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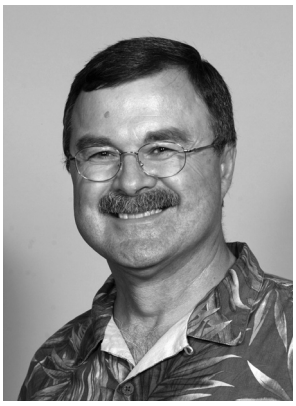
Chairman's Corner

by Robert E. McHenry, CPCU, AIC, AIS



Robert E. McHenry, CPCU, AIC, AIS, is a claims manager with the Westfield Group in Jacksonville, Florida. He earned a bachelor's degree from the University of Akron in 1973, and has served on the Board of Directors of the CPCU Society's Akron-Canton Chapter. He is currently a member of the North Florida Chapter, and in November 2005 began a three-year term as chairman of the Claims Section Committee.

Your Claims Section had a busy and very enjoyable 2006 CPCU Society Annual Meeting and Seminars at the Gaylord Opryland Hotel and Resort in Nashville, Tennessee. Most of us walked our 10,000 steps daily getting around the beautiful and huge facility.

Marcia A. Sweeney, CPCU, was honored as our Claims Section person of the year for her hard work and dedication to the *Claims Quarterly* newsletter. We presented her with an engraved pen at the section lunch. Her term expires in 2007. A subcommittee met, and chose our new editor. **Robert M. Kelso, J.D., CPCU,** has agreed to serve as the incoming editor for our newsletter. Bob was challenged to keep the high-quality standard set by Marcia as a benchmark for all interest section newsletters. Other members of the CQ editorial team are **James W. Beckley, CPCU, Eric A. Fitzgerald, J.D., CPCU, Kenneth R. Hoke, CPCU, Keith D. Mulvihill, J.D., CPCU,** and **Marcia A. Sweeney, CPCU.** All section committee members were challenged to submit at least one article.

The committee met on Saturday, September 9, 2006. Our agenda included:

- Welcoming new members **Eric A. Fitzgerald, J.D., CPCU,** of Marshall-Dennehey, Philadelphia, PA, and **Maureen P. Farran, CPCU,** Crawford & Co., Portland, OR.
- Saying goodbye to members **Ferd J. Lasinski, CPCU,** and **Ralph Riemensperger, CPCU.**
- Section membership is 1,273 as of September 8, 2006 (still the best and biggest).

We celebrated our success after earning another gold level Circle of Excellence Recognition. The subcommittee is **Barbara Wolf Levine, J.D., CPCU, Ray A. Rose, CPCU,** and **Eric J. Sieber, CPCU.** The submission was voluminous and they took steps along with the web site subcommittee to make the 2006–2007 submission go smoother. **James A. Franz, CPCU,** is one of the section governors and a member of the group that grades the submission. He met with us and said that our submission could be a benchmark for all other interest sections. Please be sure to submit your accomplishments via the forms on our web site or the ones available on the CPCU Society web site. Your submissions can be done at any time, and the earlier the better.

Art F. Beckman, CPCU, CLU, ChFC, leads our web site subcommittee. His action items include adding more articles, updating the chairman's message, sending more e-blasts, deleting the calendar function, adding meeting minutes, updating the member list, and photos. The other two members of Art's team are **William D. McCullough, CPCU, CLU, ChFC,** and **Ken Carmichael, CPCU.** Please visit the web site and send any comments or suggestions to Robertmchenry@westfieldgrp.com. Your information will be sent to Art.

John A. Giknis, CPCU, and **Tony D. Nix, CPCU,** once again planned a successful section luncheon for the Annual Meeting and Seminars. They solicited and raised funds to present each attendee with a copy of "Live Like You Were Dying" CD and booklet. They also arranged for two guest speakers from a Nashville law firm representing the music industry. After an excellent lunch and overview of the issues, one of the speakers entertained us with country music songs. He was accompanied by our own Tony Nix. Fifty people attended. John and Tony have a challenge for Hawaii. We will have a breakfast gathering rather than a lunch due to the Annual Meeting schedule and location.

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"What I need most is somebody to make me do what I can."

—Ralph Waldo Emerson

Chairman's Corner

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Donna J. Popow, J.D., CPCU, is our liaison from AICPCU/IIA. One current item on their agenda is a focus group that was established to do a "needs assessment for industry claims training." Then a similar group is being proposed for the CPCU program. **Andy L. Zagrzejewski, CPCU, CLU,** has volunteered to work with Donna.

Tony Nix is the assistant to the chairmens. He attended the section chairmen's meeting. There is an initiative proposed for the section members to be ambassadors and create new levels of membership, value in the sections, and reach out to other organizations such as NAII, PLRB, RPA, etc. Our section works with PLRB, NAII, and RPA at their meetings and local presentations. Thanks again to Tony for attending the meeting for me.

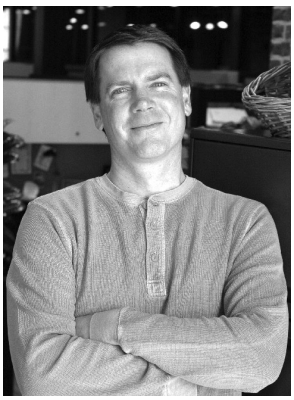
Six seminars were considered for Hawaii, and the list was narrowed down to two. The Annual Meeting Task Force recently selected one: a two-hour seminar entitled, "When the Lit Hits the Fan." This presentation involves a claim where the information obtained during the investigation changes as discovery continues. It will be a fast-paced and fun class!

In Nashville, your section presented three seminars, partnered in two more, and developed another. Several committee members were players in the mock trial where we partnered with the CLEW Section. The seminars are a lot of work and a fun experience. Please volunteer to be a participant or presenter.

I hope to see all of you in Orlando in April, and Honolulu in September. ■

Three Years After *State Farm versus Campbell*—Are the Three Gore "Guideposts" Susceptible of Principled Application Yet?

by Patrick Howe



■ **Patrick Howe** is a shareholder at the San Diego office of Shea Stokes. He focuses his litigation practice on the defense and prosecution of insurance bad faith and insurance coverage matters. He regularly represents insurers in personal and commercial lines matters, including automobile, homeowners, commercial property and liability (primary and excess) and garage claims, and fraud investigations.

In his dissent in *BMW v Gore*, the first U.S. Supreme Court decision to invalidate a punitive damages award for being too high, Justice Scalia declared the three guideposts—reprehensibility, ratio, comparable civil penalties—"[i]nsusceptible of principled application" in the real world of punitive damages litigation. He noted that "[i]n truth, the 'guideposts' mark a road to nowhere; they provide no real guidance at all." He bemoaned the lack of guidance to juries and trial courts as to what a "constitutionally proper" level of punitive damages might be. The "guideposts," he pointed out, "yield no real answers in no real cases." Particularly concerning, he noted, was this: "[T]he court nowhere says that these three 'guideposts' are the only guideposts; indeed, it makes very clear that they are not—explaining away the earlier opinions that do not really follow these 'guideposts' on the basis of additional factors, thereby 'reiterating our rejection of a categorical approach.' In other words, even these [guideposts], if they should ever happen to produce an answer, may be overridden by other unnamed considerations."

That was in 1996. Since then, *State Farm v Campbell* has been decided. Has *Campbell* done anything to assuage Justice Scalia's concerns? Probably not. Take, for example, the ratio "guidepost." On one hand, the court stated few awards exceeding a single-digit ratio (i.e., 9 to 1) between punitive and compensatory damages will satisfy due process. On the other hand, however, the court added that an award of more than four times compensatory damages might be close to the line of constitutional impropriety. Then, on yet another hand, the court opined that when compensatory damages are substantial, a lesser ratio, perhaps one to one, may reach the outermost limit of due process. On still another hand, the *Campbell* court cautioned that it was not imposing a bright-line ratio, which a punitive damages award cannot exceed. Finally, the court capped off this ratio analysis with what Justice Scalia might describe as "unnamed considerations": conduct causing physical harm is more deserving of punitive damages punishment than economic loss; a larger ratio might be constitutionally proper where a particularly egregious

act has resulted in only a small amount of economic damage or damages are otherwise hard to prove; a lesser ratio, perhaps only equal to compensatory damages, might be acceptable where compensatory damages are substantial.

It's no wonder, then, that Scalia dissented in *Campbell*, once again stating that the "punitive damages jurisprudence which has sprung forth from *BMW v Gore* is insusceptible of principled application . . ."

But not all hope is lost. Although juries and trial courts may have no more real guidance now than when *Gore* was decided nine years ago, looking at the cases that have come down since *Campbell*, one can arguably see some trends starting to emerge on at least one of the three "guideposts"—ratio. And for defendants trying to forecast possible punitive damages exposure, this is the most important guidepost of all.

Ratio "Trends"

At the American Conference Institute's April 2005 seminar on punitive damages, they handed out a very helpful chart of post-Campbell punitive damages opinions, broken down by state. Looking at the breakdown, a number of trends, if they can be called that, are emerging:

- First, for the most part, *Campbell's* single-digit ratio rule is being implemented. Of the 58 cases studied, 41 (71 percent) involved single-digit ratios; 17 (29 percent) involved double-digit ratios.
- Second, for those cases approving double-digit ratios, the courts generally have rationalized their conclusions by adopting one or more of the *Campbell* fudge factors, such as low economic damages or damages that are difficult to prove (e.g., nominal damages).
- Third, in California, reported decisions have involved a single-digit ratio. In fact, for bad-faith cases, a 4-to-1 ratio has been the norm. The higher ratios have generally been in cases involving serious bodily injury or death caused by very reprehensible conduct. In fact, one of the highest (9 to 1 in

Boeken v Phillip Morris) involved a cigarette company that fraudulently targeted the youth market for cigarette sales. As one commentator at the ACI seminar noted, unless one is representing a tobacco defendant, this presents a very persuasive argument:

> Judge, just think about it. If a cigarette company that intentionally sells a known deadly product to kids can be held to no more than a 9-to-1 ratio, my poor client should be subject to a much lower ratio.

Other Post-*Campbell* Issues

The anticipated ratio that a trial court might impose is further complicated by how one defines "compensatory" damages. The *Campbell* court held that "few awards exceeding a single-digit ratio between punitive and compensatory damages, to a significant degree, will satisfy due process." But some states do not allow punitive damages for non-tort liability. What if the jury awards both tort and non-tort compensatory damages? And what about attorneys' fees or costs imposed because of tortious conduct? Should they be considered? A few cases have dealt with these issues.

For example, in *Textron Financial Corp. v National Union Fire Ins. Co.*, a 2004 California bad-faith case, the court determined the relevant compensatory damages award for ratio purposes was the money awarded for tort damages under the bad-faith and fraud claims. But the court excluded those damages awarded for breach of contract.

On the other hand, in *Simon v San Paolo U.S. Holding Co.*, the California Court of Appeal held the amount of *harm*, rather than the actual compensatory damage award, should be used to calculate the ratio. In *Simon*, the plaintiff sued for specific performance on an alleged contract to purchase real property. The purchase price of the building was $1.1 million, but the appraised value was $1.5 million. Although the plaintiff received a compensatory damage award of only $5,000 for out-of-pocket expenses, the "effect" of the defendant's conduct was that plaintiff had lost a benefit of the bargain in the amount of $400,000. The Court of Appeal approved the use of the $400,000 "harm" in the ratio calculation. The California Supreme Court, however, reversed, finding that under the specific facts involved, the ratio could be based only on the actual compensatory damages.

The Third Circuit of Appeals in *Willow Inn v Public Service Mutual Ins. Co.* considered the attorneys' fee issue. There, the insured inn was damaged in a windstorm. The jury awarded $2,000 in actual compensatory damages. The trial court also awarded $132,000 in attorneys' fees and costs. The total punitive damages

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awarded were $150,000, resulting in an approximate 1-to-1 ratio. The appellate court affirmed. The ratio would have been 75 to 1 without the attorneys' fees and costs.

One other issue that warrants mention: evidence of the defendant's wealth. In *Gore* and *Campbell*, the U.S. Supreme Court did not completely preclude the use of defense wealth in the punitive damages calculation. Instead, it merely held that such evidence cannot save an otherwise constitutionally improper punitive damages award. California decisions continue to allow consideration of wealth in the punitive damage phase.

Practice Tips

Although ratio seems to have received all of the attention in post-*Campbell* cases, Justice Scalia's concerns about the practical application of all three guideposts continue to ring true. Trial courts continue to struggle with the issue of ratio, what evidence is admissible on reprehensibility, etc. For example, California's new CACI instructions, including instruction 3940, do not contain any information about the three guideposts. The Advisory Committee notes that the state of the law post-*Campbell* is rapidly developing and, given this, the committee has elected not to make any substantive modifications to the instructions on punitive damages. Instead, the committee advises that the court in each individual case should assess whether changes to the standard instructions are appropriate.

Thus, be prepared to discuss "guidepost" issues with the trial judge in chambers. Issue number one should be whether the jury should be instructed about any of the guideposts. The *Campbell* court indicated the jury should be instructed on the relevance of out-of-state similar acts. But is this wise? Yes, a reviewing court is required to conduct a *de novo* review of any challenged punitive damages award under *Cooper Industries*. But one could argue it is better to leave the guidepost issues to the trial judge or appellate court, not the jury. If the jury is allowed to consider the guidepost issues, a defendant may face arguments that the trier of fact has already considered these issues and its decision should be given great deference.

Whatever the case, a post-trial motion should not be the first time the "guideposts" are addressed. Discovery and pre-trial activities should focus on each of the three guideposts. Among other things:

- The defense should consider conducting discovery on a plaintiff's financial condition. In the past, it was common practice to accept the fact that a plaintiff's financial condition is irrelevant unless some type of loss of profits claim is being made. But one of the considerations under the reprehensibility guidepost is whether the plaintiff is financially vulnerable. Written and deposition discovery can be conducted on the issue. Find out about the plaintiff's assets and liabilities, as well as his or her income and expenses. If the issue is pressed hard enough, and the plaintiff does not want his or her financial condition revealed, the punitive damages claim might be voluntarily dismissed or stricken as a discovery sanction.
- Likewise, the defense should check its own house for vulnerability facts. For example, in a bad-faith case, are there comments in the claim file that the insured is having money problems because the claim is taking too long to resolve? Were advances refused even though the adjuster was aware of this?
- Demand a §402 hearing (*California Evidence Code* §402) on any similar acts evidence. The *Campbell* court held that evidence of similar out-of-state conduct cannot be used to punish a defendant, but that it can be probative to show the deliberateness or culpability of a defendant's action within the forum state. The crucial issue is whether the "other" acts are "similar" or "dissimilar." The plaintiff has the burden to prove that the proposed evidence is similar in nature to the individual conduct at issue in the case and must also show a nexus between the similar acts and the harm suffered by the plaintiff. If this evidence can be kept out at trial, there is less information to support any reprehensibility argument.
- Be aware of new case law on discovery on similar acts. After *Campbell*, it looked like the defense would be able to severely limit any similar acts discovery by plaintiffs. Two recent cases have changed the analysis somewhat. In *Saldi v Paul Revere Ins. Co.* (E.D. Penn. 2004) 224 FRD 169, a disability bad-faith case, the district court ordered the insurer to turn over volumes of documents that might show a nationwide pattern and practice of rejecting valid disability claims. Similarly, in *Permanent General Assurance Corp. v Superior Court* (2004) 122 Cal.App.4th 1493, a California bad-faith case, the court-approved plaintiff's discovery requests in a case alleging discriminatory handling of her vehicle theft claim. The plaintiff had requested claims files for other insureds with claims similar to hers. The court held that, while *Campbell* limits the use of similar acts, it does not make the use of such evidence a "universally irrelevant or inadmissible, because conduct towards others may, in the appropriate case, tend to prove the existence of the same conduct toward the plaintiff." *Id.* at 1498.

Conclusion

In short, Justice Scalia was right, to some extent, that the *Gore* guideposts are impossible to apply with any practical meaning. But the trial and appellate courts appear to be doing the best they can. Most importantly, the ratio-related holdings give some hope for a way, no matter how imprecise it may be, to help clients anticipate a range of punitive damages exposure. ■

CPCU Ethics and the Adjuster

by Jonathan G. Stein, J.D., CPCU

Jonathan G. Stein, J.D., CPCU, is a plaintiff's attorney in Sacramento, CA, as well as a board member of California Young Lawyers Association.

Stein earned his B.A. in economics from California State University, Sacramento in 1995. He then began his adjusting career with Prudential Insurance. While at Prudential, Stein began the CPCU program and completed it in 1998. At that time, he was employed by CIGNA. Subsequently, Stein worked as an adjuster at Crawford & Company. In 2002, he earned his J.D. from McGeorge School of Law with distinction.

Stein now is the principal of the Law Offices of Jonathan G. Stein where he also does expert witness work.

Introduction

No, this is not another lecture on ethics. I am not going to tell you to be ethical. That serves no purpose. I am also not going to tell you what to do and what not to do. That, too, serves no purpose. Instead, I want to take a look at the CPCU Ethics codes as "living" documents and how these documents effect claims.

I guess I first need to remind everyone that those of us who earned our designations after 1977 are bound by the AICPCU code and the CPCU Society code. (I am class of 1998, so I am bound by both.) Those of you who earned them before 1977 could voluntarily elect to be bound by the AICPCU code. I am going to assume that most of us reading this are bound by both. Even if you were not, I would urge you to follow both codes.

The CPCU Society's Code

The CPCU Society's code, which I am sure you have all read, but which is available on the web site, is broken down into two sections: specified unethical practices, and unspecified unethical practices. It probably makes sense to start with the specified practices.

Specified practice one is not to violate any law or regulation. This should be a slam-dunk. Don't break the law. Okay, so most of you know not to embezzle. But, this practice is much broader. For example, each state has a Fair Claims Settlement Practices Act. Do you read it? Are you certified by it? In California, the act requires you to be certified yearly. How many of you who handle claims in California have done that? And, if you have not, are you breaking the code?

Clearly, it is a regulation, and if you have not certified yearly, you are breaking the code. But, really, does it matter? Yes. If you start cutting corners, then the designation loses its luster. If it is okay not to certify, is it okay not to explain coverages to the insured? Is it okay not to explain denials to the insured? Is it okay to take a kickback? Where do you draw the line? The code must be followed fully.

Second, you cannot "willfully misrepresent or conceal a material fact in insurance and risk management business dealings." Willfully misrepresent? Okay, so you cannot lie. But, this is pretty broad. It also means you must do certain things. If an insured has a loss, you **must** tell the insured about all coverages that apply. You must advise the insured about what he or she is entitled to, such as choosing his or her own contractor, or body shop.

The third regulation requires you not to breach the confidential relationship with your client. This is interesting from a claims perspective. Obviously, as an attorney, I cannot breach my attorney-client privilege. But, what about the adjuster who is told something by the insured? Is there a relationship? What if the insured has a fire and says "It happened when the light for my marijuana plants exploded?" Can you share that with someone else?

While the regulation is rigid, this regulation I think must be interpreted more flexibly. For example, the insured who tells you that he or she committed fraud must be turned in to the authorities. It is your obligation to your employer, and the insured has no expectation of privacy. But, the insured who tells you that his son smokes dope probably does not require you to breach the confidentiality. Remember, the code must be a living document. Your judgment, and we know you have it because you went and earned your CPCU, must be used based on the facts presented.

Do I even need to talk about number four? To willfully misrepresent the nature or significance of the CPCU designation? If you do it, not only should you lose the designation, but we should all get a whack at you with a cane. The CPCU designation was the hardest thing I have

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CPCU Ethics and the Adjuster

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done educationally, and I am an honors graduate of a very good law school. Not only do you owe it to yourself not to misrepresent it, you owe it to all of your fellow CPCUs.

Number five is a lot like number four. Do not tell anyone you represent the Society unless you do. This has no gray area. If you are in doubt, then you ask for someone to put it in writing. The old adage that it is easier to ask forgiveness than permission does not apply when it comes to representing the Society.

Number six should be one of those no-brainers: don't aid or abet unethical practices. If it is not okay for you to misrepresent the nature of the designation, why would it be okay for you to assist someone in doing that? You cannot circumvent the rules by having someone else break them for you!

Finally, lucky number seven should be straightforward, but is it? If you have been told to stop a behavior and you engage in it, you are violating the rules. But, what if the behavior is such that you must do it? For example, if the board tells you that you must stop doing X, but you are bound to do X by another set of rules, what do you do? Well, hopefully, when you received the cease and desist you brought this up to the board, but if you didn't, have no fear. You must have faith that once you do, the board will agree with you!

The next three practices are "unspecified." This starts getting harder. These are:

1. A member shall not engage in practices which tend to discredit the CPCU Society or the business of insurance and risk management.

2. A member shall not fail to use due diligence to ascertain the needs of his or her client or principal and shall not undertake any assignment if it is apparent that it cannot be performed by him or her in a proper and professional manner.

3. A member shall not fail to use his or her full knowledge and ability to perform his or her duties to his or her client or principal.

Okay, so it boils down to this: in handling claims, don't do anything to discredit the insurance industry, put the needs of the insured first, and if you cannot do that, do not take the assignment, and remember to use all of your skill. Maybe an example would be best. If you are handling a claim, and your supervisor says "Look, we might owe this person a lot of money, see what you can do to keep our payment as low as possible" (not that this would ever happen, but the extreme example is always best), you have an obligation as a CPCU to tell your supervisor that you cannot do that because it would discredit the industry, it would be putting the insurer's needs first, and it would not be using your full knowledge.

The Institute's Code

The Institute has canons and rules that explain the canons. Similar to the CPCU Society, the Institute's code is on the web site. The canons are the important things (that would be the legal term we use in California), and the rules help explain specific behaviors that are unethical under the canons. For simplicity, I am going to focus on the canons and not the rules.

Canon 1 is relatively easy. Place the public's interest above your own. Okay, for those of you want more, try this: go out and start educating the public about insurance. What is covered, what is not covered, why things happen the way they do. As CPCUs, we have special knowledge. As insurance claims professionals, we have insight into the hardest part of insurance for most people—what happens when they have a claim. Call your local high school and see if you can go talk about insurance.

Canon 2 requires you to maintain and improve your knowledge. Those of you who are CPD qualified continue to do this. Those of you who do not, need to start attending continuing education programs. The claims business has changed. When I started as an adjuster, there was not much concern about mold. Now, every time a policyholder calls me after a water claim, he or she wants to talk about mold. You have to go out and educate yourself about these issues.

Canon 3 reminds me of the hypocratic oath—first do no harm. (I assume you all do the first part of the canon—obey all laws.) But, as adjusters, we sometimes are in a position where we could do something that might harm someone else. For example, we may know that the home that was damaged was built in 1970. We may know that there is a potential for asbestos. Under Canon 3, you are obligated to let the insured know about this, even if there is no regulation that tells you to do this.

Canon 4 requires you to be diligent and strive to improve insurance. Since, again, I trust that those of you reading this are diligent, let me focus on the second part: improving the function of insurance. I don't know how many of you have seen the claim process from my end (plaintiff/policyholder), but I assure you the view is different. How can you improve the function of insurance? The easiest way is for the rotating adjuster theory of claims to be stopped. In one claim, I can deal with five people: the property damage adjuster, the liability adjuster, the total loss adjuster, the bodily injury adjuster, and the processor, whatever that is. Not only is this inefficient, but it creates confusion on behalf of the claimants. Work to create a system that makes insurance companies easier to deal with for the public.

Under Canon 5, you should assist in raising the standards. Talk to others in the business about the value of the CPCU designation. I know the designation has

opened doors for me. But, it also changed my outlook on insurance. It made me realize that insurance is not necessarily a career, but a profession. There is a perception that claims people do not want to earn the designation. Talk to your fellow adjusters, explain the benefits to them, and encourage them to start their studies. If more adjusters would obtain the designation, the image of the adjuster as a whole would increase.

Canon 6 requires you to maintain honorable relationships with those whom you serve and other insurance practitioners. If you want to be ethical under this Canon, the easiest way is to work professionally with your vendors and fellow adjusters, but also with the insured. Remember, you have to maintain a dignified relationship with "those whom [you] serve." Do not try to "pull a fast one" or "low ball" an insured. Be fair; be honest.

Canon 7 tells you to improve the public understanding of insurance. If you do all of these other things (like speaking to the high school, explaining the policy to the insured), then this canon is easy!

Finally, Canons 8 and 9 require you to honor the designation and respect its limitations and to assist in maintaining the integrity of the Code. Do not tell people that the designation is something more than it is. But, do not let others dishonor the CPCU. We have all heard the CPCU jokes, and those are funny, but there are those out there who will take shots at the designation and our Code of Ethics. To remain a professional, you need to make sure that you honor the designation and do not let others bring down the designation and our Code of Ethics.

Conclusion

The ethical rules we bound by are not strict rules that are to be adhered to at all costs. Rather, they are living documents that must be used as a guide to help you determine the proper course of conduct in different situations. No one rule tells you how to handle claims, but if you take the rules and the canons, not only in word, but in spirit, you can ethically adjust claims. ■

Learn to Do the Impossible from Author James Bradley

Attend the CPCU Society's **2007 Annual Meeting and Seminars** to hear **James Bradley,** a bestselling author and exceptional motivational speaker, deliver a compelling Keynote Address, brimming with valuable lessons for today's leaders.

Author James Bradley will deliver the Keynote Address at the Society's 2007 Annual Meeting and Seminars in Hawaii.

Bradley is the author of *The New York Times'* bestseller book *Flags of Our Fathers*, which chronicles the lives of six men, including his father, who fought through a hail of mortar and machine-gun fire to raise the American flag at Iwo Jima in 1945. The book was made into a 2006 feature film, produced by Steven Spielberg and directed by Clint Eastwood.

In his Keynote Address, also entitled "Flags of Our Fathers," Bradley will use key moments in America's history to dramatically illustrate how ordinary people did the impossible by thinking "outside the box." Be there in person for this thrilling presentation that will challenge you to move beyond the "impossibilities" in your own life.

Register Today!

Visit **www.cpcusociety.org** to register online and for the latest information on the 2007 Annual Meeting and Seminars, being held September 8–11 in Honolulu.

Identifying Possible Medical Provider Fraud

by Doug Martin, CPCU

Doug Martin, CPCU, has been an employee of State Farm Auto Insurance for 19 years, the past nine years in a Special Investigative Unit (SIU). During his 19 years with State Farm, Martin has handled all types of auto claims including first-party property damage, medical payment, and uninsured and underinsured claims, as well as third-party property and injury claims. His current duties in the SIU Unit include investigating and handling first-party claims, such as possible auto theft and arson claims, auto theft claims, and stolen vehicle equipment claims. He has also handled investigations for homeowner theft losses for the State Farm Fire Company.

In addition to these first-party losses, while in SIU, Martin has worked on several medical provider investigations and multi-claim investigations focusing on billing issues, medical payment coverage issues, possible provider and attorney relationships, and patient solicitation. Martin is the coordinator for his zone's SIU web site and is an active member of IASIU (International Association of Special Investigative Units). Martin received his CPCU designation in 2003.

Medical provider fraud: As an insurance professional, it's possible you'll run across it, or at least suspect you have. But how do you find medical provider fraud or even begin to try to identify it? In this article, I'll discuss some ideas that may assist you in identifying situations in which a medical provider may be involved in questionable billing practices. Please keep in mind these are only indicators to identify possible medical fraud issues. This article is not intended to be the definitive word on medical fraud investigations. Although an indicator may exist, it does not mean the medical provider is engaged in fraudulent activity. It simply means in order to resolve the issue, you'll have more work to do. If you suspect you have identified a medical fraud issue, you should review the information with your management or your company's Special Investigative Unit.

First, let's take a quick look at the bigger picture.

The ***Coalition Against Insurance Fraud*** on its web site indicates that 80 percent of healthcare fraud is committed by medical providers, 10 percent is committed by consumers, and the balance by other sources. The ***Coalition Against Insurance Fraud*** web site also cites information stating that fraud adds $5.2 to $6.3 billion to the auto premiums that policyholders pay each year. Of course, these numbers affect everyone including the companies paying on these claims, the claim representatives handling the claims, and of course, the policyholders whose premiums are higher. Obviously, this is a huge problem, so how do you as a claims professional start to get a handle on potential medical provider fraud?

If you have visions of a huge sting operation, conducting surveillance, or filing a RICO action in federal court, you'll need to do some good old-fashioned investigating first. While conducting claim investigations, you'll see a variety of medical bills from many different medical providers. Indicator number one—does it seem that a certain provider is involved in more of your claims than others? Again, while this information alone is not indicative of medical fraud, it may give you a good basis to inquire further.

Once you have identified a provider that you feel may warrant additional investigation, consider checking your company's claim data information. While all companies have different data systems, most have a way to search for claim frequency information. In other words, check company data, either through the name of a provider, their address, or the Tax Identification Number (TIN), and attempt to verify the number of claims in which the medical provider is involved. If possible, your company's accounting department can give you an idea of the total payments issued to the medical provider over a specific period of time. Once again, I must stress, this information alone does not mean the medical provider is involved in a medical fraud issue. Indicator number two—are the frequency of payments and the amount paid to the provider disproportional to other medical providers in the given area? There is no magic number or percentage of claim payments or a dollar amount that will automatically tell you that a medical provider is engaged in medical fraud. However, if a provider suddenly seems to be unusually active in the area and your data collection supports that perception, then a closer look into the business practice is critical.

So what's the next step in this process? Unfortunately it is not very glamorous, however, it is very important. You'll need to start reviewing claim files, which involve the medical provider you have identified above.

While reviewing the claim files, keep an eye out for indicator number three—a pattern of ongoing activity. Patterns of concern could include the location of the accident. Do the accidents take place in the same geographical area? Is there a familiar theme to the facts of the accident? Are the accidents similar in the type of property damage, such as minor, low-impact rear bumper damage? While continuing your claim file review, consider indicator number four—why the injured parties decided to treat with this particular medical provider. Did they receive a referral from a friend or relative? Did they find out about the medical provider through an advertisement such as a mailing or through a newspaper? Did the medical provider solicit the injured person by telephone or a personal visit? Once again, this pattern of behavior alone does not mean a provider is committing medical fraud. While you continue to identify the indicators, it's essential you keep an open mind and continue your investigation.

Internal database searches and file reviews can yield associations with medical providers that are significant in your investigations. Indicator number five—is the injured party treating with the medical provider represented by an attorney? Is there a pattern of the same law firm representing individuals treating with the same medical providers? Is the medical provider assisting the patient in locating legal services? What point in the claim process was the attorney retained? If the association exists, it doesn't mean that there's medical fraud occurring; however, this may be one more piece to a very complicated puzzle, which leads you deeper into your investigation.

There can be any number of issues with indicator number six—medical bills. The topic of reviewing medical bills could be an article all to itself. Often medical professionals are consulted to review bills for coding issues, but since we are only talking about identifying possible medical provider fraud, let's keep it simple.

The first review of the medical bills should be for the dates of service on the medical bill submitted. Do they match the dates indicated on the medical records? Are any of the service dates related to treatment on a Saturday or Sunday? Anyone who has tried to locate a doctor on the weekend to obtain medical services knows this is very difficult, and the odds of a particular medical provider providing services on a Saturday or Sunday are pretty slim. However, treatment on Saturday or Sunday is not out of the question, and you'll need to verify the treatment dates. Also, take a look at the medical records themselves. Are the medical records handwritten or typed? Have the treatment notes been copied from other records? With today's computer technology, "cookie cutter" reports can be created from a database of stored medical information, then cut and pasted into a medical report.

The information in the medical report may or may not reflect the medical condition of the patient. Look for similarities when reviewing medical records for multiple individuals involved in the same loss and treating with the same medical provider. I have reviewed medical records that are word-for-word copies for each person being treating.

Further, you'll need to consider if the medical reports appear to be copies from a copy machine with the patient information filled in. In other words, does it appear generic notes are being copied with "blanks" filled in for each particular patient? I have seen a record where the "blank" indicating time off of work was filled in "four weeks." The patient was an 11-year-old boy. Coincidently, his mother also missed "four weeks" of work.

While reviewing the medical bills, consider what type of treatment the patients are receiving, again especially if there are multiple patients in a particular claim file. Would you expect a 20-year-old man to receive the exact same treatment as his 50-year-old mother and his 75-year-old grandmother who were both passengers in his vehicle? Patient treatment should be based on their individual needs as a result of their injury, age, and physical condition. The same treatment on the same day may be a sign that no individual treatment plan is being considered and, therefore, more investigation is needed.

Finally, if patients are not legally represented, the most obvious investigative tool would be to speak with them. How did they choose this particular medical provider? What was their treatment like, how long did it take, and who actually performed the services? You can verify dates of treatment with the injured party. Did they really treat five days a week for four weeks? Billing for services not rendered is obviously a huge indicator of potential fraud. These conversations or statements can lead to a wealth of information about medical providers, how they operate, and whether they are actually helping individuals recover from their injuries.

After you have carefully gathered and reviewed the information described above, you'll need to make a decision to proceed with your investigation or not. You must consider the totality of your investigation when reviewing your decision. A single event is not clear evidence of medical fraud. A combination of indicators over the course of your investigation should be considered.

Each claim should always be handled on its own merits. If you believe you find patterns of activity, inconsistencies in medical bills and documentation, or discrepancies between the medical records and the statements of the injured party, then you may want to consider discussing your findings with your management, or Special Investigative Unit. ■

Reference

Coalition Against Insurance Fraud web site, http://www.insurancefraud.org/index.html.

Coverage Gone Mild: Sixth Annual Look Back at the Year's 10 Most Significant Insurance Coverage Decisions

by Randy J. Maniloff

Randy J. Maniloff is a partner in the business insurance practice group at White and Williams, LLP in Philadelphia. He concentrates his practice in the representation of insurers in coverage disputes over primary and excess policy obligations for various types of claims, including construction defect, mold, general liability (products/premises), environmental property damage, asbestos/silica, and other toxic torts, first-party property, homeowners, director's and officer's liability, a variety of professional liability exposures, including medical malpractice, media liability, community associations, public official's liability, school board liability, police liability, computer technology liability, managed care, and additional insured/contractual indemnity issues.

The views expressed herein are solely those of the author and are not necessarily those of his firm or its clients. The author expresses his appreciation to firm associate Brad Pollack for his invaluable assistance with the preparation of this article.

Editor's note: The following article is an "excerpt" from the author's 23-page article that appeared in the January 9, 2007, issue of *Mealey's Litigation Report -Insurance*. Please feel free to contact the author for a copy of the full article at maniloffr@whiteandwilliams.com.

The article presented here will discuss the top 10 cases and provide the full discussion on three of the cases that we thought would be of most interest to the majority of the *CQ* readers.

While normally more fun than a barrel of monkeys, in 2006, insurance coverage was more like a couple of goldfish in a bowl. As hard to believe as it is, the heretics who claim that coverage can be a little bland enjoyed a rare I-told-you-so moment last year. Well, even a broken clock is right twice a day.

So how could this have happened? In 2006, the nation's highest state courts seemed to serve more decisions than usual addressing meat and potatoes coverage issues. Some years these courts pepper the basics with fusion cuisine. This wasn't one of them. Not to say that the buffet wasn't satisfying; the fare was simply claim vanilla. And since this annual insurance coverage year-in-review is usually cooked up with dish-isions selected from high court menus, it took a little extra foraging to find the tasty morsels. Thankfully, it wasn't a complete famine and there were still a few things to chew on. The coverage world didn't lay a complete egg.[1]

The following 10 coverage decisions are from the smorgasbord of the year gone by that are likely to play a significant part in setting the insurance coverage table in the years ahead.

The selection process operates throughout the year to identify coverage decisions that are most likely to impact a large number of subsequent claims. Those chosen usually, but not always, hail from state high courts and may (1) involve a frequently occurring claim scenario that has not been the subject of many, or clear-cut, decisions; (2) alter a previously held view on a coverage issue; or (3) involve a burgeoning coverage issue. The process is highly unscientific. There is no point system, blue-ribbon panel, or telephone voting, as in *American Idol*. Much like a dog show, the judging is very subjective, but does not want for hand wringing to narrow the field to those you see here.[2]

The following are the 10 most significant insurance coverage decisions of 2006 (listed in the order that they were decided):

- ***Peninsula Cleaners v Hartford Casualty Insurance Company***—Three years after MacKinnon's yellow jackets severely limited the absolute pollution exclusion, a California District Court (and others in 2006) demonstrated that insurers are not feeling the sting in every case.
- ***Contreras v U.S. Security Insurance Company***—Insurer had two choices and each was bad faith. Florida appeals court addressed whether insurers can get squeezed in the Sunshine State.
- ***French v Assurance Company of America***—Fourth Circuit made toast of a common interpretation of the "subcontractor exception" to the "your work" exclusion.
- ***Brannon v Continental Casualty Company***—Supreme Court of Alaska gave an insurer a chilly reception to its argument that the statute of limitations on an insured's action for breach of the duty to defend began to run from the time of the disclaimer. Two weeks later the Supreme Court of Nebraska did the same.

- ***Patrons Oxford Insurance Company v Harris***—High Court of Maine addressed a coverage issue as old as the state's crustaceans and still with no easy answers: The insured is presented with an opportunity to settle a case and turns to its insurer, which asserts that it has a coverage defense.
- ***Safeco Insurance Company v Superior Court of Los Angeles County***—A California appeals court addressed the burden of proof in an important contribution context. The result—more insurers can now share the burden of construction defect settlements.
- ***Guideone Elite Insurance Company v Fielder Road Baptist Church***—Don't Mess with the Duty to Defend. Supreme Court of Texas refused to consider facts outside the complaint to extinguish an insurer's duty to defend. Pennsylvania Supreme Court did the same in refusing to create a duty to defend.
- ***The Standard Fire Insurance Co. v The Spectrum Community Association***—A California appeals court added a sub-plot to insurance law's greatest work of fiction: the continuous trigger.
- ***Fiess v State Farm Lloyds***—In a long-awaited decision, the Supreme Court of Texas sang Mold Lang Syne to policyholders in many circumstances.
- ***Valley Forge Insurance Company v Swiderski Electronics, Inc.***—Face the fax: Supreme Court of Illinois transmitted an important win for policyholders in the most significant Telephone Consumer Protection Act coverage decision to date.

Significant Insurance Coverage Decisions of 2006

French v Assurance Company of America, 448 F.3d 693 (4th Cir. 2006).

The number of decisions in 2006 addressing coverage for construction defects—including at the state high court level—was staggering. And more are on the way, based on certified questions that are in the works. The question whether faulty workmanship or breach of contract constitutes an "occurrence" is the latest great debate in the coverage world. Indeed, three of the 10 cases discussed in this commentary are related to construction defect. It is unfortunate that the situation has reached this point.

Consider this. When it comes to claims for latent injury and damage, such as asbestos and hazardous waste, they were never contemplated under the historic policies that were called upon decades later to respond. That being so, it is not surprising that questions such as trigger and allocation were viewed by courts as particularly vexing, with the result being the development of different schools of thought in response to the issues. But claims for coverage for construction defects and the damage they cause are much different. It is unquestionably contemplated that such claims will be made under commercial general liability policies, especially when the insured has the word "contractor" in its name. Thus, it is unfortunate and unnecessary that so much disparity and confusion are developing in case law over the treatment of such claims, especially those involving relatively similar facts and often-times identical policy language.

In *French*, the Fourth Circuit was confronted with routine facts in a construction defect coverage case. In 1993, the Frenches contracted with Jeffco Development Corporation for the construction of a single-family chalet in Fairfax County, Virginia. Pursuant to the construction contract, *and via a subcontractor*, the exterior of the home was clad with a synthetic stucco system known as Exterior Insulating Finishing System, and even better known as EIFS. A Certificate of Occupancy for the Frenches' home was issued in December 1994. In 1999, the Frenches discovered extensive moisture and water damage to the otherwise nondefective structure and walls of their home resulting from defects in the EIFS. The Frenches spent in excess of $500,000 to correct the defects in the EIFS and to remedy the resulting damage to the otherwise nondefective structure and walls of their home. *French* at 696.

The Frenches filed suit against Jeffco alleging multiple claims, including breach of contract, and sought damages to cover the costs to correct the defects to the EIFS and to remedy the resulting damage to the otherwise nondefective structure and walls. *Id.*

The Frenches' suit gave rise to claims by Jeffco for coverage from four commercial general liability insurers. Three of the CGL insurers agreed to defend Jeffco and one declined. Just before trial, the Frenches and Jeffco reached a settlement. The settlement included a confession of judgment by Jeffco and the assignment by Jeffco to the Frenches of Jeffco's rights under certain policies. The Frenches, as assignees of Jeffco's rights, brought suit against two of the insurers. *French* at 698-699.

Cross motions for summary judgment ensued and the District Court of Virginia, applying Maryland law, granted summary judgment for the insurers and denied the Frenches' motion for partial summary judgment. The District Court relied on *Lerner Corp. v Assurance Co. of Am.*, 707 A.2d 906 (Md. Ct. Spec. App. 1998), in concluding that no coverage existed under the policies pursuant to the express exclusion of coverage for property damage expected or intended from the standpoint of the insured. *French* at 699.

The parties marched on to the Fourth Circuit, which held that the District Court was half right:

> We hold that, under Maryland law, a standard 1986 commercial general liability policy form published by the ISO does not provide liability coverage to a general contractor to correct defective workmanship performed by a subcontractor. We also hold that, under Maryland law, the same policy form provides liability coverage for the cost to remedy unexpected and unintended property damage to the contractor's otherwise nondefective work-product caused

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> by the subcontractor's defective workmanship. With respect to this last holding, we assume arguendo that no other policy exclusion applies. *French* at 706.
>
> Thus, the Fourth Circuit held that the costs to correct the defective EIFS were not covered, but coverage was available for damage to the nondefective structure and walls of the Frenches' home that resulted from moisture intrusion through the defective EIFS.

On its face, there is nothing remarkable about the Fourth Circuit's decision. Courts addressing coverage for construction defects routinely draw a distinction between noncovered damage *to* an insured's work versus damage *caused* by an insured's work, for which coverage is available.

But the Fourth Circuit's decision in *French* was a little different. There, the EIFS was installed by a subcontractor of the insured-general contractor, Jeffco. In a situation like this, it is not uncommon for those involved in construction defect coverage matters to point to the involvement of a subcontractor as the basis to depart from the ordinary rule that coverage is unavailable for damage to an insured's work. As such, the argument is now often made that coverage exists to correct defects in a subcontractor's work. The asserted basis for this departure is the "subcontractor exception" to the "your work" exclusion, which provides as follows:

> l. Damage to Your Work
> "Property damage" to "your work" arising out of it or any part of it and included in the "products-completed operations hazard."
>
> This exclusion does not apply if the damaged work or the work out of which the damage arises was performed on your behalf by a subcontractor.

However, the flaw in this argument is that the *subcontractor exception to the your work exclusion* is not called the subcontractor exception to the occurrence requirement. The *French* court recognized this and concluded that, notwithstanding that the EIFS was defectively installed by a subcontractor, such defective application does not constitute an accident, and, therefore, is not an occurrence under the CGL policy. The court reviewed the history of the development of the CGL policy's "subcontractor exception" to the "your work" exclusion before arriving at this conclusion. Therefore, coverage was unavailable for the costs to correct the defective EIFS—*subcontractor or no subcontractor*.

In the interest of being fair and balanced, see *Great American Insurance Company v Woodside Homes Corporation*, 2006 U.S. Dist. LEXIS 61453 (D. Utah), a 2006 decision that rejected this argument and held that negligent acts by an insured's subcontractor can constitute an "occurrence."

Patrons Oxford Insurance Company v Harris, et al., 2006 ME 72, 905 A.2d 819 (Me. 2006).

It is a frequently occurring scenario. An insurer is defending its insured under a reservation of rights. The insured is presented with an opportunity to settle the case within its limits of liability and would like to do so. The insurer has either not filed a declaratory judgment action to have its coverage issue(s) resolved or, if it has filed such an action, a decision will not come in time. The tension is thick. By settling, the insured can eliminate the uncertainties of trial and the risk of a verdict greater—and possibly much greater—than its coverage limits. The insurer also wants to eliminate the risk of an excess verdict, but is confronted with uncertainty over its coverage obligation and is entitled to limit such obligation to only claims that are within the confines of its policy.

Despite the frequency in which this coverage drama plays out, it has not been addressed by a significant number of courts—at least not as many as one would expect. Moreover, the decisions that have addressed the issue are not consistent, sometimes leave questions unanswered, and may also create collateral issues. For example, this situation gives rise to questions whether an insurer can settle the underlying action and then seek reimbursement if it is determined that no coverage was owed. And what about if certain damages in the settlement may be covered while others are not.[3] On a related front, if a case being defended under a reservation of rights is headed to trial, questions sometimes arise whether the insurer (1) can intervene in the underlying action; (2) can require the use of special jury interrogatories to have its coverage issue(s) resolved; and (3) is estopped from litigating facts in a coverage action that were determined in the underlying action. And the list goes on.

Incidentally, last year's installment of the Ten Most Significant Insurance Coverage Decisions of the Year included *Excess Underwriters at Lloyd's, London v Frank's Casing Crew & Rental Tools, Inc.*, 2005 Tex. LEXIS 418, in which the Texas Supreme Court addressed whether an insurer can settle a claim and then seek reimbursement from its insured if it is later determined that no coverage was owed. The *Frank's Casing* court held that, under the following circumstances, an insurer has a right to reimbursement if it has timely asserted a reservation of rights, notified the insured that it intends to seek reimbursement and paid to settle claims that were not covered: (1) when an insured has demanded that its insurer accept a settlement offer that is within policy limits; or (2) when an insured expressly agrees that the settlement offer should be accepted. *Frank's Casing* at *11. Despite issuing a decision that was obviously not on an impulse—it included a majority and three concurring opinions—on January 6, 2006, the Supreme Court of Texas granted rehearing in *Frank's Casing*.[4]

Back to *Patrons Oxford*, where the Supreme Judicial Court of Maine addressed coverage for an insured's settlement under the following circumstances. Preston Harris was the driver of a truck that hit Darrell Luce Jr. The truck was owned and insured by David Ferguson, the father of Kurt Ferguson. Harris and Kurt Ferguson arrived at a party and were confronted by a hostile crowd that demanded that they depart or else be physically harmed. They quickly reentered the truck. The crowd physically ushered Harris into the driver's seat and Ferguson into the passenger's seat. In a panic, Harris drove away from the potentially violent crowd and hit Luce, pinning him against another vehicle. *Patrons Oxford* at 822.

Luce brought suit against Harris. Patrons Oxford undertook Harris's defense, subject to a reservation of rights, as there was a question whether Harris had permission to operate the truck.[5] Patrons Oxford filed a motion to intervene in *Luce v Harris*, as well as a declaratory judgment complaint. Luce and Harris filed a stipulation for entry of judgment, with Luce agreeing not to collect a judgment from Harris personally. Luce would attempt to collect a judgment only from Patrons Oxford through Maine's reach and apply statute, if coverage was found. The parties also agreed that the trial court would determine Luce's damages. Judgment on the stipulation was entered and the court awarded Luce $32,704.68. *Patrons Oxford* at 823.

Following a bench trial, the court in the declaratory judgment action held that "Harris was an insured under the Ferguson policy because the emergency situation and the threat of bodily harm made it reasonable for Harris to believe that he was entitled to operate the vehicle to escape the potentially violent situation, despite being intoxicated and not possessing a valid driver's license." *Id.* at 823-24. The trial court noted that, given the exigency of the situation, there was no time for "extended colloquy" between the two men regarding who should drive. *Patrons Oxford* at 824. This decision was affirmed by the Maine high court. *Patrons Oxford* at 825.

Turning to the heart of the decision, Patrons Oxford argued that it was denied due process because it did not have a meaningful opportunity to litigate Harris's liability or Luce's damages. Noting that it has not previously addressed the tensions that exist between an insurer that reserves the right to deny coverage and the impact of that decision on the insured, the Supreme Judicial Court of Maine went on to do so.

First, the court noted that it agreed "with those courts that have held that 'an insurer who reserves the right to deny coverage cannot control the defense of a lawsuit brought against its insured by an injured party.'" *Patrons Oxford* at 825-26 (citations omitted).[6] On the other hand, the court was not unsympathetic to an insurer that possesses a coverage defense. Nor was the court unmindful of the risk faced by an insurer that "an insured being defended under a reservation might settle for an inflated amount or capitulate to a frivolous case merely to escape exposure or further annoyance." *Patrons Oxford* at 827, quoting *United Services Auto. Assoc. v Morris*, 741 P.2d 246, 253 (Ariz. 1987).

Taking all of these factors into consideration, the *Patrons Oxford* court set forth the following rules addressing the competing interests between an insurer with a coverage defense and a policyholder with a desire to protects its interests through settlement of an action pending against it:

> [A]n insured being defended under a reservation of rights is entitled to enter into a reasonable, noncollusive, nonfraudulent settlement with a claimant, after notice to, but without the consent of, the insurer. The insurer is not bound by any factual stipulations entered as part of the underlying settlement, and is free to litigate the facts of coverage in a declaratory judgment action brought after the settlement is entered. If the insurer prevails on the coverage issue, it is not liable on the settlement. If the insurer does not prevail as to coverage, it may be bound by the settlement, provided the settlement, including the amount of damages, is shown to be fair and reasonable, and free from fraud and collusion. The issues of the fairness and reasonableness of the settlement, as well as whether it is the product of fraud and collusion, may be brought by the insurer in the same action in which it asserts its coverage defense. If the claimant cannot show that the settlement and the damages or the settlement amount are reasonable, the claimant may recover only that portion which he proves to be reasonable. If the claimant cannot prove reasonableness, the insurer is not bound. Likewise, if the settlement is found to be the product of fraud or collusion, the insurer is not bound. *Patrons Oxford* at 828-829.

While insurers do not like to be told that they are bound by settlements to which they did not consent, the Supreme Judicial Court of Maine did not leave insurers empty-handed either. The court's decision provides insurers with avenues to challenge both coverage and the fairness and reasonableness of the settlement. Moreover, holding that insurers are not bound by any factual stipulations entered as part of an underlying settlement is important, especially if it also means that insurers are not bound by any facts that are determined at the trial of an underlying action that is subject to a reservation of rights.

The effect of *Patrons Oxford* is that insurers will be forced to decide just how strongly they feel about their coverage defenses. An insurer that asserts a reservation of rights at the outset of litigation, but now faces the prospect of a stipulated judgment, finds itself in a rubber-meets-the-road coverage situation. If the insurer does not feel confident that it can prevail on the coverage question, it may determine that its interests are better served by abandoning the reservation of rights and taking over the insured's defense of the underlying action. This is especially so if the court is going to have wide latitude on whether a settlement is "reasonable." On the other hand, an insurer that feels strongly about its

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coverage defenses can allow the stipulated judgment to proceed, secure in the knowledge that it remains free to litigate its coverage obligation—and avoid all liability—as well as having the fall-back position of a hearing to determine the fairness and reasonableness of the settlement, if coverage is determined to be owed.

Did the *Patrons Oxford* court answer every question that can arise in this situation? Probably not. But the court deserves high marks for recognizing and balancing the many competing interests that can arise when an insured has an opportunity to settle a case that its insurer asserts.

Fiess v State Farm Lloyds, 2006 Tex. LEXIS 806.

It was not an easy decision to include the Texas Supreme Court's opinion in *Fiess* as one of the year's 10 most significant. The case involves first-party property coverage. And unlike relatively standard CGL policies, first-party property forms are often subject to variation. For this reason, it's always questionable just how much influence a first-party property coverage decision will have on courts down the road.

But *Fiess* had a lot going for it. The case involves coverage for mold. And on that subject, the Texas Supreme Court's views are entitled to much weight (more so than, say, the Supreme Court of Vermont, or some other cool weather state[7]). Second, the District Court decision in the case, finding no coverage, was rejected by several subsequent courts. With this split on the issue, additional guidance was sorely needed. But it would take a long time for that to come, as the Fifth Circuit chose to certify the issue to the Supreme Court of Texas, which was in no hurry to rule. Thus, all together, the time from the District Court's decision to that of the Texas Supreme Court, including the Fifth Circuit detour along the way, was 39 months—one month longer than the gestation period for an Alpine black salamander (which has the longest gestation period of any animal). And none of this was going unnoticed, as evidenced by the boatload of amicus activity in the case.

But in the end, the real value of *Fiess*, and its reason for inclusion here, is that while the court's decision addressed coverage for mold vis-à-vis the "ensuing loss" clause contained in a Texas Department of Insurance-prescribed Homeowners Form, its applicability may not be so narrow.

At issue in *Fiess* was coverage for flooding caused by Tropical Storm Allison. The Fiesses removed drywall damaged by the flood and discovered black mold growing throughout their house. Subsequent testing determined that the mold was stachybotrys, which made the house dangerous to inhabit. The State Farm Lloyds examiner concluded that, while the flooding caused some of the mold damage, a significant percentage was caused by pre-flood roof leaks, plumbing leaks, heating, air conditioning and ventilation leaks, exterior door leaks, and window leaks. Fiess at *27-*28.

State Farm paid the Fiesses approximately $34,000 for mold remediation necessitated by the pre-flood leaks, but maintained that it was not obligated to pay for mold damage caused by the flood, as the policy explicitly excluded all damage caused by flooding. The Fiesses brought suit. *Fiess* at *28. The dispute was over the interpretation of the following policy exclusion contained in a Texas Homeowner's Form HO-B policy:

> We do not cover loss caused by:
>
> 1. wear and tear, deterioration or loss caused by any quality in property that causes it to damage or destroy itself
> 2. rust, rot, mold or other fungi
> 3. dampness of atmosphere, extremes of temperature
> 4. contamination
> 5. rats, mice, termites, moths or other insects
>
> *We do cover ensuing loss caused by* collapse of the building or any part of the building, water damage, or breakage of glass which is part of the building if the loss would otherwise be covered under this policy. *Fiess* at *2-*3 (emphasis added).

At issue before the Supreme Court of Texas was the following Certified Question from the Fifth Circuit: "Does the ensuing loss provision . . . when read in conjunction with the remainder of the policy, provide coverage for mold contamination caused by water damage that is otherwise covered by the policy?" *Fiess* at *2.

The Fiesses argued that the court must disregard how the policy provision starts ("We do not cover loss caused by mold") because of how it ends ("We do cover ensuing loss caused by water damage.") Fiess at *10. The court declined to do so, relying on *Lambros v Standard Fire Insurance Co.*, 530 S.W.2d 138 (Tex. Civ App.—San Antonio 1975, writ ref'd), which held that "water damage must be a consequence, i.e., follow from or be the result of the types of damage enumerated in [the exclusion]." Fiess at *12, quoting *Lambros*.

The *Fiess* court concluded that the "ensuing loss" clause provides coverage only if one of the relatively common and usually minor excluded risks (rust, rot, mold, humidity, wear and tear, etc.) leads to a relatively uncommon and perhaps major loss: building collapse, glass breakage, or water damage. Fiess at 17. The majority criticized the dissent for a construction that would operate to create broader coverage, as more exclusions were added to a policy containing an ensuing loss clause. *Fiess* at *21.

The *Fiess* court stated that:

> [T]he upshot of the dissent's construction would be that the more risks *excluded* in a policy containing an ensuing-loss clause, the *broader* coverage would become. Paragraphs

1(f), 1(g), and 1(h) of the HO-B policy contain roughly 22 exclusions, and each has an ensuing-loss clause listing 3 intervening risks (building collapse, water damage, and glass breakage). According to the dissent, if any one of the 22 exclusions combines with any one of the 3 intervening risks to cause any of the 22 excluded losses, the loss is no longer excluded. This would mean there are only about 1,452 possible ways to turn exclusions into coverage. Thus, the more exclusions that are added, the broader coverage gets. This cannot possibly be a reasonable construction. *Fiess* at *21.[8]

The debate between the majority and dissenting opinions went on, but the detail is somewhat beyond the scope of this brief write-up.[9]

Lastly, the *Fiess* court stated that its decision was consistent with most other jurisdictions. In so saying, the court noted that ensuing loss clauses are "common in all-risk policies, and while rarely identical they share more similarities than differences." *Fiess* at *22. In support, the court went on to cite approximately 25 decisions from around the country, with many having nothing to do with mold and containing different language than in the Texas HO-B form. E.g., *Ames Privilege Assoc. Ltd. Partnership v Utica Mut. Ins. Co.*, 742 F. Supp. 704, 708 (D. Mass. 1990) ("These are perils which are excluded by the policy [Loss caused by wet or dry rot, deterioration, settling and cracking of walls, floors, roofs or ceilings]. They cannot be, at the same time, perils which are not excluded, and for which the defendant would be liable for any ensuing loss."); *Weeks v Co-Operative Ins. Cos.*, 817 A.2d 292, 296 (N.H. 2003) ("[T]he exception to the exclusion operates to restore coverage if the damage ensues from a covered cause of loss. 'Reasonably interpreted, the ensuing loss clause says that if one of the specified uncovered events takes place, any ensuing loss which is otherwise covered by the policy will remain covered. The uncovered event itself, however, is never covered.'") (citation omitted).

While *Fiess* may have adopted a majority view, the decision demonstrates that the "ensuing loss" issue is not without much debate and arises under myriad circumstances. Therein lies the significance of *Fiess*—given its thoroughness, it has the potential to influence future "ensuing loss" cases in states other than Texas and involving losses other than mold. ■

Endnotes

1. There also seemed to be more state high court decisions than usual in 2006 addressing very fact specific coverage situations. These decisions may be important or interesting in their own right, but are less likely to be influential on courts in the years ahead.
2. One final note on the selection process: Two insurance blogs that I read to monitor coverage developments are valuable resources and worthy of your time (I promise). In last year's Top 10 Coverage Cases of the Year article I plugged Marc Mayerson's blog—Insurancescrawl.com. I once again direct your attention to this excellent blog that provides law review-like analysis of major coverage decisions. This year I must also give a shout-out to David Rossmiller's blog at www.insurancecoverageblog.com. See for yourself the superb job that this reporter-turned-lawyer does of providing daily news and commentary from the coverage world. If after a week you start saying to yourself—How does he do this every day?—you will not be alone.
3. The issue of how to distinguish between covered and uncovered damages in a settlement was the subject of some discussion last year in *Perdue Farms v Travelers Casualty & Surety Company*, 448 F.3d 252 (4th Cir. 2006). Further, the principal decision in Perdue Farms was itself important and the case was considered for inclusion as one of the year's 10 most significant coverage decisions. The Fourth Circuit held that an insurer was not entitled to reimbursement of defense costs for non-covered claims: "Under Maryland's comprehensive duty to defend, if an insurance policy potentially covers any claim in an underlying complaint, the insurer, as Travelers did here, must typically defend the entire suit, including non-covered claims. Properly considered, a partial right of reimbursement would thus serve only as a backdoor narrowing of the duty to defend, and would appreciably erode Maryland's long-held view that the duty to defend is broader than the duty to indemnify." *Perdue Farms* at 258 (citation omitted). Thus, the *Perdue Farm* court was "unwilling to grant insurers a substantial rebate on their duty to defend." Id.
4. A press release from Anderson, Kill & Olick announcing the Texas Supreme Court's decision to grant rehearing in *Frank's Casing* noted that the decision had been named one of the 10 most significant coverage decisions of 2005 by *Mealey's Insurance*. Thanks for the plug, guys. Anderson, Kill submitted an amicus brief on behalf of United Policyholders in support of Frank's Casing's position. See "Texas Supreme Court Grants Rehearing on its Decision in Frank's Casing," posted at http://www.insurancebroadcasting.com/011806-6.htm.
5. The specific policy provision at issue was an exclusion that provided, "We do not provide Liability Coverage for any 'insured' . . . [u]sing a vehicle without a reasonable belief that that 'insured' is entitled to do so." *Patrons Oxford* at 823.
6. The *Patrons Oxford* court's conclusion that an insurer who reserves the right to deny coverage cannot control the defense of a lawsuit brought against its insured by an injured party was in the context of an insured's ability to settle a case without the insurer's consent. It will likely be an easy leap for policyholders to assert that the court's decision also means that an insurer who reserves the right to deny coverage cannot select defense counsel. On this issue, see *Twin City Fire Insurance Company v Ben Arnold-Sunbelt Bev Co. of South Carolina,* 433 F.3d 365 (4th Cir. 2005), in which the Fourth Circuit (South Carolina law) addressed this argument in detail in a December 27, 2005 opinion—handed down too late for consideration in last year's edition of The Year's Ten Most Significant Insurance Coverage Decisions. The *Ben Arnold* court rejected the notion that a reservation

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Coverage Gone Mild: Sixth Annual Look Back at the Year's 10 Most Significant Insurance Coverage Decisions

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of rights letter creates a per se conflict of interest that must be remedied through the insured selecting counsel at the insurer's expense.

7. I mean no disrespect to the Vermont Supreme Court. I'm just going by the numbers. A Lexis search undertaken at the time of this writing of Vermont state and federal courts for "mold w/20 insurance or policy" returned four hits, with three coming from the Second Circuit and involving non-Vermont appeals and only one having something to do with mold (but not insurance). Compare that to the same search for Texas state and federal courts, which returned 111 hits. Now, when the search term is "ski lift" . . . .
8. Then, revealing that Justice Hecht isn't the only witty member of the Texas Supreme Court, Justice Brister added, "It is true that some combinations are unlikely, such as wear-and-tear followed by glass breakage that causes mice. But with 1,452 to choose from, no doubt plenty of options remain." *Id.*, n.31.
9. For a look at how the decision may affect future mold claims in Texas, written by a Texas policyholder attorney, see John F. Melton, "*Fiess v State Farm Lloyds*—Mold Coverage—Texas Supreme Court says Texas Insurers, Homeowners, and Texas Department of Insurance Misread Policy," *Policyholder Advocate*, October 2006, Published by Policyholders of America.

From the Editor

by Robert M. Kelso, J.D., CPCU

Robert M. Kelso, J.D., CPCU, is a senior partner with the law firm of Kightlinger and Gray in Indianapolis, IN, and is a past president of the CPCU Society's Central Indiana Chapter. Kelso concentrates on insurance defense, and also chairs the firm's Employment Practices Liability Defense Group.

The Claims Section seminars, the CQ newsletter, and the recently upgraded claims web site are provided to you for your personal and professional development.

The CQ editorial team would like to see all readers enjoy the full benefits of the educational articles, as well as those addressing personal and career development. We continue to expand our quarterly newsletter columns to include more on training and development, law and legislative updates, links to claim sites on the Internet, and new technologies for claim handling. In addition to the quarterly favorites, we provide a host of technical/functional articles that try to cross all lines of business for both property and casualty claims. Your section also sponsors quite a few seminars and other networking opportunities throughout the year. The Claims Section Committee is a group of professionals who are available to assist you in either your personal or professional development. Check out the committee member profiles and begin to network with claims professionals around the country.

If you enjoy the CQ please let us know what you like and what you would like to read more about. If you have ideas on content or format changes, want to refer an author, or want to write an article yourself, please contact me directly with your ideas. Sixty-seven percent of the articles are written by your CPCU colleagues!

Each year we publish four CQs. We typically have three technical/functional articles in each CQ, and we try to have those articles cross all lines of coverage. We also publish many other claims-related, non-technical articles. The purpose of publishing our *Claims Section Quarterly* newsletter is to provide the membership with timely information on emerging claim and legal issues that develop and enhance claim expertise at all levels. Through the CQ we want to:

- Achieve a balance of claim technical, claim legal, and claim operational articles.
- Achieve a balance of property and casualty articles.
- Promote claims education, ethical behavior, and professionalism.
- Provide a forum for networking within the Claims Section and the claim industry, and support the CPCU Society's programs and initiatives.

If you missed any of the recent CQ articles you can find them right on the CQ tab on the claims section web page or contact me directly for a copy:

Robert M. Kelso, Kightlinger and Gray
151 N. Delaware, Indianapolis IN 46204
Phone: (317) 638-4521, Fax: (317) 636-5917, E-mail: rkelso@k-glaw.com.

Sections Strategic Task Force Report Summary

by Kathleen J. Robison, CPCU, CPIW, ARM, AU

Kathleen J. Robison, CPCU, CPIW, ARM, AU, has more than 30 years of experience with leading claims organizations, and possesses a wide range of commercial and personal insurance coverage knowledge and applicability. K. Robi & Associates, LLC, which she founded in 2004, provides customized consultant services in the property and casualty insurance fields, including expert witness testimony, litigation management, claims and underwriting best practices reviews/audits, coverage analysis, and interim claims management.

She can be reached at (423) 884-3226 or (423) 404-3538; or at info@krobiconsult.com.

At the CPCU Society's 2005 Annual Meeting and Seminars, the Board of Governors created a Sections Strategic Task Force. The task force developed a strategic vision for sections, and presented it to the board at the CPCU Society's 2006 Annual Meeting and Seminars in Nashville in September. The Board of Governors accepted the report and referred it to the Executive Committee to develop detailed recommendations for consideration by the board at the April 2007 Leadership Summit meeting. This article summarizes the report and recommendations.

David Medvidofsky, CPCU, CIC, chaired the task force. Members of the task force were **Tony L. Cabot, CPCU; Matthew J. Chrupcala, CPCU; John L. Crandall, CPCU; Clint Gillespie, CPCU; Michael J. Highum, CPCU; Kelli M. Kukulka, CPCU; W. Thomas Mellor, CPCU, CLU, ChFC; Kathleen J. Robison, CPCU, CPIW; Eli E. Shupe Jr., CPCU; Nancy S. Vavra, CPCU;** and **Barry R. Midwood, CPCU,** as CPCU Society liaison.

The task force began its assessment by focusing on issues of strategy and purpose. It developed a series of strategic questions designed to answer "who, what, and why," before addressing the question of "how?"

After task force consensus on the questions, feedback was shared with designated section liaisons. The task force also met with key stakeholders at the mid-year meeting to share findings, to test attributions, and to obtain additional input.

The task force took a qualitative approach relying on member input and interviews to develop findings. Prior survey data were reviewed.

Prior to creating the strategy, the sections' current mission and vision statement were reviewed. The task force recommended the following changes.

Special Note: *One of the recommendations is to re-brand the sections into interest groups. Therefore, the reader will note the reference to interest groups rather than sections.*

Proposed Mission

The CPCU Society aligns its members within interest groups consistent with the major disciplines of the property and casualty insurance industry. Serving the industry and other stakeholders in an ethical and professional manner, interest groups add value by increasing interest in attaining the CPCU designation and by helping make CPCU the most recognized, valued, and highly respected designation in the property and casualty industry through consistent and valuable technical content.

Proposed Vision

Interest groups offer targeted educational content that make CPCU the most widely recognized, valued, and highly respected professional designation/brand in the property and casualty industry. Instead of being focused toward a value-add for a narrow target, interest groups are at the forefront for name recognition and desirability of the CPCU designation by reaching a broad audience. Although segmented by discipline, interest groups target their consistent and high-quality technical content to anyone in the industry seeking focused information.

Interest group affiliation is provided automatically to CPCU Society members. This enables consistent and ongoing technical content to reach CPCUs affording continuing education and reminding them of the value of CPCU Society membership.

Ultimately, the reach of interest groups extends beyond just CPCU Society members. All industry professionals are, therefore, exposed to CPCU through the work of its interest groups. Exposure to the high-quality, technical content of the volunteer interest groups:

1. draws industry professionals to interest groups through exposure to their work; which
2. increases interest in CPCU and other Institute programs as a course of study; which
3. increases Institute participants and program designees; which
4. increases CPCU Society and chapter membership

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Sections Strategic Task Force Report Summary

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Special Note: *The above is a recommended long-range vision for sections. Included in the recommendations are specific steps to position sections for the proposed mission. The task force believed strongly that attaining the mission would be a staged process. The sections' offerings must first be of consistently high value on par with other offerings before extending sections' reach beyond Society members.*

Proposed Strategy

The strategy is to position sections as a provider of readily available, high-quality, technical content to stakeholders. The level of content and delivery will vary based on the audience:

- **For prospective CPCU candidates,** sections offer technical information such as symposia and expertise within the disciplines of the industry.
- **For current CPCUs** the newsletter and web site are of high value and encourage CPCUs not presently part of the CPCU Society to see the benefits of joining. Retention of current CPCU Society members increases by providing consistent, high-quality, technical content within member disciplines. CPCU Society members are connected to others within a functional discipline offering networking and resource advantages not available through other industry designations or associations.

As the technical content is consistently on par with competitor offerings, "associate memberships" are offered to non-CPCUs working in the industry and to industry providers (e.g., vendors). This provides a new revenue stream for the CPCU Society and further increases name recognition of CPCU. Candidate interest in the Institute's programs increases as well as through the exposure sections create.

Accomplishing this vision requires strategic actions that are presented as a series of strategic initiatives that align with four key perspectives:

- organizational structure
- leadership development
- membership
- value-added services

These strategic initiatives are summarized with a proposed template for reporting on results.

Organizational Structure (OS)

OS1—Re-Brand Sections as Society Interest Groups

Rationale: The term "sections" does not concisely describe their purpose. Other associations with similar structures such as PMI, ABA, etc. use "interest group" terminology. As the vision for sections evolves, re-branding them as interest groups signals something "new and improved." Further, the phrase "sections" carries connotations of silos where "interests" applies whether one works in a discipline or just has "interest" in learning more.

OS2—Create Interest Group Resource and Governance Committee

Rationale: As the interest groups are exposed to a wider audience, the demand for consistent, high-quality content will increase. CPCU Society staff provides excellent support. Interest groups can enhance CPCU Society capacity by forming a rotating four-member committee overseeing standards of content (see Recommendation VA1) and providing a resource for backup, training, and consultative advice. This committee would consist of:

- a former section chairman
- a former section web liaison
- a former section newsletter editor
- an additional member with experience in one of the above tasks

OS3—Assess Current Interest Groups and Align Them with Major Industry Functions

Rationale: The industry has evolved since the creation of sections. For example, many companies no longer have "underwriting" departments—they have moved staff functions to product teams and field functions to production positions. Project management is integrated into most positions but has no discrete focus. As membership is opened, there needs to be a clear alignment between technical interests and the content focus of interest groups.

OS4—Open Interest Group Membership to all Society Members

Rationale: Open membership will expose all CPCU Society members to the work performed by interest groups. Providing newsletter and web site access will consistently remind CPCU Society members of the value they receive by belonging to the Society. This recommendation also supports the CPCU Society's goal of visibility. Continuing education is provided while leveraging one of CPCU's key differentiators: the ability to connect its members at both the interdisciplinary level (chapters) and the intradisciplinary level (interest groups).

Leadership Development (LD)

LD1—Formalize Standard Interest Group Leader Training and Orientation for the Chairman, Newsletter Editor, and Web Liaison. This training will include an operations manual and continuously updated list of best practices.

Rationale: As membership is opened, interest group offerings will have wider exposure. Content value will become more important. Formalized training and reference materials need to be provided as tools to support the key interest group roles.

LD2—Create a Developmental Scorecard for Interest Group Volunteers and CPCU Society Members

Rationale: As budget and time demands increase, employers and employees will need to understand and demonstrate the value of their commitment. A

development scorecard will show employers what their investment provides. It will also enable employees to easily articulate the value they receive. The present CPD qualifier may be promoted or modified to meet this need.

Membership (M)

M1—Create Value Statements and Other Communications Tools to Promote Interest Groups

Rationale: As the sections are re-branded and membership is opened up to all CPCU Society members, value statements and a communications strategy must be created. These efforts must crisply articulate the value of interest group membership, and describe how the value of CPCU Society membership has increased. This highlights the differentiation that interest groups provide CPCU Society members through focused technical content that CPCU Society members will continuously receive.

M2—Establish Affiliations between Interest Groups and Other Industry Organizations (e.g., PLRB, The "Big I," and RIMS)

Rationale: To promote the technical expertise of CPCU Society interest groups and to support the goal of making CPCU the most widely recognized and highly respected designation, affiliations should be formed with other associations and/or designation programs. By presenting at their conferences and contributing to their newsletters, the CPCU Society increases their reach to potential designees committed to continuous learning.

M3—Refresh the Interest Group Newsletters

Rationale: As the reach of newsletters increases (first to all CPCU Society members and longer term as a revenue-generating product) they must be refreshed. This will support the re-branding efforts. A task force should be formed to finalize recommendations—potential areas of review include electronic versus hard copy delivery (or option for both), the colors, logo, and layout, and the possibility of providing one comprehensive quarterly interest group newsletter with space for each interest group's contribution (versus publishing 14 separate newsletters).

M4—Designate Liaison(s) to Promote Interest Group Benefits to Chapters, Major Employers, and the Insurance Services Community

Rationale: The value of interest groups may be promoted by expanding the Connections concept. A discussion of the value of the interest groups must be added to the present agenda. Designating special liaisons will expand capacity to extend outreach to chapters and industry service providers.

M5—Strengthen Connection between CPCU Society and Accredited Risk Management and Insurance Degree Programs

Rationale: Students pursuing degree programs in risk management and insurance are future prospects for the Institutes' programs. Increasing awareness helps capture interested students. Recommendations to strengthen this connection include offering interest group membership to any approved university, offering a pool of guest lecturers, and providing a student forum for web site and newsletter submissions.

Value-Added Services (VA)

VA1—Develop Consistent Format and Content Standards for Core Interest Group Offerings

Rationale: As membership increases to all CPCU Society members, interest groups have an opportunity to promote their value to a wider audience. Longer term the strategy is to broaden interest group reach outside of the CPCU Society. This strategy requires content that compares favorably with alternative offerings. Specific content targets and standards assure the CPCU Society member regularly receive high-quality content. Support and governance for this recommendation is contemplated under recommendation OS3 above.

VA2—Expand Delivery Methods of Technical Content

Rationale: Time and expense dictate member participation. Present delivery methods of the newsletter and the CPCU Society's Annual Meeting and Seminars for technical content should be expanded by the interest groups to include webinars, more symposia, and chapter-ready presentations through a pool of local speakers. The possibility of on-demand or ability to purchase video of the CPCU Society's Annual Meeting and Seminars must be considered to meet the needs of our growing international presence and those who cannot attend CPCU Society's Annual Meeting and Seminars.

VA3—Encourage Interest Groups to Convert Highest-Rated CPCU Society Annual Meeting Technical Seminars into Symposia

Rationale: A great deal of work goes in to producing quality technical sessions that are presented at the CPCU Society's Annual Meeting and Seminars. In their efforts to re-brand themselves and increase awareness of their offerings, interest groups have an opportunity to convert these programs into tested and finalized symposia. Not only does this effort support the strategic goal of industry outreach, but it offers an additional revenue source to the CPCU Society.

VA4—Conduct SWOT Analysis for Each Interest Group; Implement Findings

Rationale: As the interest group expectations change and the prospective members increase to all CPCU Society members, each interest group needs to assure that their offerings align with member needs. Action plans should be developed based on the findings and reported back through the interest group governors. ■

What's In This Issue

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http://claims.cpcusociety.org

Claims Section Chairman
Robert E. McHenry, CPCU, AIC, AIS
Westfield Group
E-mail: RobertMcHenry@westfieldgrp.com

***Claims Quarterly* Editor**
Robert M. Kelso, J.D., CPCU
Kightlinger and Gray
E-mail: rkelso@k-glaw.com

Sections Manager
John Kelly, CPCU
CPCU Society

Managing Editor
Michele A. Ianetti, AIT
CPCU Society

Production Editor
Joan Satchell
CPCU Society

Design
Susan Leps
CPCU Society

CPCU Society
720 Providence Road
Malvern, PA 19355
(800) 932-CPCU
www.cpcusociety.org

Register for the 2007 Annual Meeting and Seminars

September 8–11, 2007

Honolulu, HI

Visit **www.cpcusociety.org** to register online and for the latest information on the 2007 Annual Meeting and Seminars.

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