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# INSURANCE COVERAGE
Litigation News and Analysis • Legislation • Regulation • Expert Commentary
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## WHAT'S INSIDE



## PRICE-FIXING

### Judge tosses bulk of claims in auto body shops' antitrust suit against State Farm, others

A federal judge in Florida has dismissed a large portion of a lawsuit in multidistrict litigation proceeding accusing State Farm Mutual Automobile Insurance Co. and 40 other insurers of conspiring to suppress reimbursement rates for vehicle damage repair costs.

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REUTERS/Susana Vera

***The plaintiffs, a group of Florida auto repair shops, allege that State Farm and others engaged in an illegal scheme to set maximum price limits on the shops' products and services.***

## COMMENTARY

### The case of the missing insured: A tricky variation on the consent to settle

Jonathan Schwartz and Seth Laver of Goldberg Segalla LLP give advice to attorneys on dealing with a "consent to settle" clause when an insured party is absent.

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# The case of the missing insured: A tricky variation on the consent to settle

**By Jonathan L. Schwartz, Esq., and Seth L. Laver, Esq.**
***Goldberg Segalla LLP***

There can be no dispute that a "consent to settle" clause in a professional liability insurance policy may impede settlement. As one court acknowledged, these clauses will inevitably have the effect of sapping party resources and unduly consuming judicial time and resources.[1]

Yet, for many professional liability matters, that impediment to settlement is as essential as commercial general liability claims-auto claims and the like. A professional's acknowledgement of liability can significantly damage a sterling reputation cultivated over the course of an entire career.[2] Further, reputational damage can adversely impact the professional's ability to apply for new or continuing state licensure, buy affordable insurance and seek future employment.

This reality is especially acute for medical professionals, as certain state and federal databases, such as the National Practitioner Data Bank, track trials and settlements involving allegations of medical malpractice. Hence, the professional's reputation, as well as any liability for alleged injuries, is at the center of any lawsuit resulting from alleged malpractice.

Insurer-insured disputes focusing on consent to settle clauses typically involve savvy and informed professionals who are keenly aware of the impact that an acknowledgement of liability would have on their reputations. Sometimes, however, insurers become embroiled in quagmires involving an absent insured who cannot consent to a settlement.

> There are a number of pitfalls awaiting defense counsel when the insured is missing and there is no other party to the insurance contract capable of acting on the insured's behalf.

Accordingly, an insurer and its retained defense counsel are stuck trying to extricate the insurer (and the insured) from a likely unfavorable situation. The insurer explores questions about whether the settlement is enforceable, whether defense counsel has complied with the rules of professional conduct, and whether the insurer is acting in good faith in settling the case.

Usually, the latter means terms that are favorable to the insured, not requiring the insured to contribute to the settlement. Looking more closely at these scenarios can provide guidance on how to best resolve and prevent these circumstances with efficiency and finality.

## WHAT DO CONSENT-TO-SETTLE CLAUSES LOOK LIKE?

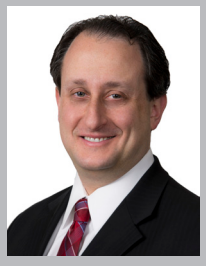
Consent-to-settle clauses, also referred to as "pride" clauses, can take various forms. One common form is the classic consent provision, where an insured may veto a settlement without any ramification.[3] A classic consent provision states, "We will not settle any claim without your written consent, which shall not be unreasonably withheld."

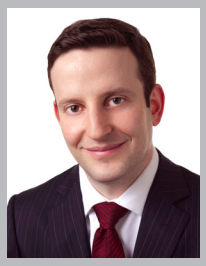
Another common form is the "full hammer" provision. If the insured refuses to consent to a settlement endorsed by the insurer, the insurer's liability for the cost of defense and indemnity is capped at the amount of the endorsed settlement. The insured is then responsible for any attorney fees and judgment in excess of the endorsed settlement amount.[4]

A typical hammer provision states as follows:

> The company shall ... not settle any claim without the written consent of the named insured, which consent shall not be unreasonably withheld. If, however, the named insured refuses to consent to a settlement recommended by the company and elects to contest the claim or continue legal proceedings in connection with such claim, the company's liability for the claim shall not exceed the amount for which the claim could have been settled, including claims expenses up to the date of such refusal, or the applicable limits of liability, whichever is less.[5]

Notably, there exists a modified-hammer provision, which operates similar to the classic hammer provision, yet the insured is liable only for a percentage of any judgment





**Jonathan L. Schwartz** (L) is a partner in the global insurance services practice group at **Goldberg Segalla LLP** in Chicago. He was chair of the 2014 DRI Insurance Coverage and Practice Symposium and vice chair of the 2014 DRI Insurance Coverage and Claims Institute. He can be reached at jschwartz@goldbergsegalla.com. **Seth L. Laver** (R) is a partner in the professional liability and employment and labor practice groups of Goldberg Segalla in Philadelphia. He was the 2013 chair of the DRI Professional Liability Seminar and serves on the professional liability steering committees for DRI and the American Bar Association. He is the editor of Goldberg Segalla's Professional Liability Matters blog and can be reached at slaver@goldbergsegalla.com.

in excess of the endorsed settlement — usually between 50 percent and 70 percent.

## YOUR OPTIONS WHEN CONFRONTED WITH AN ABSENT INSURED

There are myriad court opinions and great scholarship devoted to scenarios involving an insurer that wants to settle a lawsuit or claim and an insured who wants to clear the company name and take the case to trial. What to do, though, when the policy contains a consent-to-settle provision and the named insured does not affirmatively refuse to endorse or veto settlement, or is not deliberately withholding consent, is unclear and not well explored. Such a scenario, where the insured is missing or totally nonresponsive, does occur.

> In the case of a missing insured, defense counsel must use all the resources at their disposal to find a client who may not want to be found.

The challenges facing the insurer under this scenario are real and vexing, as the insurer generally has the burden of obtaining the insured's consent prior to settlement. As problematic as the challenges faced by the insurer are, defense counsel has its own set of serious problems.

It is not atypical for an insured to engage in a healthy debate with defense counsel and the insurer about the strategy of a would-be settlement. Some insured parties may find it difficult to accept what may feel like a concession by entering into a settlement and may spar with counsel on this point. In either case, however, the insured is, at the very least, actively engaged in the process.

A potentially more troublesome problem for the insurer and defense counsel arises in the case of an absent or missing insured.[6] There are a number of pitfalls awaiting defense counsel when the insured is missing and there is no other party to the insurance contract capable of acting on the insured's behalf.[7]

In 2012, the FBI's National Crime Information Center entered over 650,000 missing-person records, albeit many of which were cleared or canceled.[8] So, it is not too farfetched to consider the reality that the insured may unexpectedly "enter radio silence."

One option for the attorney of a missing client is to turn to the local bar association or ethics board for guidance. The American Bar Association, along with several state and local bar associations, has considered this issue and published opinions concerning an attorney's ethical challenges in the face of a missing client.[9] Several rules of professional conduct are instructive here.

Fundamentally, defense attorneys and insurers may not enter into a binding settlement on behalf of the insured without consent. Pursuant to Model Rule of Professional Conduct 1.2(a), "a lawyer shall abide by a client's decision whether to settle a matter." Without exception, a lawyer may not circumvent the delegation of authority to the client in Rule 1.2(a).[10] While an attorney has implicit authority to act on behalf of the client with respect to certain procedural matters, the decision to settle is exclusively the client's.

Next, the attorney may need to perform some detective work. In light of Model Rule 1.4, an attorney is obligated to keep the client reasonably informed about the status of the matter and to promptly inform the client of any development requiring the client's informed consent.

Accordingly, attorneys are tasked with taking "reasonable steps" to locate and inform their clients of the status of settlement discussions or other critical developments. Of course, as is the case with many ethical dilemmas, the definition of "reasonable" may vary.

In an era of GPS monitoring, social media and other technological advances, there are various tools available to counsel to search for a missing client. At a minimum, attorneys can be expected to call, email and write to the client at the last known residence and place of employment. According to a 1996 North Carolina ethics opinion, an attorney's efforts to reach the client were deemed "more than reasonable" when she attempted to locate the client via the client's health care providers, medical insurance carrier and county property listings.

Internet search engines, social networking sites, public record searches and private investigators may also provide valuable insight. Moreover, these steps, when well documented, may provide risk management support for an attorney in the event that the insured resurfaces and questions the attorney's conduct.

The attorney who has taken reasonable steps to locate a missing client may not be stuck defending the case in perpetuity. In certain circumstances, a client's failure to respond to counsel within a reasonable time may be considered a constructive discharge. Of course, the client has obligations to counsel, and the failure to meet those responsibilities may prevent the attorney from providing effective representation.

In this scenario, Model Rule 1.16 may allow the attorney to withdraw from the representation under these circumstances. To that end, in some jurisdictions, a client's disappearance constitutes appropriate grounds for the lawyer's withdrawal.[11]

## PRACTICE TIPS AND CONCLUSION

Consent to settle provisions in an insurance policy were designed to create an impediment to settlement in order to protect the policyholder's reputation. Where insured parties are missing by their own volition (*e.g.*, to escape civil or criminal liability), the policyholder's reputation may be beyond repair.

The requirement for the policyholder to consent to a settlement remains, though. That requirement presents difficult challenges for insurers and defense counsel alike, potentially thwarting any attempt to settle the insured's civil liability on a favorable basis.

We offer the following practice tips to protect defense counsel from potential breaches of their ethical duties to their clients:

- Use a detailed client intake questionnaire and regularly update the client's contact information.
- Document any difficulty in communicating with the client and inform the client of the importance of maintaining consistent communication.
- Take all reasonable steps to locate a client if the client does not timely respond to an inquiry — do not allow significant time to pass without communicating with your client.

- Document in great detail the steps taken by counsel to locate a missing client.

Defense counsel are better equipped today to find missing persons than ever before. That fact, however, raises expectations, increasing the pressure on defense counsel to deliver the policyholder defendant. Creativity and ingenuity are some of the hallmarks of successful defense counsel. In the case of the missing insured, defense counsel must use all of the resources at their disposal to find a client who may not want to be found.

Additionally, we offer practice tips to protect the insurer from exorbitant verdicts and potential subsequent bad faith exposure:

- Document all instances of non-cooperation by the insured with requests from the insurer or retained defense counsel.
- Immediately begin sending reservation of rights letters citing the policy's cooperation clause and the impact of future non-cooperation.
- As soon as the insurer has suffered significant prejudice, file a declaratory judgment action seeking a declaration that the insured committed a material breach of a condition precedent of the policy (to the extent that your jurisdiction recognizes these principles).

Insurers with a missing insured are likewise placed in an unenviable position with respect to settlement. Insurers may still have hope, however, in the form of a cooperation defense. To preserve that hope, it is imperative that the insurer document the bases for defense from the outset and contemporaneously.[12] Taking the necessary steps to gain proof for a cooperation defense can mean all the difference between an insurer being stuck in an intractable quagmire and walking away relatively unharmed. WJ

## NOTES

[1] *See Webb v. Witt*, 876 A.2d 858 (N.J. Super. Ct. App. Div. 2005); *see also Hurvitz v. St. Paul Fire & Marine Ins. Co.*, 109 Cal. App. 4th 918 (Cal. Ct. App. 2003) ("The decision to settle rather than continue litigation invariably involves a conflict between the desire to vindicate oneself and the desire to minimize the costs of litigation and avoid the risk of loss.").

[2] *See Clauson v. New England Ins. Co.*, 83 F. Supp. 2d 278, 281 (D.R.I. 2000), *aff'd*, 254 F.3d 331 (1st Cir. 2001).

[3] It is generally recognized that an insured party's consent to settlement is revocable. *See Lieberman v. Employers Ins. of Wausau*, 419 A.2d 417 (N.J. Super. Ct. App. Div. 1980).

[4] Consent-to-settle clauses even apply to settlements within the policy limits. *See Shuster v. S. Broward Hosp. Dist. Physicians' Prof'l Liab. Ins. Trust*, 591 So. 2d 174 (Fla. 2d Dist. Ct. App. 1992) (absent a consent-to-settle clause, an insurer has a right to settle, within the policy limits, any claim it deems appropriate, even arguably frivolous ones). *See Sec. Ins. Co. of Hartford v. Schipporeit Inc.*, 69 F.3d 1377, 1383 (7th Cir. 1995) (acknowledging the enforceability of a classic hammer provision); *Scottsdale Ins. Co. v. Ala. Mun. Ins. Corp.*, No. 2:11-CV-668-MEF, 2013 WL 5231928 (M.D. Ala. Sept. 16, 2013) (The insurer's invocation of the hammer clause was not in "bad faith" as the insurer "was not acting out of a greater concern for its own financial interest than [the insured's] when it refused to continue the defense of [the insured] after [the insured] refused to accept what [the insurer] reasonably believed to be a settlement that was in [the insurer's] best interest.").

[5] *See Freedman v. United Nat'l Ins. Co.*, No. CV-09-5959 AHM CTX, 2011 WL 781919, at *6 (C.D. Cal. Mar. 1, 2011) (citing *Clauson* with approval and holding that the insurer may invoke the hammer clause only if the insured unreasonably refuses to consent to the settlement, relying upon the preceding sentence, which included the language, the insurer "shall ... not settle any claim without the written consent of the named insured, which consent shall not be unreasonably withheld").

[6] An attorney's obligations to the client survive the attorney-client relationship, and therefore, an attorney must treat a missing client the same as all former clients.

[7] If defense counsel represents an additional insured, and the named insured is missing, there is yet another layer of complexity to the scenario, as there is a split of opinion regarding whether the consent must be obtained from the named insured, or whether an additional insured may provide the consent to settle. *Compare Jayakar v. N. Detroit Gen. Hosp.*, 451 N.W.2d 518 (Mich. Ct. App. 1989) (finding that the insurer need not seek consent of the additional insured), with *Mosely v. Wilson*, No. CIV. A. 91-0712, 1991 WL 134285, at *2 (E.D. Pa. July 16, 1991) (the insurer must obtain consent from the additional insured if the additional insured and not the named insured is the party defendant).

[8] FBI, National Crime Information Center Missing Person & Unidentified Person Statistics for 2012, *available at* http://www.fbi.gov/about-us/cjis/ncic/ncic-missing-person-and-unidentified-person-statistics-for-2012.

[9] A similar problem facing the plaintiff's bar is the inability to locate a pre-suit client in the face of a pressing statute-of-limitations deadline.

[10] Suzanne Lever, *Where's Waldo*, Ethics Opinion Articles, 16 N.C. State Bar J. (December 2011).

[11] *See* Wash. State Advisory Opinions 1796, 1873 & 2225.

[12] *See State Farm Fire & Cas. Co. v. King Sports Inc.*, 827 F. Supp. 2d 1364 (N.D. Ga. 2011) (To establish a material breach of the cooperation clause, the insurer must demonstrate that it made a reasonable effort to obtain the insured's cooperation); *Cincinnati Ins. Co. v. Irvin*, 19 F. Supp. 2d 906 (S.D. Ind. 1998) (collection of cases) (following the view that the insured's absence from trial, by itself, is insufficient evidence of prejudice for purposes of establishing a breach of the cooperation clause); *see also Hunter Roberts Constr. Group v. Arch Ins. Co.*, 904 N.Y.S.2d 52 (N.Y. App. Div., 1st Dep't 2010) (To prevail on a noncooperation defense, the insurer has a "heavy burden" to prove that it acted diligently and that its efforts "were reasonably calculated to obtain the insure[d]'s co-operation," but the insured still engaged in "willful and avowed obstruction").

# MetLife challenges U.S. regulators over 'systemic risk' label

MetLife Inc. has sued the federal government for classifying it as a "nonbank systemically important financial institution" that could endanger the U.S. economy if it were to suffer distress or collapse.

***MetLife Inc. v. Financial Stability Oversight Council, No. 15-45, complaint filed (D.D.C. Jan. 13, 2015).***

The designation made by the Financial Stability Oversight Council will unfairly expose the nation's largest life insurer to enhanced supervision and ultimately harm competition, the company says in its complaint in the U.S. District Court for the District of Columbia.

MetLife said in a statement that it decided to sue the FSOC after it unsuccessfully challenged the council's designation in December.

"We had hoped to avoid litigation after we presented substantial and compelling evidence to FSOC demonstrating that MetLife is not systemically important," Chairman and CEO Steven A. Kandarian said in the statement.

The FSOC is a federal organization established under the 2010 Dodd-Frank Wall Street Reform and Consumer Protection Act, Pub. L. No. 111-203, 124 Stat. 1376. The law provides the agency with the power to regulate large nonbank financial firms that pose excessive risks to the broader economy if they were to suffer material financial distress.

According to the suit, the FSOC's designation of MetLife as a nonbank systemically important financial institution was arbitrary and capricious for several reasons.

For one, the council failed to give meaningful weight to the existing "comprehensive state insurance regulatory regime" that already supervises MetLife's U.S. insurance business, the suit says.

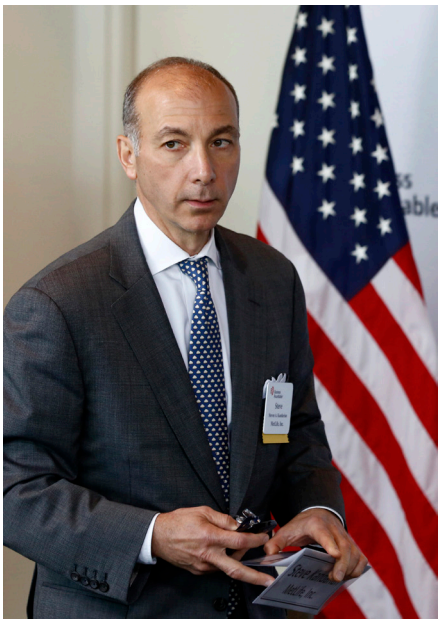
The council also wrongly fixated on MetLife's size and interconnections with other financial institutions — "factors that, considered alone, would inevitably lead to the designation of virtually any large financial company," the suit says.

Further, the FSCO reached its decision through a procedure that denied MetLife its due process rights, the insurer says.

"FSOC repeatedly denied MetLife access to data and materials consulted and relied on by the council in making its determination, thereby depriving the company of a meaningful opportunity to rebut FSOC's assumptions or otherwise respond to its analysis," the suit says.

MetLife seeks a court ruling vacating the designation. WJ

> The suit says the Financial Stability Oversight Council's designation of MetLife as a nonbank systemically important financial institution was arbitrary and capricious.



***MetLife CEO Steven Kandarian*** REUTERS/Jason Reed

**Attorneys:**
*Plaintiff:* Eugene Scalia and Amir C. Tayrani, Gibson, Dunn & Crutcher, Washington

REGULATION

# Insurer fined $27.5 million for charging unapproved broker fees in California

The California insurance commissioner has ordered Mercury Insurance Co. to pay a $27.5 million fine for charging customers fees that were not approved by the state.

From 1999 through 2004, Mercury's agents charged and collected unapproved "broker fees" from auto insurance customers on more than 180,000 policy transactions, Commissioner Dave Jones said in a statement announcing the fine.

"While the $27.5 million fine against Mercury is significant, it is commensurate with the amount of money that was unlawfully collected from Mercury policyholders," Jones said.

Under state law, independent brokers are permitted to charge broker fees, but direct employees are not.

In Mercury's case, the people collecting the fees were actually functioning as agents. This means that the fees had to be filed as part of the company's rate filing and approved by the commissioner, but Mercury did not do so, Jones said.

In assessing the fine, Jones adopted a Dec. 5 decision and recommendation by state Administrative Law Judge Michael A. Scarlett, who conducted a 15-day hearing into the matter.

In his decision, Judge Scarlett found that in addition to the 180,000 unapproved transactions, Mercury willfully violated state law because the company had actual knowledge that its designated "brokers" were de facto insurance agents charging illegal broker fees.

> "It is our strong belief that this decision is contrary to California's rate laws, due process and basic notions of fairness," Mercury Insurance Co. said.

REUTERS/David McNew

***California Insurance Commissioner Dave Jones***

According to the decision, the California Department of Insurance put Mercury on actual notice in 1998 that its practices violated the state's insurance code rate statutes.

In a statement, Mercury said it disagreed with Jones' determination and his decision to impose the penalty.

"It is our strong belief that this decision is contrary to California's rate laws, due process and basic notions of fairness," Mercury said.

The company also said it intends to litigate the matter and expects to "ultimately prevail on the merits in a court of law." WJ

# Insurer denies it rejected Viacom's entertainment liability policy claims in bad faith

An insurer is challenging a lawsuit accusing it of acting in bad faith by failing to honor an entertainment liability policy for an MTV reality show.

***Viacom International Inc. et al. v. Axis Insurance Co., No. CV14-5721, answer filed (C.D. Cal. Jan. 5, 2015).***

In an answer filed Jan. 5, Axis Insurance Co. denies allegations that it acted illegally by refusing to cover up to $5 million in costs that Viacom International spent defending against claims that the show "T.I.'s Road to Redemption" aired images of a dead man without his family's permission in 2009.

The insurer filed its answer U.S. District Judge Philip S. Gutierrez of the Central District of California ruled that Viacom may move forward with its suit.

In an in-chambers order, the judge said Dec. 19 that Viacom has pleaded sufficient facts that the policy is, at minimum, "susceptible to reasonable disagreement" as to the amount of coverage owed for the underlying litigation. *Viacom Int'l et al. v. Axis Ins. Co.*, No. CV14-5721, 2014 WL 7404124 (C.D. Cal. Dec. 19, 2014).

According to the complaint, Viacom took out a $5 million policy on the MTV show, which starred rapper T.I. The policy also covered any individual loss or "occurrence" up to $3 million.

In 2011, Viacom was hit with an invasion-of-privacy lawsuit claiming that the show filmed a dead man in a funeral home without his family's consent.

After submitting to mediation in June 2014, Viacom settled the privacy lawsuit for an amount that exceeded the $3 million individual loss limit but fell within the $5 million policy limit, according to Viacom's complaint.

However, Axis allegedly refused to pay more than $3 million, claiming that all injuries and damages alleged in the underlying suit resulted from a single "occurrence."

In its complaint, Viacom disagreed with this policy interpretation. It argued that the underlying suit alleged multiple separate occurrences and distinct losses, including the viewing and filming of the dead man's body without consent, as well as the distribution and broadcast of those images.

Allowing Viacom to move forward with its suit, Judge Gutierrez ruled that the policy is ambiguous as to the number of occurrences that sparked the underlying litigation. The wording of the policy implies a possible intent to treat an occurrence in production as separate from an occurrence in distribution, he said.

On the heels of that decision, Axis' answer says the complaint nonetheless should be dismissed in its entirety because it fails to state facts sufficient to constitute a claim against the insurer.

Axis also says the complaint is barred by Viacom's failure to mitigate damages and to satisfy the insurance policy's required self-insured retentions in order to trigger any obligations on the insurer's part.

Axis seeks a declaration that Viacom is not entitled to coverage for multiple occurrences with regard to the underlying litigation. WJ

**Attorneys:**
*Defendant:* John P. Makin and Nelson S. Hsieh, Greenan, Peffer, Sallander & Lally, San Ramon, Calif.

**Related Court Document:**
Answer: 2015 WL 273117

***See Document Section A (P. 17) for the answer.***

# Insurer wants hotel to pay for damage to Stradivarius violin

A Sheraton Hotel in Vermont is facing a subrogation action from the insurer of a musician who slipped on an icy sidewalk and severely damaged his Stradivarius violin.

***Ace Fire Underwriters Insurance Co. v. Sheraton Burlington Hotel & Conference Center, No. 5:15-cv-00007, complaint filed (D. Vt., Rutland Jan. 14, 2015).***

Ace Fire Underwriters Insurance Co. sued the Sheraton Burlington Hotel & Conference Center in the U.S. District Court for the District of Vermont, alleging it failed to treat icy and slippery conditions on the hotel's parking lot and sidewalk.

These "defectively and unreasonably dangerous" conditions were the proximate cause of insured Soovin Kim's slip and fall and the damage to the violin, which cost $89,470 to repair, according to the complaint.

The suit, which seeks more than $75,000 in damages, says the damage to the violin reduced the rare instrument's value by more than $1 million.

The hotel's owners and operators, Starwood Hotels and Resorts Worldwide Inc. and FCH/SH Leasing II LLC, also are named defendants.

Kim, a guest of the hotel Jan. 14, 2012, was carrying the violin in its case from his car to the hotel when he slipped on the sidewalk, the suit says.

Ace alleges the damage to the violin was the direct result of the hotel's "negligence, recklessness and carelessness" and did not result from any act or failure on Kim's part.

"The defendants owed Soovin Kim a duty of care to keep the premises in reasonable repair and to maintain the premises in a reasonably safe condition," the suit says.

Further, the insurer alleges, the defendants knew or should have known about the icy

conditions and that the law required them to take reasonable measure to eliminate them. WJ

**Attorney:**
*Plaintiff:* Joseph D. Fallon, Hinesburg, Vt.

**Related Court Document:**
Complaint: 2015 WL 273739

***See Document Section B (P. 21) for the complaint.***

# Medical providers can proceed with bad-faith claim against Aetna

A federal judge in Tampa, Fla., has ruled that providers of chiropractic and medical care can move forward with claims that Aetna acted in breach of contract and bad faith by denying payment on 90 percent of their claims for no valid reason.

***Tran Chiropractic Wellness Center Inc. et al. v. Aetna Inc. et al., No. 8:14-cv-47-T-36EAJ, 2015 WL 144243 (M.D. Fla., Tampa Div. Jan. 12, 2015).***

However, U.S. District Judge Charlene E. Honeywell of the Middle District of Florida rejected the plaintiffs' claim that the health insurer engaged in a fraud scheme by retaining millions of dollars in premiums without paying benefits.

According to the judge's written order, Tran Chiropractic Wellness Center Inc., which operates as Essential Chirocare, provides chiropractic services to patients covered under health care plans issued by Aetna Inc. and its affiliates. Similarly, Essential Integrative Medicine LLC, which is located at the same business address as Tran Chiropractic, provides medical services to patients covered under various Aetna plans.

## Common-law fraud in Florida

To establish a claim for common-law fraud in Florida, the plaintiffs must demonstrate that:

- The defendant made a false statement of material fact or concealed a material fact.
- The defendant intended for the plaintiffs to rely on these statements.
- The plaintiffs relied on the statements.
- The plaintiffs were damaged as a result.

— *Nationwide Mutual Insurance Co. v. Ft. Myers Total Rehab Center Inc. et al.*, 657 F. Supp. 2d 1279 (M.D. Fla. 2009).

The plaintiffs claim that beginning in October 2012 Aetna stopped paying bills for services it had regularly paid in the past. The insurer allegedly "flagged" their accounts and now demands all records pertaining to any chiropractic or medical treatment prior to payment, the order says.

The plaintiffs maintain they have provided Aetna with all requested documents in every single case but the insurer has denied receiving the records. Even when Aetna has acknowledged receiving the paperwork, it has rejected the corresponding claims for other pretextual reasons, the plaintiffs say.

Tran Chiropractic and Integrative accuse Aetna of denying at least 90 percent of their claims since October 2012, the order says.

The plaintiffs sued Aetna for various claims, including breach of contract, bad faith in violation of Fla. Stat. § 626.9541(1)(i), which bars unfair competition and unfair and deceptive acts and fraud.

The insurer moved to dismiss.

Judge Honeywell rejected Aetna's argument that the plaintiffs lack standing to sue for breach of contract as they are not parties to a contract with Aetna.

"Plaintiffs have clearly alleged that they have standing as assignees to bring a breach-of-contract claim," she said.

The judge also disagreed that the bad-faith claim is premature because the contract claim has yet to be resolved. She said a claim under Section 626 .9541(1)(i) does not require resolution of an underlying action before it can proceed.

Judge Honeywell dismissed the plaintiffs' fraud claim as they failed to allege they relied on misrepresentations Aetna made. Reliance is needed to maintain a fraud claim (see box).

A declaration by Tran identified various alleged misrepresentations but "it appears that plaintiffs always knew these statements to be false and did not rely on them," she said. WJ

**Related Court Document:**
Order: 2015 WL 144243

***See Document Section C (P. 25) for the order.***

# Insurer had no duty to defend in $7 million wrongful-death case

A federal judge in Tacoma, Wash., has ruled that an insurer did not act in bad faith when it refused to defend a policyholder's estate against an underlying claim related to a murder-suicide based on a policy exclusion for intentional and criminal acts.

***Wargacki v. Western National Assurance Co., No. C13-5373, 2015 WL 74111 (W.D. Wash. Jan. 6, 2015).***

U.S. District Judge Ronald B. Leighton of the Western District of Washington rejected the plaintiff's claim that the shooting was an act of negligence that triggered the insurer's duty to defend, and he granted summary judgment to the insurer.

According to the judge's written order, Michael Erb had a homeowners policy issued by Western National Assurance Co. Under the policy, Western agreed to defend and indemnify Erb from liability for bodily injury caused by accidental occurrences. The policy included an exclusion for criminal and intentional acts.

Erb allegedly shot his pregnant girlfriend, Anne-Marie Wargacki, in June 2010, killing her and the unborn child. He then shot and killed himself, the order says.

Following an investigation, police department concluded Erb's acts were intentional, the court document says.

Wargacki's estate subsequently sued Erb's estate for wrongful death in Washington's Pierce

County Superior Court. Wargacki's estate received a $7 million judgment and then sought payment, the order says.

Western filed a declaratory judgment action in Tacoma federal court, seeking a determination that it had no duty to indemnify Erb's estate in the wrongful-death suit.

In that declaratory action, the District Court ruled in a prior decision that the insurer had no indemnification obligation based on


REUTERS/Rebecca Cook

the intentional and criminal acts exclusion. Wargacki's estate maintained, however, that Western had a duty to defend Erb's estate in the underlying action and that its failure to do so was bad faith. The estate argued that the duty to defend is broader than the duty to indemnify.

The insurer countered that its denial of coverage and a defense was proper as case law establishes that homeowners policies do not cover shootings that are not accidental.

Both parties moved for summary judgment.

Judge Leighton granted summary judgment to the insurer, finding that the facts alleged by Wargacki's estate "offer no support for the claim that the events were 'conceivably' the result of an accident."

Wargacki's estate argued unsuccessfully it is conceivable that the shooting was an accident because no one really knows what happened.

"This claim is not enough to trigger coverage," the judge said. "It cannot be; if it were, no 'investigation' would ever allow Western to terminate the defense because it would never 'become clear' that there was no coverage."

Judge Leighton concluded that, regardless of Erb's mindset or motive, the shooting was an intentional and criminal act excluded from coverage.

"This was known to all from the very beginning, and no amount of spin, massage, speculation or sophistry can make it otherwise," he said. WJ

**Related Court Document:**
Order: 2015 WL 74111

***See Document Section D (P. 30) for the order.***

# Insurer denied ice-damming claim in bad faith, homeowner says

An Illinois homeowner says his insurer acted in breach of contract and bad faith by denying a claim for water and mold damage caused by ice damming on his roof.

***Virdi v. Allstate Insurance Co., No. 2014-L-013295, complaint filed (Ill. Cir. Ct., Cook County Dec. 24, 2014).***

The suit, filed in the Cook County Circuit Court, claims the mold rendered the house inhabitable and forced the policyholder and his family to abandon the property.

The case involves Inderjit Virdi, who owned a house in Schaumburg, Ill., insured by Allstate Insurance Co. Virdi claims that in February 2014 unusually heavy snowfall and extremely cold temperatures caused snow and ice to accumulate on his property's roof, resulting in ice damming.

Ice dams are thick ridges of ice that accumulate along a roof's eaves. They can tear off gutters, loosen shingles and cause water to back up into a house.

Virdi alleges the ice damming caused "extensive" water damage and mold and that leaking water damaged personal property.

Allstate denied Virdi's claim on the basis that any damage was caused by poor maintenance and roof deterioration, the suit says.

Virdi sued the insurer for breach of contract and bad-faith denial of coverage under the Illinois Insurance Code, 215 Ill. Comp. Stat. 5/1.

The suit alleges the insurer acted in a "vexatious and unreasonable" manner by:

- Failing to properly investigate the claim.
- Lacking a good-faith basis for concluding any damage was caused by poor maintenance.
- Lacking a good-faith basis for denying payment under the policy.

Verdi says he is entitled to a judgment of more than $50,000 for Allstate's breach of the insurance contract. In addition, he says, under 215 Ill. Comp. Stat. 5/155 entitles him to attorney fees and an unspecified penalty for "vexatious and unreasonable" denial of coverage. WJ

**Attorney:**
*Plaintiff:* Robert J. Augenlicht, Kurtz & Augenlicht, Chicago

**Related Court Document:**
Complaint: 2014 WL 7407179

***See Document Section E (P. 34) for the complaint.***

REUTERS/Vasily Fedosenko

***The policyholder sued when Allstate denied his claim that ice accumulation on his home's roof caused extensive water damage and that leaking water damaged personal property. Here, a man dislodges icicles from a building.***

## State Farm

CONTINUED FROM PAGE 1

***A&E Auto Body Inc. et al. v. 21st Century Centennial Insurance Co. et al., No. 6:14-cv-310, 2015 WL 304048 (M.D. Fla., Orlando Div. Jan. 21, 2015).***

In gutting the majority of the claims, U.S. District Judge Gregory A. Presnell of the Middle District of Florida ruled that a group of Florida auto repair shops insufficiently pleaded that the defendants engaged in an ongoing and concerted course of action to illegally control and artificially depress costs in violation of the Sherman Act, 15 U.S.C. § 1.

The ruling may be a setback for hundreds of other auto repair shops alleging similar claims against insurers in the multidistrict litigation in the District Court.

As of the date of the ruling, 22 other cases initially filed in numerous states, including Indiana, Kentucky and Virginia, are currently before Judge Presnell for coordinated pretrial proceedings. *In re Auto Body Shop Antitrust Litig.*, MDL No. 2557 (M.D. Fla.).

According to the plaintiffs in the Florida action, the defendants exercise control over labor and repair costs by entering into "direct repair program agreements," or DRPs, with body shops. In exchange for providing certain concessions of price, priority and other matters, the defendants list the shops as "preferred providers."

However, the defendants, led by State Farm, allegedly have conspired to use the DRPs as a way to set maximum price limits on the shops' products and services, according to the suit.

If the labor rates are deemed unacceptable, the defendants demand a lower rate, arguing the higher rate does not conform to the market rate and therefore violates the DRP, the plaintiffs argued.

Further, failure to comply with the defendants' demands results in removal from the preferred-provider program or improper "steering" of customers away from the "noncompliant" auto body shop's business, the plaintiffs say.

> "It is not illegal for a party to decide it is unwilling to pay a higher hourly rate than its competitors have to pay," the judge said.

But Judge Presnell ruled that the plaintiffs offered no details about how or when the insurers entered into the alleged price-fixing agreement.

The fact that a number of defendants have indicated an unwillingness to pay more than State Farm has to pay for parts or labor also does not, itself, violate the Sherman Act, he said.

"It is not illegal for a party to decide it is unwilling to pay a higher hourly rate than its competitors have to pay, and the fact that a number of the defendants made statements to that effect does not tip the scales toward illegality," Judge Presnell wrote.

The plaintiffs also failed to establish that the defendants may have engaged in boycotting activity by allegedly steering customers away from noncompliant shops, according to the ruling.

"There is no allegation that any defendants refused to allow any of its insureds to obtain a repair from such a shop or refused to pay for repairs performed at such a shop," the judge said.

The plaintiffs also cannot move forward with their claim for tortious interference with business relations, he said, because the defendants had an existing financial interest in the relationship between their insureds and the plaintiffs and were therefore "privileged to interfere in that relationship."

"For tortious interference to be unjustified, the interfering defendant must be a third party, a stranger to the business relationship," he said.

Judge Presnell did, however, permit the plaintiffs to continue with their claim for conversion, which alleges the defendants failed to make full payment for certain labor and material costs.

Other defendants in the action include 21st Century Centennial Insurance Co., Allstate Fire & Casualty Insurance Co., Geico General Insurance Co. and Hartford Accident & Indemnity Co. WJ

**Related Court Document:**
Order: 2015 WL 304048

# NEWS IN BRIEF

## COURT FINDS DEFENDANT IN DEFAULT IN COVERAGE DISPUTE OVER NUDE TAPES

A federal court has entered a default entry against a North Carolina man whom Scottsdale Insurance Co. says is owed no coverage for an underlying invasion-of-privacy suit. In a federal court complaint, Scottsdale asserted it has no duty to defend or indemnify Thomas G. Owens, a former employee of policyholder B&G Fitness Center, in a state court suit accusing him of secretly videotaping patrons undressing in the gym's tanning rooms. According to Scottsdale, policy exclusions barring coverage for sexual or physical abuse prevent the insurer from getting involved in the underlying dispute. Scottsdale asked the court in a Dec. 1 motion to find Owens in default for failing to respond to the insurer's complaint. In a one-page order, the court granted the motion, noting that Owens failed to plead or otherwise defend against the suit as required by law.

***Scottsdale Insurance Co. v. B&G Fitness Center Inc. et al., No. 4:14-cv-187, order for entry of default issued (E.D.N.C. Jan. 14, 2015).***

**Related Court Document:**
Complaint: 2014 WL 5280466

## 11TH CIRCUIT DECLINES REHEARING IN TODDLER-DEATH CASE

A federal appeals court has declined to reconsider a decision that Cincinnati Insurance Co. is not liable for a $10 million judgment assessed against the babysitters of a toddler who drowned in a swimming pool. The 11th U.S. Circuit Court of Appeals ruled in October that Cincinnati owed no duty to indemnify Shawn and Tanya Moon in the underlying case brought by the child's parents because the Moons were not insured under Cincinnati's policy at the time of the child's death. Shawn Moon's father owned the property and was the policyholder. In a petition for rehearing, the child's parents asked the 11th Circuit to revisit the decision, claiming ambiguities in the policy should have been strictly construed against Cincinnati. The appeals court denied their petition without comment Jan. 13.

***Moon et al. v. Cincinnati Insurance Co. et al., No. 14-10264, petition for reh'g en banc denied (11th Cir. Jan. 13, 2015).***

**Related Court Documents:**
11th Circuit opinion: 2014 WL 5410298
Petition for rehearing: 2014 WL 6737455

## VIRGINIA LAB FACES SUIT FOR 'FEE FORGIVENESS' PRACTICE

Cigna Corp. has sued a clinical testing laboratory for allegedly defrauding it of $84 million through an unlawful "fee forgiveness" scheme. In an amended complaint filed in Connecticut federal court, Cigna units Connecticut General Life Insurance Co. and Cigna Health & Life Insurance Co. claim Health Diagnostic Laboratory Inc. illegally waives out-of-pocket expenses for patients while billing Cigna unreasonable and excessive charges for routine services. The suit says the Richmond, Va.-based lab lures Cigna members to use its testing services by telling them they are not responsible for any copayment, co-insurance or deductible obligation.

***Connecticut General Life Insurance Co. et al. v. Health Diagnostic Laboratory Inc., No. 14-1519, amended complaint filed (D. Conn. Jan. 16, 2015).***

**Related Court Document:**
Amended complaint: 2015 WL 293315

# CASE AND DOCUMENT INDEX