CQ

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Chairman's Corner

by James A. Franz, CPCU, AIC, ARP, ARM

- Many of the Claims Section Committee members, along with myself, recently returned from the CPCU Society's **Leadership Summit,** which combines the Mid-Year Committee/Task Force and Board of Governors' meetings with the National Leadership Institute (NLI) and the chapter and section leadership training. As usual, we were busy and the time was well spent. If you haven't attended the NLI, I highly recommend it. Six of our committee members are taking the series of courses and all agree that it is a valuable and timely program.
- The Claims Section remains the largest section of the Society's 14 interest sections. If you know CPCUs who aren't Claims Section members and ought to be, please do your part to promote the visibility of the Claims Section and let them know about the benefits that are available through membership in our section. In this era of company mergers, reorganizations, and downsizing, our ranks remain solid with nearly 1,500 members but we feel that there are many more claims people in the industry that could enjoy being associated with the **"Well-Adjusted" Claims Section.**
- We are still on track to put on **three seminars in Orlando.** Ralph Riemensperger, CPCU, Claims Section Committee member is putting on a mold seminar September 12 in East Meadow, New York; and Joe Toscano is presenting the Interfire Virtual Reality (VR) program with me in Indianapolis on October 2. Let us know if you are interested in attending.
- We are currently working on a way to market the **claim workshops** that the committee has developed. Maybe you or your company can use some help training your claim folks. These are great tools and are ready to use in your classroom. You will hear more about them in the fall.
- We are in the process of developing our **great Claims Section web site.** Eric Sieber, Ralph Riemensperger, and Brain Marx are going to be our "go to" folks on this. If you have suggestions on what we need on the site to do our jobs better, let us know. Our addresses should all be on the web site now.
- The Society has introduced the **Circle of Excellence Recognition Program for Sections.** There will be three award levels. The goal of the Claims Section Committee is to win the top level award each year. You will be able to help us achieve this. The first awards will be presented in Orlando. Watch for Marcia Sweeney's article in our special edition *CQ* in October. The committee has a special project we expect to roll out in Orlando that you all can participate in.
- We've already started planning our seminars for the Annual Meeting and Seminars to be held in New Orleans in 2003. Ideas on new topics are always welcome.
- And I would like to announce that James Klauke, CPCU, AIC, RPA, was elected the incoming chairman for the Claims Section. He is a veteran member of the Claims Section Committee and he's earned it. Congratulations James! His term of office will begin immediately after the close of the Annual Meeting and Seminars in October. James will be introduced formally in an upcoming edition of the *CQ*.
- That brings you up to date with the Claims Section Committee activities. Have a great summer! ■

The Claims Section Committee hard at work during the Leadership Summit in Las Vegas, planning claim activities for the 2002-2003 year.

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Mold: Five Reasons Why It Is *Not* the "Next Asbestos"

by Randy J. Maniloff

Editor's note: *This article is reprinted with permission from* Mealey's Litigation Report: Insurance.

Mold has been the subject of much discussion lately within the insurance industry, as well as by others affected in their own right, such as lawyers, environmental consultants, and consumer groups. And it seems like every time the subject comes up, it doesn't take long for someone to chime in that mold is the "next asbestos." It's not. While mold is certainly a cause for legitimate concern by the insurance industry, there are several reasons why the stars are not aligned for mold to warrant such an ambitious label.

Before examining these reasons, consider what it will take for mold to become the "next asbestos." According to an April 10, 2002, article in *The New York Times*—front page and above the fold—American companies and insurers have spent more than $30 billion to defend and settle asbestos lawsuits. Moreover, *The Times* cites industry analyst predictions that the total bill for asbestos could exceed $250 billion. If mold is going to be the "next asbestos," it certainly has big shoes to fill.

1. The Volume of Mold Claims Will Not Enable Duplication of the "Asbestos Business Model"

There are numerous factors that have caused asbestos litigation to reach the dollar levels that it has. Most significantly is the unparalleled volume of claims. This has resulted in a fundamental change in the entire approach to litigation—to the tremendous advantage of plaintiffs. The number of mold claims, on the other hand, will not reach the same stratospheric heights as asbestos. Therefore, mold will not provide plaintiffs with the same tactical advantages that they have been able to exploit so successfully in the asbestos arena.

Faced with thousands, and sometimes even hundreds of thousands of asbestos cases pending against an insured, insurers have been left with little choice but to apply novel approaches to the problem. To avoid becoming suffocated by the volume of asbestos cases and their associated defense costs, the interested parties, with the complete blessing, if not at the insistence, of courts, have been forced to dispense with some of the traditional requirements of tort law. Enter the "global asbestos settlement."

In a global asbestos settlement, hundreds, if not thousands, of asbestos cases are resolved without strict proof that a plaintiff's asbestos-related injury was caused by exposure to a specific defendant's asbestos or asbestos-containing product. Instead, generally speaking, causation will likely be deemed satisfied as long as there is an overlap between the plaintiff and the defendant's asbestos or asbestos-containing product being present at the same location. Never mind that the asbestos at issue may not have been friable or, if it was, that the plaintiff may not have been in a position to actually inhale the specific settling defendant's asbestos. And never mind that the plaintiff's decision to smoke a couple of packs of Luckies a day for 30+ years might have had something to do with that shadow on the chest x-ray, if there is even a present injury at all.

Provided that a plaintiff's case has enough evidence to defeat the defendant's theoretical motion for summary judgment on lack of causation—which, by the way, will likely be deposition testimony of the plaintiff, recalling the details of specific workplace events from 40 to 50 years ago—it will likely make it into the global settlement. There is a price that must be paid to resolve a backlog of thousands of asbestos actions, and this sleight of hand approach to causation is it.

Herein lies the secret (although it is certainly not a secret) to the success of asbestos for plaintiffs' attorneys—the asbestos business model. Individually, each asbestos case may have several weaknesses that would prevent it from being economically worthwhile to pursue. But when thousands of such cases are filed against a single defendant, it becomes an extremely daunting and expensive task to identify such weaknesses. What's more, if the cases can not be dismissed on motion for summary judgment, then any insurer wishing to take a hard-line position on non-meritorious claims is forced to try each and every case

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individually (to the probable displeasure of the trial judge, who is likely being judged him or herself on how many cases he or she clears off the docket). The result is the global asbestos settlement.

To be fair, the global asbestos settlement is not without consideration for insurers either. In exchange for settling multiple cases in this manner, insurers are relieved of the tremendous defense costs that would be incurred if each case were to be separately handled, on its own, start to finish. As well, insurers are also relieved of the risks of taking their insureds' cases to trial. Time and time again it has been proven that even a defendant with a strong case on both causation and damages is rolling the dice when putting an asbestos case before a jury. These are the benefits of the bargain for an insurer that agrees to settle a case for, say, a few thousand dollars, even if the payment feels like extortion.

Additionally, insurers that enter into global settlements typically must be satisfied that they are receiving an adequate discount from the plaintiffs in exchange for the advantages that come from an early settlement and such significantly reduced effort on the plaintiff's part. However, lots of companies achieve success by selling their products cheap and making up the difference in volume. Given the extraordinary number of cases in their "inventory" (yes, this is actually the term that asbestos plaintiffs' attorneys use to describe their clients), asbestos plaintiffs' attorneys can afford to follow this same business model. On the other hand, mold does not lend itself to hundreds of thousands of plaintiffs suing dozens of defendants through the use of form complaints and other pleadings and cookie-cutter discovery (more on this in reasons 2 and 3). Instead, mold claims are much more likely to have to be litigated in the more traditional manner. In other words, plaintiffs' attorneys will have to incur significant effort and expense to prepare each case for trial or settlement. Therefore, mold is not likely to provide the plaintiffs bar with the ability to replicate the asbestos business model.

2. Most Mold Claims Are for Property Damage Under First-Party Policies"

If mold is supposedly everywhere, why can't it rival asbestos in terms of the number of claims?

There are a few reasons for this. While it may be true that mold is everywhere, not all mold lends itself to a cause of action against parties allegedly responsible for the situation. Case in point. The available data suggests that most mold claims have nothing at all to do with liability and arise under homeowners' policies.

As well, even though there is the potential for mold "liability" claims being brought in bulk, say, by large numbers of occupants of a public building, all alleging mold bodily injury on account of its faulty construction, such situation still does not rival asbestos in terms of the number of potential plaintiffs. Unlike asbestos, mold is not a product. Therefore, while it may be true that mold is everywhere, it is not the same mold that is everywhere. In other words, the mold in one building likely has absolutely no relationship to the mold in another building. As a result, while mold can result in multiple-plaintiff litigation, the number of potential plaintiffs that will be in a position to trace their injuries to the same source is likely to be substantially fewer than is the case with asbestos, where the same product may have been distributed on a national basis and therefore come in contact with millions of people.

One group that has examined the number of mold insurance claims that have been filed is Policyholders of America, a non-profit organization founded by Melinda Ballard, who was awarded $32.1 million in 2001 by a Texas jury in a homeowners' coverage action for mold damage (albeit, the lion's share of the damages awarded were extra-contractual). While Policyholders of America acknowledges that its list may not be all-inclusive, it calculates that from 1987 to February 5, 2002, there have been 16,059 first-party mold claims filed (in which the policyholder retained counsel), consisting primarily of homeowners' claims. By comparison, according to GeneralCologne Re, in its publication *Hazardous Times* (February 2002), there have been only 10 cases against contractors that have resulted in an award or settlement of $1 million or more, and only six cases where litigation against commercial or municipal building owners resulted in awards or settlements of $1 million or more.

Even if these claims figures are not exact, they clearly illustrate that the vast majority of

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mold claims arise under homeowners' policies, which do not cover bodily injury to the home's residents. Moreover, even claims for property damage under homeowners' policies are by no means slam-dunks. Consider that homeowners' policies actually contain exclusions for certain types of mold damage, not to mention that attempts are currently underway to broaden such exclusions. This is not to say that mold exposure for insurers under homeowners' policies is anything to sneeze at (no pun intended). However, without the potential for recovery for bodily injury, and its pain and suffering component, as well as the fact that homeowners' policy property damage claims will likely have too many unique aspects to lend themselves to Henry Ford-like automation, they are unlikely to become the basis for a high-volume plaintiffs' practice, unless, of course, the attorney sees a potential bad faith aspect to the claim. While it is not the intent of this article to examine this issue, not enough can be said about the importance of handling mold claims in such a manner to prevent a straight-forward property damage claim under a homeowners' policy from mushrooming into a *Ballard*-type situation.

As well, a homeowners' property damage claim is only intended to make the insured whole. Many insureds will likely be under-whelmed by the idea of involving a lawyer in their homeowners' claim, after discovering that, as a result, they will now only be made about 60 percent whole. A 33 to 40 percent contingent fee is much easier for a plaintiff to swallow when it is part of a settlement that has a pain and suffering component, since it is not reducing the plaintiff's recovery for out-of-pocket losses.

3. Mold Exclusions Will Likely Be Far More Effective than Asbestos Exclusions in Limiting Insurers' Financial Exposure

Even if the vast majority of mold claims will likely arise under homeowners' policies, the potential for claims being brought in bulk, by large numbers of occupants of a public building, all alleging bodily injury caused by mold, is very real. Such claims would likely be brought against the building owner and a host of entities responsible for its construction. The theory of liability here will likely be that the building was constructed in a defective manner, allowing for the penetration of water, and, as a result, the growth of mold.

Thus, there exists the potential for numerous bodily injury plaintiffs, each of whom can easily prove their extended presence in a building (for example, because they went to work there everyday), bringing actions against defendants who will each tender the claim to their commercial general liability insurer(s). Such insurers issued policies that provide coverage for third-party bodily injury. Even if this situation will not likely result in a replication of the "asbestos business model," doesn't it at least resemble the model, and therefore present an attractive case to the plaintiffs bar? Of course. But the insurance industry has begun to respond to the mold epidemic by incorporating mold exclusions and mold sublimits into commercial general liability policies.

While the loss of the availability of insurance coverage is not a bar to the prosecution of the underlying action, the likely reality is that without insurance dollars to pay any settlement or judgment, the plaintiffs bar's motivation to bring the case (and especially on a contingent fee) will be lost.

While the insurance industry responded to the asbestos crisis by making an asbestos exclusion a part of CGL policies, the nature of asbestos bodily injuries are such that this solution came too late to prevent most of the damage. The latent nature of asbestos injuries, in conjunction with various trigger theories that have been adopted by courts, has still left billions of insurance dollars on the table for the payment of such claims. Mold bodily injuries, however, may not lend themselves to a latent injury period, thereby enabling pre-mold exclusion CGL policies to be triggered in the same way that pre-asbestos exclusion policies are often triggered. Thus, mold exclusions will likely be far more effective than asbestos exclusions in limiting insurers' financial exposure.

4. Mold Is Likely To Have a Much Shorter Trigger Period than Asbestos

Mold exclusions and sublimits in homeowners' and liability policies are politically charged issues. Thus, it is possible that these exclusions and sublimits will not

achieve the same level of across-the-board incorporation as asbestos exclusions. However, even if this occurs, the nature of mold injuries, both bodily injury and property damage, does not likely lend itself to long trigger periods. Simply put, the nature of mold claims is not likely to offer plaintiffs the annualization of the policy limits of decades of coverage that has served to create the asbestos trough.

Since construction defect cases often times involve multiple defendants and are therefore labor intensive, a diminished amount of available insurance dollars—while certainly not preventing mold litigation—will surely make the litigation less attractive for a plaintiff's attorney deciding how best to use the finite number of hours in his or her work day.

As an aside, it is possible that a sixth reason why mold is not the "next asbestos" is because the nature of mold injuries are generally not as serious as asbestos, which often times involve cancers. However, given the lack of agreement in the scientific community concerning causation between exposure to mold and bodily injury, this reason was not included herein. However, it can not be ignored that a sixth reason why mold is not the "next asbestos" may be that the plaintiffs bar will lack the motivation to bring cases for injuries that frequently resemble allergy symptoms.

5. The Present Financial State of the Insurance Industry Does Not Bode Well for Mold

According to information released on April 15, 2002, by Insurance Services Office, Inc. and the National Association of Independent Insurers, the property and casualty industry suffered a $7.9 billion net loss after taxes in 2001, its first ever net loss for a full year. Compare this with 2000, in which the industry had net income of $20.6 billion. The combined ratio—which measures losses and underwriting expenses per dollar of premium—rose to a staggering 116 percent in 2001.

The media has been full of reports recently concerning enormous increases in premiums being charged for various lines of coverage. There have also been many reports of businesses that are suffering as a result of the financial stress being caused by the increases in their insurance premiums.

But what does this have to do with mold? It is likely that the proliferation of asbestos was helped by the fact that it arose at the same time as the longest bull market in history, which began in August 1982. Surely courts are more receptive to pro-plaintiff and pro-coverage arguments during a period when insurers are flush with cash. Mold, on the other hand, has arrived at a time when the industry can ill afford the financial consequences of another asbestos. Thus, courts that reach decisions that are designed to overcome some of the coverage-limiting arguments raised herein will only be passing the industry's losses back onto the insurance consumer, in the form of even higher premiums. Knowing this, courts may be unwilling to contribute to the economic hardship to businesses that comes from the lack of affordable insurance.

Conclusion

While mold is not the "next asbestos," its potential exposure for the insurance industry is nonetheless very real. Even if mold does not result in litigation factories, there is still much damage that can be done to insurers by those cases that can justify being handled by plaintiffs in the traditional litigation format. So while mold is not the "next asbestos," it would be short-sighted to dismiss it and call it the next electromagnetic fields (power lines). If the insurance industry's total exposure to date for asbestos is $30 billion, and projected by some analysts to reach $250 billion, then perhaps the strongest argument why mold is not the "next asbestos" is the simplest of them all—there is presently no need for it to be. ■

The *Mabry* Decision and Its Impact on Diminution in Value

by Douglas M. Dixon, J.D., CPCU, AIC, ARe, and Gerald Deneen, CPCU, ARe

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Introduction

In a ruling contrary to the intent of the Insurance Services Office, Inc. (ISO) Personal Auto Policy, the Georgia Supreme Court decided last November that insurance companies are indeed liable for the "diminished value" of damaged automobiles owned by Georgia policyholders. The case, *State Farm Mutual Automobile Insurance Company v. Mabry et al.,* is not the only one of its kind. Several other state courts including Florida, Texas, and Illinois are currently hearing cases concerning diminished value. These cases may have a significant financial impact on the insurance industry and its customers.

When an automobile has been damaged, its loss of market value or resale value is known as diminution in value or diminished value. For example, assume an auto has a market value of $10,000 prior to an accident. After an accident the insurer pays to have the car repaired, but now the car may have a resale value of only $9,000 because most buyers do not want a car that has been in an accident. The $1,000 loss is the diminution in value.

The insurance industry generally uses a Personal Auto Policy known as ISO PP 00 01 06 98. The form is written with the intent of limiting the insurer's liability to only the cost of repairing the vehicle and not diminution in value. Nevertheless, cases are being brought before several state courts claiming that insurers are responsible for diminished value. Now that the *Mabry* decision has set a precedent in Georgia, auto insurers should follow the issue very closely to see if other states follow Georgia's lead.

Georgia Ruling

On November 28, 2001, the Supreme Court of Georgia decided in *State Farm Mutual Automobile Insurance Company v. Mabry et al.* that "diminished value" is covered under Personal Auto Policies issued by State Farm. In doing so, the court upheld a trial court's ruling from the Superior Court of Muscogee County, Georgia, that declared diminution in value is covered under State Farm's auto policy and certified a class action lawsuit against State Farm by its policyholders. The court also upheld the lower court's ruling that directed State Farm to begin handling claims for diminution in value by an appropriate methodology and procedure.

An Associated Press report dated January 7, 2002, reported State Farm agreed to settle the class-action lawsuit after the Georgia Supreme Court upheld the lower court. In the settlement, State Farm reportedly agreed to pay diminished value to their policyholders for accident claims filed since December 22, 1993. The cost of the individual settlements with eligible policyholders could range from a minimum of $25 to as much as several thousand dollars per policyholder. State Farm estimated that diminution in value settlements for those claims dating back to 1993 could cost as much as $100 million and involve about 700,000 customers. State Farm also estimated it will pay an additional $100 million over the next five years for these types of claims. Finally, State Farm agreed to pay $50 million to the 12 plaintiffs' attorneys who brought the class-action lawsuit in Georgia.[1]

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On January 16, 2002, a few days after the State Farm settlement was announced, Reuters News Service and the *National Underwriter* announced Allstate Corp. agreed to settle a similar case in Georgia, *Earl et al. v. Allstate.* Allstate set up a $59.1 million fund to resolve the diminution in value class-action lawsuit.[2] A spokesman for Allstate said the suit involved 274,000 claims with average settlements between $150 and $215. Allstate's class-action settlement covered customers with accidents occurring over the last six years.[3]

Analysis of the Georgia Ruling

The language of the policy construed in *Mabry* is not completely delineated in the court's decision. However, the parts of the policy language cited by the court are substantially similar to the language contained in the ISO Personal Auto Policy used by most insurance companies. The ISO language (PP 00 01 06 98) states:

> Part D—Coverage for Damage to Your Auto[4]
>
> Insuring Agreement
>
> A. We will pay for direct and accidental *loss* to "your covered auto" or any other "non-owned auto," including their equipment, minus any applicable deductible shown in your Declarations . . . We will pay for *loss* to "your covered auto" caused by . . . (emphasis added)

The ISO Personal Auto Policy limits the liability of the insurer on physical damage claims to autos with the following language:

> Limit of Liability[5]
>
> A. Our limit of liability for loss will be the lesser of the:
>
> 1. Actual cash value of the stolen or damaged property; or
> 2. Amount necessary to repair or replace the property with other property of like kind and quality . . .

ISO's Personal Auto Policy also contains a provision similar to a State Farm provision cited in the *Mabry* decision. This provision is called payment of loss in the aforementioned ISO policy. It states: "We may pay for loss in money or repair or replace the damage or stolen property…"[6]

The language of the ISO Personal Auto Policy agrees to cover physical damage, but it then attempts to limit the liability of the insurer to the lesser of actual cash value of the automobile or the amount necessary to repair or replace the automobile. When an insurance company settles an auto damage claim it will either pay to repair the auto if it is not a total loss or it will pay for the actual cash value of the auto if it is a total loss. A total loss results when the cost to repair the auto is close to or exceeds the actual cash value of the auto. Insurance companies have not historically interpreted the above policy language (or similar language) to include diminution in value when calculating the amount necessary to repair or replace the damaged or stolen vehicle.

In *Mabry*, Georgia's Supreme Court said the issue of whether diminution in value is covered under personal auto policies was not a case of first impression. The court rejected State Farm's argument that its liability was limited to the cost to repair the vehicle. After reviewing several similar Georgia cases, the court decided that "value," and not the cost to repair the auto, is the key element in determining the measure of damages for auto insurers in physical damage claims.

In its defense, State Farm offered several arguments that were rejected by the Georgia Supreme Court:

- First, State Farm tried to distinguish this case from previous decisions by Georgia courts. State Farm argued the policy language in this case was different from the policy language in previous cases. The court found that State Farm's policy language was sufficiently similar to the earlier decisions to make them applicable.
- Second, State Farm argued that diminution in value is not realized until the car is sold and therefore it should not be part of a claim at the time of the auto accident. The court rejected this argument by stating the insured had suffered a loss of value at the time of the accident and therefore diminution in value was recoverable at the time of the accident.
- Next, State Farm argued that diminution in value recovery should only be allowed in claims where the repairs to the auto were defective. The court rejected this argument stating the earlier decisions did not involve claims with defective repairs.

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- Finally, State Farm contended that it had no duty to assess diminution in value unless the insured specifically requested these types of damages. The court again rejected this argument on the basis stating that nothing in the policy required the insured to assert a right to recover any particular element of damages.

The crux of the decision is that auto insurers in Georgia now have an affirmative duty to evaluate each auto for diminution in value and compensate its policyholders for this element of damages if the repairs to an auto do not return it to its pre-loss value.

Ramifications for Insurers in Georgia

Based on the *Mabry* decision, insurers in Georgia may need to raise their rates. Before *Mabry*, most insurers did not pay for diminution in value when settling first-party auto physical damage claims. It is unlikely that Georgia insurers collected premium for diminution in value. Like any other exposure, especially a claim payment exposure as frequent as this one, insurers cannot afford to make claim payments without receiving premium to pay for such claims. If insurers do not collect the additional premium, they will have to dip into policyholder surplus or face slowing surplus growth.

Other States

Currently, lawsuits similar to the one in Georgia are pending in several other states. States where these lawsuits have been filed include Delaware, Illinois, Louisiana, Massachusetts, Pennsylvania, Rhode Island, Texas, and Washington. The majority of jurisdictions still take the position diminution in value is not covered.

The Georgia Supreme Court even acknowledged in *Mabry* that other states have interpreted the same issue differently. The court cited decisions from Florida and Virginia that have ruled diminution in value is not covered under an auto policy.[7] On May 23, 2002, the Florida Supreme Court affirmed the position in Florida that diminution in value is not covered under the Personal Auto Policy.[8]

In Louisiana, a trial court recently ruled in *Floyd v. Republic Lloyd's Insurance Company* that an auto policy could cover diminished value in spite of earlier rulings by Louisiana courts rejecting cases for diminution in value. The decision has been appealed to the First Circuit Court of Appeals in Louisiana. The National Association of Independent Insurers (NAII) has filed an amicus brief in the case on behalf of Republic Lloyd's Insurance Company.[9]

In Texas, the issue is still unsettled. On June 7, 2002, the Fifth Circuit Texas Court of Appeals in Dallas held that diminution in value is covered because the insurer must restore the vehicle to its pre-accident "value."[10] This is the second appellate ruling in Texas holding that diminution in value is covered. The Ninth Circuit Court of Appeals in Beaumont held in *Schaefer v. American Manufacturers Mutual* that diminution in value is covered.[11] However, the 14th Circuit Court of Appeals in Houston concluded in *Dennis Carlton v. Trinity Universal Insurance Company*, that an insurer is not liable for "diminished value." Considering the split of opinion in the Texas appellate courts, the issue will likely be put before the Texas Supreme Court soon.

The legal issues and developments surrounding diminution in value are rapidly occurring; auto insurers should follow these cases closely. An excellent resource for following these developments is NAII's web site, www.naii.org. An insurer can use the web site to follow developments, but legal counsel should be consulted to determine the status of this issue before making business decisions.

In spite of rulings in favor of the insurance industry, these lawsuits will persist for some time. Although the ruling in Georgia is not binding on another state court, the ruling will likely embolden policyholders and their attorneys even further. There is a possibility that other states will follow Georgia's Supreme Court lead even though the decision has no binding effect on other state courts.

Coverage Exclusions

ISO has taken notice of the lawsuits filed against the users of their Personal Auto Policy

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form. In December 1999, ISO developed an exclusion to the Personal Auto Policy "clarifying" that "diminished value" is not a covered element of damages. The ISO endorsement number is PP 13 01 12 99. It adds the following definition: "'Diminution in Value' means the actual or perceived loss in market or resale value that results from a direct and accidental loss."[12]

It then adds an exclusion that reads: "We will not pay for Loss to 'your covered auto' or any 'non-owned auto' due to your 'Diminution in Value.'"[13]

The use of this endorsement is a "double-edged sword." Once an insurance company begins to use the endorsement, a plaintiff's attorney may argue the use of the form by the insurance company is tantamount to admitting that its prior policies did cover "diminished value." ISO clearly indicated when it introduced the form that the purpose was to strictly clarify the Personal Auto Policy's original intent. Additionally, with the issuance of *Mabry,* the need to clarify the intent of the policy becomes even more important. In spite of the double-edged sword argument, an insurer should carefully begin to consider use of ISO form PP 13 01 12 99.

ISO has also tried to limit claims for diminution in value in commercial auto policies. Revised forms clarifying the intent to exclude such claims can be found in the Business Auto Physical Damage Coverage Form effective 10/01 (CA 00 10 10 01), Motor Carrier Coverage Form (CA 00 20 10 01), Truckers Coverage Form (CA 00 12 10 01) and Garage Coverage Form (CA 00 05 10 01).

Claim Handling

Should a court in your state decide diminution in value is covered, each claim will have to be evaluated for diminution in value. There are a few types of first-party claims that should not include diminution in value. Examples are glass breakage claims and total losses. On glass claims, there should not be any diminution in value because there is no structural damage to the auto and no cosmetic issues, so the policyholder cannot argue the market value of the car has diminished because the glass was replaced. On total losses, there is no diminution in value because the policyholder will be compensated for the actual cash value of the auto that is similar to the market value.

Adjusters in states where courts determine diminution in value is covered must begin developing procedures for evaluating whether a diminution in value claim exists and how much to pay. The procedure for calculating should be consistent and the goal should be to determine the loss of market value to the auto. Georgia insurers are adopting a procedure in which a base value is calculated for the loss of market value to the auto. The base value is then adjusted based upon the severity of damage to the auto and mileage on the auto.

Even in states where courts have determined diminution in value is not covered, insurers should review the concept with their adjusters. They should be consistent in refusing to pay diminution in value. If an insurer is not consistent, a policyholder could argue the insurer has waived the limitations of its policy. This could lead to a class0action lawsuit.

Some may wonder whether this decision affects claim-handling practices on third-party auto liability claims. It does not. In third-party property damage liability claims, the measure of damages is the difference in the market value of the property before and after the accident. This measure already encompasses diminution in value and should be paid when warranted.

Conclusion

The Georgia Supreme Court decision is contradictory to the widely accepted insurers' interpretation of the ISO Personal Auto Policy. It is likely the decision will lead to more class-action lawsuits in other states alleging coverage for diminution in value under the Personal Auto Policy. The Georgia decision has been called an "aberration" by the NAII due to its incongruity with decisions in other states.[14] The industry should brace itself for these lawsuits and continue to defend them vigorously. Simultaneously, the industry should also review and consider use of the diminution in value exclusion. ■

Choose Your Investigative Vendor Wisely

by William C. Haigh, FCLS, WCLS

How can your company save thousands, even tens of thousands of dollars per quarter, while gaining better productivity, performance, and results? The answer to this seemingly daunting question is rather simple: choose your investigative vendors wisely.

The New Jersey State Police reports that there are more than 6,900 agencies that have been granted Private Investigator Licenses in the Garden State over the last 20 years. With the vast number of licensed agencies seeking work from your company, the following is a list of suggestions, which may provide guidance in both developing a panel of investigative firms and the type of due diligence that is necessary in the selection and maintenance processes:

1. **Centralize the selection process.** In-house SIU investigators, not claims examiners, are typically the best resources for choosing investigative vendors. SIUs are usually more informed about the reputation of investigative firms, acceptable investigative practices, legal issues related to investigation, and they are in a better position to measure the firm's performance. As specialists in this area, selection and performance of an investigative vendor panel is usually directly tied to an SIU investigator's job performance.
2. **Ensure that proper documentation is obtained.** It should be mandatory for any vendor being considered for your investigative panel to provide copies of all licensing documents, proof of insurance, and performance bonds. In fact, your company should be named as an additional insured under the vendor's policy. Further, you should require that the firm provide copies of résumés of each and every employee who performs investigative work for their company. Lastly, any potential panel firm should be required to sign a carefully worded indemnification agreement. Your company's corporate counsel should prepare this document.
3. **Only employees of the vendor/ firm should perform the work.** When your investigative assignment is "farmed out," you have given up control of the investigation to an unknown entity. This firm may perform poor quality, unethical, or even illegal work. Ultimately, your insured will hold you accountable if something should go wrong. Don't take the chance.
4. **Provide specific direction when making an investigative assignment.** Expectations of what work is to be performed and at what cost should be clearly delineated before any assignment begins. Hourly or flat-rate price schedules should be negotiated prior to assignment of any work.
5. **Closely monitor the work product.**
   - Carefully review all reports, video, documents, and invoices to ensure that all work is performed as requested and billed appropriately. Refuse to pay for work that was not assigned or of poor quality.
   - Conduct announced and, if necessary, unannounced inspections at the vendor's office and the surveillance location. This will ensure that all equipment is working, technologically up to date, and that the vendor is properly performing the work that you are paying for.
   - If a vendor is not performing up to your company's established standards, remove it from your company's panel. As evidenced by the number of licenses issued, if a vendor is not performing up to snuff, there are many other firms who would relish the opportunity to perform quality work for your company.

By choosing your investigative vendors carefully, you will realize gains in the quality of your work product as well as savings in loss dollars and loss adjustment expenses. Always remember that the vendors you select not only act as an extension of your investigation, but also will have a direct influence on the reputation of you and your company. Choose these potentially valuable business partners wisely. ■

***William C. Haigh, FCLS, WCLS**, a former SIU investigator and workers compensation supervisor, was recently named worldwide workers compensation SIU claim manager for a major carrier. He has nearly 10 years of experience in claims and SIU.*

Join us in Orlando!

The Claims Section has developed these educational seminars to be held during the CPCU Society's 58th Annual Meeting and Seminars in Orlando, FL, October 19-22, 2002.

Toxic Mold—Don't Let it Overgrow Your Bottom Line

Monday, October 21—10 a.m. - noon

What is toxic mold and why has it suddenly become the hottest topic in the industry? Learn these answers from a panel of experts in the areas of industrial hygiene, law, underwriting, and claims. You'll learn about first- and third-party coverage issues, mold remediation and abatement, what mold plaintiffs will assert, and defending mold lawsuits.

Lien on Me

Monday, October 21—1:30 - 3:30 p.m.

Anyone who has the ultimate responsibility for final claims resolution—whether from the claims or legal side—will benefit from this two-hour seminar focusing on methods to avoid post-settlement lien issues. Attendees will learn methods for identifying hidden liens arising out of primary public benefit programs, methods for resolving liens in complex claims, procedures to follow in federal lien resolution, and proactively using liens in claims resolution. Specific legal strategies for the successful resolution of liens will also be detailed.

Depositions for the Insurance Professional

Tuesday, October 22—9:45 - 11:45 a.m.

In litigation, your case can be won or lost in deposition. However, by equipping yourself with the right strategies and tactics, you can become an effective deponent. Learn all about these strategies and tactics, and how they can be put to use for you. This seminar is especially valuable to claims personnel, underwriters, and senior management, and should not be missed! *Filed for 2 CE credits.*

Call (800) 932-2728, select option 4, for Annual Meeting registration information or visit www.cpcusociety.org.

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Claims Section Committee Member Profile

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We would like to introduce a new committee member, **Brian N. Marx, CPCU.**

Brian received his CPCU designation in 2001 and was recently appointed to the Claims Section Committee. Brian will be writing informative articles primarily on workers compensation claim handling and workers compensation subrogation, and he will be involved in coordinating several of the Claims Section Committee's sponsored seminars. The February edition of the *CQ* published one of his articles, "Preserve the Evidence." Brian obtained his master's degree in business economics from Rutgers University in 1994. He enjoys writing technical articles on interesting, unique, and often misunderstood topics, which will enhance readers' understanding of the subject as well as provide practical application for use in claim handling. Look in future issues of *CQ* for additional articles by Brian.

Brian has 15 years of experience in the claims industry as both a supervisor and examiner. He spent seven years with Employers of Wausau Insurance and the last four and one-half with Chubb and Son Insurance. In 2000, he wrote a business plan and headed up Chubb's first Workers Compensation Recovery Program, which commenced operations in 2001. Due to its success, the Recovery Program is now national in scope and Brian was recently promoted to senior technical subrogation specialist. He is responsible for training and developing subrogation specialists in the Workers Compensation Recovery Unit by providing technical support on claim-handling strategies and on interpreting the various statutes and case law that define a carrier's subrogation and recovery rights. His corporate objective is to increase the frequency rate of recovery and maximize the dollar amount of recovery. He will speak at the New Jersey Chapter's I-Day, November 8, 2002, on the New Jersey workers compensation subrogation landscape.

Brian has been married for two years to Tatyana, who is currently studying to become recertified as a neurologist. They both enjoy traveling, going to the beach, the theater and hope to start a family in a few years. ■

Eric Sieber, CPCU, AIC, RPA, *taking time between the Claims Section Committee meeting and an NLI course to investigate a multi-million dollar pollution claim in Las Vegas with* ***Marcia Sweeney, CPCU, AIC, ARM, ARe*** *(not pictured).*

Workers Compensation Third-Party Investigation: A Practical Approach

by Brian Marx, CPCU

Editor's note: *Special thanks is given to Patrick Timoney, Esq. of the Law Office of Cozen and O'Connor for his assistance in some of the legal research contained in this article.*

If you have any questions regarding this article, feel free to contact Brian at (973) 360-6917 or by e-mail at bmarx@chubb.com.

Every new loss time workers compensation claim potentially has the following eight issues that need to be addressed and resolved: coverage, compensability, medical management, disability management, litigation management, SIU investigation, reserve analysis, and third-party investigation. Budgeting time and prioritizing each aspect of the claim-handling process, whether it effects the issuance of benefits or subrogation, can be very challenging, particularly on complex, catastrophic cases. Even with the assistance of specialists, such as a nurse case manager, defense attorney, or SIU investigator, the examiner is still faced with the formidable, multi-faceted and, at times, daunting task of addressing each individual issue and managing the claim to a favorable, equitable resolution. Further, while the examiner may have the assistance of a recovery department to make sure that the lien is protected and the statutory or equitable amount recovered, the third-party investigation and analysis still need to be performed by the workers compensation examiner.

The purpose of this article is to provide a workers compensation examiner with a structured framework for handling the subrogation part of a claim. The third-party investigation is often underemphasized and given low priority in the claim-handling process, as it does not involve the immediate and ongoing demands of issuing benefits. However, given the tremendous impact that a successful recovery program has on the profitability and financial stability to both an insurer or self-insured organization, there is no reason why this should be the case.

The investigation structured framework presented has the following advantages: (1) provides efficiency and effectiveness in identifying subrogation opportunities; (2) identifies those factors (negligence test, subrogation, and recovery rights), which determine the likelihood of, and the amount of recovery; (3) clarifies the analysis and thought process; and (4) provides standardization, which reduces the possibility that a subrogation opportunity would be missed.

The progressive seven-step analysis to third-party investigation that can be applied regardless of jurisdiction or whether the workers compensation carrier or injured employee is pursuing a third party. The approach is considered progressive, since only a positive response to the current step would require the examiner to move forward to the next step: a negative response to any step would rule out a subrogation opportunity. If your investigation allows you to progress through the first six steps, which would mean that there is a potential recovery, the last step would indicate the amount of recovery expected and, hence, if the pursuit of subrogation is economically viable.

Step 1: Obtain a detailed and comprehensive description of the accident from a liability perspective.

A compensability investigation focuses on whether the injury arose out of and in the course of employment. This type of investigation may not provide enough information to determine if the accident was caused by a negligent third party(ies).

Once you have obtained all the facts and circumstances of the accident from the claimant, the insured, and witnesses, and secured all the necessary evidence, you are ready to proceed with the progressive part of your analysis. Again, any step can rule out a subrogation opportunity.

Step 2: Was a third party(ies) involved in the accident?

Identify all third parties involved in the accident. A third party is defined as any person or entity other than the employer or co-employee. Technically, the employer is the first party, since it is the insured on the policy. The claimant is the second party, since he or she is the beneficiary or person receiving benefits provided by the policy.

Step 3: Did the third party(ies) identified in Step 2 cause the claimants' injury and, if so, was the third party at fault?

Of the third parties identified in Step 1, which ones, in your opinion, acted negligently and caused the claimant's injury? To determine if the third party was negligent, all of the following four elements must be satisfied:

1. Was there a legal duty owed to the claimant to act reasonably under the circumstances?

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2. Did the third party breach its legal duty to act reasonably under the circumstances (failure to conform to the standard of care required under the circumstances)?
3. Was there a causal connection between the breach of the legal duty owed and the claimant's injury?
4. Did the claimant incur actual damages (i.e. lost time, medical expenses, and functional loss)?

If your investigation reveals that a third party(ies) satisfied all four elements of negligence, then you should formulate your theory(ies) of liability as concisely as possible based on sound legal principals. The reasonable person standard or rule is used to establish a theory of liability. Defense counsel as well as experienced members of the liability department can be very useful resources in establishing a theory of liability. For the more complex, less obvious, and/or catastrophic cases, particularly products cases, an expert may need to be hired to prove or rule out liability.

Step 4: Apportion the liability between the claimant and the negligent third party(ies) collectively. If the state has a strict liability doctrine, does it apply?

Although apportioning liability is purely judgmental and based on the examiners' experience, it is necessary for two reasons:

1. Determine if the claimant can meet the judicial negligence test to recover any damages.
2. Assist in estimating your recovery if the plaintiff can meet the burden required by statute.

One way to apportion liability is to first establish whether the claimant contributed at all to his or her injury. If the claimant is noncontributory, then the analysis is straightforward and is the same if the case meets the statutory requirement for strict liability—liability is assessed 100 percent against the defendant(s), and the third-party liability case can be valued on a "pure" basis. If the claimant did contribute to his or her injury, then list each contributory action and assign a percentage, of liability to that act, add up the percentages and subtract the final number from 100 percent.

The application of strict liability, if the state has such a doctrine, varies from state to state. The strict liability doctrine is applied to either a product or an activity. It imposes 100 percent liability on the defendant for either of the following defects: manufacture/assembly, design, and warning. Further, certain types of activities are considered ultra hazardous and defined by statute. Strict liability is imposed against the defendant even if the defendant can demonstrate that it exercised all the necessary precautions to avoid injury to the public.

Keep in mind that a third-party claim with multiple defendants can contain a cause of action for both negligence and strict liability. However, if a third-party claim only involves a strict liability action and it meets the statutory requirements, then skip Step 5 and go to Step 6; otherwise go to Step 5 for each third party in which the strict liability test does not apply.

Step 5: Does the claimant meet the negligence test in the state where the accident occurred?

The statutory liability rule or negligence test sets forth the plaintiff's maximum contribution to his or her injury while still being able to recover damages in a civil action. There are four basic types of liability tests that are applied to the behavior of the claimant/plaintiff and one that is applied to the product manufactured by or activity performed by the defendant(s). The plaintiffs' behavior, depending on the jurisdiction, is measured against either the contributory negligence rule or one of four comparative negligence rules: pure, 50 percent, 49 percent, and slight versus gross.

The contributory negligence rule states that if the plaintiff contributes at all to his or her injury, even 1 percent, then he or she is barred from recovery. Comparative negligence rules allow the plaintiff to recover damages despite contributing to his or her injury. However, if the plaintiff meets the burden required by the jurisdiction, the amount of his or her award is reduced by the percentage of liability attributed to his or her actions.

States with a pure comparative negligence rule allow the claimant to recover damages, even if he or she is more at fault than the defendant(s). For example, if the plaintiff was 90 percent at fault, he or she would still be able to collect 10 percent of his damages. The 50 percent comparative rule states that the plaintiff can recover damages as long as he or she is no more at fault that than the defendant(s). The 49 percent comparative rule

states that the plaintiff must be less at fault than the defendant(s). For example, if the plaintiff was 50 percent at fault, he would be able to recover 50 percent of his or her damages in a state that had 50 percent comparative negligence rule, but barred from recovery in a state that maintained a 49 percent comparative negligence rule. Lastly, in a state that has a slight versus gross negligence rule, the plaintiff can recover only if his or her negligence is slight in comparison to the defendant(s). A states' negligence test is usually found in the state statute or code in the section relating to judicial proceedings or court procedure.

One final note, make sure you are applying the negligence law and/or strict liability doctrine of the state where the accident happened, not the state that governs the workers compensation case, also known as the benefit state. It is the benefit state that establishes which subrogation laws apply and the accident state that establishes the applicable negligence and strict liability rules.

Step 6: If the claimant meets the negligence and/or strict liability test, are there any restrictions to your subrogation and recovery rights?

A carrier's subrogation and recovery rights are usually set forth in either the workers compensation statute or case law or both. Either or both establishes a carrier's right to subrogate and to assert a lien as well as to take credit against future benefits from the bodily injury settlement proceeds. Some states, such as New York, afford the workers compensation carrier a third right, the right to consent to the amount of the bodily injury settlement.

Some of the common types of claims or situations in which either the statute or case law may affect a carriers' subrogation or recovery rights are:

1. A carrier's contribution toward plaintiff counsels' fee and expenses.
2. Uninsured motorist (UM) or underinsured motorist (UIM) claims.
3. Certain types of workers compensation settlements.
4. Certain types of civil actions or types of damages awarded.
5. Time limits for filing a notice of motion to intervene to protect the lien, for filing a notice of claim or suit against public entities, and for filing suit against private entities.
6. Employer's contribution to the claimants' injuries and the Made-Whole Doctrine.

The workers compensation statute or case law usually stipulates a carrier's contribution to both the plaintiff attorney's counsel fee and expenses. The amount of the carriers' contribution as well as the priority of the distribution of the settlement proceeds has an obvious impact on its recovery rights. Further, some states require the carrier to pay their pro rata share of the counsel fee on the total projected lien (i.e. the current and future benefits) up front. This is also known as the "Total Benefit Theory."

A carrier's subrogation rights on the proceeds of uninsured motorist (UM) or underinsured motorist (UIM) settlements are stipulated in a state's civil case law. These laws have the largest impact on carriers who have a large auto exposure, such as firms that require their employees to travel or transport people or property. The UM and UIM laws either allow or disallow subrogation rights on all settlements or determine a carrier's subrogation rights based on who owns the policy paying the proceeds. In the latter case, a state would only allow a carrier to assert a lien if the settlement proceeds came from a policy other than the claimant's own policy.

Some states allow the carrier to settle the workers compensation claim in a lump sum, but, in exchange for doing so, the carrier waives it subrogation right on that portion of the lien that represents the lump sum settlement.

Many states have restrictions on a carrier's right to assert a lien on the settlement proceeds of certain types of liability actions and/or types of damages awarded. For example, carriers do not have the right to assert a lien on death claims in Oklahoma or the survival action portion of a wrongful death claim in New Jersey. While a carrier may have a subrogation right on a third-party liability claim, it may not be able to assert a lien on certain types of damages awarded, such as loss of consortium claims, and pain and suffering.

An examiner should always be mindful of any time limitations to protect its subrogation rights. For example, Section 31-293 of the Connecticut Statute requires a carrier to file a notice of motion to intervene in 30 days after it receives notice of suit or it may waive its subrogation right. Further, all jurisdictions have a statute of limitations, which can vary depending on the type of claim, such as for personal injury, medical malpractice, and

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products liability claims. If the third party is a public entity, the time limit for filing a notice of claim or suit is usually shorter than for claims against a private entity. Lastly, each jurisdiction has a statute of repose for claims that involve improvements to real property. Once the carrier or plaintiff attorney fails to protect the Statute of limitations or statute of repose, a carrier's subrogation and recovery rights are waived forever. The time limits to file any type of action can usually be found in the Limitations of Actions section of a state's judicial proceedings.

The Made Whole Doctrine and employers negligence laws have the most profound impact on a carrier's subrogation rights. The former is viewed as more ominous, since it applies to every third-party claim when it has been determined, by either a judge or jury, that the claimant has not been "made whole" from both the benefits received from his or her workers compensation claim and damages from his civil action.[1] The latter applies only when the employer is found to have contributed to the claimant's injury.[2]

Step 7: Considering the factors in step 6, the estimated incurred loss, and the policy limits of the third party (ies), is your potential recovery large enough to justify pursuing subrogation?

The anticipated recovery is a function of the following factors: the estimated incurred loss (paid loss plus reserve), the liability carrier(s) policy limit(s), the strength of the liability case, and the workers compensation carrier's subrogation and recovery rights. As long as there are no statutory restrictions on a carrier's right to assert a lien or recover from the bodily claim, a case with a large estimated incurred loss, high policy limit(s), and strong theory of liability will yield a favorable recovery. If a carrier has to pursue a third party directly, as long as the anticipated recovery is greater than the projected cost of pursuing the third party(ies), subrogation is economically viable.

In summary, the progressive seven-step approach should not only enhance the efficiency of handling a third-party investigation, but also improve the effectiveness of the examiners' long-term recovery results through more frequent recoveries and gross dollars recovered. Clearly, an organization with a better than average recovery record has a competitive advantage in an increasingly competitive and price-sensitive marketplace. ■

Endnotes

1. Georgia's Made Whole Doctrine eliminates a carrier's lien rights, but the following states only reduce a carriers' lien by the amount the claimant is not "made whole": Florida, Kentucky, Arkansas, South Carolina, and, very recently, Montana and Indiana.
2. In North Carolina, if the employer is found to be negligent to any degree, the carrier's lien rights are eliminated. In the following states, the lien is reduced in proportion to the employer's degree of negligence: California, Connecticut, Illinois, Minnesota, and New York (for "grave injuries" only), and Louisiana.

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