authority.<sup>122</sup>

Recognizing the weight of authority supporting application of the doctrine to rates authorized by state agencies, the court in *McCray v. Fidelity National Title Insurance Co.*,<sup>123</sup> stated that “we will preclude the recovery of treble damages for a Sherman Act claim predicated on the alleged excessiveness or otherwise unreasonableness of a rate filed with a state administrative agency.”<sup>124</sup> Other insurance cases finding that the filed rate doctrine applies to state agency review include *In re Title Ins. Antitrust Cases*,<sup>125</sup> *In re Pennsylvania Title Insurance Antitrust Litigation*,<sup>126</sup> *Allen v. State Farm Fire & Casualty Co.*,<sup>127</sup> *Schermer v. State Farm Fire &*

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<sup>118</sup> *Miletak v. Allstate Ins. Co.*, No. C 06-03778 (JW), 2010 WL 809579 (N.D. Cal. Mar. 05, 2010).

<sup>119</sup> *Id.* at \*4.

<sup>120</sup> *Taffet v. S. Co.*, 967 F.2d 1483 (11th Cir. 1992).

<sup>121</sup> *Id.* at 1494 (quoting *Mont.-Dakota Utils. Co. v. Nw. Pub. Serv. Co.*, 341 U.S. 246, 251 (1951)).

<sup>122</sup> *Id.*

<sup>123</sup> *McCray v. Fid. Nat'l Title Ins. Co.*, 636 F. Supp. 2d 322 (D. Del. 2009).

<sup>124</sup> *Id.* at 328

<sup>125</sup> *In re Title Ins. Antitrust Cases*, 702 F. Supp. 2d 840, 861 (N.D. Ohio 2010).

<sup>126</sup> *In re Pa. Title Ins. Antitrust Litig.*, 648 F. Supp. 2d 663, 672 (E.D. Pa. 2009).

<sup>127</sup> *Allen v. State Farm Fire & Cas. Co.*, 59 F. Supp. 2d 1217, 1228 (S.D. Ala. 1999).

*Casualty Co.*,<sup>128</sup> *MacKay v. Superior Court*,<sup>129</sup> and *Commonwealth ex rel. Chandler v. Anthem Insurance Co.*<sup>130</sup>

#### B. APPLICATION OF THE FILED RATE DOCTRINE TO STATE LAW CLAIMS

Assuming that state agency review supports application of the filed rate doctrine, a separate issue is whether the doctrine applies to state law claims as well as to claims made under federal law. Of course, as recognized by the North Carolina Supreme Court in *N.C. Steel, Inc. v. National Council on Compensation Insurance*, federal law applying the filed rate doctrine is not controlling in a case involving violation of state law.<sup>131</sup> The doctrine, however, is often adopted and applied to state law claims, as was the case in *N.C. Steel, Inc.* in response to a challenge to the state's workers' compensation rating system.<sup>132</sup>

*In re Title Insurance Antitrust Cases* provides a comprehensive discussion of the court's decision to apply the principles underlying the filed rate doctrine to bar state law antitrust claims.<sup>133</sup> Ohio courts had not specifically ruled on whether the filed rate doctrine barred a suit for damages brought by a private plaintiff under state law alleging, for example, an antitrust violation.<sup>134</sup> The court found persuasive, however, Ohio Supreme Court authority barring regulated entities from charging rates higher than those properly filed.<sup>135</sup> According to the court, case law applying that "corollary to the filed rate doctrine," supported the conclusion

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<sup>128</sup> *Schermer v. State Farm Fire & Cas. Co.*, 721 N.W.2d 307, 312 (Minn. 2006).

<sup>129</sup> *MacKay v. Superior Court*, 115 Cal. Rptr. 3d 893, 899 (Cal. Ct. App. 2010).

<sup>130</sup> *Commonwealth ex rel. Chandler v. Anthem Ins. Co.*, 8 S.W.3d 48, 52 (Ky. Ct. App. 1999).

<sup>131</sup> *N.C. Steel, Inc. v. Nat'l Council on Comp. Ins.*, 496 S.E.2d 369, 374 (N.C. 1998). See also *In re Pa. Title Ins. Antitrust Litig.*, 648 F. Supp. 2d 663, 673 n.7 (E.D. Pa. 2009) (holding state law is the overriding authority in determining if the filed rate doctrine applies to state law claims).

<sup>132</sup> *N.C. Steel, Inc.*, 496 S.E.2d at 371.

<sup>133</sup> *In re Title Ins. Antitrust Cases* 702 F. Supp. 2d 840, 861-65 (N.D. Ohio 2010).

<sup>134</sup> *Id.* at 861-65.

<sup>135</sup> *Id.* at 862 (citing *In re Investigation of Nat'l Union Fire Ins. Co.*, 609 N.E.2d 156 (Ohio 1993)).

that the Ohio Supreme Court would apply the filed rate doctrine to the state antitrust claims involved.<sup>136</sup>

Another example of the doctrine's application to state law claims occurs in *Amundson & Associates Art Studio, Ltd. v. National Council on Compensation Insurance, Inc.*, in which the plaintiff argued that the filed rate doctrine was a weak and discredited relic continuing to exist only at the federal level.<sup>137</sup> The court noted a California case cited by the plaintiff as authority for the proposition that the doctrine should not apply at the state law level.<sup>138</sup> Nevertheless, recognizing the importance of preserving the integrity of agency decision making, the court upheld application of the doctrine to claims that state antitrust statutes were violated.<sup>139</sup>

### C. APPLICATION OF STATE AND FEDERAL LAW IN CONSTRUCTION OF THE FILED RATE DOCTRINE

Although state law is controlling in relation to state law claims,<sup>140</sup> courts addressing the doctrine's application in such cases typically find federal law relevant as well.<sup>141</sup> In addressing solely federal antitrust claims, the federal district court in *In re Pennsylvania Title Insurance Antitrust Litigation* also expressed the opinion that it could "fill in the interstices of the doctrine by drawing on state law."<sup>142</sup> In support of that conclusion, the court cited the United States Supreme Court decision of *Kamen v. Kemper Financial Services, Inc.*<sup>143</sup> In *Kamen*, the Court stated that "[t]he presumption that state law should be incorporated into federal common law is particularly strong in areas in which private parties have entered legal relationships with the expectation that their rights and obligations would be governed by state-law standards."<sup>144</sup>

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<sup>136</sup> *Id.*

<sup>137</sup> *Amundson & Assocs. Art Studio, Ltd. v. Nat'l Council on Comp. Ins., Inc.*, 988 P.2d 1208, 1213 (Kan. App. Ct. 1999).

<sup>138</sup> *Id.* at 1214 (citing *Cellular Plus, Inc. v. Super. Ct.*, 18 Cal. Rptr. 2d 308 (Cal. Ct. App. 1993)).

<sup>139</sup> *Id.* at 1215-16.

<sup>140</sup> *In re Pa. Title Ins. Antitrust Litig.*, 648 F. Supp. 2d 663, 673 n.7 (E.D. Pa. 2009).

<sup>141</sup> See *Allen v. State Farm Fire & Cas. Co.*, 59 F. Supp. 2d 1217, 1227-30 (S.D. Ala. 1999); *Prentice v. Title Ins. Co. of Minn.*, 500 N.W.2d 658, 660-62 (Wis. 1993).

<sup>142</sup> *In re Pa. Title Ins. Antitrust Litig.*, 648 F. Supp. 2d at 673.

<sup>143</sup> *Id.* (citing *Kamen v. Kemper Fin. Serv., Inc.*, 500 U.S. 90 (1991)).

<sup>144</sup> *Kamen*, 500 U.S. at 98.

Finding pertinent the fact that the federal antitrust claims presented involved application of the filed rate doctrine to a Pennsylvania regulatory agency, the court in *In re Pennsylvania Title Insurance* found “especially relevant” the treatment of the filed rate doctrine under Pennsylvania state law.<sup>145</sup> In reliance on *Pennsylvania Title Insurance Antitrust Litigation*, the court in *Clark v. Prudential Insurance Co. of America* likewise recognized that in construing the filed rate doctrine, state law may be used to “fill in the interstices” of federal common law.<sup>146</sup>

#### IX. THE AVAILABILITY OF INJUNCTIVE RELIEF TO PRIVATE PLAINTIFFS

The foreclosure of damage claims under federal and state law through application of the filed rate doctrine may result in a focus on future injunctive relief. Jurisdictions vary in regard to the application of the filed rate doctrine to claims for equitable relief. The Kansas Court of Appeals in *Amundson & Associates Art Studio, Ltd. v. National Council on Compensation Insurance, Inc.*, a case involving alleged price fixing in violation of state antitrust law, ruled that “[a]ny claim for injunctive or equitable relief in this area is permissible by the government, not individuals.”<sup>147</sup> The court in *Amundson* relied upon a decision of the North Carolina Supreme Court, *N.C. Steel, Inc. v. National Council on Compensation Insurance*,<sup>148</sup> a case in which the court refused to approve injunctive relief for private plaintiffs asserting state law claims stemming from charges imposed under the state’s workers’ compensation insurance structure.<sup>149</sup>

Better reasoned cases, however, indicate that private plaintiffs may proceed through injunctive relief in appropriate cases. Injunctive relief not implicating agency authority or previously filed rating schedules does not interfere with the twin concerns of the filed rate doctrine, justiciability and nondiscrimination. Notably, the Supreme Court in *Square D Co. v. Niagara Frontier Tariff Bureau, Inc.* affirmed the ruling of the Second Circuit Court of Appeals that although the filed rate doctrine barred the private plaintiffs’

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<sup>145</sup> *Pa. Title Ins.*, 648 F. Supp. 2d at 673.

<sup>146</sup> *Clark v. Prudential Ins. Co. of America*, 736 F. Supp. 2d 902, 912 (D.N.J. 2010) (quoting *Pa. Title Ins.*, 648 F. Supp. 2d at 673).

<sup>147</sup> *Amundson & Assocs. Art Studio, Ltd. v. Nat’l Council on Comp. Ins., Inc.*, 988 P.2d 1208, 1217 (Kan. App. Ct. 1999).

<sup>148</sup> *See id.* at 1215-16 (citing *N.C. Steel, Inc. v. Nat’l Council on Comp. Ins.*, 496 S.E.2d 369 (N.C. 1998)).

<sup>149</sup> *Id.*

claims for monetary damages, a remand was appropriate for a determination as to whether the plaintiffs were entitled to injunctive relief.<sup>150</sup> The Supreme Court in *Square D* recognized the “critical distinction” between absolute immunity from all antitrust scrutiny and a prohibition against the private treble-damages remedy.<sup>151</sup> According to the Supreme Court, that distinction was highlighted by the Court of Appeal’s remand on the issue of injunctive relief and the consent decree entered into between the parties enjoining certain acts. On the issue of the availability of injunctive relief, the Second Circuit in *Square D* further noted that the defendants had not moved for dismissal in regards to the claim for an injunction “a position well advised in light of *Georgia v. Pennsylvania Railroad Co.*,”<sup>152</sup> an earlier Supreme Court case upholding the availability of injunctive relief under the filed rate doctrine.<sup>153</sup>

Later case law generally acknowledges the availability of injunctive relief at least insofar as the filed rate is not affected.<sup>154</sup> For example, in *Saunders v. Farmers Insurance Exchange*, the Eighth Circuit Court of Appeals disagreed with the district court’s dismissal of the plaintiffs’ claims for injunctive relief stating that “[o]n appeal, defendants totally fail to support this seemingly unjustified expansion of the filed rate doctrine.”<sup>155</sup> Likewise, in *Schilke v. Wachovia Mortgage, FSB*, a case

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<sup>150</sup> *Square D Co. v. Niagara Frontier Tariff Bureau, Inc.*, 476 U.S. 409, 414 (1986).

<sup>151</sup> *Id.* at 422 n.28.

<sup>152</sup> *Square D Co.*, 760 F.2d at 1364 (citing *Ga. v. Pa. R.R. Co.*, 324 U.S. 439, 454-55 (1945)).

<sup>153</sup> Although the state of Georgia was involved in *Georgia v. Pennsylvania Railroad Co.*, federal antitrust law was involved, and the state was not a federal governmental litigant. 324 U.S. 439, 443 (1945). Even if, however, due to the involvement of the state of Georgia, *Georgia v. Pennsylvania Railroad Co.*, loses some effect as precedent regarding the availability of injunctive relief to private litigants, the plaintiffs in *Square D* were certainly private litigants. *Square D Co.*, 760 F.2d at 1349.

<sup>154</sup> *See, e.g.*, *Dolan v. Fid. Nat’l Title Ins. Co.*, 365 Fed. App’x 271, 276 (2d Cir. 2010), *cert. denied*, 131 S.Ct. 261 (2010); *Saunders v. Farmers Ins. Exch.*, 440 F.3d 940, 944 n.1 (8th Cir. 2006); *In re Title Ins. Antitrust Cases*, 702 F. Supp. 2d 840, 865 (N.D. Ohio 2010); *Schilke v. Wachovia Mortg., FSB*, 705 F. Supp. 2d 932, 944-45 (N.D. Ill. 2010), *vacated on other grounds*, 758 F. Supp. 2d 549 (N.D. Ill. 2010); *In re Pa. Title Ins. Antitrust Litig.*, 648 F. Supp. 2d 663, 686 (E.D. Pa. 2009); *see also* *Prentice v. Title Ins. Co. of Minn.*, 500 N.W.2d 658, 663 n.7 (Wis. 1993) (recognizing that the filed rate doctrine does not protect against private suits seeking other than rate-related damages).

<sup>155</sup> *Saunders v. Farmers Ins. Exch.*, 440 F.3d 940, 944 n.1 (8th Cir. 2006).

involving alleged wrongful kickbacks, the court refused to apply the doctrine to bar a claim for injunctive relief that sought the public disclosure of the portion of insurance premiums constituting commissions and brokerage fees.<sup>156</sup>

The court in *In re Title Insurance Antitrust Cases* distinguished between allowable types of injunctive relief as opposed to types of injunctive relief barred by the doctrine.<sup>157</sup> The court acknowledged Supreme Court precedent in *Georgia v. Pennsylvania Railroad Co.*<sup>158</sup> and *Square D Co. v. Niagara Frontier Tariff Bureau, Inc.*<sup>159</sup> affirming the continued viability of injunctive relief.<sup>160</sup> The court found, however, that the nonjusticiability strand of the doctrine barred injunctive relief that would alter a filed rate or that would “displace the statutory scheme and authority of the regulating agency to determine the reasonableness of rates.”<sup>161</sup> Accordingly, the court found that claims in the case seeking to enjoin future collaboration between the defendants were allowed because the relief sought could only affect future rates, not any rate already filed.<sup>162</sup> On the other hand, the court ruled that the filed rate doctrine barred claims seeking to prohibit the defendants from filing rates containing both legitimate premium costs and fees from alleged kickbacks.<sup>163</sup> The problem in the court’s view was that rather than seek to enjoin the kickbacks themselves, the plaintiffs sought an injunction addressing the way in which rates were submitted, as a single (or all inclusive) rate.<sup>164</sup> According to the court, allowing such relief would be substituting the court’s judgment as to how rate filings should be made for that of the state’s department of insurance, a direct conflict with the nonjusticiability strand of the doctrine.<sup>165</sup> Likewise, in *Dolan v. Fidelity National Title Insurance Co.*, a case in which the plaintiffs requested that the court enjoin price-fixing and

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<sup>156</sup> *Schilke v. Wachovia Mortg., FSB*, 705 F. Supp. 2d 932, 944-45 (N.D. Ill. 2010) (citing *Marcus v. AT&T Corp.*, 138 F.3d 46, 62 (2d Cir. 1998); *Green v. Peoples Energy Corp.*, No. 02C4117, 2003 WL 1712566, at \*4 (N.D. Ill. Mar. 28, 2003), *vacated on other grounds*, 758 F. Supp. 2d 549 (N.D. Ill. 2010)).

<sup>157</sup> *In re Title Ins. Antitrust Cases*, 702 F. Supp. 2d 840 (N.D. Ohio 2010).

<sup>158</sup> *Georgia v. Pennsylvania R. Co.*, 324 U.S. 439 (1945).

<sup>159</sup> *Square D Co. v. Niagara Frontier Tariff Bureau, Inc.*, 476 U.S. 409 (1986).

<sup>160</sup> *In re Title Ins. Antitrust Cases*, 702 F. Supp. 2d at 865.

<sup>161</sup> *Id.* at 865-66 (citing *Town of Norwood v. New Eng. Power Co.*, 202 F.3d 408, 420 (1st Cir. 2000)).

<sup>162</sup> *Id.* at 865.

<sup>163</sup> *Id.*

<sup>164</sup> *Id.* at 865-66.

<sup>165</sup> *Id.*

the inclusion in rates of costs for kick-backs and other illegal charges, the court stated that “[a]n injunction to remove particular costs from filed rates is exactly the sort of relief the doctrine bars.”<sup>166</sup>

An apparent conflict in decisional law regarding the type of injunctive relief available is illustrated by *In re Pennsylvania Title Insurance Antitrust Litigation*.<sup>167</sup> The court in that case expressed approval of injunctive relief prohibiting the costs of illegal costs and kickbacks in newly filed rates on the basis that the relief sought was exclusively prospective and would not interfere with rates already on file.<sup>168</sup> The court’s decision is contrary, however, to the decisions of *In re Title Insurance Antitrust Cases* and *Dolan v. Fidelity National Title Insurance Co.*, discussed above, expressing the opinion that the doctrine bars injunctive relief affecting the inclusion of alleged kickbacks in rates. It would seem that the better view is expressed in *In re Title Insurance Antitrust Cases* and *Dolan* based upon justiciability concerns and the accepted goal of the filed rate doctrine of avoiding involvement and conflict with state regulatory authorities.

In any event, as recognized in the recent case of *In re New Jersey Title Insurance Litigation*, an expansive request for injunctive relief could present a problem in regard to the filed rate doctrine.<sup>169</sup> The court in that case refused to grant injunctive relief recognizing that the plaintiffs’ “broadly conceived request for injunctive relief” attacked previously filed rates in addition to seeking prospective relief.<sup>170</sup> Without attempting to separate any allowable prospective relief from the perceived overly broad request, the court stated that granting the requested injunctive relief would interfere with the authority of the state’s insurance department.<sup>171</sup>

#### X. THE EFFECT OF THE FILED RATE DOCTRINE ON GOVERNMENTAL LITIGANTS

There is a lack of consensus in regard to the effect of the filed rate doctrine on governmental litigants. The better and more prevalent view is that the Supreme Court decisions of *Square D Co. v. Niagara Frontier*

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<sup>166</sup> *Dolan v. Fid. Nat’l Title Ins. Co.*, 365 F. App’x. 271, 276 (2d Cir. 2010), *cert. denied*, 131 S. Ct. 261 (2010).

<sup>167</sup> *In re Pa. Title Ins. Antitrust Litig.*, 648 F. Supp. 2d 663 (E.D. Pa. 2009).

<sup>168</sup> *Id.* at 686.

<sup>169</sup> *In re N.J. Title Ins. Litig.*, Consolidated Civil Action No. 08-1425, 2009 WL 3233529, at \*3 (D.N.J. Oct. 5, 2009).

<sup>170</sup> *Id.*

<sup>171</sup> *Id.*

*Tariff Bureau, Inc.*, and *Keogh v. Chicago & Northwestern Railway Co.* uphold governmental enforcement actions.<sup>172</sup> In recognizing rights of the government to enforce the Sherman Act, the Supreme Court in *Square D* quoted *Keogh* for the proposition that “[t]he fact that these rates had been approved by the Commission would not, it seems, bar proceedings by the Government.”<sup>173</sup>

Cases upholding the principle that the filed rate doctrine allows for enforcement activity by the government include *In re Title Insurance Antitrust Cases*, recognizing that the doctrine does not “prohibit the Government from seeking civil or criminal redress;”<sup>174</sup> *Prentice v. Title Insurance Co. of Minnesota*, recognizing that the “filed rate doctrine does not protect against suits by the government;”<sup>175</sup> and *Edge v. State Farm Mutual Automobile Insurance Co.*, recognizing that “[t]he filed rate doctrine bars only collateral attacks brought by private parties and not direct reviews in ratemaking cases or actions brought by a governmental agency.”<sup>176</sup>

Nevertheless, decisions are not unanimous regarding application of the filed rate doctrine to governmental enforcement efforts. The Kentucky Court of Appeals in *Commonwealth ex rel. Chandler v. Anthem Insurance Companies, Inc.* ruled that the filed rate doctrine barred an action brought by the Attorney General of Kentucky insofar as it sought damages based on alleged wrongdoing in violation of that state’s consumer protection law.<sup>177</sup> The court primarily relied on its interpretation of federal precedent, not on any type of more restrictive reading of the filed rate doctrine limited to that state.<sup>178</sup>

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<sup>172</sup> *Square D Co. v. Niagara Frontier Tariff Bureau, Inc.*, 476 U.S. 409, 419 (1986); *Keogh v. Chicago & N.W. Ry. Co.*, 260 U.S. 156 (1922).

<sup>173</sup> *Square D Co.*, 476 U.S. at 416 n.17 (quoting *Keogh v. Chicago & N. W. Ry. Co.*, 260 U.S. 156, 162 (1922)).

<sup>174</sup> *In re Title Ins. Antitrust Cases*, 702 F. Supp. 2d 840, 849 (N.D. Ohio 2010).

<sup>175</sup> *Prentice v. Title Ins. Co. of Minn.*, 500 N.W.2d 658, 663 n.7 (Wis. 1993).

<sup>176</sup> *Edge v. State Farm Auto. Ins. Co.*, 623 S.E.2d 387, 391 (S.C. 2005); *accord* *Saunders v. Farmers Ins. Exch.*, 440 F.3d 940, 944 (8th Cir. 2006) (approving statements made in *Square D* that the filed rate doctrine does not affect governmental rights).

<sup>177</sup> *Commonwealth ex rel. Chandler v. Anthem Ins. Cos., Inc.*, 8 S.W.3d 48, 53 (Ky. Ct. App. 1999). The court, however, approved the Attorney General’s action for injunctive relief or civil penalties as allowed by statute under the state’s consumer protection law. *Id.* at 53-54.

<sup>178</sup> *Id.* at 52.



Another case implying that the filed rate doctrine may be applied to bar actions brought by the government is *State ex rel. Cooper v. McClure*, a case involving an action by the state of North Carolina against one of its vendors. Rather than find that the filed rate doctrine was inapplicable to actions instituted by the government, the court allowed the case to proceed for reasons including its determination that an action against a state vendor was not the type of action involving the typical concerns of the filed rate doctrine.<sup>179</sup>

The majority of cases finding that the filed rate doctrine allows governmental enforcement action set forth the better view. The court in *In re Title Insurance Cases* characterized the doctrine as “a judicially created restriction on remedies and standing under which private plaintiffs are barred from suing for a damage recovery.”<sup>180</sup> In rejecting the plaintiff’s position that application of the filed rate doctrine would illegally extend antitrust immunity, the court relied on its determination that the filed rate doctrine allowed for governmental enforcement actions and for injunctive relief.<sup>181</sup> As the case makes clear, allowing governmental enforcement action may prevent violators from escaping consequences of illegal action. Additionally, governmental action does not raise the same concerns regarding discrimination between similarly situated individuals as would a private action by an individual plaintiff benefiting only that plaintiff.

#### XI. THE EFFECT OF THE FILED RATE DOCTRINE ON ENTITIES OTHER THAN INSURERS

Many cases assume without discussion that the filed rate doctrine applies to entities other than insurers when complaints are made involving rates filed with a state’s Department of Insurance. This is logical because the filed rate doctrine applies to rates set or approved by a regulatory agency, and there seems to be no reason to distinguish between insurers and other entities. For example, without discussing the status of the defendants, the court in *Steven v. Union Planters Corp.* applied the doctrine to bar claims that the bank-affiliated defendants placed required hazard insurance on plaintiff’s mortgaged property at an excessive premium

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<sup>179</sup> *State ex rel. Cooper v. McClure*, No. 03-CVS-005617, 2004 WL 296598, at \*11-12 (N.C. Super. Dec. 14, 2004), *rev’d on other grounds*, No. 03-CVS-005617, 2005 WL 3018635 (N.C. Super. Oct. 28, 2005).

<sup>180</sup> *In re Title Ins. Antitrust Cases*, 702 F. Supp. 2d 840, 849 (N.D. Ohio 2010).

<sup>181</sup> *Id.*

enabling the defendants to receive wrongful kickbacks from insurers.<sup>182</sup> As recognized by the court in *Steven*, “[u]nder the filed rate doctrine, an allegation that a forced placed premium is excessive, is barred as a matter of law when the rate is declared reasonable by an independent entity.”<sup>183</sup> Without further analysis of the status of the defendants, other courts have also assumed the doctrine’s application to defendants other than insurers.<sup>184</sup>

A case specifically addressing the application of the doctrine to defendants other than insurers is *Roussin v. AARP, Inc.*, in which the plaintiff claimed that AARP, a non-profit group targeting retirees, improperly received an allowance from an insurer for reasons including its sponsorship of the insurer’s policy offerings.<sup>185</sup> Noting a lack of contrary authority, the court applied the filed rate doctrine to bar the plaintiff’s claims stating as follows:

Here, although Defendants did not file the rates, Roussin [the plaintiff] indisputably seeks to challenge the reasonableness of the rates. Because she is “seeking relief for an injury allegedly caused by the payment of a rate on file with a regulatory commission,” albeit indirectly, her claims are barred by the filed rate doctrine.<sup>186</sup>

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<sup>182</sup> *Steven v. Union Planters Corp.*, No. Civ.A. 00-CV-1695, 2000 WL 33128256, at \*3 (E.D. Pa. Aug. 22, 2000).

<sup>183</sup> *Id.* at \*2.

<sup>184</sup> See *Alston v. Countrywide Fin. Corp.*, 585 F.3d 753, 764 (3d Cir. 2009) (applying the doctrine to the defending lender but finding that it did not bar claims of illegal kickbacks); *Hooks v. Am. Med. Sec. Life Ins. Co.*, No. CIV. 3:06cv71, 2008 WL 3911130 (W.D.N.C. Aug. 19, 2008) (applying the doctrine to bar claims against a non-profit organization); *Harrison v. Commercial Credit Corp.*, No. CIV.A. 4:01CV151LN, 2002 WL 548281, at \*6 (S.D. Miss. Mar. 29, 2002) (finding that the doctrine barred claims against the defending lender’s employees); *Gipson v. Fleet Mortg. Grp., Inc.*, 232 F. Supp. 2d 691 (S.D. Miss. 2002) (applying the doctrine to the defending lender but finding that it did not bar claims related to a lender’s right to place insurance in such a manner as to cause its borrowers’ payment on unnecessary fees).

<sup>185</sup> *Roussin v. AARP, Inc.*, 664 F. Supp. 2d 412, 416-19 (S.D.N.Y. Oct. 15, 2009), *aff’d*, No. 09-4932-cv, 2010 WL 2101912, at \*1 (2d Cir. May 26, 2010) (stating that the affirmation was based on the district court’s “well-reasoned opinion”).

<sup>186</sup> *Id.* at 419 (quoting *Porr v. NYNEX Corp.*, 660 N.Y.S.2d 440, 442 (App. Div. 1997)).

There is authority, however, distinguishing between insurers and other entities in the application of the filed rate doctrine. In *Richardson v. Standard Guaranty Insurance Co.*, a case involving alleged fraud committed in the sale of credit insurance policies, the court found that the claims against the defendant CitiBank, which marketed and sold the policies, should be viewed differently in relation to the filed rate doctrine because Citibank was not an insurer and did not file rates.<sup>187</sup> The court found the filed rate doctrine would only apply to bar claims against such a defendant if the defendant acted as an agent of the insurer.<sup>188</sup>

The better reasoned conclusion is that application of the filed rate doctrine is unaffected by the status of the defendant. As recognized in *Roussin v. AARP, Inc.*, the pertinent inquiry is whether the claimed injury is based on an approved rate, not the nature of the defending entity.<sup>189</sup> The primary concerns of the filed rate doctrine, nondiscrimination and the avoidance of interference with agency rate making is unaffected by the identity of the defendant.

## XII. APPLICATION OF THE FILED RATE DOCTRINE TO CLAIMS INVOLVING THE IMPROPER CALCULATION AND APPLICATION OF RATES AND RESERVES, AND OTHER ALLEGED FAILURES REGARDING REGULATORY REQUIREMENTS

### A. CLAIMS THAT RATES VARIED FROM ALLOWABLE RATES

There is authority that the filed rate doctrine is inapplicable to claims alleging that the rates charged exceeded filed rates. For example, in *Birmingham Hockey Club, Inc. v. National Council on Compensation Insurance, Inc.*, the Supreme Court of Alabama found the doctrine inapplicable to a claim that rates were assessed in excess of those approved by the state's department of insurance.<sup>190</sup> Similarly, the court in *Sandwich Chef of Texas, Inc. v. Reliance National Indemnity Insurance Co.*, refused to apply the filed rate doctrine to bar a complaint regarding premiums

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<sup>187</sup> *Richardson v. Standard Guaranty Ins. Co.*, 853 A.2d 955, 969-70 (N.J. Super. Ct. App. Div. 2004).

<sup>188</sup> *Id.* at 969 (citing *Smith v. SBC Comm. Inc.*, 839 A.2d 850, 858 (N.J. 2004)).

<sup>189</sup> See *Roussin*, 664 F. Supp. 2d at 419.

<sup>190</sup> *Birmingham Hockey Club, Inc. v. Nat'l Council on Comp. Ins., Inc.*, 827 So.2d 73, 83 (Ala. 2002).

charged in excess of filed rates.<sup>191</sup> The court reached its conclusion based upon the logical principle that the purpose of the filed rate doctrine is to prevent challenges to filed rates, not efforts to enforce rates on file.<sup>192</sup>

The filed rate doctrine was recently raised in a novel way in *Blackburn & McCune, PLLC v. Pre-Paid Legal Services, Inc.*, a case in which a law firm hired to provide services to insureds under legal insurance plans sued claiming that the fees paid to the firm by the insurer varied from the amount the insurer filed as expenses for such costs with the state.<sup>193</sup> The law firm claimed that under the filed rate doctrine it was entitled to recover the difference between what it was paid and the amount the insurer allegedly represented to the state that it incurred in expenses for the services.<sup>194</sup> The court, however, determined that the filed rate doctrine is intended to protect the relationship between an insurer and consumers, not providers.<sup>195</sup>

#### B. CLAIMS THAT RATE CATEGORIES WERE IMPROPERLY APPLIED

Generally, courts have refused to apply the filed rate doctrine to bar claims that filed rates were applied in an improper manner. For example, in *White v. Conestoga Title Insurance Co.*, Pennsylvania's intermediate court refused to apply the doctrine to bar the plaintiff's claim that, although the rate charged was a filed rate, it was the wrong rate.<sup>196</sup> The court relied on the fact that the plaintiff sought to obtain a discounted

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<sup>191</sup> *Sandwich Chef of Tex., Inc. v. Reliance Nat'l Indem. Ins. Co.*, 111 F. Supp. 2d 867, 874-75 (S.D. Tex. 2000). On appeal, class certification was revoked, however, the court recognized that a plaintiff's knowledge of the imposition of a rate other than the filed rate may be used to negate a claim of fraud. *See* *Sandwich Chef of Tex., Inc. v. Reliance Nat'l Indem. Ins. Co.*, 319 F.3d 205, 217 n.10 (5th Cir. 2003).

<sup>192</sup> *Sandwich Chef of Tex.*, 111 F. Supp. 2d at 874 (citing *Drew v. MCI Worldcom Mgmt. Co., Inc.*, No. Civ. A.3: 99-CV-1355-D, 1999 WL 1087470 (N.D. Tex. Dec. 1, 1999); *Black Radio Network, Inc. v. NYNEX Corp.*, 44 F. Supp. 2d 565, 574 (S.D.N.Y. 1999)).

<sup>193</sup> *Blackburn & McCune, PLLC v. Pre-Paid Legal Servs., Inc.*, No. M2009-01584-COA-R3-CV, 2010 WL 2670816, at \*1 (Tenn. Ct. App. June 30, 2010), *appeal denied*, (Dec. 07, 2010).

<sup>194</sup> *Id.* at \*29.

<sup>195</sup> *Id.* at \*32.

<sup>196</sup> *White v. Conestoga Title Ins. Co.*, 982 A.2d 997, 1009 (Pa. Super. 2009), *appeal granted*, 994 A.2d 1083 (Pa. 2010) (*appeal granted on an issue pertaining to class certification*).

rate to which she claimed entitlement, not challenge the insurance rates themselves.<sup>197</sup> A number of other insurance cases also recognize that the filed rate doctrine is unavailable as a defense to bar claims involving the calculation of rates.<sup>198</sup>

There is authority, however, supporting the application of the doctrine to claims involving the assessment of rates. For example, after adopting the filed rate doctrine in the jurisdiction, the South Carolina Supreme Court in *Edge v. State Farm Mutual Automobile Insurance Co.*, ruled that the doctrine barred claims that surcharges were improperly imposed based upon wrongful determinations of fault made in regard to motor vehicle accidents.<sup>199</sup> On the other hand, the dissent in *Edge* strongly and persuasively argued that the doctrine should not have been applied in that situation because the case was not a rate case.<sup>200</sup>

The dissent recognized that the filed rate doctrine, first outlined in *Keogh*, protects duly authorized and filed rates from collateral attack in court.<sup>201</sup> That was not the situation in *Edge* in which the plaintiffs complained that they were charged the wrong rate among possible rates. The dissent provided the following persuasive example in clarifying the difference between a complaint that a lower rate should have been adopted, which the filed rate bars, as opposed a complaint alleging the improper assessment of a rate from among other possible rates, which the dissent argued was allowable:

To distinguish this case from a “rate case,” it is perhaps helpful to use the following illustration: If Plaintiff claims, “in the exercise of discretion, the agency should have adopted some lower rate instead of a rate of X,” then Plaintiff is effectively asking the court to substitute its discretion for the administrative agency’s. If instead, a rate scheme authorizes a base rate of X, and further provides

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<sup>197</sup> *Id.* at 1007-08 (citing *Charles v. Lawyers Title Ins. Corp.*, No. CIV.A.06 2362 JAG, 2007 WL 1959253 (D.N.J. July 3, 2007)).

<sup>198</sup> See *Randleman v. Fid. Nat’l Title Ins. Co.*, 465 F. Supp. 2d 812, 823 (N.D. Ohio 2006); *Robinson v. Fountainhead Title Grp. Corp.*, 477 F. Supp. 2d 478, 487 (D. Md. 2006); *Richardson v. Standard Guar. Ins. Co.*, 853 A.2d 955, 967 (N.J. Super. Ct. App. Div. 2004).

<sup>199</sup> *Edge v. State Farm Mut. Auto. Ins. Co.*, 623 S.E.2d 387, 392-93 (S.C. 2005).

<sup>200</sup> *Id.* at 393 (Toal, C.J., dissenting).

<sup>201</sup> *Id.* at 393-94 (Toal, C.J., dissenting) (citing *Keogh v. Chi. & N.W. Ry. Co.*, 260 U.S. 156 (1922)).

that, if certain additional conditions exist, then a rate of Y, Plaintiff is free to argue that he does not meet the requirements for issuance of the higher rate; Plaintiff is merely disputing the rate's validity "as applied" to him.<sup>202</sup>

It seems that the dissent in *Edge* had the better argument that the filed rate doctrine allowed claims that rates were improperly applied.<sup>203</sup> The rationale behind the filed rate doctrine supports plaintiff rights in regard to rate enforcement. For example, recognizing the purposes of the filed rate doctrine to prevent price discrimination and to preserve the role of agencies in approving reasonable rates, the court in *Charles v. Lawyers Title Ins. Corp.* refused to apply the doctrine to bar enforcement of the defendant's filed rates.<sup>204</sup> The plaintiffs claimed that the defending insurer charged more than the allowable rating schedule it submitted. According to the court in *Charles*, the defendant attempted "to turn this doctrine on its head" by arguing that pursuant to the filed rate doctrine, the plaintiff's constructive knowledge of rates barred claims to enforce filed rates.<sup>205</sup> Enforcement of filed rates does not result in discrimination against policyholders nor does it interfere with agency decision making.

#### C. CLAIMS THAT RESERVES WERE IMPROPERLY SET

There is disagreement regarding whether the filed rate doctrine bars claims regarding the improper setting of insurance reserves retained for the payment of future claims. The North Carolina Court of Appeals in *Lupton v. Blue Cross & Blue Shield of North Carolina* found that the filed rate doctrine barred claims alleging the existence of excessive reserves.<sup>206</sup> By statute a regulated insurer in that state was required to retain a percentage of certain gross annual collections from membership dues until the reserve retained equaled three times the insurer's average monthly expenditures for claims and other expenses.<sup>207</sup> Reserves, however, were prohibited by statute from exceeding six times the amount of such average

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<sup>202</sup> *Id.* at 394 n.8 (Toal, C.J., dissenting).

<sup>203</sup> *Id.* at 394 (Toal, C.J., dissenting).

<sup>204</sup> *Charles v. Lawyers Title Ins. Corp.*, No. 06-2361 (JAG), 2007 WL 1959253, at \*9 (D.N.J. July 3, 2007).

<sup>205</sup> *Id.* at \*6.

<sup>206</sup> *Lupton v. Blue Cross & Blue Shield of N.C.*, 533 S.E.2d 270, 273 (N.C. Ct. App. 2000).

<sup>207</sup> *Id.* at 271 (citing N.C. GEN. STAT. § 58-65-95(b) (2009)).

monthly expenditures.<sup>208</sup> In ruling that the filed rate doctrine barred claims that the defendant accumulated excessive reserves, the court recognized that the state's Commissioner of Insurance initially approved the defendant's reserve amount and that, thereafter, the retention of reserves was governed by statute.<sup>209</sup> The court stated that the Commissioner had the authority to recalculate approved rates, thereby affecting the amount of the reserve and that "[a]ny allegation that Blue Cross accumulated an excessive reserve requires the recalculation of approved rates."<sup>210</sup> According to the court, "the plaintiffs cannot prove their claim without the rates set by the Commissioner being questioned."<sup>211</sup>

The Supreme Court of Pennsylvania, however, in *Ciamaichelo v. Independence Blue Cross*, refused to apply the filed rate doctrine to dismiss a complaint alleging the defendant's wrongful accumulation of excessive reserves.<sup>212</sup> The plaintiffs in that case alleged that the defendant violated the state's nonprofit corporation law and breached contractual and fiduciary duties through accumulating surplus funds for purposes inconsistent with its non-profit status.<sup>213</sup> Alleged violations included the use of excess funds for possible acquisitions, mergers, conversions, benefits to officers and directors, and investments in for-profit subsidiaries.<sup>214</sup> The court stated that it was unwilling, on preliminary objections, to rule that the complaint amounted to only second-guessing an approved rate. Instead, the complaint was viewed as raising the issue of whether the defendant "violated the Non-Profit Law and committed breaches of contractual and fiduciary duties in amassing a fund designated as surplus that was in amount, over and

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<sup>208</sup> *Id.* (citing N.C. GEN. STAT. § 58-65-95(c) (2009)).

<sup>209</sup> *Id.* at 273.

<sup>210</sup> *Id.*

<sup>211</sup> *Lupton v. Blue Cross & Blue Shield of North Carolina*, 533 S.E.2d 270, 273 (N.C. Ct. App. 2000) (quoting *N.C. Steel, Inc. v. Nat'l Council on Comp. Ins.*, 496 S.E.2d 369, 374 (N.C. 1998)). The court did not address the fact that apparently excessive reserves could be computed based on the prohibition that reserves not exceed six times the amount of average monthly expenditures. Subsection (d) of the statute at issue, N.C. Gen. Stat. § 58-65-95 (2009), however, granted the Commissioner authority to increase reserves under certain circumstances to more than six times average monthly expenditures. Although not cited by the court, that section could conceivably have provided additional support for the application of the nonjusticiability strand of the filed rate doctrine.

<sup>212</sup> *Ciamaichelo v. Independence Blue Cross*, 909 A.2d 1211, 1217 (2006).

<sup>213</sup> *Id.* at 1212-13 (citing Nonprofit Corporation Law of 1988, 15 PA. CONS. STAT. ANN. §§ 5101-10 (West 1995)).

<sup>214</sup> *Id.* at 1213.

above that necessary for IBC [the defendant] to operate properly, meet its legal obligations, or secure its financial solvency . . . .”<sup>215</sup> The court rejected the reasoning that “allegations in a complaint that could lead to an adjustment of an insurer’s approved rate invariably amount to a rate injury claim.”<sup>216</sup>

While little case law exists on this issue, the goal of the filed rate doctrine to avoid enmeshing courts in agency rate-making procedures supports the application of the filed rate doctrine to claims regarding insurance reserves.<sup>217</sup> Typically, state departments of insurance disapprove rates that are inadequate, unfairly discriminatory, or excessive, and oversee reserves set aside for contingencies.<sup>218</sup> The accumulation of excessive reserves would necessarily involve rates because the remedy would likely be a recalculation of premium from which reserves are obtained.<sup>219</sup> Therefore, rates and reserves are inextricably intertwined. The better view is that under the contours of the filed rate doctrine, issues involving reserves, as well as rates, are within the province of state departments of insurance.

#### D. CLAIMS OF UNMET REGULATORY REQUIREMENTS

In *Richardson v. Standard Guaranty Insurance Co.*, the court addressed the defense that the filed rate doctrine barred the plaintiffs’ allegations that benefits and policy terms were inconsistent with governing regulations of the state’s department of insurance.<sup>220</sup> Specifically, the plaintiffs claimed that the defendant violated state regulations by failing to include refund provisions in policy terms, by failing to remit premium refunds, and through use of a nonconforming form.<sup>221</sup> The court determined

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<sup>215</sup> *Id.* at 1217.

<sup>216</sup> *Id.* at 1218. The court declined to address whether the filed rate doctrine would have applied if the complaint had specifically raised a rate injury claim. *Ciamaichelo v. Independence Blue Cross*, 909 A.2d 1211, 1218 n.8 (2006).

<sup>217</sup> *See, e.g., Wegoland Ltd. v. NYNEX Corp.*, 27 F.3d 17, 19 (2d Cir. 1994) (expressing the opinion that courts should not become enmeshed in the rate-making process).

<sup>218</sup> *See Rios v. State Farm Fire & Cas. Co.*, 469 F. Supp. 2d 727, 736 (S.D. Iowa 2007); *Ciamaichelo*, 909 A.2d at 1216; *Lupton v. Blue Cross & Blue Shield of N.C.*, 533 S.E.2d 270, 273 (N.C. Ct. App. 2000).

<sup>219</sup> *See Lupton*, 533 S.E.2d at 273.

<sup>220</sup> *Richardson v. Standard Guar. Ins. Co.*, 853 A.2d 955, 961 (N.J. Super. App. Div. 2004).

<sup>221</sup> *Id.* at 968.



that “[r]ather than conflict with the doctrine, these alternative claims actually assume the application of the filed rate and filed policy terms.”<sup>222</sup> The court’s ruling is consistent with principles underlying the filed rate doctrine and cases refusing to apply the filed rate doctrine as a bar to claims seeking to recover charges imposed in excess of allowable filed rates.

### XIII. THE EFFECT OF NONCOMPLIANT FILING

Litigants opposed to application of the filed rate doctrine may raise the failure of insurers to meet administrative rate filing requirements. In addressing the issue of improper filing, courts place importance on the language of the statutory scheme involved. A crucial issue is whether the applicable regulations provide that a rate failing to comply with filing requirements is void. Assuming that improperly filed rates are not declared void, a practitioner seeking to benefit from the filed rate doctrine would likely rely upon the “technical defect” rule.<sup>223</sup> As recognized by the court in *In re Pennsylvania Title Insurance Antitrust Litigation*, “the Supreme Court has long held that technical or formal errors do not invalidate an otherwise properly filed rate that sufficiently notices the rate to be charged.”<sup>224</sup> Additionally, the court in *In re Title Insurance Antitrust Cases* stated that even if the rates in that case were improperly filed, “no statute voids those filed and approved rates so as to preclude application of the filed rate doctrine . . . .”<sup>225</sup> Other cases applying the same reasoning include *Dolan v. Fidelity National Title Insurance Co.* and *In re Pennsylvania Title Insurance Antitrust Litigation*.<sup>226</sup>

On the other hand, if an improperly filed rate is declared void, then there is no filed rate and no basis to rely upon the filed rate doctrine as a shield. The court in *In re Pennsylvania Title Insurance Antitrust Litigation* stated that the U.S. Supreme Court in *Security Services, Inc. v. K Mart*

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<sup>222</sup> *Id.*

<sup>223</sup> *See* *Sec. Srvs., Inc. v. K Mart Corp.*, 511 U.S. 431, 442 (1994).

<sup>224</sup> *In re Pa. Title Ins. Antitrust Litig.*, 648 F. Supp. 2d 663, 678-79 (E.D. Pa. 2009) (citing *Berwind-White Coal Mining Co. v. Chi. & Erie R.R. Co.*, 235 U.S. 371, 375 (1914)).

<sup>225</sup> *In re Title Ins. Antitrust Cases*, 702 F. Supp 2d 840, 861 (N.D. Ohio 2010).

<sup>226</sup> *Dolan v. Fid. Nat’l Title Ins. Co.*, 365 F. App’x 271, 273 (2d Cir. 2010), *cert. denied*, 131 S.Ct. 261 (2010); *In re Pa. Title Ins. Antitrust Litig.*, 648 F. Supp 2d at 679.

*Corp* “delineated the scope of the properly filed requirement.”<sup>227</sup> In that case, following its bankruptcy, Security Services, as debtor-in-possession, sued KMart for undercharges allegedly owed based on the difference between the contract rate KMart paid for shipment and the tariff the carrier, Security Services, had on file with the Interstate Commerce Commission.<sup>228</sup> Security Services relied on its filed rate supported by a mileage guide, purportedly filed by an agent, as the basis for mileage computation and charges. Under applicable regulations, however, the rate filing was void because of Security Service’s failure to remit costs for using the mileage guide as its filing.<sup>229</sup> As recognized by the Court, recovery may not be based on “filed, but void, rates.”<sup>230</sup> The Court referenced the filing as “an incomplete tariff insufficient to support a reliable calculation of charges.”<sup>231</sup> Consistent with *Security Services*, the court in *In re Pennsylvania Title Insurance Antitrust Litigation* recognized that the filed rate doctrine may be inapplicable in insurance cases if filing deficiencies result in an inability to calculate a rate.<sup>232</sup>

#### XIV. THE EXTENT OF ADMINISTRATIVE REVIEW REQUIRED

Courts vary on the type of administrative review required to trigger enforcement of the filed rate doctrine. Some courts find the type of review process irrelevant, some require an active review process, and some find the doctrine applicable so long as a process for administrative review is available. Additionally, rebate systems may affect the effectiveness of administrative review in regard to the filed rate doctrine.

The better view is that so long as a state department of insurance retains authority to review and disapprove rates, the filed rate doctrine should apply. Efforts by the judiciary to determine the extent and effectiveness of administrative review would result in the very threat the filed rate doctrine is designed to avoid, enmeshment of the courts in the rate-making process. Of course, the filed rate doctrine should only have application in situations in which administrative review is available. The

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<sup>227</sup> *In re Pa. Title Ins. Antitrust Litig.*, 648 F. Supp. 2d at 678 (citing *Security Serv., Inc. v. KMart Corp.*, 511 U.S. 431, 440 (1994)).

<sup>228</sup> *See Sec. Servs., Inc.*, 511 U.S. at 434.

<sup>229</sup> *Id.* at 436. As noted by Justice Ginsburg in dissent, “[t]he fee involved was approximately \$83.” *Id.* at 457 n.2 (Ginsburg, J., dissenting).

<sup>230</sup> *Id.* at 444.

<sup>231</sup> *Id.* at 443.

<sup>232</sup> *See Pa. Title Ins. Antitrust Litig.*, 648 F. Supp. 2d at 678 (citing *In re Olympia Holding Corp.*, 88 F.3d 952, 961-62 (11th Cir. 1996)).

court in *Clark v. Prudential Insurance Co. of America* correctly recognized that the filed rate doctrine is inapplicable if a rate is filed with an agency with no authority to approve or reject it.<sup>233</sup> Further rationale and authority regarding these issues and the type of administrative review required is discussed below.

A. THE POSITION THAT THE FILED RATE DOCTRINE IS APPLICABLE REGARDLESS OF MEANINGFUL ADMINISTRATIVE REVIEW

Recognizing that “[d]efining the contours of an agency’s review of a filed rate is a task best left to the legislative branch,” the federal district court in *In re Title Insurance Antitrust Cases*, approved the application of the filed rate doctrine even under the assumption that insurance filings lacked meaningful regulatory oversight.<sup>234</sup> In support of its decision, the court relied upon *Square D Co. v. Niagara Frontier Tariff Bureau*, a case in which the U.S. Supreme Court refused to require a hearing before the ICC prior to the institution of rates as a prerequisite for application of the doctrine.<sup>235</sup> According to the court in *In re Title Insurance Antitrust Cases*, “it is the *filing* of the rates with the regulating agency that triggers the filed rate doctrine not any minimum level of review undertaken by the agency.”<sup>236</sup>

Based upon similar reasoning, and in reliance on the Supreme Court’s decision in *Square D*, the court in *In re Pennsylvania Title Insurance Antitrust Litigation* concluded that “as long as the regulatory scheme requires the filing of rates with a government agency that has legal authority to review those rates, the filed rate doctrine applies regardless of the actual degree of agency review of those filed rates.”<sup>237</sup> Other cases reaching similar results include *In re New Jersey Title Insurance Litigation*, where the court stated that “application of the filed rate doctrine does not

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<sup>233</sup> See *Clark v. Prudential Ins. Co. of Am.*, No. Civ. 08-6197 (DRD), 2011 WL 940729, at \*14-15 (D.N.J. Mar. 15, 2011).

<sup>234</sup> *In re Title Ins. Antitrust Cases*, 702 F. Supp. 2d 840, 855 (N.D. Ohio 2010).

<sup>235</sup> See *Square D Co v. Niagara Frontier Tariff Bureau*, 476 U.S. 409, 417 (1986).

<sup>236</sup> *In re Title Ins. Antitrust Cases*, 702 F. Supp. 2d. at 852-53.

<sup>237</sup> *In re Pennsylvania Title Ins. Antitrust Litig.*, 648 F. Supp. 2d 663, 674-75 (E.D. Pa. 2009).

depend upon meaningful agency review of filed rates”<sup>238</sup> and *Schilke v. Wachovia Mortgage, FSB* where the court found agency power to disapprove rates sufficient for application of the filed rate doctrine.<sup>239</sup>

#### B. CASES FINDING ADEQUATE ADMINISTRATIVE REVIEW

Finding the presence of adequate administrative oversight, some courts stop short of stating that meaningful review is irrelevant for purposes of the filed rate doctrine. For example, in *McCray v. Fidelity National Title Insurance Co.*, the court cited authority to the effect that meaningful administrative review may be unnecessary for the doctrine’s application<sup>240</sup> but found that the review process of Delaware, the jurisdiction involved, was indeed “meaningful and competent.”<sup>241</sup>

The administrative scheme at issue in *McCray* was a “file and use” system, whereby rates are filed with the appropriate administrative authority and charged after their effective date unless agency objection is made.<sup>242</sup> Referencing the Supreme Court’s pronouncement in *Montana-Dakota Utilities Co. v. Northwestern Public Services Co.* that parties “can claim no rate as a legal right that is other than the filed rate, whether fixed or merely accepted by the [regulatory body],” the court upheld application of the filed rate doctrine to that type of system.<sup>243</sup> The court in *McCray* found persuasive the fact that neither the rating system involved in *Keogh* nor the one at issue in *Square D* required prior regulatory approval before going into effect.<sup>244</sup> Other cases approving file and use systems to support application of the filed rate doctrine include the Minnesota Supreme Court decision of *Schermer v. State Farm Fire & Casualty Co.*, *Anzinger v. Illinois State Medical Inter-Insurance Exchange*, decided by the Illinois Court of Appeals, and *Horwitz ex rel. Gilbert v. Bankers Life and Casualty*

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<sup>238</sup> *In re N.J. Title Ins. Litig.*, Consolidated Civil Action No. 08-1425, 2009 WL 3233529, at \*2 (D.N.J. Oct. 05, 2009) (citing *Square D Co. v. Niagara Frontier Tariff Bureau, Inc.*, 476 U.S. 409, 417 n.19 (1986)).

<sup>239</sup> See *Schilke v. Wachovia Mortgage, FSB*, 758 F. Supp. 2d 549, 560-61 (N.D. Ill. 2010).

<sup>240</sup> *McCray v. Fidelity Nat’l Title Ins. Co.*, 636 F. Supp. 2d 322, 330 (D. Del. 2009) (citing *Wegoland, Ltd. v. NYNEX Corp.*, 806 F. Supp. 1112, 1120 (S.D.N.Y. 1992), *aff’d*, 27 F.3d 17 (2d Cir. 1994)).

<sup>241</sup> *Id.* at 330.

<sup>242</sup> *Id.* at 325.

<sup>243</sup> *McCray*, 636 F. Supp. 2d at 329 (quoting *Mont.-Dakota Util. Co.*, 341 U.S. at 251) (alteration in original).

<sup>244</sup> See *id.* at 329.

Co., also decided by the Illinois Court of Appeals but applying Colorado law.<sup>245</sup>

In an unpublished decision, citing *Square D*, the Second Circuit in *Dolan v. Fidelity National Title Insurance Co.*, stated that “[i]t is well-established that the doctrine applies to all filed rates, not merely those rates investigated before their approval.”<sup>246</sup>

“Use and file” systems under which an insurer begins using rates before they are filed for regulatory review have also supported application of the filed rate doctrine. For example, the Wisconsin Supreme Court in *Prentice v. Title Insurance Co. of Minnesota* applied the filed rate doctrine to a use and file system under which insurers were required to file rates within thirty days after their effective date.<sup>247</sup> Refusing to distinguish between the doctrine’s application to use and file systems as opposed to file and use systems, the court interpreted Supreme Court precedent as follows: “Under *Keogh*, as interpreted by *Square D*, the existence of a regulatory remedy bars a private rate-related suit for damages under the antitrust laws regardless of whether the regulatory body approved the rates before or after the rates became effective.”<sup>248</sup> Noting that the state’s insurance commissioner had authority to disapprove rates, the court recognized that additionally granting courts authority over rates “would place insurers in a procrustean bed where one rate must conform to the requirements of both the Insurance Commissioner and a trier of fact.”<sup>249</sup>

### C. CASES REQUIRING SIGNIFICANT ADMINISTRATIVE REVIEW

While some insurance cases indicate that the nature of the review is not a critical concern,<sup>250</sup> others require meaningful administrative review prior to application of the filed rate doctrine. For example, in *Rios v. State*

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<sup>245</sup> See, e.g., *Schermer v. State Farm Fire & Cas. Co.*, 721 N.W.2d 307, 309 (Minn. 2006); *Anzinger v. Illinois State Medical Inter-Ins. Exchange*, 494 N.E.2d 655, 658 (Ill. App. Ct. 1986); *Horowitz ex rel. Gilbert v. Bankers Life & Casualty Co.*, 745 N.E.2d 591, 605 (Ill. App. 2001).

<sup>246</sup> *Dolan v. Fid. Nat’l Title Ins. Co.*, 365 Fed. App’x. 271, 274 (2d Cir. 2010), cert. denied, 131 S. Ct. 261 (2010) (citing *Square D Co. v. Niagara Frontier Tariff Bureau, Inc.*, 476 U.S. 409, 417 & n.19 (1986)).

<sup>247</sup> *Prentice v. Title Ins. Co. of Minn.*, 500 N.W.2d 658, 662 (Wis. 1993).

<sup>248</sup> *Id.*

<sup>249</sup> *Id.* at 663.

<sup>250</sup> See *McCray v. Fid. Na’l Title Ins. Co.*, 636 F. Supp. 2d 322, 330 (D. Del. 2009) (citing *Wegoland, Ltd. v. Nynex Corp.*, 806 F. Supp. 1112, 1120 (S.D.N.Y. 1992)).

*Farm Fire & Casualty Co.* the court recognized the necessity of meaningful review as follows:

That is, without the ability to meaningfully regulate the rates at issue, the rationale behind applying the filed rate doctrine (rates approved by an agency are deemed to be per se reasonable and nondiscriminatory) may not be appropriate. For example, if a regulatory agency is so powerless that it only rubber-stamps the rates filed, then it may be inappropriate to apply the filed rate doctrine.<sup>251</sup>

*Brown v. Ticor Title Insurance Co.*,<sup>252</sup> addressing title insurance rates in Arizona and Wisconsin, is often cited for the view that only significant administrative review justifies application of the filed rate doctrine.<sup>253</sup> In finding that prior administrative approval of rates is necessary for application of the filed rate doctrine, the court in *Brown* relied on *Wileman Brothers & Elliott, Inc. v. Giannini*, a case addressing alleged state law antitrust violations in connection with the sale of fruit.<sup>254</sup> The plaintiffs in *Wileman Brothers* claimed that the defendants conspired to wrongfully enact heightened standards for maturity of fruit before it could be marketed.<sup>255</sup> The defendants in *Wileman Brothers* claimed that they could not be held liable for the alleged violations because although the Secretary of Agriculture did not affirmatively approve the standards at issue, the Secretary tacitly approved them by failing to object as allowed by regulation.<sup>256</sup> *Brown* quoted with approval *Wileman Brothers'* disagreement with that proposition as follows:

The mere fact of failure to disapprove, however, does not legitimize otherwise anticompetitive conduct. . . . [Nondisapproval] does not guarantee any level of review

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<sup>251</sup> *Rios v. State Farm Fire & Cas. Co.*, 469 F. Supp. 2d 727, 736 (S.D. Iowa 2007) (citing *Hanson v. Acceleration Life Ins. Co.*, No. CIV A3-97-152, 1999 WL 33283345, at \*4 (D.N.D. Mar. 16, 1999)).

<sup>252</sup> 982 F.2d 386 (9th Cir. 1992).

<sup>253</sup> *E.g.*, *In re Title Ins. Antitrust Cases*, 702 F. Supp. 2d 840, 854 (N.D. Ohio 2010); *McCray*, 636 F. Supp. 2d at 329; *Schermer v. State Farm Fire & Cas. Co.*, 721 N.W.2d 307, 317-18 (Minn. 2006).

<sup>254</sup> *Wileman Bros. & Elliott, Inc. v. Giannini*, 909 F.2d 332, 333-34 (9th Cir. 1990).

<sup>255</sup> *Id.*

<sup>256</sup> *Id.* at 337.

whatsoever. . . [T]here is no affirmative process of non-disapproval which can be relied upon fairly to evaluate a committee's regulations. Second, non-disapproval is equally consistent with lack of knowledge or neglect as it is with assent.<sup>257</sup>

In the *Brown* court's view, the absence of meaningful review allowed insurers to file any rates they wanted.<sup>258</sup> The court in *Brown* did not address *Square D Co. v. Niagara Frontier Tariff Bureau*, in which the U.S. Supreme Court approved application of the filed rate doctrine although rates were not reviewed by the Interstate Commerce Commission prior to their adoption.<sup>259</sup>

Other insurance cases have also referenced a concern with perceived insufficiency in rate review in relation to application of the filed rate doctrine.<sup>260</sup> For example, in *Richardson v. Standard Guaranty Insurance Co.*, the court recognized that a criticism of the filed rate doctrine is its application without the filed rates being rigorously examined or challenged.<sup>261</sup> Although finding the type of regulatory review at issue in the case sufficient, the court stated, "as a general matter, under-enforcement of ratemaking regulations may constitute a basis for a less rigorous application of the filed rate doctrine."<sup>262</sup>

Another case refusing to apply the doctrine to an insurance dispute is *Blaylock v. First American Title Insurance Co.*,<sup>263</sup> a federal district court case in which the plaintiff homeowners sued providers of title insurance complaining of kickbacks in violation of the Washington Consumer Protection Act<sup>264</sup> and the federal Real Estate Settlement Procedures Act.<sup>265</sup>

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<sup>257</sup> *Brown*, 982 F.2d at 393 (quoting *Wileman Bros.*, 909 F.2d at 337-38).

<sup>258</sup> *Id.* at 394.

<sup>259</sup> *Square D Co. v. Niagara Frontier Tariff Bureau*, 476 U.S. 409, 417 (1986).

<sup>260</sup> *E.g.*, *Blaylock v. First Am. Title Ins. Co.*, 504 F. Supp. 2d 1091, 1102-03 (W.D. Wash. 2007); *Hanson v. Acceleration Life Ins. Co.* No. CIV A3-97-152, 1999 WL 33283345, at \*4 (D.N.D. Mar. 16, 1999); *Richardson v. Standard Guar. Ins. Co.*, 853 A.2d 955, 964 (N.J. Super. Ct. App. Div. 2004).

<sup>261</sup> *Richardson v. Standard Guar. Ins. Co.*, 853 A.2d 955, 964 (N.J. Super. Ct. App. Div. 2004).

<sup>262</sup> *Id.*

<sup>263</sup> *Blaylock*, 504 F. Supp. 2d at 1102-03.

<sup>264</sup> WASH. REV. CODE §§ 19.86.010-19.86.920 (1999 & Supp. 2012).

<sup>265</sup> 12 U.S.C. §§ 2601-17 (2006).

In addition to criticizing the filed rate doctrine in general,<sup>266</sup> the *Blaylock* court noted that a factor supporting its decision was that title insurance rates were subject to less comprehensive regulation than other insurance rates in the state.<sup>267</sup> According to the court, title insurance rates were subjected “only to superficial regulation” with no requirement that they receive any review by the insurance commissioner.<sup>268</sup> Therefore, the court left open an issue regarding the applicability of the doctrine to other forms of insurance, such as property and casualty insurance, subjected to more comprehensive regulation.

It is curious that the court in *Blaylock* did not cite another federal district court decision arising in the Western District of Washington decided the previous year, albeit an unpublished one, *Heaphy v. State Farm Mutual Automobile Insurance Co.*, in which the court recognized Washington’s adoption of the filed rate doctrine in the insurance industry.<sup>269</sup> The plaintiffs in *Heaphy* alleged that State Farm failed to properly pay diminished value property damage claims on uninsured motorist policies.<sup>270</sup> Citing *Hardy v. Claircom Communications Group*,<sup>271</sup> distinguished in *Blaylock* on the basis that it involved a rate set by a federal agency in the telecommunications context,<sup>272</sup> the court in *Heaphy* stated that “[t]here is ample authority in this and other jurisdictions to the effect that the reasonableness of a rate cannot be challenged where that rate was required to be (and was) filed with a regulatory agency authorized to review it.”<sup>273</sup> Finding the doctrine applicable in the insurance arena, the court proceeded to rule that while some claims would be allowed to proceed, premium-based claims were barred by the filed rate doctrine.<sup>274</sup>

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<sup>266</sup> *Blaylock*, 504 F. Supp. 2d at 1100 (stating that the doctrine has repeatedly been called into question since its inception).

<sup>267</sup> *Id.* at 1102-03. The more stringent regulatory procedures discussed by the court for other types of insurance included property and casualty insurance. See WASH. REV. CODE § 48.19.010 (2010); *Blaylock*, 504 F. Supp. 2d at 1095-96.

<sup>268</sup> *Blaylock*, 504 F. Supp. 2d at 1102.

<sup>269</sup> *Heaphy v. State Farm Mut. Auto. Ins. Co.*, No. C05 5404RBL, 2006 WL 278556, at \*2 (W.D. Wash. Feb. 2, 2006).

<sup>270</sup> *Heaphy v. State Farm Mut. Auto. Ins. Co.*, No. C05-5404RBL, 2005 WL 2573340 (W.D. Wash. Oct. 12, 2005) (setting forth background information on the claims).

<sup>271</sup> *Hardy v. Claircom Commc’ns*, 937 P.2d 1128 (Wash. Ct. App. 1997).

<sup>272</sup> *Blaylock*, 504 F. Supp. 2d at 1101 n.8.

<sup>273</sup> *Heaphy*, 2006 WL 278556, at \*2 (citing *Hardy*, 937 P.2d 1128, 1131).

<sup>274</sup> *Id.* at \*3.



## D. THE EFFECT OF REBATES

In a dispute involving fees imposed in connection with the provision of homeowners, automobile, and umbrella insurance, the California Court of Appeals in *Fogel v. Farmers Group, Inc.* addressed the effect of sections of the California Insurance Code allowing insurers to rebate excess premiums to policyholders.<sup>275</sup> Based on the rebate option, the court expressed the opinion that the defending insurers were not required to charge any certain rate and that the filed rate doctrine was therefore inapplicable.<sup>276</sup> According to the court, “even if the filed rate doctrine applied in the context of a rate approved by a state regulatory agency (defendants have pointed to no cases in which it was), it nevertheless would have no application here.”<sup>277</sup> The federal district court in the recent unreported decision of *Miletak v. Allstate Insurance Co.* cited with approval the reasoning of *Fogel* regarding the filed rate doctrine.<sup>278</sup>

Significantly, in *MacKay v. Superior Court*, a division of the California Court of Appeals other than the division in *Fogel* disagreed with *Fogel* in regard to the filed rate doctrine.<sup>279</sup> Allegations in *MacKay* that illegal criteria were considered in setting automobile insurance rates and issues involving the availability of a private right of action implicated the same chapter of the state’s insurance code as did the claims in *Fogel*.<sup>280</sup>

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<sup>275</sup> *Fogel v. Farmers Grp., Inc.*, 74 Cal. Rptr. 3d 61, 75 (Ct. App. 2008) (construing CAL. INS. CODE §§ 1420, 1860 (West 2005)).

<sup>276</sup> *Id.* The primary basis of the complaint was that the defending insurers charged excessive fees included in premium rates for acting as attorneys-in-fact for the plaintiffs in regard to insurance transactions. *Id.* at 65-66.

<sup>277</sup> *Id.* at 75. Several cases extending the doctrine to state administrative review are cited in Section VIII of this article although a number were issued after the 2008 *Fogel* decision.

<sup>278</sup> *Miletak v. Allstate Ins. Co.*, No. C 06-03778 JW, 2010 WL 809579, at \*4 (N.D. Cal. Mar. 5, 2010).

<sup>279</sup> *MacKay v. Superior Court*, 115 Cal. Rptr. 3d 893 (Ct. App. 2010). *Fogel* was decided by Fourth Division of the Second District of the Court of Appeal whereas *MacKay* was decided by the Third Division of the Second District.

<sup>280</sup> In addition to sections of the state’s insurance code involving rebates, both *Fogel* and *MacKay* construed sections of Chapter 9, Article 10 of the state’s insurance code entitled “Reduction and Control of Insurance Rates” and the effect of sections added by Proposition 103 approved by voters in 1988. CAL. INS. CODE §§ 1861.01-1861.16 (2005); *MacKay*, 115 Cal. Rptr. 3d at 903; *Fogel*, 74 Cal. Rptr. 3d at 66-68. With some exceptions, the statutory scheme involved pertains to insurance policies issued in the state including property and casualty policies. CAL. INS. CODE § 1851 (2005).

The court in *MacKay* found that the filed rate doctrine supported its conclusion that there could be no tort liability for charging a rate approved by the state's department of insurance expressing disagreement with *Fogel* "to the extent that it rejected the application of the filed rate doctrine to California insurance rates."<sup>281</sup> The *MacKay* court did not see the rebate system referenced in *Fogel* as a bar to application of the doctrine stating as follows in regard to the rebate system:

We do not see this as a bar to the application of the filed rate doctrine. Indeed, as a plan for rebating excess premiums to policyholders "shall not be deemed a rating plan or system," the fact that an excess premium may be rebated does not in any way impact the controlling fact that, once a rating plan has been approved, the insurer may charge no other rate.<sup>282</sup>

Of courts, rates higher than the filed rate would be barred. The court in *MacKay*, however, did not address the effect of the rebate system resulting in insureds paying less than the rate initially filed and approved. Regulatory authorities are concerned with inadequate as well as excessive rates because inadequate rates may lead to insufficient funds with which to pay claims.<sup>283</sup> An issue exists as to whether a possible lack of administrative oversight regarding rebates and reserves reduces concerns regarding the justiciability strand of the filed rate doctrine involving the preservation of agency authority.<sup>284</sup> An interesting note is that the court in *Fogel* cited, but did not analyze, a section of the state's code providing that savings may be returned to subscribers "whenever such returns do not constitute an impairment of the assets or reserves required to be maintained."<sup>285</sup> Presumably, this section would provide a method by which

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<sup>281</sup> *MacKay*, 115 Cal. Rptr. 3d at 910.

<sup>282</sup> *Id.* at 910 n.18 (quoting CAL. INS. CODE § 1860 (West 2005)). Property and casualty insurers in California operate under a prior approval system whereby rates must be approved by the state's insurance commissioner prior to use. *See Fogel*, 74 Cal. Rptr. 3d at 66 (construing CAL. INS. CODE § 1861.01(c) (2005)).

<sup>283</sup> *See In re N.Y. Conference of Blue Cross & Blue Shield Plans v. Muhl*, 684 N.Y.S.2d 312 (App. Div. 1999).

<sup>284</sup> *See Rios v. State Farm Fire & Cas. Co.*, 469 F. Supp. 2d 727, 738 (S.D. Iowa 2007) (recognizing the filed rate doctrine's application if a court decision would impact agency procedures and rate determinations).

<sup>285</sup> *Fogel*, 74 Cal. Rptr. 3d at 75 (citing CAL. INS. CODE § 1420 (West 2005)).

rebates could be policed, thus providing support for application of the filed rate doctrine.

#### XV. ISSUES OF FRAUD AND INEQUITY

Should the filed rate doctrine be disregarded when claims are based on fraud or inequity directed toward either policyholders or the administrative agency involved? The majority of insurance cases hold that claims of fraud do not prevent application of the doctrine. For example, the court in *Richardson v. Standard Guaranty Insurance Co.* reasoned that the doctrine “precludes fraud claims because it operates on the presumption that the plaintiff had knowledge of the filed rates and, thus, could not reasonably rely upon the regulated entity’s misrepresentations or omissions of material facts.”<sup>286</sup> Some courts, as discussed below, clarify that the filed rate doctrine bars claims of fraud only if rates are specifically implicated.

While refusing judicial intervention in the face of fraudulent conduct may seem inequitable, application of the doctrine in such cases avoids discrimination among policyholders and interference by the judiciary in agency affairs. As acknowledged in *Rios v. State Farm Fire and Casualty Co.*, in regulatory matters of federal law, the Supreme Court recognizes that the filed rate doctrine “may seem harsh in some circumstances”<sup>287</sup> but accepts that result in order to prevent courts from upsetting agency authority.<sup>288</sup> Consideration should also be given to the fact that policyholders subjected to fraud may have redress through the agency system in the form of rebates or premium deductions granted to all similarly situated policyholders.<sup>289</sup>

##### A. CASES FINDING THE DOCTRINE NOT BARRED BY ALLEGATIONS OF FRAUD OR INEQUITY

The federal district court for the District of Delaware in *McCray v. Fidelity National Title Insurance Co.* relied on Third Circuit precedent in the telecommunications industry in stating “that there is no fraud-in-the-

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<sup>286</sup> *Richardson v. Standard Guar. Ins. Co.*, 853 A.2d 955, 962 (N.J. Super. Ct. App. Div. 2004) (citing *Weinberg v. Sprint Corp.*, 801 A.2d 281, 286 (N.J. 2002)).

<sup>287</sup> *Rios*, 469 F. Supp. 2d at 739 (quoting *AT&T Co. v. Cent. Office Tel., Inc.*, 524 U.S. 214, 223 (1998)).

<sup>288</sup> *Id.* at 739-40 (citing *H.J. Inc. v. Nw. Bell Tel. Co.*, 954 F.2d 485, 492 (8th Cir. 1992)).

<sup>289</sup> *See H.J. Inc. v. Nw. Bell Tel. Co.*, 954 F.2d 485, 491 (8th Cir. 1992).

rate-setting exception to the filed rate doctrine.”<sup>290</sup> Similarly, the federal district court in *In re Title Insurance Antitrust Cases* broadly stated that “[e]ven assuming as true that the rates submitted by the Defendant were fraudulent or the product of unlawful conduct, the filed rate doctrine still applies to bar Plaintiffs’ claim for damages.”<sup>291</sup>

In refusing to find an exception to the doctrine based upon alleged commission of fraud upon the regulating authority, the court in *Gipson v. Fleet Mortgage Group, Inc.* stated that “by far” the majority of courts considering the issue have refused to find a fraud exception.<sup>292</sup> The court in *Korte v. Allstate Ins. Co.* also recognized that the doctrine applies to claims of fraud “with courts rejecting the idea that there is a fraud exception to its application.”<sup>293</sup> Pointing out that equity does not rule the day when the filed rate doctrine is at issue, the court in *Dolan v. Fidelity National Title Ins. Co.* stated that a court should not consider “the culpability of the defendant’s conduct or the possibility of inequitable results’ when applying the doctrine.”<sup>294</sup> Several other insurance cases also apply the filed rate doctrine to claims involving either allegations of fraud or inequitable conduct.<sup>295</sup>

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<sup>290</sup> *McCray v. Fid. Nat’l Title Ins. Co.*, 636 F. Supp. 2d 322, 332 (D. Del. 2009) (citing *AT&T Corp. v. JMC Telecom, L.L.C.*, 470 F.3d 525, 535 (3d Cir. 2006)).

<sup>291</sup> *In re Title Ins. Antitrust Cases*, 702 F. Supp. 2d 840, 857 (N.D. Ohio 2010).

<sup>292</sup> *Gipson v. Fleet Mortg. Grp., Inc.*, 232 F. Supp. 2d 691, 705 (S.D. Miss. 2002) (citing *Wegoland Ltd. v. NYNEX Corp.*, 27 F.3d 17, 20 (2d Cir.1994); *Taffet v. S. Co.*, 967 F.2d 1483, 1488-90 (11th Cir. 1992); *H.J. Inc.*, 954 F.2d at 494; *Marco Supply Co. v. AT&T Commc’ns, Inc.*, 875 F.2d 434, 436 (4th Cir. 1989)).

<sup>293</sup> *Korte v. Allstate Ins. Co.*, 48 F. Supp. 2d 647, 650 (E.D. Tex. 1999) (citing *Wegoland Ltd. v. NYNEX Corp.*, 27 F.3d 17, 20 (2d Cir. 1994)); *see also* *Transp. Data Interchange, Inc. v. AT&T Corp.*, 920 F. Supp. 86, 89-90 (D. Md. 1996).

<sup>294</sup> *Dolan v. Fid. Nat’l. Title Ins. Co.*, No. 08-CV-00466 (TCP)(WDW), 2009 WL 3934153, at \*3 (E.D.N.Y. 2009) (quoting *Marcus v. AT&T Corp.*, 138 F.3d 46, 58 (2d Cir. 1998)) *aff’d*, 365 Fed. App’x 271 (2d Cir. 2010).

<sup>295</sup> *E.g.*, *Roussin v. AARP, Inc.*, 664 F. Supp. 2d 412, 415 (S.D.N.Y. 2009), *aff’d*, No. 09-4932-CV, 2010 WL 2101912 (2d Cir. May 26, 2010); *In re N.J. Title Ins. Litig.*, No. 08-1425, 2009 WL 3233529, at \*2 (D.N.J. Oct. 5, 2009); *Hooks v. Am. Med. Sec. Life Ins. Co.*, No. 3:06CV71, 2008 WL 3911130, at \*5-6 (W.D.N.C. Aug. 19, 2008); *Alexander v. Washington Mut., Inc.*, No. 07-4426, 2008 WL 2600323, at \*2 (E.D. Pa. June 30, 2008); *Anderson v. City Fin. Co.*, No. Civ.A. 3:02CV1074LN, 2003 WL 21788947, at \*4 n.9 (S.D. Miss. July 14, 2003); *Bender v. Friedman’s Inc.*, No. Civ.A. 4:02CV509LN, 2003 WL 21497487, at \*2

Additionally, although not an insurance case, *H.J. Inc. v. Northwestern Bell Telephone Co.*, a RICO case from the telecommunications industry, is significant in regard to the relation between fraud and the filed rate doctrine.<sup>296</sup> In response to allegations that agency officials accepted bribes in regard to rate setting, the court in *H.J. Inc.* ruled as follows that even improper activity on the part of agency officials did not prevent application of the doctrine:

It is true that the Supreme Court has not considered the question of whether the filed rate doctrine applies when plaintiffs complain that the regulatory agency itself was involved in the alleged fraudulent conduct. We are convinced, however, that the underlying conduct does not control whether the filed rate doctrine applies. Rather, the focus for determining whether the filed rate doctrine applies is the impact the court's decision will have on agency procedures and rate determinations.<sup>297</sup>

In rejecting the position that the filed rate doctrine should be disregarded because the court was not asked to engage in ratemaking, the court in *H.J. Inc.* noted that damages could only be determined by measuring the difference between approved rates and rates that should have been approved absent the alleged wrongful conduct.<sup>298</sup> Making such a determination would, by definition, involve the court in ratemaking procedures.

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n.2 (S.D. Miss. May 30, 2003); *Strong v. First Family Fin. Servs., Inc.*, 202 F. Supp. 2d 536, 545 (S.D. Miss. 2002); *Kirksey v. Am. Bankers Ins. Co. of Fla.*, 114 F. Supp. 2d 526, 529 (S.D. Miss. 2000); *Uniforce Temp. Pers., Inc. v. Nat'l Council on Comp. Ins., Inc.*, 892 F. Supp. 1503, 1511-12 (S.D. Fla. 1995), *aff'd on other grounds*, 87 F.3d 1296 (11th Cir. 1996); *Horowitz ex rel. Gilbert v. Bankers Life & Cas. Co.*, 745 N.E.2d 591, 605 (Ill. App. 2001); *Commonwealth ex rel. Chandler III v. Anthem Ins. Co's., Inc.*, 8 S.W.3d 48, 53 (Ky. App. 1999); *Stepan v. Edina Realty Title, Inc.*, No. A07-0578, 2008 WL 2020434, at \*2-3 (Minn. Ct. App. 2008); *Byan v. Prudential Ins. Co. of Am.*, 662 N.Y.S.2d 44, 45 (App. Div. 1997); *In re Empire Blue Cross & Blue Shield Customer Litig.*, 622 N.Y.S.2d 843, 848 (Sup. Ct. 1994), *aff'd sub nom. Minihane v. Weissman*, 640 N.Y.S.2d 102 (App. Div. 1996).

<sup>296</sup> *H.J. Inc. v. Nw. Bell Tel. Co.*, 954 F.2d 485 (8th Cir. 1992).

<sup>297</sup> *Id.* at 489.

<sup>298</sup> *Id.* at 494.

## B. CASES CLARIFYING THAT THE DOCTRINE APPLIES TO RATE-RELATED FRAUD ONLY

The court in *Rios v. State Farm Fire & Casualty Co.* clarified that the filed rate doctrine bars only rate-related allegations of fraud.<sup>299</sup> The court discussed the history of and the reasoning behind the doctrine as well as its relationship in regard to challenges to services. The court recognized, for example, that the doctrine is implicated when a claim for excessive rates is couched as a claim for inadequate services.<sup>300</sup> In regard to the applicability of the filed rate doctrine, the court further stated that the label placed on a claim, such as fraud, is not the appropriate issue and that instead the “focus for determining whether the filed rate doctrine applies is the impact the court’s decision will have on agency procedures and rate determinations.”<sup>301</sup>

The dispute in *Rios* stemmed from State Farm’s policy regarding the timing of payments for roof repair. In the states involved, State Farm’s initial policy was that it would pay only for a roof overlay when damage was initially incurred,<sup>302</sup> withholding payment for full replacement cost until an entirely new roof was actually in place. If a policyholder did not fully replace a damaged roof within a specified time period, the policyholder never got full replacement cost reimbursement.<sup>303</sup> Later, however, for marketing purposes, State Farm decided to pay the full replacement cost “upfront” when the damage was incurred and issued policies to that effect.<sup>304</sup> After incurring significant unexpected losses, State Farm attempted to remove the upfront payment provision from policies.<sup>305</sup> Of course, outstanding policies retained the provision, and regulatory approval was required before State Farm could legitimately revert to the earlier policy provisions.<sup>306</sup> The plaintiffs alleged that State Farm continued to sell the upfront endorsement policies, although never intending to honor them, and that State Farm fraudulently reverted to the two-part payment system without obtaining regulatory approval.<sup>307</sup>

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<sup>299</sup> *Rios v. State Farm Fire & Cas. Co.*, 469 F. Supp. 2d 727 (S.D. Iowa 2007).

<sup>300</sup> *Id.* at 735.

<sup>301</sup> *Id.* at 737 (quoting *H.J. Inc.*, 954 F.2d at 489).

<sup>302</sup> A roof overlay involves laying new roof shingles on top of existing roof shingles. *Rios*, 469 F. Supp. 2d at 731.

<sup>303</sup> *Id.*

<sup>304</sup> *Id.* at 731-32.

<sup>305</sup> *Id.* at 732.

<sup>306</sup> *Id.*

<sup>307</sup> *Id.*

Under the theory of fraudulent inducement, damages in the form of rescission and disgorgement of premiums for the upfront endorsement were sought by the class of plaintiffs who had not actually sustained roof damage.<sup>308</sup> The court in *Rios* recognized that the plaintiffs could sue for “damages by having been deprived of benefits which were promised, and were consistent with the filed rate, but were not delivered.”<sup>309</sup> The court found, however, that the damages sought, return of the premiums paid for the upfront endorsement, would necessarily and plainly “challenge the rates previously approved by the Commission[er].”<sup>310</sup> In other words, the plaintiffs’ problem was that their damages could only be measured by comparing the difference between the rates the Commissioner approved with the ones that allegedly should have been approved without the upfront endorsement.<sup>311</sup> The court in *Rios* further discussed the need for and application of the filed rate doctrine in relation to the plaintiffs’ claims as follows:

While Plaintiffs argue that the Court would not be involved in any rate making or be required to second guess the rate making agency because they merely seek the full return of all premiums for the Upfront Endorsement, the Court disagrees . . . . As stated above, to appropriately measure Plaintiff’s and Class I members’ damages, the Court would first have to determine the premiums paid for the Upfront Endorsement provision (as opposed to the premiums paid for the entire homeowner’s policy), and then the Court would have to “second guess” what rate the Commissioner would have charged for each relevant Class Period for the homeowners’ policies less the Upfront Endorsement provision.<sup>312</sup>

According to the court, the relief sought by the plaintiffs “falls squarely

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<sup>308</sup> *Rios*, 469 F. Supp. 2d at 733.

<sup>309</sup> *Id.* at 739 (quoting *Richardson v. Standard Guar. Ins. Co.*, 853 A.2d 955, 967 (N.J. Super. App. Div. 2004)).

<sup>310</sup> *Id.* at 738 (quoting *H.J. Inc. v. Nw. Bell Tel. Co.*, 954 F.2d 485, 493 (8th Cir. 1992)).

<sup>311</sup> *Id.* at 739 (citing *Ark. La. Gas Co. v. Hall*, 453 U.S. 571, 577 (1981); *H.J. Inc. v. Nw. Bell Tel. Co.*, 954 F.2d 485, 494 (8th Cir. 1992)).

<sup>312</sup> *Rios*, 469 F. Supp. 2d at 739 (citations omitted).

within the filed rate doctrine.”<sup>313</sup>

Another case closely examining the filed rate doctrine in connection with allegations of wrongdoing, including fraud, is *American Bankers’ Insurance Co. of Florida v. Wells*, a case in which the Supreme Court of Mississippi addressed claims that the defending lender and insurer improperly profited from insurance the lender purportedly obtained to protect its security interest in automobiles sold to the claimants.<sup>314</sup> The court in *Wells* distinguished between allegations of wrongdoing committed in connection with performance of a contract as opposed to claims challenging policy rates. In finding that the claimants sought some premium-related damages barred by the doctrine, the court noted that one of the central allegations of the case was that the lender obtained a credit protection policy with excessive rates and provisions slanted in favor of the lender.<sup>315</sup> The court also recognized that the actual damages claimed by the plaintiffs closely paralleled the premium charges imposed.<sup>316</sup> In remanding the case, the court provided the following instructions to the trial judge.

We remand this case to the trial court for a new trial with directions that Wells and Oliver [claimants] be limited to recovery for damages (if any) resulting from tortious conduct in the performance, rather than the rates and terms, of the contract in question. The trial judge should also be careful, however, to prevent the jury from imposing liability based upon the rates of the policies in question which are subject to oversight by the Department of Insurance in the exercise of its statutory mandate.<sup>317</sup>

Following are claims in *Wells* that the court found arguably fell outside the ambit of the filed rate doctrine:

- Backdating and charging for insurance coverage that was worthless because no damage had occurred during the period.

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<sup>313</sup> *Id.* (quoting *H.J. Inc.*, 954 F.2d at 492). The court noted an unresolved issue, however, involving the state law to be applied to the proposed nationwide class and its effect on the application of the filed rate doctrine. *Id.* at 740.

<sup>314</sup> *Am. Banker’s Ins. Co. of Fla. v. Wells*, 819 So. 2d 1196 (Miss. 2001).

<sup>315</sup> *Id.* at 1204.

<sup>316</sup> *Id.*

<sup>317</sup> *Id.* at 1205 (citation omitted) (emphasis omitted).



- Requiring and charging for automobile insurance based upon an incorrect amount owed.
- Improperly requiring repossession of damaged vehicles.
- Committing fraud by basing premiums on an inaccurate time period and improperly adding surcharges to premiums.<sup>318</sup>

### C. THE EFFECT OF A FAILURE TO DISCLOSE

After addressing both the nondiscrimination and the nonjusticiability strands of the doctrine, the court in *Lentini v. Fidelity National Title Insurance Co. of New York* found the filed rate doctrine inapplicable to claims that the defendant, through its agent, wrongfully failed to disclose the availability of discounted rates for insurance to which plaintiffs were allegedly entitled.<sup>319</sup> Regarding the nonjusticiability strand of the doctrine involving the conclusiveness of agency decision making, the court recognized that the plaintiff was simply attempting to require that the defendant adhere to the approved rates.<sup>320</sup> In regard to the nondiscrimination strand of the doctrine, the court stated that the plaintiff

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<sup>318</sup> *Id.* at 1204-05. Interestingly, the court in *Wells* referenced another Mississippi Supreme Court decision decided the same year, *Am. Bankers Ins. Co. of Fla. v. Alexander*, 818 So. 2d 1073 (Miss. 2001), *overruled on other grounds by Capital City Ins. Co. v. G.B. "Boots" Smith Corp.*, 889 So. 2d 505 (Miss. 2004), which seemed to take a stronger position regarding justification for disregard of the filed rate doctrine in the face of allegations of fraud. *See Am. Bankers Ins. Co. of Fla.*, 818 So.2d at 1083-85. The *Wells* court distinguished *Alexander* on the basis that *Alexander* was reviewed on an interlocutory appeal rather than after a trial on the merits. The court in *Wells* believed the evidence presented at trial established that certain claims were based on excessive premiums in violation of the filed rate doctrine. *Wells*, 308 So.2d at 1205 n.2. The dissent in *Wells*, however, was of the opinion that *Alexander* established that the filed rate doctrine failed to bar the claims at issue in the case involving breach of fiduciary duty, breach of the duty of good faith and fair dealing, and fraud. *Id.* at 1211 (McRae, J., dissenting).

<sup>319</sup> *Lentini v. Fid. Nat'l Title Ins. Co. of N.Y.*, 479 F. Supp. 2d 292 (D. Conn. 2007).

<sup>320</sup> *Id.* at 301 (citing *Randleman v. Fid. Nat'l Title Ins. Co.*, 465 F. Supp. 2d 812 (N.D. Ohio 2006)); *Zanagara v. Travelers Indem. Co. of Am.*, 423 F. Supp. 2d 762, 776 (N.D. Ohio 2006), *vacated on other grounds*, No. 1:05CV731, 2006 WL 825231 (N.D. Ohio Mar. 30, 2006) (previous order vacated based on an issue involving subject matter jurisdiction)).

was seeking to enforce the filed rate, not obtain a lower rate than that charged to other consumers.<sup>321</sup> Of course, whether the defendant had a duty to disclose the information at issue was a question of fact for the jury.<sup>322</sup> The point of the court's ruling was that the filed rate doctrine did not bar the plaintiff from proceeding with proof.

Another case finding that allegations of nondisclosure fell outside the ambit of the filed rate doctrine is *Chambers v. Union National Life Insurance Co.*, an unreported federal district court decision.<sup>323</sup> In that case the court refused to apply the doctrine to bar claims that the defendants wrongfully failed to tell the plaintiff insureds that their policies contained waiver of premium provisions for the disabled.<sup>324</sup> The result of these cases seems correct because the rate enforcement aspect of the doctrine is not served by allowing circumvention of rates by defendants.

## XVI. CHARGES OUTSIDE THE BASIC RATE – INSTALLMENT PAYMENTS, RENEWALS, AND OTHER FEES AND CHARGES

### A. INSTALLMENT PAYMENTS

There is authority to the effect that disputes involving contractual provisions by which insureds, for a fee, may pay insurance premiums by installment are not affected by the filed rate doctrine. For example, in *Farmers Texas County Mutual Insurance Co. v. Romo*, the plaintiffs claimed that by virtue of the filed rate doctrine, the only lawfully prescribed charges were those filed with the state's department of insurance and that because the defending insurers did not file installment payment plan fees, the fees were illegal.<sup>325</sup> The court, however, found in favor of the defendants ruling that the statutes at issue did not require the filing of installment plan charges rendering moot the argument regarding the filed rate doctrine.<sup>326</sup> The case raises the issue, however, of whether the filed rate doctrine would bar judicial relief in regard to installment fees in a state requiring the filing of such fees.

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<sup>321</sup> *Lentini*, 479 F. Supp. 2d at 302.

<sup>322</sup> *Id.* at 301.

<sup>323</sup> *Chambers v. Union Nat'l Life Ins. Co.*, No. Civ.A. 301CV452WS, 2002 WL 32397267 (S.D. Miss. Mar. 29, 2002).

<sup>324</sup> *Id.* at \*4.

<sup>325</sup> *Farmers Tex. Cnty. Mut. Ins. Co. v. Romo*, 250 S.W.3d 527, 533 (Tex. App. 2008).

<sup>326</sup> *Id.* at 538.

The court in *Lapenna v. Government Employees Insurance Co.* an unreported federal district court decision, also found that the filed rate doctrine failed to bar claims regarding the improper assessment of installment payments.<sup>327</sup> According to the court, “the filed rate doctrine is inapplicable here because this dispute centers on installment fees, which are distinct from premium rates.”<sup>328</sup> The installment payment charges at issue in *Lapenna* were governed by statute,<sup>329</sup> and there was no indication that the state required the filing of fees for installment payments with the state department of insurance.

#### B. RENEWALS

In *Hooks v. American Medical Security Life Insurance Co.*, the court refused to accept the plaintiffs’ position that the filed rate doctrine was inapplicable to claims of excessive premium charges for policy renewals.<sup>330</sup> The court recognized that, by statute, readjustment of the premium rate was allowed based on an insurer’s “experience thereunder,” and that the phrase “experience thereunder” referred back to initial rate filings.<sup>331</sup> The court, therefore, reasoned that any decision regarding renewal rates would have to refer back to the initial rates; and that the filed rate doctrine applied as a bar because “[t]he plaintiffs cannot prove their claim without the rates set by the Commissioner being questioned.”<sup>332</sup>

The plaintiffs in *Hooks* also claimed that the defendants wrongfully increased premiums by retaining portions of membership fees.<sup>333</sup> The plaintiffs thought the membership fees at issue were to be paid to another organization they believed they had joined in order to obtain group rates.<sup>334</sup> The court, however, determined that the claim was barred by the filed rate doctrine because the doctrine prohibits the recovery of damages measured by comparing the approved rate and the rate that would have been charged

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<sup>327</sup> *Lapenna v. Gov’t Emps. Ins. Co.*, No. 8:05-cv-904-T-24MSS, 2007 WL 4199580 (M.D. Fla. Nov. 26, 2007), *aff’d*, 316 F. App’x 894 (11th Cir. 2009).

<sup>328</sup> *Id.* at \*2 n.3.

<sup>329</sup> *Id.* at \*3-4.

<sup>330</sup> *Hooks v. Am. Med. Sec. Life Ins. Co.*, No. 3:06cv71, 2008 WL 3911130 (W.D.N.C. Aug. 19, 2008).

<sup>331</sup> *Id.* (construing N.C. GEN. STAT. § 58-51-80(g) (2009)).

<sup>332</sup> *Id.* at \*5 (citing *Lupton v. Blue Cross & Blue Shield of N.C.*, 533 S.E.2d 270, 273 (N.C. Ct. App. 2000)).

<sup>333</sup> *Id.*

<sup>334</sup> *Id.* at \*6.

absent the alleged improper conduct.<sup>335</sup>

The *Hooks* court referenced *Euclid Insurance Agencies, Inc. v. American Association of Orthodontists*,<sup>336</sup> cited by the plaintiffs, recognizing that the court in that case “found that a claim for breach of contract for failing to adjust rates pursuant to the contract was not precluded by the filed rate doctrine.”<sup>337</sup> The court, however, did not discuss that theory further on the basis that the plaintiffs in *Hooks* had not raised a breach of contract claim.<sup>338</sup> *Hooks* raises the issue of whether in some cases by artful pleading, a litigant may be able to avoid the effects of the filed rate doctrine.

### C. OTHER ADMINISTRATIVE FEES

The Supreme Court of Texas in *Mid-Century Insurance Co. of Texas v. Ademaj* approved the assessment of a fee outside the insurer’s filed rates imposed to cover the costs of a state anti-theft program.<sup>339</sup> The state’s insurance commissioner had specifically authorized the imposition of the charge<sup>340</sup> and had promulgated a rule under which insurers were not required to include the fee in rate filings.<sup>341</sup> The plaintiffs claimed that the fee was wrongfully imposed because it was not included in premium rates filed with the state.<sup>342</sup> Although acknowledging that the filed rate doctrine was applied in the state,<sup>343</sup> the court recognized the absence of authority that charges validly approved by the commissioner would be barred by the doctrine and upheld the imposition of the fee.<sup>344</sup> The plaintiffs in *Ademaj* did not assert the filed rate doctrine as it is generally understood—as a bar to challenges of approved rates. The case illustrates, however, the various ways in which the doctrine may be asserted.

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<sup>335</sup> *Id.*

<sup>336</sup> *Euclid Ins. Agencies, Inc. v. Am. Assoc. of Orthodontists*, No. 95 C 3308, 1997 WL 548069 (N.D. Ill. Sept. 3, 1997).

<sup>337</sup> *Hooks*, 2008 WL 3911130, at \*5 n.6.

<sup>338</sup> *Id.*

<sup>339</sup> *Mid-Century Ins. Co. of Tex. v. Ademaj*, 243 S.W.3d 618 (Tex. 2007).

<sup>340</sup> *Id.* at 620.

<sup>341</sup> *Id.* at 624 (citing 28 TEX. ADMIN. CODE § 5.205(b) (1992)).

<sup>342</sup> *Id.* at 625.

<sup>343</sup> *Id.* (citing *Sw. Elec. Power Co. v. Grant*, 73 S.W.3d 211, 216-17 (Tex. 2002)).

<sup>344</sup> *Id.*

## XVII. APPLICATION OF THE FILED RATE DOCTRINE IN SPECIFIC AREAS

While the filed rate doctrine is not limited to specific realms, it does seem to appear more frequently in relation to certain types of claims. Following is a discussion of the doctrine as applied to antitrust claims, discrimination claims, alleged violations of the Racketeer Influenced and Corrupt Organizations Act,<sup>345</sup> breach of contract claims, and to allegations regarding the wrongful receipt of kickbacks or unearned premiums—all areas in which the doctrine is commonly raised.

### A. RESTRAINT OF TRADE AND ANTITRUST CLAIMS

The filed rate doctrine arises frequently in conjunction with claims of antitrust and restraint of trade violations in the insurance industry. For example, in *Allen v. State Farm Fire & Casualty Co.* the court recognized that the gravamen of the plaintiffs' claims was that the defending insurers concertedly and in restraint of trade agreed not to offer homeowners' insurance coverage in coastal areas unless a percentage-based hurricane deductible was allowed.<sup>346</sup> In ruling that the claims were barred for reasons including the filed rate doctrine, the court recognized that the doctrine "prohibits a party from recovering damages measured by comparing the filed rate and the rate that might have been approved absent the conduct in issue."<sup>347</sup> The court further set forth its reasoning as follows:

Allowing the plaintiffs to circumvent the established statutory process for approval of insurance rates by allowing the Court to become enmeshed in the rate-making process would undermine Alabama's current regulatory regime, which, through its statutory administrative remedies, is designed to be self-policing. If this Court strikes the hurricane deductible, thereby increasing coverage under the policies, that necessarily affects a decrease in the defendants' effective rates and disturbs the commissioner's rate-making authority. Therefore, pursuant

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<sup>345</sup> 18 U.S.C. §§ 1961-68 (2006 & Supp. III 2009).

<sup>346</sup> *Allen v. State Farm Fire & Cas. Co.*, 59 F. Supp. 2d 1217, 1230 (S.D. Ala. 1999).

<sup>347</sup> *Id.* at 1227 (quoting *Calico Trailer Mfg. Co. v. Ins. Co. of N. Am.*, 155 F.3d 976, 977 (8th Cir. 1998)).

to the filed-rate doctrine, this Court concludes that plaintiffs' claims challenging the unlawfulness of the defendants' rate filing, which include the hurricane deductible, are due to be dismissed.<sup>348</sup>

Many other cases have also relied on the filed rate doctrine in dismissing claims of antitrust violations arising under federal and state law,<sup>349</sup> although there is contrary authority.<sup>350</sup>

The following sections address exceptions in the insurance field that have been claimed in relation to application of the doctrine in antitrust cases. Of course, as discussed in Section V of this article, litigants in insurance cases involving interplay between state and federal law should consider the impact of the McCarran-Ferguson Act<sup>351</sup> as well as the filed rate doctrine.

#### 1. Issues Involving Alleged Non-Rate Anticompetitive Activity

Citing *In re Lower Lake Erie Iron Ore Antitrust Litigation*,<sup>352</sup> the court in the insurance case of *In re Pennsylvania Title Insurance Antitrust*

<sup>348</sup> *Id.* at 1229.

<sup>349</sup> *E.g.*, *Winn v. Alamo Title Ins. Co.*, 372 F. App'x 461, 462-63 (5th Cir. 2010); *Dolan v. Fid. Nat'l Title Ins. Co.*, 365 F. App'x 271, 272-73 (2d Cir. 2010); *In re Title Ins. Antitrust Cases*, 702 F. Supp. 2d 840, 890 (N.D. Ohio 2010); *In re N.J. Title Ins. Litig.*, No. 08-1425, 2009 WL 3233529, at \*2-4 (D.N.J. Oct. 5, 2009); *Uniforce Temp. Pers., Inc. v. Nat'l Council on Comp. Ins., Inc.*, 892 F. Supp. 1503, 1511-12 (S.D. Fla. 1995), *aff'd on other grounds*, 87 F.3d 1296, 1301 (11th Cir. 1996); *Calico Trailer Mfg. Co., Inc. v. Ins. Co. of N. Am.*, LR-C-93-717, 1994 WL 823554, at \*1-2, \*8 (E.D. Ark. Oct. 12, 1994); *Amundson & Assocs. Art Studio, Ltd. v. Nat'l Council on Comp. Ins., Inc.*, 988 P.2d 1208, 1213, 1216-17 (Kan. Ct. App. 1999) (applying the doctrine to claims arising under state antitrust claims); *N.C. Steel, Inc. v. Nat'l Council on Comp. Ins.*, 496 S.E.2d 369, 372 (N.C. 1998) (applying the doctrine to state antitrust claims); *Prentice v. Title Ins. Co. of Minn.*, 500 N.W.2d 658, 659, 663-64 (Wis. 1993) (applying the filed rate doctrine to antitrust action arising under state law).

<sup>350</sup> *See Brown v. Ticor Title Ins. Co.*, 982 F.2d 386, 393-94 (9th Cir. 1992). *Brown* is discussed in detail in Section XIV C. of this article, addressing the type of administrative review required for imposition of the doctrine. *See supra* pp. 42-48.

<sup>351</sup> 15 U.S.C. §§ 1011-15 (2006).

<sup>352</sup> *In re Pa. Title Ins. Antitrust Litig.*, 648 F. Supp. 2d 663, 680 (E.D. Pa. 2009) (citing *In re Lower Lake Erie Iron Ore Antitrust Litig.*, 998 F.2d 1144, 1159-61 (3d Cir. 1993)).

*Litigation* recognized that the Third Circuit has “carved out a non-rate anticompetitive activity exception” to the filed rate doctrine’s preclusive effect in antitrust actions. Under that exception, the filed rate doctrine does not apply to situations, such as that occurring in *Lower Lake Erie*, in which it was found that the defendants acted to inhibit lower cost competitors from entering the shipping market following technological advances enabling shipment of iron ore by means other than rail.<sup>353</sup> Specifically, the railroads illegally conspired and acted to prevent the movement of iron ore by trucking through, for example, restricting the lease and sale of railroad-owned dock property.<sup>354</sup> The plaintiffs contended that absent the conspiracy, they would have paid lower costs for the transportation of iron ore.<sup>355</sup> Addressing the fact that rates were filed with the ICC, the court in *Lower Lake Erie* explained the non-rate activity exception to the filed rate doctrine as follows:

We recognize that the success of anticompetitive non-rate activity would coincidentally implicate rates promulgated under the jurisdiction of the ICC. It is fully consistent with *Keogh* [*v. Chicago & Northwestern Railway Co*], however, to accept these rates as lawful and nonetheless to conclude that through non-rate activities, particularly the restriction on the sale or lease of dock space and the refusal to deal with potential competitors, the railroads effectively retarded entry of lower cost competitors to the market. The instrument of damage to the steel companies was the absence of the lower-cost combination. In contrast, the Supreme Court in *Keogh* made it clear that “the instrument by which *Keogh* is alleged to have been damaged is rates approved by the Commission.”<sup>356</sup>

The court in *Lower Lake Erie* recognized that “[i]t was the railroads’ hindering the development of the market which defines this antitrust litigation.”<sup>357</sup>

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<sup>353</sup> See *Lower Lake Erie*, 998 F.2d at 1159-61; *In re Pa. Title Ins. Antitrust Litig.*, 648 F. Supp. 2d at 680 (citing *Bar Techs., Inc. v. Conemaugh & Black Lick R.R. Co.*, 73 F. Supp. 2d 512, 518 (W.D. Pa. 1999)).

<sup>354</sup> *Lower Lake Erie*, 998 F.2d at 1152-53.

<sup>355</sup> *Id.* at 1154.

<sup>356</sup> *Id.* at 1159 (quoting *Keogh v. Chicago & Nw. Ry.*, 260 U.S. 156, 161 (1922)).

<sup>357</sup> *Id.* at 1160.

On the other hand, the court in *In re Pennsylvania Title Insurance Antitrust Litigation* cited *Utilimax.com, Inc. v. PPL Energy Plus, LLC*<sup>358</sup> as an example of the type of situation to which the non-rate anticompetitive activity exception is inapplicable.<sup>359</sup> In *Utilimax* the plaintiff, a retail supplier of electricity, claimed that the defendant, through its monopolistic position, exerted undue market influence over the wholesale electricity market enabling it to charge excessive rates.<sup>360</sup> The court in *Utilimax* distinguished *Lower Lake Erie* on the basis that the dispute in *Lower Lake Erie* dealt with activities wholly separate from rates.<sup>361</sup> The *Utilimax* court was of the opinion that the plaintiff, in simply claiming that the defendant “exploited its market position by raising its rates,” failed to allege non-rate anticompetitive activity and, therefore, the filed rate doctrine barred the claims.<sup>362</sup>

The court in *In re Pennsylvania Title* found that the alleged wrongdoing in that case fell closer to market exploitation, which the *Utilimax* court considered rate-related, than market exclusion, which the *Lake Erie* court considered non-rate related. The determining factor in the court’s opinion was that the plaintiffs challenged the rates themselves, not activity separate from the rates.<sup>363</sup> This exception to the filed rate doctrine is not frequently referenced in insurance cases. As the doctrine continues to develop, it would not be unexpected for plaintiffs to focus on non-rate activities in an effort to avoid the effects of the doctrine.

## 2. The Impact of “Price Squeeze” Cases

The plaintiffs in *McCray v. Fidelity National Title Insurance Co.* claimed that the filed rate doctrine was inapplicable to claims of price fixing in relation to insurance rates because the insurance regulatory regime involved was insufficiently comprehensive.<sup>364</sup> Specifically, the plaintiffs

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<sup>358</sup> 378 F.3d 303 (3d Cir. 2004).

<sup>359</sup> *In re Pa. Title Ins. Antitrust Litig.*, 648 F. Supp. 2d 663, 680 (E.D. Pa. 2009) (citing *Utilimax*, 378 F.3d at 308).

<sup>360</sup> *Utilimax*, 378 F.3d at 306.

<sup>361</sup> *Id.* at 308.

<sup>362</sup> *Id.* Although finding it inapplicable, the court in *Utilimax* also referenced a competitor exception to the filed rate doctrine. The reasoning for such a rule is that competitors are not the intended beneficiaries of rate regulation. *Id.* at 307. That exception has not been analyzed in insurance cases.

<sup>363</sup> *In re Pa. Title Ins. Antitrust Litig.*, 648 F. Supp. 2d at 680.

<sup>364</sup> *McCray v. Fid. Nat’l Title Ins. Co.*, 636 F. Supp. 2d 322, 330 (D. Del. 2009).



complained that the regulations failed to provide claimants with monetary relief for rates initially accepted by the state's department of insurance but later found to be unreasonable or fraudulent.<sup>365</sup> According to the plaintiffs, their claims fell into a type of "regulatory lacuna" counseling against the application of the filed rate doctrine.<sup>366</sup> The court noted that the plaintiffs primarily relied on "price squeeze" cases in support of their argument.<sup>367</sup>

The court in *Borough of Lansdale v. PP & L, Inc.*, a case arising in the electric industry cited by the *McCray* court,<sup>368</sup> explained that a price squeeze case generally involves a defending monopolist who supplies the plaintiff at one level, such as at the wholesale level; competes with the plaintiff on another level, such as at retail; and then seeks to destroy the plaintiff by charging the plaintiff a higher wholesale price than other retail customers.<sup>369</sup> The court in *Borough of Lansdale* recognized that when no one regulatory agency has complete jurisdiction over the rating system at issue in a price squeeze claim, the filed rate doctrine is inapplicable.<sup>370</sup> On the basis that two agencies were involved in the rating system at issue, the court refused to apply the filed rate doctrine to bar the plaintiff's price squeeze claims stating that application of the doctrine would result in "no mechanism to reiew overall ratemaking and its potential anticompetitive effects."<sup>371</sup>

The court in *McCray* correctly reasoned that the situation presented in that case did not qualify for any such exception stating: "The plaintiffs' claim falls into no regulatory lacuna. There is but one regulatory authority here . . . and it is fully empowered to regulate the one rate at issue here that involves title insurance premiums."<sup>372</sup> The court, however, stopped short of ruling that a price squeeze situation involving, for example, competing regulatory authority would fail to qualify as an exception to the filed rate

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<sup>365</sup> *Id.*

<sup>366</sup> *Id.*

<sup>367</sup> *Id.* (citing *Kirkwood v. Union Elec. Co.*, 671 F.2d 1173, 1176 (8th Cir. 1982); *City of Mishawaka v. Ind. & Mich. Elec. Co.*, 560 F.2d 1314, 1321 (7th Cir. 1977)).

<sup>368</sup> *McCray*, 636 F. Supp. 2d at 330-31 (citing *Borough of Lansdale v. PP & L, Inc.*, 503 F. Supp. 2d 730, 736 (E.D. Pa. 2007)).

<sup>369</sup> *Borough of Lansdale v. PP & L, Inc.*, 503 F. Supp. 2d 730, 735 (E.D. Pa. 2007).

<sup>370</sup> *Id.* at 742. The court, however, recognized the existence of contrary authority on the issue of whether the filed rate doctrine bars price squeeze claims implicating the jurisdiction of more than one set of rate regulations. *Id.* at 736.

<sup>371</sup> *Id.* at 742.

<sup>372</sup> *McCray*, 636 F. Supp. 2d at 331.

doctrine.

### 3. Allegations of Illegal Boycotts

Claims of boycott are typical in the antitrust arena although there is little case law addressing the relationship between boycotts and the filed rate doctrine. The court in *Arroyo-Melecio v. Puerto Rican American Insurance Co.* refused to apply the filed rate doctrine to bar allegations that private insurers, who allegedly benefited from the placement of compulsory insurance with a state-created agency, engaged in a boycott to punish an insurance broker for aiding in the private placement of compulsory insurance.<sup>373</sup> Quoting the First Circuit decision of *Town of Norwood v. New England Power Co.* for the proposition that “[t]he law on the filed rate doctrine is extremely creaky,”<sup>374</sup> the court stated that “[w]e think that boycott has little to do with the filed rate doctrine, a famously complex and sometimes criticized set of rules.”<sup>375</sup> In reaching its conclusion, the court focused on aspects of the filed rate doctrine prohibiting contractual agreements or other claims seeking rates different from those reflected in agency filings, not activity associated with boycotts.<sup>376</sup> Arguably, however, because agency procedures and rate determinations would be affected, if the gravamen of a claim is that excessive rates were charged due to a boycott, the filed rate should be applicable in jurisdictions recognizing its application in the insurance arena.<sup>377</sup>

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<sup>373</sup> *Arroyo-Melecio v. P.R. Am. Ins. Co.*, 398 F.3d 56, 69, 73 (1st Cir. 2005).

<sup>374</sup> *Id.* at 73 (quoting *Town of Norwood v. New England Power Co.*, 202 F.3d 408, 420 (1st Cir. 2000)).

<sup>375</sup> *Arroyo-Melecio*, 398 F.3d at 73. *See also In re Lower Lake Erie Iron Ore Antitrust Litig.*, 998 F.2d 1144, 1159 (3d Cir. 1993).

<sup>376</sup> *Arroyo-Melecio*, 398 F.3d at 73 (citing *Town of Norwood v. Fed. Energy Regulatory Comm’n*, 217 F.3d 24, 28 (1st Cir. 2000)).

<sup>377</sup> *See, e.g., Roussin v. AARP, Inc.*, 664 F. Supp. 2d 412, 416-17 (S.D.N.Y. 2009) (recognizing that because the plaintiff was actually complaining of rates, the filed rate doctrine applied to claims styled as breach of fiduciary duties and gross negligence), *aff’d*, 379 F.App’x 30, 31 (2d Cir. 2010); *Rios v. State Farm Fire & Cas. Co.*, 469 F. Supp. 2d 727, 735 (S.D. Iowa 2007) (refusing to countenance avoidance of the doctrine through styling a claim for excessive rates as a claim for inadequate service).

## B. DISCRIMINATION AGAINST PROTECTED CATEGORIES

Cases of unlawful discrimination in the area of insurance may involve claims of “redlining” involving allegations that a defendant refused to insure properties located in districts with a high population of minorities.<sup>378</sup> Plaintiffs have also alleged the subjection of minorities to illegal discrimination through the use of credit scores to set insurance rates.<sup>379</sup> Plaintiffs in cases alleging discrimination have had varying degrees of success when confronted with the filed rate doctrine defense. Based on the following case law, depending on the jurisdiction involved, it seems that plaintiffs may fare better in regard to avoiding the effects of the filed rate doctrine when proceeding under federal law and also when proceeding under broad based anti-discrimination laws as compared to anti-discrimination regulations specifically impacting insurance.<sup>380</sup>

### 1. Authority that the Filed Rate Doctrine Bars Discrimination Claims

*Schermer v. State Farm Fire & Casualty Co.*, decided by the Minnesota Supreme Court, involved a class action alleging that a surcharge imposed on older homes was racially discriminatory and a form of redlining.<sup>381</sup> The plaintiffs sued on the basis of a Minnesota statute prohibiting the charge of differential rates for homeowner’s insurance solely because of the age of the structure but allowing rating standards based on the age of components of the residence, such as the electrical system, affecting the risk of loss.<sup>382</sup> The plaintiffs alleged that the rate differential was illegally based on home age rather than electrical system age, as claimed by the defending insurer.<sup>383</sup> Upholding the filed rate

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<sup>378</sup> See, e.g., *Schermer v. State Farm Fire & Cas. Co.*, 721 N.W.2d 307 (Minn. 2006).

<sup>379</sup> See, e.g., *Lumpkin v. Farmers Grp., Inc.*, No. 05-2868 Ma/V, 2007 WL 6996584 (W.D. Tenn. Apr. 26, 2007).

<sup>380</sup> Compare *Schermer*, 721 N.W.2d 307 (Minn. 2006) (applying the doctrine to bar claims under state laws specifically prohibiting discrimination in the provision of home owner’s insurance), with *Saunders v. Farmers Ins. Exch.*, 440 F.3d 940 (8th Cir. 2006) (refusing to apply the doctrine to bar claims under federal anti-discrimination laws).

<sup>381</sup> *Schermer*, 721 N.W.2d 307 (Minn. 2006).

<sup>382</sup> The court referred to the statute involved, MINN. STAT. ANN. § 72A.20 (West 2011), as the “anti-redlining” statute. *Schermer*, 721 N.W.2d at 309.

<sup>383</sup> *Schermer*, 721 N.W.2d at 309.

doctrine, the court ruled that the claims were barred even assuming the truth of the plaintiffs' allegations.<sup>384</sup>

In discussing exceptions to the filed rate doctrine, the court in *Schermer* referenced *Saunders v. Farmers Insurance Exchange*,<sup>385</sup> an Eighth Circuit decision discussed further below, for the proposition that “where a rate filed with a state regulatory agency violates a federal antidiscrimination statute, the federal statute predominates under the Supremacy Clause and the filed rate doctrine is inapplicable.”<sup>386</sup> The *Schermer* court did not specifically express agreement or disagreement with the holding in *Saunders*. An issue exists, however, as to whether the court in *Schermer* would have ruled differently had a claim under federal anti-discrimination law been raised as opposed to a claim under state law specifically addressing insurance rates. Additionally, the court in *Schermer* recognized that the plaintiffs in that case had not filed a claim under the Minnesota Human Rights Act<sup>387</sup> thereby leaving open the issue of whether the filed rate doctrine would have applied in that instance.<sup>388</sup>

## 2. Authority that the Filed Rate Doctrine is Inapplicable to Discrimination Claims

In *Saunders v. Farmers Insurance Exchange*, plaintiffs sued numerous insurers under the federal Fair Housing Act<sup>389</sup> and under Sections 1981<sup>390</sup> and 1982<sup>391</sup> of the Civil Rights Acts, alleging race discrimination in connection with the provision of homeowners' insurance coverage.<sup>392</sup> The court stated that on the record involved, state regulation of insurance rates did not support applying the filed rate doctrine to bar damage claims arising under federal civil rights statutes.<sup>393</sup> In reliance on the Supremacy Clause of the United States Constitution,<sup>394</sup> the court

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<sup>384</sup> *Id.* at 319.

<sup>385</sup> *Saunders v. Farmers Insurance Exchange*, 440 F.3d 940 (8th Cir. 2006).

<sup>386</sup> *Schermer*, 721 N.W.2d at 317 (citing *Saunders v. Farmers Ins. Exch.*, 440 F.3d at 944-45).

<sup>387</sup> MINN. STAT. ANN. §§ 363A.01-41 (2011).

<sup>388</sup> *Schermer*, 721 N.W.2d at 317 n.6.

<sup>389</sup> 42 U.S.C. §§ 3601-19 (2000).

<sup>390</sup> *Id.* § 1981 (2012).

<sup>391</sup> *Id.* § 1982.

<sup>392</sup> *Saunders v. Farmers Ins. Exch.*, 440 F.3d 940 (8th Cir. 2006).

<sup>393</sup> *Saunders*, 440 F.3d at 943.

<sup>394</sup> U.S. CONST. art. VI, cl. 2.

distinguished *Keogh v. Chicago & Northwestern Railway Co.*<sup>395</sup> and *Square D Co. v. Niagara Frontier Tariff Bureau, Inc.*,<sup>396</sup> stating that in those cases the Supreme Court “harmonized two federal statutes with competing purposes, the Sherman Act and the Interstate Commerce Act, whereas here the Supremacy Clause tips any legislative competition in favor of the federal anti-discrimination statutes.”<sup>397</sup>

A perplexing issue acknowledged by the court in *Saunders* involves the effect of the number of decisions applying the filed rate doctrine based on rates filed with state regulatory agencies to bar, for example, federal RICO and antitrust claims.<sup>398</sup> The court distinguished those cases as follows based on an issue of standing:

But RICO and the Sherman Act require a plaintiff to prove injury to “his business or property.” 18 U.S.C. § 1964(c). Thus, the no-injury principle of *Keogh* applies to deprive a RICO or antitrust plaintiff of standing under federal law to challenge a filed rate that must be charged under state law. But standing to sue under federal anti-discrimination statutes such as the Fair Housing Act is far broader. See *Trafficante v. Metropolitan Life Ins. Co.*, 409 U.S. 205, 93 S.Ct. 364, 34 L.Ed.2d 415 (1972).<sup>399</sup>

No other cases have been located adopting the court’s reasoning regarding standing.<sup>400</sup>

A case in which the filed rate doctrine was raised in an unusual context in regard to a discrimination claim is *Lyons v. First American Title Insurance Co.*<sup>401</sup> The plaintiffs in *Lyons* claimed that the defendant

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<sup>395</sup> *Keogh v. Chicago & N.W. Ry. Co.*, 260 U.S. 156 (1922).

<sup>396</sup> *Square D Co. v. Niagara Frontier Tariff Bureau, Inc.*, 476 U.S. 409 (1986).

<sup>397</sup> *Saunders*, 440 F.3d at 944.

<sup>398</sup> See *id.* at 944 (citing *Texas Commercial Energy v. TXU Energy, Inc.*, 413 F.3d 503 (5th Cir. 2005); *Wegoland Ltd. v. NYNEX Corp.*, 27 F.3d 17 (2d Cir. 1994); *H.J. Inc. v. Nw. Bell Tel. Co.*, 954 F.2d 485 (8th Cir. 1992); *Taffet v. S. Co.*, 967 F.2d 1483 (11th Cir. 1992)).

<sup>399</sup> *Saunders*, 440 F.3d at 944.

<sup>400</sup> *Trafficante v. Metro. Life Ins. Co.*, 409 U.S. 205 (1972), quoted by *Saunders*, involved the standing of tenants who were not themselves denied housing to enforce rights under federal law prohibiting housing discrimination. *Id.* at 211. The filed rate doctrine was not at issue.

<sup>401</sup> *Lyons v. First Am. Title Ins. Co.*, No. C09-4156(PJH), 2009 WL 5195866 (N.D. Cal. Dec. 22, 2009).

discriminated against minority homeowners in the provision of insurance.<sup>402</sup> The defendant relied on a section of the state's code providing that acts taken pursuant to authority conferred by the rate regulation section of the state's code failed to provide grounds for civil proceedings.<sup>403</sup> The plaintiffs countered with the claim that the defendants actually relied on the filed rate doctrine, a theory that had been discredited.<sup>404</sup> The court found the plaintiffs' argument unpersuasive, stating that the filed rate doctrine is "traditionally employed as a bar to actions in the antitrust context, not the discrimination context."<sup>405</sup>

In a case involving allegations of race discrimination in connection with the use of credit scoring information to set rates, the Fifth Circuit in *Dehoyos v. Allstate Corp.* addressed the effect of the filed rate doctrine in dicta in an interlocutory appeal primarily involving the application of the McCarran-Ferguson Act<sup>406</sup> to federal anti-discrimination statutes.<sup>407</sup> Although noting that it was not required to address the issue because it was initially raised during the appeal, the court found the defendant's filed rate argument unpersuasive, expressing the opinion that application of anti-discrimination laws would not supplant the state rate controls at issue.<sup>408</sup> Likewise, in *Lumpkin v. Farmers Group, Inc.*,<sup>409</sup> the court refused to find the plaintiff's claims of racial discrimination based on the use of credit scores in pricing homeowners' insurance barred by the doctrine, stating that "[w]here consumers do not challenge the reasonableness of the insurance rates...the filed rate doctrine does not apply."<sup>410</sup>

### C. CLAIMS UNDER THE RACKETEER INFLUENCED AND CORRUPT ORGANIZATIONS ACT

The filed rate doctrine may provide a basis upon which to oppose claims under the Racketeer Influenced and Corrupt Organizations Act

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<sup>402</sup> *Id.* at \*2.

<sup>403</sup> *Id.* at \*5 (citing Cal. Ins. Code 12414.26 (West 2005)).

<sup>404</sup> *Id.* at \*5.

<sup>405</sup> *Id.* at \*7.

<sup>406</sup> 15 U.S.C. §§ 1011-15 (1994).

<sup>407</sup> *Dehoyos v. Allstate Corp.*, 345 F.3d 290 (5th Cir. 2003).

<sup>408</sup> *Id.*

<sup>409</sup> No. 05-2868(Ma/V), 2007 WL 6996584 (W.D. Tenn. Apr. 26, 2007).

<sup>410</sup> *Lumpkin*, 2007 WL 6996584 at \*8 (citing *Zangara v. Travelers Indem. Co. of Am.*, 423 F. Supp. 2d 762, 775 (N.D. Ohio 2006)).

(“RICO”)<sup>411</sup> allegedly impacting a state’s insurance rating system. Prevailing on the doctrine as a defense to a RICO claim, however, is not a certainty. For example, in addressing defenses under the McCarran-Ferguson Act and the filed rate doctrine to RICO claims, the federal district court in the recent case of *In re American Investors Life Insurance Co. Annuity Marketing and Sales Practices Litigation*, stated that “[t]hese arguments raise difficult issues, the outcome of which is uncertain.”<sup>412</sup> The logical conclusion is that RICO claims in the insurance industry would be analyzed in the same manner as other theories with the filed rate doctrine applying in situations in which the insurance rating system is implicated.

### 1. Authority Applying the Doctrine to RICO Claims

Two unpublished federal court decisions from the Southern District of New York applied the filed rate doctrine to bar RICO claims in the insurance industry. In *In re EVIC Class Action Litigation*, the plaintiffs sued on various theories complaining about insurance charges imposed by United Parcel Service, Inc.<sup>413</sup> Based on the filed rate doctrine, the court dismissed a number of counts, including RICO claims, alleging damages during the time period that the defendant was required to file tariffs with the ICC.<sup>414</sup> Similarly, the court in *Fersco v. Empire Blue Cross/Blue Shield of New York* found that the filed rate doctrine barred plaintiffs’ RICO allegations that the defendant obtained approval of its rates through the use of fraud.<sup>415</sup> The court relied heavily upon *Wegoland Ltd. v. NYNEX Corp.*,<sup>416</sup> involving RICO claims in the telecommunications industry, for the proposition that there is no fraud exception to the filed rate doctrine.<sup>417</sup> In rejecting the argument that consideration of the rate-making process was

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<sup>411</sup> 18 U.S.C. §§ 1961-68 (2006 & Supp. III 2009).

<sup>412</sup> *In re Am. Inv. Life Ins. Co. Annuity Mktg. & Sales Practices Litig.*, 263 F.R.D. 226, 242 (E.D. Pa. 2009), *enforced in part*, 695 F. Supp. 2d 157 (E.D. Pa. 2010). The court made the quoted statement in connection with the approval of a proposed class action settlement without further analysis of the filed rate doctrine. *Id.*

<sup>413</sup> *In re Evic Class Action Litig. v. United Parcel Serv.*, Nos. 00-CIV-3811(RMB), 02-CIV-2703(RMB), M-21-84(RMB), MDL-1339, 2002 WL 1766554, at \*1 (S.D.N.Y. July 31, 2002).

<sup>414</sup> *In re EVIC Class Action Litig.*, 2002 WL 1766554 at \*5-7.

<sup>415</sup> *Fersco v. Empire Blue Cross/Blue Shield of N.Y.*, No. 93 Civ. 4226 (JFK), 1994 WL 445730, at \*1 (S.D.N.Y. Aug. 17, 1994).

<sup>416</sup> *Wegoland Ltd. v. NYNEX Corp.*, 27 F.3d 17 (2d Cir. 1994).

<sup>417</sup> *Fersco*, 1994 WL 445730, at \*2 (citing *Wegoland*, 27 F.3d at 21).

not needed in order to determine if fraud was the basis for the challenged rate increase, the court stated that ascertaining damages and determining a reasonable rate “are hopelessly intertwined.”<sup>418</sup>

A number of insurance cases indicate in dicta that the filed rate doctrine applies to RICO claims.<sup>419</sup> For example, although not a RICO case, the court in *Allen v. State Farm Fire & Casualty Co.* cited with approval *Taffet v. Southern Co.*,<sup>420</sup> a RICO case arising in the electric industry, for the proposition that the filed rate doctrine applies even if the regulated entity defrauded the regulatory agency to obtain a filed rate.<sup>421</sup> Additionally, although disapproving the application of the filed rate doctrine to claims of discrimination, the Eighth Circuit in *Saunders v. Farmers Insurance Exchange* referenced with approval cases from other industries applying the doctrine to alleged RICO violations.<sup>422</sup>

## 2. Authority Refusing to Apply the Doctrine to RICO Claims

The federal district court for the Southern District of Florida in *In re Managed Care Litigation* addressed claims asserted under RICO that through misrepresentations and omissions contained in advertising, marketing, and membership materials, managed care insurers manipulated the meaning of the term “medical necessity” when encouraging plaintiffs to enroll in managed care organizations (MCO’s).<sup>423</sup> The defendants asserted that the plaintiffs’ use of wire and mail fraud as a predicate act was foreclosed by the filed rate doctrine. The court, however, refused to apply

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<sup>418</sup> *Id.* (quoting *Wegoland*, 27 F.3d at 21).

<sup>419</sup> *See, e.g.*, *Saunders v. Farmers Ins. Exch.*, 440 F.3d 940, 944 (8th Cir. 2006); *Jader v. Principal Mut. Life Ins. Co.*, 975 F.2d 525, 527 (8th Cir. 1992); *Gipson v. Fleet Mortg. Grp., Inc.*, 232 F. Supp. 2d 691, 705 (S.D. Miss. 2002); *Allen v. State Farm Fire & Cas. Co.*, 59 F. Supp. 2d 1217, 1228 (S.D. Ala. 1999); *Morales v. Attorneys’ Title Ins. Fund, Inc.*, 983 F. Supp. 1418 (S.D. Fla. 1997); *Amundson & Ass’n Art Studio, Ltd. v. Nat’l Council on Comp. Ins., Inc.*, 988 P.2d 1208, 1213 (Kan. App. 1999); *Kentucky ex rel. Chandler v. Anthem Ins. Cos.*, 8 S.W.3d 48, 53-54 (Ky. App. 1999).

<sup>420</sup> *Taffet v. Southern Co.*, 967 F.2d 1483 (11th Cir. 1992).

<sup>421</sup> *Allen v. State Farm Fire & Cas. Co.*, 59 F. Supp. 2d at 1228 (citing *Taffet*, 967 F.2d at 1494-95).

<sup>422</sup> *Saunders*, 440 F.3d at 944 (citing *Wegoland Ltd. v. NYNEX Corp.*, 27 F.3d 17 (2d Cir.1994); *H.J. Inc. v. Nw. Bell Tel. Co.*, 954 F.2d 485 (8th Cir. 1992); *Taffet v. S. Co.*, 967 F.2d 1483 (11th Cir. 1992)).

<sup>423</sup> *In re Managed Care Litigation*, 150 F. Supp. 2d 1330, 1334-35. (S.D. Fla. 2001).



the doctrine stating as follows:

The filed rate doctrine does not apply to the present case because these states do not appear to conduct administrative oversight in the extensive manner typical of situations implicating the doctrine. For example, unlike utility customers, MCO subscribers (or their employers) presumably have some flexibility to search for varying amounts of coverage at various rates other than a flat rate set by a regulatory regime.<sup>424</sup>

The court also noted that even if the doctrine applied, the plaintiffs did not challenge the rate structure itself.<sup>425</sup> Notably, the court did not entirely foreclose application of the filed rate doctrine in all RICO cases.

#### D. BREACH OF CONTRACT

Courts adopting the filed rate doctrine in the insurance area seem in agreement that it is applicable to breach of contract actions implicating the filed rate.<sup>426</sup> For example, the plaintiff in *Kirksey v. American Bankers Insurance Co. of Florida*, claimed that he was charged more than the amount to which he contractually agreed to pay for personal property insurance.<sup>427</sup> The court, however, found the claim barred stating that “[p]laintiff’s argument that the contract . . . should control is of no consequence since the filed rate controls.”<sup>428</sup> The court recognized that while it “might disagree with the amount that is allowed for this type of insurance, it has no power or authority to set legislative policy of the State of Mississippi, to usurp the duties and responsibilities of the Mississippi Department of Insurance.”<sup>429</sup> Similarly, the court in *Rios v. State Farm Fire*

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<sup>424</sup> *Id.* at 1344.

<sup>425</sup> *Id.*

<sup>426</sup> *See, e.g., Rios v. State Farm Fire & Cas. Co.*, 469 F. Supp. 2d 727 (S.D. Iowa 2007); *Allen v. State Farm Fire & Cas.Co.*, 59 F. Supp. 2d 1217 (S.D. Ala. 1999); *Korte v. Allstate Ins. Co.*, 48 F. Supp. 2d 647, 652 (E.D. Tex. 1999); *In re Empire Blue Cross & Blue Shield Customer Litig.*, 622 N.Y.S.2d 843 (App. Div. 1994), *aff’d sub nom. Minihane v. Weissman*, 640 N.Y.S.2d 102 (App. Div. 1996); *Stutts v. Travelers Indem. Co.*, 682 S.E.2d 769 (N.C. App. 2009).

<sup>427</sup> *Kirksey v. Am. Bankers Ins. Co. of Fla.*, 114 F. Supp. 2d 526 (S.D. Miss. 2000).

<sup>428</sup> *Id.* at 530.

<sup>429</sup> *Id.*

& *Casualty Co.* recognized that “[o]nce the rates are filed and approved, the ‘rights as defined by the [rate] cannot be varied or enlarged either by contract or tort of the [regulated entity]’.”<sup>430</sup>

There is case law to the effect, however, that the filed rate doctrine does not bar claims regarding either interpretation of or enforcement of a contract of insurance consistent with the filed rate. For example, although finding some of the plaintiff’s claims barred by the filed rate doctrine, the court in *Horwitz ex rel. Gilbert v. Bankers Life and Casualty Co.* disregarded the doctrine in relation to a breach of contract claim involving the interpretation of ambiguous language.<sup>431</sup> The language at issue involved the number of times the plaintiff’s premium could be increased yearly.<sup>432</sup>

Similarly, although finding some of the plaintiff’s claims barred by the filed rate doctrine, the court in *Richardson v. Standard Guaranty Insurance Co.* allowed others to proceed.<sup>433</sup> The court found that the doctrine barred claims that the defendants misrepresented the costs and benefits to be received from the purchase of the policies at issue. The court’s reasoning was that under the filed rate doctrine, the plaintiff was presumed to have knowledge of the filed rates and also that the doctrine required the conclusion that the plaintiff had suffered no ascertainable loss.<sup>434</sup> The court recognized, however, that the plaintiff could proceed on claims that the defending credit card issuers breached the terms of credit insurance policies. Allowable claims included that the defendants misconstrued contractual provisions in order to minimize benefits, failed to make timely payments, miscalculated premiums, and ignored cancellation notices.<sup>435</sup> The court explained its ruling as follows:

There is nothing about the filed rate doctrine which would preclude a consumer from suing for damages on a claim that the insurer breached the policy as written. While the doctrine precludes a claim for damages which would indirectly cause the application of rates different from the

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<sup>430</sup> *Rios v. State Farm Fire & Cas. Co.*, 469 F. Supp. 2d 727, 735 (quoting *Keogh v. Chicago & Nw. Ry.*, 260 U.S. 156, 160 (1922)).

<sup>431</sup> *Horwitz v. Bankers Life & Cas. Co.*, 745 N.E.2d 591, 606 (Ill. App. 2001) (defendant conceded that the filed rate doctrine did not apply to the claim focusing on ambiguities in the insurance contract itself).

<sup>432</sup> *Id.*

<sup>433</sup> *Richardson v. Standard Guar. Ins. Co.*, 853 A.2d 955 (N.J. Super. App. Div. 2004).

<sup>434</sup> *Id.* at 967.

<sup>435</sup> *Id.*

filed rates, and would also preclude plaintiff from seeking relief, whether equitable or legal, for having been misled by unconscionable sales practices which caused plaintiff to enter into a contract consistent with the filed rate, the filed rate doctrine does not preclude a consumer from suing for damages by having been deprived of benefits which were promised, and were consistent with the filed rate, but were not delivered.<sup>436</sup>

Other insurance cases also express the opinion that the doctrine allows actions to enforce contractual provisions not conflicting with filed rates.<sup>437</sup> A case reaching an interesting result on a motion for partial summary judgment involving a contractual dispute is *Euclid Insurance Agencies, Inc. v. American Ass'n of Orthodontists*.<sup>438</sup> The insurer in that case raised the filed rate doctrine as a defense to the claim that it had failed to honor a contractual agreement to make “adjustments...over time based on experience and actuarial calculations.”<sup>439</sup> The court, however, stated that although the reasonableness of the rates and the fact that they were governed by regulatory agencies “may be factors in deciding this issue, they are not dispositive.”<sup>440</sup> Noting that no statute or case had been cited prohibiting the insurer’s ability to fulfill its commitment, the court ruled that the issue of whether the insurer complied with the agreement by appropriately adjusting rates was one for the jury.<sup>441</sup> The court did not expand upon how it believed rates should be used as factors in deciding such a dispute.

#### E. Claims Involving Kickbacks or Unearned Premiums

Plaintiffs complaining of kickbacks paid by insurers to lenders for the placement of insurance on mortgaged properties have sued under

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<sup>436</sup> *Id.*

<sup>437</sup> *See, e.g.*, *U.S. Steel Corp. v. Lumbermens Mut. Cas. Co.*, No. CIV.A. 02-2108, 2005 WL 2106580, at \*8 (W.D. Pa. Aug. 31, 2005); *Randleman v. Fid. Nat'l Title Ins. Co.*, 465 F. Supp. 2d 812, 823 (N.D. Ohio 2006); *Beller v. William Penn Life Ins. Co. of N.Y.*, 778 N.Y.S.2d 82, 84-85 (App. Div. 2004).

<sup>438</sup> *Euclid Insurance Agencies, Inc. v. American Ass'n of Orthodontists*, No. 95 C 3308, 1998 WL 60775, at \*4 (N.D. Ill. Feb. 5, 1998).

<sup>439</sup> *Id.*

<sup>440</sup> *Id.*

<sup>441</sup> *Id.*

various legal theories. As set forth below, cases conflict on whether the filed rate doctrine bars such claims. Perhaps the better view is that while the filed rate doctrine bars claims for damages based on filed rates that are purportedly excessive, it would not prevent injunctive relief prohibiting the payment of future kickbacks not affecting current rates. Such action would not unreasonably interfere with the nonjusticiability strand of the doctrine or result in discrimination among policyholders. It should also be noted that, depending on the jurisdiction involved, plaintiffs may fare better if relief is sought under the federal Real Estate Settlement Procedures Act (hereinafter “RESPA”).<sup>442</sup>

### 1. The Filed Rate Doctrine Applied to Bar Claims

In *Schilke v. Wachovia Mortgage, FSB*, the plaintiff filed various state law claims, including fraud, against the defending insurer.<sup>443</sup> The plaintiff complained of undisclosed fees in the form of kickbacks paid by the insurer to plaintiff’s bank in connection with the forced placement by the bank of hazard insurance on mortgaged property.<sup>444</sup> Referencing its concern with preserving agency authority, the court found plaintiff’s claims for money damages barred by the filed rate doctrine.<sup>445</sup> The court noted that plaintiff’s allegations of illegality in relation to the kickbacks did not interfere with application of the doctrine.<sup>446</sup>

Similarly, the court applied the filed rate doctrine in *Roussin v. AARP, Inc.*, to bar claims that AARP improperly received an allowance for its sponsorship of insurance plans.<sup>447</sup> The plaintiffs claimed that the filed rate doctrine was inapplicable because the complaint involved gross negligence and a breach of fiduciary duties, not the filed rate.<sup>448</sup> The court disagreed, however, stating that “[i]t has repeatedly been held that a consumer’s claim, however disguised, seeking relief for an injury allegedly caused by the payment of a rate on file with a regulatory commission, is viewed as an attack upon the rate approved by the regulatory

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<sup>442</sup> 12 U.S.C. §§ 2601-17 (2006).

<sup>443</sup> *Schilke v. Wachovia Mortg., FSB*, 758 F. Supp. 2d 549 (N.D. Ill. 2010).

<sup>444</sup> *Id.* at 561. The bank was contractually entitled to purchase insurance at the plaintiff’s expense because the plaintiff failed to maintain insurance on the property. *Id.*

<sup>445</sup> *Id.*

<sup>446</sup> *Id.* at 561-62.

<sup>447</sup> *Roussin v. AARP, Inc.*, 664 F. Supp. 2d 412 (S.D.N.Y. Oct. 15, 2009), *aff’d*, 379 Fed. App’x 30 (2d Cir. 2010).

<sup>448</sup> *Id.* at 414.

commission.”<sup>449</sup> The court was persuaded that the plaintiff was seeking recovery based on the difference between what she paid in premiums and what she contended she should have paid – the type of accounting barred by the filed rate doctrine.<sup>450</sup>

In *Morales v. Attorneys’ Title Insurance Fund, Inc.*, the federal district court applied the filed rate doctrine to bar class action claims that the defending insurers violated RESPA<sup>451</sup> through the use of kickbacks and fee splitting with mortgage brokers, lenders, and other agents. The court found the doctrine applicable even assuming the correctness of the plaintiffs’ position that the proper measure of damages was the return of all premiums paid, not damages measured by the difference between the actual rate and the rate charged.<sup>452</sup> Stating that “the class action nature of the proceeding in no way affects the important concerns of agency authority, justiciability, and institutional competence,” the court in *Morales* dispensed with the plaintiffs’ position that class actions reduce concerns of discrimination thereby negating the need for the filed rate doctrine.<sup>453</sup> According to the court, the plaintiffs had no legal right to pay anything but the promulgated rates; they had no injury; and, therefore, they lacked standing to complain.<sup>454</sup> As set forth below, not all courts agree with the *Morales* decision.

## 2. The Filed Rate Doctrine Found Inapplicable

Noting disagreement with *Morales v. Attorneys’ Title Insurance Fund, Inc.*, discussed above, the Third Circuit in *Alston v. Countrywide Financial Corp.*,<sup>455</sup> declined to apply the doctrine to bar claims of illegal

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<sup>449</sup> *Id.* at 416 (quoting *Porr v. NYNEX Corp.*, 230 A.D.2d 564, 660 (App. Div. 1997)).

<sup>450</sup> *Id.* at 416-17.

<sup>451</sup> *Morales v. Att’ys Title Ins. Fund, Inc.*, 983 F. Supp. 1418 (S.D. Fla. 1997); 12 U.S.C. §§ 2601-17 (2006).

<sup>452</sup> *Morales*, 983 F. Supp. at 1428.

<sup>453</sup> *Id.* (quoting *Wegoland*, 27 F.3d at 22).

<sup>454</sup> *Id.* at 1429. Although the plaintiff did not name lenders as defendants, the court in *Steven v. Union Planters Corp.*, No. 00-cv-1695, 2000 WL 33128256 (E.D. Pa. Aug. 22, 2000) likewise applied the filed rate doctrine to bar claims under RESPA that the defending bank-related defendants improperly received kickbacks from the plaintiff’s property insurer.

<sup>455</sup> 585 F.3d 753 (3d Cir. 2009).

kickbacks under RESPA.<sup>456</sup> The court in *Alston* was of the opinion that the plaintiffs challenged illegal kickbacks or fee splitting, not the fairness of rates.<sup>457</sup> In support of its decision, the court quoted *Kay v. Wells Fargo & Co.*<sup>458</sup> as follows:

Statutes like RESPA are enacted to protect consumers from unfair business practices by giving consumers a private right of action against service providers. Plaintiffs may not sue under the veil of RESPA if they simply think that the price they paid for their settlement services was unfair. Alternatively, plaintiffs bringing a suit under RESPA may allege a violation of fair business practices through the use of illegal kickback payments. The filed-rate doctrine bars suit from the former class of plaintiffs and not the latter.<sup>459</sup>

The court in *Alston* further cited the following four factors in support of its decision: (1) The measure of damages was set by RESPA, so there was no need to second guess rates; (2) All consumers affected were to be protected by RESPA, not just those bringing suit; (3) Congress intended that RESPA apply to mortgage insurance; and (4) RESPA, as a remedial statute, should be construed broadly.<sup>460</sup> The court concluded by stating that it was clear that the plaintiffs challenged defendant Countrywide's allegedly wrongful conduct, "not the reasonableness or propriety of the rate that triggered that conduct."<sup>461</sup>

Another case leaving open the possibility that claims brought under RESPA may survive application of the filed rate doctrine is *Schilke v. Wachovia Mortgage, FSB*.<sup>462</sup> The court in *Schilke* relied on the filed rate doctrine in dismissing state law claims for damages made against the defending insurer in relation to alleged wrongful kickbacks. The court, however, distinguished *Alston* on the basis that the plaintiff was not "suing

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<sup>456</sup>12 U.S.C. §§ 2601-17 (2006); *Alston*, 585 F.3d at 764 (expressing disagreement with *Morales*).

<sup>457</sup>*Alston*, 585 F.3d at 764 (citing *Alexander v. Wash. Mut., Inc.*, No. 08-8043, 2008 WL 2600323, at \*3 (E.D. Pa. June 30, 2008); *Kay v. Wells Fargo & Co.*, 247 F.R.D. 572 (N.D. Cal. 2007)).

<sup>458</sup>*Kay v. Wells Fargo & Co.*, 247 F.R.D. 572, 576 (N.D. Cal.2007).

<sup>459</sup>*Alston*, 585 F.3d at 764 (quoting *Kay*, 247 F.R.D. at 576).

<sup>460</sup>*Id.*

<sup>461</sup>*Id.* at 765.

<sup>462</sup>*Schilke v. Wachovia Mortg., FSB*, 758 F. Supp. 2d 549, 562 (N.D. Ill. 2010).

under RESPA or any other federal law stemming from Congressional intent to circumvent the filed rate doctrine.”<sup>463</sup>

Additionally, the court in *Gipson v. Fleet Mortgage Group, Inc.* refused to apply the file rate doctrine to bar a complaint that the defending lender wrongfully entered into an arrangement with an insurer by which the lender received fees and commissions recouped from borrowers through the payment of higher insurance premiums.<sup>464</sup> The plaintiff claimed that by doing so, the lender breached its contract and also violated its duty of good faith and fair dealing. In refusing to apply the filed rate doctrine, the court stated that the challenge was “not so much a challenge to the rate itself as it is to the lender’s right under the lending contract to place insurance in such a manner as to cause its borrowers’ payment of unnecessary fees.”<sup>465</sup>

#### XVIII. THE FUTURE OF THE FILED RATE DOCTRINE

What about the future of the filed rate doctrine? At the federal level, Congress has taken no action to abrogate the doctrine. Additionally, the U.S. Supreme Court recently denied certiorari in a case involving the filed rate doctrine, *Dolan v. Fidelity National Title Insurance Co.*,<sup>466</sup> which is not surprising in view of the Court’s pronouncement in *Square D Co. v. Niagara Frontier Tariff* that “[i]f there is to be an overruling of the *Keogh* rule, it must come from Congress, rather than from this Court.”<sup>467</sup>

As previously mentioned, ongoing disagreement regarding the doctrine’s application in the insurance arena is illustrated by the recent cases of *In re Title Insurance Antitrust Cases*<sup>468</sup> and *Clark v. Prudential Insurance Co. of America*<sup>469</sup> reaching conflicting decisions regarding application of the doctrine to claims arising under Ohio state law.<sup>470</sup>

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<sup>463</sup> *Id.* at 560.

<sup>464</sup> *Gipson v. Fleet Mortg. Grp., Inc.*, 232 F. Supp. 2d 691 (S.D. Miss. 2002).

<sup>465</sup> *Id.* at 707. The court in *Gipson* did, however, apply the doctrine to bar a claim that the defending insurer illegally obtained rates through committing fraud on the state’s department of insurance. *Id.* at 703.

<sup>466</sup> 365 Fed. App’x 271 (2d Cir. 2010), *cert. denied*, 131 S. Ct. 261 (2010).

<sup>467</sup> *Square D Co. v. Niagara Frontier Tariff Bureau, Inc.*, 476 U.S. 408, 424 (1986).

<sup>468</sup> 702 F. Supp. 2d 840 (N.D. Ohio 2010).

<sup>469</sup> *Clark v. Prudential Ins. Co. of Am.*, No. Civ. 08-6197 DRD, 2011 WL 940729 (D.N.J. Mar. 15, 2011).

<sup>470</sup> Compare *In re Title Ins. Antitrust Cases*, 702 F. Supp. 2d at 861-65 (adopting the filed rate doctrine in regard to claims under Ohio state law), *with*

Disagreement regarding the doctrine is further illustrated by the conflicting decisions of *MacKay v. Superior Court*<sup>471</sup> and *Fogel v. Farmers Group, Inc.*,<sup>472</sup> involving the application of the filed rate doctrine to property and casualty insurance in California.

An issue, however, on which consensus could likely be reached is the importance of the doctrine in the area of insurance law. For example, although the parties had provided notification of a tentative settlement, the *MacKay* court exercised its discretion to issue an opinion stating that one reason for doing so was that the issues “are of major importance to both insurers and policy holders in California and are clearly of continuing public interest and are likely to recur.”<sup>473</sup> Although the filed rate doctrine was not the only issue considered by the court, it was a significant matter addressed in depth.<sup>474</sup>

A review of cases cited in this article illustrates the large number decided in the last few years as well as the fact that many courts have struggled with the interpretation and the application of the doctrine. A primary difference in rationale seems to occur between courts expressing the opinion that the doctrine applies to bar claims whenever a rate must be consulted in order to determine damages versus courts that allow claims to continue so long as the claims themselves do not implicate the filed rate.<sup>475</sup>

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*Clark*, 2011 WL 940729 at \*12-14 (rejecting application of the filed rate doctrine to claims arising under Ohio state law).

<sup>471</sup> *MacKay v. Superior Court*, 115 Cal. Rptr. 3d 893 (Cal. Ct. App. 2010).

<sup>472</sup> *Fogel v. Farmers Group, Inc.*, 74 Cal. Rptr. 3d 61 (Cal. Ct. App. 2008).

<sup>473</sup> *MacKay*, 115 Cal. Rptr. 3d at 912 n.21.

<sup>474</sup> *Id.* at 910-11.

<sup>475</sup> *Compare H.J. Inc. v. Nw. Bell Tel. Co.*, 954 F.2d 485, 489 (8th Cir. 1992) (stating that the underlying conduct does not control whether the doctrine applies and that the appropriate focus is the impact the court’s decision would have on agency procedures and rate determinations), *In re Pa. Title Ins. Antitrust Litig.*, 648 F. Supp. 2d 663, 680 (E.D. Pa. 2009) (finding that plaintiffs complaint of kickbacks actually went to rates), *Rios v. State Farm Fire & Cas. Co.*, 469 F. Supp. 2d 727, 735 (S.D. Iowa 2007) (recognizing that the filed rate doctrine extends to complaints about services as well as to complaints about rates), *Morales v. Attorneys’ Title Ins. Fund, Inc.*, 983 F. Supp. 1418, 1429 (S.D. Fla. 1997) (recognizing that complaints regarding kickbacks and fee splitting actually went to the state’s rate structure), *and Uniforce Temp. Pers., Inc. v. Nat’l Council on Comp. Ins., Inc.*, 892 F. Supp. 1503, 1511-12 (S.D. Fla. 1995) (recognizing that the filed rate doctrine barred claims that the defendants forced the plaintiff into the assigned risk market), *aff’d on other grounds*, 87 F.3d 1296 (11th Cir. 1996), *with Arroyo-Melecio v. Puerto Rico Am. Ins. Co.*, 398 F.3d 56, 73 (1st Cir. 2005) (expressing the opinion that the doctrine fails to bar any action which might



Another basic difference in outlook is expressed in cases construing the doctrine as applied to claims of illegal discrimination in violation of federal law based on criteria such as race.<sup>476</sup>

The issue of administrative review and action may be another fertile ground for litigation. As discussed in Section XIV of this article, many courts have discussed the type of administrative review required for application of the doctrine. Interestingly, however, in determining whether the doctrine should be applied, neither litigants nor the courts have delved into the enthusiasm with which state agencies have taken action against alleged wrongdoing. Of course, that would involve quite an undertaking and large amounts of discovery. Additionally, obtaining such proof in and of itself may impact the nonjusticiability strand of the doctrine involving the principle that courts should refrain from interfering with the affairs of agencies entrusted by the legislative branch with authority over rate issues.<sup>477</sup>

Considering the number of cases construing the filed rate doctrine in the insurance arena in the last few years coupled with the significant disagreement in existence regarding the specific contours of the doctrine, it appears that the filed rate doctrine will be a significant source of future litigation. Issues impacted by the doctrine are far reaching with puzzling and complex disputes involving the role of state departments of insurance, the interests of insurers, and the rights of consumers.

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“arguably and coincidentally implicate rates”), *Alston v. Countrywide Fin. Corp.*, 585 F.3d 753, 764 (3d Cir. 2009) (recognizing that the plaintiffs did not directly challenge any rate and refusing to apply the doctrine); *In re Managed Care Litig.*, 150 F. Supp. 2d 1330, 1334 (S.D. Fla. 2001) (refusing to apply the doctrine as a bar and recognizing that the plaintiffs did not challenge the rate structure per se), and *Ciamaichelo v. Independence Blue Cross*, 909 A.2d 1211, 1218 (Pa. 2006) (rejecting the position that allegations that could lead to an adjustment of an insurer’s rate “invariably amount to a rate injury claim”).

<sup>476</sup> Compare *Schermer*, 721 N.W.2d at 307 (applying the doctrine to claims of race discrimination), with *Saunders*, 440 F.3d at 940 (refusing to apply the doctrine to claims of race discrimination).

<sup>477</sup> See, e.g., *Wegoland Ltd.*, 27 F.3d at 19 (asserting that courts should not become enmeshed in the rate-making process).

**A JURISPRUDENTIAL SURVEY OF BAD FAITH  
CLAIMS IN THE WORKERS' COMPENSATION  
CONTEXT AND A CALL FOR A UNIFIED  
STATUTORY REMEDY**

STEVEN PLITT\*

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*The article advocates for an exclusive unified remedial approach to insurer bad faith claims in the worker's compensation context as opposed to a mixed statutory and common law approach. The article considers the various jurisprudential positions on common law bad faith causes of action. The article then details the legislative response to the bad-faith cause of action, with a focus on legislation designed to make the Worker's Compensation Act the exclusive remedy for bad faith misconduct by insurers. The judicial response to this legislation is also highlighted. The article then focuses on legislative attempts to impose penalties on insurers as a deterrent to insurer misconduct. Lastly, the article proposes in detail a unified approach utilizing an administrative adjudicatory system that benefits from knowledgeable and experience triers of fact. The article proposes keeping the current statutory framework in place but with an escalating scale of penalties for insurer misconduct that would be coupled with a requirement that insurers keep records of complaints filed against them, as well as penalties assessed against them, for improper claims handling. The penalties would then be escalated according to an insurer's penalty experience rating.*

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The issue of whether a specific Workers' Compensation Act precludes common-law tort actions for an insurer's bad faith conduct in mishandling a claim for benefits has arisen in many American

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jurisdictions.<sup>1</sup> The issue has been resolved in different ways; the results depend upon the particular facts alleged, the elements of the tort of common-law bad faith within the jurisdiction, and the exclusivity and penalty provisions of the relevant Workers' Compensation Act. The courts are almost equally divided on this issue. There has been minimal scholarly commentary analyzing the competing legal viewpoints which populate the debate regarding the proper forum for resolving unfair claim handling committed in the workers' compensation context.

A large number of courts have held that common-law bad faith actions are barred by the exclusivity provisions<sup>2</sup> of a particular Workers' Compensation Act.<sup>3</sup> Still other courts have recognized actions for conduct

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<sup>1</sup> One court has observed that the tort of workers' compensation bad faith arises when an insurance company or a self-insured employer intentionally fails to process or pay a claim without a reasonable basis for such action and the carrier either knows or it is being unreasonable or fails to conduct an investigation adequate to determine whether its conduct was reasonable. *See Rowland v. Great States Ins. Co.*, 20 P.3d 1158, 1166 n.5 (Ariz. Ct. App. 2001).

<sup>2</sup> The exclusive remedy provisions of the Workers' Compensation Acts are designed to balance the interests of both employers and employees. On the one hand the employer assumes liability for "accidental" injuries to employees regardless of fault and, on the other hand, the employer is relieved of the possibility of large damage verdicts which may jeopardize the future of the employer's business. *See Gunter v. Mersereau*, 491 P.2d 1205, 1206-07 (Or. Ct. App. 1971) (motivating philosophy behind workmen's compensation acts is that loss arising from accidents in industry should be distributed between employer and consumer as cost of production); *Woolsey v. Panhandle Refinery Co.*, 116 S.W.2d 675, 676 (Tex. 1938) (workers' compensation objective is to do away with issues of negligence, unavoidable accident, and contributory negligence, and to fix amount recoverable free from uncertainty). Generally, under the exclusivity provisions of the Act employees are not barred from bringing actions for intentional torts against their employer, but if the employee elects to pursue a claim under the Act the employee may waive his cause of action for the intentional tort. *See, e.g., Reed Tool Co. v. Copelin*, 610 S.W.2d 736, 739 (Tex. 1980) (intentional tort action waived by proceeding under Act from injuries derived in course of employment); *H.L. Hutton & Co. v. District Court of Kay County*, 398 P.2d 530, 534 (Okla. 1965) (election of remedy waives other claims).

<sup>3</sup> *See, e.g., Garvin v. Shewbart*, 442 So. 2d 80 (Ala. 1983) (provision for circuit court action provides remedy for negligent or bad faith failure to pay medical expenses); *Stafford v. Westchester Fire Ins. Co. of New York, Inc.*, 526 P.2d 37 (Alaska 1974), *overruled by Cooper v. Argonaut Ins. Cos.*, 556 P.2d 525 (Alaska 1976) (20 percent penalty for late payment of benefit installments provides

constituting bad faith although the tort was not characterized as such.<sup>4</sup> As an example, a plurality of jurisdictions that have precluded a bad faith cause of action have nevertheless recognized that certain other common-law tort actions, particularly actions for intentional infliction of emotional distress,<sup>5</sup> can be maintained against a workers' compensation insurer.<sup>6</sup>

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remedy for negligent or bad faith delay); *Sandoval v. Salt River Project Agric. Impr. & Power Dist.*, 571 P.2d 706 (Ariz. Ct. App. 1977) (Act provides procedures in event of failure to provide benefits); *Cervantes v. Great American Ins. Co.*, 140 Cal. App. 3d 763, 189 Cal. Rptr. 761 (1983) (10 percent penalty for unreasonable delay in payment is exclusive remedy for willful and intentional, as well as negligent delay); *Old Republic Ins. Co. v. Whitworth*, 442 So. 2d 1078 (Fla. Ct. App. 1983) (penalty and attorney fee provisions are exclusive remedies for bad faith); *Robertson v. Travelers Ins. Co.*, 448 N.E.2d 866 (Ill. 1983) (50 percent penalty for unreasonable or vexatious delay remedies insurer's malicious deception or outrageous conduct); *Harned v. Farmland Foods, Inc.*, 331 N.W.2d 98 (Iowa 1983) (statutory procedure for resolving dispute over treatment constitutes exclusive remedy); *Hormann v. New Hampshire Ins. Co.*, 689 P.2d 837 (Kan. 1984) (8 percent interest when carrier refuses to pay without just cause or excuse is remedy for intentional refusals); *Paradissis v. Royal Indem. Co.*, 507 S.W.2d 526 (Tex. 1974) (self-help and administrative procedures provide sole relief for insurer's negligence).

<sup>4</sup> See, e.g., *Martin v. Travelers Ins. Co.*, 497 F.2d 329 (1st Cir. 1974); *Gibson v. Nat'l Ben Franklin Ins. Co.*, 387 A.2d 220 (Me. 1978); *Broaddus v. Ferndale Fastener Division*, 269 N.W.2d 689 (Mich. Ct. App. 1978).

<sup>5</sup> The standard of proof for an intentional tort in the workers' compensation context can be very difficult to satisfy. As an example, a tort claim against a workers' compensation insurer alleging a bad faith failure to pay an insurance claim is barred by the exclusivity provisions of Alabama's Workers' Compensation Act. *Stewart v. Matthews Indus., Inc.*, 644 So. 2d 915 (Ala. 1994) (citing ALA. CODE §§ 25-5-11, -52, -53 (1975)); *Farley v. CNA Ins. Co.*, 576 So. 2d 158 (Ala. 1991); *Garvin*, 442 So. 2d at 80; *Oliver v. Liberty Mut. Ins. Co.*, 548 So. 2d 1025 (Ala. 1989); *Nabors v. St. Paul Ins. Co.*, 489 So. 2d 573 (Ala. 1986); *Moore v. Liberty Mut. Ins. Co.*, 468 So. 2d 122 (Ala. 1985); *Waldon v. Hartford Ins. Group*, 435 So. 2d 1271 (Ala. 1983). Although the Alabama Supreme Court has held that a claim alleging bad faith failure to pay an insurance claim—in the context of a workers' compensation claim—is barred by the exclusivity provisions of the Act, the court has also recognized that the tort of outrageous conduct or intentional infliction of emotional distress can occur in a workers' compensation setting. See, e.g., *Farley*, 576 So. 2d at 158; *Garvin*, 442 So. 2d at 80. The Court in *Garvin v. Shewbart* observed:

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The [Workers' Compensation] Act is designed to compensate those who are injured on the job and provides immunity from common law suits for those employers and carriers who come within the Act. A suit seeking recovery under the tort of outrageous conduct does not seek compensation [or] medical benefits for the original on-the-job injury. The connection with the physical injury that gave rise to the original workmen's compensation claim is tenuous. *The conduct giving rise to the tort of outrageous conduct in the context of this kind of case can be more accurately characterized as mental assault than as failure to pay compensation or medical benefits even though it may arise in a failure to pay context.* Conduct constituting the tort of outrageous conduct cannot reasonably be considered to be within the scope of the Act. When the employer or carrier's conduct crosses the line between mere failure to pay and intent to cause severe emotional distress, the cloak of immunity is removed.

*Garvin*, 442 So. 2d at 83 (emphasis added).

Under Alabama law, the tort of outrageous conduct or intentional infliction of emotional distress involves "extreme and outrageous conduct" by one who "intentionally or recklessly causes severe emotional distress to another." *American Road Service Co. v. Inmon*, 394 So. 2d 361, 365 (Ala. 1980). In order to present a case of outrageous conduct, the plaintiff must show that the conduct was "so outrageous in character and so extreme in degree as to go beyond all possible bounds of decency, and to be regarded as atrocious and utterly intolerable in a civilized society." *Id.*; see also *Bearden v. Equifax Services*, 455 So. 2d 836 (Ala. 1984); *Strickland v. Birmingham Bldg. & Remodeling*, 449 So. 2d 1242 (Ala. 1984); *Cates v. Taylor*, 428 So. 2d 637 (Ala. 1983).

The severe emotional distress required for the tort of outrage requires the following:

The emotional distress . . . must be so severe that no reasonable person could be expected to endure it. Any recovery must be reasonable and justified under the circumstances, liability ensuing only when the conduct is extreme. By extreme we refer to conduct so outrageous in character and so extreme in degree as to go beyond all possible bounds of decency, and to be regarded as atrocious and utterly intolerable in a civilized society.

*Am. Road Serv. Co.*, 394 So. 2d at 365 (citations omitted).

Some courts recognize tort actions for bad faith outside of the relevant Workers Compensation Act.<sup>7</sup> Other jurisdictions have held that statutory penalty provisions, although available, do not constitute exclusive remedies for insurer bad faith.<sup>8</sup>

This article will explore the utility of a modified statutory approach to unfair claim handling practices in the workers' compensation context. Part I of the article surveys the competing jurisprudential viewpoints on whether to allow a common-law bad faith cause of action. The debate among these courts center upon the legislative intent regarding the scope of a particular Workers' Compensation Act exclusivity provision. A small number of courts have straddled the issue and determined that their state's Workers' Compensation Act provided only partial immunity through exclusivity for most routine delays in payment of compensation benefits alleged to have been withheld in bad faith while permitting a common law bad faith tort action where egregious and willful misconduct is involved. A few courts have adopted a breach of contract theory regarding bad faith misconduct in the workers' compensation context. Each of these competing theories is surveyed in Part I.

Part II of the article briefly discusses legislative intervention following judicial recognition of a common-law bad faith tort action. Legislative intervention, overturning the judicial recognition of the tort, has met with mixed success.

Part III of the article discusses statutory penalties and deterrents. There is wide variation of severity and scope in state workers'

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The outrageous conduct must be established by clear and convincing evidence. *Farley*, 576 So. 2d 158.

<sup>6</sup> See *Garvin*, 442 So. 2d at 80; *Stafford*, 526 P.2d at 37; *Sandoval*, 571 P.2d at 706 (tortious conduct as breaking and entering not immunized); *Unruh v. Truck Ins. Exch.*, 498 P.2d 1063 (Cal. 1972); *Sullivan v. Liberty Mut. Ins. Co.*, 367 So. 2d 658 (Fla. Dist. Ct. App. 1979) (statute provides exceptions for intentional assault and automobile accidents); *Robertson v. Travelers Ins. Co.*, 448 N.E.2d 866 (Ill. 1983) (penalty might not be exclusive remedy in *Unruh*-like facts); *Paradissis v. Royal Indem. Co.*, 507 S.W.2d 526 (Tex. 1974) (willful torts such as fraud or outrageous conduct not within exclusivity bar of Texas Act).

<sup>7</sup> See, e.g., *Hollman v. Liberty Mut. Ins. Co.*, 712 F.2d 1259 (8th Cir. 1983) (under South Dakota law); *Hayes v. Aetna Fire Underwriters*, 609 P.2d 257 (Mont. 1980); *Coleman v. Am. Universal Ins. Co.*, 273 N.W.2d 220 (Wis. 1979).

<sup>8</sup> See, e.g., *Martin v. Travelers Ins. Co.*, 497 F.2d 329 (1st Cir. 1974) (20 percent penalty for late payment not exclusive remedy); *Gibson v. Nat'l Ben Franklin Ins. Co.*, 387 A.2d 220 (Me. 1978) (similar ruling).

compensation penalty statutory remedies. Courts have reached mixed conclusions on whether a particular state's penalty provision provides adequate deterrence to prevent insurer misconduct.

Part IV of the article analyzes the statutory unification of bad faith remedies through increased penalties and the maintenance of exclusivity. It is the thesis of this article that an exclusive unified remedial approach to insurer bad faith is preferable to a combination of statutory and common-law remedies. An effective unified remedial approach would utilize the administrative apparatus in current use which benefits from a knowledgeable trier of fact. The current statutory approach would be supplemented with a significant penalty system coupled with measures to require the annual record-keeping of penalty experience rating. Statistics regarding findings of misconduct could be used to assess greater penalties and would permit insurance company executives to understand the true cost of improper claim handling practices.

#### I. JURISDICTIONAL SURVEY ON WHETHER TO ALLOW OR REJECT COMMON-LAW BAD FAITH IN THE WORKERS' COMPENSATION CONTEXT.

Courts are almost evenly divided over the issue of whether a workers' compensation insurer may invoke the employer's immunity from suit in the workers' compensation context against charges that the insurer committed bad faith in its handling of an employee's compensation claim.<sup>9</sup> Set forth below are the four principle viewpoints on this issue.

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<sup>9</sup> The following courts held that the workers' compensation insurer is entitled to immunity: Alabama (*Stewart*, 644 So. 2d at 915; *Oliver v. Liberty Mut. Ins. Co.*, 548 So. 2d 1025 (Ala. 1989)); Arkansas (*Liberty Mut. Ins. Co. v. Coleman*, 852 S.W.2d 816 (Ark. 1993); *Johnson v. Houston Gen. Ins. Co.*, 536 S.W.2d 121 (Ark. 1976)); California (*Goetz v. Aetna Cas. & Sur. Co.*, 710 F.2d 561 (9th Cir. 1983) (interpreting California law); *Stoddard v. Western Employer's Ins. Co.*, 245 Cal. Rptr. 820 (Cal. Ct. App. 1988)); Connecticut (*DeOliveira v. Liberty Mut. Ins. Co.*, 870 A.2d 1066 (Conn. 2005)); District of Columbia (*Hall v. C&P Telephone Co.*, 793 F.2d 1354 (D.C. Cir. 1986), *reh'g denied*, 809 F.2d 924 (D.C. Cir. 1987)); Georgia (*Bright v. Nimmo*, 320 S.E.2d 365 (Ga. 1984); *Aetna Cas. & Sur. Co. v. Davis*, 320 S.E.2d 368, 370 (Ga. 1984)); Idaho (*Van Tine v. Idaho State Ins. Fund*, 889 P.2d 717 (Idaho 1994)); Illinois (*Robertson v. Travelers Ins. Co.*, 448 N.E.2d 866 (Ill. 1983); *Perfection Carpet, Inc. v. State Farm Fire and Cas. Co.*, 630 N.E.2d 1152 (Ill. App. Ct. 1994)); Indiana (*Stump v. Commercial Union*, 601 N.E.2d 327 (Ind. 1992); *Borgman v. State Farm Ins. Co.*, 713 N.E.2d 851 (Ind. Ct. App.

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1999)); Kentucky (Coker v. Daniel Const. Co., 664 F. Supp. 1079 (W.D. Ky. 1987), *aff'd*, 848 F.2d 189 (6th Cir. 1988)); Zurich Ins. Co. v. Mitchell, 712 S.W.2d 340 (Ky. 1986); General Acc. Ins. Co. v. Blank, 873 S.W.2d 580 (Ky. Ct. App. 1993)); Louisiana (Bergeron v. North American Underwriters, Inc., 549 So. 2d 315 (La. 1989); Banes v. American Mut. Liab. Ins. Co., 544 So. 2d 700 (La. Ct. App. 1989)); Massachusetts (Kelly v. Raytheon, Inc., 563 N.E.2d 1372 (Mass. App. Ct. 1990); Boduch v. Aetna Life & Cas. Co., 528 N.E.2d 1182 (Mass. App. Ct. 1988)); Minnesota (Denisen v. Milwaukee Mut. Ins. Co., 360 N.W.2d 448 (Minn. Ct. App. 1985)); Missouri (Young v. U. S. Fid. & Guar. Co., 588 S.W.2d 46 (Mo. Ct. App. 1979)); Nebraska (Ihm v. Crawford & Co., 580 N.W.2d 115 (Neb. 1998)); New Mexico (Chavez v. Kennecott Copper Corp., 547 F.2d 541 (10th Cir. 1977); Cruz v. Liberty Mut. Ins. Co., 889 P.2d 1223 (N.M. 1995)); New York (Burlaw v. Am. Mut. Ins. Co., 472 N.E.2d 682 (N.Y. 1984)); Pennsylvania (Winterberg v. Transp. Ins. Co., 72 F.3d 318 (3rd Cir. 1995); Fry v. Atl. States Ins. Co., 700 A.2d 974 (Pa. Super. Ct. 1997)); Rhode Island (Cianci v. Nationwide Ins. Co., 659 A.2d 662 (R.I. 1995)); South Carolina (Cook v. Mack's Transfer & Storage, 352 S.E.2d 296 (S.C. Ct. App. 1986)); Utah (Savage v. Educators Ins. Co., 908 P.2d 862 (Utah 1995); Gunderson v. May Dept. Stores Co., 955 P.2d 346 (Utah Ct. App. 1998)); Washington (Wolf v. Scott Wetzel Services, Inc., 782 P.2d 203 (Wash. 1989)).

The following courts allowed common-law bad faith claims against workers' compensation insurers: Arizona (Hayes v. Cont'l Ins. Co., 872 P.2d 668 (Ariz. 1994); Franks v. U. S. Fid. & Guar. Co., 718 P.2d 193 (Ariz. Ct. App. 1985)); Colorado (Travelers Ins. Co. v. Savio, 706 P.2d 1258 (Colo. 1985)); Connecticut (Carpentino v. Transport Ins. Co., 609 F. Supp. 556 (D. Conn. 1985), *but see DeOliveira*, 870 A.2d 1066 (where the court held that bad faith actions are not available, except under the intentional act exception to exclusivity)); Delaware (Correa v. Pa. Mfrs. Ass'n Ins. Co., 618 F. Supp. 915 (D. Del. 1985); Pierce v. Int'l Ins. Co. of Ill., 671 A.2d 1361 (Del. 1996)); Hawaii (Hough v. Pacific Ins. Co., Ltd., 927 P.2d 858 (Haw. 1996)); Iowa (Reedy v. White Consol. Indus., Inc., 503 N.W.2d 601 (Iowa 1993); Boylan v. American Motorists Ins. Co., 489 N.W.2d 742 (Iowa 1992), *reh'g denied*, (Oct. 23, 1992)); Minnesota (Kaluza v. Home Ins. Co., 403 N.W.2d 230 (Minn. 1987), *but see* Hastings v. Fireman's Fund Ins. Cos., 404 N.W.2d 374 (Minn. Ct. App. 1987)); Mississippi (S. Farm Bureau Cas. Ins. Co. v. Holland, 469 So. 2d 55 (Miss. 1984)); Montana (Brewington v. Employers Fire Ins. Co., 992 P.2d 237 (Mont. 1999); Spadaro v. Midland Claims Service, Inc., 740 P.2d 1105 (Mont. 1987); Birkenbuel v. Montana State Comp. Ins. Fund, 687 P.2d 700 (Mont. 1984)); Nevada (Falline v. GNLV Corp., 823 P.2d 888 (Nev. 1991)); North Carolina (Johnson v. First Union Corp., 496 S.E.2d 1 (N.C. Ct. App. 1998), *on reh'g*, 505 S.E.2d 808 (N.C. Ct. App. 1998)); Ohio (Balyint v. Ark. Best Freight System, Inc., 480 N.E.2d 417 (Ohio 1985)); Oklahoma (Sizemore v. Cont'l Cas. Co., 142 P.3d 47 (Okla. 2006)); South Dakota (*Hollman*, 712 F.2d 1259,



The following principles regarding liability for delayed payment can be gleaned from the decisions in those jurisdictions which have rejected a common-law tort of bad faith. First, without significant analysis, courts have found that their state's exclusive remedy statute forecloses a common-law bad faith tort. Second, a cause of action generally will not arise from delayed payment of a workers' compensation claim unless the insurer or self-insured employer has committed offenses greater than mere delay of payment. Third, the existence of a penalty for late payment of claims generally indicates that the legislature intended to expand a statute's exclusive remedy provision to bar bad faith claims arising from delayed payment.<sup>10</sup> Fourth, even where the statutory penalties do not adequately

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*aff'd*, 752 F.2d 311 (8th Cir. 1985)); Texas (*Aranda v. Ins. Co. of North America*, 748 S.W.2d 210 (Tex. 1988), *aff'd*, 833 S.W.2d 209 (Tex. Ct. App. 1992), *reh'g denied*, (June 18, 1992); *Aetna Cas. and Sur. Co. v. Marshall*, 724 S.W.2d 770 (Tex. 1987); *Escajeda v. Cigna Ins. Co. of Texas*, 934 S.W.2d 402 (Tex. Ct. App. 1996)); Wisconsin (*Coleman*, 273 N.W.2d 220; *Messner v. Briggs & Stratton Corp.*, 353 N.W.2d 363 (Wis. Ct. App. 1984)).

<sup>10</sup> Some courts have concluded that the exclusivity principle is manifest through the penalty award provisions in the Workers' Compensation Act. *See, e.g.*, *Cain v. Nat'l Union Life Ins. Co.*, 718 S.W.2d 444, 444 (Ark. 1986) (rejecting workers' compensation claim for late payment because statutes provide remedies for late payment); *Hormann v. N. H. Ins. Co.*, 689 P.2d 837, 840 (Kan. 1984) (denying independent claim for tortious behavior because statute providing penalties provided exclusive remedy); *Kelly*, 563 N.E.2d at 1374-75 (dismissing claim for intentional and negligent infliction of emotional distress for failure to compensate because workers' compensation laws provided exclusive remedy of statutory penalties); *Wood v. Union Elec. Co.*, 786 S.W.2d 613, 614 (Mo. Ct. App. 1990) (denying claim for recovery of work-related medical expenses because penalty provision provided exclusive remedy); *Dunlevy v. Kemper Ins. Grp.*, 532 A.2d 754, 756 (N.J. Super. Ct. App. Div. 1987) (holding that penalty in statute for failure to pay compensation benefits provided sole remedy); *Messner*, 353 N.W.2d at 368 (dismissing claim for bad faith denial of workers' compensation because penalty provision provided exclusive remedy). *See also* Michael A. Rosenhouse, Annotation, *Tort Liability of Worker's Compensation Insurer for Wrongful Delay or Refusal to Make Payments Due*, 8 A.L.R. 4th 902 (1981).

In *Dunlevy*, the Court held that New Jersey's Workers' Compensation Act provided the exclusive remedy for an insurance company's intentional conduct in failing to provide benefits. The Court observed that the New Jersey Legislature recognized the need to impose sanctions when the party responsible for providing benefits unreasonably or negligently failed to do so. It provided the specific remedy of penalties in N.J. STAT. ANN. § 34:15-28.1. Had the New Jersey

compensate the employee for damages caused by late payments, the imposition of a penalty reveals a legislative intent to preempt common-law causes of action.<sup>11</sup>

One commentator has observed: “[w]hether one views the workers’ compensation system as a well-oiled, humming engine of adequate

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lawmakers intended common-law redress also to be available for intentional conduct in failing to provide benefits, the Court found that the Legislature could have readily done so in the manner of N.J. STAT. ANN. § 34:15-8. In essence, the Court found the specific nature of New Jersey’s remedial legislation for failure of an employer to pay required benefits as its rationale for sustaining the exclusivity in face of common-law actions for redress.

In *Flick v. PMA Ins. Co.*, 928 A.2d 54 (N.J. Super. App. Div. 2007), the Court reaffirmed its prior ruling that New Jersey’s Workers’ Compensation Act’s exclusive remedy provisions foreclosed a common-law tort action for bad faith. The Court observed that the New Jersey Legislature specifically envisioned that there would be situations in which an employer or its insurance carrier would “unreasonably or negligently delay” providing compensation to an injured worker entitled to compensation benefits. N.J. STAT. ANN. § 34:15-28.1 imposes a 25% penalty on amounts due plus any reasonable legal fees incurred as a result of such delays or refusals.

<sup>11</sup> A few jurisdictions have allowed bad faith claims despite the existence of statutory penalties. In general, these jurisdictions have based their conclusions on two factors: the failure of the relevant statutes to identify specific penalties for bad faith or injurious delay of payment, and a failure to provide penalties to adequately compensate employees for the real harm suffered as a result of delayed payments. *See, e.g., Gibson*, 387 A.2d at 220; *Aranda*, 748 S.W.2d at 210; *Coleman*, 273 N.W.2d at 220.

In *Travelers Ins. Co. v. Savio*, 706 P.2d 1258 (Colo. 1985), Travelers argued that the penalty provisions in the Workers’ Compensation Act provided claimants with a remedy for an insurer’s misconduct. *See* 3 COLO. REV. STAT. § 8-44-106 (1973). The Act provides that “[i]f any insurance carrier intentionally, knowingly, or willfully violates any of the provisions of articles 40 to 54 of this title, the commissioner of insurance, on the request of the director, shall suspend or revoke the license or authority of such carrier to do a compensation business in this state.” *Id.* The Court noted that while such conduct on the part of the insurer was risky for any insurer to engage in, the statute did not provide any remedy for the individual injured thereby. *Savio*, 706 P.2d at 1266. Citing other penalty provisions, (*see* 3 COLO. REV. STAT. §§ 8-53-124, 8-53-126, 8-53-127, 8-53-129 (1973) (repealed by Laws 1990, H.B.90-1160, § 77, eff. July 1, 1990)), while they serve to deter conduct which violates the Workers’ Compensation Act, the penalty statutes did not provide any direct remedy to employees who may claim injuries from the same conduct which is proscribed by the penalty provisions.

compensation, or a conglomerate of discordant parts meting out rough justice, the exclusivity principle, which mandates workers' compensation as the virtual sole means of compensation for work-related injuries, serves as the system's cornerstone."<sup>12</sup>

#### A. THE EXCLUSIVE REMEDY BAR

Some commentators have adopted an inflexible view of the exclusive remedy principle. These commentators hold that "the exclusive remedy principle mandates, which the compensation system holds, sway over all workers' compensation-related causes of action, whether they relate to the injury, or sound in tort or contract law."<sup>13</sup> This is reflected in Professor Larson's rejection of a bad faith tort in his renowned treatise:

It seems clear that a compensation claimant cannot transform a simple delay in payments into an actionable tort by merely invoking the magic words "fraudulent, deceitful and intentional" or "intentional infliction of emotional distress" or "outrageous conduct." [sic] in his complaint. The temptation to shatter the exclusiveness principle by reaching for the tort weapon whenever there is a delay in payments or a termination of treatment is all too obvious, and awareness of this possibility has undoubtedly been one reason for the reluctance of courts to recognize this tort except in cases of egregious cruelty or venality.<sup>14</sup>

"The exclusivity principle is the great fence that seeks to enclose all work-related tort-like injuries. The overriding fear is that the exclusivity principle will begin to disintegrate, with each new application of judicial gloss forcing the law to 'become honeycombed with independent and conflicting rulings of the courts.'"<sup>15</sup> Were this to occur, the objective of the

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<sup>12</sup> Joel E. Fenton, *The Tort of Bad Faith in Iowa Workers' Compensation Law*, 45 DRAKE L. REV. 839, 847 (1997).

<sup>13</sup> *Id.* at 848.

<sup>14</sup> *Id.* at 848 (citing 6 ARTHUR LARSON, WORKERS' COMPENSATION LAW § 68.34(c), at 13-229 to 13-230 (1997)).

<sup>15</sup> Fenton, *supra* note 12, at 848 (citing *Noe v. Travelers Ins. Co.*, 342 P.2d 976, 979 (Cal. Dist. Ct. App. 1959)).

Legislature in enacting Workers' Compensation Acts and the whole pattern of workers' compensation could thereby be partially nullified.<sup>16</sup>

One California court has observed:

In these days of ever shrinking judicial resources, the plaintiff's bar would be well advised to heed these rules [re exclusive jurisdiction of the WCAB] and to concentrate its energy on securing swift and simple compensation for the injured employee in the forum which has exclusive jurisdiction over the claims. Its continual efforts to make end-runs around the exclusivity provisions of the workers' compensation system would be more appropriately addressed to the Legislature . . . .<sup>17</sup>

The jurisprudence of Kentucky, Connecticut, Rhode Island, Louisiana, Pennsylvania and Massachusetts provide good examples of state jurisdictions where the courts have held that the exclusivity provisions of the state's Workers' Compensation Act bar a common-law tort of bad faith because the insurer is immunized.

Kentucky's exclusive remedy statute in the Workers' Compensation Act is set forth in KY. REV. STAT. § 342.690(1). The Kentucky exclusive remedy statute grants immunity for liability arising from common-law and statutory claims, meaning those claims which could not be pursued in the courts of the Kentucky Commonwealth.<sup>18</sup> The Kentucky Supreme Court has observed that the grant of exclusive immunity was part of the bargain provided by the Act whereby employers are made strictly liable to their employees for compensation for work-related injuries. The Kentucky Supreme Court has held that the statute continues by specifically extending the immunity to the employer's workers' compensation insurance carrier:

The exemption from liability given an employer by this section shall also extend to such employer's carrier and to all employees, officers or directors of such employer or

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<sup>16</sup> Noe v. Travelers Ins. Co., 342 P.2d 976, 980 (Cal. Dist. Ct. App. 1959).

<sup>17</sup> Caplan v. Fireman's Fund Ins. Co., 220 Cal. Rptr. 549, 550 (Cal. Ct. App. 1985) (citing United States Borax & Chem. Corp. v. Superior Court, 213 Cal. Rptr. 155, 158 (Cal. Ct. App. 1985)).

<sup>18</sup> Ky. Emp'rs Mut. Ins. v. Coleman, 236 S.W.3d 9, 13 (Ky. 2007).

carrier, provided that the exemption from liability given an employee, officer or director or an employer or carrier shall not apply in any case where the injury or death is proximately caused by the willful and unprovoked physical aggression of such employee, officer or director.<sup>19</sup>

The effect of KY. REV. STAT. § 342.690(1) is to shield a covered employer *and its insurer* from any other liability to a covered employee for damages arising out of a work-related injury.<sup>20</sup> The Kentucky courts have found that the immunity granted by the statute is “[e]xtensive, ranging from disputes over the payment of injuries of the employee to allegations of tortious conduct related to dealing with the workers’ compensation claim itself.”<sup>21</sup>

In *DeOliveira v. Liberty Mut. Ins. Co.*, the Connecticut Supreme Court held that Connecticut would not recognize a common-law cause of

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<sup>19</sup> *Coleman*, 236 S.W.3d at 13.

<sup>20</sup> *Coleman*, 236 S.W.3d at 13 (emphasis added); *Travelers Indem. Co. v. Reker*, 100 S.W.3d 756, 760 (Ky. 2003). *See also* *Zurich Ins. Co. v. Mitchell*, 712 S.W.2d 340, 341 (Ky. 1986) (“[T]he Workers’ Compensation Act provides an exclusive remedy and consequently bars an employee’s tort action for separate damages due to the untimely payment of benefits.”); *Reker*, S.W.3d at 759 (reaffirming this principle rejecting a civil lawsuit alleging bad faith in the workers’ compensation context for a violation of Kentucky’s Unfair Claims Settlement Practices Act, KY. REV. STAT. § 304.12-230, as being barred by the exclusive remedy provision of the workers’ compensation statute); *Reker*, S.W.3d at 762 (reasoning that the Workers’ Compensation Act provided administrative remedies for a delay in payment or failure to pay: “[T]he the statutory scheme of the Workers’ Compensation Act . . . provides[s] civil remedies for an employee who is injured by an employer’s ‘bad faith’ refusal to settle or to make payments when due.”) (alteration in the original); KY. REV. STAT. § 342.040(1) (West 2008) (allowing for the imposition of interest at the rate of 18% upon an ALJ finding that a “[D]enial, delay, or termination in payment of income benefit was without reasonable foundation.”).

<sup>21</sup> *Coleman*, 236 S.W.3d at 14; *Gen. Acc. Ins. Co. v. Blank*, 873 S.W.2d 580, 582-83 (Ky. Ct. App. 1993) (holding that the Act precludes suit against the carrier for alleged violation of the Consumer Protection Act and the UCSPA); *Zurich Ins. Co. v. Mitchell*, 712 S.W.2d 340, 341 (Ky. 1986) (holding that the Act precludes a civil action against the insurance carrier for failure to pay medical expenses under either a common law “bad faith” theory or under the tort of outrage theory); *Brown Badgett, Inc. v. Calloway*, 675 S.W.2d 389 (Ky. 1984).

action for bad faith handling of a workers' compensation claim.<sup>22</sup> Central to the Court's ruling was the conclusion that the statutory penalties within Connecticut's Workers' Compensation Act demonstrated a legislative intent to confine the available remedies to those provided by the relevant penalty statutes.

The Court began its analysis of the issue by addressing the exclusivity provision in Connecticut's Workers' Compensation Act.<sup>23</sup> Connecticut's Act provided a number of statutory penalties against insurers for improper delay in providing benefits.<sup>24</sup> The Legislature had vested in the Commission the jurisdiction to hear employee complaints and award interest, attorney's fees, and penalties for improper claim handling.<sup>25</sup> A \$500 penalty for "undue" delay in adjusting a claim is provided for within the Connecticut Act, together with provisions for the awarding of attorney's fees and interest to the claimant if it was determined that the insurer unreasonably contested liability or delayed payment.<sup>26</sup> The Act also provided a 20% penalty when an insurer failed to make timely payments pursuant to an award or voluntary agreement.<sup>27</sup> The Court in *DeOliveira* found that the existence of the statutory penalty provisions revealed both a legislative awareness of the serious problems injured workers faced when insurers acted in bad faith, and a legislative solution to those problems "In other words, by providing remedies for such conduct, the legislature evinced its intention to bar a tort action for the same conduct proscribed and penalized under the act."<sup>28</sup> The Court found that a recognition of a bad faith cause of action would "usurp" the legislative function.<sup>29</sup> The Court noted that Connecticut's Workers' Compensation Act, which was carefully balanced between rights and remedies, limited but also guaranteed that benefits would be timely paid without regard to fault.

The Court in *DeOliveira* bolstered its legislative intent analysis by examining the Workers' Compensation Act's legislative history. The Court focused on legislative testimony between 1979 through 1993 (when the Act

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<sup>22</sup> *DeOliveira v. Liberty Mut. Ins. Co.*, 870 A.2d 1066, 1070-71 (Conn. 2005).

<sup>23</sup> *Id.* at 1071 (citing CONN. GEN. STAT. ANN. § 31-284(a) (West 1961)).

<sup>24</sup> CONN. GEN. STAT. ANN. §§ 31-288(b), 31-295 (West 1961).

<sup>25</sup> CONN. GEN. STAT. ANN. § 31-300 (West 1961).

<sup>26</sup> *See* CONN. GEN. STAT. ANN. §§ 31-288(b), 31-295(c), 31-300 (West 1961).

<sup>27</sup> *DeOliveira*, 870 A.2d at 1072 (citing CONN. GEN. STAT. ANN. § 31-303 (West 1961)).

<sup>28</sup> *Id.* at 1073.

<sup>29</sup> *Id.* at 1074.

underwent major revisions) which described the “horrific circumstances” that resulted from bad faith claims handling as evidence that the legislature was fully aware of those type of problems and that the solution they fashioned through the adoption of various statutory penalty provisions was the legislature’s response to the problem. The Court concluded that “[t]he legislature clearly was aware of the scope and nature of this problem and presumably crafted the remedies that it deemed fit.”<sup>30</sup> Based upon this legislative history, the Court in *DeOliveira* found that bad faith claims handling was clearly a “[r]isk contemplated by the compensation bargain” and therefore fell within the Act’s exclusive remedy provisions.<sup>31</sup> The Court also found that the various statutory penalties for undue or unreasonable delay were “[b]road enough to encompass the bad faith processing of a workers’ compensation claim,<sup>32</sup> thus preempting a judicially created common-law cause of action.<sup>33</sup>

In *Cianci v. Nationwide Ins. Co.*,<sup>34</sup> the Supreme Court of Rhode Island held that the exclusivity provisions of Rhode Island’s Worker’s Compensation Act applied to any suit against an employer’s workers’ compensation insurer.<sup>35</sup> The Court held that the Worker’s Compensation Act provided an efficient mechanism permitting employees and the insurer to resolve disputes relating to work-related injuries and medical payments in a timely manner.<sup>36</sup> An employee covered under the Act has no common-law right of action against the insurer because the Act expressly addressed such claims and thus immunized the insurer from liability.

Under Louisiana law, no civil common-law cause of action for an insurer’s arbitrary refusal to pay medical expenses in an accident covered

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<sup>30</sup> *Id.* at 1073-74.

<sup>31</sup> *Id.* at 1076.

<sup>32</sup> *Id.* at 1077.

<sup>33</sup> *Contra* *Boylan v. American Motorists Ins. Co.*, 489 N.W.2d 742, 744 (Iowa 1992) (“We conclude that it is unlikely that the legislature intended the penalty provision in section 86.13 to be the sole remedy for all types of wrongful conduct by carriers . . . .”). *See also id.* at 744 (referencing other Iowa Supreme Court decisions holding that statutory penalties did not exclude independent bad faith actions); *Gibson v. ITT Hartford Ins. Co.*, 621 N.W.2d 388, 396-97 (Iowa 2001).

<sup>34</sup> *Cianci v. Nationwide Ins. Co.*, 659 A.2d 662, 688 (R.I. 1995).

<sup>35</sup> *Contra* *Lopes v. G.T.E. Products Corp.*, 560 A.2d 949, 951 (R.I. 1989) (holding that there was no intentional tort exception to the exclusivity provisions of the Act); *Coakley v. Aetna Bridge Co.*, 572 A.2d 295, 296 (R.I. 1990) (holding the same).

<sup>36</sup> *Cianci*, 659 A.2d at 669.

by workers' compensation is allowed.<sup>37</sup> The sole remedy for arbitrary failure to pay workers' compensation benefits is the recovery of penalties and attorney's fees under LSA-R.S. § 23:1201.2.<sup>38</sup> The crucial inquiry is whether the insurer had an articulable and objective reason to deny benefits at the time it took action.<sup>39</sup> In order to reasonably controvert a claim, the insurer must have some valid reason or evidence upon which to base the denial of benefits.<sup>40</sup>

Under LSA-R.S. § 23:1032, an employee's exclusive remedy against his employer for injuries suffered in the course and scope of his employment lies within the Louisiana Workers' Compensation Act. The Louisiana courts have held that the exclusivity statute manifested the following legislative intent: "The rights and remedies herein granted . . . shall be exclusive of all other rights and remedies of such employee . . . against his employer[.]"<sup>41</sup> The statute provides an exception for employees injured as a result of an "intentional act" on the part of their employers.<sup>42</sup> In order to constitute an intentional act within the meaning of LSA-R.S. § 23:1032, the employer must have consciously desired the physical result of

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<sup>37</sup> *Bergeron v. North Am. Underwriters, Inc.*, 549 So. 2d 315 (La. 1989).

<sup>38</sup> *Id.* at 315; *see also* LA. REV. STAT. ANN. § 23:1201(F) (1989) (stating that under Louisiana's workers' compensation statutes, penalties and attorney's fees are recoverable if the employer or insurer fails to commence payments of benefits timely or to pay continued installments or medical benefits timely, unless the claim is reasonably controverted); *Jackson v. Wal-Mart Stores, Inc.*, 868 So. 2d 813, 820 (La. Ct. App. 2004) (holding Louisiana's penalty and attorney's fees statute is designed to discourage indifference and undesirable conduct by insurers and are essentially penal in nature); *Cooper v. St. Tammany Parish School Bd.*, 862 So. 2d 1001, 1008-10 (La. Ct. App. 2003) (holding that although the Worker's Compensation Act is to be liberally construed under Louisiana law in regards to benefits, penal statutes generally are to be strictly construed in Louisiana).

<sup>39</sup> *McLin v. Indus. Specialty Contractors, Inc.*, 851 So. 2d 1135, 1144 (La. 2003).

<sup>40</sup> *Brown v. Texas-LA Cartage*, 721 So. 2d 885, 890 (La. 1998).

<sup>41</sup> *Banes v. Am. Mut. Liab. Ins. Co.*, 544 So. 2d 700, 704 (La. Ct. App. 1989).

<sup>42</sup> LA. REV. STAT. ANN. § 23:1032.A.(1)(a) (1995) (Louisiana's exclusivity statute). *But see* LA. REV. STAT. ANN. § 23:1032.B (1995) ("Nothing in this Chapter shall affect the liability of the employer, or any officer, director, stockholder, partner, or employee of such employer or principal to a fine or penalty under any other statute or the liability, civil or criminal, *resulting from an intentional act.*" (emphasis added)).



his act or have known that that result was substantially certain to follow from his conduct.<sup>43</sup>

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<sup>43</sup> *Yousufali v. Southland Corp.*, 467 So. 2d 191, 193 (La. Ct. App. 1985); *Courtney v. BASF Wyandotte Corp.*, 385 So. 2d 391, 392-93 (La. Ct. App. 1980) (stating under Louisiana law, “intentional acts” is to be interpreted as the equivalent of intentional torts. Thus the only statutory exception to worker’s compensation as a remedy is for intentional torts); *Banes*, 544 So. 2d at 705 (stating Louisiana courts have held that the Legislature has expressly concerned itself not only with assuring compensation to the injured workers, but with policing the procedures under which the claims are made and paid); *id.* at 705 (holding LSA-R.S. §§ 23:1201(E) and 23:1201.2 [now codified in LSA-R.S. § 23:1201 (F), (I), (J)] provide that penalties and attorney’s fees are awarded to a claimant who is denied worker’s compensation coverage when such denial is arbitrary, capricious and without probable cause) (alteration in the original); *Mott v. River Parish Maint., Inc.*, 432 So. 2d 827, 832 (La. 1983) (holding a violation of the statutes alone are not per se an intentional act that would result in the employers tort liability even if injuries sustained by the employee because of the violation); *Physicians and Surgeons Hosp. v. Leone*, 399 So. 2d 806, 807-08 (La. Ct. App. 1981) (holding damages for emotional and mental anguish arising from an insurer’s failure to pay an employee’s medical benefits is covered by the exclusivity remedy of the Workers’ Compensation Act penalties. Thus, a worker’s compensation insurer of the employer is immune from a tort proceeding). *See also* LA. REV. STAT. ANN. § 23:1032.B (1995) (Louisiana’s exclusivity statute permitting a civil cause of action for civil or criminal intentional acts). In *Boudoin v. Bradley*, 549 So. 2d 1265 (La. Ct. App. 1989), the Court considered whether an employee could maintain an action in tort for intentional infliction of emotion distress against the employer’s workers’ compensation insurer. It was alleged that the employee’s benefits were termination by the insurer in order to place the employee in a position of having to financially accept the insurer’s settlement offer even though the offer was unreasonably low. The Court found that to recover damages for the intentional infliction of mental distress, the employee was required to prove that the insurer damages for the intentional infliction of mental distress, the employer was required to prove that the insurer either actively desired to bring about mental anguish or realized to a virtual certainty that it would occur. The Court noted that recovery in such cases had generally been limited to instances of outrageous conduct. *Steadman v. South Central Bell Tel. Co.*, 362 So. 2d 1144, 1145-46 (La. Ct. App. 1978). By “outrageous” it is meant conduct “so extreme in degree, as to go beyond all possible bounds of decency, and to be regarded as atrocious, and utterly intolerable in a civilized community.” Having recognized this standard, the Court in *Boudoin* noted that the Workers’ Compensation Act provisions for penalties and attorney’s fees were part of the legislative compromise which governed the rights of employees and employers in work-related accidents.

In *Kuney v. PMA Ins. Co.*, the Pennsylvania Supreme Court addressed a claim for damages arising from an insurer's bad faith failure to pay workers' compensation benefits.<sup>44</sup> The Court utilized the following rationale to hold that Pennsylvania's Workers' Compensation Act provided the claimant's sole remedy:

Reduced to its essence, the appellee's claim is that the insurance company wrongfully delayed his receipt of compensation benefits. This is clearly a matter pertaining to a workers' compensation claim and must therefore be adjudicated within the framework of the statute, which, as

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To allow recovery in tort against a compensation insurer under a standard less than that articulated by the Louisiana Court in *Steadman* would upset the balance struck by this compromise by permitting tort damages where the legislature has determined that an administrative penalty is the plaintiff's appropriate remedy. *Boudoin*, 549 So. 2d at 1267. The Court in *Boudoin* cited with approval Professor Larson's treatise on workers' compensation law:

It seems clear that a compensation claimant cannot transform a simple delay in payments into an actionable tort by merely invoking the magical words "fraudulent, deceitful and intentional" or "intentional infliction of emotional distress" or "outrageous" conduct in his complaint. The temptation to shatter the exclusiveness principle by reaching for the tort weapon whenever there is a delay in payments or a termination of treatment is all too obvious, and awareness of this possibility has undoubtedly been one reason for the reluctance of courts to recognize this tort *except in cases of egregious cruelty or venality*.

One final factor may be noted that has figured in many of these cases: *the presence in the statute of an administrative penalty for the very conduct on which the tort suit is based*. A majority of the courts have taken the view that this evidences a legislative intent that the remedy for delay in payments, even vexatious delay, shall remain in the system in the form of some kind of penalty.

*Id.* at 1268 (emphasis added) (citing 2A LARSON, WORKMEN'S COMPENSATION LAW § 68.34(c) (1987), at 13-145).

<sup>44</sup> *Kuney v. PMA Ins. Co.*, 578 A.2d 1285, 1286-87 (Pa. 1990).

stated above, has specific remedies for such a grievance. . . . It is fruitless to argue that the appellee has nevertheless failed to receive full indemnification for the injury he suffered through the insurance company's allegedly fraudulent handling of his claim. Benefits payable under the Workmen's Compensation Act are normally the limit of a worker's recovery even though compensatory damages in a tort action might be much higher. . . . We have long recognized that the adequacy of [workers'] compensation [awards] is solely a matter for the legislature.<sup>45</sup>

Similarly, in *Kelly v. Raytheon, Inc.*, the insurer refused to pay a workers' compensation award until the trial court issued a contempt order.<sup>46</sup> The Massachusetts Court of Appeals held that, however egregious the insurer's delay of payment, its obvious bad faith "adds nothing of substance to the claim that the delay was not justified."<sup>47</sup> Thus, the Court reasoned that: "the exclusivity provisions of [the Massachusetts workers' compensation statute], in conjunction with the . . . penalties for delayed payments, reveal a legislative intent that the remedies [for delayed payment] should remain within the system and should be exclusive of all other common law and statutory remedies. . . . [T]he touchstone of [this] claim is the delay in the payment of benefits, and . . . [even] the extraordinary duration and intensity of the dispute between the parties is inadequate to overcome the plain legislative scheme."<sup>48</sup>

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<sup>45</sup> *Id.* at 1287. In *Cook v. Mack's Transfer & Storage*, 352 S.E.2d 296, 299 (S.C. Ct. App. 1986), the Court observed: "The Act itself provides for speedy adjudication of all controversies over the processing of an injured worker's claim for benefits. If the dispute concerns an alleged wrongful denial of statutory benefits, the Commission has exclusive jurisdiction to adjudicate the controversy. Whether the denial is willful, in bad faith, negligent, or the result of a good faith difference is immaterial to the question of the Commission's exclusive jurisdiction." The Court in *Cook* held that because a remedy existed under South Carolina statute, the injured worker had no right to bring a common-law action in the courts.

<sup>46</sup> 563 N.E.2d 1372, 1373 (Mass. App. Ct. 1990).

<sup>47</sup> *Id.* at 1374.

<sup>48</sup> *Id.* at 1374-75.

## B. COMMON-LAW BAD FAITH ALLOWED

A central viewpoint of those courts which have allowed a common-law tort of bad faith in the workers' compensation context is that a cause of action that reaches the status of an intentional tort is not within the purview of the exclusive remedy provisions of their state's Act because the exclusive remedy provisions are only designed to insulate the employer against common-law liability for the ordinary hazards of employment. A "bad faith" workers' compensation claim requires the insurer to indulge in intentional misconduct which places it outside the framework of a state's workers' compensation system. Thus, the insurance company, by its own conduct, abandons the defense that a claimant's exclusive remedies arise under the workers' compensation framework when the insurer commits bad faith.

A bad faith cause of action is a fault-based tort and does not arise under workers' compensation laws even when the state's workers' compensation framework provides the basic relationship between the parties for the action.<sup>49</sup> These courts have concluded that a bad faith claim does not arise under their state's workers' compensation law merely because an independent fault-based tort occurs in that context. The courts of Iowa, Hawaii and South Dakota provide examples of this approach.

In *Boylan v. American Motorists Ins. Co.*, the Iowa Supreme Court recognized a bad faith cause of action by an employee against the insurance carrier in delaying or failing to pay compensation benefits.<sup>50</sup> The lawsuit brought by the employee alleged that American Motorists Insurance Company delayed and then terminated weekly wage and medical benefits in bad faith causing an aggravation of the employee's work-related injuries.<sup>51</sup> The trial court analogized the claim brought by the employee to third-party bad faith suits which Iowa courts did not recognize and, therefore, dismissed the claim.<sup>52</sup> However, the Iowa Supreme Court reversed. Referring to Iowa's Workers' Compensation Act, where penalties may be assessed when benefits are unreasonably delayed or denied, the Iowa Supreme Court declared that the Act mandated an obligation to furnish medical and hospital supplies to an injured employee as well as to

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<sup>49</sup> *Spearman v. Exxon Coal USA, Inc.*, 16 F.3d 722, 725 (7th Cir. 1994).

<sup>50</sup> 489 N.W.2d 742, 742 (Iowa 1992).

<sup>51</sup> *Id.*

<sup>52</sup> *Id.*

provide temporary disability or healing period benefits.<sup>53</sup> The Court found that these statutory obligations ran from the insurance company to the employee directly making the employee's claim analogous to a first party bad faith lawsuit, which Iowa did recognize.<sup>54</sup> In so holding, the *Boylan* Court recognized that an implied contract existed between the workers' compensation insurer and the injured employee.<sup>55</sup>

The Court in *Boylan* disregarded the penalty provision under Iowa statute for the insurer's wrongful conduct in the administration of benefits.<sup>56</sup> The Court in *Boylan* concluded that it was "unlikely that the legislature intended the penalty provision in [IOWA CODE] section 86.13 to be the sole remedy for all types of wrongful conduct by carriers with respect to administration of workers' compensation benefits."<sup>57</sup> The Court reached this conclusion for the following reasons: (1) looking at the terms of the penalty provision, "it provides applies only to delay in commencement or termination of benefits;"<sup>58</sup> (2) the penalty provision did not contemplate the "willful or reckless acts" necessary for a bad faith cause of action, but only negligent conduct;<sup>59</sup> (3) the penalty provision did not provide a remedy "for delay or failure to pay medical benefits;"<sup>60</sup> and (4) other jurisdictions had held that a common-law bad faith action was not

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<sup>53</sup> *Id.* at 743.

<sup>54</sup> Iowa first recognized first party bad faith in *Dolan v. AID Ins. Co.*, 431 N.W.2d 790, 790 (Iowa 1988). However, in *Long v. McAllister*, 319 N.W.2d 256, 262 (Iowa 1982), the Iowa Supreme Court refused to recognize a bad faith cause of action permitting a third-party to recover against the tortfeasor's liability insurer for failing to settle a liability claim against the insured.

<sup>55</sup> 489 N.W.2d at 743. The *Dolan* Court also emphasized that a contractual relationship existed between the insurer and insured. 431 N.W.2d at 794. The insurer in *Dolan* was found to have a duty to act in the best interest of the insured because of its insurance contract with the insured. *Id.* Applying this duty to the facts of *Boylan*, the Supreme Court found that American Motorists Ins. Co., whose contract was with the employer, had a duty to act in good faith to the employee who was not a party to the insurance contract. 489 N.W.2d at 744.

<sup>56</sup> See IOWA CODE § 86.13 (1991); *Boylan*, 489 N.W.2d at 744.

<sup>57</sup> *Boylan*, 489 N.W.2d at 744.

<sup>58</sup> *Id.*

<sup>59</sup> *Id.*

<sup>60</sup> *Id.*

precluded by “[p]enalty provisions for mere delay in payment or improper termination of benefits.”<sup>61</sup>

The Hawaii courts permit a cause of action for insurer bad faith in the workers’ compensation context.<sup>62</sup> In *Hough v. Pacific Ins. Co., Ltd.*, the Court held “[b]y its plain language, HRS § 386-5, and indeed, the entire workers’ compensation scheme, applies only to ‘work injuries.’”<sup>63</sup> In *Hough* the plaintiff filed a claim for, *inter alia*, bad faith and intentional and negligent infliction of emotional distress against his previous employer’s workers’ compensation insurer for injuries allegedly incurred in the handling of his claim for benefits. The Court ruled that “[b]ecause Hough’s common-law tort claims do not ‘arise under’ HRS Chapter 386, the director of labor and industrial relations does not have original jurisdiction under HRS § 386-73.”<sup>64</sup> Additionally, the Court found that the relevant statutory language under Hawaii’s Workers’ Compensation Act did not reasonably envision emotional and physical suffering allegedly

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<sup>61</sup> *Id.* The *Boylan* Court’s interpretation of legislative intent is questionable. The Court’s reasoning that IOWA CODE § 86.13 applied only to delay in commencement or termination of benefits and not to delays at other times would appear to frustrate the purpose of § 86.13. Just as the Court concluded that “it [was] unlikely that the Legislature intended the penalty provision . . . to be the sole remedy” for delays in payment, it is equally unlikely that the Iowa Legislature intended to award penalties only for damages in commencement or termination of benefits. *Id.* There is no rational basis to make the distinction between the two types of payments and the court did not attempt to make such a distinction. The Court’s conclusion that the penalty provision did not provide a remedy “for delay or failure to pay medical benefits” is also flawed because section 86.13 does apply to delay or termination of benefits inasmuch as it does not list specific benefits. *See* IOWA CODE § 86.13 (1991); *Boylan*, 489 N.W.2d at 744. Section 86.13 is broad enough to provide a penalty for all types of benefits allowable under the Workers’ Compensation Act. Finally, the Court’s reasoning that the penalty provision “contemplates negligent conduct rather than the willful or reckless acts” required for a bad faith action can be questioned. *Boylan*, 489 N.W.2d at 744. Certainly the fact that the Iowa Legislature adopted a penalty of “fifty percent of the amount of benefits that were unreasonably delayed or denied” was a substantial penalty to deter wrongful conduct. IOWA CODE § 86.13 (1991). Moreover, if the Iowa Legislature had intended to allow a common-law cause of action, the Legislature could have statutorily provided for a bad faith cause of action.

<sup>62</sup> *Hough v. Pac. Ins. Co., Ltd.*, 927 P.2d 858, 869-70 (1996). Hawaii’s exclusivity statute is HAW. REV. STAT. § 386-5 (1993).

<sup>63</sup> *Hough*, 927 P.2d at 865.

<sup>64</sup> *Id.* at 867.

caused by an insurer's outrageous and intentional denial of medical benefits and disability payments as an injury arising out of and in the course of employment.<sup>65</sup>

The South Dakota courts have recognized a cause of action for bad faith in the workers' compensation context. The South Dakota courts follow a two-prong test in cases of alleged bad faith failure to pay by a workers' compensation carrier:

[F]or proof of bad faith, there must be an absence of a reasonable basis for denial of policy benefits and the knowledge or reckless disregard [of the lack] of a reasonable basis for denial, implicit in that test is our conclusion that the knowledge of the lack of a reasonable basis may be inferred and imputed to an insurance company where there is a reckless disregard of a lack of a reasonable basis for denial or a reckless indifference to facts or to proofs submitted by the insured.

Under these tests of the tort of bad faith, an insurance company, however, may challenge claims which are fairly debatable and will be found liable only where it has intentionally denied (or failed to process or pay) a claim without a reasonable basis.<sup>66</sup>

In *Hein v. Acuity*, the South Dakota Supreme Court discussed the unique contours of a bad faith cause of action in the workers' compensation context:

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<sup>65</sup> *Id.* at 866. *See also* *Catron v. Tokio Marine Mgmt., Inc.*, 978 P.2d 845, 849-50 (1999). Under Hawaii law, a bad faith cause of action against a workers' compensation insurer is originally cognizable in court and does not fall within the original jurisdiction of the director under HAW. REV. STAT. §386. *Jou v. Nat'l Interstate Ins. Co. of Hawaii*, 157 P.3d 561, 567 (Haw. Ct. App. 2007). A workers' compensation insurance carrier has a duty to act in good faith in dealing with workers' compensation claimants, and a breach of this duty gives rise to a cause of action in tort for insurer bad faith. *Wittig v. Allianz*, 145 P.3d 738, 743 (Haw. Ct. App. 2006); *See also Hough*, 927 P.2d at 869-70. A reasonableness standard governs bad faith claims in Hawaii. *Best Place, Inc. v. Penn Am. Ins. Co.*, 920 P.2d 334, 347 (Haw. 1996).

<sup>66</sup> *Walz v. Fireman's Fund Ins. Co.*, 556 N.W.2d 68, 70 (S.D. 1996) (citing *Champion v. U.S. Fid. & Guar. Co.*, 399 N.W.2d 320, 324 (S.D. 1987)).

Customarily, bad faith litigation can be classified as either first- or third-party bad faith. Third-party bad faith is traditionally based on principles of negligence and arises when an insurer wrongfully refuses to settle a case brought against its insured by a third-party. Third-party bad faith exists when an insurer breaches its duty to give equal consideration to the interests of its insured when making a decision to settle a case.

First-party bad faith, on the other hand, is an intentional tort and typically occurs when an insurance company consciously engages in wrongdoing during its processing or paying of policy benefits to its insured. In these cases, the parties are adversaries, and therefore, an insurer is permitted to challenge claims that are fairly debatable. However, a frivolous or unfounded refusal to comply with a duty under an insurance contract constitutes bad faith.

Wrongful conduct toward an employee claimant by the employer's insurer in a workers' compensation case does not fit the traditional definition of either first- or third-party bad faith. A bad faith claim related to workers' compensation is not based on an insurer's refusal to settle its own insured's suit as in third-party cases, but exists when an insurer breaches its duty to deal in good faith and fairly when processing a workers' compensation claim. And, unlike first-party bad faith, the claimant, not the insured employer, brings the action against the insurer. Nonetheless, it is within the first-party bad faith context that multiple jurisdictions, including South Dakota, recognize a bad faith cause of action based on an insurer's conduct in a workers' compensation case. . . .

[T]here exists a key difference between bad faith in a workers' compensation action and bad faith in a traditional first-party insured-insurer relationship. In workers' compensation cases, the claimant is not the insured. In true first-party claims, there exists a contractual relationship, whereby the insurer has accepted a premium from its insured to provide coverage. Under those circumstances,



we recognized . . . that bad faith can extend to situations beyond mere denial of policy benefits.

Nonetheless, in a dispute between a workers' compensation claimant and the employer's insurer, no contractual relationship exists. . . . Bad faith arising out of workers' compensation proceedings does not have the necessary attribute of a traditional first-party bad faith claim, i.e., a contractual relationship.<sup>67</sup>

A bad faith action cannot proceed once the South Dakota Department of Labor has determined that the plaintiff was not entitled to benefits.<sup>68</sup> Thus, claimants must exhaust administrative remedies.

### C. PARTIAL IMMUNITY

A few courts have found that their state's workers' compensation statutes grant immunity to insurers for routine bad faith delay claims but allow a common-law tort action where extreme misconduct is involved.<sup>69</sup> This approach has been utilized by the courts in Alaska<sup>70</sup> and Florida.<sup>71</sup> As an example, in *Stafford v. Westchester Fire Ins. Co. of New York, Inc.*, the Alaska Supreme Court held that ALASKA STAT. § 23.30.155 was enacted

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<sup>67</sup> Hein v. Acuity, 731 N.W.2d 231, 235-36 (S.D. 2007) (internal citations omitted).

<sup>68</sup> Zuke v. Presentation Sisters, Inc., 589 N.W.2d 925, 930 (S.D. 1999) (citing *Jordan v. Union Ins. Co.*, 771 F. Supp. 1031 (D. S.D. 1991)).

<sup>69</sup> See, e.g., *McCutchen v. Liberty Mut. Ins. Co.*, 699 F. Supp. 701, 711 (N.D. Ind. 1988) (holding insurer's mockery of claimant while repeatedly refusing to pay psychiatric treatment claims rose to the level of a separate tort committed during claim settlement and was not barred by workers' compensation statute); *Cont'l Cas. Ins. Co. v. McDonald*, 567 So. 2d 1208, 1219 (Ala. 1990) (stating delay of payment cannot give rise to tort actions unless delay is "so outrageous in character and so extreme in degree as to go beyond all possible bounds of decency, and to be regarded as utterly intolerable in a civilized society"); *Young v. Hartford Accident & Indem. Co.*, 492 A.2d 1270, 1279 (Md. 1985) (holding claimant's stated cause of action when she alleged insurance carrier forced her to submit to psychiatric exam for sole purpose of making her abandon her claim or commit suicide).

<sup>70</sup> *Stafford v. Westchester Fire Ins. Co. of N.Y.*, 526 P.2d 37, 43-44 (Alaska 1974).

<sup>71</sup> *Aguilera v. Inservices, Inc.*, 905 So. 2d 84, 95 (Fla. 2005).

by Alaska's Legislature to cover situations where the employer or insurer negligently, or willfully, failed to make timely compensation payments to claimants.<sup>72</sup> However, the Court held that ALASKA STAT. § 23.30.155, Alaska's penalty statute, was not intended to operate as the exclusive remedy for all intentional wrongdoings.<sup>73</sup> In those circumstances where there has been tortious conduct that goes beyond the bounds of untimely payments, the Court in *Stafford* held that exclusive immunity from suit provided by the Alaska Workers' Compensation Act is lost.<sup>74</sup>

The Court in *Stafford* observed that normally an insurer must investigate claims in order that the compensation scheme of payments for actual injuries will be properly administered. However, intentional torts committed in connection with the investigation of claims and payments thereof are not protected.<sup>75</sup> In *Stafford*, the claimant alleged that Westchester did more than delay in making benefit payments; claimant asserted that Westchester intentionally and maliciously misled him about his right to compensation and discouraged him from exercising his rights, resulting in emotional injury. The Court in *Stafford* held that these types of allegations, if proven, could form the basis of an independent bad faith tort action.

The Court in *Stafford* adopted the rationale of the California Supreme Court in *Unruh v. Truck Ins. Exch.*<sup>76</sup> The Alaska Supreme Court's observation of the *Unruh* decision was that the *Unruh* Court had reasoned that the insurer obtained immunity by being the alter ego of the employer, and that exclusive immunity was lost when the insurer exceeded its proper role in the process. The *Unruh* Court had concluded that the insurer's committing of intentional torts, placed the insurer outside the role of being the alter ego of the employer, and became a "person other than the

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<sup>72</sup> *Stafford*, 526 P.2d at 43.

<sup>73</sup> *Id.* ALASKA STAT. § 23.30.155(e) (1962) is one of several provisions in the Alaska Workers' Compensation Act that directly penalizes employers for failure to comply with the Act's requirements. The statute provides for a civil penalty up to \$1,000 for failure to file reports. ALASKA STAT. § 23.50.155(e) (1962). Under ALASKA STAT. § 23.30.155(f) (1962), a 25% penalty on unpaid awards payable under the terms of an award. The Commission can also award attorney's fees to claimants. *See* ALASKA STAT. § 23.30.145 (1962). The employer faces felony liability for failure to pay compensation due. *See* ALASKA STAT. § 23.30.255 (1962).

<sup>74</sup> *Stafford*, 526 P.2d at 43.

<sup>75</sup> *Id.* at 43-44.

<sup>76</sup> *Id.* at 43 (adopting *Unruh v. Truck Ins. Exch.*, 498 P.2d 1063 (Cal. 1972)).

employer” against whom the employee is entitled to bring a civil action for damages. The *Unruh* Court refused to allow tort recovery for negligent acts by the insurer reasoning that the system of workers’ compensation would be subjected to a process of partial disintegration as a result. However, the *Unruh* Court found that permitting suits for intentional torts would subserve the laudable objectives of the compensation scheme, while encouraging the insurer to fulfill its proper role in that scheme.<sup>77</sup>

In *Aguilera v. Inservices, Inc.*, the Florida Court recognized that minor delays in payment, and conduct amounting to simple bad faith in claim handling procedures of the employee’s compensation claim are protected by immunity.<sup>78</sup> The Court stated that mere delay of payments or simple bad faith in handling workers’ compensation claims are not actionable torts, and that employees are not permitted to transform such simple delays into actionable torts cognizable by the courts.<sup>79</sup> However, where the conduct of the insurer goes beyond a simple claim of delay or termination of benefits and alleges harm caused subsequent to and distinct from the original workplace injury, the Court found that Florida’s Workers’ Compensation Act did not permit compensation insurance carriers to cloak themselves with blanket immunity in circumstances where the carrier has not merely breached the duty to timely pay benefits, or acted negligently, but has actually committed an intentional tort upon an employee. The Court stated:

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<sup>77</sup> *Id.* at 42-43 (citing *Unruh v. Truck Ins. Exch.*, 498 P.2d 1063, 1073) (Cal. 1972)).

<sup>78</sup> *Aguilera v. Inservices, Inc.*, 905 So. 2d 84, 91 (Fla. 2005).

<sup>79</sup> *Id.* See also *Sheraton Key Largo v. Roca*, 710 So. 2d 1016, 1017 (Fla. Dist. Ct. App. 1998) (stating an employee cannot avoid the exclusivity of the workers’ compensation law and transform a mere delay in payments into an actionable tort simply by calling that delay outrageous, fraudulent, deceitful, or an intentional infliction of emotional distress); *Assoc. Indus. of Fla. Prop. & Cas. Trust v. Smith*, 633 So. 2d 543, 544 (Fla. Dist. Ct. App. 1994) (“Because Florida’s compensation law contains mechanisms to insure timely payment and provides an array of sanctions which may be imposed when a carrier wrongfully withholds payment, the remedy under the act is exclusive.”); *Old Republic Ins. Co. v. Whitworth*, 442 So. 2d 1078, 1079 (Fla. Dist. Ct. App. 1983) (determining that while the employee alleged a bad faith refusal to timely compensate him for his disabilities, the complaint did not allege that the insurance carrier intentionally harmed the employee).

The workers' compensation system was never designed or structured to be used by employers or insurance carriers as a sword to strike out and cause harm to individual employees during the claim process and then provide a shield from responsibility for an employee's valid intentional tort claim for that conduct through immunity flowing under the law. Most certainly, the workers' compensation system was never intended to function as a substitute for an employee's right to seek relief in a common law intentional tort action against an employer or insurance carrier, but was only intended to provide employers and insurance carriers with immunity for negligent workplace conduct which produced workplace injury. Minor delays in payments, and conduct amounting to simple bad faith in claim handling procedures of the employee's compensation claim have been captured within the immunity.<sup>80</sup>

The Court in *Aguilera* held that an insurance carrier that utilizes the process of administering benefits to intentionally injure a worker is not afforded immunity.<sup>81</sup>

#### D. BREACH OF CONTRACT THEORY

The courts in Delaware<sup>82</sup> and Utah<sup>83</sup> have found that their state's Workers' Compensation Act did not bar a cause of action brought *in contract* against the claimant's workers' compensation insurer. As an example, in *Pierce v. Int'l Ins. Co. of Illinois*, the Delaware Supreme Court ruled that Delaware's Workers' Compensation Act did not bar a cause of action in contract brought by claimants against a workers' compensation insurance carrier alleging bad faith delay in payment of claims.<sup>84</sup> According to the Court in *Pierce*, the claimant is limited to contract remedies which include breach, consequential and punitive damages.<sup>85</sup>

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<sup>80</sup> *Aguilera*, 905 So. 2d at 91.

<sup>81</sup> *Id.* at 98.

<sup>82</sup> *Pierce v. Int'l Ins. Co. of Ill.*, 671 A.2d 1361 (Del. 1996).

<sup>83</sup> *Savage v. Educators Ins. Co.*, 908 P.2d 862 (Utah 1995).

<sup>84</sup> *Pierce*, 671 A.2d at 1362.

<sup>85</sup> *Id.* at 1367.

However, damages for emotional distress do not arise from the breach of the duty of good faith and fair dealing when the insurer allegedly acts in bad faith by delaying payment of claims.<sup>86</sup>

The Utah Supreme Court in *Savage v. Educators Ins. Co.* concluded that injured workers cannot pursue a tort action for bad faith.<sup>87</sup> This was predicated upon the jurisprudence of Utah which had previously held that a breach of the implied contractual covenant of good faith and fair dealing did not give rise to a tort claim because the claim was actionable only as a contractual breach.<sup>88</sup> Because injured claimants do not have a contractual relationship with the workers' compensation insurer, the Court in *Savage* held that no cause of action exists between the injured employee claimant and the workers' compensation insurer for breach of the covenant of good faith and fair dealing.<sup>89</sup> To support this conclusion, the Court in *Savage* recognized that a cause of action in favor of employees against an insurer for the manner in which it adjusted a workers' compensation claim was inconsistent with the workers' compensation scheme and, in fact,

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<sup>86</sup> *Id.*

<sup>87</sup> *Savage*, 908 P.2d 862, 866.

<sup>88</sup> *Id.*

<sup>89</sup> *Id.* The relationship between a workers' compensation insurer and an injured employee is different from the relationship between an insurance company and a normal third-party. However, some courts examining the relationship have concluded that it involves the same level of intimacy as does the relationship between an insurer and a first-party insured. *See, e.g., Travelers Ins. Co. v. Savio*, 706 P.2d 1258, 1272 (Colo. 1985) (holding that covered employee stands in the same position as an insured in a private insurance contract). The roots of this relationship are grounded in the purpose of workers' compensation statutes, which is to provide speedy, equitable relief to injured employees. *See State Tax Comm'n v. Indus. Comm'n*, 685 P.2d 1051, 1053 (Utah 1984). Under worker's compensation statutes, employees relinquish their common-law claims against their employers in return for the promise that employers and their workers' compensation insurers will fairly compensate them for injuries sustained in the course of employment. From the time of injury, employees in most areas rely on workers' compensation insurers for protection from the severe financial adversity associated with disabling injuries. This reliance, combined with the exclusive control workers' compensation insurers exercise over the processing of claims creates a considerable disparity in bargaining power. Thus, injured employees are particularly vulnerable to delaying tactics and other bad faith acts by workers' compensation insurers. *See Scott Wetzel Servs., Inc. v. Johnson*, 821 P.2d 804, 810 (Colo. 1991).

could do substantial harm to the workers' compensation system as a whole. The Court observed:

[B]eyond the legalistic objection to appellant's position, we must point out that if delay in medical service attributable to a carrier could give rise to independent third party court actions, the system of workmen's compensation could be subjected to a process of partial disintegration. In the practical operation of the plan, minor delays in getting medical service, such as for a few days or even a few hours, caused by a carrier, could become the bases of independent suits, and these could be many and manifold indeed. The uniform and exclusive application of the law would become honeycombed with independent and conflicting rulings of the courts. The objective of the Legislature and the whole pattern of workmen's compensation could thereby be partially nullified.<sup>90</sup>

The Court in *Savage* observed that Utah's workers' compensation system contemplated situations where a claim for medical benefits was denied by a workers' compensation insurer.<sup>91</sup> Under the Workers' Compensation Act, an employee who disagreed with the denial of benefits could apply for a hearing with the Industrial Commission.<sup>92</sup> Therefore, the Court found that the workers' compensation system provided an efficient and definite remedy to employees who disagreed with the decision of a workers' compensation insurer.<sup>93</sup> The Court observed that both the Legislature and the Commission provided penalties to be imposed where an insurer or employer delayed payment without good cause.<sup>94</sup>

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<sup>90</sup> *Savage*, 908 P.2d at 867 (citing with approval the Florida Court of Appeals in *Sullivan v. Liberty Mut. Ins. Co.*, 367 So. 2d 658, 660-61 (Fla. Dist. Ct. App. 1979)); *see also* *Noe v. Travelers Ins. Co.*, 342 P.2d 976, 979-80 (Cal. Dist. Ct. App. 1959).

<sup>91</sup> *Savage*, 908 P.2d at 867.

<sup>92</sup> *Id.*

<sup>93</sup> *Id.*

<sup>94</sup> *Id.*

## II. LEGISLATIVE INTERVENTION AFTER JUDICIAL RECOGNITION OF A COMMON-LAW BAD FAITH TORT.

In a few instances, the state legislatures have reacted to their state's judicial adoption of a common-law bad faith tort in the workers' compensation context by passing legislation to strengthen the exclusivity provision of the Workers' Compensation Act to include bad faith misconduct. These corrective legislative attempts have experienced mixed success.

The seminal case for extending bad faith tort responsibility to workers' compensation claimants is the Wisconsin Supreme Court's decision in *Coleman v. American Universal Ins. Co.*<sup>95</sup> The Wisconsin Supreme Court in *Coleman* reasoned that a bad faith action predicated upon the settlement practices of the workers' compensation insurer was an "independent" claim for injuries that was not covered by the Wisconsin Workers' Compensation Act.<sup>96</sup> The Court rejected the insurer's contention that the Workers' Compensation Act provided the claimant's sole remedy reasoning that the available compensation remedy is exclusive, "only if the injury falls within the coverage of the Act."<sup>97</sup> The injury asserted by *Coleman*, according to the Court, was "distinct in time and place" from the original industrial injury and, as such, it did not fall within the purview of Wisconsin's Workers' Compensation Act.<sup>98</sup> Therefore, the Court concluded, the exclusivity provision of the Act was not a bar to a claim grounded on tort principles. In finding that *Coleman's* injury was separate and distinct from the original injury suffered in the course of employment, and not merely an aggravation or extension of the original injury, the Court in *Coleman* quoted Professor Larson to illustrate its finding:

It is true that but for the original injury the investigation would never have been undertaken and the second injury would not have occurred. But must we go on to say that the carrier acquires complete tort immunity ever after for anything its agents do to carry out their investigation? Suppose the agent had decided to burglarize the claimant's house to get needed evidence. Suppose claimant died of

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<sup>95</sup> *Coleman v. Am. Universal Ins. Co.*, 273 N.W.2d 220, 221 (Wis. 1979).

<sup>96</sup> *Id.*

<sup>97</sup> *Id.* at 222.

<sup>98</sup> *Id.* at 223.

fright on seeing the burglar. Is the compensation act the exclusive remedy, merely because the activity involved, which was the collecting of evidence, was in the mainstream of the agent's duties?

Again, suppose a claimant has a compensable broken toe, and is being tailed by a photographer. Claimant sees him in the bushes, a scuffle ensues, and claimant receives a skull fracture as a result of a blow from the camera. Is this skull fracture nothing but an aggravation of the broken toe?<sup>99</sup>

The Court in *Coleman* focused upon the Compensation Act's penalty provision, finding that it did not foreclose an action for the tort of bad faith. The Court found that the penalty provision was designed to avoid litigation by promoting the automatic payment of benefits where there was no justification for delay.<sup>100</sup> In instances where the insurer inexcusably delayed payment due to its own mismanagement or deficient administration, the penalty provision was applicable.<sup>101</sup> However, the Court based its decision, allowing for a bad faith cause of action, on the public policy consideration of providing a remedy in instances where the penalty provision may be wholly inadequate.<sup>102</sup> "The inexcusable-delay provision . . . does not contemplate that the intentional tort of bad faith can be expiated merely by payments augmented in the amount of 10 percent."<sup>103</sup> Where insureds have been harmed to the extent that the remedies available in the penalty provision are inadequate, the insured can bring an action for the tort of bad faith.<sup>104</sup>

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<sup>99</sup> *Id.* at 223-24 (quoting 2A ARTHUR LARSON, WORKMEN'S COMPENSATION LAW, § 65.00, at 13-36 to 13-37 (1978)).

<sup>100</sup> *Coleman*, 273 N.W.2d at 224 (interpreting WIS. STAT. ANN. § 102.22(1) (West 1977) allowing for increase of compensation award of 10% as penalty for inexcusable delay of payments).

<sup>101</sup> *Id.*

<sup>102</sup> *Id.*

<sup>103</sup> *Id.*

<sup>104</sup> *Id.* (citing *Martin v. Travelers Ins. Co.*, 497 F.2d 329, 331 (1st Cir. 1974) (federal Longshoremen's and Harbor Workers' Compensation Act does not prohibit separate tort action for insurer's bad faith conduct outside bounds of Act); *Stafford v. Westchester Fire Ins. Co. of N.Y.*, 526 P.2d 37, 43 (Alaska 1974) (penalty provision of Alaska's Workers' Compensation Act no bar to recovery of intentional bad faith torts of insurer committed in processing worker's claim)).



The Wisconsin Legislature successfully overturned the *Coleman* decision in 1981 when it replaced the old penalty provision of the Workers' Compensation Act with a new penalty provision giving an exclusive remedy for an insurer's bad faith conduct.<sup>105</sup>

In *Stump v. Commercial Union*, 601 N.E.2d 327 (Ind. 1992), the Indiana Supreme Court permitted workers to sue workers' compensation insurers for bad faith.<sup>106</sup> The Court observed that Indiana's statutes granted a right to injured employees to assert actions for damages against persons other than the employer or a fellow employee.<sup>107</sup> The Indiana courts had consistently held the exclusive remedy provisions do not apply to bar the right of an employee to assert actions against third-parties.<sup>108</sup> Under Indiana law, the exclusive remedy provisions precluded separate actions for employee injuries only when the injury or death (a) occurred by accident, (b) arose out of employment, and (c) arose in the course of employment.<sup>109</sup> Actions for employee injuries or death not meeting each of these prerequisites were not excluded and could be pursued in the courts.<sup>110</sup> The Indiana courts observed:

The relationship of the compensation insurance carrier to the employer should not afford it special immunity. Various entities may also be involved in assisting employers in fulfilling their obligations under the worker's compensation laws. Ambulance services, physicians, hospitals, pharmacies, medical device manufacturers, and others may participate in providing medical and rehabilitative care covered by worker's compensation. We find no adequate justification to absolve worker's compensation insurance carriers and other such third parties of their responsibilities in the event of additional

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<sup>105</sup> See WIS. STAT. ANN. § 102.18(3)(bp) (West Supp. 1984) (providing exclusive remedy for employers or insurers' bad faith conduct through lesser of 200% of compensation due or \$15,000).

<sup>106</sup> *Stump v. Commercial Union*, 601 N.E.2d 327 (Ind. 1992).

<sup>107</sup> *Id.* at 330 (citing IND. CODE § 22-3-2-13 (1992)).

<sup>108</sup> *Stump v. Commercial Union*, 601 N.E.2d 327, 330 (Ind. 1992); *Rosander v. Copco Steel & Eng'g Co.*, 429 N.E.2d 990, 991 (Ind. Ct. App. 1982).

<sup>109</sup> *Evans v. Yankeetown Dock Corp.*, 491 N.E.2d 969, 973 (Ind. 1986).

<sup>110</sup> *Id.*

injuries or harm proximately caused by their actionable conduct.<sup>111</sup>

After the *Stump* decision, the Indiana Legislature enacted IND. CODE § 22-3-4-12.1(a), the so-called bad faith statute, which became effective in July 1997. The statute provides as follows:

The worker's compensation board, upon hearing a claim for benefits, has the exclusive jurisdiction to determine whether the employer, the employer's worker's compensation administrator, or the worker's compensation insurance carrier has acted with a lack of diligence, in bad faith, or has committed an independent tort in adjusting or settling the claim for compensation.<sup>112</sup>

Based upon the statutory language, the Compensation Board has exclusive jurisdiction in bad faith situations.<sup>113</sup>

In *Borgman v. State Farm Ins. Co.*, the constitutionality of Indiana's workers' compensation bad faith statute was challenged.<sup>114</sup> It was argued that the statute violated the "open courts" provision of the Indiana Constitution<sup>115</sup> because the statute improperly granted the Board authority to consider claims beyond work-related incidents.<sup>116</sup> The Court upheld the constitutionality of the statute finding that the Indiana Legislature, in enacting the bad faith statute, had merely acted to restrict the remedy available for a breach of duty imposed upon the worker's compensation insurance carrier.<sup>117</sup> Additionally, the Court in *Borgman* noted that the statute did nothing more than designate the proper forum for bringing the enumerated claims against the worker's compensation insurance carrier and did not operate to strip the Borgmans of an established right of recourse.

While the Wisconsin and Indiana Legislatures were successful in re-establishing exclusivity after their courts had permitted a common-law bad faith tort, the Arizona Legislature was unsuccessful. In two opinions

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<sup>111</sup> *Stump*, 601 N.E.2d at 331.

<sup>112</sup> IND. CODE ANN. §22-3-4-12.1(a) (West 2011).

<sup>113</sup> *Borgman v. State Farm Ins. Co.*, 713 N.E.2d 851, 855 (Ind. Ct. App. 1999).

<sup>114</sup> *Id.*

<sup>115</sup> *Id.* at 855.

<sup>116</sup> *Id.*

<sup>117</sup> *Id.* at 856.

the Arizona Court of Appeals held that the exclusivity doctrine of Arizona's Workers' Compensation Act did not bar common-law actions for bad faith against workers' compensation carriers.<sup>118</sup> In response to these cases, the Arizona Legislature enacted ARIZ. REV. STAT. § 23-930 which provides in relevant part:

- A. The Commission has exclusive jurisdiction as prescribed in this section over complaints involving alleged unfair claim processing practices or bad faith by an employer, self-insured employer, insurance carrier or claims processing representative relating to any aspect of this chapter. The commission shall investigate allegations of unfair claim processing or bad faith either on receiving a complaint or on its own motion.
- B. If the Commission finds that unfair claim processing or bad faith has occurred in the handling of a particular claim, it shall award the claimant, in addition to any benefits it finds are due and owing, a benefit penalty of twenty-five per cent of the benefit amount ordered to be paid or five hundred dollars, whichever is more.
- C. If the Commission finds that an employer, self-insured employer, insurance carrier or claim processing representative has a history or pattern of repeated unfair claim processing practices or bad faith, it may impose a civil penalty of up to one thousand dollars for each violation found. The civil penalty shall be deposited in the state general fund.

Under ARIZ. REV. STAT. § 23-930(E), the Commission was charged with adopting rules to define unfair claim processing practices and bad faith. In formulating those rules and definitions, the Commission was statutorily required to consider "among other factors, recognized and approved claim processing practices within the insurance industry, the Commission's own

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<sup>118</sup> Boy v. Fremont Indem. Co., 742 P.2d 835 (Ariz. Ct. App. 1987); Franks v. U.S. Fid. & Guar. Co., 718 P.2d 193 (Ariz. Ct. App. 1985).

experience in processing workers' compensation claims and the workers' compensation and insurance laws of [Arizona]."

In *Hayes v. Continental Ins. Co.*, the Arizona Supreme Court considered the Legislature's adoption of ARIZ. REV. STAT. § 23-930. The issue before the Court was whether the statute deprived the courts of jurisdiction over plaintiff's common-law action for bad faith. The Court in *Hayes* questioned whether the timing of the statute's adoption expressed a legislative intent to overrule the prior case law establishing a common-law tort of bad faith.<sup>119</sup> The Court noted that the penalties imposed by ARIZ. REV. STAT. § 23-930 were relatively modest. Although the penalty amount was not dispositive in itself to the Court's ruling, the Court observed that it could not say that the penalties were so flexible, and the administrative remedies so comprehensive, that the Legislature must have intended for them to provide the sole remedy for, or deterrent to, the serious abuses that the common-law addresses.<sup>120</sup> At the conclusion of its statutory analysis, the Court in *Hayes* concluded that ARIZ. REV. STAT. § 23-930 did not divest Arizona courts of jurisdiction over the common-law causes of action previously recognized by the courts.<sup>121</sup>

### III. STATUTORY PENALTIES AND DETERRENCE.

Workers' compensation statutes often contemplate questionable denials of benefits and provide remedies to the injured employee by providing a forum for the resolution of those types of disputes and, in many

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<sup>119</sup> *Hayes v. Cont'l Ins. Co.*, 872 P.2d 668, 672 (Ariz. 1994).

<sup>120</sup> *Hayes*, 872 P.2d at 675 (citing *Thunder Basin Coal Co. v. Reich*, 510 U.S. 200, 216 (1994) (statutory scheme so comprehensive that it, along with statute's history, demonstrated legislative intent to preclude district court review of administrative orders); *CETA Workers' Org. Comm. v. City of N.Y.*, 617 F.2d 926, 930-31 (2d Cir. 1980) (the statutes comprising the Comprehensive Employment and Training Act cannot be construed to authorize a private right of action for breach because "the totality of these provisions, comprehensive and well-crafted to the Act's administrative, institutional, and political exigencies, affirms the primacy and suggests the exclusivity of the [administrative] procedures . . ."). *See also* *Carpentino v. Transport Ins. Co.*, 609 F. Supp. 556, 561 (D. Conn. 1985) (relatively low penalties are an important factor in determining whether to allow common-law tort actions); *Southern Farm Bureau Cas. Ins. Co. v. Holland*, 469 So. 2d 55, 58 (Miss. 1985) (penalty provisions for workers' compensation bad faith inadequate to deter intentional carrier wrongdoing).

<sup>121</sup> *Hayes*, 872 P.2d at 678.

cases, contain penalty provisions designed to provide a remedy for unreasonable conduct on the part of the insurance company.<sup>122</sup> As an example, in Texas an insurer is subject to a 15% penalty if the insurer fails to pay benefits or file a notice of controversion within 20 days of receiving notice of the claim.<sup>123</sup> Additionally, a 12% penalty plus “reasonable attorney’s fees for the prosecution and collection of the claim” may be imposed as a sanction against an insurer who fails to promptly pay the proceeds of a settlement.<sup>124</sup> In Alaska, an employer can be subjected to a civil penalty up to \$1,000 for the failure to file reports<sup>125</sup> and can face a 20% penalty on unpaid awards payable under the terms of an award. The Workers’ Compensation Commission can also award attorney’s fees to claimants.<sup>126</sup> Significantly, an employer can face felony liability for failure to pay compensation due.<sup>127</sup>

In *Robertson v. Travelers Ins. Co.*<sup>128</sup> the Illinois Supreme Court held that the common-law tort of bad faith was barred by the exclusivity provisions of Illinois’ Workers’ Compensation Act. Central to the Court’s finding was the observation that Section 19(k) of the Illinois Workers’ Compensation Act provided for the payment of penalties of 50% of the amount of compensation payable whenever “there has been any unreasonable or vexatious delay of payment or intentional underpayment of compensation, or proceedings have been instituted or carried on by the one liable to pay the compensation, which . . . are merely frivolous or for delay.”<sup>129</sup> The Court found that the statute was applicable not only to cases involving ordinary delay without justification, but also where the delay was malicious.<sup>130</sup> The Court held that a common-law action should not, without other evidence of legislative intent, be held to survive the Act’s exclusivity

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<sup>122</sup> See, e.g., *Robertson v. Travelers Ins. Co.*, 448 N.E.2d 866, 870-72 (Ill. 1983) (claim for vexatious delay and alleged outrageous conduct held to be within the penalty provision of the Illinois Workers’ Compensation Act and such remedy was exclusive).

<sup>123</sup> TEX. REV. CIV. STAT. ANN. art. 8306, § 18(a) (repealed by Acts 1989, 71st Leg., 2nd C.S., ch. 1, § 16.01(7) to (9), eff. Jan. 1, 1991).

<sup>124</sup> TEX. LAB. CODE ANN. § 410.208(d) (West 2005).

<sup>125</sup> ALASKA STAT. § 23.30.155(c).

<sup>126</sup> See ALASKA STAT. § 23.30.145.

<sup>127</sup> See ALASKA STAT. § 23.30.255.

<sup>128</sup> *Robertson v. Travelers Ins. Co.*, 448 N.E.2d 866, 867 (Ill. 1983).

<sup>129</sup> ILL. REV. STAT. 1973, ch. 48, par. 138.19(k).

<sup>130</sup> *Robertson*, 448 N.E.2d at 869.

provisions merely because the remedy provided in the Act for the injury alleged applies to other kinds of injuries as well.<sup>131</sup>

However, some jurisdictions have allowed bad faith claims despite the existence of statutory penalties. In general, these jurisdictions have based their conclusions on two factors: (1) the failure of the relevant statutes to identify specific penalties for bad faith or injurious delay of payment; and (2) a failure to provide penalties to adequately compensate employees for the real harm suffered as a result of delayed payments.<sup>132</sup> Examples of the former reasoning can be found in Iowa and Colorado. An example of the latter reasoning can be found in Arizona.

The Iowa and Colorado courts have permitted bad faith lawsuits because their state WCA statutes did not have penalty provisions specifically addressing bad faith. The Court in *Boylan v. American Motorists Ins. Co.* concluded that it was “unlikely that the legislature intended the penalty provision in [Iowa’s WCA] to be the sole remedy for all types of wrongful conduct by carriers with respect to the administration of workers’ compensation benefits.”<sup>133</sup> The Court in *Boylan* observed that Iowa’s penalty provisions only applied to delays in the commencement or termination of workers’ compensation benefits<sup>134</sup> but did not address issues

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<sup>131</sup> *Id.* In *Perfection Carpet, Inc. v. State Farm Fire & Cas. Co.*, 630 N.E.2d 1152, 1156 (Ill. App. Ct. 1994), the Court observed that the purpose of the Workers’ Compensation Act was to provide financial protection to workers for accidental injuries arising out of and in the course of employment. Under Section 5(a) of Illinois’ Workers’ Compensation Act, workers do not have a common law or statutory right to recover damages from their employer for an injury sustained while in the line of duty other than the compensation provided in the Act. Illinois’ Workers’ Compensation Act also recognized that under certain circumstances additional compensation or penalties should be assessed against the insurance carrier. Section 19(k) provided penalties in the amount of 50% of the amount of compensation payable where “there has been any unreasonable or vexatious delay of payment or intentional underpayment of compensation.” The Court noted that Section 19(l) provided additional compensation where “the employer or his insurance carrier shall without good and just cause fail, neglect, refuse or unreasonably delay the payment of weekly compensation benefits due to an injured employee during the period of temporary total disability.” The Court reaffirmed the *Robertson* decision.

<sup>132</sup> *See, e.g.*, *Gibson v. Nat’l Ben Franklin Ins. Co.*, 387 A.2d 220, 220 (Me. 1978); *Aranda v. Ins. Co. of North Am.*, 748 S.W.2d 210, 210 (Tex. 1988); *Coleman v. Am. Universal Ins. Co.*, 273 N.W.2d 220, 220 (Wis. 1979).

<sup>133</sup> *Boylan v. Am. Motorists Ins. Co.*, 489 N.W.2d 742, 744 (Iowa 1992).

<sup>134</sup> *Id.*

regarding compensation benefits themselves because there was no provision within the Iowa statute for penalty benefits for failing to provide appropriate medical care.<sup>135</sup> The Court in *Boylan* implicitly suggested that the penalty provisions were nothing more than some sort of administrative prod to dissuade insurance carriers from negligence in claims handling, but that the penalty statutes did not specifically contemplate willful, reckless, or otherwise egregious acts that the recognition of a tort of bad faith would be presumed to cover.<sup>136</sup> The Colorado Supreme Court in *Travelers Ins. Co. v. Savio*, observed that while the penalty provisions in Colorado's Workers' Compensation Act applied to conduct which violated the Act, the penalty statutes<sup>137</sup> did not provide any direct remedy to employees who may claim injuries from the same conduct which is proscribed by the penalty provisions.<sup>138</sup>

There is wide variation regarding the nature and extent of penalties provided by the various state Workers' Compensation Acts. Courts have reached differing conclusions as to whether penalty provisions provide adequate deterrence for insurer misconduct in the workers' compensation context. As an example, in Arizona, the courts have determined that the penalty statutes in Arizona's Workers' Compensation Act do not provide significant deterrence. In *Hayes v. Continental Ins. Co.*, the Arizona Supreme Court noted that the penalties imposed by the Workers' Compensation Act<sup>139</sup> were relatively modest.<sup>140</sup> In assessing the strength of

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<sup>135</sup> *Id.* (citing *Klein v. Furnas Elec. Co.*, 384 N.W.2d 370, 375 (Iowa 1986)).

<sup>136</sup> See Michelle M. Lasswell, *Workers' Compensation – Employee's Allegations that Workers' Compensation Insurer Terminated His Benefits in Bad Faith Stated Bad Faith Tort Claim Against the Insurer – Boylan v. American Motorists Ins. Co.*, 489 N.W.2d 742 (Iowa 1992), 43 DRAKE L. REV. 477, 478 (1994); Fenton, *supra* note 12, at 850-51.

<sup>137</sup> See 3 COLO. REV. STAT. §§ 8-43-304, 8-43-305, 8-43-306, 8-43-401, 8-43-401.5 (2010).

<sup>138</sup> *Travelers Ins. Co. v. Savio*, 706 P.2d 1258, 1276 (Colo. 1985).

<sup>139</sup> ARIZ. REV. STAT. § 23-930 (1987).

<sup>140</sup> *Hayes v. Continental Ins. Co.*, 178 Ariz. 872 P.2d 668, 675 (citing *Thunder Basin Coal Co. v. Reich*, 510 U.S. 200, 216 (1994) (statutory scheme so comprehensive that it, along with statute's history, demonstrated legislative intent to preclude district court review of administrative orders)); *CETA Workers' Org. Comm. v. City of N.Y.*, 617 F.2d 926, 930-31 (2d Cir. 1980) (the statutes comprising the Comprehensive Employment and Training Act cannot be construed to authorize a private right of action for breach because "the totality of these provisions, comprehensive and well-crafted to the Act's administrative,

the penalty provisions set forth in ARIZ. REV. STAT. § 23-930(B), the Court in *Hayes* noted:

A.R.S. § 23-930(B) authorizes a penalty, payable to the claimant, of 25% of the amount wrongfully withheld or \$500, whichever is greater. In addition, under section (C), if the Commission finds a pattern of abuse, it may impose a civil penalty of up to \$1,000 for each violation, payable to a special fund rather than to the claimant. This penalty structure seems to discourage claimants from bringing bad faith claims if the amount in controversy is small because there is little chance of recovering enough money to pay an attorney. It is an equally weak deterrent to bad faith practices in larger cases because a 25% penalty can easily be absorbed by an insurer who selectively targets abusive practices to those cases likely to succeed. Moreover, even if an insurer faces the added penalty for a pattern of abuse, the penalty is only \$1,000, regardless of the amount the insurer wrongfully withholds. Thus, in cases in which a \$1,000 fine is small compared to the amount the insurer would stand to gain, the fixed fine provides little deterrent to unfair practices if the insurer selects only those cases in which the practices are most likely to succeed in preventing workers from pressing genuine claims. It is therefore questionable whether these penalties are adequate to discourage bad faith practices. This, of course, is not to say that the legislature could not have meant a relatively weak set of remedies to be the sole remedy for bad faith practices, but it more logically indicates the opposite intent.<sup>141</sup>

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institutional, and political exigencies, affirms the primacy and suggests the exclusivity of the [administrative] procedures . . . .”). *See also* *Carpentino v. Transport Ins. Co.*, 609 F. Supp. 556, 561 (D. Conn. 1985) (relatively low penalties are an important factor in determining whether to allow common-law tort actions); *Southern Farm Bureau Cas. Ins. Co. v. Holland*, 469 So. 2d 55, 58 (Miss. 1985) (penalty provisions for workers’ compensation bad faith inadequate to deter intentional carrier wrongdoing).

<sup>141</sup> *Hayes*, 872 P.2d at 676 n.14.



However, the New Mexico Supreme Court observed that New Mexico's Workers' Compensation Act penalty provisions provided sufficient deterrence to prevent an insurer from denying benefits in bad faith while enforcing the public policy against the bad faith handling of workers' compensation claims. In *Cruz v. Liberty Mut. Ins. Co.*, the New Mexico Supreme Court interpreted Section 52-1-28.1 and considered its effect on bad faith claims.<sup>142</sup> Specifically, the New Mexico Supreme Court considered the size of the award available to the worker. The Court stated:

Further, Section 52-1-28.1 provides an adequate remedy. The purpose of the bad-faith action in the Act is to secure benefits for the employee and penalize the employer or insurer. Under Section 52-1-28.1, the employee receives all compensation for benefits due and owing and "shall receive" an extra "benefit penalty" of up to twenty-five percent of the claim. Section 52-1-28.1(B). Although this penalty may not be a great amount when the amount of the claim is small, it provides sufficient deterrence to prevent an insurer from denying benefits in bad faith and enforces the public policy against the bad-faith handling of workers' compensation claims. In addition, although this Section may not provide a recovery for emotional distress or an award of punitive damages, we previously have held that "the employer or insurer's liability is limited to that set forth in the Act."<sup>143</sup>

#### IV. UNIFYING REMEDIES FOR BAD FAITH THROUGH EXCLUSIVITY AND INCREASED PENALTIES.

Cogent legal analysis supports the competing views adopted by various courts in deciding whether to permit or disallow a common-law cause of action for insurance company bad faith in the workers' compensation context. Judicial reluctance to permit a common-law bad faith remedy as an exception to the exclusive remedy rule stems from a judicial unwillingness to tamper with what courts see as the fixed terms of the carefully designed legislative bargain underlying workers'

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<sup>142</sup> *Cruz v. Liberty Mut. Ins. Co.*, 889 P.2d 1223, 1226 (N.M. 1995).

<sup>143</sup> *Id.*

compensation.<sup>144</sup> Courts taking this view regard the exclusive remedy rule as a reluctantly conceded bargaining chip essential to the original deal and, in turn, to the preservation of the compensation system.<sup>145</sup> Some of these courts perceive that their authority to modify the bargain is constrained and therefore they defer to legislatures for the enactment of any needed reforms.<sup>146</sup> Indeed there are sound policy reasons for denying such claims. As an example, the Court in *Noe v. Traveler's Ins. Co.* recognized that "if delay in medical service attributable to a carrier would give rise to independent third-party court actions, the system of workmen's compensation could be subjected to a process of partial disintegration."<sup>147</sup> The Court observed "the uniform and exclusive application of the law would become honeycombed with independent and conflicting rulings of the courts. The objective of the Legislature and the whole pattern of workmen's compensation could thereby be partially nullified."<sup>148</sup>

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<sup>144</sup> The Workers' Compensation Acts shift from the employee to the employer the risk of work-related injuries incident to modern industrial activity. In return, they require the worker, as a condition for receiving the benefits of the Acts, to surrender his or her right to sue a common law. This balancing of advantages is embodied in the exclusive rights and remedies provision of the respective Act. The exclusive remedy provision typically bars all actions against an employer where a personal injury to an employee comes within the Act. The exclusive remedy provision makes the Act the exclusive means of settling all such claims. However, the amount of compensation available under the Act may be substantially less than could be recovered in a successful common-law action; but in other cases, the employee will receive benefits he would not otherwise have enjoyed because of his inability to establish the employer's common-law liability. This is the balance that was struck by the state legislatures in order to afford the widest practical coverage for work-related injuries.

The Workers' Compensation Act provides an exclusive remedy of compensation and derogation of common-law rights and is not cumulative or supplemental thereto but wholly substitutional. The compensation afforded by the Act is statutory in character, and the right of any claimant thereto is dependent upon the terms and conditions of the statute. These include the procedures for adjudicating a compensation claim as well as the terms and conditions of substantive entitlement.

<sup>145</sup> See Note, *Exceptions to the Exclusive Remedy Requirements of Workers' Compensation Statutes*, 96 HARV. L. REV. 1641, 1654 (1983).

<sup>146</sup> *Id.*

<sup>147</sup> *Noe v. Travelers Ins. Co.*, 342 P.2d 976, 979 (Cal. Ct. App. 1959).

<sup>148</sup> *Id.* at 979-80.

One commentator has correctly observed that a bad faith cause of action “stems” from the same source as the original action – a compensable workers’ compensation injury.<sup>149</sup> Certainly, a cause of action for bad faith arises out of the originating statutory proceedings. “[T]he fact that a claimant makes application for workers’ compensation benefits under the policy and under the Act is tied to the fact that there was a compensable injury in the first place.”<sup>150</sup>

It is hard to argue, conceptually, with the notion that insurer bad faith is “inextricably interwoven” with the insurer’s status in the workers’ compensation process. Reasoning that investigation by an insurer “constitutes a service ‘inextricably interwoven’ with the insurer’s status,” the Court in *Unruh v. Truck Ins. Exch.* concluded that as long as the insurer acts within the role contemplated by the Act, liability should not be imposed beyond the provisions within the Act.<sup>151</sup> However, the tortious conduct constituting bad faith occurs “after the injury, outside the workplace, and away from the employer. It occurs in the context of administration and investigation of the claim under the insurance policy . . .”<sup>152</sup>

Courts have circumvented the exclusivity provisions of workers’ compensation statutes by allowing an independent action against an insurer for intentional infliction of emotional distress.<sup>153</sup> As an example, in *Unruh v. Truck Ins. Exch.*, the Court allowed the claimant to recover for the intentional torts committed by the insurer under the dual capacity doctrine.

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<sup>149</sup> Lasswell, *supra* note 136.

<sup>150</sup> Fenton, *supra* note 12, at 851.

<sup>151</sup> *Unruh v. Truck Ins. Exch.*, 498 P.2d 1063, 1071 (Cal. 1972). The Court reinstated the counts alleging assault and battery, intentional infliction of emotional distress, and punitive damages for the reason that such insurer conduct removed the insurer from its normal role. *Id.* at 1073.

<sup>152</sup> Fenton, *supra* note 12, at 851.

<sup>153</sup> See *Martin v. Travelers Ins. Co.*, 497 F.2d 329, 331 (1st Cir. 1974) (intentional infliction of mental and emotional suffering under Maine law); *Stafford v. Westchester Fire Ins. Co. of New York*, 526 P.2d 37, 39, 42 (Alaska 1974) (conscious infliction of mental distress); *Unruh v. Truck Ins. Exch.*, 498 P.2d 1063, 1073 (Cal. 1972) (intentional infliction of emotional distress); see also *Robertson v. Travelers Ins. Co.*, 427 N.E.2d 302, 307 (Ill. App. Ct. 1981) (intentional infliction of emotional distress); *Gibson v. Nat’l Ben Franklin Ins. Co.*, 387 A.2d 220, 222 (Me. 1978) (intentional infliction of physical and emotional distress); *Hayes v. Aetna Fire Underwriters*, 609 P.2d 257, 261-62 (Mont. 1980) (intentional infliction of emotional distress).

<sup>154</sup> The dual capacity doctrine allows an injured employee a separate tort against his employer who has dual legal personalities; one as an employer and another in a secondary non-employer capacity.<sup>155</sup> The Court in *Unruh* found that the insurer had stepped out of its proper role of “insurer”<sup>156</sup> by embarking upon a detestable course of conduct and, therefore, as one acting under a different capacity, should not be afforded protection under the workers compensation exclusivity provision.<sup>157</sup>

As this case law developed, courts appeared to act upon a concern that there would be a wave of tort actions based on intentional delays and

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<sup>154</sup> *Unruh*, 498 P.2d at 1063 (Cal. 1972).

<sup>155</sup> *See Duprey v. Shane*, 249 P.2d 8, 13-15 (Cal. 1952).

<sup>156</sup> Some employers do not purchase workers’ compensation insurance at all. They are authorized to act as self-insurers under the state’s Workers’ Compensation Act. Some courts have held that self-insureds may be held directly liable for bad faith in the handling of a worker’s compensation claim. *See, e.g.*, *Falline v. GNLV Corp.*, 823 P.2d 888, 893 (Nev. 1991); *Sizemore v. Cont’l. Cas. Co.*, 142 P.3d 47, 54 (Okla. 2006). The Court in *Reedy v. White Consol. Indus., Inc.*, 503 N.W.2d 601, 603 (Iowa 1993), observed: “[We] see no distinction between a workers’ compensation insurance carrier for an employer and an employer who voluntarily assumes self-insured status under the act.”

Some states levy fines against self-insureds who delay payments but it has been observed that “although administrative fines may have some deterrent effect on self-insured employers, they do not purport to address the plight of the injured worker who may suffer great deprivation as a result of the tortuous denial or delay of his or her benefits.” *Falline*, 823 P.2d at 894; *see also Hough v. Pac. Ins. Co.*, 927 P.2d 858, 868 (Haw. 1996). At least one court has found that a self-insured’s bad faith exposure cannot be avoided by contracting out its claim handling functions to a third-party administrator (TPA). *See, e.g.*, *Scott Wetzel Servs., Inc. v. Johnson*, 821 P.2d 804 (Colo. 1991) (en banc).

A question arises as to whether a TPA can be held directly liable for bad faith. The few courts that have considered this issue are split on the issue. As an example, some jurisdictions have held that because the covenant of good faith and fair dealing imposes obligations of a non-delegable nature and because there is a lack of privity between the TPA and the insured employee, the TPA cannot be held directly liable. *See, e.g.*, *Simmons v. Congress Life Ins. Co.*, 791 So. 2d 360, 365 (Ala. Civ. App. 1998) *rev’d on other grounds sub nom. Ex parte Simmons*, 791 So. 2d 371 (Ala. 2000). *See also Walter v. Simmons*, 818 P.2d 214 (Ariz. Ct. App. 1991). However, other courts have found that TPAs may be directly liable “even in the absence of contractual privity with the employee.” *E.g.*, *Scott Wetzel Services, Inc.*, 821 P.2d at 813; *see also Dellaira v. Farmers Ins. Exch.*, 102 P.3d 111, 115 (N.M. Ct. App. 2004).

<sup>157</sup> *Unruh*, 498 P.2d at 1077.

terminations of payments. Some courts began to demand that the insurer's conduct be "conspicuously contemptible."<sup>158</sup> Under this rationale, an insurer's mere delay in making compensation payments would not be a sufficient basis on which to ground an action in tort.<sup>159</sup>

Generally, outrageous or deceitful conduct was needed to maintain a tort action outside the exclusive remedy provision.<sup>160</sup> Mere delay in making compensation payments would not be a sufficient basis to ground an action in tort while only extreme and outrageous conduct would be actionable at common law.<sup>161</sup> Clearly, the conduct which gives rise to the

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<sup>158</sup> See *Martin v. Travelers Ins. Co.*, 497 F.3d 329, 330 (1st Cir. 1974) (insurer stopped payment on valid compensation payments only after claimant had deposited and made withdrawals against them, resulting in severe embarrassment and emotional distress); *Coleman v. Am. Universal Ins. Co.*, 273 N.W.2d 220, 221 (Wis. 1979) (action for tort of bad faith and intentional infliction of emotional distress after insurer stopped payments three times, causing plaintiff to be evicted).

<sup>159</sup> See *Martin*, 497 F.2d at 331 (mere late payment not sufficient basis for tort action); *Stafford v. Westchester Fire Ins. Co. of N.Y. Inc.*, 526 P.2d 37 (1974) (tortious conduct must go beyond untimely payments to pierce exclusivity defense); *Unruh*, 498 P.2d at 1071-72 (mere negligence of compensation carrier will not give rise to tort liability); *Coleman*, 273 N.W.2d at 224 (mere delay is adequately compensated by 10% penalty award).

<sup>160</sup> *Ricard v. Pac. Indem. Co.*, 183 Cal. Rptr. 502, 506 (Cal. Ct. App. 1982) (outrageous and deceitful conduct needed to maintain tort action outside exclusive remedy provision); *Robertson v. Travelers Ins. Co.*, 427 N.E.2d 302, 307 (Ill. Ct. App. 1981) (outrageous conduct required to state action in tort).

<sup>161</sup> The state of Alabama has attempted to reconcile the concept of exclusive remedy with the provision of the limited intentional torts of "outrageous conduct" or "intentional infliction of emotional distress." This approach addresses standard or simple bad faith under the Workers' Compensation Act while extreme bad faith is handled outside the Act. This leaves a gap where moderate bad faith is not adequately addressed by the Act and not allowed as an independent tort.

A tort claim against a workers' compensation insurer alleging a bad faith failure to pay an insurance claim is barred by the exclusivity provisions of Alabama's Workers' Compensation Act. *Stewart v. Matthews Indus., Inc.*, 644 So. 2d 915, 918 (Ala. 1994) (citing ALA. CODE §§ 25-5-11, -52, -53 (1975)); *Farley v. CNA Ins. Co.*, 576 So. 2d 158 (Ala. 1991); *Garvin v. Shewbart*, 442 So. 2d 80 (Ala. 1983); *Oliver v. Liberty Mut. Ins. Co.*, 548 So. 2d 1025, 1026 (Ala. 1989); *Nabors v. St. Paul Ins. Co.*, 489 So. 2d 573 (Ala. 1986); *Moore v. Liberty Mut. Ins. Co.*, 468 So. 2d 122 (Ala. 1985); *Waldon v. Hartford Ins. Grp.*, 435 So. 2d 1271 (Ala. 1983). Although the Alabama Supreme Court has held that a claim alleging bad faith failure to pay an insurance claim, in the context of a workers' compensation claim, is barred by the exclusivity provisions of the Act, the court

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has also recognized that the tort of outrageous conduct or intentional infliction of emotional distress can occur in a workers' compensation setting. *See, e.g., Farley*, 576 So. 2d at 158 and *Garvin*, 442 So. 2d at 80. The Court in *Stewart* observed:

The [Workers' Compensation] Act is designed to compensate those who are injured on the job and provides immunity from common law suits for those employers and carriers who come within the Act. A suit seeking recovery under the tort of outrageous conduct does not seek compensation [or] medical benefits for the original on-the-job injury. The connection with the physical injury that gave rise to the original workmen's compensation claim is tenuous. *The conduct giving rise to the tort of outrageous conduct in the context of this kind of case can be more accurately characterized as mental assault than as failure to pay compensation or medical benefits even though it may arise in a failure to pay context.* Conduct constituting the tort of outrageous conduct cannot reasonably be considered to be within the scope of the Act. When the employer or carrier's conduct crosses the line between mere failure to pay and intent to cause severe emotional distress, the cloak of immunity is removed.

*Stewart*, 644 So. 2d at 918 (emphasis added) (citing *Garvin*, 442 So. 2d at 83).

Under Alabama law, the tort of outrageous conduct or intentional infliction of emotional distress involves "extreme and outrageous conduct" by one who "intentionally or recklessly causes severe emotional distress to another." *Am. Road Serv. Co. v. Inmon*, 394 So. 2d 361, 365 (Ala. 1980). In order to present a case of outrageous conduct, the plaintiff must show that the conduct was "so outrageous in character and so extreme in degree as to go beyond all possible bounds of decency, and to be regarded as atrocious and utterly intolerable in a civilized society." *Am. Road Serv. Co.*, 394 So. 2d at 365. *See also Cates v. Taylor*, 428 So. 2d 637 (Ala. 1983); *Bearden v. Equifax Services*, 455 So. 2d 836 (Ala. 1984); *Strickland v. Birmingham Bldg. & Remodeling*, 449 So. 2d 1242 (Ala. 1984).

The severe emotional distress required for the tort of outrage requires the following:

"The emotional distress ... must be so severe that no reasonable person could be expected to endure it. Any recovery must be reasonable and justified under the circumstances, liability ensuing only when the conduct is extreme." *Am. Road Serv. Co.*, 394 So. 2d at 365.

tort of bad faith can be independent enough from the workplace injury to be considered as not being truly under the umbrella of the workers' compensation system.<sup>162</sup> The problem lies in finding the separation point where the exclusive remedy principle becomes a tangential issue to the recognition of a tort remedy for bad faith rather than a sticking point which calls into question the entire cause of action. Some bad faith conduct is extreme in nature which separates the tortious bad faith conduct by the insurer or its agent from the original workplace injury, which was otherwise meant to be compensated by the no-fault workers' compensation system.

Statutory remedies may provide a reasonable method to resolve common cases of payment delay or refusal, however some remedy provisions do not contemplate the harm which may arise from an insurer's intentional bad faith conduct.<sup>163</sup> Compensation laws should be exclusive only when they provide an adequate remedy.<sup>164</sup> Are the penalties adequate?

Virtually all states have enacted statutory penalty provisions to provide a remedy for an insurer's inexcusable or unreasonable withholding of benefits.<sup>165</sup> The penalties are added to the amount of unpaid compensation<sup>166</sup> and range from 10%<sup>167</sup> to 200%.<sup>168</sup> In some states

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The outrageous conduct must be established by clear and convincing evidence. *Farley*, 576 So. 2d at 158.

<sup>162</sup> *Boylan v. Am. Motorists Ins. Co.*, 489 N.W.2d 742, 743-44 (Iowa 1992).

<sup>163</sup> *Gibson v. Nat'l Ben Franklin Ins. Co.*, 387 A.2d 220, 223 (Me. 1978) (penalty provision of Workers' Compensation Act not sufficient to redress claimant since fines assessed to insurer paid to state rather than claimant); *Coleman*, 273 N.W.2d at 224 (10% remedy provision does not adequately compensate worker for detriment occasioned by intentional tort).

<sup>164</sup> *Stafford*, 526 P.2d at 43.

<sup>165</sup> *See, e.g.*, GA. CODE ANN. § 34-9-221(e) (2011) (providing 15% penalty for insurer's inexcusable delay of compensation benefits); ME. REV. STAT. ANN. tit. 39, § 104-A(2) (1984) (forfeiture of \$25 per day for insurer's failure to pay compensation); TEX. REV. CIV. STAT. ANN. art. 8306, § 18a(a) (West 1985) (providing for 15% penalty of all past due compensation).

<sup>166</sup> *See, e.g.*, LA. REV. STAT. ANN. § 22:658 (West 1978) (12% of difference between amount tendered or paid and amount found due); 820 ILCS 305/19(k) (percentage award of compensation "additional to that otherwise payable"); W.S.A. § 102.18(1)(bp) (percentage of "total compensation due").

<sup>167</sup> *See* CAL. LAB. CODE § 5814(b) (West 2004) (10% for delay); FLA. STAT. ANN. § 440.20(7) (West 2011) (punitive penalty of 20% of unpaid installment).

attorney's fees may be awarded.<sup>169</sup> Oftentimes the penalty provisions are fixed to a specific percentage of the compensation award irrespective of the quality of the insurer's misconduct.<sup>170</sup> Some states have adopted penalty provisions which take into consideration instances where an insurer acts intentionally or unreasonably in denying benefits by increasing the percentage awarded to the claimant.<sup>171</sup>

The penalties can be significant. As an example, the Illinois statute increases the penalty to 50% of the benefits due where the insurer has unreasonably or vexatiously delayed payments, intentionally underpaid compensation, or instituted frivolous proceedings for the purpose of delay where no real controversy ever existed as to the insurer's liability for paying the compensation.<sup>172</sup> Under Wisconsin's penalty provision, a claimant may have his or her unpaid compensation benefits increased by 25% where the insurer has not acted in "good faith" in processing a claim.<sup>173</sup> The Wisconsin penalty statute also provides for those instances when a carrier engages in "malicious or bad faith" conduct by awarding a claimant "the lesser of 200% of total compensation due or \$15,000."<sup>174</sup> Under the Wisconsin statute, the Department of Labor defines what conduct demonstrates malice or bad faith in assessing a penalty. Under

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<sup>168</sup> See WIS. STAT. ANN. § 102.18(1)(bp) (West 2011) (up to 200% or \$30,000 penalty may be assessed against insurer for malicious or bad faith failure to pay compensation benefits).

<sup>169</sup> See ILL. COMP. STAT. ANN. 48/138.16 (West 2011) (reasonable attorney's fees are recoverable where insurer's delay is unreasonable); LA. REV. STAT. ANN. § 22:658 (punitive penalty of 12% and "all reasonable attorney's fees for the prosecution and collection of such amount").

<sup>170</sup> See, e.g., CAL. LAB. CODE § 5814(b) (West 2004) (penalty fixed at 10% of compensation award); GA. CODE ANN. § 114-705(e) (2011) (penalty designated at set rate of 15% after 14 days); TEX. REV. CIV. STAT. Ann. art. 806, § 18a (West 2011) (penalty not to exceed 15% of unpaid compensation).

<sup>171</sup> See 215 ILL. COMP. STAT. 5/155 (2004) (penalty imposed against insurer whose actions are "unreasonable," "vexatious," or "intentional"); LA. REV. STAT. ANN. § 23:1201 (percentage penalty plus attorney's fees where insurer's conduct "arbitrary, capricious, or without probable cause"); MINN. STAT. ANN. § 176.225(1) (penalty assessed against insurer who acts "unreasonably or vexatiously"); WIS. STAT. ANN. § 102.18(1)(bp) (penalty imposed where insurer's conduct malicious or in bad faith).

<sup>172</sup> See 820 ILL. COMP. STAT. ANN. 305/19 (k) (West 2011).

<sup>173</sup> See WIS. STAT. ANN. § 102.18(1)(b) (West 2010).

<sup>174</sup> See *id.* § 102.18(1)(bp).



Wisconsin common law, however, in order to show an insurer's "bad faith" the plaintiff must show "[t]he absence of a reasonable basis for denying benefits of the policy and the defendant's knowledge or reckless disregard of the lack of a reasonable basis for denying the claim."<sup>175</sup>

Penalty statutes can hold an insurer accountable for its actions by imposing fair and adequate penalties where the circumstances dictate. Penalty statutes can also provide the claimant with an adequate remedy for any detriment he or she may have suffered and create an incentive for the insurer to act reasonably in settling an employee's claim. Additionally, by barring common-law recoveries, exclusive remedy penalty provisions can foreclose the possibility of high damage verdicts being assessed against an insurer and the possible disintegration of the workers' compensation scheme. Certainly the adoption of a bad faith tort action can assist in equalizing the bargaining power between the worker and insurer during claim processing by prompting the insurer to act reasonably and in good faith in processing claims.<sup>176</sup> Significant penalties can also achieve this goal.

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<sup>175</sup> See *Anderson v. Cont'l Ins. Co.*, 271 N.W.2d 368, 376 (Wis. 1978).

<sup>176</sup> See *Kranzush v. Badger State Mut. Cas. Co.*, 307 N.W.2d 256, 261 (Wis. 1981) (bad faith action good policy since promotes assurance workers "exclusive remedy will not be denied through the intentional wrongdoings of the insurer"); *accord Eckenrode v. Life of Am. Ins. Co.*, 470 F.2d 1, 5 (7th Cir. 1972) (insureds forced to take insurance contracts "as is," leaving little or no remedy); *Christian v. Am. Home Assur. Co.*, 577 P.2d 899, 902 (Okla. 1977) (insured has essentially no bargaining power in insurance contract; relegated to terms of contract as basis of decision to extend insured's bad faith tort action). *But see Hayes v. Aetna Fire Underwriters*, 609 P.2d 257, 262-63 (Mont. 1980) (Harrison, J., specially concurring) (recognition of independent action may place insurers at disadvantage in settle claims).

In *Izaguirre v. Texas Employers' Ins. Ass'n*, 749 S.W.2d 550 (Tex. App. 1988), the court found that the penalties provided by Texas' Workers' Compensation Act were not exclusive remedies for any wrongful denials or delays of payments stating "a special relationship arises out of the parties' unequal bargaining power and the nature of insurance contracts which would allow unscrupulous insurers to take advantage of their insured's misfortunes in bargaining for settlement or resolution of claims." *Id.* at 554. The court in *Izaguirre* went on to state that the statutory regulation and existing statutory penalties were not adequate to equalize the bargaining power between workers and insurers in settling claims. *Id.* at 554-55. *But see Bowen v. Aetna Life & Cas. Co.*, 512 So. 2d 248, 250 (Fla. Dist. Ct. App. 1987); *Robertson v. Travelers Ins. Co.*,

One commentator has observed that through the promulgation of statutory penalties and guidelines, a state legislature can fashion a “bad faith” remedy to compensate employees for the detriment they may suffer as a result of insurer “bad faith” while the insurer is protected by limiting the amount which may be recovered.<sup>177</sup> The commentator’s legislative proposal was modeled after the statutes which had been enacted in Illinois, Minnesota and Wisconsin.<sup>178</sup> The proposal, which includes statutorily regulated penalties for an insurer’s bad faith conduct, is aimed at balancing the bargaining powers between the parties by creating an incentive for the insurer to deal fairly and in good faith when processing a claim.<sup>179</sup> The following is the proposed amendment to state Workers’ Compensation Acts:

**Additional Award as Penalty for Bad Faith Conduct of Insurance Carriers or Employers in the Processing or Settlement of Employee Claims**

- (a) After notice and a hearing or upon the opportunity to be heard,<sup>180</sup> the [insert name of jurisdictional body, *i.e.*, Industrial Commission], or upon appeal, a court of competent jurisdiction, may in its discretion award additional compensation which it considers just, up to, but not exceeding, the lesser of 200% of the compensation then past due or \$70,000<sup>181</sup> in any case where an insurance carrier or employer has:

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448 N.E.2d 866 (Ill. 1983); *Gonzales v. U. S. Fid. & Guar. Co.*, 659 P.2d 318, 320 (N.M. Ct. App. 1983).

<sup>177</sup> Frederick L. Streck, III, *Bad Faith Claims Practices in Texas – Do They Exist?: Extending a Bad Faith Cause of Action to Texas Workers’ Compensation Insurance Claimants*, 16 ST. MARY’S L.J. 679, 703 (1985).

<sup>178</sup> *Id.* at 704 (citing 820 ILL. COMP. STAT. ANN. 305/19(k) (West 2011); MINN. STAT. ANN. § 176.225(1) (West 1985); WIS. STAT. ANN. § 102.18(1)(bp) (West 2010)).

<sup>179</sup> Streck, *supra* note 178, at 704.

<sup>180</sup> See MINN. STAT. ANN. § 176.225(1) (West 1985) (providing party against whom proceeding brought opportunity to be heard so as to refute charges against him and provide due process under law) *cited in* Streck, *supra* note 178, at 704 n.137.

<sup>181</sup> See WIS. STAT. ANN. § 102.18(1)(bp) (West 2010) (where the compensation commission was empowered to award just compensation “not to

- (1) instituted proceedings and/or interposed a defense where no real or present controversy exists as to the carrier's liability to pay the compensation, but which are only frivolous or are for delay;<sup>182</sup> or
  - (2) unreasonably, vexatiously, or in bad faith delayed or refused compensation payments;<sup>183</sup> or
  - (3) intentionally underpaid compensation.<sup>184</sup>
- (b) The penalty award as provided in this section is to be the employee's exclusive remedy against an insurance carrier or employer for engaging in conduct described in subsection (a)(1), (a)(2), or (a)(3).
- (c) Actions or conduct rising to the level described in subsections (a)(1), (a)(2), or (a)(3) are to be defined by

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exceed the lesser of 200% of total compensation due or \$15,000”) *cited in Streck, supra* note 178 at 704 n.139.

<sup>182</sup> See 820 ILL. COMP. STAT. ANN. 305/19(k) (West 2011) (penalty available where “proceedings have been instituted or carried by one liable to pay the compensation, which do not present a real controversy, but are merely frivolous or for delay”); MINN. STAT. ANN. § 176.225(1)(a) (West 1985) (“instituted a proceeding or interposed a defense which does not present a real controversy but which is frivolous or for the purpose of delay”) *cited in Streck, supra* note 178 at 704-05 n.140.

<sup>183</sup> See 820 ILL. COMP. STAT. ANN. 305/19 (k) (West 2011) (penalty imposed where insurer’s conduct unreasonable or vexatious in delaying payments); WIS. STAT. ANN. § 102.18(1)(bp) (West. 2010) (statute sets applicable standard of recovery for bad faith action) *cited in Streck, supra* note 178, at 705 n.141.

<sup>184</sup> See MINN. STAT. ANN. § 176.225(1)(d) (West 1984) (penalty may be imposed where employer or insurer has “intentionally underpaid compensation”) *cited in Streck, supra* note 178, at 705 n.142.

rule of the [insert name of jurisdictional body, *i.e.*, Industrial Commission].<sup>185</sup>

The commentator contemplates that the penalty provision will be discretionary with the governing Industrial Commission or the courts.<sup>186</sup>

The proposed amended statutory penalty provision addresses the social cost associated with permitting tort liability in the workers' compensation context.<sup>187</sup> The author of the amendment provides the following support for the amendment's adoption:

The exclusive remedy proviso of the legislative enactment has the distinct advantage of guaranteeing greater protection for the employee and, at the same time, the proposal adequately insulates the insurer from liability in tort and its resultant high damages. The insulation of the insurer from excessive liability in tort will also ultimately protect the consumer by indirectly maintaining the price of goods. In a workers' compensation situation, the employer pays the premium to the insurer with the employee being named as a third-party beneficiary. When the insurer is burdened with a tort verdict, the penalty passed on to the employer in the form of increased premiums are thereafter transferred to the consumer through an increase in the cost of the employer's goods and services. This 'passing the buck' situation would be almost nonexistent under the proposed legislation due to the reduced likelihood of insurer tort liability.<sup>188</sup>

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<sup>185</sup> See WIS. STAT. ANN. § 102.18(1)(bp) (West 2010) ("department may, by rule, define actions which demonstrate malice or bad faith") *cited in* Streck, *supra* note 178, at 705 n.144.

<sup>186</sup> See, *e.g.*, WIS. STAT. ANN. § 102.18(1)(b) (West 2010) (imposition of penalty left to discretion of department of labor); *see also* MINN. STAT. ANN. § 176.225(1) (West 1985) (assessment of penalty award discretionary with compensation judge or court) *cited in* Streck, *supra* note 178, at 705 n.145.

<sup>187</sup> See Glenn L. Allen, *Insurance Bad Faith Law: The Need for Legislative Intervention*, 13 PAC. L.J. 833, 857 (1982) (society as the consumer ultimately bears the risk of loss in the form of higher premiums for policies sold occasioned by unlimited tort verdicts rendered against insurers).

<sup>188</sup> Streck, *supra* note 178, at 706.

The proposed amended statutory penalty provision is triggered by a single act of bad faith and the available penalty compensation is based upon a specific delayed payment. An alternative approach would be to establish a two tier monetary penalty provision. Instructive is the National Association of Insurance Commissioners' ("NAIC") Model Unfair Claims Settlement Practices Act which utilizes a two tier penalty structure.

The first tier of monetary penalties under the NAIC Model Unfair Claims Settlement Practices Act has a per-violation cap of \$1,000 and an aggregate cap for all violations of \$100,000.<sup>189</sup> Second tier penalties are applicable where the violation was committed "flagrantly and in conscious disregard of [the] Act."<sup>190</sup> Many jurisdictions trigger tier two penalties where the insurance company knew or should have known that its conduct violated their respective Acts.<sup>191</sup> Second tier penalties are capped at \$25,000 for each violation with an aggregate cap of \$250,000.<sup>192</sup>

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<sup>189</sup> See, e.g., ALASKA STAT. § 21.36.125(a)(13) (2000); ARIZ. REV. STAT. ANN. § 20-461(A)(12) (2002); IOWA CODE ANN. § 507B.4(9)(l) (West 1988); KY. REV. STAT. ANN. § 304.12-230(12) (West 2004).

<sup>190</sup> See, e.g., NEB. REV. STAT. § 44-1542(1) (2004); N.Y. INS. LAW § 2601 (McKinney 2000); N.C. GEN. STAT. § 58-63-15(11) (2003); N.D. CENT. CODE § 26.1-04-03 (2000).

<sup>191</sup> See, e.g., COLO. REV. STAT. § 10-3-1108(a) (2004); CONN. GEN. STAT. ANN. § 38a-817(b) (West 2000); DEL. CODE ANN. tit. 18 § 2308(a)(1) (2005); GA. CODE ANN. § 33-6-8(a)(1) (2000); HAW. REV. STAT. § 431:12-201(a)(1) (1993). The Alaska Legislature provided its Commissioner with the elements to be considered and weighed in assessing the amount of a monetary penalty. The Alaska Commissioner is to consider: (1) the amount of loss or harm caused by the violation; (2) the amount of benefit derived by the insurance company by reason of the violation; (3) the seriousness of the violation; (4) the promptness and completeness of the insurance companies remedial action; (5) whether a single act or a pattern of practice was involved; and (6) deterrence. ALASKA STAT. § 21.36.320 (2004).

The South Dakota Legislature provided similar guidance to its Commissioner. In determining an appropriate penalty, the Division of Insurance will balance four specific factors of the insurance company and the insured: (1) the magnitude of the harm to the insured or claimant; (2) the actions taken by the insurance company, insured and/or claimant that either lessen or worsen the result of the violation; (3) any impediments that the insured or the claimant caused to the insurance company in either the process or the settling of the claim; and (4) the actions of the insurance company, specifically those that worsen the harm to the claimant or the insured from the violation. S.D. CODIFIED LAWS § 58-33-68 (2000).

In order to use a two tier penalty system where the most severe penalties are based upon both flagrant and conscious disregard of the Workers' Compensation Act, there would need to be built into the Workers' Compensation Act a provision for monitoring insurance company misconduct across various claims.

In the context of the NAIC Model Unfair Claims Settlement Practices Act, seventeen states have adopted provisions in their Act which require insurance companies to maintain records regarding complaints of

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Vexatious conduct has been elaborately addressed by the Missouri Legislature in the context of third party claim settlement practices. MO. ANN. STAT. § 375.420 (West 2002). There are seven elements that the Missouri courts look to in conducting an analysis of vexatiousness under the Unfair Claims Act. First, the insured's claim must be assessed and determined as it was presented to the insurance company at the time it was presented. *Hopkins v. Am. Econ. Ins. Co.*, 896 S.W.2d 933, 939 (Mo. Ct. App. 1995). Second, the insured must show that the refusal to pay by the insurance company "was willful and without reasonable cause of excuse, as facts would have appeared to a reasonable person before trial." *Id.*; accord *State ex. rel. Pemiscot County, Missouri v. Western Surety Co.*, 51 F.3d 170, 174 (8th Cir. 1995); *Nelson v. Aetna Life Ins. Co.*, 359 F. Supp. 271, 298 (W.D. Mo. 1973); *Bickerton, Inc. v. Am. States Ins. Co.*, 898 S.W.2d 595, 602 (Mo. Ct. App. 1995). Third, the "existence of a litigable issue, either factual or legal, does not preclude the statutory penalty where there is evidence that the insurer's attitude was vexatious and recalcitrant." *Liberty Life Ins. Co. v. Schaffer*, 853 F.2d 591, 592 (8th Cir. 1988). Fourth, a holding that coverage is adverse to the insurance company in and of itself does not mandate damages be assessed to the insurer's vexatious delay in paying. *Id.* at 593; see also *Morris v. J.C. Penney Life Ins. Co.*, 895 S.W.2d 73, 76 (Mo. Ct. App. 1995). Fifth, the insurance company is liable for vexatious delay in paying when it continues to refuse to pay even after it becomes aware that its defense is without merit. *Kostelec v. State Farm Fire & Cas. Co.*, 64 F.3d 1220, 1227-28 (8th Cir. 1995); *Allen v. State Farm Mut. Auto Ins. Co.*, 753 S.W.2d 616, 620-21 (Mo. Ct. App. 1988). Sixth, despite the fact that the insurance company may have had a valid dispute on a question of law or fact up through trial, does not prevent a statutory penalty for unfairly treating the insured. *DeWitt v. Am. Family Mut. Ins. Co.*, 667 S.W.2d 700, 710 (Mo. 1984) (*en banc*). Seventh, a jury may consider all of the evidence and surrounding circumstances of the case and even without any direct evidence, find the insurance company guilty of a vexatious delay. *Laster v. State Farm Fire & Cas. Co.*, 693 S.W.2d 195, 197 (Mo. Ct. App. 1985).

<sup>192</sup> ALASKA STAT. § 21.36.125(a)(11) (2004); ARIZ. REV. STAT. ANN. § 20-461(A)(10) (2002); CONN. GEN. STAT. ANN. § 38a-816(6)(j) (2000).

improper claim handling.<sup>193</sup> Typically these states require insurance companies to keep a “complete record of all complaints of its insureds.” Most states that impose this requirement specify that the records must indicate the total number of complaints, their classification by type of insurance, the nature of each complaint, the disposition of the complaint, and the time it took to process each complaint.<sup>194</sup> While most states require information regarding “complaints,” four states (Vermont,<sup>195</sup> Florida,<sup>196</sup> Kansas<sup>197</sup> and Massachusetts<sup>198</sup>) also require recordation of any “grievance” in addition to “complaints.” Only New Hampshire requires an annual report to the insurance department regarding complaints.<sup>199</sup> Moreover, New Hampshire permits claimants to use this information in administrative and judicial proceedings.<sup>200</sup>

Evidence as to the numbers and types of complaints to the insurance department against an insurer, and said department’s complaint experience with other insurers writing similar lines of insurance, shall be admissible in evidence in an administrative or judicial proceeding brought under this title, provided that no insurer shall be

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<sup>193</sup> ARK. CODE ANN. § 23-66-206 (4)(A) (West 2001); CONN. GEN. STAT. § 38a-816(7) (West 2004); DEL. CODE ANN., tit. 18 § 2304(17); FLA. STAT. ANN. § 626.9541 (1)(i)(3)(j); KAN. STAT. ANN. § 40-2404(10) (West 2000); LA. REV. STAT. § 22:1214(17) (2006); MASS. GEN. LAWS Ch. 176D § 3(a)(10) (West 2007); MICH. COMP. LAWS SERV. § 500.2026(2) (LexisNexis 2008); MONT. CODE ANN. § 33-21-105(i) (2011); N.H. REV. STAT. ANN. § 417:4(XV)(a)(13) (2009); N.J. STAT. ANN. 17:29B-4(10) (West 2007); N.Y. INS. LAW § 2601(b) (McKinney 2009); OKLA. STAT. ANN. Tit. 36 § 1250.5(14) (West 2011); 40 PA. STAT. ANN. § 1171.5(a)(11) (West 1999); TEX. INS. CODE ANN. § 21.21-3(b)(6) (repealed 2005); VT. STAT. ANN. tit. 8 § 4 724(10) (2005); W. VA. CODE § 33-11-4(10) (LexisNexis 2011).

<sup>194</sup> Arkansas, Connecticut, Delaware, Kansas, Louisiana, Massachusetts, Michigan, New Jersey, Oklahoma, Pennsylvania, Texas, Vermont, and West Virginia.

<sup>195</sup> VT. STAT. ANN. tit. 8 § 4724(10) (2005).

<sup>196</sup> FLA. STAT. ANN. § 626.9541 (1)(i)(3)(j) (West 2004).

<sup>197</sup> KAN. STAT. ANN. § 40-2404(10) (West 2000).

<sup>198</sup> MASS. GEN. LAWS ANN. Ch. 176D § 3(a)(10) (West 2007).

<sup>199</sup> N.H. REV. STAT. ANN. § 417:4(XV)(a)(13) (2009).

<sup>200</sup> *Id.* § 417:4(XV)(b).

deemed in violation of this section solely by reason of the numbers and types of such complaints.<sup>201</sup>

The standard time frame for keeping this complaint information is from the date of the last insurance department examination. However, Massachusetts only requires the information to be kept for two years;<sup>202</sup> Oklahoma requires information to be kept for three years or since the date of its last financial examination, whichever is longer;<sup>203</sup> Texas requires the information be kept for three years or since the date of its last examination, whichever time is shorter;<sup>204</sup> and Pennsylvania requires the information to be kept for a four year period.<sup>205</sup>

To effectively work within the workers' compensation context, insurers would be required to keep statistics on each penalty imposed, including the nature of the misconduct and the penalty award amount, during the processing of a claim. The insurer would also need to maintain statistics which allow aggregate calculations to be generated. To some extent, misconduct would need to be aggregated into categories and each award would have to identify the specific misconduct category(ies) found as the basis of the award. Categorization would permit necessary standardization to permit the statistical analysis. Penalties could also be categorized to correspond to the misconduct type. Statistics would be state specific.

Abandoning a common-law tort of bad faith in favor of an exclusive penalty regulatory approach has three distinct advantages: (1) uniformity in the standard of conduct; (2) an efficient administrative hearing process; and (3) accurate record keeping.

#### A. UNIFORMITY IN THE STANDARD OF CONDUCT.

A regulatory approach would bring certainty regarding appropriate and inappropriate conduct. Currently, the common-law tort of bad faith is defined by vague legal constructs like "good faith and fair dealing" or "fair debatability." The creation of a specific inventory of regulated improper claim handling practices would provide greater certainty to the insurance

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<sup>201</sup> *Id.* See also N.Y. INS. LAW § 2601(b) (McKinney 2009).

<sup>202</sup> MASS. GEN. LAWS ch. 176D § 3(a)(10) (West 2007).

<sup>203</sup> OKLA. STAT. ANN. tit. 36 § 1250.5(14) (West 2011).

<sup>204</sup> TEX. INS. CODE ANN. § 542.005 (West 2005).

<sup>205</sup> 40 PA. STAT. ANN. § 1171.5(a)(11) (West 1999).



industry regarding what conduct is forbidden in the workers' compensation context and, conversely, what specific conduct should be engaged in. As an example, the NAIC Model Act proscribes fourteen unfair claims practices. The Model Act contains a general requirement that insurance companies "adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies."<sup>206</sup> The various Industrial Commissions could do the same.

#### B. AN EFFICIENT ADMINISTRATIVE HEARING PROCESS

A regulatory administrative adjudicatory process would have the benefit of a knowledgeable trier of fact. The administrative adjudicatory process, utilizing administrative hearing officers or administrative law judges, brings to the hearing process a knowledgeable trier of fact who understands the purpose of the WCA as well as the focused workers' compensation segment of the insurance industry and its standards, customs and practices. Because the trier of fact will have a significant understanding of the insurance industry, the workers' compensation penalty hearing process can be abbreviated and become more focused upon creating a record regarding each individual claim which can then be aggregated into an annual report for oversight purposes.

Utilization of a regulatory administrative hearing process can lead to speedy resolution of disputed claims through an abbreviated administrative hearing process that limits discovery. By limiting discovery and abbreviating the overall process, lower costs in presenting the claim should be realized.

#### C. ACCURATE RECORD KEEPING

A regulatory administrative approach would permit a better record to track improper claim handling practices within an insurance company so that when penalties are assessed there is an adequate record, especially for tier two penalties, to prove a pattern or frequency in improper claim handling. Although the aggregate of penalties in a given year may approximate a large monetary loss, insurance company executives will not

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<sup>206</sup> See, e.g., 2 Nat'l Ass'n Ins. Commissioners Proc. 367-70 (1976). The Act and regulations are also set out at II National Association of Insurance Commissioners Official NAIC Model Insurance Laws, Regulations and Guidelines, 890-1 to 890-4, 900-1 to 900-10 (2011).

be able to be dismissive about what produced the financial loss, i.e., a rogue jury.

The availability of accurate information regarding the failure of a particular insurance company's claim handling guidelines within its field offices is essential to positive change. Presently, only 13 states require insurance companies to keep records regarding all complaints and/or grievances made as the result of perceived claim mishandling under the NAIC Model Act.<sup>207</sup> A uniform adoption of mandatory record keeping in the workers' compensation context must be a focus of any regulatory approach to claim handling practices. Requiring insurance companies to provide detailed annual reports to the insurance department and industrial commission in the states in which they underwrite business regarding the number of complaints and grievances classified by type of violation and information regarding the nature of each complaint, together with the complaint's disposition would assist not only insurance departments in regulating the industry, and assist administrative law judges in assessing penalties but would also assist insurance company executives. Information regarding fines/penalties imposed which can be allocated by classification, together with a report of attorney's fees expended would bring to the forefront the true cost of claim mishandling.

## V. CONCLUSION

Courts are equally divided on whether a common-law tort of bad faith should be permitted in the workers' compensation context. The legal analysis used by courts for these competing viewpoints on this issue are cogent and cannot be dismissed easily.

The respective state Workers' Compensation Acts provide an efficient mechanism for employees and insurers to resolve disputes relating to work-related injuries in a timely and expeditious manner. The system provides a knowledgeable trier of fact through experienced hearing officers and administrative law judges. Utilizing the existing workers' compensation system to resolve issues involving alleged insurer misconduct and bad faith would permit a timely resolution of any impediments to the disposition of an employee's compensation for work-related injuries. However, in order to provide sufficient deterrence,

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<sup>207</sup> Arkansas, Connecticut, Delaware, Kansas, Louisiana, Massachusetts, Michigan, New Jersey, Oklahoma, Pennsylvania, Texas, Vermont and West Virginia.

substantial penalties for insurer misconduct and bad faith must be provided to the trier of fact.

Any regulatory penalty framework must include a requirement that insurers track penalties that have been awarded with sufficient specificity to create a positive informational feedback to insurance company executives regarding the actual and cumulative cost of inappropriate claim processing.

## THE SPANISH PROPERTY INSURANCE CARTEL

FRANCISCO MARCOS\*

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*Inherent Defects Insurance (“IDI”) for new housing buildings has been mandatory in Spain since 2000. The institution of this requirement prompted an upsurge in the IDI market in following years. Having been confronted with competition, major insurance carriers active in the property insurance market formed a cartel, which involved IDI reinsurers. This article examines the features of the Spanish IDI cartel, as uncovered by the National Competition Commission (“NCC”) in 2009. The companies involved in the cartel were punished with a fine of over €120 million, the largest fine ever imposed by competition authorities in Spain. This article describes how the cartel was organized and operated, and emphasizes the reinsurers’ key role in assuring and propagating the effectiveness of the minimum price agreement throughout the property insurance market. It also critically analyzes the Spanish NCC’s assessment of the cartel, and how it dealt with the arguments submitted by the reinsurers to defend their behavior.*

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## I. INTRODUCTION

This article describes how the Spanish property insurance cartel was organized and operated, beginning with the introduction of legally required Inherent Defects Insurance (“IDI”) for new housing in May 2000. Direct insurers took initial steps in the formation of the cartel, and reinsurance companies were crucial in spreading its anticompetitive effects throughout the IDI market.

The Spanish National Competition Commission (“NCC”) discovered the cartel in early 2009. By the end of the year, the three major companies selling property insurance (Asefa, MAPFRE Empresas and Caser) as well as the majority of the reinsurers for property insurance (Suiza/Swiss Re, SCOR and MÜNCHENER) were fined a total of €120,728,000.<sup>1</sup> The companies were condemned for infringing Article

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<sup>1</sup> See Comisión Nacional de la Competencia (Spanish National Competition Commission), *Compañías de Seguro Decenal Resolución*, S/0037/08 (Nov. 12, 2009) [hereinafter NCC Decennial IDI Resolution]. However, the NCC resolution has been appealed in court and a decision is pending on several grounds (mainly concerning the existence of a violation and the amount of the fines). See Brief, *La Comisión Nacional de la Competencia (CNC) Imposes €120.728.000 in Fines on Insurance Companies Cartel*, EUR. COMPETITION NETWORK (Jan. 2010), [http://ec.europa.eu/competition/ecn/brief/01\\_2010/brief\\_01\\_2010\\_short.pdf](http://ec.europa.eu/competition/ecn/brief/01_2010/brief_01_2010_short.pdf); Michael Bradford, *Spain Charges Big Insurers Developed Construction Coverage Cartel*, BUS. INS. (Nov. 23, 2009),

101.1 of the Treaty on the Functioning of the European Union (“TFEU”) and Section 1 of the Spanish Competition Act (“SCA”) by organizing and taking part in a conspiracy to raise the prices of mandatory property insurance for new buildings.<sup>2</sup>

## II. SPANISH DECENNIAL INSURANCE FOR NEW HOUSING

The Spanish building industry sprawl of the 1980s and 1990s was followed by complaints regarding the quality of buildings and protection of buyers. For that reason, new legislation was enacted in the late 1990s to strengthen and clarify liability rules in this area.

The Spanish Act 38/1999 on building regulations was put into effect on May 6, 2000.<sup>3</sup> The Act introduced a complete and modern legal framework for the building industry in Spain. It clarified the duties and liabilities of all the agents involved in the building process, with the aim of assuring better quality of new buildings (including functionality, security and occupancy), as well as better conditions and guarantees for purchasers of the new buildings.

Among other relevant provisions, the 38/1999 Act requires property promoters or developers to subscribe to a ten-year IDI policy for newly constructed housing.<sup>4</sup> Building developers are legally responsible for

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<http://www.businessinsurance.com/article/20091122/ISSUE01/311229973?tags=|76|80>.

<sup>2</sup> See Consolidated Version of the Treaty on the Functioning of the European Union art 101.1, Mar. 30, 2010, 2010 O.J. (C 83) 88 [hereinafter TFEU], *available at* <http://eur-lex.europa.eu/en/treaties/index.htm>; Defensa de la Competencia art. 1 (B.O.E. 2007, 159) (Spain) [hereinafter SCA] (unofficial translation *available at* [http://www.cncompetencia.es/Inicio/GestionDocumental/tabid/76/Default.aspx?EntryId=18425&Command=Core\\_Download&Method=attachment](http://www.cncompetencia.es/Inicio/GestionDocumental/tabid/76/Default.aspx?EntryId=18425&Command=Core_Download&Method=attachment)).

<sup>3</sup> Ordenación de la Edificación (B.O.E 1999, 266) (Spain).

<sup>4</sup> Articles 9.2.d and 19.1.c, and Additional Disposition 2.1 of the Spanish Building Regulations Act gives the builder the option of buying the insurance on behalf of the developer, who initially has the legal obligation to purchase insurance [Section 19.2.d]. Before 2000, liability insurance for architects and builders was available and regularly purchased in accordance with Section 1591 of Spanish Civil Code, which makes architects and builders liable for building defects over a period of 10 years beginning with the end of the construction work (if the defects had to do with vices on ground, construction, or direction of building work). Based on general insurance contract law, prior to the 1999 Act there were different insurance products available to those involved in building work, including professional liability insurance, liability insurance, all-risks building insurance, and

any harm resulting from the building's foundation and other structural elements for 10 years after the completion of the building's construction. The extent of decennial liability includes material damages to the building arising from inherent vices or defects in the masonry, supports, beams, framework, load-bearing walls or any other structural elements that threaten the building's solidity, mechanical resistance and stability. The Act makes the purchase of insurance for such liabilities compulsory, and makes the buyer of the home the beneficiary to the policy.<sup>5</sup> IDI provides a mechanism for reducing or avoiding construction defects litigation.

The mandatory nature of decennial IDI, including an obligatory 100% coverage of construction management expenses, such as paying professional fees and permits (deductibles could not exceed 1% of the total sum insured), had the effect of providing a background in which an anticompetitive agreement by insurance and reinsurance companies could easily flourish. Neither policyholders (namely, housing developers) nor insurers have much choice regarding certain features of the policy, including whether to contract and the extent of coverage to insure.<sup>6</sup> Obviously, in this sense, demand for decennial IDI is highly inelastic (*must-contract service*).

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decennial liability insurance. See Josefa Brenes, GARANTÍAS POR DEFECTOS EN LA CONSTRUCCIÓN EN LA LEY DE ORDENACIÓN DE LA EDIFICACIÓN 51-71 (Apr. 2005); Ángel Carrasco Perera, *Comentario al artículo 19*, in COMENTARIOS A LA LEY DE ORDENACIÓN DE LA EDIFICACIÓN 351, 358-66 (Ángel Carrasco Perera, Encarna Cordero Lobato, M<sup>a</sup> del Carmen González Carrasco eds., 3d ed. 2005).

<sup>5</sup> According to Section 20.1 of the Spanish Building Regulations Act, the insurance policy details must be presented to the Notary and must be included in the public deed of the building to be registered in the Real Estate Registry. Without this, registration is not possible, and any further sale transactions would not be notarized. See Brenes, *supra* note 4, at 357-79; Antonio J. Jiménez Clar, *El Sistema de Seguros en la Ley de Ordenación de la Edificación*, 6 REVISTA DE DERECHO PATRIMONIAL 19, at 43-45, 61-64 (2001); JESÚS ESTRUCH ESTRUCH, LAS RESPONSABILIDADES EN LA CONSTRUCCIÓN 855-59 (2d ed. 2005).

<sup>6</sup> Contractual freedom and choice is severely limited, if not abolished, although some authors assert that there still remains the possibility for both potential policyholders and insurers to choose their contractual parties and alert them to possible distortions provoked by the mandatory nature of IDI, ranging from insurance companies' inclusion of abusive contract terms against the insured to excessive judicialization or an increase in housing prices. See Eduardo Pavelek Zamora, *Seguros Obligatorios y Obligación de Asegurarse*, 106 REVISTA ESPAÑOLA DE SEGUROS 235, 240 (2001); FEDERICO ARNAU MOYA, LOS VICIOS DE LA CONSTRUCCIÓN: SU RÉGIMEN EN EL CÓDIGO CIVIL Y EN LA LEY DE ORDENACIÓN DE LA EDIFICACIÓN 295-96 (July 2004).

Aside from mandatory ten-year insurance coverage for building developers, optional supplementary coverage is available in three-year increments in accordance with the 38/1999 Act decrees on water tightness of roofs and walls, as well as other elements that affect the stability and habitability of a building. The Act also prescribes a one-year liability period for the builder regarding the condition of finishing elements (“snagging list”). Supplementary coverage for this liability is also available. In these last two instances, insurance is not required. However, insurance companies frequently offer voluntary, supplementary coverage to housing promoters who purchase the mandatory decennial insurance for new residential developments.<sup>7</sup>

The requirement of mandatory insurance was also the starting point of a new market for decennial insurance in Spain that grew hand-in-hand with the growth of the construction industry until 2007, but which decreased dramatically thereafter (*see* Table 1).

TABLE 1. THE DECENNIAL IDI MARKET IN SPAIN (2000-2008)

Year	Number of contracts	Coverage Amount (€)	Total Price (€)
2000	2,042	2,193,975,000	15,056,000
2001	14,948	10,471,910,000	65,486,000
2002	26,143	21,922,843,000	145,258,000
2003	26,302	31,062,129,000	225,002,000
2004	32,559	41,865,225,000	312,895,000
2005	35,157	46,650,215,000	355,069,000
2006	38,111	52,080,802,000	386,404,000
2007	36,508	50,505,917,000	355,557,000
2008	17,515	25,632,962,000	174,116,000

**Source:** NCC Resolution of 12 November 2009, S/0037/08, Finding of Fact 2.4.

On the other hand, the origins and evolution of the decennial IDI market in Spain were characterized by the substantial concentration of the offering of this type of insurance by three companies. From the beginning, insurers Asefa, MAPFRE and Caser together held 60% of the market.<sup>8</sup> The

<sup>7</sup> For more information on the additional coverage normally included in IDI policies in excess of the mandatory coverage, *see* Brenes, *supra* note 4, at 180-86.

<sup>8</sup> Asefa is co-owned by the French insurance company Société Mutuelle d’Assurance du Bâtiment et des Travaux Publics (SMABTP) and the French



rest of the market was fragmented in smaller shares held by about fifteen other insurance companies.

On the other hand, from its inception, the decennial IDI market was deeply affected by reinsurance contracts between the four primary reinsurers active in this market: Suiza, MÜNCHENER, SCOR and MAPFRE RE.<sup>9</sup> In general, the influence of reinsurers on contractual and underwriting conditions of any direct insurance contract is well known.<sup>10</sup>

Firstly, two of the four reinsurance companies were affiliates of two of the main IDI insurers (SCOR and MAPFRE RE). Secondly, when mandatory IDI was established in May 2000, reinsurance contracts for decennial IDI were structured as proportional quota share schemes, shifting

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reinsurer SCOR. See NCC Decennial IDI Resolution, *supra* note 1, Finding of Fact 1.1, at 7. Apparently, Asefa is heavily dependent on its insurance activities in the construction market, in which it is strongly specialized.

<sup>9</sup> MAPFRE RE mainly reinsured the decennial IDI contracted with MAPFRE Empresas, and later on retroceded it to the other three main IDI reinsurers. See NCC Decennial IDI Resolution, *supra* note 1, Finding of Fact 2.7, at 20. Despite being two independent legal entities, both companies belonged to the same corporate group, and the NCC took that into consideration when assessing their behavior, deciding they did not deserve separate fines. See *id.*, Legal Ground 9th, at 68-69.

<sup>10</sup> Underwriting philosophy and underwriting success by direct insurers are conditions considered by reinsurers before signing a reinsurance contract with them. See Aviva Abramovsky, *Reinsurance: The Silent Regulator?*, 15 CONN. INS. L.J. 345, 375 (2009) (“Just as with primary insurance, the existence of a reinsurance agreement limits the options of insurer action if they wish to benefit from the reinsuring agreement.”); see also *id.* at 377 (“Rather it is the identification that terms and standards common to the reinsurance relationship have the potential to affect insurance company action as regards their *primary* policyholder in areas that come within the bounds of current insurance regulatory interests. Specifically, insurer practices in underwriting and claims handling.”). In the Decision of Dec. 20 1989, relating to a proceeding under Article 85 of the EEC Treaty, the EU Commission showed how a collaborative agreement among reinsurers restricted competition both in German reinsurance and in direct insurance markets for machinery loss-of-profits insurance and space insurance. See Commission Decision IV/32.408-TEKO of 20 Dec. 1989, 1990 O.J. (L 13) 34. Indeed, regarding the limits reinsurers face in exercising their influence on insurance carriers, the EU Commission held that “TEKO’s coordination activity goes well beyond the influence of reinsurers that is otherwise customary on the market, since reinsurers generally confine themselves to checking the premiums and the terms and conditions worked out by direct insurers and neither calculate the direct insurers’ offers for them at the outset nor serve as a permanent joint information and advisory body for a specific group of undertakings.” *Id.* at 36.

a higher share of risk exposure to the reinsurers, who correspondingly shared an even proportion of the premium.<sup>11</sup> Premiums and losses were shared on the same pro-rata basis (for more on this, *see infra* § 2.1). Because of the agreement amongst the four reinsurers active in the IDI market, no alternative type of reinsurance contracts were available for purchase. This severely constrained potential competition in the market by both direct insurers and reinsurers willing to follow other contractual schemes.<sup>12</sup> Only in 2007, when the cartel was brought to light by the NCC, did facultative reinsurance contracts and non-proportional reinsurance agreements come into use.<sup>13</sup> Such agreements came into use in the form of stop-loss or excess-loss, in which the basis is the loss incurred and not the risk ceded, with the reinsurer covering a set amount of the loss exceeding the amount retained by the insurance carrier.<sup>14</sup>

### III. THE MECHANICS OF THE SPANISH PROPERTY INSURANCE CARTEL

According to the evidence discovered by the NCC, the year after the 38/1999 Act became effective (i.e., when mandatory decennial IDI was established), there were contacts amongst IDI carriers and IDI reinsurers concerning excessive competition in this new market. Apparently, competition led to a dramatic decrease in IDI premiums, and some of the companies active in that market decided something needed to be done to stop that trend. It is unclear how many meetings took place and who was part of those meetings, but it is well settled that there was a common understanding between Asefa and MAPFRE (the IDI carriers) and Suiza, MÜNCHENER and SCOR (the reinsurers) that premiums had to be increased and that uniform contracting conditions should be followed throughout the decennial insurance market.<sup>15</sup>

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<sup>11</sup> See Patrick L. Brockett, Robert C. Witt & Paul R. Aird, *An Overview of Reinsurance and the Reinsurance Markets*, 9 J. INS. REG. 432, 435-37 (1991).

<sup>12</sup> It does not seem that the proportional quota share reinsurance and the refusal to write any other type of reinsurance contract was aimed at protecting reinsurers' financial health, but only to ensure that no primary insurer would be able to sell IDI contracts that did not follow the premiums fixed by the cartel. See *Hartford Fire Ins. Co. v. California*, 509 U.S. 764, 792 (1993).

<sup>13</sup> Indeed, no more proportional quota share treaties were written after that time.

<sup>14</sup> See NCC Decennial IDI Resolution, *supra* note 1, Findings of Fact 2.6-2.7, at 17-20.

<sup>15</sup> See *id.*, Findings of Fact 3-6, at 22-23.

The main outcome of this understanding was a draft prepared by Asefa at the end of August 2001, entitled “*Corrective Measures Decennial Damage Insurance*”, which set market-wide standards for technical and commercial features of decennial insurance. The Asefa draft contained some technical requirements for IDI contracting and quality control, as well as several measures that involved a minimum price-fixing agreement. In December 2001, after discussions with MAPFRE and the IDI reinsurers, a new version of the document was finally agreed upon by Asefa, MAPFRE Empresas, MÜNCHENER, Suiza and SCOR, entitled “*Corrective Measures Decennial Damage Insurance-2002*”.<sup>16</sup>

#### A. CARTEL ORGANIZATION AND OPERATION

Several other meetings between IDI insurers, reinsurers and third-party IDI providers (including savings and bank associations) took place in 2002 to fine-tune the pricing conditions agreed upon for IDI contracts, but according to the NCC, the effects of the cartel commenced in January 2002.<sup>17</sup> Starting at that point, IDI reinsurance contracts included the agreed upon corrective measures; indeed, minimum pricing and underwriting conditions for direct IDI established by the cartel were annexed to reinsurance contracts between 2002 and 2007.<sup>18</sup>

Reinsurance was key in the organization of the cartel.<sup>19</sup> The generalization of proportional quota share reinsurance treatises as the only

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<sup>16</sup> See *id.*, Findings of Fact 7-11, at 23-24.

<sup>17</sup> See *id.*, Findings of Fact 13-19, at 26-28. Some cartel members raised doubts regarding the compliance of all reinsurers with the agreed-upon corrective measures. See *id.*, Finding of Fact 15, at 26-27. Apparently, the most important moment took place on May 7, 2002, when Asefa and all the reinsurers agreed to new minimum price conditions and monthly monitoring meetings to examine defections. See *id.*, Finding of Fact 18, at 27-28.

<sup>18</sup> See *id.*, Findings of Fact 12, 20-24, at 24-26, 28. The NCC assumes a year (from January to December) as the minimum duration of a cartel, because that is the typical duration of reinsurance contracts. *Id.*

<sup>19</sup> In other competition cases in the insurance market, authorities have found reinsurance crucial to structuring anticompetitive behavior. See EU Commission Decision of 30 March 1984, relating to a proceeding under Article 85 of the EEC Treaty, ¶¶ 10, 16, 23 (IV/30.804- Nuovo CEGAM, OJ L99, of April 11, 1984, 29-37) (regarding engineering insurance in Italy). In one famous U.S. case, reinsurers were key in a conspiracy by direct insurers to change certain policy terms on commercial liability insurance and property insurance policies (reducing risk exposure to insurance carriers). *Hartford Fire Ins. Co. v. California*, 509 U.S. 764,

type of reinsurance available in the IDI market gave way to a situation in which reinsurers depended greatly on the ceding insurer. Proportional quota share reinsurance “involves the cession by reinsured of a fixed proportion of business within the scope of the reinsurance contract to the reinsurer.”<sup>20</sup> Reinsurance companies did not offer alternative contractual schemes in which the reinsured had a choice as to what risks he would cede. Indeed, in that situation, IDI insurers could easily be considered mere agents of the reinsurers.<sup>21</sup> Proportional quota share treatises strengthened the influence of the reinsurers on the IDI market.<sup>22</sup> As the most profitable

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775-77, 792 (1993); *see also* Edward Correia, *How to Reform the McCarran-Ferguson Act*, 22 MEMPHIS STATE U. L. REV. 43, 62-65 (1991); Charles R. McGuire, *Regulation of the Insurance Industry After Hartford Fire Insurance v. California: The McCarran-Ferguson Act and Antitrust Policies*, 25 LOY. U. CHI. L.J. 303, 334-35 (1994); James P. Rhatican, *Hartford Fire Insurance Co. v. California: A Mixed Blessing for Insurance Antitrust Defendants*, 47 RUTGERS L. REV. 905, 907-09 (1995). The involvement of reinsurers was also critical in some conspiracies detected within the U.S. fire insurance market. *See* St. Paul Fire & Marine Ins. Co. v. Barry, 438 U.S. 531, 560-61 (1978) (Stewart, J., dissenting); U.S. v. Se. Underwriters Ass’n, 322 U.S. 533, 535-36 (1944).

<sup>20</sup> *See* Nicholas Legh-Jones (ed.), MACGILLIVRAY ON INSURANCE LAW, ¶ 33-13 (2003); *see also* EU Commission, BUSINESS INSURANCE SECTOR INQUIRY, INQUIRY INTO THE EUROPEAN BUSINESS INSURANCE SECTOR PURSUANT TO ARTICLE 17 OF REGULATION 1/2003, INTERIM REPORT, Jan. 2007, 24-25, *available at* [http://ec.europa.eu/competition/sectors/financial\\_services/inquiries/interim\\_report\\_24012007.pdf](http://ec.europa.eu/competition/sectors/financial_services/inquiries/interim_report_24012007.pdf); Gary Patrik, *Reinsurance*, in FOUNDATIONS OF CASUALTY ACTUARIAL SCIENCE, 342-43, 348-49 (2001, 4th ed.).

<sup>21</sup> *See* OECD, COMPETITION AND RELATED REGULATION ISSUES IN THE INSURANCE INDUSTRY, 1998, DAFPE/CPL(98), 27, *available at* <http://www.oecd.org/dataoecd/34/25/1920099.pdf> (“However, as in other industries, the vertical relationships that arise through reinsurance may act to facilitate collusion. In particular, a situation might arise where the upstream reinsurance market is relatively concentrated. In this circumstance the downstream insurers may be able to utilize the reinsurer as a tool for enforcing collusive arrangements. For example, the insurers (via the reinsurer) argue that ‘uniformity of premiums and policy conditions is required to make the calculation of the tariffs for reinsurance possible’. The reinsurer, by enforcing tariff uniformity (at the cartel price) becomes the mechanism by which collusion is enforced.”).

<sup>22</sup> Apart from the specific type of reinsurance used in the decennial IDI market, there has allegedly been an overall shift in the relationships among insurance carriers and reinsurers. *See* PEDRO PORTELLANO DÍEZ, EL REASEGURO: NUEVOS PACTOS 26-27 (2007). Reinsurers are increasingly vertically integrated with insurers, through “captive insurance firms,” and there is an increasing reciprocal influence or intervention in direct insurance, not only informally, but

type of reinsurance for reinsurers, proportional quota share treaties are normally used for homogeneous risks and when there is difficulty foreseeing the accident or loss rate. Such treaties provide reinsurers with a balanced, continuous business flux, in which a proportionate quota share of all IDI premiums is ceded independent of its amount. Of course, a similar proportion of risk exposure is also transferred to the reinsurer.

The automatic cession framework pushed reinsurers and reinsureds into a community of interest, in which the direct IDI contracts written by insurance companies have a straightforward and immediate impact on reinsurers. As the reinsurers' stake in the functioning of decennial IDI grew larger, the reinsurers sought to control different features of premiums and risk exposure by imposing conditions and requirements in underwriting direct insurance contracts, specifically, a minimum premium.

Compared to other insurance products, setting premiums for decennial IDI contracts requires accounting for different elements related to the characteristics and location of the building, and although some sophistication by the housing developers purchasing this type of insurance can be assumed, the process is not a straightforward exercise. The NCC found a good deal of evidence illustrating how reinsurers fixed minimum premiums for direct IDI insurance throughout the market by requiring uniform minimum pricing conditions to be followed by direct insurers if they wanted their IDI contracts to be subject of cession to IDI reinsurers.

Indeed, pricing conditions for IDI contracts were agreed upon by cartel members, including: (1) the minimum percentage of decennial IDI coverage for apartments and houses, (2) the minimum flat amount per IDI contract and per housing unit, (3) identical percentages of supplementary coverage outside of mandatory IDI (such as coverage for water tightness of roofs and walls and stability of non load-bearing walls), (4) extra percentages charged for resignations to claims against other agents in the building process and IDI price references per square meter of building area to correct for low-value declarations that could imply lower premiums.<sup>23</sup> The conditions agreed to by cartel members were exact and precise, and

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also through contractual means. *Id.* at 45-51. *See also* EU Commission, *supra* note 21, at 26-27.

<sup>23</sup> *See* NCC Decennial IDI Resolution, *supra* note 1, Finding of Fact 25, at 29. According to the NCC, these conditions were the same "corrective measures" for decennial damage insurance contract agreed to by the cartel members in 2001.

were to be applied to the coverage amount in the calculation of the commercial premiums.<sup>24</sup>

In sum, the reinsurance side of the cartel heavily influenced direct IDI contracts written from 2002 onward, imposing minimum premiums and even correcting for possible value changes in housing that could lead to underinsurance.<sup>25</sup> The NCC sampled twenty different direct IDI contracts underwritten by Asefa, MAPFRE and Caser, and found that minimum price conditions set by the cartel were strictly followed.<sup>26</sup>

#### B. MONITORING AND POLICING COMPLIANCE WITH CARTEL

Operating at two different levels, insurance and reinsurance, the property insurance cartel faced difficulties in monitoring compliance with the established minimum price conditions. The NCC provides several examples of how reinsurance and insurance carriers, whether they were part on the cartel or not, acted as the primary agents in monitoring IDI offerings below the price set by the cartel, while the reinsurers were also the *judges* and *executioners* acting against any potential defections (*see*

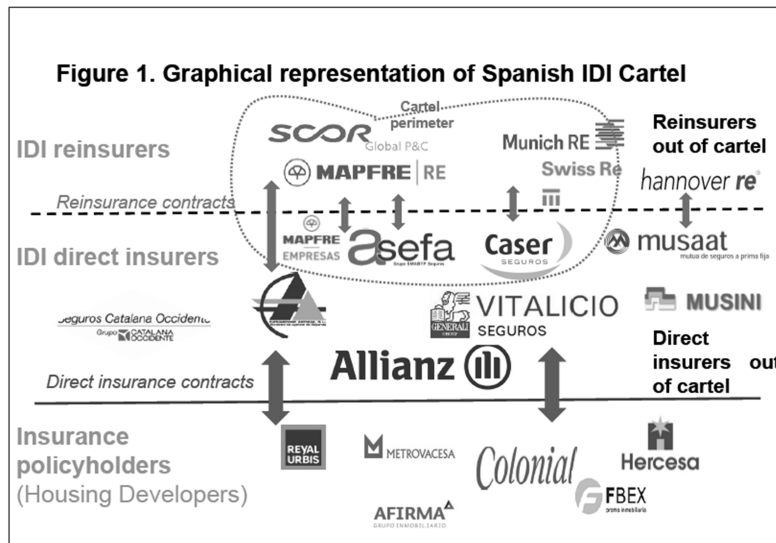
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<sup>24</sup> In setting the premium to be paid, insurers start from a technical calculation of the risk covered (probability of accident), taking into account the sum insured and the contract duration (this is called the *gross premium* or the *premium at risk*), but the final premium charged (i.e., the *commercial premium* or the *net premium*) is the result of adding certain other expenses (administrative and other charges, including the profit to be earned by the insurer) to the gross premium. According to the NCC, the cartel went into the details of fixing the final premiums to be charged by IDI carriers.

<sup>25</sup> *See* NCC Decennial IDI Resolution, *supra* note 1, Finding of Fact 26, at 31. A similar device was found to be essential in the operation of the fire insurance cartel in Germany. *See* Case 45/85, *Verband der Sachversicherer e.V. v Comm'n of the European Cmty.*, 1987 E.C.R. 405, 455 (“German re-insurance companies decided to include in their contracts of re-insurance concerning the same risks a special ‘premium calculation clause’ according to which premium rates which fail to conform to the recommendation are to be treated in the event of a claim as under-insurance.”).

<sup>26</sup> *See* NCC Decennial IDI Resolution, *supra* note 1, Finding of Fact 28 and Legal Ground 3rd, at 31, 53-54. The NCC reckoned that technical features of some buildings may introduce additional risks that require additional surcharges, and some other circumstances that may give way to further discounts and surcharges (type of soil, slope, phreatic stratum, foundations and type of structure) that were out of the minimum pricing conditions set by the cartel.

Figure 1 for a graphical representation of the cartel structure and organization).<sup>27</sup>



In practice, every time a potential defection by direct insurers was detected, the action moved upstream to the reinsurance level of cartel members. Upstream reinsurance cartel members were in charge of adopting measures to prevent IDI offerings that did not comply with the cartel terms from being underwritten in the market. Reinsurers refused to allow the cession of any IDI contracts that did not comply with the pricing conditions set by the cartel, and even cancelled those that were agreed to below cartel prices.

The biggest challenge to the cartel took place at the end of 2006, when the insurer Mutua de Seguros a Prima Fija (MUSAAT) negotiated a non-proportional excess-loss reinsurance contract with the reinsurer Hannover Re, which would have altered the standard contractual provisions employed by IDI reinsurers and would have led to a violation of the cartel’s minimum prices. However, the original cartel members, along with Caser, persuaded Hannover Re to withdraw the reinsurance contract it had offered to MUSAAT.<sup>28</sup>

<sup>27</sup> See *id.*, Findings of Fact 29-34, at 31-32. The NCC considered claims not only by cartel members but also by the insurers Vitalicio and Allianz. See *id.*, Findings of Fact 36, 39, at 33.

<sup>28</sup> See *id.*, Findings of Fact 40-44, at 33-35. Caser was not considered to be an original member of the cartel and, initially, it only followed the conditions set by

Nevertheless, the initiative of MUSAAT destabilized the cartel and led to its breakdown in 2007. MUSAAT eventually managed to get reinsured under conditions different than those imposed by the cartel. Although several meetings by cartel members took place during 2007 in order to reinforce the cartel's strength,<sup>29</sup> the initiation of investigations by NCC ultimately put an end to the cartel.

### C. CARTEL EFFECTS: ECONOMIC RELEVANCE

In order to estimate the economic significance of the cartel and its impact on the pricing of decennial IDI, the Spanish NCC utilized statistics on the evolution of the decennial insurance market from 2001 to 2007. Although both direct insurers and reinsurers were members of the cartel, the NCC determined that only the direct IDI market was affected by the cartel. Using the available data, the NCC calculated the average premium rate per sum insured for the period 2002-2007. This calculation permitted the NCC to observe an increase in average premiums while the cartel was in place (*see* Table 2). According to NCC calculations, the total excess in decennial IDI premiums paid by residential building developers from 2002 to 2007 amounted to around 17% of the premiums paid over the duration of the cartel (about €242,436,072).<sup>30</sup>

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reinsurers. However, the NCC considered its role changed in 2006, when it started playing a relevant function in monitoring defections from the minimum pricing agreement. *See id.*, Legal Ground 6, ¶ 4, at 60-63.

<sup>29</sup> *See id.*, Findings of Fact 45-58, at 35-37.

<sup>30</sup> *See* NCC Decennial IDI Resolution, *supra* note 1, Finding of Fact 59, at 31. The reinsurers and insurance carriers involved in the cartel acknowledged an increase in average premiums for IDI after 2002, but they denied that it had anything to do with a cartel. For them, it was the result of normal market operations. Instead, the NCC attributed the entire increase in average premiums to the effect of the cartel. According to the NCC, it amounted to around 17% of the premium paid over the duration of the cartel.



**TABLE 2. CALCULATION OF CARTEL IMPACT ON IDI PRICES (2002-2007)**

Year	Sum Insured € (A)	Total Premiums € (B)	B/A in %	B/A absent cartel <sup>1</sup> in % (C)	CxA Total Premium absent cartel € (D)	B-D Premium excess due to cartel €
2002	21.9228	145.258	0.66	0.63	138.1139	7.1440
2003	31.0621	225.002	0.72	0.63	195.6914	29.3105
2004	41.8652	312.895	0.75	0.63	263.7509	49.1440
2005	46.6502	355.069	0.76	0.63	293.8963	61.1726
2006	52.0808	386.404	0.74	0.63	328.1090	58.2949
2007	50.5059	355.557	0.70	0.63	318.1872	37.3697

(<sup>1</sup>) Total percentage of premiums per sum insured in the year prior to the existence of cartel (in millions), year 2001 (Source: NCC Resolution of 12 November 2009, S/0037/08, findings of fact 2.4 and 59).

In the words of the NCC, the minimum price agreement “eliminated all competition in prices in all the decennial IDI market, all policyholders had to pay, at least, the minimum prices set.”<sup>31</sup> Surely, reinsurers competed amongst themselves in the commissions charged and could compete in setting different proportions of risk exposure taken, but it is clear that they all took part in an anticompetitive agreement that froze competition in both the IDI reinsurance market and the direct IDI market. Competition amongst reinsurers was severely restrained by the condition that only proportional pro quota share treaties were available and, consequently, by the identical underwriting and pricing conditions IDI reinsurers set for the direct IDI market. Concerning the latter, it is true that there were variations in the commercial conditions offered by insurance carriers over the minimum prices set by the cartel, which might be explained by the complex criteria used to set final prices as well as the existence of some competition by direct insurers above the cartel minimum prices.

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<sup>31</sup> *Id.*, Legal Ground 10, at 73-81.

Another consequence of the cartel was that while it was in effect, cartel members at both primary insurance and reinsurance levels maintained and even increased their market shares. Only the breakdown of cartel in 2007 allowed other insurance companies (for example, MUSAAT) to gain a substantial market share, as the minimum pricing agreement ceased to be in effect and alternative reinsurance contracts started to become available.<sup>32</sup>

#### IV. LEGAL ASSESSMENT BY NCC

The evidence above led the Spanish National Competition Commission to determine that insurers Asefa and MAPFRE and reinsurers SCOR, Suiza and MÜNCHENER had violated Article 101.1 of the TFEU and Section 1.1.a of the SCA. As described above, the cartel operated at two levels (direct IDI and IDI reinsurance), limiting the types of reinsurance contracts available for IDI carriers and setting a minimum premium for decennial property insurance in Spain from 2002 to 2007. The two-level structure of the cartel was crucial for its effectiveness. The cartel was deeply rooted on the relationships among IDI carriers and IDI reinsurers (and vice versa). However, the NCC considered the horizontal dimension of the agreement at both levels -either among direct insurers or among IDI reinsurers - to be prevalent to the vertical dimension.<sup>33</sup> Moreover (as mentioned earlier, *supra* § III.C), the NCC focused its attention on the cartel's impact on competition within the direct IDI market, although it is clear that competition was also restrained in the IDI reinsurance market.

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<sup>32</sup> See *id.*, Legal Ground 10, ¶ 6, at 70. There is some controversy regarding the data used by the NCC to make these calculations. The NCC used the data available from the Investigación Cooperativa entre Entidades Aseguradoras y Fondos de Pensiones (ICEA). This was the first Spanish association of insurance companies founded in 1963 (see more information at <http://www.icea.es>). Its reports and statistics are constructed with data provided by member insurance and reinsurance companies. Cartel members complained about the inaccuracy and variability of ICEA's data and statistics. However, the NCC considered that despite possible defects and variations in the statistics used, there was enough evidence of the violation committed which, moreover, the SCA and the TFEU prohibited because of its object, no matter the effect it might have had in the market. See also *id.* ¶¶ 5, 7-11, at 70-72.

<sup>33</sup> See NCC Decennial IDI Resolution, *supra* note 1, Legal Ground 6, at 60-63.

## A. APPLICABLE LAW AND POSSIBLE EXEMPTIONS

Regarding EU competition law, the cartel created a minimum pricing agreement in violation of Article 101.1.a of the TFEU that affected member state trade, as it covered the entire Spanish market and prevented reinsurance companies offering no proportional treaties, facultative reinsurance contracts, and other pricing conditions different from those set by the cartel from entering the Spanish market.<sup>34</sup> In making this determination, the NCC ascertained that the cartel had fragmented the Spanish decennial IDI market.

Regarding domestic competition law, although the cartel operated when the 1989 SCA was in force, the NCC investigation and proceedings did not take place until after the 2007 SCA had been adopted.<sup>35</sup> In any case, an agreement fixing minimum prices, such as the one that occurred in the decennial IDI cartel, was a violation of both versions of the SCA, as no relevant change was introduced on this prohibition in the new Act. In fact, the language in the newly adopted SCA is identical to the language of the previous SCA.

However, both EU law and Spanish domestic law contemplate that, due to the specific nature and regulated character of the insurance industry,

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<sup>34</sup> See Joined Cases C-295/04 to C-298/04, *Manfredi v. Lloyd Adriatico Assicurazioni SpA, Cannito v. Fondiaria Sai SpA, Tricarico v. Assitalia SpA*, 2006 E.C.R. § 52; Case C-309/99, *Wouters v. Algemene Raad van de Nederlandse Orde van Advocaten*, 2002 ECR I-1653, § 95 (“As regards the question whether intra-Community trade is affected, it is sufficient to observe that an agreement, decision or concerted practice extending over the whole of the territory of a Member State has, by its very nature, the effect of reinforcing the partitioning of markets on a national basis, thereby holding up the economic interpenetration which the Treaty is designed to bring about.”) (citing Case 8/72 *Bereening van Cementhandelaren v. Comm’n* [1972] ECR 977, ¶ 29; Case 42/84 *Remia & Others v Comm’n* [1985] ECR 2545, ¶ 22; and *CNSD*, ¶ 48). See also Commission Notice - Guidelines on the effect on trade concept contained in Articles 81 and 82 of the Treaty, 2004 O.J. (C 101) § 78 (“Horizontal cartels covering the whole of a Member State are normally capable of affecting trade between Member States. The Community Courts have held in a number of cases that agreements extending over the whole territory of a Member State by their very nature have the effect of reinforcing the partitioning of markets on a national basis by hindering the economic penetration which the Treaty is designed to bring about.”).

<sup>35</sup> Moreover, the NCC determined that the cartel existed and continued producing effects several months after the 2007 SCA was in force (Sept. 1, 2007), so even the latter would be applicable. NCC Decennial IDI Resolution, *supra* note 1, Legal Ground 1, at 40-42.

some business practices in insurance markets are exempted from prohibitions on competition.<sup>36</sup> Therefore, one could foresee that the companies accused of organizing the IDI cartel would raise the defense that their actions were covered by the insurance exemption. Firstly, cartel members argued that per EC Regulation 358/2003, decennial liability constituted a “new risk” that should be covered by the special regime set by the Block Exemption Regulation (“BER”).<sup>37</sup> According to cartel members, mandatory decennial IDI for housing as required by the 28/1999 Act gave way to a new class of insurance, and all of the arrangements made by insurers and reinsurers concerning decennial IDI were justified due to the lack of information on the risk and adequate coverage.<sup>38</sup> In the same vein, it was argued that the proportional treatise by reinsurers were promulgated as a natural consequence of such a situation and, moreover, that it allowed reinsurers to substantially limit the risk assumed by controlling direct insurance conditions.<sup>39</sup> The NCC dismissed each of these arguments by examining the evidence of how the price fixing agreement was conceived as the anticompetitive solution that Asefa, MAPFRE and the reinsurers designed to correct what they understood to be excessive market competition. According to the documentary proof obtained by the NCC in the form of minutes from the cartel members’ meeting, the first year the 38/1999 Act was in force, the cartel members considered decennial IDI

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<sup>36</sup> See FRANCISCO MARCOS & ALBERT SÁNCHEZ-GRAELLS, *ACTIVIDAD ASEGURADORA Y DEFENSA DE LA COMPETENCIA: LA EXENCIÓN ANTITRUST DEL SECTOR ASEGURADOR*, Instituto del Ciencias del Seguro, <http://www.mapfre.com/ccm/content/documentos/fundacion/cs-seguro/libros/Actividad-aseguradora-y-defensa-de-la-competencia-la-exencion-antitrust-del-sector-asegurador.pdf> (for an explanation of the insurance sector exemption both in EU Law and Spanish Law). In this article, references are made to Commission Regulation (EC) No. 358/2003, 2003 O.J. (L 53/8), but the exemption has been significantly rewritten by Commission Regulation (EU) No. 267/2010, 2010 O.J. (L 83/1).

<sup>37</sup> Commission Regulation (EC) No. 358/2003, *supra* note 37, at 8-16 (on the application of Article 81(3) of the Treaty to certain categories of agreements, decisions and concerted practices in the insurance sector).

<sup>38</sup> Brenes, *supra* note 4, at 242 (When discussing premium calculation in her study of decennial IDI, Brenes mentions the lack of experience in the Spanish insurance market on the risks covered by this type of insurance that greatly encumber the pricing process).

<sup>39</sup> NCC Decennial IDI Resolution, *supra* note 1, Legal Ground 3rd, ¶¶ 3-4, at 49-55.

premiums to be too low and agreed that something needed to be done to substantially increase them.<sup>40</sup>

Moreover, Spanish general insurance legislation includes an obligation for each insurance company to avoid underinsurance by setting minimum premium schedules with adequate technical provisions, and by requiring that the measures adopted to comply with these requirements do not restrict competition (Section 25.3 of the 2004 Spanish Insurance Regulation).<sup>41</sup> The agreements entered into by the direct IDI insurers and reinsurers did not comply with that provision, as they agreed to and imposed minimum commercial premium rates throughout the Spanish IDI market.<sup>42</sup> Therefore, a legal exemption could not exist that would be applicable to the behavior of companies in the IDI market in accordance with Section 2.1 of the 1989 SCA (currently, Section 4.1 of 2007 SCA). Furthermore, such an exemption would not be available and operative against an application of Article 101.1 of TFEU.<sup>43</sup>

Finally, the NCC brushed aside any possible exemption for the cartel agreement that could have been given due to beneficial market effects or the efficiencies arising from it (in accordance with Article 101.3 of TFEU and Section 1.3 of 2007 SCA). It also disregarded arguments that the Spanish Ministry of Development's enactment of the LOE justified the cooperation amongst cartel members.<sup>44</sup>

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<sup>40</sup> *Id.*, Legal Ground 3rd, ¶¶ 7-9, at 50-51.

<sup>41</sup> Royal Legislative Decree 6/2004 (R.C.L. 2004, OSJ 267) (Spain). (“The premium rates shall be sufficient, on reasonable actuarial assumptions, to enable the insurer to meet all the obligations arising from insurance contracts and, in particular, to establish adequate technical provisions...They also shall respect free competition in the insurance market without, for this purpose, being considered a restraint of competition the use of risk premium rates based on common statistics.”) (approving the revised text of the Law on regulation and supervision of private insurance).

<sup>42</sup> NCC Decennial IDI Resolution, *supra* note 1, Legal Ground 3rd, ¶ 4, at 50 (The dissenting opinion considers this legal provision as grounds for awarding a legal exemption to IDI insurers and reinsurers in accordance with Section 2.1 of the 1989 Spanish Competition Act 16/1989, of July 17).

<sup>43</sup> See Francisco Marcos, *Comentario Artículo 4*, in *COMENTARIO A LA LEY DE DEFENSA DE LA COMPETENCIA* 239, 274-79 (Jose Manuel Sala Arquer ed., 2d ed. 2010).

<sup>44</sup> NCC Decennial IDI Resolution, *supra* note 1, Legal Ground 4th, ¶¶ 6-8, at 57-58.

## B. DIRECT EVIDENCE OF THE CARTEL

Although the NCC established strong evidence regarding the minimum price fixing agreement and its operation, cartel members denied its existence. They acknowledged their reciprocal contacts and participation in meetings as proven by the NCC, but asserted that these meetings were aimed only at sharing information and experiences of purely technical character regarding decennial IDI coverage.<sup>45</sup>

According to the cartel members' defense, their contacts and meetings contemplated sharing technical information and cooperatively calculating coverage costs that were intercommunicated amongst companies within the exemption provided by the 2003 BER. The NCC responded that the cartel members' behavior exceeded the strict scope and conditions imposed by Article 3 of 2003 BER. This provision requires that information and data shared by insurance companies be of a purely technical nature (that is, actuarial data) and not contain any indication of the level of commercial premiums.<sup>46</sup> Article 4 excluded from the exemption those agreements that *oblige* companies to use the information and data shared when conducting their insurance business.<sup>47</sup> The NCC showed that both final commercial premiums and mandatory premiums were established and imposed throughout the IDI market by the cartel.

According to the evidence put forward by the NCC, Asefa, MAPFRE Empresas, Caser, MÜNCHENER, Suiza and SCOR were part of a price fixing scheme; the commercial premiums were agreed upon and compliance was mandatorily imposed on insurance carriers that were part

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<sup>45</sup> See *id.*, Legal Ground 3rd, ¶¶ 1-2, at 49.

<sup>46</sup> See Commission Regulation 267/2010, 2010 O.J. (L 83) 1, 2 (EU) ("It is therefore appropriate to stipulate in particular that *agreements on commercial premiums are not exempted*. Indeed, commercial premiums may be lower than the amounts indicated by the compilations, tables or study results in question, since insurers can use the revenues from their investments in order to reduce their premiums. Moreover, *the calculations, tables or Studies in question should be non-binding and serve only for reference purposes.*") (emphasis added). See also Alessandro De Nicola & Donatella Porrini, *Scambio di Informazioni e Mercato Assicurativo: Analisi Economica del Diritto Antitrust in Italia e USA*, in CARTELLI A PERDERE. ASSICURAZIONI, ANTITRUST, E SCAMBIO D'INFORMAZIONI, 131, 153-55 (Rubbettino ed., 2008); MARCOS & SÁNCHEZ-GRAELLS, *supra* note 37, at § 4.1.

<sup>47</sup> See *id.*

of the cartel and indirectly imposed on the rest of the market through the influence of reinsurers (*see supra* §§ III.B, C).<sup>48</sup>

#### C. LACK OF AN ALTERNATIVE COMPETITIVE EXPLANATION

If the direct evidence of the existence of the cartel was not enough, the NCC also rejected alternative explanations of their agreements that were put forward by cartel members.<sup>49</sup> In providing a more solid ground for its conclusions, the NCC set aside all of the arguments advanced by the conspiring insurers and reinsurers on plausible lawful and competitive reasons that could justify their behavior.

Of course, the NCC did not determine that the proportional share treaties agreed to by conspiring reinsurers and direct IDI insurers, in which reinsurers fixed some minimum direct insurance pricing terms, were anticompetitive *per se*. Nevertheless, it was suspicious that no other type of reinsurance was available, and that the reinsurance members of the cartel acted against any attempt for any other type of reinsurance contracts to be written.

However, the NCC determined that it was more than suspicious that there was no competition below certain threshold premiums in IDI insurance (following the pricing conditions set by IDI reinsurers which were identical throughout the market, *see supra* § III.A). There is no plausible explanation for the uniform premiums in the IDI market other than the minimum price fixing agreement by reinsurers (and the three larger IDI carriers), in violation of Article 101.1 of TFEU and Section 1 of SCA.

#### D. FINES AND DAMAGE CLAIMS

The NCC deemed Asefa, MAPFRE Empresas, Caser, MÜNCHENER, Suiza and SCOR to be part of a cartel that fixed minimum prices in the IDI market from 2002 to 2007. Operating at two levels, reinsurance and insurance, the cartel had an atypical and complex structure that included horizontal agreements at each of the two levels coupled with

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<sup>48</sup> *See* NCC Decennial IDI Resolution, *supra* note 1, Legal Ground 3rd, ¶¶ 10-16, at 53-57. The NCC even found evidence indicating that cartel members knew about the unlawful nature of their behavior, with several references made by them as to how important it was to keep all their contacts and agreements secret and away from competition authorities. *See id.*, Legal Ground 4th, ¶¶ 3-5, at 54.

<sup>49</sup> *See id.*, Legal Ground 5th, at 58-60.

vertical agreements among the three IDI carriers and all of the reinsurers that were active in the IDI market (*see supra* Figure 1).<sup>50</sup>

The agreement amongst cartel members was a single and complex agreement, which included fixing minimum prices for decennial IDI insurance, monitoring compliance by direct insurers, and detecting and prosecuting defections from cartel prices. There was a concerted action by some insurance carriers and all the IDI reinsurers to fix and control premiums on the decennial IDI market, boycotting and retorting against those direct insurers that did not comply with cartel conditions, and the NCC considered this a single and continuous infringement of Article 101.1 of TFEU and Section 1.1 of SCA.<sup>51</sup>

In setting the amount of the fine, the NCC applied Section 10 of the 1989 SCA.<sup>52</sup> This Section gives discretion to set the level of the fines, with

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<sup>50</sup> *See id.*, Legal Ground 7th, at 63-66.

<sup>51</sup> Following EU case law, the NCC does not apportion the responsibility of cartel members in the conspiracy, nor does it deconstruct the different parts of the complex violation. *See* Joined Cases T-101/05 and T-111/05, *BASF AG & UCB v. Comm'n*, 2007 E.C.R. II-4959, ¶¶ 159-61; Joined Cases T-305/94 to T-307/94, T-313/94 to T-316/94, T-318/94, T-325/94, T-328/94, T-329/94 and T-335/94, *Limburgse Vinyl Maatschappij & Others v. Comm'n*, 1999 E.C.R. II-945, ¶696. *But see* NCC Decennial IDI Resolution, *supra* note 1, Legal Ground 2nd, at 42-49 (The dissenting opinion criticized the NCC's refusal to apportion responsibility in a conspiracy).

<sup>52</sup> *See* The Competition Act § 10 (B.O.E. 1989, 170) (Spain) ("1. The Court may impose on the economic agents, undertakings, associations, unions or groups that have either deliberately or through negligence breached the terms of Sections 1, 6 and 7, or failed to comply with a condition or obligation foreseen in Article 4.2, fines of up to 150.000.000 pesetas (901.518,16 euros), amount which may be increased up to 10 percent of the turnover corresponding to the financial year immediately prior to the Court resolution. 2. The amount of the sanction shall be determined according to the importance of the breach, for which purpose the following factors shall be taken into consideration: a) The type and scope of the restriction upon competition. b) The dimension of the market affected. c) The market share of the corresponding undertaking. d) The effect of the restriction upon competition had on the actual or potential competitors, the other parties in the economic process and the consumers and users. e) The duration of the restriction upon competition. f) The reiteration of the prohibited conduct."). *But see* NCC Decennial IDI Resolution, *supra* note 1, Legal Ground 7th, at 63-66 (The dissenting opinion suggested that the cap set by § 10 of 1989 SCA was inappropriately exceeded by the majority opinion because the aggravating circumstance considered was indeed part of the cartel itself, which should have meant that a cap of 901,518.16 euro per firm was applicable. However, that



the only condition being that the NCC must assess all concurring circumstances proportionally. First, the NCC considered the cartel duration of January 1, 2002 to December 31, 2007.<sup>53</sup> Second, being a long-term violation, the NCC also took into account the severe nature of the violation, the relevant position in the market of the insurance carriers and reinsurers involved with the cartel, the mandatory nature of decennial IDI insurance (which made demand inelastic), the possibility for housing developers to transfer the cost of insurance to final clients (i.e., consumers were the final victims of the cartel), and the deliberate nature of the violation.

To calculate the fine within the framework of Section 10 of 1989 SCA,<sup>54</sup> the NCC surreptitiously used its 2009 Communication on the Quantification of Sanctions.<sup>55</sup> First, to estimate the base amount of the fine, the sales volume affected by the violation was calculated (taking into account the duration of the violation).<sup>56</sup> The base amount is the percentage of the sales volume affected, ranging from 10% to 30% (varying with the severity of the infringement and its capacity for producing cascade effects in other markets).<sup>57</sup>

Subsequently, the NCC adjusted the base amount applicable to each firm. In the case of Asefa, the NCC considered its behavior as the frontrunner in organizing the cartel and policing and controlling defections to be an aggravating factor. Concerning Caser, although it was a late member of cartel, its role in monitoring cartel defections was similarly

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assessment is mistaken, as the cap applies only to business firms and agents lacking a business turnover.).

<sup>53</sup> See NCC Decennial IDI Resolution, *supra* note 1, Finding of Fact 12, at 20-24.

<sup>54</sup> Most of the information on the quantification of the fine has been purged from the public text of NCC resolution (due to confidentiality issues), which greatly hinders the analysis that can be done here.

<sup>55</sup> See The Competition Act art. 1-3 (B.O.E. 2007, 159) (Spain); Consolidated Version of the Treaty on European Union, art. 81-82, Dec. 29, 2006 O.J. (C 321) 1, 73-75; see also Andrew Ward & Carmen Hernández, *Clemencia y Sanciones*, in LA LEY DE DEFENSA DE LA COMPETENCIA: BALANCE DE SU APLICACIÓN 251, 252 (Sergio Baches ed., 2010). *But see* Begoña Barrantes, *Dos Años de Aplicación del Artículo 1 de la Ley 15/2007, de 3 de Julio, de Defensa de la Competencia: Balance y Asuntos Más Destacados*, in LA LEY DE DEFENSA DE LA COMPETENCIA: BALANCE DE SU APLICACIÓN 127, 157-59 (Sergio Baches ed., 2010) (criticizing the application of the NCC Communication in this case).

<sup>56</sup> See NCC Decennial IDI Resolution, *supra* note 1, at 4-5.

<sup>57</sup> See *id.* at 5.

considered an aggravating factor.<sup>58</sup> Similarly, aggravating circumstances were considered in the case of the reinsurer SCOR due its boycott of MUSAAT, as well as in the cases of Suiza<sup>59</sup> and MÜNCHENER. Only MAPFRE was not considered to have been involved in any aggravating circumstances.<sup>60</sup> No attenuating circumstances were considered for any of the cartel participants. Table 3 details the final amount of fines imposed to each company. For now, it suffices to say that, if NCC estimations are correct, the total amount of fines imposed (€120,728,000) is only half the amount of the harm inflicted to the victims (which, according to the data provided by the NCC, would amount to €242,436,072, *see supra* Table 2). If the data used by the NCC is accurate, the fines are far below both the illegal profits and the consumer harm.

TABLE 3. FINE CALCULATION

Companies	Basis (€)	Amount of fine (€)
Asefa	25,235,000	27,759,000
MAPFRE Empresas/ MAPFRE RE	21,632,000	21,632,000
Caser	12,947,000	14,241,000
SCOR	16,908,000	18,599,000
MÜNCHENER	15,101,000	15,856,000
Suiza /Swiss Re	21,563,000	22,641,000

Source: NCC Decennial IDI Resolution

The companies considered the fines to be disproportionately large, and have rushed to appeal the fines imposed to the competent judicial court (*Audiencia Nacional*) on several grounds. The fate that awaits the NCC resolution is still unknown. Recently, several fines imposed by the NCC

<sup>58</sup> *See supra* note 25. The implication of Caser in the cartel may be one of the weakest points of the NCC Resolution. Proportionally, it got a larger fine than its fellow cartel members, specially bearing in mind it only took part in the last two years of the cartel.

<sup>59</sup> *See* NCC Decennial IDI Resolution, *supra* note 1, Legal Ground 8th, at 66-68 (justifying why Suiza, being a wholly owned subsidiary of Swiss Re, should be considered responsible together and inseparably with the latter, and only one fine was imposed to them).

<sup>60</sup> *See* NCC Decennial IDI Resolution, *supra* note 1, Legal Ground 9th, at 68-69.

have been repealed and lowered by the National Court and/or the Supreme Court.

On the other hand, and somewhat unexpectedly, the NCC resolution did not fuel any damage claims in court against cartel members. This dearth of private claims for damages is puzzling and revealing, not only due to the weak competition culture and the difficulties still faced for private enforcement of competition law in Spain, but also because of the specific features and intricacies of the decennial insurance cartel that may well hamper judicial claims for damage compensation against conspiring insurers and reinsurers.<sup>61</sup>

## V. CONCLUSION

This article has analyzed the property insurance cartel that operated in Spain from 2002 to 2007. Insurance and reinsurance firms active in the Spanish property insurance market promoted it as a reaction to increased competition in the market after IDI was required by law in 2000. Understanding the cartel organization, as well as its dynamics and effectiveness, underlines the role of reinsurance companies as the monitors and enforcers of the minimum pricing agreement. By restricting reinsurance contracts available to proportional share treaties, reinsurers (SCOR, MÜNCHENER and Suiza/Swiss Re) exerted total control over the IDI direct insurance market, contributing greatly to the minimum pricing conditions agreed to by some insurers (Asefa, MAPFRE and Caser). The Spanish NCC uncovered the cartel in 2007 and imposed fines totaling more than €120 million to the companies.

The cartel owed its origin to the imposition of mandatory decennial insurance in 2000, but the characteristics of the close relationship among insurance companies and reinsurers in this context and sectorial regulation in the matter favored the creation and development of a perfect conspiracy to restrain competition in the Spanish market for property insurance.

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<sup>61</sup> See Francisco Marcos, *Why There Might Not Be Many Damage Claims Arising From the Spanish Property Insurance Cartel?*, in PRIVATE ENFORCEMENT OF COMPETITION LAW, 303, 319-30 (Velasco San Pedro et al. eds., 2011).

# NOT IN THE FINE PRINT: RECOMMENDED CHANGES TO LIFE INSURANCE POLICY DISCLOSURES REGARDING RETAINED ASSET ACCOUNTS

MICHAEL A. BARRESE\*

## I. INTRODUCTION

Tom is the primary breadwinner of his family. In order to protect his wife and children financially in the event that he passes away, he goes online and researches life insurance policies. After becoming familiar with the different forms of life insurance, Tom purchases a \$250,000 life insurance policy from a large insurance company. When he purchases the policy, he makes his wife, Melissa, the primary beneficiary. Under the policy, in the event that Tom dies, Melissa is entitled to a lump-sum \$250,000 payment.

Six months after purchasing the policy Tom dies in a car accident. Melissa, as beneficiary, is entitled to a lump sum \$250,000 payment per the terms of the policy. In the past, this would have been no problem, the insurance company would merely write the \$250,000 check to Melissa. However, in 1984, something changed.<sup>1</sup> Some large insurance companies rolled out a new form of payment, the Retained Asset Account.

Retained Asset Accounts (“RAAs”) are created when life insurance carriers provide the beneficiary of a life insurance policy with a pseudo-checkbook instead of a single lump sum check.<sup>2</sup> Instead of being paid out with a check for the entire amount of the life insurance policy, the proceeds are placed into the insurer’s general corporate account from which the beneficiary can draft funds with the use of the pseudo-checkbook.<sup>3</sup>

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<sup>1</sup> ADVOCATE LAW GROUP P.C., RETAINED ASSET ACCOUNTS, <http://www.retainedassetaccounts.com/> (last visited Mar. 18, 2012).

<sup>2</sup> *Id.*

<sup>3</sup> David Evans, *Fallen Soldiers' Families Denied Cash as Insurers Profit*, BLOOMBERG, (July 28, 2010, 10:00 AM), <http://www.bloomberg.com/news/2010-07-28/fallen-soldiers-families-denied-cash-payout-as-life-insurers-boost-profit.html> (“The ‘checks’ that Cindy Lohman wrote, the ones rejected by retailers, were actually drafts, or IOUs, issued by Prudential. Even though the ‘checks’ had

Because of this change, Melissa does not receive a lump-sum payment; rather she receives a pseudo-checkbook from the insurance company that appears to be drawn from Bank A. Confused by this, Melissa reads the policy disclosure and learns that this pseudo-checkbook entitles her to write checks against the Retained Asset Account up to the value of the insurance policy. With this knowledge, Melissa realizes that she has some options. She can write a pseudo-check for the full amount of the policy and deposit it into her own bank account or she can leave the funds, in whole or in part, in the Retained Asset Account until she has an immediate need for them.

As it turns out, the insurance company has not deposited any of Melissa's funds into an account at Bank A. Instead, the funds were deposited in the insurance company's corporate account at Bank C. When Melissa attempts to deposit a pseudo-check at her bank, Bank B, there is a delay. The delay is caused by the clearing process that the pseudo-check has to go through in order to be deposited. Instead of Bank B drawing the funds directly from Bank A, Bank B must go to the insurance company who then requests the release of funds from Bank C to Bank B. At the end of the day, Melissa still gets the money she is owed, it just takes longer than it would have if she had received an ordinary check for the full amount of the policy from the start.

The practice of providing Retained Asset Accounts in lieu of a lump-sum check was critically described in the article "Fallen Soldiers' Families Denied Cash as Insurers Profit," by Bloomberg journalist, David Evans.<sup>4</sup> The issue made its way into other media outlets and eventually lawsuits were filed in Federal District Court regarding the policy disclosures and administration of the Retained Asset Accounts.

This note expands upon the discussion in the mainstream media by presenting a description of both benefits and criticisms of Retained Asset Accounts as well as recommendations for changes to policy disclosures that would improve the image of this type of account. In Section II, the paper discusses the benefits and criticisms of Retained Asset Accounts. In Section III, disclosure issues are identified and solutions are presented. The note concludes that there are benefits to both the beneficiaries and to the insurance companies but there are also components of Retained Asset Accounts that are questionable and need to change. Because of these

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the name of JPMorgan Chase & Co. on them, Lohman's funds weren't in that bank; they were held by Prudential. Before a check could clear, Prudential would have to send money to JPMorgan, bank spokesman John Murray says.").

<sup>4</sup> *Id.*

questionable components of Retained Asset Accounts, it would be wise for insurance companies to improve their disclosure statements regarding Retained Asset Accounts in order to avoid both bad publicity and potential litigation.

## II. RETAINED ASSET ACCOUNTS

In 2010, insurance companies had over \$28 billion invested in Retained Asset Accounts.<sup>5</sup> Metropolitan Life Insurance Company (“MetLife”) alone had 36 percent of that total and makes an estimated \$100 to \$300 million a year on Retained Asset Accounts.<sup>6</sup>

Retained Asset Accounts are created when an insurance company “pays the proceeds from a life insurance policy or annuity contract to a beneficiary by sending the beneficiary ‘a checkbook instead of a check.’”<sup>7</sup> For example, if a life insurance policy is supposed to be paid in a lump-sum, instead of sending a check for the full amount of the policy, the insurance company will send a pseudo-checkbook that permits the beneficiary to write pseudo-checks (drafts) against the Retained Asset Account.

### A. BENEFITS

While the mainstream media has provided several articles criticizing Retained Asset Accounts, there are some benefits to using them to pay life insurance benefits to beneficiaries.

First, the intention behind RAAs was to give beneficiaries immediate access to the proceeds from insurance policies.<sup>8</sup> Traditionally, lump sum checks issued by insurance companies took two weeks to clear once deposited in the beneficiary’s bank account.<sup>9</sup> By providing the pseudo-checks attached to a Retained Asset Account insurance companies were, in effect, providing easier access to funds at the time families needed

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<sup>5</sup> *Id.*

<sup>6</sup> *Id.* (“Gerry Goldsholle, the man who invented retained-asset accounts, says MetLife makes \$100 million to \$300 million a year from investment returns on the death benefits it holds. A former president of MetLife Marketing Corp., Goldsholle, 69, devised the accounts in 1984.”).

<sup>7</sup> ADVOCATE LAW GROUP P.C., RETAINED ASSET ACCOUNTS, *supra* note 1.

<sup>8</sup> ADVOCATE LAW GROUP P.C., *Benefits of Retained Asset Accounts*, RETAINED ASSET ACCOUNTS, <http://www.retainedassetaccounts.com/benefits-of-retained-asset-accounts.htm> (last visited Mar. 18, 2012).

<sup>9</sup> *Id.*

it most. The immediate use of funds is not possible under the traditional single lump-sum check payment method.<sup>10</sup>

Second, RAAs provide continuous interest payments to beneficiaries as soon as the claim is approved and until the beneficiary withdraws all of the money they are entitled to.<sup>11</sup> As previously stated, it takes several weeks for a bank to clear a single lump-sum check, the clearing time effectively reduces the interest that can be earned on the lump sum payment. Combine this delay with the mailing delay of the check and RAAs pay interest on the funds for a longer period than a single lump-sum check. RAAs also allow the beneficiary to move the funds into higher yield accounts more quickly than they could with a single lump-sum check.

As originally designed, insurance companies guaranteed that RAAs would pay beneficiaries and interest rate that was equal to or greater than the average rate paid “banks and money market mutual funds on similar accounts.”<sup>12</sup> In addition to guaranteeing a level of payment equal to or greater than bank rates, the insurance company also provided a floor, below which interest rates on RAAs would not fall.<sup>13</sup> In the current economic climate, this floor provides significant upside for RAAs due to extremely low interest rates on regular bank accounts.

In addition, RAAs were designed with consumer protection in mind. Instead of relying solely on the insurance company to back the accounts, they were designed to also be insured by State Sponsored Guarantee Associations (“SSGA”).<sup>14</sup> While it is not FDIC insurance, State Sponsored Guaranty Associations do provide some protection against insurance company insolvency.

Finally, RAAs were designed in the mold of a standard bank account. They would pay interest, provide monthly statements and also provide mutual benefit to the beneficiary and insurance company that maintained the account.<sup>15</sup> In order to provide a return to beneficiaries, the insurance company has to use their funds to make money, similar to how a bank lends out money from a savings account at an interest rate higher than it pays to account holders.

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<sup>10</sup> *Id.*

<sup>11</sup> *Id.*

<sup>12</sup> *Id.*; AMERICAN COUNCIL OF LIFE INSURERS, *About Retained Asset Accounts*, (July 29, 2010), available at <http://www.acli.com/Newsroom/Documents/80af916fc317435cb9340a17bdbaf052AboutRetainedAssetAccounts.pdf>.

<sup>13</sup> AMERICAN COUNCIL OF LIFE INSURERS, *supra* note 12.

<sup>14</sup> ADVOCATE LAW GROUP P.C., *Benefits of Retained Asset Accounts*, *supra* note 8.

<sup>15</sup> *Id.*

## B. CRITICISMS

Journalistic criticisms present several important questions about RAAs, these include: whether RAAs are a permitted distribution method per the initial contract with the policyholder; do beneficiaries understand how RAAs operate as a payment option; is interest paid on the funds in the RAA and, if so, is the rate competitive with financial alternatives; and are they as safe as depositing the funds into an FDIC insured bank account, a common alternative available to beneficiaries.

One problem highlighted in the journalistic efforts is the claim that insurance companies provide beneficiaries with pseudo-checks that the beneficiary believes to be the same as a check from their bank. What the insurance companies actually provide are drafts. Several beneficiaries have encountered difficulties when trying to use these drafts as several retailers have rejected the beneficiary's draft even though the Retained Asset Account had more than enough money in it to cover the transaction.<sup>16</sup> It has been suggested that beneficiaries do not generally understand that the funds in RAAs are not readily available for payment in the bank against which the pseudo-checks are drawn. This is based on the perception that insurance companies have intentionally refrained from disclosing important facts regarding Retained Asset Accounts.

Instead of paying the entire policy benefit in one lump sum payment, the RAA scheme permits life insurance companies to retain the funds in their general account and provide beneficiaries with a book of drafts.<sup>17</sup> The drafts are issued against the insurance company's general corporate account rather than an individual beneficiary account.<sup>18</sup> This scheme permits the life insurance company to retain substantial funds in their general corporate account, an account that earned over 4% interest in 2010.<sup>19</sup> While all of the insurance providers pay interest on the accounts, and several pay more than the average Money Market Account,<sup>20</sup>

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<sup>16</sup> Evans, *supra* note 3.

<sup>17</sup> *Id.*

<sup>18</sup> *Id.*

<sup>19</sup> *Id.*

<sup>20</sup> *Money Market Definition*, INVESTOPEDIA.COM, <http://www.investopedia.com/terms/m/moneymarket.asp>, (last visited Mar. 18, 2012) ("The money market is used by a wide array of participants, from a company raising money by selling commercial paper into the market to an investor purchasing CDs as a safe place to park money in the short term. The money market is typically seen as a safe place to put money due the highly liquid nature of the securities and short maturities, but



journalists have called attention to the spread between the return the insurance provider receives on its investment and the amount of interest it pays beneficiaries.<sup>21</sup> “Prudential’s general account earned 4.4 percent in 2009, mostly from bond investments, according to SEC filings. The company has paid survivors 0.5 percent in 2010.” Met Life also paid approximately 0.5 percent to beneficiaries with Retained Asset Accounts, a rate that was less than half the rate paid in some banks. The fact that there is a spread between the interest paid to beneficiaries and the earnings from retained funds by the life insurer is no different from the fact that any firm in the financial sector holding funds for an investor attempts to earn more on the retained funds than they pay to the investor. In order to be a valid criticism, it would have to be based on evidence that the risk-adjusted return to the RAA beneficiary is not sufficient and disclosed. The evidence suggests that some of the largest life insurance companies paid between 0.5% and 1.5% interest to beneficiaries on the retained RAA funds during between 2008 and 2010.<sup>22</sup> In addition to paying lower interest rates, if the money were put in a bank, it would be insured by the FDIC up to two hundred fifty thousand dollars (\$250,000).<sup>23</sup>

By comparison, banks paid between 0.1% and 4.0% on their FDIC insured money market accounts during this same period.<sup>24</sup> RAA funds are offered some protection against insolvency by industry solvency protection plans but few non-governmental insurance plans match the risk protection provided in the government’s FDIC plan. The level of protection against the insolvency of the insurer is another question that leads to criticism of industry disclosure practices.

While not relevant to the purpose of this paper, two similar classes of Retained Asset Accounts have been identified by the mainstream media; beneficiaries of military policies and beneficiaries of non-military policies. The main difference lies in the fact that military personnel *have* to use Prudential for their life insurance needs while non-military policyholders can get insurance from any insurance company that is legally able to offer life insurance in the state. Again, while not important for the purposes of

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there are risks in the market that any investor needs to be aware of including the risk of default on securities such as commercial paper.”).

<sup>21</sup> Evans, *supra* note 3.

<sup>22</sup> *Id.*

<sup>23</sup> *Id.*

<sup>24</sup> *Online Savings Account Interest Rates History*, THE SUNS FINANCIAL DIARY.COM (Jan. 21, 2009), <http://www.thesunfinancialdiary.com/personal-finance/online-savings-account-interest-rates-history>.

this paper, the journalistic attention to RAAs appears to be stimulated by attention to the effect on the families of military personnel.<sup>25</sup>

Retained Asset Accounts are seen by the providers as a useful to beneficiaries, giving them time to think about what they want to do with the money they have received instead of having a single check which they “could lose” weighing heavily on them.<sup>26</sup> Insurance companies have been quick to point out that a beneficiary can withdraw all of the money in the account whenever they want, even on the day they receive the pseudo-checkbook. However, the insurance company has not adequately disclosed important information including the potential delay for each pseudo-check to clear, that the checks may not be widely accepted by retailers, and that holding funds in Retained Asset Accounts benefits the insurance company itself.<sup>27</sup>

Through proper disclosure, the insurance companies offering RAAs can reduce the misperception that beneficiaries think they are receiving their own personal account similar to that which they can obtain from their local bank. Insurers need to make a better effort to ensure that beneficiaries understand that instead of a single “lump sum” payment drawn on funds deposited in a bank account they receive a right to make a request for funds held in the insurance company’s general corporate account without the security of FDIC insurance and used by the insurer for their corporate purposes until the beneficiary has closed the account by withdrawing all of the remaining funds due.

While there is likely no quantifiable harm done by lack of disclosure regarding Retained Asset Accounts and thus there will be no ability for beneficiaries to recover damages in court from this failure to disclose pertinent information to policy holders and beneficiaries until there is a failure of the insurance provider, regulatory agencies should still require clear and concise disclosure of the actual nature and extent of insurance backing of Retained Asset Accounts for the benefit of the reputation of the industry generally.

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<sup>25</sup> Evans, *supra* note 3.

<sup>26</sup> Bloomberg News, *V.A. Agreed to Withholding of Benefits, Documents Say*, N.Y. TIMES, Sept. 13, 2010, available at [http://www.nytimes.com/2010/09/14/business/14insure.html?\\_r=1&src=twr](http://www.nytimes.com/2010/09/14/business/14insure.html?_r=1&src=twr).

<sup>27</sup> *Id.*

## 1. Federal Deposit Insurance Corporation

The Federal Deposit Insurance Corporation (“FDIC”) is an independent corporation that insures deposits in banks and thrift institutions against failure.<sup>28</sup> The FDIC was created as part of the Glass-Steagall Act of 1933 in response to the over nine thousand bank failures during the Great Depression.<sup>29</sup> The FDIC insures deposit accounts for up to two hundred fifty thousand dollars (\$250,000) per individual, per bank.<sup>30</sup> An individual could put \$1 million in a single FDIC insured bank and be covered for only \$250,000 of that sum or that same individual could spread that \$1 million into 4 or more FDIC insured banks and be insured for the entire \$1 million. The FDIC does have ways to receive more than \$250,000 worth of coverage at one bank provided certain criteria are met, such as having accounts in different asset categories.<sup>31</sup>

**Example 1: Single Account** (owned by one person): \$250,000 per owner.<sup>32</sup>

<b>Example of Insurance Coverage for Single Accounts<sup>33</sup></b>		
<b>Depositor</b>	<b>Type of Deposit</b>	<b>Amount Deposited</b>
Jane Smith	Savings account	\$25,000
Jane Smith	Certificate of Deposit	\$250,000
Jane Smith	NOW account	\$50,000
Jane Smith's sole proprietorship	Checking account	\$50,000
<b>Total Deposited</b>		<b>\$375,000</b>

<sup>28</sup> *Who is the FDIC?*, FED. DEPOSIT INS. CORP., <http://www.fdic.gov/about/learn/symbol/index> (last updated Aug. 11, 2011).

<sup>29</sup> Robert Stammers, *The History of the FDIC*, INVESTOPEDIA.COM (Jan. 6, 2009), <http://www.investopedia.com/articles/economics/09/fdic-history.asp>.

<sup>30</sup> *Who is the FDIC?*, *supra* note 28.

<sup>31</sup> *Deposit Insurance FAQ*, FED. DEPOSIT INS. CORP., [https://www.fdic.gov/edie/fdic\\_info.html](https://www.fdic.gov/edie/fdic_info.html) (last visited Jan. 21, 2011).

<sup>32</sup> *Id.*

<sup>33</sup> *Id.*

<b>Insurance Available</b>	<b>\$250,000</b>
<b>Uninsured Amount</b>	<b>\$125,000</b>

The FDIC is funded through premiums paid by banks and thrifts and from earnings on U.S. Treasury Securities.<sup>34</sup> These premiums are paid regularly and go into what is described by some as a “war chest”.<sup>35</sup> “To provide an effective banking safety net, it is necessary for the FDIC to replace cash (of the failed bank) with cash from the FDIC at the moment the bank fails.”<sup>36</sup> The FDIC insures traditional bank accounts, savings, checking, trust, certificates of deposit (“CDs”), money market savings accounts and IRA accounts.<sup>37</sup> Since its creation in 1934, no depositor insured by the FDIC has lost a single penny of insured funds as a result of a bank failure.<sup>38</sup> It is because of this success that the FDIC has gained such prominence and respect from individuals and businesses alike. A further discussion of more complex formations for FDIC coverage is discussed in the Appendix.

## 2. State Sponsored Guaranty Associations

The Metropolitan Life Insurance Company observed that the financial integrity of Retained Asset Accounts is provided primarily by the company’s own financial strength but also through state insurance guaranty associations.<sup>39</sup> Like the banking industry, the insurance industry offers protection against the insolvency of an insurer. The insurance industry protection, however, is not a nationally uniform system like the FDIC is. This section describes some pertinent issues of the so-called State Sponsored Guaranty Associations. This issue important because Retained

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<sup>34</sup> *Id.*

<sup>35</sup> Peter G. Gallanis, President, Nat’l Org. of Life and Health Ins. Guar. Ass’n, Address at the American Bar Association’s Insurer Relationship and Run-off: The Next Level, Tort Trial & Insurance Practice Session: NOLHGA, the Life and Health Insurance Guaranty System and the Financial Crisis of 2008-2009, at 9 (June 5, 2009), available at <http://www.nolhga.com/resource/file/NOLHGAandFinancialCrisis.pdf>.

<sup>36</sup> *Id.* at 10.

<sup>37</sup> *Insured or Not Insured?*, FED. DEPOSIT INS. CORP., <http://www.fdic.gov/consumers/consumer/information/fdiciorn.html> (last updated Apr. 11, 2011).

<sup>38</sup> *Who is the FDIC?*, *supra* note 28.

<sup>39</sup> Evans, *supra* note 3.

Asset Accounts are not insured by the FDIC and there is an open question about whether they are insured by SSGAs.

In a letter written by FDIC Chairman Sheila C. Bair to the National Association of Insurance Commissioners (“NAIC”), Ms. Bair expressly denied the fact that Retained Asset Accounts were insured by the FDIC.<sup>40</sup> The letter indicated that the only way Retained Asset Accounts could be insured by the FDIC is if the insurance company is holding the funds as a Fiduciary to the policyholders and beneficiaries.<sup>41</sup> In *Clark v. Metropolitan Life Ins. Co.*, the plaintiff filed a claim against Met Life for breach of fiduciary duty.<sup>42</sup> The claim was summarily dismissed when Met Life submitted a motion to dismiss on the issue indicating that the insurance company is not acting as a fiduciary in maintaining RAAs for beneficiaries.<sup>43</sup>

The National Organization of Life & Health Insurance Guaranty Associations (“NOLHGA”) and State Sponsored Guaranty Associations, on the other hand, have been providing “security” for RAAs since 1983.<sup>44</sup> NOLHGA is “a voluntary association made up of the life and health insurance guaranty associations of all 50 states, the District of Columbia and Puerto Rico.”<sup>45</sup>

State Sponsored Guaranty Associations “were created to protect state residents who are policyholders and beneficiaries of policies issued by a life or health insurance company that has gone out of business.”<sup>46</sup> Most insurance companies licensed to write life and health insurance or annuities in a given state are required to be members of the state’s SSGA.<sup>47</sup> Should one of these companies fail, the SSGA issues an assessment for funds to continue the coverage promised by the failing insurance company subject

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<sup>40</sup> *Retained Asset Accounts and FDIC Deposit Insurance Coverage*, FED. DEPOSIT INS. CORP. <http://www.fdic.gov/news/news/financial/2010/fil10048.html> (last updated Aug. 11, 2010).

<sup>41</sup> *Id.*

<sup>42</sup> *Clark v. Metro. Life Ins. Co.*, No. 3:08-cv-00158-LRH-VPC, 2010 U.S. Dist. LEXIS 95097, at \*19 (D. Nev. Sept. 10, 2010).

<sup>43</sup> *Id.*

<sup>44</sup> *Facts & Figures*, NAT’L ORG. OF LIFE AND HEALTH INS. GUAR. ASS’NS, <http://www.nolhga.com/factsandfigures/main.cfm> (last visited Jan. 21, 2011).

<sup>45</sup> *Id.*

<sup>46</sup> *Policy Holder Information: Frequently Asked Questions*, NAT’L ORG. OF LIFE AND HEALTH INS. GUAR. ASS’NS, <http://www.nolhga.com/policyholderinfo/main.cfm/location/questions> (last visited Jan. 21, 2011).

<sup>47</sup> Gallanis, *supra* note 35, at 3.

to the limits of the SSGA.<sup>48</sup> Unlike the FDIC, State Sponsored Guaranty Associations do not collect funds on the national level; instead they are collected only in the state of the failing insurance company and collections are based upon the market share of insurance companies from the previous year.<sup>49</sup> This has led some commentators to raise concerns about the sufficiency of the funds if some of the larger suppliers of life insurance were to fail.<sup>50</sup>

Each SSGA “is authorized by its enabling statute to assess and collect, from insurance companies writing covered lines of business in the state (the Guaranty Association’s ‘member insurers’), the amount needed to satisfy the Guaranty Association’s obligations to policyholders.”<sup>51</sup> Due to funding constraints, the limits of the SSGA may be lower than the limits of the failed insurer’s contract.<sup>52</sup> The fact that the SSGA limits to the amount of coverage they will continue is not unlike the fact that the FDIC limits the return to a failed bank depositor. However, unlike the coverage provided by the FDIC, there is no national standard for SSGA coverage. SSGA coverage limits are established by state law and vary from state to state.<sup>53</sup> In the area of life-health insurance, most states provide at least the following coverage:

\$300,000 in life insurance death benefits  
\$100,000 in cash surrender or withdrawal values for life insurance  
\$100,000 in withdrawal and cash values for annuities  
\$100,000 in health insurance policy benefits<sup>54</sup>

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<sup>48</sup> Advisory Commission on Intergovernmental Relations, STATE SOLVENCY REGULATION OF PROPERTY-CASUALTY AND LIFE INSURANCE COMPANIES 68 (Dec. 1992).

<sup>49</sup> *National Organization of Life and Health Insurance Guaranty Associations*, INVESTOPEDIA.COM, <http://www.investopedia.com/terms/n/nolhga.asp> (last visited Jan. 21, 2011).

<sup>50</sup> *Id.*

<sup>51</sup> Gallanis, *supra* note 35, at 9.

<sup>52</sup> *Id.*

<sup>53</sup> The National Organization of Life and Health Insurance Guaranty Associations and The National Conference of Insurance Guaranty Funds, *Joint Comments of NOLHGA and NCIGF in Response to FIO’s Request for Public Input*, <http://www.nolhga.com/pressroom/articles/NOLHGA-NCIGF%20FIO%20SUBMISSION.PDF>.

<sup>54</sup> *Policy Holder Information*, *supra* note 46; AMERICAN COUNSEL OF LIFE INSURERS, *supra* note 12.

In the event that an insurer is judged by regulators to be insolvent, the legal process of liquidation begins. The liquidation process allows the sale of the firms' assets and the use of the funds raised to pay liabilities. If and when the funds are not sufficient to pay liabilities, the SSGA supplies necessary funds from assessments on in-state insurers.<sup>55</sup> The SSGA member companies are obligated to pay the assessments, however the assessments, which are generally allocated based on the firm's market share from the previous year within the state and are generally limited to a maximum of 2% of collected premiums in the prior year.<sup>56</sup> With the exception of New York State, SSGAs do not have an FDIC style "war chest" available ready to pay claims *before* a company fails.<sup>57</sup> The SSGA's funding comes from assessments that are collected only when are needed. In other words funds are only collected *after* a failure occurs and income from the sale of firm assets is depleted.<sup>58</sup> The FDIC needs the war chest because bank accounts and checking accounts are "demand obligations" whereas life insurance and annuity products are generally promises to pay in the future.<sup>59</sup> Given that RAAs are modeled after standard bank accounts, it stands to reason that SSGAs should have a war chest to cover on demand obligations from holders of RAAs.

Like bank depositors, in order to recover the difference in coverage limits and contractual benefits, the policyholder would have to file suit against the estate of the failed insurance company and get in line behind all other creditors to receive a potential payout when the failed company's

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<sup>55</sup> *State Laws and Provisions Report*, NAT'L ORG. OF LIFE AND HEALTH INS. GUAR. ASS'NS, <http://www.nolhga.com/policyholderinfo/main.cfm/location/questions> (last updated Dec. 31, 2011).

<sup>56</sup> *Id.* (Rhode Island maxes out at 3% and North and South Carolina max out at 4%); *Joint Comments of NOLHGA and NCIGF in Response to FIO's Request for Public Input*, NAT'L ORG. OF LIFE AND HEALTH INS. GUAR. ASS'NS, <http://www.nolhga.com/pressroom/articles/NOLHGA-NCIGF%20FIO%20SUBMISSION.PDF>.

<sup>57</sup> Gallanis, *supra* note 35, at 9.

<sup>58</sup> *Id.*

<sup>59</sup> *Id.*; *see also* Evans, *supra* note 3 (If one insurer is unable to meet its obligations, people could lose faith and demand payment from other companies triggering a panic similar to a bank run. The purpose of the FDIC was to put an end to bank runs, allowing insurance companies to act like this with Retained Asset Accounts could set the economy up for another failure due to an inability of insurance companies to meet their payment obligations should people lose faith in the system and demand immediate payment on their "accounts.").

assets are liquidated.<sup>60</sup> The likelihood of any significant recovery by a policyholder or beneficiary in this situation is very small.

### 3. The Financial Strength of the Insurance Company

As previously discussed, Retained Asset Accounts are not FDIC insured. Instead, the primary “insurance” for RAAs is the financial strength of the insurance company.<sup>61</sup> In light of recent economic events, including the scandals involving Enron, WorldCom, AIG, and Lehman Brothers among others, corporate assurances of financial might does little to instill confidence in beneficiaries.<sup>62</sup>

Perhaps the most well known example of why CEOs and corporate executives are not trusted by investors and the general public is the failure of Enron. Once a tremendous economic success, Enron’s misrepresentation of its finances almost singlehandedly led to a nationwide recession. Between 1997 and 2001 Enron claimed substantial growth in annual profits.<sup>63</sup> Media outlets and financial analysts applauded Enron for its success only to learn later that it was all a sham.<sup>64</sup> In the end, even Enron had to admit that “[f]inancial statements for [1997 through the first two quarters of 2001] and the audit reports relating to the year-end financial statements for 1997 through 2000 should not be relied upon.”<sup>65</sup>

Unfortunately analysts and investors did not hesitate to consider the complexity of Enron’s financial statements before investing and they paid dearly for the trust they put in the public statements of Enron’s Chief Officers.<sup>66</sup>

After Enron collapsed, WorldCom pushed the economy down further with its own series of questionable accounting decisions. Between 1999 and 2002 WorldCom used “shady accounting methods” to make its

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<sup>60</sup> Gallanis, *supra* note 35, at 2.

<sup>61</sup> *Id.*

<sup>62</sup> See Penelope Patsuris, *The Corporate Scandal Sheet*, FORBES (Aug. 26, 2002), <http://www.forbes.com/2002/07/25/accountingtracker.html> (for an in-depth look at the corporate scandals of the late 1990s and early 2000s).

<sup>63</sup> Dan Ackman, *Enron Says, ‘Oops’*, FORBES (Nov. 9, 2001), <http://www.forbes.com/2001/11/09/1109topnews.html>.

<sup>64</sup> Howard Kurtz, *The Enron Story That Waited to be Told*, WASH. POST (Jan. 18, 2002), <http://www.washingtonpost.com/wp-dyn/articles/A64769-2002Jan17.html>.

<sup>65</sup> Ackman, *supra* note 63.

<sup>66</sup> Kurtz, *supra* note 64.



books look better than they were.<sup>67</sup> WorldCom accomplished this fraud in two ways. First, their accounting department “underreported ‘line costs’ (interconnection expenses with other telecommunication companies) by capitalizing these costs on the balance sheet rather than properly expensing them.”<sup>68</sup> Second, WorldCom would inflate their revenues by using falsified accounting entries “from ‘corporate unallocated revenue accounts.’”<sup>69</sup> On July 21, 2002, WorldCom filed for Chapter 11 bankruptcy in what would be the largest such bankruptcy filing in the history of the United States.<sup>70</sup> In 2003, it was “estimated that the company’s assets had been overstated by \$11 billion.”<sup>71</sup>

The failure of Enron, WorldCom and many others are examples of why Met Life’s assurances that their policies are insured by the financial strength of the company are not going to reassure investors and beneficiaries.<sup>72</sup> While these assurances may have meant something to investors in the early 1990s, because of the misstatements by others, these statements no longer hold water with investors and beneficiaries. This may be unfair, but it is true none-the-less. Because of this, insurance companies need to do more to inform beneficiaries about their products, specifically about RAAs.

In 1990, the House Subcommittee on Oversight & Investigations and the House Committee on Energy & Commerce investigated and reported on the current status of the regulation of insurance companies and on the financial condition of the insurance industry.<sup>73</sup> The report is known as the Dingell Report: Failed Promises. The House Committee indicated in this report that financial failures in insurance companies come with

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<sup>67</sup> *WorldCom Scandal: A Look Back at One of the Biggest Corporate Scandals in U.S. History*, YAHOO ASSOCIATED CONTENT, [http://www.associatedcontent.com/article/162656/worldcom\\_scandal\\_a\\_look\\_back\\_at\\_one.html](http://www.associatedcontent.com/article/162656/worldcom_scandal_a_look_back_at_one.html) (last visited Jan. 21, 2011).

<sup>68</sup> *Id.*

<sup>69</sup> *Id.*

<sup>70</sup> *Id.*; Luisa Beltran, *WorldCom Files Largest Bankruptcy Ever: Nation’s No. 2 Long-Distance Company in Chapter 11 – Largest with \$107 Billion in Assets*, CNN MONEY (July 22, 2002), [http://money.cnn.com/2002/07/19/news/worldcom\\_bankruptcy/](http://money.cnn.com/2002/07/19/news/worldcom_bankruptcy/).

<sup>71</sup> *WorldCom Scandal: A Look Back at One of the Biggest Corporate Scandals*, *supra* at note 67.

<sup>72</sup> Evans, *supra* note 3.

<sup>73</sup> *Id.*

consistent elements.<sup>74</sup> These elements are: “rapid expansion, over-reliance on managing general agents, extensive and complex reinsurance arrangements, excessive under-pricing, reserve problems, false reports, reckless management, gross incompetence, fraudulent activity, greed, and self dealing.”<sup>75</sup> According to the report, the following list contains the primary causes of insurer insolvencies:

1. Inefficient, reckless, and deplorable middle and upper management, including personnel deficiencies;
2. Gross incompetence/bad business judgment;
3. Rapid and/or over expansion and diversification;
4. Over-reliance upon and a failure to monitor and supervise Managing General Agents (MGAs), including the improper delegation of responsibilities;
5. Expensive and complex reinsurance arrangements, including the problem of uncollectible reinsurance;
6. Excessive underpricing and inadequate pricing schemes;
7. Poor investment policies;
8. Inadequate reserve problems;
9. False financial reporting and fraudulent activity;
10. Greed and self-dealing;
11. Under-capitalization; and
12. Inadequate regulation by state regulators and/or independent public accounting firms, including the failure to identify and correct the insurer's problems.<sup>76</sup>

These issues consistently resulted in over-leveraged insurance companies that filed unclear or misleading statements of financial condition.<sup>77</sup> The

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<sup>74</sup> Steven W. Schwabb et al., *Caught Between Rocks and Hard Places: The Plight of Reinsurance Intermediaries Under U.S. and English Law*, 16 MICH. J. INT'L L. 485, 489 (1995); STAFF OF SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS, HOUSE COMM. ON ENERGY AND COMMERCE, 101st Cong., 2d Sess., FAILED PROMISES: INSURANCE COMPANY INSOLVENCIES 2 (Comm. Print 1990) [hereinafter COMMITTEE REPORT].

<sup>75</sup> COMMITTEE REPORT, *supra* note 74, at 2.

<sup>76</sup> COMMITTEE REPORT, *supra* note 74, at Opening remarks of Chairman Rep. John D. Dingell (D. MI.); David W. Evans & Paul S. Cohen, Professional Liability Targets in Cases of Insolvency: Directors and Officers, and Accountants, 580 PLI/Comm 157, 161-65 (1991).

Dingell Report also “cited the states' failure to regulate the reinsurance market as another significant cause of insolvencies.”<sup>78</sup> Specifically, the Dingell Report suggested that due to an absence of adequate supervision by state regulators, insurance companies maintained very low capital levels that could be manipulated as needed to continue operations.<sup>79</sup>

In addition to the Dingell Report, the Advisory Commission on Intergovernmental Affairs investigated the regulation of life insurance companies in 1992 and similarly found that capital reserves held by life insurance companies were not adequate given the level of business they were conducting during the period.<sup>80</sup> The Advisory Commission's report also notes that because insurance companies are able to predict their payout schedule with greater accuracy for life insurance policies than for other types of insurance, such as property-casualty insurance, life insurance companies are able to make more long term and speculative investments.<sup>81</sup>

Given the findings in the Dingell Report, the findings of the Advisory Commission, and the recent financial scandals at prominent companies such as Enron, WorldCom and AIG, it would be unwise to trust that the financial strength of an insurance company will insure Retained Asset Accounts against loss. Because of the criticisms discussed above, significant changes to policy disclosures should be made so that policyholders and beneficiaries are more aware of the pros and cons of holding funds in a Retained Asset Account.

### III. DISCLOSURE

The issue with RAAs is not necessarily whether the “accounts” are actually insured by the FDIC but the perception that life insurance companies have not adequately disclosed the fact that these so called accounts are not insured by the FDIC. While State Sponsored Guaranty

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<sup>77</sup> COMMITTEE REPORT, *supra* note 74, at Opening remarks of Chairman Rep. John D. Dingell (D. MI.).

<sup>78</sup> *Id.*; David W. Evans & Paul S. Cohen, Professional Liability Targets in Cases of Insolvency: Directors and Officers, and Accountants, 580 PLI/Comm 157, 161-65 (1991).

<sup>79</sup> John L. Ingersoll et al., Federal Regulation of Insurance: The Industry's Response to H.R. 4900 and H.R. 1290, 23 SPG Brief 10, 11-12 (1994).

<sup>80</sup> ADVISORY COMMISSION ON INTERGOVERNMENTAL RELATIONS: STATE SOLVENCY REGULATION OF PROPERTY-CASUALTY AND LIFE INSURANCE COMPANIES 53 (Dec. 1992).

<sup>81</sup> *Id.*

Associations often provide coverage of \$300,000 per life,<sup>82</sup> if an insurance company fails, there is both a question of whether the SSGA provides coverage for RAAs and the fact that some individuals are entitled to more than the amount provided by SSGAs and they will be forced to either take the loss or file suit against the failing insurance company in the hope that there will be enough money left over from liquidation to allow them to recover.<sup>83</sup>

The potential for beneficiaries such as the surviving spouse of a member of the Armed Forces to incur unanticipated losses or file suit against failed insurance companies are not ideal options for the beneficiary or the insurance industry. This is why adequate disclosure is necessary. With adequate disclosure beneficiaries are better able to appropriately assess the risks and rewards of the Retained Asset Account versus taking payment from the insurer and placing their money in a different and perhaps more secure investment such as a savings account, money market account or United States Treasury Bonds. Without appropriate disclosure individuals will not have sufficient information to make intelligent investment decisions.

Journalistic efforts suggest that insurance companies have presented Retained Asset Accounts to policy holders and beneficiaries as though they are Money Market Accounts or in the alternative as though they are accounts similar to bank accounts in that each beneficiary has their own account with their name on it where their money is deposited.<sup>84</sup> In *Clark v. Metropolitan Life Ins. Co.*, the issue of how Retained Asset Accounts are presented as though they are Money Market savings accounts was mentioned, but not thoroughly discussed.<sup>85</sup>

In their disclosure statements, Met Life's RAA is presented as the "Total Control Account Money Market Option."<sup>86</sup> In a recent suit over RAAs against Met Life, the U.S. District Court for the District of Nevada

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<sup>82</sup> *Facts & Figures*, *supra* note 44.

<sup>83</sup> *Policy Holder Information*, *supra* note 46.

<sup>84</sup> See *Clark v. Metro. Life Ins. Co.*, No. 3:08-cv-00158-LRH-VPC, 2010 U.S. Dist. LEXIS 95097, at \*2-14 (D. Nev. Sept. 10, 2010) (Met Life Retained Asset Accounts are formed when policy disbursements exceed \$5,000. The funds are placed in an account named the "Total Control Account Money Market Option" (TCA for short). The account name was found to be "inherently deceptive" due to its implication that the funds were in a Money Market Account or its equivalent and that they were FDIC insured.).

<sup>85</sup> *Id.* at \*12-13.

<sup>86</sup> *Id.*

found Met Life's use of the term Money Market "inherently deceptive."<sup>87</sup> The Court noted that using the term "Money Market" in their RAA description created the impression that the beneficiary would receive their own Money Market Account and that that account would be insured by the FDIC.<sup>88</sup> Although the court noted that the disclosure statement was "inherently deceptive," the court granted Met Life's motion for summary judgment because the beneficiary was unable to demonstrate suffering any harm from Met Life's breach.<sup>89</sup> The court limited its finding to the fact that because Met Life has not failed (been deemed insolvent by the SSGA), and thus the beneficiary had not lost any money, there was no recovery to be had.<sup>90</sup> While it did not decide the issue of RAA disclosure, it did lay the foundation for how courts will discuss Retained Asset Accounts in subsequent cases. If Met Life and other insurance companies continue to characterize RAAs as "money market" accounts, that name will likely be considered "inherently deceptive" by courts and in the event of a failure will likely result in a damage award. To avoid such a situation, it is in the best interest of insurance companies to correct the flaws in their disclosure statements that lead to criticisms of the true nature of their Retained Asset Accounts.

*Clark* appears to have been a wakeup call for Met Life. Starting in July 2010, twenty-five years after Met Life began using Retained Asset Accounts, the customer agreement signed by the policy holder disclosed that Retained Asset Accounts will, at least initially, hold funds for their beneficiaries and that Retained Asset Accounts are not the same as the money market accounts one might hold at a local bank. The section goes on to inform the policy holder that the Retained Asset Account that will be designated for the payout of their benefits will not be insured by the FDIC in any capacity.<sup>91</sup>

While MetLife's actions are certainly a step in the right direction, they are not the only life insurance company using these accounts. Every company in the industry can be tainted by the behavior of a few. As such, more needs to be done in regulating proper disclosure this area of the insurance industry in order to make sure there are proper safeguards against collapse and to educate "account" holders on what they are really getting

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<sup>87</sup> *Id.*

<sup>88</sup> *Id.*

<sup>89</sup> *Id.*

<sup>90</sup> *Clark*, 2010 U.S. Dist. LEXIS 95097, at \*12-13.

<sup>91</sup> Evans, *supra* note 3.

when and insurance company informs them that the proceeds from their policy will be paid through a Retained Asset Account.

#### IV. CONCLUSION

Retained Asset Accounts have been subject to significant criticism by the mainstream media, however their criticisms do not tell the whole story. While insurance companies have failed to make adequate disclosure regarding the nature of Retained Asset Accounts, the accounts do provide several benefits to both beneficiaries and the insurance company. It has been noted that Retained Asset Accounts are not traditional savings accounts, checking accounts, CDs, or money market accounts, but they are similar financial vehicles. The mainstream media has criticized RAAs because of the misperception that the insurance company is making this money off of benefits that were supposed to have been paid out to beneficiaries. While it is true that the benefits were supposed to be distributed to beneficiaries, RAAs pay competitive interest rates and provide beneficiaries with time to decide what to do with the funds distributed to the by the insurance company.

Instead of paying out benefits in the lump sum, life insurance companies have been sending draft books that allow beneficiaries to draw against the balance of the Retained Asset Account. While this does not immediately raise any concerns, the way insurance companies have disclosed the nature of RAAs is a serious issue. The RAA disclosure statements have not clearly identified what a Retained Asset Account is, how it is insured, the interest rate paid and how it differs from a conventional checking, savings or money market account. While to date the only harm that has come from these accounts is psychological and emotional, in the event of another financial downturn or simply the failure of a large insurance company, the threat of harm is great. Because of this, it would be wise for insurance companies to adequately disclose the various benefit payment options and to adequately describe these options, specifically Retained Asset Accounts, so that purchasers and beneficiaries understand what type of security they hold.

Although NOLHGA and the insurance industry discuss State Sponsored Guaranty Associations as an equal to FDIC insurance, this is not an accurate representation of the SSGA system. SSGAs do not provide the same type of coverage as the FDIC, nor do they have the same amount of money available to them at a moment's notice. SSGAs rely on contributions from non-failing insurance companies at the time of failure to support an insurance company's obligations while the FDIC relies on a

“war chest” made up of annual payments from banks into a central account to support its activities.<sup>92</sup>

Although the public statements of executives at insurance companies like Met Life indicate that SSGAs are a secondary insurance policy behind the financial might of the insurance company. The leaders of similarly situated companies such as Enron, Tyco, AIG, Lehman Brothers, and WorldCom, among others made the same statements regarding the investment quality of their securities. Each of these companies failed to live up to the promises made by their CEO. In the current economic climate, statements by the CEO regarding the financial strength of a company are taken with a grain of salt.

Insurance providers should be required to disclose exactly how they are planning to pay benefits in the event that they receive a valid claim on a policy. If they agree to pay a lump sum, they should describe how the lump sum will be paid, whether it is in a single check or through the use of a Retained Asset Account. This means that insurance companies must inform both the policy purchaser and eventually the beneficiary how their funds will be distributed at the outset of the insurer/insured relationship, rather than waiting until after a claim is made and benefits are paid out. Describing the payment options in detail will help policy holders understand what they are purchasing as well as improve the image of the insurance company as there will be no surprises when a beneficiary receives pseudo-checks when they were expecting a single lump-sum payment.

Only through adequate disclosure can potential harms resulting from insolvency in the insurance industry be avoided. Proper disclosure should accompany every life insurance contract so that policyholders and beneficiaries understand what they are entitled to should a claim be filed. By providing adequate disclosure, beneficiaries will be able to evaluate whether they want to keep a Retained Asset Account or transfer the funds to a safer investment vehicle. In addition, adequate disclosure will lessen bad press against insurance companies because they will have explained exactly what is being distributed to beneficiaries from the outset. Because of this, insurance companies should strive to provide adequate disclosure regarding Retained Asset Accounts.

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<sup>92</sup> Gallanis, *supra* note 35, at 9.

**APPENDIX**

## FEDERAL DEPOSIT INSURANCE CORPORATION

The Federal Deposit Insurance Corporation (“FDIC”) is an independent corporation that insures deposits in banks and thrift institutions against failure.<sup>93</sup> The FDIC was created as part of the Glass-Steagall Act of 1933 in response to the over nine thousand bank failures during the great depression.<sup>94</sup> The FDIC has successfully carried out its business without losing a single dollar of insured funds for over 75 years.<sup>95</sup>

The FDIC insures deposit accounts for up to two hundred fifty thousand dollars (\$250,000) per individual, per bank.<sup>96</sup> The FDIC does more than insure a single individual for \$250,000 worth of deposits. It insures a single individual for \$250,000 in *each* FDIC insured bank that they maintain an account at. That means that an individual could put \$1 million in a single FDIC insured bank and be covered for only \$250,000 of that sum or that same individual could spread that \$1 million into 4 or more FDIC insured banks and be insured for the entire \$1 million sum. The FDIC does have ways to receive more than \$250,000 worth of coverage at one bank provided certain criteria are met, such as having accounts in different asset categories.<sup>97</sup>

There are four main categories of assets, a single account, joint account, IRA and retirement accounts and revocable trusts. The FDIC explains the process by which their coverage works for each of these assets as follows:

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<sup>93</sup> *Who is the FDIC?*, *supra* note 28.

<sup>94</sup> Stammers, *supra* note 29.

<sup>95</sup> *Who is the FDIC?*, *supra* note 28; Stammers, *supra* note 29.

<sup>96</sup> *Who is the FDIC?*, *supra* note 28.

<sup>97</sup> *Deposit Insurance FAQ*, *supra* note 31.



**Example 1: Single Account** (owned by one person): \$250,000 per owner.<sup>98</sup>

<b>Example of Insurance Coverage for Single Accounts</b>		
<b>Depositor</b>	<b>Type of Deposit</b>	<b>Amount Deposited</b>
Jane Smith	Savings account	\$25,000
Jane Smith	Certificate of Deposit	\$250,000
Jane Smith	NOW account	\$50,000
Jane Smith's sole proprietorship	Checking account	\$50,000
<b>Total Deposited</b>		<b>\$375,000</b>
<b>Insurance Available</b>		<b>\$250,000</b>
<b>Uninsured Amount</b>		<b>\$125,000</b>

**Example 2: Joint Accounts** (two or more persons): \$250,000 per co-owner. “[Assume] John and Mary have three joint accounts totaling \$600,000 at an insured bank. Under FDIC rules, each co-owner’s share of each joint account is considered equal unless otherwise stated in the bank’s records. John and Mary each own \$300,000 in the joint account category, putting a total of \$100,000 (\$50,000 for each) over the insurance limit.”<sup>99</sup>

<b>Joint Account Example</b>		
<b>Account Title</b>	<b>Type of Deposit</b>	<b>Account Balance</b>
Mary and John Smith	Checking	\$50,000
John or Mary Smith	Savings	\$150,000
Mary Smith or John Smith	CD	\$400,000

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<sup>98</sup> *Id.*

<sup>99</sup> *Id.*

<b>Total Deposits</b>			\$600,000
<b>Insurance coverage for each owner is calculated as follows:</b>			
<b>Account Holders</b>	<b>Ownership Share</b>	<b>Amount Insured</b>	<b>Amount Uninsured</b>
John	\$300,000	\$250,000	\$50,000
Mary	\$300,000	\$250,000	\$50,000
<b>Total</b>	<b>\$600,000</b>	<b>\$500,000</b>	<b>\$100,000</b>

In this example, both John and Mary have ownership shares in the accounts of \$300,000 [in other words, each one of them has ownership of one half of the checking account (\$25,000), one half of the savings account (\$75,000), and one half of the CD (\$200,000), for a total of \$300,000]. As discussed above, because each individual is insured for up to \$250,000 per bank, Mary's coverage in the joint ownership category is limited to \$250,000, and \$50,000 is uninsured. The same is true for John, giving him \$250,000 worth of coverage and leaving \$50,000 uninsured.

**Example 3: IRAs and other certain retirement accounts:** \$250,000 per owner.<sup>100</sup>

<b>Example of Insurance Coverage for Self-Directed Retirement Accounts</b>	
<b>Account Title</b>	<b>Account Balance</b>
Bob Johnson's Roth IRA	\$110,000
Bob Johnson's IRA	\$75,000
<b>Total</b>	<b>\$185,000</b>
<b>Amount Insured</b>	<b>\$185,000</b>

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<sup>100</sup> *Id.*

**Example 4: Revocable trust accounts:** “Each owner is insured up to \$250,000 for the interests of each beneficiary, subject to specific limitations and requirements.”<sup>101</sup>

<b>Example — POD Accounts with Multiple Owners and Beneficiaries</b>			
<b>Account Title</b>	<b>Account Balance</b>	<b>Amount Insured</b>	<b>Amount Uninsured</b>
Husband and Wife POD 3 children	\$1,500,000	\$1,500,000	\$0
Husband POD wife	\$250,000	\$250,000	\$0
Wife POD husband	\$250,000	\$250,000	\$0
Husband POD niece and nephew	\$500,000	\$500,000	\$0
Husband and wife POD grandchild	\$600,000	\$500,000	\$100,000
<b>Total</b>	<b>\$3,100,000</b>	<b>\$3,000,000</b>	<b>\$100,000</b>

<sup>102</sup>

The FDIC is funded through premiums paid by the banks and thrifts and from earnings on U.S. Treasury Securities.<sup>103</sup> These premiums are paid regularly and go into what is described by some as a “war chest.”<sup>104</sup> “To provide an effective banking safety net, it is necessary for the FDIC to replace cash (of the failed bank) with cash from the FDIC at the moment the bank fails.”<sup>105</sup> The FDIC insures traditional bank accounts, savings, checking, trust, certificates of deposit (“CDs”), money market savings

<sup>101</sup> *Id.*

<sup>102</sup> *Id.*

<sup>103</sup> *Who is the FDIC?*, *supra* note 28.

<sup>104</sup> Gallanis, *supra* note 35, at 9.

<sup>105</sup> *Id.* at 10.

accounts and IRA accounts.<sup>106</sup> The FDIC does not, however, insure mutual funds, safe deposit boxes, annuities, stocks or bonds.<sup>107</sup> Since its creation in 1934, no depositor insured by the FDIC has lost even a single penny of insured funds as a result of a bank failure.<sup>108</sup> To give an idea of how incredible this accomplishment is, the FDIC reports that since the year 2000, 457 banks have failed.<sup>109</sup> It is because of this success that the FDIC has gained such prominence and respect from individuals and businesses alike.

In addition to its role insuring deposits after a bank failure, the FDIC acts preemptively by “examining and supervising financial institutions for safety and soundness and consumer protection.”<sup>110</sup> “The FDIC is a recognized leader in promoting sound public policies, addressing risks in the nation's financial system, and carrying out its insurance, supervisory, consumer protection, and receivership management responsibilities.”<sup>111</sup> In carrying out its duties, the FDIC produces Annual Reports to the President of the United States and Congress, a Privacy Program, Strategic Plans about the FDIC’s short and long-term strategic goals and Financial Reports on its internal business.<sup>112</sup>

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<sup>106</sup> *Insured or Not Insured?*, *supra* note 39.

<sup>107</sup> *Id.*

<sup>108</sup> *Who is the FDIC?*, *supra* note 28.

<sup>109</sup> *Failed Bank List*, FED. DEPOSIT INS. CORP., <http://www.fdic.gov/bank/individual/failed/banklist.html> (last updated Mar. 31, 2012).

<sup>110</sup> *FDIC Mission, Vision, and Values*, FED. DEPOSIT INS. CORP., <http://www.fdic.gov/about/mission/index.html> (last visited Jan. 14, 2011).

<sup>111</sup> *Id.*

<sup>112</sup> *Privacy Program*, FED. DEPOSIT INS. CORP., <http://www.fdic.gov/about/strategic/report/index.html> (last updated Jan. 14, 2011); *Annual Reports*, FED. DEPOSIT INS. CORP., <http://www.fdic.gov/about/privacy> (last updated June 16, 2011).

# STANDARDS FOR PLEADING A CLAIM UNDER CUIPA: NO EXCEPTIONS TO THE CONNECTICUT FACT PLEADING REQUIREMENT

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### I. INTRODUCTION

In her complaint, a plaintiff alleges that her insurer failed to settle her claim in a timely fashion when her house burned down. In order to prevail on her claim, she must allege that other people insured by the same company experienced the same misconduct. It seems likely that she is not the only one who has experienced a delay in settling a claim with this insurer, so in her complaint, she claims that, “upon information and belief”, other insureds have suffered the same misconduct. If her complaint is deemed factually insufficient upon a motion to strike, she has no opportunity to conduct discovery to prove that she is not the only one who suffered, and no opportunity to pursue her claim. If her complaint is found

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to be sufficient, however, the insurer will be subjected to a time-consuming, expensive, and exhaustive discovery procedure, based on the plaintiff's unsubstantiated allegations that other insureds suffered similar misconduct.

Pleading standards serve a critical function in our judicial system in that they set a threshold by which frivolous claims are stricken or dismissed, leaving room for meritorious claims to be tried in court.<sup>1</sup> Compliance with pleading standards is essential to prevail on a claim; without adequate pleadings, a claim essentially fails before the case ever begins. Inadequate pleadings are targets waiting to be stricken, and result in loss of opportunity to conduct discovery, the inability to present a case, and ultimately, no possibility of obtaining relief.<sup>2</sup>

The standards for pleading a claim in federal and Connecticut state courts are set forth in the Federal Rules of Civil Procedure<sup>3</sup> and in Connecticut's Trial Rules.<sup>4</sup> In Connecticut, the courts require the plaintiff to set forth a concise statement of material facts in support of their allegations.<sup>5</sup> However, the standards for pleading a claim of unfair settlement practices against an insurer have recently become a subject for debate, causing a split amongst Connecticut trial courts. Some courts believe that pleadings should be construed liberally, giving the plaintiff the benefit of doubt over the insurer.<sup>6</sup> Others adhere to strict construction of pleading standards, suggesting that there should not be an exception to the state's fact pleading rule for insurance claims.<sup>7</sup> This note analyzes the standards for pleading a claim under the Connecticut Unfair Insurance

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<sup>1</sup> Arthur R. Miller, *From Conley to Twombly to Iqbal: A Double Play on the Federal Rules of Civil Procedure*, 60 DUKE L.J. 1, 48-49 (2010) (discussing the district court judge's role in filtering cases based on pleadings and motions to dismiss and the uncertainty of separating frivolous and meritorious claims).

<sup>2</sup> Adam N. Steinman, *The Pleading Problem*, 62 STAN. L. REV. 1293, 1294-95 (2010).

<sup>3</sup> FED. R. CIV. P. 8(a).

<sup>4</sup> CONN. PRAC. BOOK § 10-1.

<sup>5</sup> *Id.*

<sup>6</sup> See, e.g., *Blakeslee Arpaia Chapman, Inc. v. U.S. Fid. & Guar. Co.*, No. 520348, 1994 WL 76383, at \*10 (Conn. Super. Ct. Mar. 4, 1994) (interpreting a CUIPA claim liberally under CUTPA because the statutes are remedial in nature).

<sup>7</sup> See, e.g., *Tomonto v. Progressive N. Ins. Co.*, No. CV044001543, 2006 WL 2053723, at \*2 (Conn. Super. Ct. July 7, 2006) ("This is a fact pleading jurisdiction. Practice Book § 10-1 states, in part: 'Each pleading shall contain a plain and concise statement of the material facts on which the pleader relies . . . .'" (citing CONN. PRAC. BOOK § 10-1)).

Practices Act, and will suggest that there is no adequate reason to suspend Connecticut's fact pleading standard for this singular area of law.

## II. PLEADING STANDARDS IN FEDERAL AND STATE COURTS

Until recently, claims for relief in federal court were governed by the notice pleading approach, wherein the claimant is only required to provide "a short and plain statement of the claim showing that the pleader is entitled to relief."<sup>8</sup> The goal of notice pleading is to "give the defendant fair notice of what the plaintiff's claim is and the grounds upon which it rests."<sup>9</sup> Under a notice pleading standard, if a claim for relief is sufficient to put the defendant on notice of the claim against him, it will survive a motion to strike, with factual discovery occurring later in the pretrial process.<sup>10</sup>

Notice pleading was adopted because, in many cases, the defendant is in control of information that is relevant to the plaintiff's claim, as they have the knowledge and evidence the plaintiff is seeking to prove their case.<sup>11</sup> Notice pleading balances out this advantage by giving the plaintiff the benefit of the doubt that they have a legitimate claim, and by not requiring the plaintiff to cite facts that they cannot be expected to know at an early stage of litigation.<sup>12</sup> However, the lower the pleading standard, the higher the economic cost, as vague and unsubstantiated pleadings may permit plaintiffs to conduct extensive and costly discovery inquiries into the defendant's affairs.<sup>13</sup>

In 2007, the United States Supreme Court reconsidered the federal notice pleading standard in *Bell Atlantic Corp. v. Twombly*, a consumer antitrust action against telephone and telecommunications providers alleging a conspiracy in violation of the Sherman Act.<sup>14</sup> The *Twombly*

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<sup>8</sup> FED. R. CIV. P. 8(a)(2). The United States Supreme Court adopted the notice pleading standard in *Conley v. Gibson*, 355 U.S. 41, 47 (1957).

<sup>9</sup> *Conley*, 355 U.S. at 47.

<sup>10</sup> Miller, *supra* note 1, at 4.

<sup>11</sup> Paul Stancil, *Balancing the Pleading Equation*, 61 BAYLOR L. REV. 90, 114-15 (2009).

<sup>12</sup> *Id.*

<sup>13</sup> *Id.* at 116 ("In particular, the lower the pleading standard, the greater the potential disparity between defendant's and plaintiff's costs for several claim types . . . because the range of permissible inquiry into defendant's affairs increases as pleading specificity requirements decrease, especially for claims in which the plaintiff's own conduct is of little moment.").

<sup>14</sup> *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 550, 553 (2007).

Court adopted a slightly higher standard than notice pleading, holding that enough facts must be stated to make a claim for relief “plausible” on its face.<sup>15</sup> In 2009, the Supreme Court again leaned away from the notice pleading standard in *Ashcroft v. Iqbal*, which relied on and enforced the plausibility pleading requirement set forth in *Twombly*.<sup>16</sup> The *Iqbal* Court dismissed a civil rights complaint filed by a Pakistani man who was detained after the September 11 attacks.<sup>17</sup> Mirroring the language in *Twombly*, the *Iqbal* Court stated that discriminatory animus on the part of the federal officials was “not a plausible conclusion” based on the facts pled.<sup>18</sup> This newly-formed federal pleading standard has become known as “plausibility pleading”; a standard that imposes a higher burden on plaintiffs, requiring just slightly more facts be pled in comparison to the notice pleading standard.<sup>19</sup> The holdings in *Twombly* and *Iqbal* regarding pleading standards are significant in that they indicate a moving away from the explicit focus on giving notice.<sup>20</sup> However, this movement is modest, as the Court has stated that “plausibility” should not be interpreted as a demanding standard.<sup>21</sup>

In contrast to the standards for pleading a claim in federal court, Connecticut takes a fact pleading approach, requiring that “[e]ach pleading shall contain a plain and concise statement of the material facts on which the pleader relies, but not of the evidence by which they are to be proved . . . .”<sup>22</sup> By focusing on a plain statement of specific facts, courts avoid subjecting defendants to frivolous litigation and the overall cost of operating the judicial system is reduced, as fewer claims survive this strict pleading standard.<sup>23</sup> However, some claims that appear frivolous due to lack of factual pleading might be dismissed, despite the potentially valid claims they assert.<sup>24</sup>

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<sup>15</sup> *Id.* at 570.

<sup>16</sup> *Ashcroft v. Iqbal*, 129 S. Ct. 1937, 1952 (2009).

<sup>17</sup> *Id.* at 1950-51.

<sup>18</sup> *Id.* at 1952.

<sup>19</sup> Steinman, *supra* note 2, at 1310.

<sup>20</sup> Robert G. Bone, *Twombly, Pleading Rules, and the Regulation of Court Access*, 94 IOWA L. REV. 873, 883 (2009); *Iqbal*, 129 S. Ct. at 1949.

<sup>21</sup> Bone, *supra* note 20, at 883-84 (citing *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007)).

<sup>22</sup> CONN. PRAC. BOOK § 10-1.

<sup>23</sup> Stancil, *supra* note 11, at 148-49.

<sup>24</sup> *Id.* at 149.



The main purpose of more lenient pleading standards is simply to make a party aware of the claims against them.<sup>25</sup> The requirements set forth by notice and plausibility pleading standards are easy enough to satisfy, which helps to ensure that a litigant gets his or her day in court.<sup>26</sup> Despite the long-standing history of lenient pleading standards in federal courts, many state courts find it preferable to take a fact pleading approach, including Connecticut.<sup>27</sup> Attorneys handling full workloads of civil litigation cases find that fact pleading standards make their cases “more focused, and ultimately less expensive and less time-consuming” than if a more lenient pleading approach was followed.<sup>28</sup> The adoption and practice of fact pleading in Connecticut is therefore not arbitrary or accidental, but serves to benefit the judicial system by conserving resources and expediting meritorious cases.

### III. PLEADING A CUIPA CLAIM

The Connecticut Unfair Insurance Practices Act (CUIPA) was derived from the National Association of Insurance Commissioner's Model Act, which has been adopted by most states.<sup>29</sup> CUIPA was adopted to prohibit persons from engaging in unfair or deceptive behavior in the practice of insurance within the state of Connecticut.<sup>30</sup> The statute specifically lists sixteen prohibited practices, including misrepresenting the benefits of a policy, disseminating false information to the public, and engaging in unfair claim settlement practices,<sup>31</sup> the last of which is the

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<sup>25</sup> Christopher M. Fairman, *The Myth of Notice Pleading*, 45 ARIZ. L. REV. 987, 990 (2003).

<sup>26</sup> *Id.*

<sup>27</sup> U. OF DENV. INST. FOR THE ADVANCEMENT OF THE LEGAL SYS., *Fact-Based Pleading: A Solution Hidden in Plain Sight*, 1 (May 2010), <http://iaals.du.edu/news-room/fact-based-pleading-a-solution-hidden-in-plain-sight> (follow “Read More” link) (“While fact-based pleading has not been a part of the federal civil process since the 1930s, it remains alive and well in many of the country’s biggest and busiest state courts, including California, New York, Pennsylvania, Florida, Texas, Missouri, Virginia, Illinois, New Jersey, Connecticut and Louisiana. These are courts that collectively handle millions of civil cases every year.”).

<sup>28</sup> *Id.*

<sup>29</sup> *Chapell v. LaRosa*, No. CV990552801, 2001 WL 58057, at \*5 (Conn. Super. Ct. Jan. 5, 2001).

<sup>30</sup> CONN. GEN. STAT. § 38a-815 (2012).

<sup>31</sup> *Id.* § 38a-816.

violation this paper will focus on. The list of prohibited acts is followed by a blanket prohibition on any unlisted, unfair insurance practices.<sup>32</sup>

CUIPA claims are handled by the Connecticut Insurance Department, and the Act gives the Commissioner of Insurance broad discretion to investigate potential unfair practices and enforce its provisions.<sup>33</sup> Once a CUIPA claim is properly pled, therefore, it is at the discretion of the Commissioner to determine whether the alleged practice should be investigated, and to request and view any pertinent information. The Act also established an administrative procedure through which the Commissioner of Insurance can take action and impose sanctions against an insurer found to be in violation of its provisions.<sup>34</sup>

If a plaintiff has experienced unfair insurance claim settlement practices, bringing a claim under CUIPA is not the only opportunity for redress. Every contract is accompanied by an implied covenant of good faith and fair dealing.<sup>35</sup> When an insurer withholds payment of a valid insurance claim in bad faith, in violation of an insurance contract, they subject themselves to liability in tort.<sup>36</sup> A plaintiff can bring a claim of common law bad faith sounding in tort, and will succeed if they can prove that the insurer committed an unfair practice with a dishonest purpose or ill will.<sup>37</sup> The payoff to the plaintiff who succeeds in their common law bad faith claim will not be substantial, however, as punitive damages under

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<sup>32</sup> *Id.* § 38a-818 (permitting charges “[w]hensoever the commissioner has reason to believe that any person engaged in the business of insurance is engaging in this state in any method of competition or in any act or practice in the conduct of such business which is not defined in section 38a-816 . . .”).

<sup>33</sup> *Martin v. Am. Equity Ins. Co.*, 185 F. Supp. 2d 162, 166 (D. Conn. 2002).

<sup>34</sup> Elizabeth J. Stewart, *Environmental Insurance Coverage Disputes in Connecticut*, 70 CONN. B.J. 280, 306 (1996).

<sup>35</sup> *Hoskins v. Titan Value Equities Grp. Inc.*, 749 A.2d 1144, 1146-47 (Conn. 2000).

<sup>36</sup> *Wiacek v. Safeco Ins. Co. of Am., Inc.*, No. 329601, 1998 WL 161378, at \*2 (Conn. Super. Ct. Mar. 31, 1998).

<sup>37</sup> *Buckman v. People Exp., Inc.*, 530 A.2d 596, 599 (Conn. 1987); *see also* *Chapman v. Norfolk & Dedham Mut. Fire Ins. Co.*, 665 A.2d 112, 120 (Conn. 1995) (“[I]n order to receive punitive damages under CUTPA, the plaintiffs were required to produce evidence that the defendants' actions had a reckless indifference to the rights of others or that the defendants had engaged in an intentional and wanton violation of those rights.”) (internal quotation marks omitted).

Connecticut common law are limited to the amount of attorney's fees.<sup>38</sup> Bringing an action under CUIPA is therefore significantly more attractive to those who have been subjected to unfair settlement practices than a claim sounding in tort, as a successful CUIPA claim could potentially award the plaintiff actual damages, attorney's fees, and punitive damages.<sup>39</sup>

#### A. DOES CUIPA PROVIDE A PRIVATE CAUSE OF ACTION?

Since its inception, individuals have turned to CUIPA to seek redress from insurers for treating claimants unfairly during the claim settlement process. However, individuals cannot succeed on such claims, as the Second Circuit has held that there is no such private cause of action under CUIPA.<sup>40</sup> The Connecticut Supreme Court has not addressed this issue, and the lower courts are split as to whether CUIPA provides a private cause of action.<sup>41</sup> A minority of courts rule that a private right of action does exist,<sup>42</sup> but the majority opinion is that there is no private right of action under CUIPA.<sup>43</sup> For the purposes of this paper, the majority position will be adopted, and it will be assumed that there is no private right of action under CUIPA.

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<sup>38</sup> Charles T. Lee, *Insurance Coverage Litigation in Connecticut: Is There a Level Playing Field in the "Insurance State"?*, 74 CONN. B.J. 362, 379 (2000).

<sup>39</sup> CONN. GEN. STAT. § 42-110g (2012). "[U]nder a combination of the Connecticut Unfair Insurance Practices Act . . . and the Connecticut Unfair Trade Practices Act, . . . insureds may recover substantial punitive damages, if they can show a defendant engaged in a general business practice of unfair or deceptive settlement conduct." Lee, *supra* note 38, at 379.

<sup>40</sup> *Lander v. Hartford Life & Annuity Ins. Co.*, 251 F.3d 101, 118 (2d Cir. 2001).

<sup>41</sup> *W. World Ins. Co. v. Architectural Builders of Westport, LLC*, 520 F. Supp. 2d 408, 411 (D. Conn. 2007).

<sup>42</sup> See, e.g., *George's Auto Parts, Inc. v. Providence Wash. Ins. Co.*, No. CV000439407, 2001 WL 206081 (Conn. Super. Ct. Feb. 8, 2001); *Edelman v. Pac. Emp'r Ins. Co.*, No. CV 93 0533463, 1994 WL 590632 (Conn. Super. Ct. Oct. 20, 1994).

<sup>43</sup> See, e.g., *Am. Progressive Life & Health Ins. Co. of N.Y. v. Better Benefits, LLC*, 7591S, 2001 WL 1178596, at \*2 (Conn. Super. Ct. Aug. 30, 2001); *Chieffo v. Yannielli*, No. CV000159940, 2001 WL 950286, at \*4 (Conn. Super. Ct. July 10, 2001); *Joseph v. Hannan Agency Inc.*, No. 323310, 1997 WL 15424, at \*1 (Conn. Super. Ct. Jan. 9, 1997); *Stabile v. S. Conn. Hosp. Sys., Inc.*, No. 326120, 1996 WL 651633, at \*3 n.6 (Conn. Super. Ct. Oct. 31, 1996).

Although the Connecticut Supreme Court has expressly declined to rule on this issue,<sup>44</sup> the lack of definite authority doesn't serve to restrict private claims. Even if no private right of action exists under CUIPA, the plaintiff is not left without redress; a claim for relief can be made under the Connecticut Unfair Trade Practices Act (CUTPA) alleging a breach of CUIPA.<sup>45</sup> The CUTPA, which prohibits unfair or deceptive acts or practices in the conduct of any trade or commerce, does create a private right of action.<sup>46</sup> For the purposes of this paper, pleadings alleging unfair settlement practices will be referred to as claims under CUIPA, regardless of whether they are being brought in conjunction with a CUTPA claim.

Although a plaintiff is entitled to bring a claim under CUTPA alleging a violation of CUIPA, the claim is not proper unless the alleged unfair practice actually violates CUIPA.<sup>47</sup> As a Connecticut statute, CUIPA is subject to governance by Connecticut's Trial Rules. Such a claim therefore must contain a statement of the material facts forming the basis of the allegation, and meet the criteria set forth in both CUTPA and CUIPA.

#### B. REQUIREMENTS FOR PLEADING A CUIPA CLAIM

Of the sixteen causes of action contained in CUIPA, the unfair settlement practices cause of action is unique in that it requires a showing of multiple instances of misconduct by the same insurer.<sup>48</sup> When asserting a claim of unfair settlement practices under CUIPA, the claimant must plead that the insurer performed certain actions constituting misconduct in conjunction with the settlement of their insurance claim.<sup>49</sup> Such misconduct encompasses misrepresenting the insurance policy provisions at issue, attempting to settle a claim for less than a reasonable person would have expected, or refusing to pay claims without reasonable investigation.<sup>50</sup> These actions must not have been committed only as to the plaintiff; they

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<sup>44</sup> *Lees v. Middlesex Ins. Co.*, 643 A.2d 1282, 1285 n.4 (Conn. 1994) (“With respect to the CUIPA count, the defendant contends that CUIPA does not create a private cause of action. We decline to consider that claim because it is unnecessary for us to do so.”).

<sup>45</sup> *Mead v. Burns*, 509 A.2d 11, 18 (Conn. 1986).

<sup>46</sup> 16 Conn. Prac. Series, Elements of an Action § 11:2 (“A statutory cause of action is created by C.G.S.A. § 42-110g for any person who suffers a loss of money or property as the result of an unfair trade practice.”).

<sup>47</sup> *Martin v. Am. Equity Ins. Co.*, 185 F. Supp. 2d 162, 168 (D. Conn. 2002).

<sup>48</sup> CONN. GEN. STAT. § 38a-815 (2012).

<sup>49</sup> *Id.* § 38a-816(6).

<sup>50</sup> *Id.*

must have been committed “with such frequency as to indicate a general business practice.”<sup>51</sup> This clause has led Connecticut courts to conclude that pleading a claim of unfair settlement practices under CUIPA requires the claimant to show more than one instance of misconduct on the part of the insurer.<sup>52</sup>

The language in the unfair settlement practices cause of action therefore requires a showing of multiple prohibited acts, whereas the other causes of action under CUIPA require that only one prohibited act be asserted.<sup>53</sup> By including this language in the statute, the legislature clearly intended that insurers only be punished for unfair settlement practices occurring with some frequency, rather than for isolated incidences of misconduct.<sup>54</sup> This indicates that isolated incidences of misconduct, although unfortunate, are not so seriously in violation of state public policy as to mandate statutory intervention.<sup>55</sup>

Furthermore, CUIPA’s protection is not meant to extend to a plaintiff who claims that multiple unfair settlement practices occurred in relation to just one insurance claim.<sup>56</sup> This point was emphasized in *Lees v. Middlesex Insurance Company*, where the plaintiff alleged that the insurer failed to acknowledge inquiries regarding her claim, failed to affirm or deny coverage, failed to make a good faith effort to settle the claim promptly, and failed to properly explain her insurance policy.<sup>57</sup> The court in *Lees* held that multiple instances of alleged misconduct in relation to one insurance claim does not rise to the level of a general business practice.<sup>58</sup>

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<sup>51</sup> *Id.*

<sup>52</sup> *Mead v. Burns*, 509 A.2d 11, 19 (Conn. 1986) (recognizing “the legislative determination that isolated instances of unfair insurance settlement practices are not so violative of the public policy of this state as to warrant statutory intervention”).

<sup>53</sup> *Ferreira v. Safeco Ins. Co. of Am.*, No. 323152, 1996 WL 411999, at \*1 (Conn. Super. Ct. July 5, 1996); *see also* *Lees v. Middlesex Ins. Co.*, 229 Conn. 842, 848 n.5 (1994) (“We note that of the sixteen categories of unfair insurance practices proscribed by General Statutes § 38a-816, only subsection (6) expressly requires proof that the unfair claim settlement practices enumerated therein were committed or performed ‘with such frequency as to indicate a general business practice.’”).

<sup>54</sup> *Lees*, 229 Conn. at 849.

<sup>55</sup> *Martin v. Am. Equity Ins. Co.*, 185 F. Supp. 2d 162, 166 (D. Conn. 2002).

<sup>56</sup> *Lees*, 229 Conn. at 848.

<sup>57</sup> *Id.* at 848 n.7.

<sup>58</sup> *Id.* at 849.

## IV. DEFENDING AGAINST CUIPA CLAIMS

The main strategy for defending against CUIPA claims in state court is by filing a motion to strike.<sup>59</sup> A motion to strike is used to contest the legal sufficiency of the allegations of a complaint.<sup>60</sup> In evaluating a motion to strike, the court considers the facts set forth in the complaint and construes them in the light most favorable to the plaintiff, admitting all well-pleaded facts.<sup>61</sup> Only the facts alleged in the complaint can be considered; legal conclusions or opinions will not be admitted.<sup>62</sup> If the facts set forth would support the cause of action asserted, the motion to strike will be denied.<sup>63</sup> A motion to strike a claim of unfair settlement practices under CUIPA is often based on the grounds that the pleading violates Connecticut Trial Rules by stating insufficient specific facts.

CUIPA claims can also be litigated in federal court if there is diversity jurisdiction.<sup>64</sup> In federal court, the proper motion to defend against a pleading that fails to state a claim upon which relief can be granted is a motion to dismiss.<sup>65</sup> A motion to dismiss is evaluated in largely the same way as a motion to strike; the court accepts as true all the factual allegations in the complaint, and draws inferences in the light most favorable to the movant.<sup>66</sup> The action will be dismissed only if it is clear that no relief can be granted based on the facts and allegations contained in the complaint.<sup>67</sup> It is important to note that, because the standard for

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<sup>59</sup> Robert B. Yules & Cynthia W. S. Rowen, *Insurance Bad Faith Litigation, A Primer*, 67 CONN. B.J. 380, 393 (1993).

<sup>60</sup> Fort Trumbull Conservancy, LLC v. Alves, 815 A.2d 1188, 1200-01 (Conn. 2003).

<sup>61</sup> Colon v. Geico Cas. Co., No. CV 980419197, 1999 WL 596245, at \*1-2 (Conn. Super. Ct. July 28, 1999) (quoting Waters v. Autuori, 676 A.2d 357, 359-60 (Conn. 1996)).

<sup>62</sup> Wiacek v. Safeco Ins. Co. of Am., Inc., No. 329601, 1998 WL 161378, at \*1 (Conn. Super. Ct. Mar. 31, 1998).

<sup>63</sup> *Id.*

<sup>64</sup> 28 U.S.C. § 1332 (2006). The District Court has jurisdiction over civil actions where the amount in controversy exceeds \$75,000 and is between citizens of different states. When considering diversity of incorporated insurers, a corporation is deemed to be a citizen of both the state it is incorporated in and the state where it has its principal place of business.

<sup>65</sup> FED. R. CIV. P. 12(b)(6).

<sup>66</sup> W. World Ins. Co. v. Architectural Builders of Westport, LLC, 520 F. Supp. 2d 408, 410 (D. Conn. 2007).

<sup>67</sup> Hishon v. King & Spalding, 467 U.S. 69, 73 (1984).

pleading in federal courts is plausibility pleading, the complaint does not have to contain specific facts; the plaintiff must simply plead sufficient facts to “nudge[] their claims across the line from conceivable to plausible.”<sup>68</sup>

A strong motion to dismiss or strike comes with the potential benefit to insurers that the complaint will be immediately disposed of, and will not survive to be litigated in court.<sup>69</sup> Alternatively, upon realizing the strong legal arguments contained in the motion, the plaintiff might be more willing to engage in settlement discussions, or settle at a lower price.<sup>70</sup> On the other hand, if the motion is granted, the plaintiff might come back with stronger legal arguments that are more difficult to defeat at trial.<sup>71</sup> Because of this delicate balancing act, it is critical for an insurer to evaluate the pros and cons of moving to strike or dismiss a CUIPA action before any such motion is filed.

#### V. LEVEL OF SPECIFIC FACTUAL DETAIL REQUIRED

At the trial level, Connecticut courts are split as to the minimum facts that must be pled to support a claim under CUTPA and CUIPA.<sup>72</sup> “The point of contention among these decisions centers on the requirement that ‘a CUPTA claim based on an alleged unfair claim settlement practice . . . require[s] proof, as under CUIPA, that the unfair claim settlement practice had been committed or performed by the defendant with such frequency as to indicate a general business practice.’”<sup>73</sup> The problem therefore often lies in the ability of an individual plaintiff to state sufficient facts indicating that not only did the insurer perpetrate misconduct against

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<sup>68</sup> Bell Atl. Corp. v. Twombly, 550 U.S. 544, 547 (2007).

<sup>69</sup> Mark Thomas Smith, *Strategic Motions to Dismiss (Or Lack Thereof)*, AMERICAN BAR ASSOCIATION, [http://www.abanet.org/litigation/litigationnews/trial\\_skills/pretrial-motion-dismiss.html](http://www.abanet.org/litigation/litigationnews/trial_skills/pretrial-motion-dismiss.html) (last visited Mar. 28, 2012).

<sup>70</sup> *Id.*

<sup>71</sup> *Id.* “Practice Book § 10-44 permits a party to file a new pleading within fifteen days after a motion to strike has been granted . . . .” *Crespan v. State Farm Mut. Auto. Ins. Co.*, No. LLICV054002121S, 2006 WL 280009, at \*2 (Conn. Super. Ct. Jan. 13, 2006) (quoting *Johnson v. Mazza*, 834 A.2d 725, 729 (Conn. 2003)).

<sup>72</sup> Mark B. Seiger & Elizabeth F. Ahlstrand, *When Pleadings Lack Specific Facts*, CONN. L. TRIB., Feb. 8, 2010, at 14-15 (quoting *Lees v. Middlesex Ins. Co.*, 643 A.2d 1282, 1286 (Conn. 1994)).

<sup>73</sup> *Id.*

the plaintiff, but also that this misconduct is repeated with frequency sufficient to render it a general business practice.

Pleadings alleging a violation of CUIPA often state facts asserting that the claimant experienced unfair settlement practices, and that “upon information and belief” the defendant has regularly engaged in such practices with other insureds.<sup>74</sup> Some courts have taken a lenient approach when factually sparse pleadings are set forth, and have permitted pleadings that contain either a factual allegation of a specific violation combined with an assertion that this is a regular business practice, or pleadings containing several claims based on the same incident.<sup>75</sup> However, the majority of courts have held that general allegations of unfair business practices are insufficient, without giving any indication as to the precise level of fact required to state a sufficient claim.<sup>76</sup>

The subsections of CUIPA describing the acts prohibited in settling insurance claims are both broad and vague, and the pleadings filed by plaintiffs vary widely depending on the nature of each insurance claim.<sup>77</sup> The issue of how much factual detail is required is significant, because the facts set forth in the pleadings often control the scope of discovery.<sup>78</sup> If a complaint that alleges unfair settlement practices “on information and belief” survives an insurer’s motion to strike, the claimant may then have the opportunity to conduct prolonged, intrusive, and expensive discovery, inconveniencing both the claimant and the insurer.<sup>79</sup>

To date, the Connecticut Supreme Court has not had the opportunity to consider the level of factual detail required to adequately plead a CUIPA claim. The defensive motion to strike removes some CUIPA claims from court before a decision is reached. Insurers often settle CUIPA claims that survive a motion to strike; they would rather pay the plaintiff a settlement than subject themselves to the broad discovery

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<sup>74</sup> *Id.*

<sup>75</sup> Lee, *supra* note 38, at 380; Lees v. Middlesex Ins. Co., 643 A.2d 1282 (Conn. 1994); Quimby v. Kimberly Clark Corp., 613 A.2d 838 (Conn. App. 1992).

<sup>76</sup> Lee, *supra* note 38, at 380.

<sup>77</sup> Chapell v. Larosa, No. CV990552801, 2001 WL 58057, at \*8 (Conn. Super. Ct. Jan. 5, 2001) (questioning how inappropriate behavior by insurers can be ascertained, given the vague and broad language of the CUIPA statute).

<sup>78</sup> Seiger & Ahlstrand, *supra* note 72, at 14-15 (quoting Lees v. Middlesex Ins. Co., 643 A.2d 1282, 1286 (Conn. 1994)).

<sup>79</sup> *Id.*



discretion of the Commissioner of Insurance permitted under CUIPA.<sup>80</sup> Particularly for a large insurer, the costs associated with such discovery, such as time spent sorting documents, copying and shipping fees, and storage fees, serve as an incentive to settle the case rather than try it in court.<sup>81</sup>

In the trial courts, there are two conflicting lines of cases outlining the level of fact necessary to state a claim that meets the general business practice requirement of CUIPA. These cases differ not only in the facts set forth in the various pleadings, but also in the legal analyses the courts apply. The first line of cases requires that the plaintiff state facts demonstrating a general business practice that go beyond the unfairness immediately suffered by the plaintiff personally.<sup>82</sup> The second line of cases takes precisely the opposite position, holding that as long as the plaintiff alleges that other insureds have been subjected to the same unfair settlement practices, specific factual descriptions of these alleged instances are not required.<sup>83</sup>

#### A. LINE 1: SPECIFIC FACTS REQUIRED TO ILLUSTRATE GENERAL BUSINESS PRACTICE

The first line of cases reviewing the standards for pleading a CUIPA claim concludes that pleadings must conform to Connecticut's Trial Rules, and as such, must contain a plain and concise statement of the material facts. Such cases state that, despite the rule that pleadings must be read in the light most favorable to the plaintiff, "an allegation based upon 'reasonable information and belief' is properly viewed as a legal conclusion, particularly when the plaintiff has made no attempt to plead facts establishing any other instance or instances to demonstrate the

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<sup>80</sup> See, e.g., Stancil, *supra* note 11, at 116 ("Fishing expeditions are sometimes so expensive that the defendant will pay the plaintiff to leave even a lake the defendant knows to be empty.").

<sup>81</sup> See, e.g., Scott A. Moss, *Litigation Discovery Cannot Be Optimal but Could Be Better: The Economics of Improving Discovery Timing in A Digital Age*, 58 Duke L.J. 889, 945 (2009) (stating that increased discovery costs have the effect of "increasing parties' incentives to settle early, before much discovery . . . but also increasing the incentive to file frivolous lawsuits that defendants would settle to avoid discovery costs.").

<sup>82</sup> Wirth v. Progressive Cas. Ins. Co., No. CV095012844S, 2010 WL 654392, at \*2 (Conn. Super. Ct. Feb. 14, 2010).

<sup>83</sup> *Id.* at \*3.

frequency of the alleged CUIPA violation.”<sup>84</sup> This line of cases suggests that, in order to properly plead unfair settlement practices as a general business practice, the plaintiff must allege specific facts indicating that the insurer’s misconduct has occurred with such frequency as to go beyond the immediate claims of the plaintiff.<sup>85</sup>

One such case is *Quimby v. Kimberly Clark Corporation*, where the plaintiff sought damages and injunctive relief from her employer, based on alleged wrongful conduct in the treatment of the plaintiff’s workers’ compensation claims.<sup>86</sup> All eight counts of the complaint were stricken by the trial court, among which two were stricken because the plaintiff failed to allege sufficient facts indicating that the defendant’s misconduct constituted a general business practice in violation of CUIPA.<sup>87</sup> In *Quimby*, not only did the plaintiff fail to state sufficient facts indicating a general business practice, she did not even allege that other claimants had been treated in a similar manner.<sup>88</sup> Without such an allegation, the facts stated did not meet the well-settled requirement that a single act of misconduct is insufficient to plead a claim under CUIPA.<sup>89</sup> Therefore, the court affirmed the trial court’s decision to strike the plaintiff’s complaint.<sup>90</sup> The *Quimby* case is one of few cases concerning the standards of pleading a CUIPA claim to have been considered on the appellate level, and as the complaint in question did not suggest that the unfair settlement practices occurred with frequency, the precise amount of fact required to plead a CUIPA claim was not addressed.

In some cases, the plaintiff will allege, without factual substantiation, that other insureds have experienced the same unfair settlement practices, in an attempt to fulfill the general business practice element of CUIPA. This was the case in *Ciarleglio v. Fireman’s Fund Ins. Co.*, where the plaintiff was denied workers’ compensation benefits after suffering job-related injuries.<sup>91</sup> In considering the insurer’s motion to strike plaintiff’s CUIPA claim, the court noted that, “[i]n what may be an attempt

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<sup>84</sup> *Wiacek v. Safeco Ins. Co. of Am., Inc.*, No. 329601, 1998 WL 161378, at \*3 (Conn. Super. Ct. March 31, 1998).

<sup>85</sup> *Wirth*, 2010 WL 654392 at \*3.

<sup>86</sup> *Quimby v. Kimberly Clark Corp.*, 613 A.2d 838, 840-41 (Conn. App. 1992).

<sup>87</sup> *Id.*

<sup>88</sup> *Id.* at 845.

<sup>89</sup> *Id.*

<sup>90</sup> *Id.*

<sup>91</sup> *Ciarleglio v. Fireman's Fund Ins. Co.*, No. CV90 0276028 S, 1993 WL 541609, at \*1 (Conn. Super. Ct. Dec. 16, 1993).

to avoid prompt demise of the fourth count, the plaintiff has inserted the magic words of other acts of insurance misconduct by the defendant, although not stating the factual basis for that claim.”<sup>92</sup>

The *Ciarleglio* court viewed this strategy as problematic, in that the language in the pleadings constituted a legal conclusion due to the fact that the plaintiff did not name any other claimants whose workers’ compensation claims were handled inappropriately, and legal conclusions are not properly admitted on a motion to strike.<sup>93</sup> Furthermore, the court acknowledged that the plaintiff had filed discovery to find other claimants in a similar position in order to bolster his CUIPA claim, but held that merely filing such a discovery request to give the appearance of fulfilling the requirements of a CUIPA claim is insufficient.<sup>94</sup> Because the complaint failed to allege sufficient facts to support a claim of unfair settlement as a general business practice, the court granted the insurer’s motion to strike.<sup>95</sup>

The plaintiff’s complaint in *Hellberg v. Travelers Home & Marine Insurance Co.* exhibited elements of the complaints in both *Quimby* and *Ciarleglio*. There, the plaintiff asserted seven violations of CUTPA/CUIPA with respect to one insurance claim that the insurer allegedly refused to pay.<sup>96</sup> The plaintiff further stated that “these violations are part of a ‘pattern or frequency of similar unfair trade practices engaged in by the defendant.’”<sup>97</sup> In determining whether the complaint would survive the insurer’s motion to strike, the court cited the holdings in *Lees* and *Mead*, noting that more than one instance of misconduct must be demonstrated.<sup>98</sup> The court not only relied on these key cases, but also quoted a similar Connecticut Superior Court case, *Finocchio v. Atlantic Mutual Insurance Co.*, in granting the insurer’s motion to strike:

A recent Superior Court decision examined the level of detail required in § 38a-816(6) claims holding that: “[a] close examination of the plaintiff’s allegations . . . reveals that there are no specific factual references to the defendant’s action towards other insureds . . . . As all of the

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<sup>92</sup> *Id.* at \*3.

<sup>93</sup> *Id.*

<sup>94</sup> *Id.*

<sup>95</sup> *Id.*

<sup>96</sup> *Hellberg v. Travelers Home & Marine Ins. Co.*, No. HHDCV095030438S, 2010 WL 3584551, at \*1 (Conn. Super. Ct. Aug. 13, 2010).

<sup>97</sup> *Id.*

<sup>98</sup> *Id.* at \*3.

factual allegations in [the count at issue] involve only the settlement negotiations between the plaintiff and the defendant and fail to reference other insureds, the plaintiff has not alleged a general business practice.” In that case, the court held that allegations that the defendant “has in the past engaged, and continues to engage in unfair and deceptive acts and/or practices” were insufficient for the purpose of § 38a-816(6).<sup>99</sup>

In some cases, the court explicitly analyzes how the Connecticut fact pleading standard should be applied to CUIPA claims. One such case is *Currie v. Aetna Casualty & Surety Co.*, where there was disagreement amongst the parties as to the limits of the plaintiffs’ insurance policy when the plaintiffs’ store and warehouse burned down.<sup>100</sup> Aetna moved to strike the plaintiffs’ CUIPA claims, as the plaintiffs had made the broad allegation that they and “other insureds and policy holders of the defendants” had suffered misconduct.<sup>101</sup> In granting defendant’s motion to strike, the court held that:

[s]uch bald allegations are properly seen as legal conclusions, particularly since the plaintiffs make no attempt to plead any facts identifying these “other occasions.” It is recognized that while Connecticut is a fact pleading jurisdiction, requiring that “[e]ach pleading shall contain a plain and concise statement of the material facts on which the pleader relies,” the pleader, nevertheless, is not required to plead “the evidence by which [material facts] are to be proved.” But here, no facts are alleged essential to establishing an unfair pattern of general business practice by Aetna, as required by Section 38a-816(6). As Aetna contends, the plaintiffs “have inserted the magic words of other acts of insurance misconduct by the defendant, although not stating the factual basis for that claim.”<sup>102</sup>

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<sup>99</sup> *Id.* (quoting *Finocchio v. Atl. Mut. Ins. Co.*, No. FSTCV095009607S, 2009 WL 1335073, at \*4 (Conn. Super. Ct. Apr. 22, 2009)).

<sup>100</sup> *Currie v. Aetna Cas. & Sur. Co.*, No. CV 960558900, 1999 WL 682041, at \*1 (Conn. Super. Ct. Aug. 12, 1999).

<sup>101</sup> *Id.* at \*4.

<sup>102</sup> *Id.* (internal citations omitted).

This line of cases clearly indicates that a plaintiff cannot merely insert key phrases and plural terms into their complaint to make it appear as though other claimants have suffered the same unfair settlement practices. For a complaint to be factually sufficient to survive a motion to strike under Connecticut's fact pleading standard, the plaintiff must provide information as to the identities of other insureds that have suffered misconduct, and must demonstrate that they have suffered the same type of misconduct alleged in their complaint.

For example, in *National Publishing Co., Inc. v. Hartford Fire Insurance Co., Inc.*, the plaintiff sought insurance coverage following a series of thefts, but had difficulty collecting covered costs from the insurer.<sup>103</sup> The plaintiff attempted to illustrate the frequency of misconduct by listing eight other parties who had allegedly filed complaints against the insurer with the Connecticut Insurance Department.<sup>104</sup> In granting the insurer's motion to strike, the court recognized that "the plaintiff fails to establish what facts, if any, support those entities' complaints. The only misconduct pleaded, therefore, is the 'isolated instance' of wrongdoing that occurred against the plaintiff."<sup>105</sup> Because the complaint failed to establish these facts, the court held that the plaintiff's CUIPA claim was not sufficiently pled, and granted the insurer's motion to strike.<sup>106</sup>

This first line of cases sheds light on the level of fact required to state a CUIPA claim in accordance with Connecticut fact pleading standards. From these cases, we can derive a general rule that plaintiffs must do more than allege that the insurer's misconduct has occurred with frequency;<sup>107</sup> they must plead sufficient supporting facts, rather than merely using plural terms alleging that "others" have suffered the same misconduct.<sup>108</sup> The judges considering these cases have analyzed not only the purpose of the CUIPA statute itself, but have taken it into consideration in conjunction with the legislative intent of the statute and the Connecticut

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<sup>103</sup> Nat. Publ'g Co. v. Hartford Fire Ins. Co., No. CV 970156478S, 1998 WL 166169, at \*1 (Conn. Super. Ct. Mar. 25, 1998).

<sup>104</sup> *Id.* at \*2.

<sup>105</sup> *Id.*

<sup>106</sup> *Id.*

<sup>107</sup> *Quimby v. Kimberly Clark Corp.*, 613 A.2d 838, 845 (Conn. App. Ct. 1992).

<sup>108</sup> *Ciarleglio v. Fireman's Fund Ins. Co.*, No. CV90 0276028 S, 1993 WL 541609, at \*3 (Conn. Super. Ct. Dec. 16, 1993); *Currie v. Aetna Cas. & Sur. Co.*, No. CV 960558900, 1999 WL 682041, at \*4 (Conn. Super. Ct. Aug. 12, 1999); *National Pub. Co. v. Hartford Fire Ins. Co.*, No. CV 970156478S, 1998 WL 166169, at \*2 (Conn. Super. Ct. Mar. 25, 1998).

standards for pleading a claim. The strength of this line of cases, therefore, is that it takes into consideration Connecticut law as a whole, and does not merely pick and choose certain rules to follow in certain circumstances.

#### B. LINE 2: LIBERAL CONSTRUCTION OF THE PLEADINGS

The second line of cases reviewing the standards for pleading a CUIPA claim concludes that claims alleging limited material facts may survive a motion to strike. The rationale for these holdings is that CUTPA and CUIPA are remedial in nature, and as such, should be construed liberally to benefit claimants.<sup>109</sup> Given that there is no appellate authority governing how much factual detail is required to allege a general business practice, and the district courts are split on this issue, courts that follow this second line of reasoning apply liberal construction in holding that such pleadings are sufficient to survive a motion to strike.<sup>110</sup>

The clear deficiency with these cases is that they fail to apply the Connecticut standard of fact pleading in evaluating the motion to strike. In *Wirth v. Progressive Casualty Insurance Company*, for example, the plaintiff brought a claim of unfair settlement practices under CUTPA/CUIPA against her insurer, in addition to claims of breach of contract and bad faith.<sup>111</sup> The insurer moved to strike the count under CUTPA/CUIPA, arguing that the complaint was factually insufficient and failed to set forth facts indicating unfair claim settlement as a general business practice.<sup>112</sup> In denying the insurer's motion to strike, the court noted that Connecticut courts are split as to the specificity of pleadings required, but gave deference to the fact that other trial courts had held that pleading specific instances of misconduct involving other insureds is not

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<sup>109</sup> *Nation v. Allstate Ins. Co.*, No. CV040093456S, 2005 WL 2364932, at \*2 (Conn. Super. Ct. Sept. 7, 2005) (“The court is aware that there is no appellate authority as to whether a plaintiff must plead other specific instances of unfair settlement practices on the part of an insurer in order to satisfy the allegation of a general business practice and that superior court decisions are split on this issue. Given the remedial nature of CUIPA and given that it is to be liberally construed to give effect to the legislature's intent, the court holds that the allegation of a general business practice in the plaintiff's complaint is sufficient to withstand a motion to strike.”).

<sup>110</sup> *Id.*

<sup>111</sup> *Wirth v. Progressive Cas. Ins. Co.*, No. CV095012844S, 2010 WL 654392, at \*1 (Conn. Super. Ct. Feb. 14, 2010).

<sup>112</sup> *Id.*

required.<sup>113</sup> There was no reasoning or discussion as to why these cases should be followed over those requiring specific instances of misconduct, and no rationale was given as to why notice-style pleadings are sufficient. The court in *Wirth* further stated that “[t]he plaintiff’s allegations of insurer misconduct reach beyond the plaintiff’s individual claim, as evidenced by her use of the plural ‘claims’ and ‘insureds.’ The plaintiff’s choice of words demonstrates that the acts are not confined to the plaintiff herself.”<sup>114</sup> However, the court never questioned how the plaintiff knew that other “insureds” had been similarly affected, or what the factual basis for these claims was. Because the court in *Wirth* did not evaluate or discuss the merits of the pleadings under Connecticut’s fact pleading rule, it is difficult to say whether merely pluralizing words in a complaint causes the pleading to contain facts sufficient to allege a general business practice.

The court in *Pettibone Tavern, LLC v. OneBeacon Midwest Ins. Co.* provided a more thorough analysis of its reasoning in denying an insurer’s motion to strike, but still neglected to apply Connecticut’s fact pleading standard in considering the merits of the complaint.<sup>115</sup> The insurer moved to strike the insured’s complaint alleging CUIPA violations, asserting that “[t]he better approach . . . is to require the plaintiff to do more than merely parrot the language contained within the CUIPA count and allege facts that demonstrate that the defendant engaged in a pattern of misconduct.”<sup>116</sup> The insured’s response was that “the more persuasive line of cases does not require that it allege specific instances of insurer misconduct.”<sup>117</sup>

In its reasoning, the *Pettibone Tavern* court considered the language of CUIPA, as well as the holding in *Lees* that the plaintiff must provide proof that the misconduct occurred with such frequency as to indicate a general business practice.<sup>118</sup> However, the court concluded that because the plaintiff included language that the misconduct occurred in “other claims”, the complaint survived the insurer’s motion to strike.<sup>119</sup> The court did not provide any reasoning as to why including this phrase in the

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<sup>113</sup> *Id.* at \*2-3.

<sup>114</sup> *Id.* at \*4.

<sup>115</sup> *Pettibone Tavern, LLC v. OneBeacon Midwest Ins. Co.*, No. CV106006711S, 2010 WL 4723384 (Conn. Super. Ct. Oct. 28, 2010).

<sup>116</sup> *Id.* at \*4.

<sup>117</sup> *Id.*

<sup>118</sup> *Id.* at \*5 (citing *Lees v. Middlesex Ins. Co.*, 643 A.2d 1282, 1283 (Conn. 1994)).

<sup>119</sup> *Id.* at \*6.

complaint made it sufficient, nor did it mention how its conclusion fit in with the requirement of proving frequency as stated in *Lees*.

Some opinions stemming from cases in this line not only fail to consider the applicable state law, they provide no analysis whatsoever as to the level of fact must be pled in order to constitute a general business practice. In *Bates v. Utica Mutual Insurance Co.*, the plaintiff brought a CUIPA claim against her insurer, alleging that her workers' compensation claims were handled inappropriately during settlement.<sup>120</sup> In her complaint, she set forth six instances of alleged misconduct pertaining to her single workers' compensation claim.<sup>121</sup> Although the court acknowledged that a CUIPA claim must include a showing of more than a single act of misconduct under *Mead* and *Quimby*, the insurer's motion to strike was denied.<sup>122</sup> The court reasoned that "[t]he plaintiff has also alleged that the defendant has committed the same acts 'with such frequency as to indicate a general business practice.' . . . The allegation of a general business practice in the plaintiff's complaint is sufficient to withstand a motion to strike."<sup>123</sup> In doing so, the court in *Bates* not only failed to discuss the Connecticut fact pleading standard, they also ignored the reasoning in cases requiring more factual support to allege a general business practice. They provided no explanation as to why the plaintiff's allegations were sufficient. Finally, the court in *Bates* did not offer any discussion as to why an allegation of a general business practice is an appropriate factual component of a pleading, rather than a legal conclusion.

What is missing in these cases is an analysis of Connecticut law as a whole. Cases in this line do not take into consideration the level of facts required in a complaint under Connecticut fact pleading standards. While most of the cases in this line of reasoning acknowledge widely-followed cases such as *Mead*, *Quimby* and *Lees*, which require proof of frequent insurer misconduct, they merely cite these cases as a rule and then form their own, unrelated conclusions.<sup>124</sup> Many such cases hold that it is factually sufficient to assert that several other persons have suffered similar insurer misconduct, without naming those persons or stating any facts to demonstrate how the instances of misconduct were similar. Furthermore, it is difficult to tell how the courts reason through their decisions in this line

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<sup>120</sup> *Bates v. Utica Mut. Ins. Co.*, No. CV020088925S, 2003 WL 21327656, at \*1 (Conn. Super. Ct. May 29, 2003).

<sup>121</sup> *Id.* at \*2.

<sup>122</sup> *Id.* at \*3.

<sup>123</sup> *Id.*

<sup>124</sup> *See, e.g., id.* at \*3.



of cases, as there is rarely a thorough discussion or analysis of the relevant law. These courts often rely on other trial-level decisions stating that no facts concerning other instances of misconduct are required, without explaining their reliance or analyzing the justification for these holdings.

This line of cases is more favorable to insureds, who may have meritorious claims but lack the factual detail to properly articulate these claims at the pleading stage. However, denying a motion to strike does provide a plaintiff their day in court, but it does so at an enormous potential discovery cost to the insurer. Courts analyzing a complaint without the full force of Connecticut law in mind are exposing insurers to needless litigation that was not intended by the legislature in crafting the CUIPA statute.

### C. PLEADING STANDARDS APPLIED TO CUIPA CLAIMS IN FEDERAL COURTS

CUIPA claims heard in federal court by diversity jurisdiction are subject to federal pleading standards.<sup>125</sup> Because the federal plausibility pleading standard is less stringent than Connecticut's fact pleading standard, one might assume that more CUIPA claims survive dismissal in federal court. However, this is not the case; the Connecticut District Court has held that unsubstantiated allegations of unfair settlement as a general business practice are not compliant with the plausibility pleading standard.

In 2010, the Connecticut District Court applied the *Twombly* and *Iqbal* plausibility pleading standard to a CUIPA claim in *Ensign Yachts, Inc. v. Arrigoni*.<sup>126</sup> In *Ensign Yachts*, a yacht insured by Lloyd's of London was damaged during transportation for sale.<sup>127</sup> In its complaint, Ensign Yachts alleged that the insurer violated CUIPA's prohibition against unfair settlement practices by refusing to cooperate in the claims process and ultimately denying the claim without justification.<sup>128</sup> However, the complaint asserted facts describing the unfair settlement practices suffered by Ensign Yachts and alleged that this was a general business practice of Lloyd's, but did not identify any other specific instances of similar unfair claim settlement practices.<sup>129</sup>

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<sup>125</sup> See discussion of federal pleading standards *supra* Part II.

<sup>126</sup> *Ensign Yachts, Inc. v. Arrigoni*, No. 3:09-cv-209, 2010 WL 918107, at \* 3 (D. Conn. Mar. 11, 2010).

<sup>127</sup> *Id.* at \*1-2.

<sup>128</sup> *Id.* at \*17.

<sup>129</sup> *Id.*

In its decision, the *Ensign Yachts* court commented on the split amongst Connecticut trial courts as to whether unsubstantiated allegations of unfair claims settlement as a “general business practice” are sufficient to plead a CUIPA claim. The court stated:

Given the remedial nature of CUTPA and CUIPA, the Court would be inclined to agree with those courts which have held that the allegation of a general business practice, unsupported by specific instances of insurer misconduct in other cases, is sufficient to withstand a motion to dismiss. However, the applicable pleading standard for this forum requires a complaint to “contain sufficient factual matter, accepted as true, to ‘state a claim to relief that is plausible on its face.’” “A pleading that offers labels and conclusions or a formulaic recitation of the elements of a cause of action will not do. Nor does a complaint suffice if it tenders ‘naked assertion[s]’ devoid of ‘further factual enhancement.’” Thus, under the *Iqbal* pleading standard, a mere assertion of a general business practice without anything more is insufficient to sustain Ensign’s “CUIPA through CUTPA” claims against Lloyds . . . for violation of Conn. Gen. Stat. § 38a-816(6). Accordingly, the Court dismisses these claims.<sup>130</sup>

The Connecticut District Court has reached similar conclusions in other cases applying the *Twombly* and *Iqbal* plausibility standard. One such case is *O’Neill v. Riversource Life Ins. Co.*, where the plaintiff asserted that “upon information and belief” the defendant had evaded disability income claims “as a general business practice.”<sup>131</sup> The court in *O’Neill* dismissed the plaintiff’s CUIPA claim, stating that “[w]hile pleading ‘upon information and belief’ is permitted, O’Neill is obligated to do more than recite the elements of the cause of action.”<sup>132</sup>

The District Court’s application of the plausibility standard is notable for two reasons. First, cases such as *Ensign Yachts* and *O’Neill* illustrate that pleadings asserting unfair claims settlement as a general business practice “upon information and belief” do not pass the threshold

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<sup>130</sup> *Id.* (citations omitted).

<sup>131</sup> *O’Neill v. Riversource Life Ins. Co.*, No. 3:10-CV-898 JCH, 2010 WL 3925988, at \*3 (D. Conn. Sept. 29, 2010).

<sup>132</sup> *Id.* (citation omitted).

of the plausibility pleading standard. As such, similar unsubstantiated pleadings would not comply with Connecticut's more stringent fact pleading standard. Also, the fact that the federal courts apply federal pleading standards to CUIPA claims raises a potential *Erie* issue. The *Erie* doctrine discourages forum shopping between state and federal jurisdictions by binding the federal court to apply local substantive law and federal procedural law to matters sitting in diversity.<sup>133</sup> If the standards for pleading a CUIPA claim were found to be substantive law for *Erie* purposes,<sup>134</sup> the federal courts might be required to apply Connecticut pleading standards.<sup>135</sup> Although not the focus of this note, the treatment of CUIPA claims in federal courts would be a factor worth considering if this issue reaches the Connecticut Supreme Court.

## VI. ANALYSIS FOR FUTURE DEVELOPMENTS

Although a split opinion amongst courts as to the factual standards for pleading a CUIPA claim might be confusing, it is not unusual. Cases and motions are decided based on a judge's objective opinion, and each judge emphasizes different facts and arguments within a case.<sup>136</sup> As a result, the body of case law is not always perfectly consistent, but varies based on which judge was hearing a particular case and what facts and precedent they chose to emphasize. Our legal system is based on precedent, and in deciding which decisions to rely on, the judge must objectively analyze the facts at hand and identify similarities with past cases.<sup>137</sup> When opinions on a point of law appear to be split amongst the courts, as in this

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<sup>133</sup> *Erie R. Co. v. Tompkins*, 304 U.S. 64 (1938). "Except in matters governed by the Federal Constitution or by acts of Congress, the law to be applied in any case is the law of the state." *Id.* at 78.

<sup>134</sup> One might assume that pleading standards are procedural law; however, other seemingly procedural laws have been found substantive for purposes of *Erie* analysis. *See, e.g.,* *Resolution Trust Corp. v. Deloitte & Touche*, 818 F. Supp. 1406, 1407-08 (D. Colo. 1993) (finding state statute concerning notice of settlement to nonparty persons to be substantive law).

<sup>135</sup> *But see* *Gasperini v. Ctr. for Humanities, Inc.*, 518 U.S. 415, 427 n.7 (1996) (noting that where the matter in question is governed by the Federal Rules of Civil Procedure, "the Federal Rule applies regardless of contrary state law").

<sup>136</sup> David Lyons, *Formal Justice and Judicial Precedent*, 38 VAND. L. REV. 495, 499 (1985).

<sup>137</sup> *Id.* at 501.

case, the judge must analyze how another court justified its decision in determining whether it is appropriate to join it.<sup>138</sup>

For some legal issues, splits amongst trial courts persist until legislation is drafted in an attempt to clarify the law and assist the courts in rendering consistent decisions amongst cases with similar facts and claims. Despite the conflicting trial court decisions stemming from the general business practice requirement to plead an unfair settlement practice under CUIPA, the legislature has yet to enact any law to correct this issue. In 2009, a bill was proposed in the Connecticut General Assembly that would eliminate the portion of CUIPA requiring that unfair settlement practices occur “with such frequency as to indicate a general business practice.”<sup>139</sup> The stated purpose of the bill was “[t]o allow a private cause of action for unfair claim settlement practices without the necessity of showing a general business practice on the part of an insurer.”<sup>140</sup> However, this bill was not enacted.

The fact that new legislation has not been enacted speaks to the importance of the legislature’s intent in adopting the language of the statute. The role of the courts is to construe and apply the plain language of the statute, and the legislature is free to step in and provide instructions if the court misconstrues its intentions.<sup>141</sup> Inaction by the legislature is characterized as acquiescence in the court’s construction of a statute.<sup>142</sup> The fact that the legislature has not acted to remove the “general business practice” language of CUIPA therefore indicates its acquiescence with this language, and with the courts’ requirement of a showing of multiple unfair practices by an insurer to satisfy a CUIPA claim.

The treatment of CUIPA claims in federal court is also indicative of how the Connecticut Supreme Court might rule on this issue. As seen in cases such as *Ensign Yachts* and *O’Neill*, the Connecticut District Court has held that allegations of unfair claim settlement as a “general business practice” are insufficient to plead a CUIPA claim when applying a plausibility pleading standard.<sup>143</sup> The plausibility pleading standard is not as demanding as fact pleading, requiring just slightly more factual allegations than notice pleading.<sup>144</sup> If unsubstantiated allegations are

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<sup>138</sup> *Id.* at 502.

<sup>139</sup> S.B. 763, Gen. Assemb., Jan. Sess. (Ct. 2009).

<sup>140</sup> *Id.*

<sup>141</sup> *Hall v. Gilbert & Bennett Mfg. Co.*, 695 A.2d 1051, 1060 (Conn. 1997).

<sup>142</sup> *Id.*

<sup>143</sup> *See supra* Part V.C.

<sup>144</sup> Steinman, *supra* note 2, at 1298.

insufficient to comply with plausibility pleading standards, it is likely that the Connecticut Supreme Court would find them similarly insufficient to meet the state's more stringent fact pleading standard.

Public policy rationale may also play a significant role in the future analysis of the standards for pleading a CUIPA claim. If pleading standards are too stringent, plaintiffs may be deterred from bringing valid CUIPA claims simply because they do not have specific facts illustrating the insurer's general business practice, and no access to discovery to ascertain such facts. Insurers should not be permitted to repeatedly commit unfair insurance practices purely because plaintiffs cannot meet Connecticut's stringent fact pleading standard.

If the Connecticut Supreme Court were to place high value on these public policy considerations, there may be ways to accommodate plaintiffs without circumventing the fact pleading standard. For example, plaintiffs could be granted a limited opportunity for discovery before a complaint is dismissed for lack of specific facts. Alternatively, the Connecticut Insurance Department or other regulatory entities could assist plaintiffs by keeping records of unfair settlement claims, which plaintiffs could use to identify other insureds who suffered similar wrongdoing. However, although these proposed solutions might address public policy concerns, they also have the potential to place undue strain on insurers; more insureds may take advantage of the limited opportunity for discovery, thus subjecting insurers to more frequent, costly and time-consuming discovery expeditions. Because public policy considerations have serious implications for both insureds and insurers, any proposed solutions should be considered carefully, noting that well-reasoned trial court cases, the lack of corrective legislation, and the treatment of CUIPA claims in federal courts all indicate that specific facts must be pled alleging a general business practice.

## VII. CONCLUSION

Based on the plain language of the statute, CUIPA was intended for use against insurers that commit more than a single and isolated act of misconduct.<sup>145</sup> However, trial court judges apply different standards in analyzing the level of facts necessary to plead a general business practice. As long as the general business practice requirement exists, and until the issue is decided at the appellate level, there will continue to be debate amongst judges over the level of fact required to plead a CUIPA claim.

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<sup>145</sup> *Lees v. Middlesex Ins. Co.*, 643 A.2d 1282, 1285 (Conn. 1994).

When thoughtfully considered, it is clear that there is no compelling reason to excuse CUIPA claims from following Connecticut's fact pleading standard. It is true that it is difficult for individual plaintiffs to find factual evidence to support their allegations of general business practice without the benefit of full trial discovery, but it is by no means impossible. Therefore, plaintiffs should not be permitted to plead claims "based on information and belief," or with unsubstantiated conclusions that others have experienced the same misconduct, as such pleadings do not meet the Connecticut fact pleading standard.

# **SUBPRIME AND CREDIT CRISIS INVESTIGATIONS: WHAT CONSTITUTES A CLAIM FOR THE PURPOSES OF PROFESSIONAL LIABILITY INSURANCE?**

CAITLIN P. HOLT\*

## I. INTRODUCTION

The subprime mortgage and credit crisis has generated an unprecedented wave of lawsuits and government investigations of lenders and financial institutions. The lending companies and financial institutions have turned to their Directors and Officers (D&O) and Errors and Omissions (E&O) liability insurance policies to cover the substantial costs of defending against the regulatory investigations and lawsuits.<sup>1</sup> The scope of coverage under D&O and E&O policies varies significantly, with a number of exclusions and policy limitations excusing insurance companies from their duty to defend or reimburse the insureds under certain circumstances. The financial crisis has given rise to controversy over what legal and investigative proceedings constitute a “claim” for the purposes of triggering coverage under D&O and E&O policies. With substantial legal fees and considerable government fines at stake, the definition of a “claim” is of increasing importance to insurance companies and the financial institutions they insure.

Although a number of jurisdictions have addressed the meaning of a “claim” in the context of a professional liability policy, the law regarding whether government and regulatory investigations trigger coverage under D&O and E&O policies continues to evolve. Two Court of Appeals decisions recently examined whether government and regulatory investigations fell within the policy definitions of a “securities claim” and reached divergent conclusions as a result of differing facts and policy language.<sup>2</sup> These cases will have important ramifications for the treatment of government and regulatory investigations of corporate wrongdoing, as

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<sup>1</sup> It is estimated that as many as 95% of Fortune 500 companies have D&O liability policies. David M. Gische, *Directors and Officers Liability Insurance*, FINDLAW (2000), <http://library.findlaw.com/2000/Jan/1/241472.html>.

<sup>2</sup> *Office Depot, Inc. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.*, 453 F. App'x 871, 873-75 (11th Cir. 2011); *MBIA Inc. v. Fed. Ins. Co.*, 652 F.3d 152, 155 (2d Cir. 2011).

well as the professional liability insurance industry as a whole. The purpose of this article is to examine the recent wave of government and regulatory investigations related to the subprime mortgage and credit crisis and its implications for D&O and E&O liability insurance. More specifically, this article will explore the kinds of legal proceedings that have been interpreted by courts to fall within policy definitions of a “claim,” so as to evaluate whether government and regulatory investigations into subprime lending practices will be covered by D&O or E&O policies.

## II. THE INVESTIGATIONS

Given the catastrophic financial losses associated with the 2008 subprime mortgage and credit crisis and the subsequent financial meltdown, it is not surprising that government and regulatory agencies have commenced investigations into corporate and lending behavior.<sup>3</sup> The financial crisis provoked investigations into corporate wrongdoing by a number of state and federal watchdogs, among them the Securities and Exchange Commission (SEC), the Federal Bureau of Investigation (FBI), the Federal Deposit Insurance Corporation (FDIC), the Federal Trade Commission (FTC), and several State Attorneys General.<sup>4</sup> The SEC began its investigation into subprime mortgage lending in 2007 when it formed a working group to investigate whether companies involved in subprime mortgage lending were liable under federal securities law for failure to disclose information to investors.<sup>5</sup> In the five years since, the SEC has brought lawsuits against a range of financial institutions, including Fannie Mae and Freddie Mac.<sup>6</sup> The FBI also launched investigations into subprime lending practices shortly after the crisis unfolded; in 2008, it announced it was investigating fourteen corporations that had been involved in subprime lending as part of its larger Subprime Mortgage Industry Fraud Initiative

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<sup>3</sup> John F. McCarrick, *Subprime Claims: D&O and E&O Liability and Coverage Implications*, 775 PLI/Lit 299, 303-04 (April 2008).

<sup>4</sup> Kenneth M. Breen & Thomas R. Fallati, *Subprime Lending Meltdown – Part Three: Federal and State Investigations*, STAY CURRENT (Paul Hastings LLP, New York, N.Y.), July 2007, at 1-2, available at <http://www.paulhastings.com/assets/publications/742.pdf>.

<sup>5</sup> *Id.* (citing Karey Wutkowski, *SEC’s Cox Reveals CDO Probes, Fund Valuation Review*, REUTERS (June 26, 2007, 8:49 PM), <http://www.reuters.com/article/2007/06/27/sec-congress-idUSN2625573520070627>).

<sup>6</sup> Press Release, U.S. Sec. and Exch. Comm’n, SEC Charges Former Fannie Mae and Freddie Mac Executives with Securities Fraud (Dec. 16, 2011).



launched the prior year.<sup>7</sup> The FBI's probe focused on firms suspected of engaging in accounting fraud, improperly securing loans, and insider trading.<sup>8</sup>

In 2010, the FDIC, a federal agency responsible for investigating crime at financial institutions, announced that it was intensifying efforts to identify wrongdoing and punish recklessness, fraud, and other criminal behavior that contributed to the bank failures.<sup>9</sup> The agency launched fifty criminal investigations of bank executives, directors, and employees of failed U.S. banks across the country.<sup>10</sup> The Wall Street Journal reported that “[h]undreds of ‘demand’ letters [were] sent to former executives, directors and other employees, as well as their professional-liability insurers, putting them on notice of potential claim . . . .”<sup>11</sup> Since then, the FDIC has filed over two dozen lawsuits against failed institutions and authorized many more.<sup>12</sup> The FDIC investigations and lawsuits come several years after the initial wave of bank failures, but officials say it takes a minimum of 18 months to prepare for legal action after a bank fails.<sup>13</sup> It is thus entirely possible the investigations will continue to multiply as the agency turns its attention to more recent bank failures.

States have also assumed an active role in the subprime investigations. The Attorneys General in New York, California, Illinois, Massachusetts, Ohio and Connecticut have all initiated investigations of financial institutions that were involved in the subprime crisis in their

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<sup>7</sup> *Subprime Loans and More: It's a Bull Market for Financial Fraud*, FBI (Jan. 31, 2008), [http://www.fbi.gov/news/stories/2008/january/fin\\_fradu013108](http://www.fbi.gov/news/stories/2008/january/fin_fradu013108).

<sup>8</sup> Kirke M. Hasson & Ernest T. Patrikis, *Here Come the Regulators*, PILLSBURY (June/July 2008), <http://www.pillsburylaw.com/siteFiles/Publications/5217C99E2A691AA548942891FDB7C691.pdf>.

<sup>9</sup> Jean Eaglesham, *U.S. Sets 50 Bank Probes*, WALL ST. J., Nov. 17, 2010, at A1, available at <http://online.wsj.com/article/SB10001424052748703628204575619000289073686.html>.

<sup>10</sup> *Id.*

<sup>11</sup> *Id.*

<sup>12</sup> The FDIC website states: “As of March 20, 2012, the FDIC has authorized suits in connection with 54 failed institutions against 469 individuals for D&O liability with damage claims of at least \$7.9 billion. This includes 27 filed D&O lawsuits (2 of which have been dismissed after settlement with the named directors and officers) naming 222 former directors and officers.” *Professional Liability Lawsuits*, FDIC, <http://www.fdic.gov/bank/individual/failed/pls/> (last visited Mar. 21, 2012).

<sup>13</sup> *Id.*

states.<sup>14</sup> The state investigations have focused on whether mortgage lenders are liable under federal and state laws and regulatory statutes for deceptive disclosure practices with borrowers.<sup>15</sup> Depending on the state, consumer protection violations of this kind can result in both criminal and civil liability.<sup>16</sup> In his 2012 State of the Union address, President Obama announced that Attorney General Eric Holder would launch “a special unit of federal prosecutors and leading state attorneys general to expand [the] investigations into the abusive lending and packaging of risky mortgages that led to the housing crisis.”<sup>17</sup>

In addition to government and regulatory investigations into subprime-related activity, financial institutions may commission internal or “special litigation committee” investigations of their own.<sup>18</sup> If a corporation believes its officers or directors may be involved in wrongdoing, it may choose to perform its own internal investigation. Sometimes the internal investigation is prompted by an external investigation similar to the examples discussed above. At other times, internal investigations are brought about in response to a demand by a shareholder who is planning to bring a derivative lawsuit.<sup>19</sup> Either way, corporations commonly form “special litigation committees” to conduct independent investigations of suspected misconduct.<sup>20</sup>

The costs of defending a policyholder against government or regulatory investigations of corporate wrongdoing are staggering. It is not uncommon for companies to spend millions of dollars responding to government and regulatory investigations and defending against follow-up litigation. For example, in a recent New York case a company sued its insurer to recover \$29.5 million it spent responding to a SEC and state

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<sup>14</sup> Breen & Fallati, *supra* note 4, at 1; Nat’l Ass’n of Attorneys Gen., *The Housing Bust and Approaches to the Mortgage Foreclosure Crisis*, NAAGazette (2007).

<sup>15</sup> Breen & Fallati, *supra* note 4, at 1-3.

<sup>16</sup> *Id.* at 2.

<sup>17</sup> President Barack Obama, State of the Union Address (Jan. 24, 2012).

<sup>18</sup> AMERICAN COLLEGE OF TRIAL LAWYERS, RECOMMENDED PRACTICES FOR COMPANIES AND THEIR COUNSEL IN CONDUCTING INTERNAL INVESTIGATIONS 1 (2008).

<sup>19</sup> *Id.*

<sup>20</sup> Edwards Angell Palmer & Dodge LLP, *Addressing Coverage for SLC-Incurred Legal Costs*, LAW360 (Jan. 28, 2010), <http://www.law360.com/articles/146250/addressing-coverage-for-slc-incurred-legal-costs>.

investigation, only \$6.4 million of which the insurer agreed to pay.<sup>21</sup> The costs associated with corporate investigations are substantial for several reasons. First, the investigations typically involve a large number of individuals, thus requiring a lot of time, money, and legal assistance.<sup>22</sup> Secondly, the investigation periods may consume months, or in some cases, years.<sup>23</sup> Moreover, indemnification obligations often require corporations to cover the legal expenses incurred by individuals employed by the corporation.<sup>24</sup> In many cases, state corporate indemnification statutes require companies to indemnify their directors and officers in order to shield them from personal liability should they make an unwise business decision.<sup>25</sup> If an investigation leads to a lawsuit, the insurer may find itself exposed to many more millions of dollars worth of claims. Indeed, a number of the biggest financial institutions have already reached \$400 to \$600 million-dollar settlements in subprime-related litigation.<sup>26</sup> Subprime-related investigations thus threaten to cost insurance companies vast sums under D&O and E&O policies, whether the investigations reach the courts or not.

### III. WILL D&O AND E&O INSURANCE COVER THE COSTS OF DEFENDING AGAINST SUBPRIME-RELATED INVESTIGATIONS?

With so many subprime-related investigations surfacing on the heels of the financial crisis, both insurers and policyholders should be concerned with whether D&O and E&O (together sometimes referred to as “professional liability”) policies will cover the costs of responding to investigative inquiries and paying for legal defense fees. D&O insurance,

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<sup>21</sup> *MBIA Inc. v. Fed. Ins. Co.*, No. 08 civ. 4313, 2009 WL 6635307, at \*4 (S.D.N.Y. Dec. 30, 2009), *aff'd in part, rev'd in part*, 652 F.3d 152, 172 (2d Cir. 2011).

<sup>22</sup> Patricia Bronte, *D&O Coverage for Corporate Criminal Investigations*, 7 NO. 11 INS. COVERAGE L. BULL. 1, 2 (2008).

<sup>23</sup> *Id.*

<sup>24</sup> *Id.*

<sup>25</sup> Joseph P. Monteleone & Nicholas J. Conca, *Directors and Officers Indemnification and Liability Insurance: An Overview of Legal and Practical Issues*, 51 BUS. LAW. 573, 574 (1996).

<sup>26</sup> Kevin LaCroix, *A Status Update on the Subprime and Credit Crisis-Related Litigation*, THE D&O DIARY (Jan. 9, 2012), <http://www.dandodiary.com/2012/01/articles/subprime-litigation/a-status-update-on-the-subprime-and-credit-crisisrelated-litigation>.

which was developed after the 1929 stock market crash, is intended to cover the cost of indemnifying and defending a corporation's directors and officers for wrongful acts committed while carrying out their corporate responsibilities.<sup>27</sup> In contrast, E&O insurance provides more general coverage for defense costs arising from wrongful acts committed by the corporation and its employees.<sup>28</sup> Generally, the insurance company's duty to defend a policyholder is activated when a lawsuit is initiated.<sup>29</sup> If the allegations in the complaint support a cause of action that falls within the scope of the policy, coverage is triggered.<sup>30</sup>

Whether the policy will cover the costs associated with responding to and defending against a government or regulatory investigation depends, of course, on the actual language of the policy.<sup>31</sup> D&O and E&O insurers do not share a common form, so policies vary from carrier to carrier.<sup>32</sup> While most policies share similar conditions and exclusions, insurance companies have developed their own terms and wordings over the years.<sup>33</sup> What may seem like a trivial difference in the wording of a key term could make all the difference with regard to the policy's coverage.<sup>34</sup> Insurance policies feature a number of exclusions and limitations on coverage, and it is common for insurance companies to deny coverage as a result. Absent an applicable policy exclusion, insurers have relied on ambiguities in the policy terms to deny coverage. Recently, insurers have capitalized on ambiguity in the term "claim" to avoid covering fees and costs associated with investigations.

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<sup>27</sup> JOSEPH P. MONTELEONE & CARRIE E. COPE, *DIRECTORS' AND OFFICERS' (D&O) LIABILITY: EXPOSURES, RISK MANAGEMENT AND INSURANCE COVERAGE* 1 (2008).

<sup>28</sup> Charles Allen Yuen, *Errors & Omissions Insurance Coverage: Common Claim Scenarios*, 827 PLI/Lit 65, 67 (June 2010).

<sup>29</sup> 1 ALLAN D. WINDT, *INSURANCE CLAIMS AND DISPUTES: REPRESENTATION OF INSURANCE COMPANIES AND INSURED* § 4:1 (5th ed. 2010).

<sup>30</sup> *Id.*

<sup>31</sup> Bronte, *supra* note 22, at 2.

<sup>32</sup> Randy Paar, *Directors and Officers Insurance*, in *D&O LIABILITY & INSURANCE 2004: DIRECTORS & OFFICERS UNDER FIRE* 9, 21 (2004).

<sup>33</sup> CATHERINE HANNA, *SUBPRIME PRIMER: WHERE'S THE PRIMARY EXPOSURE?* 4 (2008), available at <http://www.hannaplaut.com/publications/SubprimePrimer.pdf>.

<sup>34</sup> Robert D. Chesler & Cindy Tzvi Sonenblick, *Does A Subpoena Constitute A 'Claim' For Purposes Of D&O Insurance Coverage?*, 14 MEALEY'S EMERGING INS. DISPUTES 1, 1 (2009).

Should a policyholder be denied coverage under its professional liability policy, it has a number of remedies. Most often, the insured brings a declaratory judgment action against the insurer seeking a declaration of coverage under the policy.<sup>35</sup> Policyholders also have the option of suing for breach of contract damages<sup>36</sup> or breach of good faith and fair dealing.<sup>37</sup> Insurers must therefore be cautious when denying coverage. In D&O and E&O coverage disputes, the policyholder has the burden of proving that the claim falls within the policy's coverage.<sup>38</sup> When a policy exclusion is at issue, however, the insurer has the burden of proving that the exclusion applies.<sup>39</sup>

#### IV. WHAT CONSTITUTES A "CLAIM" FOR THE PURPOSES OF D&O AND E&O INSURANCE?

D&O and E&O policies are designed as "claims made" policies, meaning coverage can only be triggered when a "claim" is made against the insured.<sup>40</sup> The scope of the term "claim" is unclear. As companies are increasingly confronted with subpoenas, document requests and similar inquiries in connection with government and regulatory investigations and lawsuits prompted by the financial crisis, the companies have submitted claims to their insurers seeking coverage under their D&O and E&O policies. In turn, a number of insurers have denied coverage on the premise that the subpoena, document request or inquiry does not constitute a "claim" under the policy. As a result, the meaning of a "claim" has recently become a hotly contested issue in determining whether coverage extends to government and regulatory investigations.<sup>41</sup>

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<sup>35</sup> See, e.g., *Diamond Glass Companies, Inc. v. Twin City Fire Ins. Co.*, No. 06-CV-13105(BSJ)(AJP), 2008 WL 4613170, at \*1 (S.D.N.Y. Aug. 18, 2008); *St. Paul Mercury Ins. Co. v. Foster*, 268 F. Supp. 2d 1035, 1040 (C.D. Ill. 2003); *Foster v. Summit Med. Sys., Inc.*, 610 N.W.2d 350, 353 (Minn. Ct. App. 2000).

<sup>36</sup> E.g., *Diamond Glass Companies*, 2008 WL 4613170, at \*1.

<sup>37</sup> E.g., *Ctr. for Blood Research, Inc. v. Coregis Ins. Co.*, 305 F.3d 38 (1st Cir. 2002).

<sup>38</sup> WINDT, *supra* note 29.

<sup>39</sup> *Id.*

<sup>40</sup> Monteleone & Conca, *supra* note 25, at 588.

<sup>41</sup> ORRICK, HERRIGTON & SUTCLIFFE LLP, *When Is a Claim Not a Claim? Insurance for Government and Regulatory Investigations, Insurance Recovery Case Law Update*, ORRICK 1 (2009), [www.orrick.com/fileupload/2055.pdf](http://www.orrick.com/fileupload/2055.pdf).

## A. DEFINING A "CLAIM"

In determining whether or not coverage applies to an investigation or noncourt proceeding, the policyholder and insurer must ask themselves whether the action in question gives rise to a "claim," and whether that claim was made during the policy period.<sup>42</sup> It follows that the critical question is, "What is a claim?" In the 1980's and 90's very few professional liability policies defined the term.<sup>43</sup> In one early case, the court quoted Justice Frankfurter as saying that "claim" is one of those "words of many-hued meanings [which] derive their scope from the use to which they are put."<sup>44</sup> When the meaning of the term was disputed in the earlier coverage cases, courts looked to the accepted meaning of the word within the context of the agreement, since "an insurance policy, like any contract, must be construed to effectuate the intent of the parties as derived from the plain meaning of the policy's terms."<sup>45</sup> The courts have determined that the term has no special meaning in the insurance industry.<sup>46</sup> The Merriam-Webster Dictionary defines the word "claim" as "a demand for something due or believed to be due."<sup>47</sup> According to Black's Law Dictionary, a "claim" is:

- (1) The aggregate of operative facts giving rise to a right enforceable by a court. (2) The assertion of an existing

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<sup>42</sup> Peter S. Selvin, *Parsing Policies*, LA DAILY J., May 29, 2009, at 7.

<sup>43</sup> Bronte, *supra* 20, at 2. Examples of cases disputing the meaning of the term in the absence of a policy definition include *Andy Warhol Found. for the Visual Arts, Inc. v. Fed. Ins. Co.*, 189 F.3d 208 (2d Cir.1999); *Winkler v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.*, 930 F.2d 1364 (9th Cir. 1991); *Polychron v. Crum & Forster Ins. Cos.*, 916 F.2d 461 (8th Cir. 1990); *MGIC Indem. Corp. v. Home State Savs. Ass'n*, 797 F.2d 285 (6th Cir. 1986); *In re Ambassador Group, Inc. Litig.*, 830 F. Supp. 147 (E.D.N.Y. 1993); *Mt. Hawley Ins. Co. v. Federal Sav. & Loan Ins. Corp.*, 695 F. Supp. 469 (C.D. Cal. 1987)).

<sup>44</sup> *MGIC*, 797 F.2d at 288 (quoting *Powell v. U.S. Cartridge Co.*, 339 U.S. 497, 529 (1950) (Frankfurter, J., dissenting)).

<sup>45</sup> *Andy Warhol*, 189 F.3d at 215 (citing *In re Prudential Lines, Inc.*, 158 F.3d 65, 77 (2d Cir. 1998)). See, e.g., *Polychron*, 916 F.2d at 463; *Joseph P. Bornstein, Ltd. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa.*, 828 F.2d 242, 245 (4th Cir. 1987); *Richardson Elecs, Ltd. v. Fed. Ins. Co.*, 120 F. Supp. 2d 698, 700-01 (N.D. Ill. 2000); *Resolution Trust Corp. v. Ayo*, 1992 WL 245552, at \*3 (E.D. La. Sept. 9, 1992), *aff'd*, 31 F.3d 285 (5th Cir. 1994).

<sup>46</sup> *Cent. Ill. Pub. Serv. Co. v. Am. Empire Surplus Lines Ins. Co.*, 642 N.E.2d 723 (Ill. App. Ct. 1994).

<sup>47</sup> MERRIAM-WEBSTER COLLEGIATE DICTIONARY 227 (11th ed. 2011).

right; any right to payment or to an equitable remedy, even if contingent or provisional. (3) A demand for money, property, or a legal remedy to which one asserts a right.<sup>48</sup>

Many courts have relied on a definition of an insurance “claim” as the “assertion, demand or challenge of something as a right; the assertion of liability to the party making it to do some service or pay a sum of money.”<sup>49</sup>

Due to the frequency of corporate scandals over the last decade, insurers have become more careful about defining key terms in insurance policies. Today, most D&O and E&O policies expressly define the term “claim,” albeit with variation.<sup>50</sup> The majority of D&O and E&O policies associate a “claim” with a civil lawsuit commenced by the service of a complaint.<sup>51</sup> Apart from civil lawsuits, however, the scope of the definition varies from policy to policy.<sup>52</sup> Some policies include criminal or administrative proceedings within the definition, and others define a “claim” more broadly to include arbitrations and mediations as well.<sup>53</sup> The definition may explicitly include government or regulatory investigations.<sup>54</sup> A “claim” is also sometimes defined more generally as the start of a “judicial or administrative proceeding.”<sup>55</sup>

Since the definition varies from one policy to the next, the precise wording is critical to determining if coverage extends to certain actions.<sup>56</sup> Where the definition specifically includes a “government or regulatory investigation” or a “judicial or administrative proceeding,” it is likely a formal government investigation into a company’s alleged wrongdoing related to subprime lending practices would fall within the meaning of a “claim.” Likewise, definitions that encompass “investigations by any

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<sup>48</sup> BLACK’S LAW DICTIONARY 281-82 (9th ed. 2009).

<sup>49</sup> See, e.g., *Mt. Hawley Ins. Co. v. Fed. Savs. & Loan Ins. Corp.*, 695 F. Supp. 469, 479 (C.D. Cal. 1987).

<sup>50</sup> Bronte, *supra* note 22, at 3.

<sup>51</sup> *When Is a Claim Not a Claim?*, *supra* note 41. The service of a complaint is “relatively easily recognizable as a claim.”

<sup>52</sup> *When Is a Claim Not a Claim?*, *supra* note 41.

<sup>53</sup> *Id.*

<sup>54</sup> *Id.*

<sup>55</sup> David E. Borden & Ellen B. Van Vechten, *Directors’ and Officers’ Liability Insurance*, in 4 *LAW AND PRACTICE OF INSURANCE COVERAGE LITIGATION* 47-12, 47-18 (David L. Leitner et al. eds., 2005).

<sup>56</sup> HANNA, *supra* note 33, at 4.

governmental entity into possible violation of law” will probably provide coverage for formal subprime investigations.<sup>57</sup>

The more challenging question is whether a preliminary investigation or proceeding – marked by a grand jury subpoena, document request, or informal inquiry or the like – falls within one of the policy definitions of a “claim.” Professional liability policies are frequently unclear as to whether coverage extends to preliminary investigations and noncourt proceedings commenced before the corporation or its directors and officers are formally threatened with a suit or charged with misconduct.<sup>58</sup> The majority of D&O and E&O policies “intend to treat as covered only those SEC or government fees and expenses incurred after the date the SEC elevates an investigation to formal status or the government issues a ‘target’ letter to an insured party.”<sup>59</sup> If the definition of a “claim” does not explicitly include the action in question (e.g. a subpoena, document request, target letter, etc.), the insurance company may have a basis for denying coverage for the costs associated with such an action.<sup>60</sup>

#### B. SUBPOENAS AND INVESTIGATIVE DEMANDS

Generally, investigations into corporate wrongdoing – whether led by an attorney general, a regulatory agency or a grand jury – begin with the issuance of a subpoena.<sup>61</sup> Most courts have held that a subpoena constitutes a “claim.”<sup>62</sup> The decisions, however, have been highly fact sensitive.<sup>63</sup> Any variation in policy wording or the facts of a case may affect the insurer’s duty to defend.

One of the first cases to address whether a subpoena or grand jury investigation falls within the meaning of a “claim” under a professional liability insurance policy was *Polychron v. Crum & Forster Ins. Co.*<sup>64</sup> After

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<sup>57</sup> R. Mark Keenan & Craig M. Hirsch, *Subprime Lending Litigation and Investigations: Insuring Against the Costs*, COMPLINET (May 2, 2007), <http://www.andersonkill.com/webpdfext/Complinet-May2007-KeenanAndHirsch.pdf>.

<sup>58</sup> Jonathan C. Dickey & Amy L. Goodman, Practising Law Institute, *Indemnification, D&O Insurance, and Other Funding Mechanisms*, in SECURITIES LITIGATION: A PRACTITIONER’S GUIDE 14-1, 14-24 (Jonathan C. Dickey ed., 2008).

<sup>59</sup> McCarrick, *supra* note 3, at 312.

<sup>60</sup> *When Is a Claim Not a Claim?*, *supra* note 41.

<sup>61</sup> Chesler & Sonenblick, *supra* note 34, at 1.

<sup>62</sup> *Id.*

<sup>63</sup> *Id.*

<sup>64</sup> *Polychron v. Crum & Forster Ins. Cos.*, 916 F.2d 461 (8th Cir. 1990).



a D&O insurer refused to reimburse a bank president for legal fees incurred during a grand jury investigation, the bank president (the policyholder) brought action to recover his losses.<sup>65</sup> He argued that the grand jury investigation, which began with receipt of a subpoena for documents, constituted a “claim” against him under the policy.<sup>66</sup> The insurance company, on the other hand, contended that a “claim” didn’t manifest until the grand jury indicted him – which occurred after the policy had expired.<sup>67</sup> Since the insurance policy did not define a “claim,” the court examined the ordinary meaning of the word and determined that the term was broad enough to encompass the grand jury investigation prior to the indictment:

The function of a subpoena is to command a party to produce certain documents and therefore constitutes a “claim” against a party. The subpoena, it is true, was directed to the bank, but the documents demanded . . . related to the plaintiff’s conduct as a bank official. Further, the grand jury’s investigation and the questioning by the Assistant United States Attorney amounted, as a practical matter, to an allegation of wrongdoing against [the policyholder], for which he prudently hired an attorney. The defendant’s characterization of the grand jury investigation as mere requests for information and an explanation underestimates the seriousness of such a probe.<sup>68</sup>

Likewise, in *Richardson Electronics, Ltd., v. Federal Insurance Co.* the U.S. District Court held that subpoenas and other demands made in a government investigation constituted a claim for the purposes of a professional liability policy.<sup>69</sup> After racking up more than \$5 million in legal fees in connection with a criminal antitrust violation investigation by the Antitrust Division of the Justice Department, Richardson Electronics (hereafter “Richardson”) sought reimbursement under its D&O policy.<sup>70</sup> As part of the investigation, the Justice Department served a Civil

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<sup>65</sup> *Id.* at 462.

<sup>66</sup> *Id.*

<sup>67</sup> *Id.*

<sup>68</sup> *Id.* at 463.

<sup>69</sup> *Richardson Elecs., Ltd. v. Fed. Ins. Co.*, 120 F. Supp. 2d 698, 701 (N.D. Ill. 2000).

<sup>70</sup> *Id.* at 699.

Investigative Demand and subpoenaed documents and testimony by Richardson executives and employees.<sup>71</sup> When Federal Insurance Co. (hereafter “Federal”) refused to pay, Richardson sued. Federal argued that the antitrust investigation did not constitute a “claim” under the policy, and as a result the costs associated with the investigation were not covered by insurance.<sup>72</sup> Although the policy defined a number key terms, like “wrongful act” and “losses,”<sup>73</sup> it did not supply a definition of the term “claim.”<sup>74</sup> The court examined the dictionary definition of the term (“a demand for something due or believed to be due”<sup>75</sup>) and concluded that the Justice Department’s investigation sufficed because it “required Richardson and its officers and directors to comply with various demands for testimony and production of documents.”<sup>76</sup> The court emphasized that a claim is a “demand for *something* due,” but not necessarily money.<sup>77</sup>

#### 1. A “Claim” is More than a Mere Threat or Document Request

The mere threat of litigation or legal action does not give rise to a “claim.”<sup>78</sup> By its very nature, a “claims-made” policy provides coverage for “claims” *made* against the insured. The threat of legal action is merely a potential claim, since it has not met the condition that a claim actually have been made.<sup>79</sup> The distinction between a potential claim and “claim” giving rise to coverage was described in *Bensalem Township v. Western World Insurance Co.*, where the court held that “‘notice that it is [someone’s] intention to hold the insureds responsible for a Wrongful Act’ is an event

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<sup>71</sup> *Id.* at 700.

<sup>72</sup> *Id.* The policy provided that Federal would pay “on behalf of each of the insured persons all loss for which [he] is not indemnified by the insured organization legally obligated to pay on account of any claim(s) made against him . . . for a wrongful act committed . . . before or during the policy period.” *Id.* at 699 n.3.

<sup>73</sup> *Id.* at 699 n.3.

<sup>74</sup> *Id.* at 700-01.

<sup>75</sup> Richardson Elecs., Ltd., 120 F. Supp. 2d at 701 (quoting Cent. Ill. Pub. Serv. Co. v. Am. Empire Surplus Lines Ins. Co., 642 N.E.2d 723, 725 (Ill. App. Ct. 1994)).

<sup>76</sup> *Id.*

<sup>77</sup> *Id.*

<sup>78</sup> Winkler v. Nat’l Union Fire Ins. Co. of Pittsburgh, Pa., 930 F.2d 1364, 1366 (9th Cir. 1991).

<sup>79</sup> *Id.* See also *MGIC Indem. Corp. v. Home State Savs. Ass’n*, 797 F.2d 285, 288 (6th Cir. 1986).

commonly antecedent to and *different in kind from* a ‘claim.’”<sup>80</sup> Thus, letters or actions that “indicate the likelihood, if not inevitability, of some future claim . . . do not constitute a ‘claim made’ . . . .”<sup>81</sup> It is also well settled that “requests for explanations, expressions of dissatisfaction or disappointment, mere complaining, or the lodging of grievance” do not constitute “claims.”<sup>82</sup>

Similarly, courts have differentiated between a mere request for information and a more serious government or regulatory investigation.<sup>83</sup> In *Trice v. Employers Reinsurance Corp.* it was held that a request for information did not constitute a “demand for money or services” within the meaning of a claim, even though the request specifically alluded to the possibility of a lawsuit.<sup>84</sup> The court said that “an actual claim is distinguished from an ‘event’ which could give rise to an actual claim in the future.”<sup>85</sup> In *St. Paul Mercury Insurance Co. v. Foster* the court held that a letter from an attorney requesting information about the company did not constitute a “claim.”<sup>86</sup> The court distinguished between the letter at hand and the Justice Department’s demand for documents in *Richardson*.<sup>87</sup> “[T]he seriousness of [the Justice Department’s] investigation was clearly material to the district court’s determination [in *Richards Electronics*] . . . .”<sup>88</sup> While “a formal lawsuit is not required to present ‘a demand for money or services,’ the inquiry must present more than a mere request for information.”<sup>89</sup> The court explained that such a broad construction of a claim would be “bad public policy” because it would produce “a flood of notices of ‘claims’ based on requests for information or efforts at

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<sup>80</sup> *Bensalem Twp. v. W. World Ins. Co.*, 609 F. Supp. 1343, 1348 (E.D. Pa.1985) (quoting language from Article VI of the policy in question).

<sup>81</sup> *In re Ambassador Group, Inc.*, Litig. 830 F. Supp. 147, 154 (E.D.N.Y. 1993).

<sup>82</sup> *Monteleone & Conca*, *supra* note 25, at 589.

<sup>83</sup> *See, e.g.*, *Richardson Elecs., Ltd., v. Fed. Ins. Co.*, 120 F. Supp. 2d 698, 701 (N.D. Ill. 2000).

<sup>84</sup> *Trice v. Emp’rs Reinsurance Corp.*, No. 97-1271, 1997 WL 449736, at \*3 (7th Cir. 1997) (citing *Nat’l Fire Ins. Co. v. Bartolazo*, 27 F.3d 518, 519 (11th Cir. 1994)).

<sup>85</sup> *Id.* (quoting *Emp’rs Ins. of Wausaw v. Bodi-Wachs Aviation Ins. Agency, Inc.*, 39 F.3d 138, 143 (7th Cir. 1994)).

<sup>86</sup> *St. Paul Mercury Ins. Co. v. Foster*, 268 F. Supp. 2d 1035, 1047 (C.D. Ill. 2003).

<sup>87</sup> *Id.*

<sup>88</sup> *Id.*

<sup>89</sup> *Id.* (citing *Trice*, 1997 WL 449736 at \*3).

intimidation by attorneys that may never materialize into demands against any insurance policies.”<sup>90</sup>

A survey of the case law shows that the determining factor as to whether a demand for information constitutes a claim is its seriousness. For example, the court in *National Stock Exchange v. Federal Ins. Co.* found that a request for an informal document regarding subprime activities did not constitute a “claim.”<sup>91</sup> The distinction drawn between a demand and a request in cases like *National Stock Exchange* can spell trouble for policyholders who comply with an informal request in hopes of nipping the inquiry in the bud. If a “regulatory request and investigation is informal and a settlement is made in compromise to avoid a formal investigation, coverage may be precluded entirely.”<sup>92</sup>

In contrast, the court in *Dan Nelson Automotive Group v. Universal Underwriting* held that a civil investigative demand by various states attorneys general gave rise to a claim under an E&O policy.<sup>93</sup> The court found that the demands, which requested that the plaintiff produce certain documents regarding its business practices, “functioned to command the Plaintiffs to produce documents and provide information relevant to the alleged violations of statutes, and therefore constitute a claim . . . within the meaning of the policy.”<sup>94</sup>

In *Ace American Insurance Company v. Ascend One Corporation*, the U.S. District Court for the District of Maryland weighed the seriousness of state subpoenas and investigative demands and whether they constituted a “claim.”<sup>95</sup> In this case, Amerix, the policyholder, was served by the Office of the Attorney General of Maryland with an “administrative subpoena” pursuant to the Maryland Consumer Protection Act.<sup>96</sup> Among other things, the subpoena sought documents relating to the company’s structure, governance, relationship and interactions with consumers. A year later, the Texas Attorney General’s Consumer Protection Division served Amerix with a “civil investigative demand.”<sup>97</sup> In response, Amerix hired

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<sup>90</sup> *Id.*

<sup>91</sup> *Nat’l Stock Exch. v. Fed. Ins. Co.*, No. 06 C 1603, 2007 WL 1030293, at \*6 (N.D. Ill. 2007).

<sup>92</sup> HANNA, *supra* note 16, at 5.

<sup>93</sup> *Dan Nelson Auto. Grp. v. Universal Underwriting*, 2008 U.S. Dist. LEXIS 4987 (D.S.D. Jan. 15, 2008).

<sup>94</sup> *Id.* at \*16-17.

<sup>95</sup> *Ace Am. Ins. Co. v. Ascend One Corp.*, 570 F. Supp. 2d 789, 796 (D. Md. 2008).

<sup>96</sup> *Id.* at 791.

<sup>97</sup> *Id.* at 792.

attorneys, produced “tremendous quantities” of information and data for the state officials, and paid over \$140,000 in fees and expenses.<sup>98</sup> Unsurprisingly, ACE denied the claim on the basis that neither the subpoena nor the demand contained a “claim for wrongful acts,” as required under the policy.<sup>99</sup> The court determined otherwise. “Claim” was defined as “a *civil, administrative or regulatory investigation* against any Insured commenced by the filing of a notice of charges, investigative order or similar document.”<sup>100</sup> The court evaluated the seriousness of the documents in order to determine whether or not they constituted an “investigation” under the definition, noting that both documents came from state attorneys general offices.<sup>101</sup> It found that both the “caption on the subpoena (‘In re: Amerix’) and the specific inquiries into Amerix’s marketing and credit counseling activities” indicated that the policyholder was the target of an investigation and “not simply a source of information.”<sup>102</sup> It concluded that:

The extent and specificity of the Subpoena and Texas Demand indicate that the documents were issued to serve the function of an investigative order. This is further supported by the fact that the sole investigatory tool granted to the Maryland Attorney General’s office under the Consumer Protection Act is subpoena power. Therefore, the Subpoena . . . and related Texas Demand are, or at the very least are equivalent to, the filing of an investigative order or similar document.<sup>103</sup>

Some courts have drawn a distinction between a subpoena issued to a custodian of records for the purposes of producing records, and a subpoena seeking more than just information. In *Center for Blood Research, Inc. v. Coregis Insurance Co.* the First Circuit of the U.S. Court of Appeals addressed whether a subpoena served by an Attorney General constituted a “claim,” when there was no indication that the government

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<sup>98</sup> *Id.*

<sup>99</sup> *Id.*

<sup>100</sup> *Id.* at 793.

<sup>101</sup> *Ace Am. Ins. Co.*, 570 F. Supp. 2d at 796.

<sup>102</sup> *Id.* at 797.

<sup>103</sup> *Id.* at 798.

was seeking anything more than information from the organization.<sup>104</sup> The policy definition of “claim” included “any judicial or administrative proceeding in which any insured(s) may be subjected to a binding adjudication of liability for damages or other relief.”<sup>105</sup> The court reasoned that a subpoena for the production of records “could not possibly” subject the policyholder “to a binding adjudication of liability in the investigation before the assistant United States attorney.”<sup>106</sup> Even if the investigation uncovered information leading to the commencement of civil or criminal proceedings, those proceedings would “have had to have been pursued in a different form.”<sup>107</sup> The court chided the policyholder on not recognizing the “limitations of the investigation and of the scope of coverage under the insurance policy.”<sup>108</sup> Notably, subpoenas or investigative demands from private counsel are not enough to establish the existence of an “investigation” for these purposes.<sup>109</sup>

## 2. A “Claim” is a Demand for Damages or Relief

Most professional liability policies require a claim for damages.<sup>110</sup> Some define a “claim” as a “written demand for money”<sup>111</sup> or a “written demand for monetary or non-monetary relief.”<sup>112</sup> Others include within the definition of a “claim” a requirement that there be a “binding adjudication of liability for damages or relief.”<sup>113</sup> The damages and relief requirements can prove problematic for policyholders who are under investigation and seeking insurance coverage. When D&O and E&O policies require a claim for “damages,” a policyholder may have difficulty convincing the court that

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<sup>104</sup> *Ctr. for Blood Research, Inc. v. Coregis Ins. Co.*, 305 F.3d 38, 42 (1st Cir. 2002).

<sup>105</sup> *Id.*

<sup>106</sup> *Id.*

<sup>107</sup> *Id.* at 42-43.

<sup>108</sup> *Id.* at 42.

<sup>109</sup> *St. Paul Mercury Ins. Co. v. Foster*, 268 F. Supp. 2d 1035, 1048 (C.D. Ill. 2003) (holding that a demand for documents from a private attorney was not a ‘claim’).

<sup>110</sup> Selvin, *supra* note 42.

<sup>111</sup> Borden et al., *supra* note 55.

<sup>112</sup> *When Is a Claim Not a Claim? Insurance for Government and Regulatory Investigations*, *supra* note 39.

<sup>113</sup> *Foster v. Summit Medical Systems, Inc.*, 610 N.W.2d 350, 354 (Minn. 2000); *Ctr. for Blood Research v. Coregis Ins. Co.*, 305 F.3d 38, 40 (1st Cir. 2002).

a regulatory action seeking restitution or civil penalties is covered.<sup>114</sup> In such cases, claims seeking restitution, disgorgement, fines or civil penalties have been found to fall outside of the policy's coverage. In *Bank of the West v. Superior Court*, for example, the court held that sums of money paid as disgorgement were not "damages" within the meaning of the insurance policy.<sup>115</sup>

The concept of "relief" as it relates to the definition of a "claim" has been a focus of much litigation. In *Foster v. Summit Medical Systems, Inc.* the Minnesota Court of Appeals held that a SEC investigation was not a covered claim because it did not subject the directors and officers or company to a binding adjudication for relief, as required by the D&O policy.<sup>116</sup> The policy defined a "Securities Action Claim" as "any judicial or administrative proceeding initiated against any of the Directors and Officers or the Company based upon, arising out of, or in any way involving [securities laws and regulations] . . . in which they may be subjected to a binding adjudication of liability for damages or other relief. . . ." <sup>117</sup> The court held that a SEC subpoena did not fit within either the ordinary or legal meaning of the term "relief."<sup>118</sup>

In *Minuteman International, Inc. v. Great American Insurance Co.* the court advanced a much broader interpretation of "relief."<sup>119</sup> The facts of the case resemble most other claim disputes. The SEC issued an order directing a private investigation of Minuteman International Inc. (hereafter "Minuteman") and sent it a subpoena and a notice of investigation.<sup>120</sup> Minuteman spent nearly \$1 million complying with document production, retaining counsel, and complying with a subsequent SEC cease-and-desist order.<sup>121</sup> The insurance carrier declined to reimburse Minuteman, claiming that the SEC investigation did not constitute a "claim" under the D&O policy because no relief was sought.<sup>122</sup> The insurer tried to draw a distinction between "seeking relief in the form of monetary damages,

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<sup>114</sup> Selvin, *supra* note 42 ("One of the most challenging issues from a policyholder's perspective is establishing that the FTC or other regulatory action seeks damages, as distinct from restitution or penalties.").

<sup>115</sup> *Bank of the West v. Superior Court*, 2 Cal. 4th 1254 (1992).

<sup>116</sup> *Foster*, 610 N.W.2d at 351.

<sup>117</sup> *Id.* at 354.

<sup>118</sup> *Id.*

<sup>119</sup> *Minuteman Int'l. Inc. v. Great Am. Ins. Co.*, No. 3 C 6067, 2004 WL 603482 (N.D. Ill. Mar. 22, 2004).

<sup>120</sup> *Id.* at \*2.

<sup>121</sup> *Id.*

<sup>122</sup> *Id.* at \*3.

injunctive-type sanctions, or criminal charges and performing the investigation that leads up to a request for that type of relief.”<sup>123</sup> The court disagreed, finding that the relief sought by the subpoena was the production of documents or testimony.<sup>124</sup> “Consistent with *Richardson* and *Polychron*, the [SEC] Order and subsequent subpoenas served on plaintiff were demands for relief in that they were demands for something due. A demand for ‘relief’ is a broad enough term to include a demand for something due, including a demand to produce documents or appear to testify.”<sup>125</sup>

Not every court has agreed with *Minuteman’s* broad interpretation of the term “relief.” In *Diamond Glass Companies, Inc. v. Twin City Fire Insurance Co.*, the court rejected *Minuteman’s* conclusion, choosing instead to rely on the ordinary and accepted meaning of the word.<sup>126</sup> *Diamond Glass Co.* (hereafter “Diamond”) was issued a subpoena by a federal grand jury seeking the production of documents and testimony as part of a government investigation into the company’s business practices.<sup>127</sup> When Diamond submitted the claim to its insurer, the insurer categorized the matter as a “notice of a potential claim.”<sup>128</sup> The insurer asked Diamond to notify it when an actual claim was made against the company, and said any defense costs incurred prior to the matter rising to the level of an actual claim would not be covered.<sup>129</sup> Litigation ensued over whether the grand jury investigation and subpoena constituted a “claim” for the purposes of the D&O policy.

Diamond made three unsuccessful arguments for why insurance coverage should have attached.<sup>130</sup> First, it unsuccessfully argued that the

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<sup>123</sup> *Id.* at \*5.

<sup>124</sup> *Id.* at \*7.

<sup>125</sup> *Minuteman Int’l. Inc.*, 2004 WL 603482 at \*7.

<sup>126</sup> *Diamond Glass Cos. v. Twin City Fire Ins. Co.*, No. 06-CV-13105(BSJ)(AJP), 2008 WL 4613170 (S.D.N.Y. Aug. 18, 2008).

<sup>127</sup> *Id.* at \*1.

<sup>128</sup> *Id.* at \*2.

<sup>129</sup> *Id.*

<sup>130</sup> *Id.* The policy definitions, in pertinent part, are as follows:

“Entity Claim” means any:

- (1) written demand for monetary damages or nonmonetary relief commenced by the receipt of such demand; [or]
- (2) civil proceeding commenced by the service of a complaint or similar pleading; or
- (3) criminal proceeding, or formal administrative or regulatory proceeding commenced by the return of an indictment, filing of a notice of charges, or similar document;



investigation was a criminal proceeding within the definition of an “Entity Claim.”<sup>131</sup> The court rejected the argument on the grounds that the policy language expressly required “the return of an indictment, filing of a notice of charges or similar document.”<sup>132</sup> In the absence of such proceedings, the investigation was not a criminal proceeding within the meaning of the policy. Next, Diamond made an argument that the grand jury subpoenas constituted “written demands for non-monetary relief” as described in the definition of an “Entity Claim.”<sup>133</sup> The court rejected Minuteman’s broad description of the word “relief” and held that the ordinary meaning of the word and the term’s context in the policy make clear that investigative subpoenas and search warrants are not “demands for non-monetary relief.”<sup>134</sup> Diamond’s last argument for why the investigation constituted a “claim” involved the “target” language under the definition of an Insured Person Claim.<sup>135</sup> Diamond claimed that it became a “target” within the meaning of the policy when it was subpoenaed to testify before a grand jury and informed that it was a subject in the grand jury investigation.<sup>136</sup> The court held that coverage did not apply because Diamond never received “written notice” identifying it as a “target individual against whom formal charges may be commenced.”<sup>137</sup> For the reasons stated above, the court determined that Diamond had failed to state a claim and was not entitled to coverage under the liability policy.<sup>138</sup>

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against an Insured Entity.

“Insured Person Claim” means any:

(1) written demand for monetary damages or nonmonetary relief commenced by the receipt of such demand;

against an Insured Person

“Insured Person Claim” also means a formal civil, criminal, administrative, or regulatory investigation commenced by the service upon or other receipt by an Insured Person of a written notice from an investigating authority specifically identifying such Insured Person as a target individual against whom formal charges maybe commenced.

<sup>131</sup> *Id.* at \*3.

<sup>132</sup> *Diamond Glass Cos.*, 2008 WL 4613170 at \*3.

<sup>133</sup> *Id.* at \*4.

<sup>134</sup> *Id.*

<sup>135</sup> *Id.* at \*5.

<sup>136</sup> *Id.*

<sup>137</sup> *Id.*

<sup>138</sup> *Diamond Glass Cos.*, 2008 WL 4613170 at \*5.

Furthermore, the court in *Andy Warhol Foundation for Visual Arts, Inc. v. Federal Ins. Co.* held that a letter that requested additional information and informed the insured of a willingness to take “all reasonable and necessary steps . . . to effect a recovery in this matter” did not state a “claim” because it made no demand for relief.<sup>139</sup> In *MGIC Indem. Corp v. Home State Sav. Ass’n*, the court emphasized that the policy agreement is “speaking not of a claim that wrongdoing occurred, but a claim for some discrete amount of money owed to the claimant on account of the alleged wrongdoing.”<sup>140</sup> The court said that claims “made in the newspapers that directors and officers . . . engaged in wrongful acts” would “obviously not be the kind of ‘claims’ that could make [an insurance company] liable under the insuring agreement.”<sup>141</sup> Only claims that demand payment of “some amount of money” could trigger the insurer’s obligation to cover the expenses.<sup>142</sup>

#### V. RECENT DEVELOPMENTS: THE SECOND AND ELEVENTH CIRCUITS ADDRESS D&O COVERAGE FOR REGULATORY INVESTIGATIONS

Last year proved to be an important one in solving the recurring question whether D&O coverage extends to expenses incurred in connection with informal government and regulatory investigations of the policyholder. In 2010 both the Second and Eleventh Circuits for the U.S. Court of Appeals reviewed appeals addressing the issue and came to different results, one finding coverage and the other not. The cases highlight just how fact sensitive the determination remains, since both opinions relied heavily on the specific circumstances and key policy definitions at issue.

##### A. MBIA, INC. V. FEDERAL INSURANCE CO.

In the widely publicized case *MBIA, Inc. v. Federal Ins. Co.*, the U.S. District Court for the Southern District of New York was confronted with whether a company’s D&O policy covered defense costs incurred in

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<sup>139</sup> *Andy Warhol Found. for Visual Arts, Inc. v. Fed. Ins. Co.*, 189 F.3d 208, 216 (2d Cir. 1999).

<sup>140</sup> *MGIC Indem. Corp, v. Home State Sav. Ass’n.*, 797 F.2d 285, 288 (6th Cir. 1986).

<sup>141</sup> *Id.*

<sup>142</sup> *Id.*

connection with an SEC order of investigation and several subpoenas issued by the SEC and the New York Attorney General (NYAG).<sup>143</sup> In 2001, the SEC issued an Order Directing Private Investigation and began an inquiry into alleged accounting misstatements in the insurance industry.<sup>144</sup> In 2004, it issued subpoenas compelling MBIA to produce various documents concerning transactions involving “non-traditional products.”<sup>145</sup> That same year, the NYAG joined the investigation and served MBIA with similar subpoenas.<sup>146</sup> When MBIA alerted its insurers and asked for their consent to retain counsel and respond to the agency’s inquiries, the insurers denied that the subpoenas triggered coverage under the D&O policies. Concerned with the investigation’s negative market impact, MBIA asked regulators to forgo the issuance of further subpoenas and volunteered to comply with additional informal requests for information.<sup>147</sup> MBIA subsequently filed suit against its insurers for breach of contract and sought a declaratory judgment of coverage.<sup>148</sup>

MBIA’s D&O policy provided coverage for defense costs for “Securities Claims,” defined as “a formal or informal administrative or regulatory proceeding or inquiry commenced by the filing of a notice of charges, formal or informal investigative order or similar document” that “in whole or in part, is based upon, arises from or is in consequence of the purchase or sale of, or over to purchase or sell any securities issued by [MBIA].”<sup>149</sup> The district court found coverage under the definition for both the SEC and NYAG investigations. The NYAG subpoena was held to have triggered coverage because “an ordinary businessperson would view a subpoena as a ‘formal or informal investigative order’ based on the common understanding of these words.”<sup>150</sup> Also of importance in the

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<sup>143</sup> MBIA, Inc. v. Fed. Ins. Co., No. 08 civ. 4313 (RMB), 2009 WL 6635307, at \*1 (S.D.N.Y. Dec. 30, 2009). MBIA held a \$15 million primary D&O insurance policy with Federal Insurance Company (Federal) and a \$15 million excess policy with ACE American Insurance Company (ACE) (collectively, the insurers). *Id.* at \*2. The two policies were the same in all relevant respects, and are thus collectively referred to as the policy. *Id.* at \*1.

<sup>144</sup> *Id.*

<sup>145</sup> *Id.*

<sup>146</sup> *Id.*

<sup>147</sup> *Id.* at \*3.

<sup>148</sup> *Id.* at \*1.

<sup>149</sup> MBIA, Inc. v. Fed. Ins. Co., 2009 WL 6635307 at \*2.

<sup>150</sup> *Id.* at \*6. The subpoena stated, “WE HEREBY COMMAND YOU . . . [to] deliver and turn over to the [NYAG] all documents and information requested . . .

court's decision was the inclusion of the term "similar document" in the definition of a "claim." The court held that even if the subpoena were not an "order" within the policy definition of a "Securities Claim," it is a "similar document" capable of commencing an investigation.<sup>151</sup> The court also held that legal costs incurred by a special litigation committee (SLC) were covered under the company's D&O policy.<sup>152</sup> In the midst of the SEC and state investigations into MBIA's investments, several shareholders filed derivative suits against the company.<sup>153</sup> As is common, MBIA formed an SLC comprised of members of its Board of Directors to investigate the allegations made in the derivative actions.<sup>154</sup> The insurer declined to reimburse MBIA for the costs associated with the internal SLC investigation (namely attorney fees) because the committee engaged in "independent decision-making" and consequently the attorney that was hired to assist it "could not have represented the company through its representation of the SLC."<sup>155</sup> The court disagreed, noting that the SLC "was vested with full and exclusive authority . . . to determine whether pursuit of the litigation was in the best interest of MBIA."<sup>156</sup> The court thus held that the internal investigation fell within the policy's definition of a "Securities Claim."

On appeal, the Second Circuit affirmed the district court's holdings with regard to the SEC order, NYAG subpoena, and the SLC. The insurers' argument that the NYAG subpoena was a "mere discovery device" and dissimilar to an investigative order fell flat.<sup>157</sup> Referencing *ACE Am. Ins. Co. v. Ascend One Corp.*, the court said a NYAG subpoena is "at the absolute minimum, a 'similar document' to those listed in the definition of a 'Securities Claim' because it is similar to other forms of investigative demands by regulators."<sup>158</sup> The Second Circuit also agreed with the district court's assessment that a businessperson would view the NYAG subpoena as a "formal or investigative order" based on the common understanding of the words.<sup>159</sup> With regards to the SLC matter, the Second Circuit broadened

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.” *Id.* The court noted that MBIA’s failure to comply with the order “may subject [it] to prosecution.” *Id.*

<sup>151</sup> *Id.* at \*6.

<sup>152</sup> *Id.* at \*9.

<sup>153</sup> *Id.* at \*4.

<sup>154</sup> *Id.* at \*4, \*9.

<sup>155</sup> *MBIA, Inc. v. Fed. Ins. Co.*, 2009 WL 6635307 at \*9.

<sup>156</sup> *Id.*

<sup>157</sup> *MBIA Inc. v. Fed. Ins. Co.*, 652 F.3d 152, 160 (2d Cir. 2011).

<sup>158</sup> *Id.* at 159-60.

<sup>159</sup> *Id.* at 159.

the district court's holding and ruled that the SLC expenses fell within the policy's definition of "Defense Costs."<sup>160</sup> The court based its decision on the fact that MBIA directed and acted through the SLC when the SLC moved to dismiss the derivative suit, and thus constituted an "insured person" under the policy.<sup>161</sup>

B. OFFICE DEPOT, INC. V. NATIONAL UNION FIRE INSURANCE CO. OF PITTSBURG, PA.

In *Office Depot, Inc. v. Nat'l Union Fire Ins. Co. of Pittsburg, Pa.*, the U.S. District Court for the Southern District of Florida held that costs incurred by Office Depot, Inc. in connection with an informal SEC investigation and an internal investigation and audit were not covered by the office supply company's D&O insurance policy.<sup>162</sup> Upon receipt of a letter informing it that the SEC was "conducting an inquiry" into the company to determine whether it had violated federal securities laws, Office Depot voluntarily produced various documents and made its employees and officers available for sworn testimony.<sup>163</sup> Because the informal SEC investigation never culminated in the filing of any judicial or administrative complaints against the company or its directors or officers, coverage for the investigation was denied.<sup>164</sup> Office Depot sued for over \$23 million in reimbursement for legal fees and expenses incurred in connection with the informal SEC investigation, as well as an internal audit and investigation of the company's accounting practices initiated in response to a whistleblower complaint.<sup>165</sup> Applying Florida law, the district court granted the insurers' motions for summary judgment, holding that the SEC investigation was not a "Securities Claim" within the policy's definition.<sup>166</sup>

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<sup>160</sup> *Id.* at 162.

<sup>161</sup> *Id.* at 163-64.

<sup>162</sup> *Office Depot, Inc. v. Nat'l Union Fire Ins. Co. of Pittsburg, Pa.*, 734 F. Supp. 2d 1304 (S.D. Fla. 2010).

<sup>163</sup> *Id.* at 1310.

<sup>164</sup> *Id.* at 1308.

<sup>165</sup> *Id.* at 1312.

<sup>166</sup> *Id.* at 1309. The policy definition of "Securities Claim" was as follows:

"(y) "Securities Claim" means a Claim, *other than an administrative or regulatory proceeding against, or investigation of an Organization*, made against any insured:

(1) alleging a violation of any federal, state, local or foreign regulation, rule or statute regulating securities . . . ; or

Thereafter, the U.S. Court of Appeals for the Eleventh Circuit issued an unpublished *per curiam* opinion affirming the lower court's holding and denying coverage for Office Depot's defense costs.<sup>167</sup> The Eleventh Circuit rejected Office Depot's argument that "administrative or regulatory proceeding" was an undefined and ambiguous term and could thus reasonably include an investigation of the insured entity.<sup>168</sup> The court determined that the expenses incurred after the SEC's request for voluntary cooperation were "in furtherance of its pre-suit discovery" and "constituted an 'investigation' rather than an 'administrative or regulatory proceeding.'"<sup>169</sup> Since the policy's definition of a "Securities Claim" expressly excepted both "an administrative or regulatory proceeding against" and "an investigation of" Office Depot,<sup>170</sup> the court held that the costs were not covered.<sup>171</sup> The Eleventh Circuit also affirmed the district court's holding that the investigation did not fall within the definition of a "claim" under the insured party indemnification provision, since the letters sent by the SEC "only broadly request[ed] information to assist the SEC in determining whether Office Depot committed securities violations."<sup>172</sup> Unlike a Wells Notice, which all parties agreed triggered a claim under the

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(2) brought derivatively on the behalf of an Organization by a security holder of such Organization.

*Notwithstanding the foregoing, the term "Securities Claim" shall include an administrative or regulatory proceeding against an Organization, but only if and only during the time such proceeding is also commenced and continuously maintained against an Insured Person.*" (Emphasis added by court).

<sup>167</sup> Office Depot, Inc. v. Nat'l Union Fire Ins. Co. of Pittsburgh, Pa., No. 11-10814, 2011 WL 4840951, at \*1 (11th Cir. Oct. 30, 2011).

<sup>168</sup> *Id.* at \*3.

<sup>169</sup> *Id.*

<sup>170</sup> *Id.*

<sup>171</sup> *Id.* at \*3.

<sup>172</sup> *Id.* at \*4 (alteration in the original). The policy defined, in relevant part, a 'Claim' as: (2) a civil, criminal, administrative, regulatory or arbitration proceeding for monetary, non-monetary or injunctive relief which is commenced by: (i) service of a complaint or similar pleading; (ii) return of an indictment, information or similar document (in the case of a criminal proceeding); or (iii) receipt or filing of a notice of charges; or (3) a civil, criminal, administrative or regulatory investigation of an Insured Person: (i) once such Insured Person is identified in writing by such investigating authority as a person against whom a proceeding described in Definition (b)(2) may be commenced; or (ii) in the case of an investigation by the SEC or a similar state or foreign government authority, after the service of a subpoena upon such Insured Person. *Id.* at \*3.

definition, the SEC letters at issue did “not allege that violations have occurred or identify specific individuals that could be charged in future proceedings.” Since the correspondence did not fall within the policy’s definition of a “claim,” it did not trigger coverage.

## VI. CONCLUSION

Although a number of jurisdictions have addressed the meaning of a “claim” in the context of a government or regulatory investigation, the coverage analysis remains incredibly fact sensitive. The outcomes of the cases have depended in large part on the factual circumstances, seriousness of the investigation, and specific language of the policy. Because the Second Circuit broadly interpreted “Securities Claim” to include informal regulatory and government investigations, policyholders will likely “cite MBIA for the proposition that a company does not forfeit its D&O coverage when it volunteers to cooperate with investigative agency requests.”<sup>173</sup> When seeking reimbursement under D&O and E&O policies, policyholders will also look to the Second Circuit’s holding that coverage extends to expenses incurred by a special litigation committee. On the other hand, insurers will undoubtedly rely on *Office Depot* when denying coverage for costs associated with informal SEC investigations. Since both the Second and Eleventh Circuit opinions are heavily rooted in the policy language and specific circumstances presented, it may be easy for future litigants to distinguish *MBIA* and *Office Depot* from other cases. Nonetheless, both decisions are important examples of situations where a court found or denied coverage for costs associated with regulatory and government investigations into corporate wrongdoing.

A number of practical implications for insurers and policyholders flow from this discussion. The case law illustrates the importance of seeking the most favorable definition of the term “claim” or “Securities Claim” possible. Given the high cost of responding to subpoenas and investigations and defending against subsequent legal proceedings,

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<sup>173</sup> Richard Bortnick & Micah J. M. Knapp, *Guest Post: 2nd Circ. Holds D&O Policies Cover Voluntary Compliance Expenses and Special Litigation Committee Costs*, THE D & O DIARY (July 29, 2011, 3:30 AM), <http://www.dandodiary.com/2011/07/articles/d-o-insurance/guest-post-2nd-circ-holds-do-policies-cover-voluntary-compliance-expenses-and-special-litigation-committee-costs/>. *But see Id.* Observers have noted that the MBIA analysis was “heavily influenced by the facts” and the “impact of the decision may be limited based on the particular policy language at issue and the facts of the case.”

insurance carriers should structure their policy agreements carefully. Likewise, it is of the utmost importance that companies and financial institutions carefully examine their current D&O and E&O liability policies to determine what types of noncourt proceedings and investigations constitute a “claim.”<sup>174</sup> The uncertainty over government and regulatory investigations falling within the definition of a “claim” has provoked insurers and policyholders alike to take another look at their policies. As a result, the insurance industry continues to evolve. Insurance companies are now introducing professional liability policies that specifically agree to cover the costs of certain internal investigations, most often investigations commenced at the bequest of shareholders, and costs incurred in anticipation of a formal regulatory investigation.<sup>175</sup> As regulatory investigations become more frequent, at least one carrier has introduced a separate insurance product to provide coverage for informal SEC investigations.<sup>176</sup> It will be interesting to watch as D&O and E&O policies continue to evolve in the coming years as the law on coverage for investigations develops.

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<sup>174</sup> Michael R. Sarner, *Coverage Under a D&O Policy for Costs Related to a Subpoena Issued by a Government Agency*, PROFESSIONAL LIABILITY UNDERWRITING SOCIETY, Sept. 2009 Issue XXII Vol. 9, 10 (“From a policyholder perspective, the importance of the definition of Claim under a D&O policy cannot be overstated.”).

<sup>175</sup> Dickey & Goodman, *supra* note 59.

<sup>176</sup> Kevin LaCroix, *The Top Ten D&O Stories of 2011*, THE D&O DIARY (Jan. 4, 2012, 3:33 AM), <http://www.dandodiary.com/2012/01/articles/d-o-insurance/the-top-ten-do-stories-of-2011/>.