

# FEDERATION OF REGULATORY COUNSEL, INC.

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### FOR WHOSE PROTECTION?

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A pair of recent Montana judicial decisions of first impression dictate that two provisions common in insured employee benefit plans - discretionary review of plan administrators' decisions and exclusion of benefits when recovery is available from a liable third party - will be routinely disapproved by the Montana Commissioner of Insurance. Conferring broad discretion upon the Commissioner to interpret the Montana Insurance Code, Title 33, MCA, they elevate protection of the single consumer over industry uniformity, affordability, and availability.

#### **Standard Insurance Company v. Montana Department of Insurance**

It was acceptable past practice in Montana, and other states, for employers or employee organizations establishing ERISA employee benefit plans to confer upon the claim administrator discretionary authority to determine eligibility for benefits or to construe the terms of the plan by means of express language commonly referred to as a "discretionary clause." Historically, the Montana State Auditor, *ex-officio* Commissioner of Insurance [Commissioner]<sup>1</sup> approved insurance forms relating to group disability insurance issued by disability insurers<sup>2</sup> in Montana that contained discretionary clauses.

Federal courts review disputed benefit determinations under an abuse of discretion standard if the employee benefit plan includes a "discretionary clause" giving the ERISA plan administrator discretionary authority to interpret the terms of the plan.<sup>3</sup> Absent such a clause, benefit determinations are reviewed *de novo*.<sup>4</sup> Under abuse of discretion review, a plan administrator's decision will be upheld "if it is based upon a reasonable interpretation of the plan's terms, . . . was made in good faith," and is supported by substantial evidence.<sup>5</sup> ERISA was enacted to promote availability of employee benefit plans.<sup>6</sup> Abuse of discretion review furthers a primary goal of ERISA, i.e., to provide an inexpensive and expeditious method for workers and beneficiaries to resolve benefits disputes. Limiting review to the administrative record, as the abuse of discretion standard does, promotes this goal.<sup>7</sup>

Shortly after taking office,<sup>8</sup> however, Commissioner John Morrison, with strong trial bar support, began a concerted campaign to eliminate their use, claiming discretionary clauses violated Montana law, specifically 33-1-502, MCA, because they are "inherently ambiguous." The Commissioner characterized discretionary clauses as a convention of the insurer, alleging the clauses "negate the operative terms of the insurance contract . . . and leave entitlement to benefits to [the decision of] . . . each . . . insurance company";<sup>9</sup> "give[ ] with one hand (policy provisions) and take[ ] away with the other (discretionary clause)";<sup>10</sup> allow a profit-motivated company to "remove[ ] the contractual promise to pay and replace[ ] it with a possibility of payment"<sup>11</sup> "saying, 'maybe - and trust us to decide,'"<sup>12</sup> "turn[ing] upside down 80 years of settled Montana law that states ambiguous policy provisions are construed in favor of the insureds."<sup>13</sup> Relying upon his general authority "to ensure that the interests of insurance consumers are protected,"<sup>14</sup> the Commissioner insisted they must be struck down because "Montana courts consistently and uniformly interpret insurance coverage questions in favor of insureds, not the insurers."<sup>15</sup> They must be struck down because of the "uncertainty they create regarding entitlement to benefits."<sup>16</sup> **17**

After several years of comment, discussion and exchange of correspondence between the Commissioner and the insurance industry, and failed rulemaking,<sup>18</sup> the Commissioner implemented an unannounced practice of blanket disapproval or withdrawal of approval of all forms containing such a clause. The Commissioner's

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public statements, however, revealed that the objective of his practice was to effect a *de novo* standard of review in disputed ERISA benefit determinations.<sup>19</sup>

When Standard Insurance Company [SIC] questioned disapproval of discretionary clauses contained in its group disability and disability income policy forms, the Commissioner claimed 33-1-502, MCA, required him to do so. Consequently, SIC sought judicial reversal of the Commissioner's conclusion of law that discretionary clauses were inherently ambiguous and ruling that his practice was not a proper exercise of his statutory duties.<sup>20</sup>

Relying upon 33-15-304, MCA, which expressly permits provisions in insurance contracts not inconsistent with Title 33 and that are "desired by the insurer and neither prohibited by law nor in conflict with any provisions required to be included," SIC advocated continued use of discretionary clauses, pointing out that nowhere in Title 33 are they expressly prohibited nor are employers or employee organizations prohibited from contractually conferring discretionary authority upon their plan administrators. Accordingly, discretionary clauses are presumptively valid in Montana and, therefore, the Commissioner may only disapprove an insurance form that contains such a clause if the clause is "inconsistent, ambiguous, or misleading" or contains "exceptions and conditions which deceptively affect the risk purported to be assumed in the general coverage of the contract."<sup>21</sup>

Since the Commissioner has only those powers specifically conferred upon his office by the Legislature,<sup>22</sup> SIC argued, the Commissioner may not establish law or usurp the Legislature's authority in determining public policy.<sup>23</sup> Where the Legislature has not announced other regulatory goals, the Commissioner may only regulate the business of insurance within the existing statutory framework that permits an insurance contract to contain provisions "desired by the insurer and neither prohibited by law nor in conflict with any provisions required to be included . . ."<sup>24</sup> Section 33- 1-502, MCA, requires a Commissioner only to disapprove an *individual* policy form if it is "inconsistent, ambiguous, or misleading."<sup>25</sup> Because the Commissioner engaged in no analysis of individual policy forms, but simply disapproved them by way of a check-off list, his practice of blanket disapproval exceeded the scope of his statutory authority. While insurers would not dispute the general rule of law that ambiguities in an insurance policy are construed against the insurer, they did dispute that *all* discretionary clauses, however drafted, are *per se* ambiguous and may be disapproved without individual analysis. Indeed, drafted in plain language, clauses clearly disclosing not only the scope and nature of the discretion being granted, but also potential limitations inherent in judicial review of an adverse decision, are not ambiguous and should be encouraged.

Noting the case was one of first impression, the trial court, with little analysis, reiterated the general principle that in Montana insurance contracts must be construed as a whole and any ambiguity must be construed against the insurer. Because the insurer not only drafted the insurance contract, but also under the authority conferred by the discretionary clause, the insurer was afforded the right to construe its terms and determine participant eligibility, the court held that "on its face" the clause was "ambiguous and inconsistent" and the Commissioner correct in disapproving it under 33-1-502 (2), MCA.<sup>26</sup>

### **Blue Cross and Blue Shield of Montana, Inc. v. Montana State Auditor**

In 2001, Blue Cross and Blue Shield of Montana, Inc. [BCBS] submitted forms to the Commissioner for approval containing coverage exclusions under which BCBS would not pay for health care costs of its injured members if the members received, or were entitled to receive, benefits from any automobile or premises liability policy. After reaching agreement over specific disputed language, the Commissioner approved the coverage exclusions for use in BCBS policies. In 2007, the Commissioner disapproved new forms submitted with the agreed exclusions on the ground that the exclusions conflicted with statutory subrogation duties and that they "deceptively affect[ed] the risk purported to be assumed in the general coverage of the contract," citing his authority under 33-1-502, MCA. BCBS challenged the Commissioner's decision in state district

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court and on appeal to the Montana Supreme Court. In a 4-1 decision the Montana Supreme Court upheld the Commissioner's conclusion of law and disapproval.<sup>27</sup>

First, BCBS challenged the trial court's determination that the Commissioner was acting in the scope of his authority under 33-1-502 in withdrawing prior approval of language he had negotiated and approved. The Supreme Court agreed, underscoring the Commissioner's broad powers.

The Commissioner has broad statutory power over the content of insurance documents, and the statutes require that this power be exercised to protect the insured public and to further the goals of Montana's laws on insurance. Section 33-1-311, MCA. The position of BCBS here, and particularly its argument that the Commissioner waived any right to [withdraw prior approval] by agreeing to them in 2002, would immortalize any provision of an insuring document approved in a similar manner . . . however onerous or deceptive the provision proved to be. The provision would survive even if there were statutory changes that caused it to conflict with express law . . . contrary to public policy as expressed in [Title 33] . . . .<sup>28</sup>

The critical holding of *Blue Cross*, however, was that approval of the exclusions was properly withdrawn because they constituted impermissible subrogation by BCBS, violating statutory restrictions in 33-30-1101 and -1102, MCA. Section 33-30-1102 provides that a health service corporation's subrogation right "may not be enforced until the injured insured has been fully compensated for his injuries." Ignoring legal distinctions between exclusions and equitable subrogation, the Court upheld the trial court's agreement with the Commissioner that the BCBS exclusions allowed it to exclude, limit or offset health insurance benefits otherwise due to the insured before the insured was fully compensated for his injuries or "made whole."<sup>29</sup> "Only when the insured is made whole as defined in Montana law, and then only after BCBS has paid out benefits to its insured, could BCBS be entitled to claim subrogation."<sup>30</sup>

The strongly-worded dissent decried the majority's confusion of the distinctly different doctrines.

A key component to subrogation is consideration -the insured pays a premium in exchange for the insurer's assumption of his risk of loss. . . . On the other hand, exclusions are "insurance-policy provision[s] that except[ ] certain events or conditions from coverage." We have held that exclusions "will be narrowly and strictly construed because they are contrary to the fundamental protective purpose of an insurance policy." . . . [T]hese provisions do not even include the *concept* of subrogation. [T]he Court . . . has acted with "violent hands . . . to include a risk clearly excluded by the insurance contract" and for which BCBS would receive no payment.<sup>31</sup>

### Conclusion

Both decisions disappoint in that in the name of public protection they blur distinct legal and insurance doctrines to advantage only the individual insurance consumer. Until the Montana Legislature announces express public policy or the courts cure the legal confusion, however, insurers are cautioned that policy forms filed with discretionary clauses or exclusions will be disapproved as *per se* ambiguous and in violation of Montana insurance law.

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1. The Commissioner is responsible for the administration, supervision, and control of the Insurance Department which is charged by statute with regulating the business of insurance in the State of Montana. Mont. Code Ann. §§ 2-15-1902, -1903, 33-1-311(1)-(2).
2. The term "disability insurance" is used in the Montana Code Annotated to mean health insurance coverage. "Disability insurance" is defined as "insurance of human beings . . . against bodily injury, disablement, or death by accident or accidental means or the medical expense or indemnity involved; or against disablement or medical expense or indemnity resulting from sickness." Mont. Code Ann. § 33-1-207 (1). Disability income insurance is separately defined as ". . . insurance that primarily provides payment . . . upon lost wages or other earned income or business or financial losses as a result of an inability to work due to sickness, injury, or a combination of sickness and injury." Mont. Code Ann. § 33-1-235.
3. *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110 (1989).
4. *Id.* at 115.
5. *Boyd v. Bert Bell/Pete Rozelle NFL Players Ret. Plan*, 410 F.3d 1173, 1178 (9th Cir. 2005).
6. 29 U.S.C. § 1001(b); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983).
7. *Boyd*, 410 F.3d. at 1178; *Taft v. Equitable Life Assur. Society*, 9 F.3d 1469, 1472 (9th Cir. 1994).
8. The Montana State Auditor is elected. The office is subject to term limits, two four-year terms. Morrison took office in 2001.
9. Morrison's Brief in Opposition to Standard's Motion for Summary Judgment [Morr. Opp'n], SIC at 9; Brief in Support of [Morrison's cross] Motion for Summary Judgment [Morr. Main Brf.], SIC at 8.
10. *Id.*
11. Morr. Opp'n at 13; Morr. Main Brf. at 12.
12. Morr. Opp'n at 16; Morr. Main Brf. at 14. The Commissioner also worried that "without plenary court review," the clause would cause coverage in the policy to "vary from company to company." Morr. Main Brf. at 12.
13. Morr. Opp'n at 2, 9-10; Morr. Main Brf. at 2, 9-10 (citing multiple cases). This view also ignores that under a deferential standard of review, courts do overturn benefits decisions when unreasonable or not supported by substantial evidence. See, e.g., *Metropolitan Life Ins. Co. v. Glenn*, \_ U.S. \_, 128 S. Ct. 2343; *Wirries v. Reliance Standard Life Ins. Co.*, 247 Fed. Appx. 870, 2007 WL 2301250, at \*2 (9th Cir. Aug. 10, 2007); *Oliver v. Coca Cola Co.*, 497 F.3d 1181, 1195-98, 1202 (11th Cir. 2007); *Boyd v. Aetna Ins. Co.*, 438 F. Supp. 2d 1134, 1155-56 (C.D. Cal. 2006).
14. Mont. Code Ann. § 33-1-311(3) ("The commissioner shall administer the department to ensure that the interests of insurance consumers are protected.").
15. Morr. Opp'n at 8.
16. Morr. Main Brf. at 11.

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17. Morrison relied upon the administrative practice of two other states to support his practice of blanket disapproval. A handful of states have enacted statutes or implemented rulemaking regulating the use of discretionary clauses in some insurance policies. Of those that have, not all have prohibited them. With the exception of New York, where the Superintendent ultimately withdrew the prohibition on discretionary clauses as it had not been properly promulgated through the rulemaking process, no other state insurance regulator has without process simply announced the practice based upon the regulator's personal distaste for such a provision.
18. Morrison twice failed to promulgate rules to prohibit the use of discretionary clauses in all policy forms, in the face of opposition from industry representatives, including the American Council of Life Insurers, America's Health Insurance Plans, Blue Cross and Blue Shield of Montana, Inc. and the American Insurance Association, as well as the Montana Chamber of Commerce and Montana insurance producer organizations. In the matter of the proposed adoption of New Rule I pertaining to prohibition of discretionary clauses in insurance policy forms, NOTICE OF PUBLIC HEARING ON PROPOSED ADOPTION, MAR Notice No. 6-138; In the matter of the proposed adoption of New Rules I and II pertaining to prohibition of discretionary clauses in insurance policy forms, NOTICE OF PROPOSED ADOPTION NO PUBLIC HEARING CONTEMPLATED, MAR Notice No. 6-140. The Commissioner met with representatives of the insurance industry to discuss his practice of blanket disapproval of discretionary clauses. In that meeting, the Commissioner informed industry representatives that he would not pursue rulemaking. In the stead of rulemaking, he presented for industry input a draft Advisory bulletin he proposed to circulate to insurers advising of the Commissioner's policy of blanket disapproval of discretionary clauses in ERISA life, health, and disability income policies. Upon consideration of the draft bulletin, insurer representatives reiterated their opposition to the practice and to specific representations of the Commissioner's Advisory. The Advisory was not finalized and distributed. The noticed proposed rules lapsed without adoption.
19. During the same foregoing period of time, the Commissioner announced to practitioners in the State Bar of Montana his intention to disapprove and withdraw approval of all policy forms containing discretionary clauses, including but not limited to seminars conducted by the Montana Trial Lawyers Association, the Montana Defense Trial Lawyers, and the First Judicial District Bar Association. The Commissioner continued to publicly announce the policy he adopted to state practitioners in subsequent meetings of the named associations and others.
20. *Standard Ins. Co. v. Mont. Dept. of Ins.*, Mont. 1st Dist., CDV 2006-706.
21. Mont. Code Ann. § 33-1-502 (emphasis added).
22. Mont. Const. art. VI, § 4 (5); *Polson v. Pub. Serv. Comm'n.* (1970), 155 Mont. 464, 473 P.2d 508, cited with approval in, *Anaconda Co. v. Dep't. of Rev.* (1978), 178 Mont. 254, 257, 583 P.2d 421, 423-34.
23. E.g., *State v. Brown*, 2008 MT 115, ¶ 18, 342 Mont. 476, 182 P.3d 75; *State ex rel. Holt v. Dist. Court* (1936), 103 Mont. 438, [hns 6, 7], 63 P.2d 1026, 1030-31; *State v. Gateway Mortuaries* (1930), 87 Mont. 225, [hns 2, 3], 287 P. 156, 157.
24. Mont. Code Ann. § 33-15-304.
25. Mont. Code Ann. § 33-1-502 (2).
26. Memorandum and Order on [Cross] Motions for Summary Judgment, Standard (Dec. 3, 2008) at 7-9. SIC chose not to appeal.
27. *Blue Cross & Blue Shield of Mont., Inc. v. Mont. St. Auditor*, 2009 MT 318, 352 Mont. 423, \_ P.3d \_.

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28. *Id.* ¶ 13.

29. *Id.* ¶¶ 17-19, citing *Swanson v. Hartford Ins. Co.*, 2002 MT 81, ¶ 28, 309 Mont. 269, 46 P.3d 584; *Oberson v. Federated Mut. Ins. Co.*, 2005 MT 329, ¶¶ 14-15, 330 Mont. 1, 126 P.3d 459; *Skauge v. Mountain States T. & T.*, 172 Mont. 521, 524 565 P.2d 628, 630 (1977)

30. *Id.* ¶ 18.

31. *Id.* ¶¶ 27-35 (citations omitted; some alterations in original; emphasis in original).

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## KEY COMPONENTS OF A SUCCESSFUL NATIONAL HEALTH CARE REFORM PACKAGE

### *What Maine's Experience Tells Us*

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As Congress and the Obama administration struggle to enact comprehensive health care reform, comparisons are being made to proposed solutions being offered in Washington with what has happened in several states that have already enacted similar types of reform packages in the past few years. As reported previously in this journal, 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").<sup>1</sup> Just like the various federal initiatives being debated currently, two key goals of Maine's reform package were to improve access to health care through expanding private insurance and public Medicaid coverage and to control costs.<sup>2</sup> Maine has attempted to expand private health insurance coverage through a subsidized state-sponsored insurance plan called DirigoChoice, which is administered by the Dirigo Health Agency ("DHA"). This coverage expansion is funded with a surcharge on insurance premiums paid by individual subscribers and was also intended to control cost growth by reducing cost-shifting. 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.

A review of the track record of the Dirigo reforms over the past five years shows that the funding mechanism for private coverage expansion has been fraught with financial, political and legal problems, and the impact on enrolling previously uninsured individuals in the DirigoChoice product has fallen far short of expectations. Just as stark is the failure of the Dirigo model to reduce the overall cost of health care. A review of this track record will reveal what has not worked and why and points the way to several key components of a successful health care reform plan on the national level.

### **I. Maine's Dirigo Health Reforms - The Track Record**

When signed in 2003, Governor Baldacci's administration promised that by 2009 the program would arrange for coverage of all of the approximately 128,000 of Maine's then-uninsured. System-wide controls on hospital and physician costs would hold down insurance premiums. There would be no new taxes to fund the coverage expansion. Providing insurance for all Mainers would also save businesses and patients money by reducing cost-shifting from uninsured and underinsured (including Medicare and Medicaid beneficiaries for whom the

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federal government pays less than the cost of care to hospitals and physicians) to those insured under private, fully-insured or self-funded plans.

In reality, the cost to taxpayers who also pay for their private health insurance coverage, in the form of the so-called "Savings Offset Payment" ("SOP") surcharge added to their premiums, has totaled \$155 million over the past five years. Annual hearings to set the amount of the SOP and related court challenges have consumed millions of state and private dollars. Instead of 128,000, actual enrollment in the subsidized DirigoChoice product has been far less than projected, hitting a peak of 15,000 enrolled in 2006. That figure has dropped to below 10,000, and, in fact, a majority of these people already had some form of private insurance and chose to drop their prior coverage in favor of the subsidized product. Maine has greatly expanded Medicaid eligibility and coverage over this period, now covering 22% of the population, which is twice the national average and covers families with up to \$44,000 per year in income. Even with this expansion, the total number of uninsured in Maine today is only slightly lower than in 2004.<sup>3</sup>

In addition, the promised controls on hospital costs, which were part of the original Dirigo Reform Act legislation, were stripped out in the final hours of legislative negotiations and were replaced by "voluntary" cost targets.<sup>4</sup> Maine has experienced a moderation in the rate of hospital cost growth since 2003, when Maine's cost growth was among the highest in the nation. This "regression to the mean," however, is completely predictable in actuarial circles.<sup>5</sup> Moreover, Maine's overall reduction in the rate of cost growth since 2003 is consistent with the experience in many other states in the country that have not had any similar health reform in place during this period.<sup>6</sup> A stark barometer of the failure of the Dirigo model to control costs is the simple fact that health insurance premiums in Maine continue to be among the highest in the nation.<sup>7</sup>

## **II. What Caused Maine's Track Record to Fall Far Short of Promised Levels?**

First, many of the sickest Mainers - those with the most expensive to treat conditions - crowded into DirigoChoice. This adverse selection makes the premiums so high that even with subsidies fewer than expected low-income people could afford the subsidized product.

Second, the DirigoChoice product offers only one, extremely rich benefit package, making the premium too high even with subsidies, even for healthy individuals. Massachusetts by comparison in its "Connector" program offers a range of coverage and benefit packages on a sliding price scale. As funding through the annual SOP process was far less than projected by DHA, it froze enrollment rather than offering a pared-down range of benefit packages.

Third, in the early 1990's Maine imposed community rating and guaranteed issue requirements on insurers, much like components of several of the federal proposals now being considered. These reforms have driven up health insurance costs to levels significantly higher than in neighboring states. This factor, coupled with Maine's high medical cost growth experience, has caused premiums over the past five years to increase by over 70%.<sup>8</sup>

Fourth, four years of contentious SOP hearings have consistently resulted in decisions by the Maine Superintendent of Insurance that the alleged savings due to the Dirigo program were far less than claimed by DHA. These decisions have left DHA with insufficient funding to provide subsidies for the DirigoChoice product. Therefore, despite the original promise not to impose new taxes to fund this coverage expansion and the other DHA initiatives, the DHA and the Baldacci administration in 2008 sought legislation imposing new taxes on soda, juice, wine and beer to do just that. These taxes were passed by the legislature but then vetoed by a statewide referendum permitted under Maine law.<sup>9</sup>

Fifth, in 2009 DHA and the Baldacci administration were back with legislation to enact a fixed 2.14% of paid claims as a statutory assessment to replace the SOP annual assessment. The legislature enacted this

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"assessment," which now in perpetuity will be assessed as a surcharge on all those Mainers covered under fully-insured or self-funded plans.<sup>10</sup>

Sixth, Maine unlike the federal government, has a balanced budget requirement in its state constitution. It cannot engage in "deficit spending." Therefore, absent sufficient SOP funding, and even with newly enacted legislation providing for a special assessment on policyholders in Maine, the DHA does not have enough funding to expand eligibility in DirigoChoice. Waiting lists grow longer and the number of uninsured Mainers is not being meaningfully reduced.

Like similarly ambitious programs in Massachusetts and Tennessee<sup>11</sup>, the Maine experiment has proven to be very expensive while achieving very limited success in its original goal of expanding access to care and coverage, mainly through expanding Medicaid eligibility, and has made no significant progress in achieving its other key goal, reducing overall the underlying health care costs.

### **III. Key Components of a Successful National Health Reform Package Based on Maine's Experience**

#### **a. Reforms must come at the national level.**

As noted previously in this journal, the federal government controls a very large segment of the total health care expenditures in the country through its operation of the Medicare and Medicaid programs. Federal matching funding must be secured to enable states to expand their respective Medicaid programs to cover more low-income people. Moreover, to significantly increase Medicaid enrollment it must be done nationally and not left to each state, as there is tremendous variation by state in the Medicaid eligibility requirements (and the percentage of uninsured people). Moreover, Medicare and Medicaid do not even pay the full *cost* to providers (as opposed to the charges of hospitals and doctors). This unmet shortfall is passed on to the insured population and is referred to as "cost shifting." Any comprehensive health care reform package must address the cost shifting problem and only the federal government is in a position to do so.

#### **b. Funding must be broad-based.**

Special assessments, such as Maine's SOP or the recently enacted legislative assessment, do not raise sufficient funding to cover the cost of providing anything close to universal health coverage. Tax dollars already pay for Medicare and Medicaid. Tax policy is an integral part of all federal options now being considered, such as deductibility of premiums and taxes on high-priced plans. The burden of such major program expansions must be distributed widely throughout the population through the tax structure to be sustainable over the long-term.

#### **c. Mandated coverage must be meaningful to be effective.**

Massachusetts has enacted a mandate for individuals and employers to obtain coverage as part of its health reform package. The penalty for an employer that does not obtain mandated coverage is far less than the cost to provide coverage, which makes the mandate very ineffective in causing every Massachusetts employer subject to the mandate to obtain coverage for its employees. Likewise, Karen Ignagni, president of America's Health Insurance Plans, the leading health insurance industry advocacy group, has objected to the mandate penalty provision in various proposed federal models as being too lenient, which would not force younger, healthier, currently uninsured people to purchase coverage. This in turn would dilute the insured pool and would undermine the insurers' ability to drive down underwriting costs.<sup>12</sup>

#### **d. Insurance reforms will drive up premiums.**

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Maine has already enacted at least two market reforms - community rating and guaranteed issue - that are currently being debated in Washington. These requirements help to reduce the number of uninsured, but clearly they also have driven up premiums in Maine versus neighboring states.<sup>13</sup> We must expect similar results nationally if such reforms are enacted. There must be true savings in other parts of a national reform package to offset these projected increases.

### e. Cost Controls - the Pink Elephant.

Noticeably absent from most of the coverage of the federal debate is a sharp focus on the dramatic and steadily increasing amount that this country spends on hospital, physician and pharmacy services, and what specific steps will be included in a national plan to control and reduce these costs. Even the insurance industry, as it reacts to various proposals and is increasingly portrayed as the scapegoat in the debate, seems reluctant to openly call for cost controls. Yet Medicare and Medicaid already control costs by dictating how much hospitals, physicians and pharmacies will be paid for services provided to beneficiaries. Ironically, at least one proposal would create "savings" by cutting the amount paid to these providers under Medicare and Medicaid over time. Similar cuts to physicians in the past have been subsequently lobbied out of the law prior to the effective date, but they have propped up the projected savings Congress has promised the taxpayer. To the extent that such cuts in Medicare and Medicaid payments to providers remain in any enacted national reform, they will only add more pressure to the current cost shifting, which will cause private health insurance premiums to increase down the road.

The underlying nemesis to meaningful health reform is how to control the cost of care paid by private insurers to providers on behalf of their subscribers. If the federal government really did control these underlying costs, then insurers could charge less for their coverage. Switzerland has adopted a similar approach, whereby the federal government sets budget limits for hospital care, and then private insurers provide coverage up to these limits. Yet in Maine such controls were stripped out of the Dirigo Health Reform Act. Massachusetts, which is now faced with exploding costs from its new reform package, is trying to push back by proposing widespread controls on hospital costs. This effort is facing fierce opposition from the hospital industry in the state.<sup>14</sup> There appears to be no clearly articulated component of any of the current federal proposals that tackles this issue. Trying to solve the crisis in the cost and availability of health care coverage without meaningful cost controls ignores the underlying costs that the entire health insurance system is designed to cover and cannot succeed over time.

### f. Public Option - now or later?

Maine's DirigoChoice product is not a true public option. Instead it is much like a private health insurance plan with subsidies to help people afford coverage who otherwise could not. Given the much smaller than expected enrollment, and the limited success of voluntary cost limits and reductions in cost shifting due to fewer uninsured in Maine, the Dirigo experiment has not meaningfully reduced the overall cost of health care in Maine. A key element of a true public option should be to grant the authority - like that given to Medicare and Medicaid - to control underlying hospital, physician and pharmacy costs. Senator Snowe from Maine had been quoted as favoring a "wait and see" approach on the public option. She proposed giving the private insurance industry some time to work to control the cost of premiums, and if they are not successful, to then adopt a public option. It is hard to see how the insurance plans can do this without legislation to control the underlying costs that they insure. Such legislation must come at the federal level. Yet such provisions are nowhere to be found in the current proposals being discussed on Capital Hill.

The public option was eliminated from the Senate bill, but was included in the House bill. As the action shifts to conference committee, it bears close watching to see if any meaningful controls on underlying costs are included and ultimately enacted. It is not likely to happen, however, as this would be seen as creating an uneven playing field for any public option versus insurers. It would be better policy but probably not

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politically feasible to enact such cost controls nationally so that, as in Switzerland, private insurers could benefit from them and pass that benefit along to subscribers in the form of lower premiums.

If we do not adopt a public option with underlying cost controls, it is very likely that these costs will continue to increase dramatically, which will drive up premiums, and we will be faced with a huge tax increase to fund one of the biggest expansions in Medicaid enrollment of all time. As noted in prior articles on this subject in this journal, this crippling increase in premiums and new taxes could over time cause the collapse of the system as we currently know it. If that happens, then the public option will re-surface. Only then the federal government may be forced to run the entire system, like the British government did following World War II. Cost controls would be a key part of such a comprehensive federal program. One way or another the problem of controlling underlying costs will not go away. Our public policymakers are simply deciding when we will be forced to deal with it.

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## Endnotes

1. Public Law 2003, ch. 469 (effective Sept. 13, 2003), as amended by Public Law 2005, ch. 400 (effective Sept. 17, 2005).
2. The third goal of the Act was to improve the quality of health care through the establishment of the Maine Quality Forum, which is charged with undertaking a broad range of initiatives including: collection and dissemination of research on evidence-based medicine and patient safety to promote best practices; adoption of quality and performance measures to evaluate and compare health care quality and provider performance; coordination of collecting health care quality data; collection of comparative health care quality data from providers and insurers in a format usable to consumers, purchasers and policymakers; consumer education; technology assessment to guide the use and distribution of new technology; encouraging the development of electronic data for medical records and claims; making recommendations for the state health plan; providing annual reports to the public and the state legislature including provider-specific performance data and infection prevention activities. *See* 24-A M.R.S.A. § 6951(1-11).
3. "No Maine Miracle Cure: Another Public Option that Failed," Wall Street Journal, September 17, 2009.
4. *See* 22 M.R.S.A. § 1722 (current statutory codification of original Dirigo Reform Act voluntary cost controls).
5. The Maine Association of Health Plans offered expert testimony on this point from Milliman, an industry leading actuarial consulting firm, in the year 4 administrative hearings to set the amount of the SOP. *See In re: Review of Aggregate Measurable Cost Savings ("AMCS") Determined by Dirigo Health for the Fourth Assessment Year*, Docket No. INS. 08-900.
6. Comparative state-by-state hospital cost growth data was admitted into the record in the year four AMCS administrative hearing. *Id.*
7. For example, family coverage in Maine costs in excess of \$15,000 per year.
8. "No Maine Miracle Cure," Wall Street Journal, September 17, 2009.
9. The authority for Maine's "people's veto referendum" appears in the Maine Constitution, Article IV, section 17, and the related procedures are codified at 21-A M.R.S.A. § 901 *et seq.*

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10. *See* Public Law, Chapter 359, An Act to Stabilize Funding and Enable DirigoChoice to Reach More Uninsured, codified at 24-A M.R.S.A. § 6917(1). The 2.14% of paid claims figure was based on the amount approved by the Superintendent in the 2008 AMCS/SOP hearings process. The Maine Association of Health Plans, the Maine Chamber of Commerce and the Maine Automobile Dealers Insurance Trust challenged this decision in court and after the new law was enacted, received a decision vacating the Superintendent's decision and rejecting much of the underlying basis for the amount of the assessment. The matter is on remand to the DHA but will only affect the SOP for one year; the 2.14% assessment in the new law is still in effect for the current and future years.
11. "No Maine Miracle Cure," Wall Street Journal, September 17, 2009.
12. Gregg Hitt and Janet Adamy, "Insurers Push Back as Senate Health Vote Nears," Wall Street Journal, October 13, 2009. In a related public television interview, Ms. Ignagni stated that "...the experience at the state level indicates that you have to have everybody participate. .. And what happened in the states was...[those] states that enacted market reform without everyone participating, you had rate shock. You had people leaving the pool who were young and healthy, spiraling up the costs for everyone. This is not a projection. This is what happened at the state level." Quoted from an interview on the NewsHour with Jim Lehrer, October 12, 2009.
13. "No Maine Miracle Cure," Wall Street Journal, September 17, 2009.
14. "Hospitals Attack State Pay Proposal," Boston Sunday Globe, October 4, 2009 (page 1).

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### TOPICAL REVIVAL OF AN OLD CONCEPT - ACTUAL CASH VALUE - AND CHALLENGES TO ITS USE

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With the rapid decline in recent years of real property values, both residential and commercial, resurgence of the concept of "actual cash value" has arisen as a way of limiting payment in total property loss situations due to such perils as fire. Full cost of replacement is often inflated due to rising building materials and other construction costs. On the other hand, market value, which can be considerably less than full replacement cost in the case of a building, offers advantages in loss adjustment. Yet, there are legal and regulatory challenges to implementation of "actual cash value" (in insurance parlance, known as "ACV").

Illustrating the resulting clash of adjusting advantages and law-based challenges is the recent Iowa case of *Farmers Cas. Co. v. Birkby*,<sup>1</sup> in which fire destroyed the insured building. Insurer paid the owner of the building \$26,140 based upon the market value of the building at the time of the loss. However, the building had been insured for \$80,000 and the owner claimed he was entitled to that amount. By statute in some states, known as the "valued policy" rule, the value insured is the payout under the policy.<sup>2</sup> However, this approach did not govern in *Birkby*.<sup>3</sup> While the Court indicated the cost to replace the building should be considered in determining "actual cash value," expert testimony on market value is usually taken as such, when market value can be ascertained.<sup>4</sup> Only in the event that actual cash value cannot be ascertained does replacement cost, or stated value, govern.<sup>5</sup> *Birkby* followed the long-standing pattern in which a variety of factors are utilized for determining actual cash value (referred to as the "broad evidence rule").<sup>6</sup> The seminal case was

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*McAnarney v. Newark Fire Ins. Co.*<sup>7</sup> There, the New York Court of Appeals noted that recovery based on a definition of actual cash value as replacement cost minus depreciation could provide a windfall to an insured and that "in order to effectuate complete indemnity, every fact and circumstance which logically tends to the formation of a correct estimate of the loss" should have been utilized.<sup>8</sup> In *Birkby*, this was interpreted to mean that the market value of only \$26,140, not the stated or insured value of \$80,000, was required to be paid by the insurance company to the insured.

The lesson to be garnered from this case is that it is futile for insurers to craft a definition of "actual cash value" in their policy. Of necessity, agents will be required to explain, at the time of purchase of the policy, that replacement cost may not govern. Indeed, as a consumer safeguard against possible unfair surprise, the Iowa Commissioner of Insurance requires all insurers to provide notice in advance of valuation methods in claims settlement on "actual cash value" policies.<sup>9</sup>

Meanwhile, case law remains far from clear. Issues include whether to allow a depreciation offset.

For example in *Reliance Ins. Co. v. Substation Products Corp.*,<sup>10</sup> if recovery is based on insurance policies, it was held that the correct measure of damages is the actual cash value of the property at the time of loss, but not exceeding the cost of repair or replacement of the building with goods of like kind within a reasonable time after loss; in other words "actual cash value" means what the property is worth in money, allowing for depreciation. And in, *American Reliance Ins. Co. v. Perez*,<sup>11</sup> actual cash value of damaged property covered by homeowners' insurance policy was deemed to require consideration of depreciation. Put another way, according to *Manduca Datsun, Inc. v. Universal Underwriters Ins.*,<sup>12</sup> in determining whether "actual cash value" of a building destroyed by fire should include a deduction for depreciation, the fire policy must be read and considered as a whole.

However, under some policies, the term "actual cash value," when applied to a partial loss under homeowner's policy means cost to repair without any reduction for depreciation.<sup>13</sup> Likewise, in *General Cas. Co. v. Tracer Industries, Inc.*,<sup>14</sup> considering obsolescence of a commercial building destroyed by fire was held to be unnecessary in determining its actual cash value.

Again, a statute can override the facts of each case. In *Farmers Merchants Bank & Trust Co. v. Katherine Ins. Co.*,<sup>15</sup> a valued policy law was interpreted to require fire insurance to pay, in a total loss, the face value of the policy, with the provision that the insured is not criminally at fault. The public policy behind the valued policy law is very strong in those states where it is the rule and the statute is interpreted liberally in favor of the insured.<sup>16</sup>

In the eyes of courts in states with this orientation, the insurance policy is viewed as a contract of indemnity.<sup>17</sup> And, of course, the parties may agree upon entirely different methods of adjustment of the loss.<sup>18</sup> The cardinal rule is that the insured is to be placed in as good a financial condition as before the fire.<sup>19</sup> Of course, the age and condition of the property must be considered.<sup>20</sup>

Some perspective is in order. Despite the failing nature of real property values, the meaning of "actual cash value" is not a significant issue. It is a term used primarily in commercial, rather than personal property policies. Accordingly, further regulatory intervention, in the form of a mandate that the term must be defined in policies, is unnecessary and would simply discourage the availability in the marketplace of property insurance.

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1. 2008 WL 238599 (Iowa Ct. App. 2008), *aff'd* 746 N.W.2d 280 (Iowa 2008).
  2. *See e.g.* Ark. Code Ann. §23-88-101; La. Code Ann. 22:695. A "valued policy" is one where the value of the insured property is agreed to by the parties in the contract in advance, and, as a consequence, the insured does not have to prove the actual value of the destroyed property. *St. Paul Fire & Marine Ins. Co. v. Griffin Construction Co.*, 993 S.W.2d 485 (Ark. 1999).
  3. An Iowa statute, Iowa Code §515.135, provides that insured value constitutes "prima facia" evidence of "actual value." However, the Court made clear that under another state, Iowa Code §515.137, "actual value" meant market value, or "actual cash value," in most cases. In other words, Iowa is not a "valued policy" state.
  4. *Court View Centre, L.L.C. v. Witt*, 755 N.E.2d 75 (Ind. Ct. App. 2003).
  5. *Britven v. Occidental Ins.*, 13 N.W.2d 791 (Iowa 1944), cited in *Birkby*.
  6. *Strauss Bros. Packing Co. v. American Ins. Co.*, 298 N.W.2d 108 (Wis. App. 1980).
  7. *McAnarney v. Newark Fire Ins. Co.*, 159 N.E. 702 (N.Y. 1928).
  8. *Id.* at 904-05.
  9. Bull. 09-03 (Iowa Insurance Division).
  10. *Reliance Ins. Co. v. Substation Products Corp.*, 404 So.2d 598 (Ala.1981).
  11. *American Reliance Ins. Co. v. Perez*, 689 So.2d 290 (Fla. App. Dist.Ct. 1997).
  12. *Manduca Datsun, Inc. v. Universal Underwriters Ins.*, 676 P.2d 1274 (Idaho Ct. App. 1984).
  13. *Thomas v. American Family Mut. Ins. Co.*, 666 P.2d 676 (Kan. 1983).
  14. *General Cas. Co. v. Tracer Industries, Inc.*, 674 N.E.2d 473 (Ill. App. Ct. 1996). *See also, McMillin v. American Family Ins. Co.*, 950 S.W.2d 242 (Mo. App. 1997).
  15. *Farmers Merchant Bank & Trust Co. v. Katherine Ins. Co.*, 693 So.2d 876 (La. Ct. App. 1997).
  16. *Id.*
  17. *Kingsley v. Spoffoud*, 11 N.E.2d 487 (Mass. 1937)
  18. *DeSantis v. Michigan Basic Property Ins. Ass'n*, 265 N.W.2d 634 (Mich. Ct. App. 1978).
  19. *Marshall Produce Co. v. St. Paul Fire & Marine Ins. Co.*, 98 N.W.3d 280 (Minn. 1959).
  20. *Lee v. Providence Wash. Ins. Co.*, 266 P.2d 640 (Mont. 1928).
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## THE WINDS OF CHANGE

### *How Wind Storms Changed the Course of Regulation in Florida*

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For decades the property insurance market in Florida differed little from the rest of the country. Competition kept rates affordable and regulatory oversight focused more on company practices than rate management. Historically, consumer protection was addressed through solvency regulation and ensuring that rates were adequate.<sup>1</sup> Everyone seemed oblivious to the storm risk facing the peninsula. The population grew, particularly in coastal areas where large expensive structures replaced modest concrete or wooden structures built on pylons.

#### **1992 -Hurricane Andrew**

In 1992 everything would change. On August 24th, Hurricane Andrew struck the southern part of Dade County. Over 25,000 homes were destroyed and more than 100,000 were damaged. The Insurance Information Institute estimated insured losses totaled more than \$16 billion. Eleven insurance companies went bankrupt, and 30 others lost up to 20 percent or more of their surplus. Several Florida companies required an infusion of capital from their parent companies to cover the losses and remain operational. Surviving companies took measures to reduce their exposure. Some withdrew from the state entirely, others reduced or stopped writing coverage along the coast, leaving 930,000 policyholders with no coverage options.<sup>2</sup> As insurance companies fled the state, lawmakers and regulators had to find a way for homeowners to get insurance coverage. This noble effort to provide affordable coverage would result in the creation of the largest "residual" market in the country and arguably the most heavily subsidized property insurance market. Two risk pools were established-the Joint Underwriting Association, and the Florida Windstorm Underwriting Association.<sup>3</sup> Another change was the creation of the Florida Hurricane Catastrophe Fund ("Cat Fund") which was created to provide low cost reinsurance to private insurers. Still, public policy focused on creating capacity.

#### **2004-2005 Hurricane Season**

In the fall of 2004, four hurricanes made landfall in Florida: Charlie, Francis, Ivan and Jean; as well as tropical storm Bonnie. Reinsurers Swiss Re and Munich Re estimated that the 2004 hurricane season (the four hurricanes and Tropical Storm Bonnie) represented more than two million claims. Total insured losses in Florida in 2004 exceeded \$25 billion. <sup>4</sup> In August 2005, Hurricane Katrina made landfall in Florida as a category one storm. While it did not cause substantial damage in Florida, the hurricane strengthened over the Gulf of Mexico and was a category three storm when it made landfall near New Orleans, Louisiana causing catastrophic losses from wind, storm surge, and flooding in excess of \$81 billion.<sup>5</sup> Hurricane Katrina impacted the cost and availability of reinsurance, the perception of risk associated with writing insurance coverage in coastal regions, and the rate of return that investors would expect for placing their capital at risk. In addition to Hurricane Katrina, Hurricanes Rita, Wilma, and Dennis made landfall in Florida in 2005. Insured losses in Florida from the four hurricanes were in excess of \$10.8 billion.<sup>6</sup> Total insured losses in Florida from the 2004 and 2005 hurricane seasons were approximately \$36 billion.<sup>7</sup> After the 2004-2005 hurricane season, insurance carriers reevaluated their exposure to catastrophic risks in coastal states, in particular Florida, where 79 percent of the state's insured value consists of coastal exposure totaling

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\$2.5 trillion in total insured value (including cost to replace structures, contents, additional living expense and business interruption insurance).<sup>8</sup> This resulted in a significant increase in rate filings where a rate increase was sought. The Governor's Property and Casualty Insurance Reform Committee stated that in 2006, "52 of Florida's 167 property insurance carriers requested significant rate increases (over 25 percent) related primarily to the considerable increase in the cost of reinsurance (75 percent) and the heightened expectations of future losses related to hurricanes." This produced a public outcry and the demonization of the insurance industry based upon the belief that insurers were simply using this as an excuse to gouge consumers.

## HB 1A

Newly-elected Governor Charlie Crist in his inaugural address declared property insurance reform to be his number one priority: "I pledge the full resources of my office to work with the leaders of the House and Senate along with our new chief financial officer to bring our people the relief they need," Governor Crist announced.

Lawmakers moved quickly. A special session was called in January of 2007 to address property insurance rates and related issues. As a result of the special session, House Bill 1A ("HB 1A") was passed. The Governor signed the bill on January 25, and it took effect immediately. Less than a week after the bill was enacted, the Governor and Cabinet, sitting as the Financial Services Commission, adopted an emergency rule<sup>9</sup> freezing personal lines residential rates and prohibiting non-renewals and cancellations. The legislation represented a public policy shift away from rebuilding a competitive private market and toward rate relief for property owners making major changes in four areas: the Florida Hurricane Catastrophe Fund, the residual market (Citizens), rate rollbacks, and the regulatory process.

All residential property insurers are required to participate in the CAT Fund. Prior to the passage of HB 1A, the CAT fund provided up to \$16 billion in coverage for residential losses above an aggregate industry retention of \$6 billion. The premium insurers pay to the CAT Fund is based on their exposure; typically 25 percent of what comparable coverage would cost in the private reinsurance market. The CAT Fund does not maintain reserves or a surplus sufficient to cover its exposure. In the event of a deficit, the Fund issues bonds and then levies assessments on all lines of property and casualty insurance except medical malpractice, accident and health, and workers' compensation premiums, to provide a revenue stream to pay off the bonds. Assessments are capped at 6 percent with respect to a deficit attributable to a single contract year, and 10 percent with respect to all deficits combined. HB 1A substantially expanded the reinsurance offered by the CAT Fund through the addition of several new layers of coverage and the additional capacity. The additional coverage was optional, but because the coverage was offered at prices well below private reinsurance market rates most insurance companies purchased the coverage. There was also an additional layer of optional coverage priced above private market rates that was added to create additional reinsurance capacity in a hard market.

When Citizens was formed in 2002, it was intended to be the insurer of last resort and was subject to strict eligibility requirements that limited eligibility to property owners who were not able to procure coverage from licensed insurance companies at any price. Citizens was also subject to ratemaking standards that required it to charge noncompetitive rates pegged to the highest rates in the market. Perhaps one of the most significant changes made by HB 1A was to establish Citizens as a competitor with private sector insurance companies. Citizens' ability to write coverage was also expanded to enable the company to write full homeowners' policies in areas in which it previously was able to write only windstorm policies. Further, Citizens holds an unfair advantage over the private sector in that it does not pass on reinsurance cost, is a tax-exempt entity and its rates were frozen at early 2006 levels.

Another change implemented by HB 1A was to suspend an insurance company's ability to elect arbitration<sup>10</sup> as an alternative to an administrative challenge of the agency's action on a rate filing. This was a significant

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change that adversely affected companies' ability to challenge an unfavorable decision by the regulator. Since 1996 insurers making rate filings for property and casualty insurance under Section 627.062, Florida Statutes, other than medical malpractice, have been allowed to elect binding arbitration of a rate filing denial by the Florida Office of Insurance Regulation ("OIR"). If the OIR issued a notice of intent to disapprove a rate filing, insurers had the option of requesting arbitration before a panel of three arbitrators, conducted pursuant to the rules of the American Arbitration Association ("AAA"), or an administrative hearing held pursuant to Florida's Administrative Procedures Act (Chapter 120, Florida Statutes). Under arbitration, the insurer and the OIR each selected one arbitrator, and the third was chosen by the other two arbitrators. An arbitrator had to be certified by the American Arbitration Association and could not be an employee of an insurance company or insurance regulator. Arbitration panels typically conducted a *de novo* review of the rate filing, and the decision of the panel constituted final approval of the rate filing. Either party could have appealed the panel's decision, but the grounds for vacation were very high. Absent a showing of corruption or fraud, evident partiality by an arbitrator, and action beyond the arbitrators' powers or jurisdiction, an arbitration panel's decision could not be overturned. Insurers have fared much better in arbitration proceedings than they have in administrative hearings. Since the 1996 inception of the arbitration provision, approximately fifteen arbitrations have been held, and the OIR prevailed in just one case.<sup>11</sup>

With the suspension (and ultimate repeal) of arbitration, all challenges of agency action with respect to a rate filing are subject to the provisions of the APA. Under the APA, a formal adversarial hearing is held before a state Administrative Law Judge (ALJ) with the Division of Administrative Hearings. Once the hearing is completed, the ALJ issues a recommended order to the OIR. The recommended order contains findings of fact and conclusions of law as found by the ALJ. The OIR then has 90 days to issue a final order which may reject or modify the conclusions of law contained in the recommended order. An insurer may then appeal the OIR's final order to the First District Court of Appeal.

### TODAY

As a result of the changes that occurred after the 2004-2005 hurricane season, Florida lawmakers created a system that has adversely affected the private market. State run Citizens, the CAT Fund, and the Florida Insurance Guarantee Association (which handles claims of insolvent property and casualty insurers) do not have sufficient capital to cover their exposure. Many observers have said that Florida's property insurance market is a house of cards that one major storm could bring tumbling down and literally bankrupt the state. Citizens, once the insurer of last resort, no longer is required to set premiums higher than the private market. The company is now free to compete with private market insurers, but in most areas of the state the private market cannot compete with Citizens because its rates are below private markets' rates resulting in Citizens becoming the state's largest insurer with over 1 million policyholders. Citizens' rates are set by the OIR and are not subject to the rate adequacy requirements of Section 627.062, Florida Statutes. In addition, Citizens does not maintain funds sufficient to cover its exposure, and instead relies on bond issues ultimately paid for by assessments to cover any shortfall. According to Citizens' actuaries, its rates must be increased by nearly 50 percent in order to become actuarially sound and to have sufficient funds to pay claims without imposing a "hurricane tax" on all automobile and business insurance premiums.

The CAT Fund's current liabilities top \$25 billion; but it only has about \$4 billion in hard assets. It would have to pay the remaining balance by selling bonds which would also be paid for by assessments. However, it appears doubtful that the CAT Fund could ever sell enough bonds to cover its deficit, since no state has every issued more than \$11 billion in bonds at one time; and the CAT fund failed to sell even \$6 billion in bonds intended to provide for pre-event financing. If it could sell the bonds, the resulting assessment on virtually every insurance policy in the state would be substantial. A typical car insurance premium could potentially double. If bonds could not be issued, there would be no realistic way to pay off the debt without some sort of federal bailout given that Florida's constitution limits the state's revenue raising options. In fact, the CAT Fund still has \$654 million in outstanding claims for the 2004-2005 hurricane season -prior to the expansion-

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that will have to be paid through emergency assessments.

The consequences to the private market have been woeful. The OIR has approved very few double digit rate increases, which insurers have claimed are necessary to maintain solvency. Four of the state's largest insurance companies, State Farm, Allstate, Nationwide and USAA, have all stopped writing new policies. State Farm, the state's second largest insurer after Citizens has announced plans to leave the state. Last year Nationwide cut 39,000 policies, and in October of this year it announced plans to cut another 60,000 policies. While some companies have expressed a desire to pick up policies and start-up companies have entered the market, it is doubtful that they will provide sufficient capacity, and it is likely that Citizens will continue to swell.

Whether lawmakers can unravel the situation remains to be seen. Most measures initiated during the 2008 legislative session did not materialize. The 2009 session did result in some legislation that may help. The Citizens' rate freeze was lifted; but the maximum increase that the company can obtain was capped at 10 percent. However, the OIR recently announced that it will approve only a 5 percent increase; so it does not appear that Citizens' rates will become actuarially sound any time soon.<sup>12</sup>

Lawmakers and regulators face a daunting task. A large part of the state's economy and revenue base is driven by growth and development, and a large percentage of her residents are seniors that live on a fixed income. Floridians have been hit hard by the economic downturn, especially as it pertains to the housing market. Eliminating the CAT Fund, removing the moratorium from Citizens' rate increase, and requiring Citizens to function like a private market insurer would result in substantial rate increases. Many Floridians are currently struggling just to make ends meet. A significant rise in insurance costs could push them over the edge and cause further damage to the housing market and the state's stressed economy. Hopefully, lawmakers will come up with a fiscally sound solution. In the meantime, Floridians are crossing their fingers hoping that the next changes come before the wind blows down the house of cards.

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## Endnotes

1. C. Nyce and P. Maroney, "Granularity in the Florida Property Insurance Market," Florida Catastrophic Storm Risk Management Center, June, 2009.
2. R. Hartwig, "Florida Case Study : Economic Impacts of Business Closures in Hurricane Prone Countries". Insurance Information Institute, 2002
3. In 2002, the Joint Underwriting Association ("JUA") and the Florida Windstorm Underwriting ("FWU) Association became Citizens Insurance Company ("Citizens"). Citizens' original purpose, like its predecessors, was to provide insurance coverage to those who could not obtain coverage from private insurance companies.
4. P. Maroney, "The Capitalization of Stricter Building Codes in Miami, Florida House Prices," February, 2009
5. E. Blake, E. Rappaport, and C. Landsea. "The Deadliest, Costliest, and Most Intense United States Tropical Cyclones From 1851 to 2006 (and Other Frequently Requested Hurricane Facts)," Table 5. NOAA Technical Memorandum NWS TPC-5, National Weather Service, National Hurricane Center Miami, April 2007.
6. Florida Office of Insurance Regulation, 2006.

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7. P. Maroney, "The Capitalization of Stricter Building Codes in Miami, Florida House Prices," February, 2009
8. *Id.*
9. Emergency Rule 69OER07-1 was adopted for the purpose of preventing certain insurer actions prior to the effective date of rolled-back rates. The emergency rule froze rates for residential property coverage to rates that were in effect on January 25 until the insurer makes, and the regulator approves, a rate filing reflecting the cost savings that were or would be realized if the insurer purchased reinsurance from the CAT Fund as well as suspending the cancellation of policies.
10. The arbitration option was repealed in the 2008 legislative session
11. OIR was unable to provide the exact number in time for publication.
12. The legislature gave Citizens four years to implement the 40 percent increase the company said was necessary to establish actuarially sound rates. The rate increase each year is capped at 10 percent. However, this year OIR will only approve a 5 percent increase.

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### CALIFORNIA STATUTORY CHANGES TO PROTECT BROKER FEE CHARGES ON INSURANCE POLICIES

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In the 2006 Summer Edition of the FORC Journal, this author reported on the legal conflict relating to the distinction between an insurance agent and broker in California.<sup>1</sup> Whether an insurance producer is deemed to be an agent or broker in an insurance transaction is important in order to determine insurer liability for agent's conduct, insurer compliance with the rating law, and the propriety of broker fees charged by brokers.

Since 2004, broker fees have been under attack by class action lawyers who aligned themselves with then Insurance Commissioner Garamendi,<sup>2</sup> who was in his second term as California Insurance Commissioner. In the leading case of *Krumme v. Mercury*,<sup>3</sup> class action lawyers who sought refunds of all broker fees alleged that brokers who placed business with Mercury Insurance Company performed acts on behalf of Mercury, were controlled by Mercury, and thus were defacto agents of Mercury ineligible to charge broker fees.

In its amicus brief filed in the case, the California Department of Insurance ("CDI"), relying on the statutory definition of a broker, asserted that brokers who performed "any act" on behalf of an insurer would be designated as an agent of that insurer subjecting the broker to a refund of collected broker fees and a violation by the insurer of the California rating law for failure to file and obtain approval for the fees charged.<sup>4</sup>

The legal basis relied on by the plaintiff lawyers and the CDI included: 1) the definitions of agent and broker in Sections 1621 and 1623 of the California Insurance Code ("Code") which establish that the agent transacts on behalf of the insurer while a broker, on behalf of another person, transacts insurance with, but not on behalf of the insurer.<sup>5</sup> Plaintiffs argued that i) these definitions preclude a broker from transacting insurance "in any way" on behalf of an insurer; and ii) that Section 1732 of the Code provides an exception only for a broker to

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act as an agent in the collection and transmission of premium, returning premium funds and delivering policies and other documents evidencing insurance.<sup>6</sup>

In support of the plaintiff lawyers, the CDI helped advance the "any one act" test by codifying as a precedent the "any one act test" in a settlement involving American Reliable Insurance Company. That case involved a settlement in which the Commissioner created a list of criteria or factors which could be undertaken only by an appointed insurance agent. The Insurance Commissioner announced through his Order that the factors listed were a precedent for future cases.<sup>7</sup>

Although the appellate decision in the Krumme case did not agree that the "any one act" test was the test to determine broker v. agent, the fact that the CDI supported the one act theory through the precedential decision gave plaintiff lawyers an opportunity to file additional class action suits against insurers and brokers seeking refunds of broker fees. Subsequently, two suits were filed under a defacto agency theory asserting that the brokers were underwriting and binding policies on behalf of the insurer, acts which could only be performed by agents. The first was against Infinity Insurance Company and broker Eastwood Insurance Services, and the second against Coast National Insurance Company, and broker Academy Insurance Services. Plaintiff lawyers also submitted demand letters to other insurers threatening similar litigation.

## PROPOSED SOLUTION GOALS

In 2005, two of the producer trade associations criticized Garamendi's any one act test on broker fees. The Alliance of Insurance Agents and Brokers began advancing a legislative solution to representatives of agent and broker groups to denounce any one act and codify "totality of the circumstances" as the test to determine the status of a producer as an agent or broker. Independent Brokers and Agents of the West (IBA West) took the lead in successfully challenging the precedential decision, alleging in a legal brief to the Office of Administrative Law that the precedential decision was an underground regulation, since it had not followed the regulation adoption process.<sup>8</sup>

After Steve Poizner was elected Insurance Commissioner in 2006, members of his Agent and Broker Advisory Committee suggested that further clarification between agents and brokers was needed in order to put an end to class action suits. A special subcommittee which consisted of members of various producer groups and legal experts was appointed to recommend a solution to clarify the difference between an agent and a broker.<sup>9</sup> The subcommittee concluded that legislation was needed: i) to provide greater specificity in the definition of "broker"; ii) to eliminate legal challenges which claim that insurance agents act as defacto agents under the "any one act" test; and iii) to confirm by statute the long-standing common law test of "totality of the circumstances" in situations where it was not clear whether a broker was acting as a broker or agent.

The subcommittee members then drafted and sponsored what became AB 2956.

## OPPOSITION

The cornerstone to determine whether a producer is an agent or broker is the totality of circumstances test which is commonly used in agency law. This incorporates a review of all of the facts and circumstances to determine on whose behalf the producer is acting.<sup>10</sup>

In opposition to the legislation, the plaintiff lawyers argued that "totality" was not the appropriate test to determine whether a producer should be classified as an agent or broker. They argued that the existing language in Section 1623 combined with Section 1732 suggested that a licensee may not act on behalf of the insurer in any respect other than as permitted in Section 1732 and still enjoy broker status.

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Consumer Watchdog, a leading consumer advocate and drafter of Proposition 103, also opposed the legislation arguing that broker fees were a method of "double-dipping" in which insurance customers are forced to pay the same person both an agent commission and a broker fee.<sup>11</sup> Consumer Watchdog suggested alternative language that a producer that charges a broker fee should be prohibited from receiving any commission from the insurer.

The Assembly Insurance Committee Analysis, which was favorable to the bill, relied on the reasoning in *Krumme v. Mercury* that the court did nothing to change the long-standing common law rule that whether a producer is acting as a broker or agent is determined by the totality of the circumstances and the fact that the court had rejected the "any one act" theory as advanced by the CDI as the correct rule of law.<sup>12</sup>

On the Senate side, the legislative consultant also in agreement with his counterpart in the Assembly, noted that in the leading case on the issue, *Marsh & McLennan v. City of Los Angeles*,<sup>13</sup> the court looked at the totality of the circumstances to determine agent or broker status.<sup>14</sup> The legislative counsel noted that while "totality" recognizes the uniqueness of each case, in order to resolve perceived vagueness of that term, a definition of "totality" would be helpful. As a result, the proposed legislation was amended to include a definition of totality.<sup>15</sup> Although members of Commissioner Poizner's subcommittee sponsored AB 2956, the Commissioner opposed the first version of the bill, suggesting that the bill was incomplete and needed to include a list of acts that brokers would be prohibited from engaging in.

The drafters then provided language to resolve the concerns of the legislative consultant and the Commissioner by providing language on the meaning of totality of the circumstances, how it should be applied, and creating four specific acts which brokers could not engage in. The legislation also included a list of disclosures to be given by the broker to the customer, covering among other disclosures, the broker fee amount and services to be provided. As a result of these changes, the Commissioner ended his opposition and supported the bill.

## LEGISLATION

A summary of AB 2956 is as follows:

1. The presumption of broker as contained in Section 1623 was changed. The former language created a presumption of broker "for licensing purposes only" if the application showed that the person is acting as a broker and licensed as a broker. This language was considered too vague. AB 2956 changed the presumption language by: (a) clarifying that a person is presumed to be acting as an insurance broker if the person is licensed to act as a broker, maintains a broker bond, and a written agreement signed by the consumer includes disclosures on each of the following:

- i. that the person is transacting on behalf of the consumer;
- ii. a description of the basic services to be performed as a broker;
- iii. amount of broker fee charged;
- iv. if applicable, the fact that the broker may be entitled to receive compensation from the insurer for the consumer's purchase of insurance.

Newly created Section 1623(b) permits a wholesale intermediary broker to avail itself of the presumption if it provides the above written disclosures to the retail broker.

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Section 1623(c) provides that any of the following acts will rebut the presumption: if the licensee is appointed; has a written agreement with the insurer authorizing the licensee to obligate or bind the insurer without prior notification; appoints a licensee; or is authorized to pay claims. In all other cases, the presumption of broker status may be rebutted based only on the totality of the circumstances which, upon review of all facts and circumstances, reflects that the broker is acting on behalf of the insurer as opposed to the customer.

Section 1623(e) defines "totality of the circumstances" as evidence indicating whether the producer is acting on behalf of the insurer or on behalf of a third person. It also sets forth that the evidentiary determination is made through a review of all relevant facts and circumstances. It establishes that the review cannot be limited to any particular fact or factors or requires that any particular circumstance receive greater or lesser weight than another circumstance. Finally, Section 1732 was clarified to permit a broker, on behalf of an insurer, to collect and transmit premium and deliver policies evidencing insurance.

While the totality of the circumstances test refers specifically to the presumption in Section 1623, legislative consultants for both the Assembly and Senate confirmed in their written analysis of the bill that totality of the circumstances had been the long-standing test in California to determine whether a producer is acting as a broker or agent and rejected the "any one act" test argued by class action lawyers and the CDI.

## THE EFFECT OF AB 2956

When the bill became law on January 1, 2009, Plaintiff's class suit against broker Eastwood was in the discovery phase. Plaintiff sought reimbursement of broker fees charged by Eastwood on business it placed with Infinity Insurance Company from 2003-2007. Eastwood filed a Motion for Summary Judgment. On July 15, 2009, Orange County Superior Court Judge Ronald L. Bauer granted Eastwood Insurance Services' Motion for Summary Judgment filed in the class-action suit, *Munn v. Eastwood* finding that:

1. As in *Krumme*, the plaintiffs alleged that Eastwood was not a broker acting on behalf of the customer, but a defacto agent acting on behalf of Infinity.
2. The plaintiffs' arguments on defacto agency were that:
  - i) Infinity's broker agreement was a defacto agency agreement which exerted control by Infinity over Eastwood; and
  - ii) Eastwood performed defacto field underwriting for Infinity and bound coverage at the point of sale.<sup>16</sup>

Plaintiffs argued that if a broker acts on behalf of an insurer in any way, the broker is an agent, and it is immaterial what the broker's relationship is with the customer. The court disagreed with each of the plaintiff's arguments.

Although it is a Superior Court case, the court's written decision is the first since *Krumme* and AB 2956 to distinguish the difference between an agent and broker in a broker fee dispute case. The decision confirmed the totality of the circumstances as the test to determine agent or broker, and dismissed the "any one act" test advocated by plaintiff. Further, the court found that Eastwood met the presumption of broker as amended by AB 2956.

In its ruling, the court held:

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1) That the essential issue in the case was whether Eastwood was acting as an insurance agent on behalf of Infinity or an insurance broker on behalf of the plaintiffs-insureds. Eastwood contended that at all times it had acted as a broker entitled to charge its customers a broker fee.

2) In focusing on which test should be applied to determine the agent/broker question, the court concluded that "any of the proposed tests lead to the conclusion that Eastwood was acting as a broker..."<sup>17</sup>

3) Without making a final determination on the retroactive effect of the revised presumption language in AB 2956 (see Section 1623(a)), Judge Bauer held that the AB 2956 legislative history reflects the desire to clarify existing law rather than change the law. He noted that the history "implies that the earlier presumption language of Section 1623 should be given the same meaning and effect as the new version." The court also held that Eastwood's standard written broker fee agreement with its customers met the disclosure requirements which trigger the application of the new presumption language.

4) In the event the new presumption language in Section 1623 is not applicable since the suit was brought before January 1, 2009, the court applied the totality of the circumstances test in examining Eastwood's business to determine whether it was a broker or an agent. The court dismissed plaintiffs' claim that Eastwood was underwriting and binding policies on behalf of the insurer.<sup>18</sup>

### AFTERMATH OF AB 2956

On September 4, 2009 Consumer Watchdog filed a proposed state-wide ballot measure which among other issues seeks to restrict broker fees in California. Under this initiative, a broker would be prohibited from charging a broker fee if the broker receives a commission from the insurer on the transaction. It further requires that broker fees be fair and reasonable and not unfairly discriminatory. It requires the Commissioner to adopt regulations to establish broker fee limits. The initiative would define as premium any amount charged by an insurer or its agent, thereby subjecting all charges to the review and approval of the Department and be subject to premium tax.

The initiative attempts to regulate broker fees that are not part of the rate and nullify AB 2956, which was unanimously passed by the legislature last year. It appears that Watchdog's intent is to qualify the initiative for California's November 2010 ballot.<sup>19</sup>

### CONCLUSION

AB 2956 resolved a decade of the CDI and plaintiff lawyers' attempt to curtail the charging of broker fees by advocating the "any one act" test as the basis to clarify the difference between an agent and broker. AB 2956 codified the long-standing totality of the circumstances test through amendment to CIC Section § 1623. Whether Consumer Watchdog will be able to nullify the effects of AB 2956 and curtail the charging of broker fees will depend upon whether its initiative proposal will qualify for the November 2010 ballot and then be approved by a majority of voters in that election.

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### Endnotes

1. FORC Quarterly Journal of Insurance Law and Regulation, Vol. XVII, Edition II, June 1, 2006.

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2. John Garamendi served his second term as California Insurance Commissioner from 2002-2006.
3. *Krumme v. Mercury Ins. Co.*, 123 Cal.App. 4th 924 (2004).
4. CIC Section § 1861.05 *et seq.*; § 2641.1 *et seq.* Title X, California Administrative Code.
5. CIC Section § 1621: "An insurance agent is a person authorized by and on behalf of an insurer to transact all classes of insurance except life insurance." § 1623: "An insurance broker is a person who, for compensation and on behalf of another person, transacts insurance other than life insurance with, but not on behalf of, an insurer."
6. § 1732: "A person licensed as a fire and casualty broker/agent acting as an insurance broker may act as an insurance agent in collecting and transmitting premium or return premium funds and delivering policies and other documents evidencing insurance."
7. 2006 CDI Decision and Order, File No.: DISP 06091926.
8. Petition to the Office of Administrative Law on behalf of the Independent Brokers and Agents of the West, September 26, 2006.
9. ABAC Subcommittee on Distinguishing Agents and Brokers: Robert Hogeboom - Barger & Wolen, LLP; Mike D'Arelli and David Nielsen - Alliance of Insurance Agents and Brokers; Hank Haldeman - The Sullivan Group; Shari McHugh - National Association of Financial and Insurance Advisors; Ken Nigohosian and Alan Smith - Western Insurance Agents Associates; Clark Payan and Steve Young - IBA West; and Ted Pierce - Surplus Lines Association.
10. *See General Acc. Assur. Co. v. Caldwell*, 59 F.2d 473, 475 (1932) ("whether the broker is acting for the insured or as an agent of the insurer will depend upon the special circumstances proved"). Also see *Detroit Transcontinental Ins. Co.*, 105 Cal.App. 395, 399 (1930) ("the question of agency must be determined from all the facts and circumstances of the case together with the conduct and communications within the parties"). Also see *Maloney v. Rhode Island Insurance Company*, 115 Cal.App. 2d 238 (1953) ("the actual relationship is determined by what the parties do and say...").
11. Consumer Watchdog letter to Joe Coto, Chair-Insurance Committee, dated April 23, 2008.
12. Assembly Committee on Insurance Analysis compared by Mark Rakich, dated April 24, 2008.
13. *Marsh & McLennan of Cal., Inc. v. City of Los Angeles*, 62 Cal.App. 3d 108 (1976).
14. Senate Committee and Banking Finance and Insurance Consultant Michael Miller, June 18, 2008.
15. CIC Section § 1623(e) for the purposes of this section, "Totality of the Circumstances" means "evidence indicating whether a broker/agent was acting on behalf of the insurer or was acting on behalf of a third person. In determining the totality of the circumstances, all relevant facts and circumstances shall be reviewed and the review is not limited to any particular fact or factors, and this section does not require that any particular circumstance receive greater or lesser weight."
16. *Munn v. Eastwood Insurance Services*, Superior Court of California, County of Orange, Minute Order of Judge Ronald L. Bauer, dated July 15, 2009.

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17. Tests include: i) new presumption language in 2956 effective 1-1-09; ii) prior presumption language in 1623; and iii) totality of the circumstances.
18. Plaintiff counsel filed a Notice of Appeal on September 10, 2009.
19. The Stop Insurance Overcharges Act by Consumer Watchdog, certified by California Secretary of State, November 3, 2009.

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