

FEDERATION OF REGULATORY COUNSEL, INC.

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FUNDING HEALTH INSURANCE EXPANSION PROGRAMS:

Maine's Quandary & The Need For A Federal Solution

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Maine was one of the first states in the nation to enact comprehensive health care reform with the passage of the Dirigo Health Reform Act of 2003 (the "Act").¹ As reported previously in this journal, the laudable goals of this ambitious program include improving the quality of and access to health care and controlling costs. A centerpiece of the improving access-to-care component is the expansion of health insurance coverage through a subsidized state-sponsored insurance plan called DirigoChoice, which is administered by the Dirigo Health Agency ("DHA"). This coverage expansion was also intended to control cost growth by reducing cost-shifting. Certain other initiatives under the broad auspices of the Dirigo Health Program have made noteworthy progress. Medicaid eligibility has been greatly expanded, giving more Mainers access to care and coverage and resulting in Maine having one of the lowest rates of uninsured people in the nation. Moreover, various quality improvement programs have been launched with early signs of success. As will be discussed below, however, Maine's experience in funding the DirigoChoice insurance coverage expansion - for those who do not qualify for Medicaid and either have no employer-sponsored coverage or cannot afford commercial insurance plans for individuals - has been plagued with financial, political and legal problems. This experience sheds light on the problems of other states and on the challenges facing the Obama administration as it addresses the crisis in health care and health insurance at the federal level.

Maine's Model for Funding Coverage Expansion - The Savings Offset Payment

The funding for the subsidy of DirigoChoice policies is provided through an assessment on insurers and those who pay for health insurance, including employers and employees covered under fully-insured and self-funded plans. In theory, decreasing the rolls of the uninsured decreases cost shifting, and this dynamic produces "savings." The Act provides for an annual, administrative two-step hearing process to determine the amount of these savings (called "Aggregate Measurable Cost Savings" or "AMCS" under the Act).² These savings are supposed to "offset" the assessment to be paid by insurance carriers and others and provide an upper bound for the amount of the assessment, called the "Savings Offset Payment" or "SOP."³ The DHA Board is charged under the Act with making a recommended determination of AMCS, and then the Superintendent of Insurance is charged with reviewing the proposed determination and approving or disapproving it, in whole or in part, based on whether the determination is reasonably supported in the record.

4

A Contentious History and a Failed Attempt to Replace the SOP Through New Taxes

In each of the last three years the insurance industry through the Maine Association of Health Plans ("MEAHP"), the major employers of the state through the Maine State Chamber of Commerce ("Chamber"), and a variety of organizations providing coverage through self-funded plans including the Maine Automobile Dealers Association Insurance Trust ("Trust"), have challenged AMCS figures proposed by the DHA that have ranged from \$42 to \$230 million. Initially, these groups challenged the DHA's interpretation of the AMCS provision in the Act on the grounds that the plain meaning of section 6913(1)(A) and the underlying legislative intent limited "savings" to cost reductions relating to reduced bad debt and charity care attributable to the DirigoChoice program. In their challenge to the Year 1 AMCS determination through the Maine courts, these parties claimed that DHA had gone far beyond the plain meaning of the language in section 6913(1)(A)

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and the legislative intent in developing "savings" methodologies that went beyond the Dirigo Choice product to encompass other Dirigo Health initiatives. These included, among others, per-unit cost reductions by hospitals allegedly due to the voluntary cost growth limits in the Dirigo Act.⁵ The Maine Supreme Court found the AMCS provision to be "ambiguous,"⁶ but nonetheless upheld the DHA's broad authority to interpret this provision, deferring to the DHA's interpretation on this key point.⁷ Two more annual rounds of highly contentious AMCS hearings followed, with repeated claims that DHA was exceeding its authority to interpret an ambiguous statutory provision in proposing huge AMCS amounts.

This year, because of significantly eroded support for the SOP funding approach, the Legislature enacted a replacement funding mechanism that consisted of a flat 1.8% of paid claims assessment on insurers, plus a variety of taxes on soft drinks, juices, beer and wine. Some thought this was the end of the annual AMCS/SOP hearings. This new enactment did not sit well with Maine voters, however, who took advantage of a "Peoples' Veto" provision in Maine law, whereby sufficient signatures were collected to place the question on the November 2008 ballot.⁸ The measure passed overwhelmingly, knocking out the replacement funding mechanism and forcing a reversion to the SOP vehicle.

The Year 3 AMCS Hearings

This unusual action resulted in another round of the annual AMCS/SOP "two step": the DHA Board held a hearing resulting in proposed savings of \$149 million; and, as in each of the prior three years, the Superintendent of Insurance dramatically reduced the AMCS figure this year to \$48.7 million.⁹ Moreover, based on direction from the Superintendent in the Year 3 case, the DHA developed a new AMCS methodology to calculate hospital savings based on a multi-state multivariate regression analysis. DHA also developed an entirely new model for calculating savings relating to the reduction in bad debt and charity care, again based on a complex multi-state, multivariate regression analysis. Further, much to the dismay of the so-called "payor intervenors" (the MEAHP, the Chamber and others), DHA expressly declined to consider whether any of the "savings" were recoverable by insurers from hospitals in the form of lower charges. To the payor intervenors, recoverability of savings is critical to "savings" being able to offset payment of the SOP assessment and is the keystone of this funding mechanism. The Superintendent declined to review the DHA's latest interpretation of the Act on this point, deferring to the DHA Board.¹⁰

Further Legal Challenges to the AMCS Model on Constitutional Grounds

The Superintendent's decision on this critical point directly contradicted the DHA and Superintendent's rulings in the Year 3 case,¹¹ and it caused these intervenors to file suit challenging the AMCS provision in the Act itself on constitutional grounds.¹² In essence, these parties have asserted that the Act contains no meaningful definition of AMCS or standards or guidelines to reasonably limit the discretion of the DHA and the Superintendent in interpreting the Act in calculating AMCS each year. The Act does not define AMCS, but directs the Board to:

determine annually not later than August 1st the aggregate measurable cost savings, including any reduction or avoidance of bad debt and charity care costs to health care providers in this state as a result of the operation of Dirigo Health and any increased MaineCare enrollment due to an expansion in MaineCare eligibility occurring after June 30, 2004. 24-A M.R.S.A. § 6913(1)(A).

The variety of new and different categories of alleged savings initiatives,¹³ the wildly inflated proposed AMCS figures and dramatic reduction each year,¹⁴ and the direct contradiction on a key point - recoverability - between years 3 and 4 as noted above, have all been cited in support of the claims that this provision of the Act as applied is unconstitutionally vague and constitutes an unauthorized delegation of the power of taxation

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by the Legislature to the Executive Branch agencies.¹⁵ As noted above, in the Year 1 case, these same parties appealed the AMCS decision of the Superintendent to the Maine Supreme Court, but did not challenge the Act on these constitutional grounds. Nonetheless, one Justice wrote a lengthy and spirited dissent in which he both captured the gravity of the issue and foretold that this constitutional challenge would eventually be made:

when such vague and ambiguous statutory terminology gives an agency license to act based on preferences or criteria so subjective that they are virtually unreviewable, [the Law Court] has held that such subjective license is an improper delegation of legislative authority to the executive. *See Maine Association of Health Plans et al v. Superintendent of Ins., et al*, 2007 ME 69, ¶71, 923 A.2d, 918, 936.

Lessons Learned In Maine

A decision by the Superior Court and a very likely subsequent appeal to the Maine Supreme Court means that a final decision from Maine's highest court is not likely until the fall or winter of 2009. Although the arguments in favor of declaring the AMCS provision unconstitutional are very strong, this is a highly-charged political question that makes it difficult to predict the outcome. Nevertheless, there are several observations worth noting, based on the Maine experience with implications for other states and at the national level, relating to the extremely difficult issue of how to finance coverage expansions.

In Maine, as noted above, the Legislature enacted a flat-rate assessment on insurers, coupled with a variety of other taxes, and this package was soundly rejected by voters across the state. Governor Baldacci's administration is not likely to propose another broad-based tax to replace the controversial and legally challenged AMCS/SOP assessment mechanism. This policy void leaves the program with no currently viable funding options should the courts strike down this provision. Even with the current AMCS/SOP funding mechanism, enrollment in DirigoChoice has been frozen for two years due to operating deficits. Moreover, although hospital cost growth has slowed since the Dirigo Act was enacted, this has been true in many states that have no program like Dirigo Health in place. Finally, there has been no significant reduction in hospital charges, and insurance premiums continue to rise rapidly.

Similar Trends in Other States

In 2006, Massachusetts enacted health care and insurance reforms that included coverage expansion under the "connector" component of the Commonwealth Care Health Insurance Program. This program resembles the Maine experiment and has signed up nearly 450,000 people for health insurance (although it is reported that as many as 80,000 were simply put on Medicaid and 176,000 more on government-subsidized plans like DirigoChoice). By contrast, DirigoChoice has never insured more than 20,000 new, previously uninsured enrollees. However, in Massachusetts it is reported that the program will survive only with continued and increasing federal subsidies involving tax dollars from residents from other states,¹⁶ an approach that will be controversial.

Maine, Massachusetts and Vermont were among the first to enact similar, comprehensive health care reform legislation that included coverage expansion as a key provision. Since then, several other states, including California, have debated these reforms but have had less success in enacting such measures. Quite often, the biggest stumbling block is how to fund coverage expansion. This obstacle seems to have only become greater in the past several months with the downturn in the economy and the various financial sector and other bailout and stimulus packages being debated. Controlling health care and health coverage costs also presents practical and political roadblocks at the state level, especially since 46% of health care spending in the entire U.S. comes from the federal government in Medicare and Medicaid and other programs. ¹⁷ These programs are the major causes of cost-shifting, because they do not pay the full cost of providing care to hospitals and doctors.

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This funding shortfall not only has created access to care issues but creates a problem of insurmountable proportions at the state level for any state.

What the Experience of the States Tells Us About Health Insurance Reform at the Federal Level

At the federal level, as the Obama administration begins its work, the United States devotes 16 percent of its gross domestic product to medical care, more per capita than any other nation in the world. Yet, numerous measures indicate the country lags in overall health: it ranks 29th in infant mortality, 48th in life expectancy and 19th out of 19 industrialized nations in preventable deaths.¹⁸ Maine's experience and that of other states clearly indicate that finding ways to fund coverage expansion cannot be done meaningfully at the state level. This is especially true now, with enormous budget deficits in states across the country. It also seems clear that meaningful controls on health care costs must come from the federal government, given its already predominant share of overall health expenditures and its ability to centralize controls in a uniform way. In a prior article, I posed the question of whether a collapse of our health care and health insurance systems will be the only way to put the pieces back together in a way that will truly achieve the goals of making healthcare available and affordable for all Americans. The federal budget deficit is already skyrocketing with more tax cuts, stimulus packages and spending plans coming. Nonetheless, given Maine's and other states' experience in the past year, and the course of events at the national level, it seems more likely that the crisis in health care and health insurance will continue to build so that a national solution will be the only way forward.

Endnotes

1. Public Law 2003, ch. 469 (effective Sept. 13, 2003), as amended by Public Law 2005, ch. 400 (effective Sept. 17, 2005).
2. *See generally* 24-A M.R.S.A. § 6913(1)(A)-(C).
3. 24-A M.R.S.A. § 6913(2)(C). The SOP may not exceed the lesser of AMCS or 4% of paid claims. *Id.* § 6913(3)(B).
4. 24-A M.R.S.A. § 6913(1)(C).
5. These voluntary cost growth limits on hospitals in Maine are currently codified at 22 M.R.S.A. § 1722.
6. *Maine Association of Health Plans et al v. Superintendent of Ins., et al*, 2007 ME 69 ¶37, 923 A.2d 918, 928.
7. *MEAHP*, 2007 ME 69 ¶46-59, 923 A.2d at 930-34.
8. The provisions of Maine's "people's veto referendum" are codified at 21-A M.R.S.A. § 901 *et seq.*
9. INS-08-900 at 3 (Superintendent's Decision). The Superintendent's decision in the Year 4 case will be available shortly at http://www.maine.gov/pfr/insurance/laws_rules.htm#decisions at docket number INS-08-900.
10. *See* INS-08-900 at 4 and 37.
11. In the four years of AMCS hearings since their inception in 2003, there have been three different Superintendents ruling on the DHA board's proposed AMCS determination: Superintendent Alessandro Iuppa

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in Years 1 and 2, and recently appointed Superintendent Mila Kofman in Year 4. Acting Superintendent Eric Cioppa presided over the hearing in Year 3.

12. *See Maine Automobile Dealers Association Insurance Trust, Maine State Chamber of Commerce, Maine Association of Health Plans and Anthem Health Plans of Maine, Inc. v. Superintendent of Insurance and Dirigo Health Agency*, Docket Nos. AP-08-71 to -74 (consolidated) (Kennebec County Superior Court).

13. In addition to the new and extremely complex multi-state, multivariate regressions models for hospital savings and uninsured initiatives, DHA has, over the first four years, proposed additional savings categories including: payment of overdue Medicaid reimbursement to hospitals and physicians, certificate of need and capital investment fund initiatives, voluntary underwriting gain limit initiatives, and in Year 4 a medical loss ratio initiative. It is beyond the scope of this article to explore each of these initiatives, but they are mentioned to demonstrate the breadth of the DHA's interpretation of the AMCS provision. Moreover, DHA has struggled to define AMCS consistently, sometimes defining it as refunds to certain policyholders (medical loss ratio initiative), at other times as savings to the Maine health care system as a whole (uninsured initiatives), and yet others as a subset of the Maine healthcare marketplace (hospital savings) without regard to whether a projected reduction in the rate of hospital cost growth by a mythical virtual hospital was - or even could be - passed on to the purchasers of health insurance policies.

14. In Years 1 through 4 the DHA Board proposed AMCS in the following amounts, followed by the amount actually approved by the Superintendent: Year 1- \$136.8 M reduced to \$43.7M; Year 2 - \$41.8M reduced to \$34.3 M; Year 3 - \$78.1M reduced to \$32.8M; Year 4 - \$149.6M reduced to \$48.7 M. Moreover, in Year 4 the Superintendent, with significant assistance from outside expert consultants, found that even with substantial revisions to the Year 4 DHA hospital savings methodology, it still carried a \$350 million margin of error. INS-08-900 (Decision of Superintendent) at 14.

15. The Maine Constitution explicitly includes the doctrine of separation of powers, using both all-encompassing language and also more specific forms. Article III, Section 2 provides that: "No person or persons, belonging to one of these departments, shall exercise any of the powers belonging to either of the others, except in the cases herein expressly directed or permitted." Article III, Section 1 creates "three distinct departments, the legislative, executive and judicial." Two other more specific provisions are set forth at Article I, section 22 - "No tax or duty shall be imposed without the consent of the people or of their representatives in the Legislature." Article IX, section 9 provides that "The legislature shall never, in any manner, surrender the power of taxation." Numerous arguments supporting these claims have been advanced, but are beyond the scope of this article. These include, for example, the argument that the SOP is a tax and not a fee or duty, given that the SOP is used to fund a state-wide insurance plan.

16. Pipes, Sally C., President and CEO of the Pacific Research Institute, quoted from an op-ed article in the Wall Street Journal, December 5, 2008, entitled "Obama Will Ration Your Health Care."

17. *Id.*

18. Connolly, Ceci, "Many Experts Say Health-Care System Inefficeint, Wasteful." Washington Post, Nov. 30, 2008.

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PROTECTION OF THIRD PARTY CLAIMANTS UNDER THE NAIC MODEL UNFAIR CLAIMS SETTLEMENT ACT

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The Delaware Department of Insurance recently brought unfair claims settlement practices charges¹ against a liability carrier under Delaware's version of the NAIC Unfair Claims Settlement Practices Model Act.² The matter was ultimately dismissed on grounds that the Department failed to establish that the liability carrier in question had engaged in a general business practice. However, what makes the matter of special interest is that it is the first enforcement in recent memory in which the Delaware Department attempted to bring unfair claims settlement charges against a carrier for claims settlement activities related to a *third party claimant*. Counsel for the carrier³ argued, *inter alia*, that the matter should be dismissed because the Unfair Claims Settlement Practices Act should not be made applicable to third party claims but, because the matter was dismissed on other grounds and because Delaware courts have not squarely addressed the question, the issue remains alive in Delaware.

At first blush, one might view the victims of an insured's malfeasance as the persons who are in the greatest need for the protections afforded by the statute. After all, these persons, who are not in privity of contract with the liability carrier, cannot rely on traditional contract remedies in the event a liability carrier fails to pay a claim to the satisfaction of the claimant. Thus, it would seem, extending the Unfair Claims Settlement Practices Act to third parties is in concert with the insurance regulator's duty to protect the public. In fact, however, extension of the Unfair Claims Settlement Practices Act to third party claimants would run headlong into established law in most jurisdictions holding that the duty of a liability carrier runs only to its insured and not to third party claimants.

Parties to an insurance contract are expected to deal with others in good faith, and the right to control settlement gives rise to a corresponding duty of good faith and fair dealing with the insured.⁴ The heart of every bad faith action is the fiduciary relationship between the insurer and the insured and the duty of good faith and fair dealing implicit in every contract.⁵ That this duty runs only to an insurance company's insured is derived from the covenant implicit in the insurance contract establishing the insurer as the representative of the insured.⁶ By contrast, the third party claimant has no contract with the insurer or the insured, has not paid any premiums and has no legal relationship to the insurer or special relationship of trust with the insurer.⁷ It follows that the tort of bad faith is not available to third party claimants who are strangers to the insurance contract.⁸

It has oft been noted that giving third parties the right to bring insurance bad faith claims in connection with settlement actions of a tortfeasor's insurer gives rise to a serious conflict for the insurer, who not only must protect the interests of its insured, but also must safeguard its own interests from the adverse claims of the third party claimant. This conflict disrupts the settlement process and may disadvantage the insured.⁹ The existence of this conflict has not gone unnoticed in Delaware. In *Hostetter v. Hartford Ins. Co., Inc.*,¹⁰ the Delaware Superior Court considered a commercial general liability policy issued by The Hartford to an installer of woodstoves. Following a fire caused by one of the insured's installed stoves, the injured plaintiff demanded that The Hartford settle plaintiff's claim. Initially, The Hartford denied coverage but later reconsidered that decision and settled a portion of the claim and went to arbitration on the remainder. Following arbitration, the plaintiff/claimant brought suit alleging bad faith, fraud and associated claims. In granting summary judgment in favor of The Hartford, the court held:

The insurer has a fiduciary duty to the insured, but an adversary relationship with the victim. The effect of the policy is to align the insurer's interests with

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those of the insured.

* * *

The special duties imposed on issuers with regard to their insureds are derived from the special fiduciary relationship between insurer and insured. No special justification exists for imposing greater duties on an insurer in dealing with an injured third party than in any other interaction between adversaries.¹¹

The well-reasoned arguments in favor of precluding a third party claimant from bringing suit against a tortfeasor's liability insurer operate with equal force when applying the Unfair Claims Settlement Practices Act to the insurer's handling of third party claims. In particular, is the acute conflict of interest imposed upon every liability carrier each time it is faced with a third party claim. If the insurer acts to protect the interests of its insured, as it must under its duty to defend,¹² it will inevitably cause some delay in the settlement of the claim, and because counsel retained by the insurer for the insured must represent the interests of the insured and not the insurer, the claim may well not settle at all. If, as recognized by the Delaware Superior Court, the insurer is in an adversarial relationship to the third party claimant with respect to the insured's relative liability for the claim and the damages that follow, it cannot simultaneously have a duty to the same third party to settle and pay the claim.

A number of courts have recognized this inherent conflict and, building on the lack of any duty under common law theories, have held that the Unfair Claims Settlement Practices Act does not extend to third party claimants.¹³ The Connecticut Superior Court in *Richards v. Deaton*,¹⁴ addressed the issue of whether a cause of action for an unfair claims settlement practice under Connecticut's Unfair Claims Settlement Practices Act can originate from a complaint by a third party who is not insured under the defendant insurer's policy. The *Richards* Court rejected any notion that an unfair settlement practice could exist under such circumstances and specifically noted that to allow such a claim would "interfere with the insurance company's right and duty to defend its insured."¹⁵ Furthermore, the Court noted that to allow a third party to "short circuit" the insurer's obligation and duty to defend "would undercut the constitutional right to contest a claim and have a trial."¹⁶ The Texas Supreme Court came to a similar conclusion in *Allstate Ins. Co. v. Watson*:

Recognizing concomitant and coextensive duties under art. 21.21 to third party claimants, parties adverse to the insured, necessarily compromises the duties the insurer owes to its insured. In fact, the logical result of permitting a separate and direct cause of action in favor of third party claimants allows third parties to sue for unfair claim settlement practices *even though the insured has no claim for an unfair claim settlement practice*. As troublesome, it is conceivable that in attempting to settle claims pursuant to the demands of a third party claimant, insurers may be liable to the insured for settling too quickly. [citing cases] In refusing to provide a direct cause of action for third party claimants, the legislature may well have been aware of this potential for conflicting duties. We will not construe art. 21.21 or *Vail*, absent explicit directive from the legislature, so as to compromise the insurer's loyalties and obligations owed to the insured.¹⁷

Adopting similar reasoning, a number of other courts have also held that the Unfair Claims Settlement Practices Act does not extend to third party claimants.¹⁸ Naturally, there is an exception to every rule, and in this case, a number of jurisdictions have expressly allowed a third party claimant to enforce the Unfair Claims Settlement Practices Act against a liability carrier; however, in each of these jurisdictions a special statutory provision was relied upon by the courts in order to extend the Act to third party claimants.¹⁹ At least two

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courts have denied a third party the right to a private cause of action, but nonetheless imply, *in dicta*, that the Commissioner might have enforcement authority. ²⁰ The author finds no court, however, that has squarely addressed the issue of whether a Commissioner may enforce the Unfair Claims Settlement Practices Act in a state that prohibits it to third parties; and we think that if and when the issue does come directly before these courts, such offhand *dicta* will be given careful scrutiny given that enforcement by the Insurance Commissioner has precisely the same deleterious effects as enforcement by private citizens.²¹

Given the weight of authority generally against the application of the Unfair Claims Settlement Practices Act to third party claims (absent special statutory provisions), courts in states such as Delaware that have yet to consider the issue should tread carefully when presented with the opportunity to do so. When the time comes, these courts should hold that the Act should not apply to a third party, either in the case of a private lawsuit or in the case of an appeal from an administrative enforcement action. To do otherwise is to open the door to an untenable conflict of interest, forced settlements in cases when the insured's liability is questionable, an infringement of the insured's right to a jury trial, and a general increase in litigation burdening our already overtaxed courts.

Endnotes

1. *In Re Joseph Renzi*, Docket No. 811-2008, DE DOI No. 37890
2. 18 *Del. C.* § 2304(16)
3. The author hereof
4. 14 *Couch on Ins.*
5. *Kranzush v. Badger State Mut. Cas. Co.*, 307 N.W.2d 256, 261 (Wis. 1981).
6. *Id.* (citing *Murray v. Mossman*, 355 P.2d 985 (Wash. 1960)); *Duncan v. Lumbermans Mut. Cas. Co.*, 23 A.2d 325 (N.H. 1941).
7. *Allstate Ins. Co., v. Watson*, 876 S.W.2d 145, 149 (Tex. 1993).
8. *Messina v. Nationwide Mut. Ins. Co.*, 998 F.2d 2, 5 (U.S. Ct. App. D.C. 1993)(citations omitted); see also *Simmons v. Pau*, 94 P.3d 667 (Haw 2004).
9. *Moradi-Shalal v. Fireman's Fund Ins. Cos.*, 758 P.2d 58,67 (Cal. 1988); *Krupnik v. Hartford Acc. and Ind. Co.*, 34 Cal.Rptr.2d 39; *Chapell v. Larosa*, 2001 WL 58057 at * 7 (Conn. Super., Jan. 5, 2001).
10. 1992 WL 179423 at *7-8 (Del. Super. Jul. 13, 1992).
11. *Id.* Delaware courts have permitted third party suits in special circumstances in which the plaintiff was an intended third party beneficiary. See *Pierce v. International Ins. Co. of Ill.*, 671 A.2d 1361 (Del. 1996) (giving employees rights to bring bad faith claims against employer's workers compensation carrier as intended third party beneficiaries); *Swain v. State Farm Mut. Auto. Ins. Co.*, 2003 WL 2285345 (May 29, 2003) (relying on *Pierce*, holding injured automobile passenger was intended third party beneficiary of driver's uninsured motorist coverage).

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12. For duty to defend generally, see 16 *Williston on Contracts* § 49:103 (4th ed.); 1 Insurance Claims and Disputes 5th § 4:1.
13. Generally, these are courts in jurisdictions that allow private causes of action under the Unfair Claims Settlement Practices Act.
14. 1993 WL 78613 at *2 (Conn. Super. March 11, 1993).
15. *Id.*
16. *Id.*
17. *Allstate Ins. Co. v. Watson*, 876 S.W.2d at 150.
18. See *Moradi-Shalal*, *supra*; *Wilson v. Wilson*, 468 S.E.2d 495 (N.C. App.1996); *Scroggins v. Allstate Ins. Co.*, 393 N.E.2d 718 (Ill. App. 1979); *Herrig v. Herring*, 844 P.2d 487 (Wyo. 1992).
19. See, e.g., *Auto-Owners Ins. Co.*, 658 So.2d 928 (Fla. 1995)(applying Fl. Stat. Ann. § 624.155); *Jenkins v. J.C. Penney Cas. Ins. Co.*, 280 S.E.2d 252 (W.Va.1981)(overruled on other grounds *State ex rel. State Farm Fire & Cas. Co. v. Madden*, 451 S.E.2d 721 (W.Va. 1994))(applying W.Va. Code § 55-7-9); *Shilhanek v. D-2 Trucking*, 70 P.3d 721 (Mont. 2003)(applying Mont. Code Ann. § 33-18-242); *Farris v. United States Fidelity and Guaranty Co.*, 587 P.2d 1015 (Or. 1978)(applying Or. Rev. Stat. § 746.230(b)); *State Farm Mut. Auto. Ins. Co., v. Reeder*, 763 S.W.2d 116 (Ky. 1988)(applying Ky. Rev. Stat. Ann. § 446.070).
20. *Kranzush*, *supra* at 268; *Dassault ex rel. Walker-Van Buren v. American Intl. Group, Inc.*, 99 P.3d 1256, 1259 (Wash. App. 2004).
21. The NAIC revised the Unfair Claims Settlement Practices Act in 1990 to revise it and remove it from the Unfair Trade Practices Model Act. These changes and revisions did not include any general extension of protection to third parties. See NAIC Unfair Claims Settlement Practices Act, WestLaw 900-1; NAIC Unfair Claims Settlement Practices Act Legislative history, Westlaw 900-9; and NAIC Unfair Property/Casualty Claims Settlement Practices Model Regulation, Westlaw 902-1.

THE CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT AND THE FUTURE OF THE SCHIP PROGRAM IN TODAY'S ECONOMIC CLIMATE

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Obtaining or maintaining adequate health care coverage is one of the primary concerns facing American families in today's faltering economy and job market. State legislators are faced with addressing health

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coverage and accessibility while state budgets will be hard to meet. Indeed, at least 46 states are facing significant budget shortfalls and those problems have the potential to continue well into the future.¹ The Center on Budget and Policy Priorities estimates that state budget deficits may total some \$145 billion.² Moreover, as economic conditions deteriorate and the unemployment rate increases, demand for Medicaid, the State Children's Health Insurance Program (SCHIP), and other services is expected to increase.³ Each percentage point rise in the national unemployment rate, according to the Kaiser Family Foundation, may be expected to increase Medicaid and SCHIP enrollment by 1 million people: 600,000 children and 400,000 nonelderly adults.⁴

This article provides a brief overview of the SCHIP program and then discusses new federal SCHIP legislation aimed at addressing some of the serious healthcare concerns raised by the current economic climate. The article also examines the choices surrounding the new federal legislation that Texas legislators, and their counterparts across the country, will face in the near future when deciding how to implement the federal legislation in their state.

I. Background and Overview of SCHIP

Congress originally established the SCHIP program in 1997, under title XXI of the Social Security Act, to address the significant number of uninsured children in the United States.⁵ In 1997, SCHIP provided \$48 billion in state grants over 10 years to provide free or low-cost health insurance for uninsured children aged 18 and younger.⁶ State health programs now cover more than 6 million children whose parents earn too much to qualify for the federal health insurance program for the poor, Medicaid, but who otherwise cannot afford private insurance.⁷ The SCHIP program is jointly financed by federal and state governments and is administered by the states. Within federal guidelines each state determines the design of its program, eligibility groups, benefit packages, payment levels for coverage, and administrative and operating procedures. ⁸

The SCHIP program has distinct policy differences from Medicaid. Unlike Medicaid, SCHIP is not an entitlement program, and federal funds that are available to the states through a matching arrangement are capped.⁹ This means that states have greater flexibility to design a benefits package, require recipients to share in the cost of care, and limit enrollment. Although benefits vary from state to state, once children are insured, they generally are able to receive regular check-ups, hospital care, immunizations, eyeglasses, and prescription drug coverage.¹⁰

II. The Children's Health Insurance Program Reauthorization Act of 2009

On February 4, 2009, President Obama signed into law the Children's Health Insurance Program Reauthorization Act of 2009, reauthorizing SCHIP through 2013.¹¹ President Bush vetoed two similar bills citing a concern that the legislation unacceptably encouraged families to leave the private insurance market.¹² Without congressional and presidential action, SCHIP would have expired on March 31, 2009. The stated purpose of the act, which is set to take effect on April 1, 2009, is to "provide dependable and stable funding for children's health insurance under titles XXI and XIX of the Social Security Act in order to enroll all six million uninsured children who are eligible, but not enrolled, for coverage today through such titles."¹³

A. Expansion of SCHIP Eligibility

The act not only reauthorizes SCHIP, it also expands SCHIP eligibility through a number of new measures. The most dramatic measure seeks to use a 61-cent increase in the cigarette tax to cover 4 million additional, currently uncovered, children.¹⁴ The act also seeks to add more children by giving states the authority to cover children whose families have an income as high as 300 percent of the federal poverty level, or about

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\$66,000 for a family of four. The act provides for a lower federal match for states that cover families making more than 300 percent of the poverty limit. ¹⁵The act also expands SCHIP's scope by authorizing the expenditure of an additional \$32.8 billion in federal funds on SCHIP and allowing legal immigrants to qualify for SCHIP. Previously, legal immigrants were generally barred from Medicaid and SCHIP for five years after they entered the United States. Although the act diminishes that delay for legal immigrants, it does not open the program to undocumented immigrants who remain ineligible for coverage. ¹⁶ Indeed, the act continues to require that states verify that people covered by the children's health programs are United States citizens or legal residents, and states now have the option of verifying eligibility by matching a person's name and Social Security number against federal records. ¹⁷

B. Additional SCHIP Coverage

In addition to expanding SCHIP eligibility, the act also requires states to provide additional coverage under their version of SCHIP. States now must provide dental care as part of SCHIP coverage and under the new law will be able to provide dental coverage as a supplement to private insurance. ¹⁸ The act generally requires states to provide equal coverage for mental and physical illnesses-mental health "parity"-under the children's health program. ¹⁹

III. Challenges Facing the States

The main question now facing state legislators is how to design and pay for their respective state children's health programs in light of the changes to SCHIP contained in the act. An analysis of the environment in Texas may be instructive.

A. The Texas SCHIP Program

The Texas Legislature established its SCHIP program in 1999 and began enrolling children in June 2000. ²⁰ Beginning in June 2000, the number of SCHIP enrollees increased steadily until it reached a peak of 529,211 children in May 2002. ²¹ Facing a projected state budget deficit, in 2003 Texas passed legislation that imposed barriers to entry into the SCHIP program and resulted in a large reduction in the number of enrollees. ²² The 2003 law required SCHIP enrollees to prove their continued eligibility every six months, pass an assets test, and wait 90 days before enrollment could take effect. These changes led to a decline of more than 200,000 SCHIP enrollees. By imposing those and other barriers to the SCHIP program, Texas turned away almost \$1 billion in federal matching funds. ²³

In 2005, Texas approved an expansion of SCHIP to include a new perinatal benefit to cover pregnant women with a family income of up to 200 percent of the federal poverty level. And, in 2007, legislative momentum shifted, and the Texas Legislature voted to restore the measures implemented during the 2003 budget crisis. The legislation extended SCHIP eligibility to one full year without reapplication. It also created separate periods of continuous eligibility for children's Medicaid (6 months) and SCHIP (12 months), resulting in a large expansion in the SCHIP program. ²⁴ As of January 2009, 450,751 Texas children were covered by SCHIP, but the state has yet to reach the SCHIP enrollment high of more than 500,000 children in 2002. ²⁵ Texas continues to have the nation's highest percentage of uninsured children. ²⁶

B. Legislative Decisions

In Texas, SCHIP provides health insurance for children in families who make too much money to qualify for Medicaid but less than 200 percent of the federal poverty level (about \$44,000 for a family of four). Thus, with the option under the act of covering children whose families make up to 300 percent of the federal poverty level, Texas legislators must now decide how much to appropriate for these programs. It is estimated that if Texas allocates the full amount of the federal funding to its SCHIP program 180,000 enrollees may be

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added to the program. 27

While the act opens the door for Texas to help more children, the issue facing Texas legislators is how much of its own money Texas will have to spend to draw down those SCHIP dollars from the federal government. The act provides that up to \$395 million of additional federal financing is available to Texas to expand the SCHIP program, which is significant considering the total current federal financing level in Texas is \$550 million. 28 For each dollar Texas spends on SCHIP, 72 cents comes from the federal government and the remainder comes from the state.29In essence, Texas would have to spend about \$100 million of its own money to maximize its share of federal SCHIP dollars.30

IV. Conclusion

Texas, like other states, is again facing a budget deficit. Similar to the decisions facing legislators across the country, Texas legislators must make tough choices in the near future on how to allocate state funds and whether to spend the money necessary to drawn down the entirety of the available SCHIP funds from the federal government. These decisions will be made even tougher by the challenging economic climate.

Endnotes

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3. Stan Dorn, The Urban Institute, *Health Coverage in a Recession* (December, 2008), available at http://www.urban.org/UploadedPDF/411812_health_coverage_in_a_recession.pdf.
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FEDERATION OF REGULATORY COUNSEL, INC.

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 13. Children's Health Insurance Program Reauthorization Act of 2009, H.R. 2, 111th Cong., §§ 2, 3 (2009).
 14. *Id.*
 15. *Id.* at § 114.
 16. *Id.* at § 605.
 17. *Id.* at § 211.
 18. *Id.* at § 501.
 19. *Id.* at § 502.
 20. Kalese Hammonds, Texas Public Policy Foundation, 2009-2010 Legislators' Guide to the Issues, Children's Health Insurance Program (December, 2008), available at <http://www.texaspolicy.com/pdf/2008-LegeEntry-CHIP-KH.pdf>.
 21. *Id.*
 22. *Id.*
 23. David D. Lowery, Alberta Phillips, Bruce Hight, *Another Snub of Funds to Insure Texas Kids*, Austin American-Statesman, February 8, 2009, at F2.
 24. Kalese Hammonds, Texas Public Policy Foundation, 2009-2010 Legislators' Guide to the Issues, Children's Health Insurance Program (December, 2008), available at <http://www.texaspolicy.com/pdf/2008-LegeEntry-CHIP-KH.pdf>.
 25. David D. Lowery, Alberta Phillips, Bruce Hight, *Another Snub of Funds to Insure Texas Kids*, Austin American-Statesman, February 8, 2009, at F2.
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FLORIDA STATE AND FEDERAL COURTS IMPOSE POLICY FORM REVIEW AND APPROVAL REQUIREMENTS ON SURPLUS LINES INSURERS

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FLORIDA STATE AND FEDERAL COURTS IMPOSE POLICY FORM REVIEW AND APPROVAL REQUIREMENTS ON SURPLUS LINES INSURERS

Surplus lines insurance covers a risk that admitted or authorized insurers are unable or unwilling to insure due to the nature of the risk. Because surplus lines insurers provide coverage for risks where admitted or authorized carriers are unwilling to take on risk, state insurance regulations are less onerous on surplus lines insurers, including in the area of policy forms and rates that otherwise must be approved by the state. However, opinions issued by the Florida Supreme Court and the Eleventh Circuit Court of Appeals may now result in surplus lines insurers being subject to greater regulation in Florida in the area of policy form review and approval requirements.

Essex Ins. Co. v. Zota ("Zota"),¹ originally commenced as a negligence suit filed in Florida state court against a commercial property owner and a general contractor by an individual injured while painting at the property construction site. Essex Insurance Company ("Essex"), the surplus lines insurer that insured the commercial property owner, filed a declaratory action in federal district court seeking a determination of its rights and obligations to the parties in the state negligence action. The federal district court entered a summary judgment declaring that Essex was precluded from denying coverage because it failed to deliver the policy to the insured, as required by sections 626.922 and 627.421, Fla. Stats.² Thereafter, plaintiffs filed a motion for attorneys' fees against Essex pursuant to section 627.428, Fla. Stat., which the federal district court granted.³

Essex then appealed the two federal district court orders entered in *Zota I* to the Eleventh Circuit Court of Appeals, which in turn certified to the Florida Supreme Court five questions of Florida law that it viewed unanswered by existing Florida precedent.⁴ Of the five questions certified by the Eleventh Circuit Court of Appeals in *Zota II*, the Florida Supreme Court answered only one:

Whether Fla. Stat. § 626.922 or § 627.421, or both, require delivery of evidence of insurance directly to the insured, so that delivery to the insured's agent is insufficient.

In selecting the above-referenced certified question, the Florida Supreme Court in *Zota* observed that the federal district court appeared to have based the entry of its summary judgment upon an interpretation of sections 626.922 and 627.421, Fla. Stats., that would alter the prior precedent in this area. Specifically, the Florida Supreme Court noted that the federal district court held that these statutes abrogated Florida's long-standing common-law agency rules by placing an affirmative duty upon a surplus lines insurer or its direct surplus lines agent to deliver a copy of a surplus lines insurance policy directly to the insured, notwithstanding the successful delivery of the relevant policy to the representative of the insured, who was acting as an insurance broker in this particular transaction.⁵ The Florida Supreme Court further observed that as a result of the entry of the summary judgment, the federal district court did not examine or develop many of the factual issues implicated by the Eleventh Circuit's certified questions and, instead, simply estopped the surplus lines insurer from relying on the language of the relevant policy exclusions.⁶

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In answering the above certified question in *Zota* in the negative, the Florida Supreme Court began its analysis by construing the scope of Chapter 627, Fla. Stat., because it believed that a number of issues in the case depended on provisions contained in that chapter. However, none of these issues included the requirements of section 627.410, Fla. Stat., concerning filing and approval of policy forms. Essex asserted that surplus lines insurers were exempt from Chapter 627 in its entirety because section 627.021(2)(e), Fla. Stat. provided that "[T]his chapter does not apply to . . . [s]urplus lines insurance placed under the provisions of ss. 626.913-626.937." However, the Florida Supreme Court viewed Essex's interpretation of section 627.021(2)(e), Fla. Stat. as too literal and narrow, noting that if followed, such an interpretation would render provisions of Part I's scope meaningless, a disfavored result under established rules of statutory construction.

To bolster its view that Essex's position was incorrect, the Florida Supreme Court reaffirmed its opinion in *Nat'l Corporacion Venezolana, S.A. v. M/V Manauve V*,⁷ that section 627.021(2), Fla. Stat., applied only to Part I of Chapter 627. In *Manauve V*, the Florida Supreme Court examined whether section 627.021(2), Fla. Stat., excluded marine insurance from then section 627.7262, Fla. Stat. The court determined that the statute's usage of the phrase "[t]his chapter does not apply to," was a scrivener's error made by the Statutory Revision Department when preparing Florida's newly enacted Insurance Code for placement in Florida Statutes, and that the Legislature actually intended to refer to Part I of Chapter 627, the "Rating Law," and not the entire Chapter 627. In applying *Manauve V* to *Zota*, the Florida Supreme Court asserted that the Legislature must have intended to exclude surplus lines from only Part I of Chapter 627, Fla. Stat., because it amended section 627.021(2), Fla. Stat., to include surplus lines after the *Manauve V* decision, and the Legislature was presumed to have known the existing judicial construction of that provision prior to amending Section 627.012(2), Fla. Stat.

Approximately one month after the Florida Supreme Court's decision in *Zota*, the Eleventh Circuit Court of Appeals issued an opinion in *CNL Hotels & Resorts, Inc. v. Twin City Fire Insurance Company*, which for all practical purposes extends *Zota's* holding.⁸ The issue before the Eleventh Circuit was whether the surplus lines excess carrier, which had provided an additional \$10 million in coverage in excess of the underlying admitted carrier's policy must reimburse CNL for \$5.5 million which CNL paid to the plaintiff in attorneys' fees. The underlying coverage issued by the admitted carrier contained a disputed endorsement form ("Endorsement 17"), which the district court determined excluded coverage under that policy. The district court granted summary judgment in favor of the surplus lines insurer.

However, the district court's summary judgment order was reversed by the Eleventh Circuit because it determined that the district court had not resolved the factual question of whether Endorsement 17 was filed with the Florida Office of Insurance Regulation pursuant to section 627.410, Fla. Stat. The Eleventh Circuit determined that the district court erroneously interpreted section 627.021(2)(e), Fla. Stat., to exclude surplus lines from all of Chapter 627, including section 627.410, because *Zota* had recently rejected that interpretation.

Like *Zota*, *CNL Hotels* did not discuss or analyze Florida's Surplus Lines Law. Furthermore, *CNL Hotels* did not discuss or analyze the issue that the key exclusionary language contained in Endorsement 17 only appeared in the underlying insurance policy issued by an authorized insurer subject to the form filing requirements of section 624.410, Fla. Stat., and not that of the surplus lines insurer.

To date, the Florida Office of Insurance Regulation has not issued any orders, bulletins or memoranda regarding the applicability of section 627.410, Fla. Stat. to surplus lines policy forms. However, the Florida Office of Insurance Regulation did file an amicus brief in *CNL Hotels* in support of Appellees' Motion for Rehearing.⁹

In its brief, the Florida Office of Insurance Regulation asserted that section 627.410, Fla. Stat., was inapplicable to surplus lines insurers because surplus lines was regulated by the Florida Surplus Lines Law,

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which is part of Chapter 626, Fla. Stat. One of the purposes of the Surplus Lines Law is to:

[P]rotect such authorized insurers, who under the laws of this state must meet certain standards as to policy forms and rates, from unwarranted competition by unauthorized insurers who, in the absence of this law, would not be subject to similar requirements.... 10

The Florida Office of Insurance Regulation also asserted that two statutory provisions requiring approval of surplus lines policy forms demonstrated the Legislature's intention for a general exemption of surplus lines insurers from form filing and approval requirements applicable to admitted insurers under section 627.410, Fla. Stat. Section 626.916(1)(c), Fla. Stat., requires form approval where the coverage is to be exported under a unique form of policy designed for use with respect to a particular subject of insurance if a copy of such form is filed with the Florida Office of Insurance Regulation by the surplus lines agent desiring to use the same, and is subject to the disapproval of the office within 10 days of filing such form. Section 718.111(11)(a)2, Fla. Stat., requires surplus lines insurers to file policy forms and rates when it seeks to issue a group insurance policy covering condominium associations.

It is very likely that legislation exempting surplus lines from policy form filing and approval requirements of section 627.410, Fla. Stat., will be filed in anticipation of Florida's 2009 Regular Session, which commences in early March 2009. Drafters of such proposed legislation should take into account that, notwithstanding the few occasions where surplus lines insurance carriers are explicitly made subject to particular statutory sections within Chapter 627 or are explicitly mentioned in a particular section,¹¹ the terms "insurer" and "authorized insurer" are used throughout Chapter 627, Fla. Stat. and unless otherwise defined, the term "insurer" may include a surplus lines insurer.¹² For example, section 627.428, Fla. Stat., an attorneys' fee provision for policyholders that successfully sue on insurance contracts, applies to surplus lines insurers, though there is no mention of surplus lines insurers.¹³ Another example is section 627.7019, Fla. Stat. regarding standardization of requirements applicable to insurers after natural disasters. This statutory provision only refers to "insurers"; but it applies to surplus lines insurers.¹⁴ Therefore, any proposed legislation, if not carefully drafted, may create more uncertainty about the applicability of Chapter 627 to surplus lines insurers, rather than resolving the current ambiguity in surplus lines regulation in Florida created by the *Zota* and *CNL Hotel* opinions.

Endnotes

1. 985 So. 2d 1036 (Fla. 2008).
2. §626.922, Fla. Stat. is specific to surplus lines agents and surplus lines insurance policies.
3. *See Essex Ins. Co. v. Zota*, 18 Fla. L. Weekly Fed. D609, 2005 WL 2456860 (S.D. Fla. April 13, 2005), *final summary judgment granted*, 18 Fla. L. Weekly Fed. D611, 2005 WL 2456081 (S.D. Fla. June 2, 2005) (collectively "*Zota I*").
4. *See Essex Ins. Co. v. Zota*, 466 F.3d 981, 990 (11th Cir. 2006) ("*Zota II*").
5. *See Zota I*, 18 Fla. L. Weekly Fed. at D610.
6. *See id.* at D610-11.
7. 511 So. 2d 968, 970-71 (Fla. 1987).

FEDERATION OF REGULATORY COUNSEL, INC.

8. 291 F. App'x 220, 2008 WL 3823898 (11th Cir. 2008).
9. Appellees' Motion for Rehearing was ultimately denied by the Eleventh Circuit.
10. §626.913(2), Fla. Stat.
11. *See* §627.912, Fla. Stat. (surplus lines carriers to make certain reports regarding professional liability insurance on risks in Florida); *see generally*, §627.701(6)(d)4., Fla. Stat. (mentioning surplus lines carriers).
12. An insurer includes every person engaged as indemnitor or surety or contractor in the business of entering into contracts of insurance or annuity. *See* §624.03, Fla. Stat. An authorized insurer is one authorized by a certificate of authority issued by the Florida Office of Insurance Regulation to transact insurance in Florida. *See* §624.09, Fla. Stat.
13. *See, e.g.*, *Underwriters at Lloyd's London v. Osting-Schwinn*, 545 F.Supp.2d 1261 (M.D. Fla. 2008); *Chacin v. Generali Assicurazioni Generali Spa*, 655 So. 2d 1162 (Fla. 3d DCA. 1995); *English & Am. Ins. Co. v. Swain Groves, Inc.*, 218 So. 2d 453 (Fla. 4th DCA 1969).
14. *See* Rule 69O-142.015(1)(a), F.A.C., which implements §627.7019, Fla. Stat.

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