



## Message from the Chairman

by David S. Medvidofsky, CPCU, CIC, AAI



**David S. Medvidofsky, CPCU, CIC, AAI**, is vice president of operations for The Main Street America Group, a property and casualty insurer writing business through independent agents in 16 states; and general manager of Information Systems & Services, a subsidiary offering third-party administration solutions to property and casualty carriers. During his career, he has worked on the agency and company side, and has held staff and line positions in underwriting, marketing, and product development.

Medvidofsky is a summa cum laude graduate of Franklin Pierce College (B.S. degree in business management), where he was selected to the Alpha Lambda Sigma National Honor Society, and was the top graduate within his major. He also holds a master's degree in leadership from Franklin Pierce. He is active in educational pursuits, including CPCU instruction, and has been published in *The National Underwriter*, the *CPCU Journal*, *Underwriting Trends*, *Best's Review*, and *Technology Decisions*. He currently serves as chairman of the CPCU Society's Underwriting Section Committee, and has served on many Automobile Insurance Plan committees.

**M**ark your calendars for September 9–12, 2006. That's when the CPCU Society's Annual Meeting and Seminars will be held in Nashville, TN! The Annual Meeting, themed this year around "Character & Confidence," is once again full of top-notch educational seminars. Participants know that the Annual Meeting creates networks and friends for life, and provides an excellent means for associating with industry professionals. This year promises to be no different.

In our role as Underwriting Section Committee members we use the Annual Meeting to support our strategic goals of providing our membership:

- timely information
- educational materials
- career development tools
- networking opportunities



**CPCU Society**  
Annual Meeting & Seminars  
September 9-12, 2006  
**Nashville, TN**

How do we do this? Your Underwriting Section Committee will again be sponsoring two educational seminars and a presentation luncheon. Plan on attending these great events:

**1. Underwriting Section Luncheon**  
**Sunday, September 10, 2006**  
**11:30 a.m. – 1 p.m.**

This is a great opportunity to network and learn more about the Underwriting Section Committee.

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# Message from the Chairman

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As an added bonus, we offer an opportunity to walk away with a special gift. This year's luncheon will include a discussion on emerging issues in insurance.

## 2. "High-Tech Tools: How's the ROI?"

Tuesday, September 12, 2006  
8 – 10 a.m.

Presented in partnership with Accenture and co-developed by the IT Section, this seminar will use a recent Accenture survey conducted with input from more than 800 Underwriting Section members. You will hear about how some industry leaders are using technology to change the underwriter's role and maximize underwriting profitability. Key industry executives will also assess the survey findings such as:

- The participant's belief that technology has actually increased the underwriter's workload. Could this really be true? If so, what can be done to reverse this trend while improving the quality of underwriting decisions?

- How technological changes are, in many cases, supporting outmoded underwriting practices.
- The role of technology in attracting tomorrow's leaders as seasoned underwriters.
- Ways companies are reducing premium leakage, lowering expenses, and improving profitability.
- How technology may be used to attain a competitive advantage.

## 3. "Society's Addictions and Their Impact on Insurance"

Tuesday, September 12, 2006  
1:30 – 3:30 p.m.

This session will examine how the rise in activities such as drug use and nonrecreational gaming are increasing loss exposures.

- Learn how societal trends, particularly addictions, impact workers compensation, property, crime, and inland marine underwriting, pricing, and claims.
- Hear the magnitude of addiction on today's society.

- Identify clues to addictions that agents, underwriters, and loss control professionals can utilize.
- Assess trends and risk management techniques, such as drug testing.

Register today for the CPCU Society's Annual Meeting and Seminars at [www.cpcusociety.org](http://www.cpcusociety.org).

For more information, contact the Society at (800) 932-2728, and select option 5.

This year promises to be another excellent event. The Underwriting Section looks forward to seeing you September 9–12 in Nashville! ■



## The Underwriting Section Committee

*We put the YOU in underwriting. The importance of this slogan is that insurance is still a people and relationship business. People make the difference.*

*Make sure to put the YOU in the underwriting process.*

# The Auto Insurance Residual Market: An Overview

by Charles P. Kwolek Jr., CPCU, CPA, CFE, CLU, ChFC, PMP, AIS



■ **Charles P. Kwolek Jr., CPCU, CPA, CFE, CLU, ChFC, PMP, AIS**, is vice president of field operations for AIPSO. He directs all home office and regional office staff responsible for the delivery of services and products to AIPSO customers. He also directs the organization's regulatory and industry affairs, communication and customer liaison, regional office management, and management team leadership.

Prior to joining AIPSO, Kwolek worked for the State of Rhode Island's Department of Business Regulation, where he rose to the position of superintendent of insurance. In that capacity, he served on a number of key executive and legislative work groups, including the Governor's Task Force to reform workers compensation, the Governor's Automobile Insurance Reform Task Force, and the legislative committee studying the laws and regulations pertaining to insurance companies operating in Rhode Island. He also has eight years of experience in public accounting.

Kwolek graduated cum laude from Providence College with a bachelor of science degree.

In 2004, "it" accounted for a 1.8 percent share of the total automobile insurance market, more than 3.4 billion in written premium. If "it" were an insurance company, those numbers would place it among the top 15 auto insurance writers in the country. In spite of "its" size, however, it normally does not receive a lot of attention from many insurance executives and elected officials. "It" is the auto insurance residual market, the "market of last resort" for hundreds of thousands of personal auto and commercial auto risks that cannot obtain coverage in the voluntary market.

In the early days of the automobile, there were no requirements for motorists to buy auto insurance. Insurance companies were free to insure only those who met their underwriting criteria as acceptable risks within the framework of their rates. The overwhelming majority of today's car owners are still able to purchase auto insurance coverage in this manner, in what is known as the voluntary market.

As car ownership grew, the financial consequences of the increasing number of automobile accidents became apparent. States began passing laws making the

possession of automobile liability insurance a practical necessity for most motorists. Under financial responsibility laws, those who didn't have coverage faced the loss of their right to drive if they were unable to pay for damages resulting from accidents they caused. Insurance companies faced the dilemma of satisfying legal, social, and economic needs for automobile insurance in an equitable manner.

The solution was to establish in each state a mechanism that would provide coverage for those drivers who were unable to obtain insurance in the voluntary market due to factors such as their poor driving records or their inexperience as motor vehicle operators. The first such mechanism was established in New Hampshire in 1938, and every state had one by 1959. Taken collectively, these mechanisms make up what is known today as the auto insurance residual market in the United States.

There are currently several different types of mechanisms employed in this residual market. The most common by far is the Automobile Insurance Plan (AIP, the Plan). In 42 states and the District of Columbia, applicants who cannot obtain insurance in the voluntary market are shared equitably among all insurers licensed to write automobile insurance. The applicants are distributed to insurance companies in proportion to the amount of business each insurer writes voluntarily in the state. Each insurer then services these policyholders as it services its other customers, and absorbs the profit or loss. This procedure is applicable generally to private passenger and miscellaneous nonfleet risks.

In 36 jurisdictions, there is within the framework of the AIP a provision for modification of the risk distribution procedure—the Limited Assignment Distribution (LAD). Under this program, companies that wish to be relieved from servicing private passenger and

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# The Auto Insurance Residual Market: An Overview

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miscellaneous nonfleet direct assignments may do so by executing agreements with the plan and servicing companies (or, in some states, directly with the servicing companies) and by payment of “buy-out” fees. The servicing companies process assignments of buy-out companies in addition to their own. The objective of this program is to relieve companies from servicing their share of assignments, as well as to improve service and reduce costs. According to the latest available statistics, approximately one-third of the total private passenger premium written in the 36 auto insurance residual market, (more than \$300 million) represents business assumed from “buy-out” companies by LAD servicing companies. In four jurisdictions with direct assignment of commercial risks, a similar provision for modification of the risk distribution procedure is the Commercial Limited Assignment Distribution Procedure (CLAD). As with the LAD, companies that wish to be relieved from servicing commercial direct assignments have the opportunity to negotiate with CLAD servicing companies to buy out of their quota of such risks.

While the AIP mechanism was conceived originally to service private passenger risks, commercial exposures were also eligible for coverage through the plan, as they did not generate more than a minimal amount of premium and included few large risks. Special Risks Distribution Programs (SRDPs) and a Servicing Carrier Program (SCP) were introduced in nine jurisdictions in the mid-1970s to provide a special program to deal with the larger commercial risks. At the same time, insurers were experiencing a sharp increase in the number and size of commercial

risks. This trend accelerated with passage of the Motor Carrier Act of 1980 and the Bus Regulatory Reform Act of 1982. These two legislative acts required greater minimum financial responsibility limits of liability and coverage than previously provided by the plans.

Methods to handle the expected increase in commercial risks were studied by the insurance industry, and in 1982, a pooling mechanism known as the Commercial Automobile Insurance Procedure (CAIP) was introduced. In CAIP, a limited number of companies act as servicing carriers for eligible risks on behalf of all insurers writing commercial automobile business in the voluntary market. These carriers record CAIP experience as direct business, and then cede 100 percent to the appropriate state plan. The plan subscriber companies assume their proportionate share of the pool’s operating results. Now running in 38 states and the District of Columbia, CAIPs are the most prevalent among the commercial auto pooling mechanisms adopted for the residual market.

The New York Plan introduced an SRDP in 1986. A special program for handling that state’s taxis and limousines—the Taxi and Limousine Pool—was also introduced. This program was later redefined as the Public Automobile Pool (PAP) to include all vehicles classified as a public automobile. Participation in the New York SRDP and PAP is voluntary; a company may elect to receive direct assignment of SRDP and PAP-type risks, or to share in the results of the programs. A modified approach to the CAIP, known as the Commercial Assignment Procedure (CAP), was developed in Pennsylvania in

1991. Risks eligible for this program are similar to those of the early SRDPs. Under this program, eligibility for application of the pooling concept is restricted to specific classifications requiring specialized expertise (e.g., truckers, taxis, buses) and to risks requiring higher limits of coverage than those generally available through the state plan.

A Joint Underwriting Association (JUA) is a pooling mechanism under which a limited number of companies act as servicing carriers. Producers generally submit applications directly to the servicing carriers, which issue and service the policies. JUA operating results are shared among member companies in proportion to their share of the voluntary market. An exception to this procedure is found in the Michigan Automobile Insurance Placement Facility, in which agents submit applications to the Facility’s office, which then distributes the applications to the servicing carriers. In addition to Michigan, four other states employ JUAs.

Under yet another pooling system, a reinsurance facility, each auto insurer is required to provide coverage and service the claims for any applicant, but is permitted to cede a percentage of its policies to the facility. The results of operations on facility business are shared equitably among all auto insurance companies licensed in the state in proportion to their share of the market. North Carolina and New Hampshire are currently the only two states with active reinsurance facilities.

In Maryland, a state fund was established to provide automobile insurance to applicants who cannot obtain coverage in the voluntary market. While private insurers do not participate directly in the fund, they are required by law to subsidize any losses resulting from the Maryland operation, and are permitted to recover these losses by surcharging their own policyholders.





In every state, a law or insurance regulation establishes that state's auto insurance residual market mechanism. These laws and regulations stipulate that all companies licensed to write auto insurance in the state are required to participate in the state's residual market mechanism as approved by the state's insurance regulator. Each of the state mechanisms provides for the formation of a governing body charged with the overall administration and operations of the mechanism, again subject to regulatory approval. These governing bodies may be referred to as an advisory committee or a board of governors in some jurisdictions, but the overwhelming majority of states refer to them as governing committees. Representatives from insurance companies constitute the majority of each governing committee's membership. Producer representatives and consumer representatives are also appointed to serve as voting members of a committee.

Given the significant responsibilities associated with the daily administration and operation of an auto insurance residual market mechanism, the governing committees in 49 states and the District of Columbia have contracted AIPSO as a management organization and service provider for the various insurance industry groups responsible for administering the residual market. As AIPSO is a nonprofit organization, the funding it receives from automobile insurers generally covers only its operating costs. These costs are shared among the insurers on a market share basis in each of the jurisdictions where AIPSO provides services. Many of these services are provided directly to or on behalf of the governing committees in each state. Once again, AIPSO's service components are frequently subject to the prior approval of the respective state insurance regulators.

AIPSO began as the Automobile Insurance Plans Service Office, a department within the old Insurance Advisory Bureau. AIPSO's responsibilities at that time included rate making for

automobile insurance plans, printing and distributing AIP manuals and forms, and determining monthly assignment quota distribution formulas for AIPs. When the IAB was dissolved at the end of 1972, insurance industry representatives agreed that AIPSO should carry on its functions as an independent organization.

With its home office in Johnston, Rhode Island, AIPSO today is a national organization of nearly 400 employees that serves local customer needs with a wide variety of services, including:

- plan management services
- quota sharing and members participation services
- policy forms services
- legal counsel services
- servicing carrier audit services
- regulatory affairs services
- management consulting services
- commercial automobile safety program services
- pool operations support services
- financial services
- rating services
- uniform operating rules services
- application processing services
- automated information systems services
- producer certification services
- fraud containment services

AIPSO provides each of these services through a team management approach that supports the residual market efforts of many different customer groups within the insurance industry. In 36 states and the District of Columbia, AIPSO offers all of its services in its capacity as manager of the auto insurance residual market mechanism. Varying levels of service are provided for all other residual market mechanisms except that of Massachusetts.

Centralization and standardization are key to many AIPSO services because of the inherent economies of scale and other efficiencies. However, the organization is based on customer focus, and recognizes the need for flexibility in serving customer groups with diverse interests. Services are tailored to meet local state residual market needs. AIPSO staff working in its nine home office departments and 10 regional offices work together to serve the industry. While its home office is organized functionally, AIPSO's teams share responsibility for providing all services to the organization's customers throughout the country.

AIPSO is governed by 13 industry representatives who constitute the organization's Board of Directors. The insurance industry's major trade associations—the American Insurance Association and the Property Casualty Insurers Association of America—each select three members to represent them on the Board. Non-affiliated insurers elect three Board members to represent them. These nine members select three “at-large” members from a group of insurance companies that have expressed an interest in serving on AIPSO's Board of Directors. The thirteenth member of the Board represents the largest auto insurance residual market mechanism managed by AIPSO.

AIPSO's customers—the many and varied segments of the insurance industry—continually challenge the organization to provide services at higher levels of excellence. In accepting these challenges, AIPSO's philosophy of serving the insurance industry is to respond to its customers' requests, while simultaneously focusing on efficient management and cost containment.

To learn more about AIPSO, its services, and its mission on behalf of the insurance industry, please visit our web site at [www.aipso.com](http://www.aipso.com) ■

## 2006 Annual Meeting Seminars Developed by the Underwriting Section



*The Underwriting Section's 2005 Annual Meeting seminars attracted 198 attendees.*

### High-Tech Tools: How's the ROI?

Tuesday, September 12  
8 – 10 a.m.

When it comes to the use of technology in the underwriting profession, stakeholders have a right to ask, "Are we maximizing the return on investment?" This seminar will examine how industry leaders are using technology to change the underwriter's role and thereby maximize underwriting profitability. Much of the information presented in this seminar is based on a survey of 800 CPCUs conducted by Accenture.

*Developed by the Information Technology and Underwriting Sections, and Accenture.*

#### Presenters:

**J. Brian Murphy, CPCU**  
Brokers' Risk Placement Service (moderator)

**John B. Hennessy**  
CNA

**Gail E. McGiffin**  
partner, Accenture

**Richard Shellito, CPCU, CLU**  
State Farm Insurance Companies

### Society's Addictions and Their Impact on Insurance

Tuesday, September 12  
1:30 – 3:30 p.m.

Every underwriter, risk manager, agent, loss control professional, and claims professional must understand the impact of social trends, particularly addictions, on underwriting, pricing, and claims. A diverse panel of speakers will discuss hazards created by addictions in workers compensation, property, crime, and inland marine lines of coverage. They will discuss the roles of the insurer's Special Investigation Unit, local and federal law enforcement, and social workers.

*Developed by the Underwriting Section.*

#### Presenters:

**Gregory J. Massey, CPCU, CIC**  
Selective Insurance Company (moderator)

**Wayne Suss**  
Liberty Mutual Group

*Visit [www.cpcusociety.org](http://www.cpcusociety.org) for updated speaker information.*

**Register today for the 2006 Annual Meeting and Seminars at [www.cpcusociety.org](http://www.cpcusociety.org)!**

# Six Tips for a More Fulfilled Life

by Marsha D. Egan, CPCU, ACC



■ **Marsha D. Egan, CPCU, ACC**, is a celebrated keynote, facilitator, author, and ICF-certified coach. Egan speaks from experience as president of the energetic success coaching firm, The Egan Group, Inc. She is an ATHENA Foundation Award recipient and 25-year veteran of corporate and volunteer America. Egan intuitively reinvents leadership by igniting leaders with positive change and innovation. Services include keynotes, half- or full-day programs, and one-on-one coaching—designed to inspire individuals and organizations to maximize their potential. The firm publishes and produces numerous “how-to” e-books, CDs, and a biweekly e-zine, *The SIGNAL*—for more than 20,000 success-seekers worldwide. Egan is past president of the national CPCU Society, an Accredited Certified Coach, and a graduate of Duke University. Go to [www.marshaegan.com](http://www.marshaegan.com) to learn more about success and career tips.

To have a more fulfilling life, it is helpful for you to try to run your life rather than having it “run you.” Here are some tips to help you do that.

## Know and Live Your Values

First of all, it is important for you to know what your values are. Values drive the way you live your life. They are the backbone that will help you make decisions when there is no roadmap. Values are personal, and they should be yours alone. Take some time and write them down.

It’s a challenge to continually live your values. That’s why it is important to write them down and review them regularly. It has been said that people judge you by your actions, while you judge yourself by your intentions. Make sure your actions and intentions match!

## Have Goals

Once you’ve articulated your values, it’s time for you to think about your life goals. Some of these are long term, and some can be short term. The harsh reality is that only about 2 percent of everyone in the world has goals. Yet goals are instrumental in helping people achieve what they want. But even more than that, it is important to have goals that are **big**. It’s true that if you write goals down, you’ll be much more likely to accomplish them. So try it. See what happens!

When you have goals, you have focus. They will give you direction and purpose. They enable you to work your plan, rather than planning your work. They give you a greater sense of control and excitement for your life.

## Live in Balance

Values and goals are lived best when you have balance in your life. Fulfillment in one area fuels each other area. Too much emphasis in one area can drain the others. It’s important to assess your balance, from time to time, and to take steps to assure that your life is

well-rounded physically, emotionally, intellectually, attitudinally, and purposefully.

## Live in the Moment

When you believe that only **you** control your attitude, and you combine it with recognizing your ability to live in the moment, you can truly control your enjoyment of life. Too many people live in the past or the future, and it inhibits their ability to enjoy the actual moment they’re experiencing. You have a **choice** to be happy or sad, a **choice** to worry or anticipate, a **choice** to be positive or negative. What is yours?

## Be Passionate

Lastly, it is important that you fill your life with passion. Be passionate about who you are, what you have, and what you do. If you don’t have passion for these things, you are just walking through your life. Knowing that your attitude is your choice, you can also have a choice about being passionate.

## Be Willing to Change

When some part of your life doesn’t seem to be working, you should be willing to make changes. Changing is difficult, but a lackluster life may be even more difficult over the long run! Figure out what it is you want to change, set a goal to do it, work that plan, then celebrate your new fulfillment!

## How to Determine Your Values

When you write your values, write them in the present. Here are some examples: “I am financially secure,” “I add value,” “I am physically fit.” Here are some areas that you might consider for articulating your values: finances, community, family, relationships, work, education, health, and attitude.

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# Six Tips for a More Fulfilled Life

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The best way to set about articulating your values is to take some private time, and write down as many of your values as you can. They will start to fall into groups or categories with a major value defining them. They'll fall into values with clarifying statements. Here's an example:

- I am financially secure.
- I pay my bills in advance.
- I save x% of my income.
- I have x% of my salary in reserve.
- I review my insurance annually.

## How to Write Goals

Goals should describe the result, or what success looks like, rather than the way you will get there. Don't say, "I will be on the ABC diet for three weeks," because that describes the means, rather than the end. Goals should also be SMART: Specific, Measurable, Achievable, Relevant, and Timebound. Instead of saying, "I want to lose weight," it's more effective to say, "I will lose 10 pounds by May 1. By giving yourself definite targets with specific dates, your chances of meeting or exceeding your goals will increase.

Some of the goals might drive directly from your values; as an example, if your value is to save x% of your income, and you are not there yet, that could be one of your goals.

I like to have my clients vision themselves at age 90, sitting on their front porches, rocking happily, thinking back on their lives, smiling over what they'd accomplished. If that were you, what would those accomplishments be? To put a child through college? To run a marathon? To visit every state in the United States? ■





# Negligent Entrustment

by Paul Farrell

**Author's Note:** Disclaimer—The author is not an attorney, and the information contained in this article is not to be considered legal or professional advice.

■ **Paul Farrell** is the CEO of SafetyFirst, a team of experts from the transportation, insurance, and software industries that specialize in reducing commercial auto collisions through management information systems and programs, such as 24/7 call center and “Safety Is My Goal” decals for vehicles. The decals feature a phone number to a call center encouraging motorists to report risk-taking behaviors by drivers. The company provides solutions in partnership with insurance carriers and transportation firms. More information can be found at [www.safetyfirst.com](http://www.safetyfirst.com).

The pursuit of negligent entrustment verdicts in the aftermath of commercial auto claims is unsettling for policyholders and defending insurers. Settlements are often large, and judgments can often include punitive damages. In effect, the pursuit of a negligent entrustment verdict is a second claim for the same collision event—the first claim is that of negligence on the part of the driver, but the second is against the management team for having entrusted the vehicle to the driver. Fortunately, there are basic steps that management teams can take to guard against the allegation of negligent entrustment.

## What Does Negligent Entrustment Mean?

In simple terms, negligent entrustment means to charge someone with a trust or duty in an inattentive or careless fashion or without completing required process steps.

In commercial vehicle operations, a case of “negligent entrustment” may arise when someone allows another person to use a vehicle knowing, or having reason to

know, that the use of the vehicle by such person creates a risk of harm to others.

There are two other theories of employer liability that are closely related to negligent entrustment: *respondeat superior* and *negligent hiring*.

Simply stated, *respondeat superior* holds an employer responsible for the conduct of an employee while the employee is acting within the scope of his or her employment.

*Negligent hiring* holds an employer responsible for the conduct of an employee if the employer failed to use due care in hiring and retaining such employee. An example of a circumstance involving negligent hiring would be the employer's failure to check a driver applicant's driving record where it would have revealed a poor driving history.

In the case of commercial vehicle operations, charges of negligent entrustment often arise after a collision where the employee or contractor was dispatched on a run without due regard for his or her qualification/ability to safely operate the vehicle.

Although the driver's own negligence in causing the accident is usually the primary issue, the two main focuses of investigation of a negligent entrustment charge are your company's policies and practices. Basic questions are asked: Did your company have a policy regarding driver selection and training? Did your management team actually adhere to the terms and conditions of that policy?

## What Elements “Make Up” Negligent Entrustment?

There are several issues that are examined in a case or claim alleging negligent entrustment:

- The driver must be incompetent.
- The employer knew or should have known of this incompetence.
- The employer must have entrusted the vehicle to the driver.



- The driver was negligent on the occasion in question.
- The driver's negligence proximately caused the crash.

Let's examine each of these five issues in more detail.

## How Can It Be Shown that the Driver Is Incompetent?

Cases in many jurisdictions have focused on establishing the minimum competency of drivers by using the Federal Motor Carrier Safety Regulations (FMCSR) as a reference. In simple terms, these regulations require that a driver:

- be of legal driving age for the state where his or her license was issued
- be able to read and speak the English language
- by reason of experience or training, be able to safely operate the vehicle
- by reason of experience or training, be able to determine whether the cargo is securely loaded
- be physically qualified to operate the vehicle
- hold a valid driver's license
- complete an application form for employment
- complete a driving test in the type of vehicle the applicant is expected to operate and be deemed qualified to operate the vehicle (have not committed a criminal offense)

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# Negligent Entrustment

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A complete review of the FMCSR is beyond the scope of this document.

Although enacted to govern companies that are under the authority of the Department of Transportation (DOT), the Federal Motor Carrier Safety Regulations are increasingly being referenced as a benchmark to measure the qualifications of a “professional driver” (a person with driving as a regular part of his or her job duties). When allowed as evidence in cases involving companies who are not under the authority of the DOT, this principle can make a big impact on the outcome of a court decision.

Of course, the easiest method of demonstrating a driver’s incompetence is a long history of traffic violations and/or collisions.

## **How Can It Be Shown that the Employer Knew or Should Have Known of the Driver’s Incompetence?**

Typically, all pertinent employment records of the driver will be reviewed by the plaintiff’s counsel. They will also do a thorough investigation of the driver’s background, including his or her driving record. If the employment records do not contain an accurate and complete driving history of that employee, then the plaintiff’s attorney will assert that the employer “knew” or should have known of the incompetence. If the plaintiff’s counsel independently discovers records indicating incompetency, then the employer should have been able to discover the same knowledge.

## **How Can It Be Shown that the Employer Entrusted the Vehicle to the Driver?**

If the driver is performing within the scope of his or her job duties and the vehicle was not taken without permission, the vehicle has presumably been entrusted to the driver by the employer.

## **How Can It Be Shown that the Driver was Negligent on the Occasion in Question?**

An investigation of the accident scene, interviews with the parties involved and witnesses, and other evidence, such as a citation issued to the driver, can be used to prove a finding of negligence.

## **How Can It Be Shown that the Driver’s Negligence Proximately Caused the Crash?**

There are several ways that this may be established, often involving investigations by “expert witnesses,” but a simple test is to determine whether the driver was issued a citation, was criminally charged, or otherwise ruled to have been “at-fault” after a presentation of evidence.

## **What Can My Company Do to Reduce Our Exposure?**

There are several areas of a human resources and safety program that should be examined:

- driver recruiting and selection practices
- new hire evaluation and orientation
- ongoing driver review and training
- post-accident reviews and training

## **Driver Recruiting and Selection Practices**

How your company attracts and then selects drivers is very important. Regardless of negligent entrustment allegations, it just makes good business sense to attract and hire the very best candidates for the job.

When recruiting drivers, you should make it clear in the advertisement that the position requires driving, and that candidates, in order to be qualified, should possess certain qualifications. These qualifications should be spelled out in detail to avoid interviewing unqualified prospects. These qualifications will vary from job to job, but examples could include:

- Possess a valid drivers license.
- Possess a specific type of license (i.e., commercial license with applicable endorsements).
- Have a clear Motor Vehicle Record.
- Have experience operating a vehicle similar to the one that they will use on the job.

Some companies may need to focus on selecting people for their technical skills or sales skills as a first priority, and then consider their driving ability. In this situation, the company should set and follow certain standards for driving ability: if the person can not meet those standards, he or she will not drive. If he or she meets the minimum standards, but is considered “conditional” (i.e., the candidate could fall below the standard with one new violation or accident), then a training and monitoring plan should be enacted to enhance driving skills and to watch for inappropriate risk-taking behaviors that could endanger the driver or the public.

Companies with multiple locations that do not have centralized control of recruiting and hiring need to conduct audits to be sure that corporate guidelines are being carried out at every location. Exceptions to existing guidelines should not be tolerated.

Management teams should review their driver recruiting and selection practices annually to be sure that they continue to attract a suitably qualified driver for each position. The review should also note any changes in position descriptions, especially if driving time increases or is added to a position’s responsibilities. Changes in state or federal regulations affecting the position should also be reviewed and incorporated into company policy as needed.

The “bottom line” is this: job requirements need to be clearly communicated, and only qualified candidates should be placed into those jobs.



## New Hire Evaluation and Orientation

Once an employee has been hired, additional verification of qualifications may be necessary. Medical reviews, drug and alcohol screening, road testing, and other types of required evaluations may need to be completed in order to meet state or federal regulations. Any newly discovered shortcomings should be documented and addressed. For example, a driver who demonstrates inappropriate behaviors during a road test should receive documented training aimed at improving those demonstrated behaviors. If a driver has serious problems in this phase, he or she should not drive until the issues have been fully rectified.

Management also has an opportunity to provide some type of indoctrination to the duties and expectations that come with the job. This may be accomplished in a number of ways:

- deliver a “driver handbook”
- deliver an “employee manual”
- provide classroom instruction

If delivering written materials, the employer should have the employee sign an acknowledgment that he or she has received the manual and is required to read it. It may also be necessary to follow up with each employee at a later time to verify that the manual has, indeed, been read.

Management should monitor their driver orientation, testing, and training

programs to be sure that poor driving behaviors are discovered and addressed promptly. Periodic review of the effectiveness of the programs will ensure that programs that are becoming outdated can be replaced.

For a multi-location company, periodic reviews of each location should occur to make sure company evaluation and orientation standards are followed consistently.

## Ongoing Driver Review and Training

It is not prudent to qualify a driver only once, at the time of hire, and then never revalidate his or her qualifications. People change over time, and so do their habits. Drivers who are subject to the Federal Motor Carrier Safety Regulations need to participate in an annual review of their performance conducted by their employer. This often includes obtaining an up-to-date motor vehicle record (MVR) from the driver’s state of license.

Companies that are not subject to the authority of the DOT should carefully consider implementing some form of annual review. This may be as simple as obtaining an updated MVR on each driver or as extensive as holding a formal performance review that includes annual road tests designed to validate behind-the-wheel performance.

Ongoing training is also helpful in maintaining safety awareness among drivers. Training can take on many forms:

- skill training delivered via audio cassette (while operating the vehicle)
- video training programs (classroom)
- self-led training programs (at home)
- oral presentations by management or technical expert (classroom)

Other awareness building opportunities exist via safety posters, newsletters to drivers, and safety announcements in payroll checks.

Training shows a commitment to safety by management, but should be carefully documented to verify, precisely, which drivers actually attended and/or completed the coursework.

## Post-Accident Reviews and Training

Most companies have established specific accident reporting procedures. Typically, a driver completes a recordkeeping kit at the scene of the collision, and then reports the details of the crash to a supervisor at his or her home terminal/location. Follow-up investigations may be completed by special teams, committees, specially trained managers, or experts.

Although the purpose of these investigations is not to establish blame or fault, the records associated with the investigation may appear to do so. These records could become evidence especially if the driver in question has had multiple accidents that have been investigated.

The process is important to improving safety by understanding why accidents happen. The investigations should not be abandoned simply because the report may be discoverable. Investigators should exhibit care when documenting their case to avoid humorous remarks that could be misinterpreted, and they should keep the file and its contents confidential.

Additionally, when it becomes clear that a lawsuit is being filed, the records should be secured to ensure their availability.

The results of any investigation should be carefully considered by management. If a gap in safety procedures is found, an action plan to correct the deficiency should be made and carried out. Ignoring the report’s conclusions invites trouble by potentially painting a picture of management as indifferent toward safety results.

If the driver was responsible for the accident and specific behaviors or a lack of knowledge/ability was involved, plan and enact a driver-specific action plan.

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# Negligent Entrustment

*Continued from page 11*

This might include driver training or coaching by a supervisor. Again, to ignore skill or knowledge gaps may reflect poorly on management's commitment to safety.

## What About Contracted Employees or Loans of Vehicles to Non-Employees?

Contracted employees who operate company-owned/leased vehicles could expose your company to allegations of negligent entrustment. Examples of this type of situation could include:

- a contracted security guard who uses a company pool car for patrols
- a temporary employee (from an employment service) who takes a car to the post office
- a temporary employee (from an employment service) who makes deliveries
- a maintenance contractor who needs to run out for a part or another location to do work
- transportation operations who contract with owner operators or run on other companies' DOT rights
- trip leasing

If this exposure exists, qualify the operators of the vehicles, or avoid the risk.

Similarly, providing company vehicles to non-employees represents a risk to your company. Although the entrusted person is not acting within the scope of employment for your firm, your company's vehicle has been made available for their use and their qualifications should be evaluated.

What was perceived as a harmless use of the vehicle can be potentially damaging, e.g., loaning a delivery vehicle on the weekend to accomplish a household move to a new residence.

Another potential exposure comes from permitting spousal use of company cars without attempting to qualify their driving ability/history. If you haven't seen the benefit of a corporate vehicle use policy until now, there is no better justification than the issue of negligent entrustment!

## Summary

Negligent entrustment and its associated theories of liability can lead to costly litigation. Effective safety and qualification programs are critical to avoiding these types of litigation, and top management's commitment to make these programs produce results; your firm may be able to avoid unfortunate outcomes.

Additional resources and information are available through your insurance carrier, trade associations, and specialty firms that provide products and service to the fleet industry. ■



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*Retired FDNY Battalion Commander Richard Picciotto will speak at the CPCU Society's Annual Meeting on September 10, one day before the fifth anniversary of 9/11.*



*Photo courtesy of Nashville CVB and Heavenly Perspectives.*

# Underwriting Audits—Opportunities to Excel

by Kathryn A. Fastner, CPCU, AIM

■ **Kathryn A. Fastner, CPCU, AIM**, is owner of Education Segue, a Houston-based firm specializing in training and consulting for insurance professionals and organizations. The firm's services also include underwriting and reinsurance audits, as well as expert witness projects. Fastner has conducted underwriting and reinsurance audits throughout her career in various underwriting-related positions. She received her CPCU in 1980, and has taught CPCU courses on behalf of the CPCU Society's Houston Chapter, serving as the chapter's education director. She can be reached at [kfastner@att.net](mailto:kfastner@att.net).

If you are an underwriter for very many years, ultimately your work will be subjected to scrutiny by senior management, reinsurers, or if an MGA underwriter, by the issuing carrier. If you dread the arrival of the auditor to review your work, there is a way to not only pass underwriting audits with ease, but to put the audits to work for you. Over the years, both as an underwriter and auditor, I have watched with fascination as underwriters have worked themselves into a dither at the thought of home office or outside auditors evaluating their work. I hope that your experience was not with an auditor that had an "agenda" that does not serve the best interests of the company nor the underwriter.

Underwriting audits are designed to ensure that the very best skills, knowledge, and business practices are

brought to the task, and they are of immense value when used as tools for identifying those that are performing well (as well as those that are not), identifying early in the process any problems with compliance, either statutory or internal, and helping the underwriting staff to develop into stronger underwriters. Underwriting audits should not have as its purpose "gotcha" as it no longer becomes a tool to improve the underwriting staff, and instead becomes a weapon wielded against underwriters. So assuming that the goal of an auditor is to provide a tool instead of a weapon, I would like to contribute the business practices that most impact my evaluation when conducting underwriting audits.

## Underwriting Guidelines/ Lines of Authority

The primary goal of most underwriting audits is to verify that the underwriting staff is following the guidelines established by the organization and operate within the authority granted for each position. For an audit to be truly objective, the auditor must be able to measure the underwriters' performance against clearly defined underwriting guidelines so that the underwriters are directed to bind risks on behalf of the insurance company. In bringing the most value to the underwriting process, the underwriting guidelines should be specific on what types of risks are eligible for the underwriter to accept, and even more important, what is not eligible. The underwriting guidelines should include the criteria that are relevant to the book of business being underwritten. The underwriting criteria encompass those things that fine tune the factors that make an individual risk of an eligible class, the best of the class (e.g. set a minimum for time in business/tenure of experience, loss experience, age limitations, economic factors, ancillary coverages, MVR history, protections). Last but not least, the underwriting guidelines should contain pricing guidelines that set maximum and minimum pricing for individual

risks as well as for the book of business. As the market and industry change, the underwriting guidelines should also change as the need arises.

Recognizing that underwriters in any organization have differing levels of experience and knowledge, not every underwriter should have the full authority of the insurance company. The lines of authority should take into account the experience of each individual underwriter, and allow binding and pricing authority within parameters that match the person's level of knowledge and experience. Lines of authority establish maximum limits of liability, territorial limitations, discretionary credit/debit limitations, and clear reporting instructions when the risk exceeds the line authority of the underwriter.

Once the underwriting activity has been evaluated against the underwriting guidelines and lines of authority, most underwriting audits look to whether the underwriters are applying good practices in making their daily decisions. Good underwriting practices are the habits of individuals that allow for quality work performance. It also shows auditors that the underwriter knows the best approach in analyzing risk, and that the appropriate steps are taken in the decision-making process. The underwriting practices consist of documentation, hazard evaluation, loss history/experience, and policy issuance.

## Documentation (Documentation, Documentation!)

An auditor's first impression of an underwriter is the state of the file—is it organized or are documents filed in a haphazard manner or, worse, not filed? Even more important than file organization is what is contained within the file. For that purpose, an auditor notes whether or not the underwriter had sufficient information to evaluate the exposures and properly classify and price the account. Below are the questions I



ask myself in evaluating the adequacy of documentation:

- **Applications and Supplemental Information**
  - Does the file contain a completed application with all relevant questions answered?
  - Does the file contain sufficient loss history?
  - Is supplemental information needed, such as financials, MVRs, OSHA logs, IRS 941s, loss control reports, appraisals, schedules of property or vehicles, etc.?
  - Does the application contain information relevant to the underwriting guidelines, especially with respect to underwriting criteria? If not, has the underwriter taken the initiative to find out the information?
  - Does the file contain experience rating worksheets, where applicable?
- **Correspondence**
  - Does the file contain the correspondence between the underwriter and agent?
  - Is there documentation specific to the agreed terms for providing insurance protection?
- **IRPM and Scheduled Credit/Debit Worksheets**
  - Does the file contain the appropriate filed form for the use of IRPM or scheduled debits and credits?
  - Does the information in the file justify the use of specific categories (e.g. credit for strong financial status when no financials are present in the file)?
  - Does the file information contradict the use of a debit or credit in any category (e.g. credit for well-maintained premises when the loss control report indicated the premises are ill-kept)?

- **Miscellaneous**

- If the class or pricing exceeds the underwriter's authority, is evidence of referral in the file?
- If reinsurance is used, does the file reflect the cessions clearly?
- If facultative reinsurance is purchased, is the certificate from the reinsurer in the file and does it reflect the agreed-upon terms?

## Hazard Evaluation

Assuming that the underwriter has collected sufficient information to properly evaluate risk exposures, the next part of the review looks at the analysis of the hazards presented for the prospective insured's operations. These are questions to take into account when analyzing the hazards of the risk:

- **Exposure Analysis**

- Has the underwriter considered the hazards associated with the class of business as well as the applicant's specific characteristics?
- Does the underwriter know everything about the named insured's operations?
- Has the minimum underwriting criteria been met?
- What modifications of coverage are required in light of the hazard analysis?
- If a renewal, what has changed since the underwriter last reviewed the account?
- Are there any discontinued operations, new products, or changing environment?

- **Risk Classification**

- Has the underwriter properly classified the risk?
- Is the hazard an eligible class under the underwriting guidelines?
- Is the risk exposure properly classified for rating purposes?

## Loss History/Experience

Every underwriter knows that an account's prior loss history is indicative of future loss experience. The underwriting guidelines should give an indication of how many prior years' loss experience an underwriter needs to evaluate. Long-tail loss exposures will require a longer history than short-tail loss exposures due to the development patterns. Are you asking yourself these questions when evaluating loss history and loss experience on existing accounts?

- **Loss History (New Business)**

- Are loss runs supplied by prior carriers on a policy year, accident year, or calendar year data basis?
- Is the line of business long tail or short tail?
- Is the exposure to loss frequency, severity or frequency of severity?
- Is the applicant's experience out of the norm for the class?
- Are loss descriptions consistent with an underwriter's analysis of the hazards?
- Has the underwriter taken into account deductibles in looking at loss history?
- Were deductibles utilized by the prior carrier to deal with frequency of loss, and how does it compare with coverage request now?
- How was pricing established in relation to the account's loss history?

- **Current Carrier Experience (Renewals)**

- What improvements have been made (or not) in the insured's operations, and are they reflected in current loss experience?
- If deductibles were used to improve loss experience for frequency of loss, has the carrier's loss experience shown improvement?
- Are managers or the underwriters using large loss reports to evaluate risk after a loss?

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# Underwriting Audits—Opportunities to Excel

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- Are there exposures not contemplated by the class that emerges from the loss experience?
  - Are losses consistent with the application and prior loss history?
  - Has the underwriter considered actions that should be taken not only on renewal but also throughout the life of the policy in light of loss experience (e.g. changes in coverage, cancellation, non-renewal)?
  - Is the underwriter responding with a “knee-jerk” reaction to adverse loss experience, or a measured underwriting decision?
- Has the agent or policyholder’s risk manager inserted changes to a standard form or manuscript form?
  - If so, has the underwriter considered the importance of the changes in the context of the entire policy?

## Policy Issuance

The underwriting process is not complete until the policy is issued, and then issued in the manner in which it has been agreed by the underwriter and agent. The results of the World Trade Center litigation showed how important not only documentation between underwriter and agent is, but the importance of policy issuance to forestall coverage disputes. Much debate took place in court on which policy form, WillProp or something different, that was the intended policy form. Had the policies been issued, there would have been no need for this to be litigated. As an auditor, I look for the answers to these questions:

- **Timing Issues**

- How much time passed between the policy effective date and policy issue date?
- Are the agreed terms and conditions as stated by the underwriter in the file documentation reflected in the final insurance contract?
- Does booked policy premium and reinsurance follow the underwriter’s instructions?

- **Contract Analysis**

- Is it a manuscript form and is the underwriter aware of differences in the form to standard forms?

I speak without hesitation when I say that there are many very good underwriters around the country, and as an auditor I view their work with pride in what we collectively have achieved over the years. I celebrate the keen minds that can slice and dice the risk, analyzing the exposures for a well thought-out selection of risk for the best risk price. Good underwriters meet the challenge of their fiduciary responsibility to the insurance company’s stakeholders, (i.e. fellow employees, reinsurers, policyholders, and stockholders) by employing skills and knowledge to risk selection and pricing that protects the assets of the company while meeting the objectives of the insurance industry to provide insurance protection—and are able to do so during both hard markets and soft markets.

Knowledge of what to expect when an auditor hits your doorstep is a road map to conducting your daily activities in such a manner that the audit outcome highlights your talent and value to the organization. A word of warning that this is no magic elixir that will turn your book of business into an overnight success; if you have not already incorporated these practices in your work process, it will take time to achieve a “winning” book of business. As I have been told many times by managers and underwriters, these habits are more time-consuming than their current process, and I acknowledge that it does take more time to fulfill these tasks than to skip them. I hope that you can see the value of adding this to your underwriting process, and should I happen to be the next auditor at your organization, I would have the pleasure of congratulating you on the talent you have exhibited in managing your book of business. ■



# Clear Eye for the Claims Guy:

## Fifth Annual Look Back at the Year's 10 Most Significant Insurance Coverage Decisions

by Randy J. Maniloff



■ **Randy J. Maniloff** is an attorney 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, directors and officers 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 author expresses his appreciation to firm partner Gale White for her invaluable assistance in the preparation of this article. The views expressed herein are solely those of the author and are not necessarily those of his firm or its clients.

**Editor's note:** The following article is an "excerpt" from the author's 24-page article that appeared in the January 10, 2006 issue of *Mealeys' Litigation Report—Insurance*. Please feel free to contact the author at [maniloffr@whiteandwilliams.com](mailto:maniloffr@whiteandwilliams.com) for a copy of the full article. The article presented here will discuss the top 10 cases, and provide a longer discussion on four of them that this editor feels would be of most interest to the majority of the *Underwriting Trends* readers.

An insurance claims manager says to a customer, "Thank you for your patronage, Mr. Smith. I wish we had 20 policyholders just like you." "Gee, it's nice to hear you say that," Mr. Smith replied. "But I have to admit, I'm kind of surprised. As you know, I make many claims and my premium payments are always late." "That's okay," the claims manager replied. "We'd still like 20 customers just like you. The problem is, we have 200."<sup>1</sup>

Insurance is about one thing—claims. So it shouldn't come as a surprise to anybody that there are a lot of them. One consequence of so many claims is that a large number of decisions addressing insurance coverage—likely in the thousands—are collectively issued each year by all levels of state and federal courts. I am grateful for the opportunity to make the case for 10 decisions from this huge pool from the year gone by that are likely to play a significant part in shaping the insurance coverage landscape in the years ahead.

There is nothing scientific or democratic about the method used to select these cases. It is an entirely subjective process based generally on the following criteria. Each decision (1) is (for the most part) from a state supreme court or circuit

court of appeal; (2) addresses a coverage issue that has the potential to affect a large number of future claims; and (3) either alters a previously held position or sheds light on a burgeoning issue.

The following were the most significant insurance coverage decisions in 2005 (listed in the order that they were decided):

**General Agents Insurance Company of America v Midwest Sporting Goods Company**—Illinois Supreme Court put the kibosh on an insurer's attempt to recover defense costs following a declaration that the insurer had no duty to defend. But the California and Montana Supreme Courts disagreed. The Texas Supreme Court allowed reimbursement in the indemnity context in *Excess Underwriters at Lloyd's, London v Frank's Casing Crew & Rental Tools*.

**State Fire and Tornado Fund of the North Dakota Insurance Department v North Dakota State University**—North Dakota Supreme Court addressed a key coverage issue concerning Hurricane Katrina five months before the first raindrop in New Orleans. It doesn't get much more prescient than this.

**Nav-Its, Inc. v Selective Insurance Company of America**—New Jersey Supreme Court finally ended its silence on the absolute pollution exclusion. The high court limited the exclusion to the Swamps of Jersey. An absolute pollution exclusion honorable mention goes to *The Quadrant Corporation, et al. v American States Insurance Company*, in which the Supreme Court of Washington told policyholders: How do you like them

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apples? Bonus case—Judge Alito on the sudden and accidental pollution exclusion.

## **Liberty Mutual Insurance**

### **Company v Treesdale, Inc.—**

Liberty Mutual got back up on the horse after Spaulding Composites sought to enforce its non-cumulation clause. Third Circuit's response: Money does not grow on Treesdale. Honorable mention to *Hivaldo v Allstate Insurance Company*—New York Court of Appeals addressed a non-cumulation clause.

## **The Goodyear Tire & Rubber Co.**

**v Dynamic Air, Inc.**—Minnesota Supreme Court ruled that a party insured by an insolvent insurer remained liable for any portion of the claim between the maximum amount available from the guaranty association (\$300,000) and the liability limit of the insolvent insurer's policy. This question will soon be decided by the New Jersey Supreme Court.

## **Chelsea Associates, LLC v**

### **Laquila-Pinnacle—**

New York Appellate Division gave insurers one more reason to adopt ISO's recent additional insured endorsements that preclude coverage for an additional insured's sole negligence.

## **BP America, Inc. v State Auto**

**Property & Casualty**—Supreme Court of Oklahoma issued a treatise on the distinction between the phrases "any insured" and "the insured" as used in policy exclusions.

## **Taurus Holdings, Inc. v**

**USF&G**—Florida Supreme Court addressed whether liability policies issued to gun manufacturers were triggered for suits by municipalities. The court's comprehensive discussion of the phrase "arising out of" also made the decision significant.

## **Hooters of Augusta v American Global Insurance Company—**

Eleventh Circuit fired the latest (but not most significant) shot in the see-saw battle over the availability of advertising injury coverage for junk faxes. The real shelling over this issue took place in Illinois.

## **Significant Insurance Coverage Decisions in 2005**

### **General Agents Insurance Company of America, Inc.**

**v Midwest Sporting Goods Company, et al.**, 215 Ill. 2d 146, 828 N.E.2d 1092 (2005); *Excess Underwriters at Lloyd's, London v Frank's Casing Crew & Rental Tools, Inc.*, 2005 Tex. LEXIS 418

In *Midwest Sporting Goods*, the Illinois Supreme Court answered whether an insurer that reserved its rights to do so was entitled to reimbursement of its costs to defend an insured in an underlying action in which it was later judicially determined that no duty to defend was owed.

General Agents Insurance Company of America (Gainsco) funded the defense of *Midwest Sporting Goods* in an underlying action brought by the City of Chicago alleging that *Midwest* created a public nuisance by selling guns to inappropriate persons. *Midwest Sporting Goods* at 1093. Gainsco funded the defense subject to a reservation of rights, specifically informing the insured that such rights "include[d] the right to recoup any defense costs paid in the event that it is determined that the Company does not owe the Insured a defense in this matter." *Midwest Sporting Goods* at 1095.

Gainsco filed an action seeking a declaration that it did not owe *Midwest Sporting Goods* a defense in the underlying *City of Chicago* litigation, and that Gainsco was entitled to recoup all defense costs paid to *Midwest's* counsel



in the litigation. It was ultimately determined that Gainsco did not owe a defense to *Midwest* because the plaintiffs in the underlying litigation were seeking damages for economic loss and not bodily injury. That decision was affirmed by the Illinois Appeals Court and *Midwest* did not seek further review. *Midwest Sporting Goods* at 1094–1095.

Having established that no duty to defend *Midwest* was owed, the trial and appeals courts also held that Gainsco, which reserved its right to recoup defense costs, was now entitled to their recovery. That issue made its way to the Illinois Supreme Court.

*Midwest* argued before the Supreme Court that the Gainsco policy contained no provision allowing for the recovery of defense costs. Gainsco's position was that this argument must fail because, following the courts' determination that no duty to defend was owed, there was no contract governing the parties' relationship. *Midwest Sporting Goods* at 1097.

The court acknowledged that other jurisdictions allow an insurer to recover

defense costs from its insured where the insurer provides a defense under a reservation of rights, including the right to recoup defense costs, the insured accepts the defense, and a court subsequently determines that the insurer did not owe a defense. *Midwest Sporting Goods* at 1100. Nonetheless, the Illinois Supreme Court determined to follow the minority position.

The Illinois Supreme Court also rejected Gainsco's argument that, following the lower courts' decision that no duty to defend existed, there was no contract governing the parties' relationship. The Supreme Court noted that the problem with this argument was that Gainsco was defining its duty to defend based on the outcome of the declaratory judgment action, yet an insurer's duty to defend arises as soon as damages are sought. *Midwest Sporting Goods* at 1103.

Despite its conclusion, the Illinois Supreme Court did not rule out the possibility of an insurer recovering defense costs under different circumstances:

Certainly, if an insurer wishes to retain its right to seek reimbursement of defense costs in the event it later is determined that the underlying claim is not covered by the policy, the insurer is free to include such a term in its insurance contract. Absent such a provision in the policy, however, an insurer cannot later attempt to amend the policy by including the right to reimbursement in its reservation of rights letter.

*Midwest Sporting Goods* at 1103.

***Chelsea Associates, LLC, et al. v Laquila-Pinnacle, et al.*, 21 A.D.3d 739, 801 N.Y.S.2d 15 (2005)**

When it comes to coverage for additional insureds, it's the oldest story in the book. A subcontractor is obligated by agreement to name the general contractor as an additional insured under the subcontractor's commercial general liability policy. The



subcontractor complies. An employee of the subcontractor is later injured on the worksite, and brings suit against the general contractor for failure to maintain a safe premises. The general contractor seeks coverage as an additional insured under the subcontractor's policy. The subcontractor's insurer declines coverage because it asserts that the general contractor's liability clearly did not arise out of the subcontractor's work, as required by the additional insured endorsement. Coverage litigation ensues, often brought by the general contractor's own insurer seeking to shift its liability to the subcontractor's insurer. The insurer for the subcontractor frequently loses this case because the court concludes that coverage for the general contractor, as an additional insured under the subcontractor's policy, is not precluded by a finding of negligence (even sole negligence) on the general contractor's part.

The number of cases that follow this pattern are too numerous to count. While last year's decision by the New York Appellate Division in *Chelsea Associates, LLC v Laquila-Pinnacle* is simply another one that can be added to this long list, its timing makes it significant.

First, a quick look at *Laquila-Pinnacle*, followed by the timing issue. *Laquila-Pinnacle* was a concrete subcontractor that had been hired by Turner Construction Company, the general contractor on a high-rise apartment project. As required by its contract, *Laquila-Pinnacle* procured general liability insurance naming Turner as an additional insured. A laborer employed by *Laquila-Pinnacle* commenced an action against Turner, among others, for injuries sustained when, en route to his work, he tripped on plywood being used as a temporary ramp near the entrance to the job site. *Laquila-Pinnacle* at 740.

The additional insured endorsement contained in *Laquila-Pinnacle*'s policy was a common one and provided as follows:

WHO IS AN INSURED (Section II) is amended to include as an insured the person or organization shown in the Schedule, but only with respect to liability arising out of "your work" performed for that insured by you or on your behalf.

*Laquila-Pinnacle* at 741.

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The majority concluded that coverage for Turner as an additional insured was afforded under this coverage grant. The court stated:

It is further undisputed that (Laquila-Pinnacle's employee) was injured as he was entering the job site, en route to his work assignment. The "contract could not be performed, of course, unless (the subcontractor's) employees could reach and leave their workplaces on the job site," and therefore the "instant injuries, occurring during such a movement, must be deemed as a matter of law to have arisen out of the work." Any negligence by the Turner group is not material to an additional insured endorsement.

*Laquila-Pinnacle* at 740–741.

The dissent, making the common counter-argument to decisions like this, stated that the majority's decision improperly focused not on the cause of the accident but upon the general nature of the operation in the course of which the injury was sustained:

[S]uch an interpretation reads out of the clause the key words pertinent to its application here: "but only with respect to liability arising out of [Laquila's] work."

*Laquila-Pinnacle* at 742.

Now, a word about the timing of this New York Appellate Division decision. In July 2004, Insurance Services Office, Inc., in an effort to stem the tide of unintended additional insured coverage, introduced changes to its various additional insured endorsements. At the heart of these changes was the preclusion of coverage for an additional insured's sole negligence—something that many courts around the country, based on the language of certain previous ISO endorsements, have not hesitated to provide. ISO set out to eliminate coverage for an additional insured's sole negligence by amending its endorsements to specify that coverage is only available for their vicarious or contributory negligence (when the named insured is also one of the negligent parties). The

amended language of the additional insured endorsements provides in relevant part as follows (ISO Form CG 20 10 07 04) (underlined text added and bracketed text deleted):

Section II—Who Is An Insured is amended to include as an additional insured the person(s) or organization(s) shown in the Schedule, but only with respect to liability [arising out of your ongoing operations performed for that insured] for "bodily injury," "property damage" or "personal and advertising injury" caused, in whole or in part, by:

1. Your acts or omissions; or
2. The acts or omissions of those acting on your behalf; in the performance of your ongoing operations for the additional insured(s) at the location(s) designated above.

*Laquila-Pinnacle* is precisely the situation that the new additional insured language is intended to address. The opinion confirmed that *Laquila-Pinnacle*, the named insured, played no part in the laborer's injuries. As a concrete subcontractor, it was obviously not responsible for the placement of plywood used as a temporary ramp that led from the sidewalk to the building. Thus, under the amended additional insured endorsement, Turner, an additional insured, would not have been afforded coverage from its subcontractor's insurer because the "bodily injury" to the laborer was *not caused, in*



*whole or in part*, by *Laquila-Pinnacle's acts or omissions* in the performance of its ongoing operations for Turner.<sup>2</sup> It hardly seems unfair for Turner to be denied coverage under *Laquila-Pinnacle's* policy and have to look to its own policy. After all, Turner played a part in the cause of the injury, and *Laquila-Pinnacle's* insurer likely received no premium, or very little, to name Turner as an additional insured.

Despite the fact that ISO has amended its additional insured endorsements to limit coverage for an additional insured to its vicarious or contributory negligence, insurers—likely for various reasons—are sometimes slow to incorporate new forms into their underwriting practices. Not that there hasn't been enough writing on the wall for insurers to see that the use of additional insured endorsements that contain an "arising out of" trigger places them at real risk for providing free coverage for potentially huge losses, *Laquila-Pinnacle* will perhaps be the push that some need to make certain that they are now using the July 2004 version of ISO's additional insured endorsements. And, if not, there are a dozen more reasons—all from 2005 alone.<sup>3</sup>

## ***BP America, Inc. v State Auto Property & Casualty*, 2005 Okla. LEXIS 65**

In *BP America*, the Supreme Court of Oklahoma answered certified questions from the Northern District of Oklahoma concerning the meaning of the phrase "any insured" contained in the Auto Exclusion of a commercial general liability policy. The exclusion at issue provided as follows:

This insurance does not apply to:

g. Aircraft, Auto Or Watercraft

"'Bodily injury' or 'property damage' arising out of the ownership, maintenance, use or entrustment to others of any ... 'auto' ... owned or operated by or rented or loaned to any insured. Use includes operation and 'loading or unloading' ..."

*BP America* at \*\*3.



The court provided a sparse (and somewhat confusing) description of the facts of the underlying litigation. BP America was listed as an additional insured under a general liability policy issued to a construction company. A construction company employee was driving a dump truck that was involved in a multi-car accident resulting in several fatalities. BP America sought coverage under the general liability policy. The CGL insurer presumably declined to provide coverage on the basis of the policy's Auto Exclusion.

BP America argued that only negligent insureds should be denied coverage. Since the construction company, and not BP America, was responsible for the accident, BP argued that the Auto Exclusion, which precludes coverage for "bodily injury" arising out of the ownership, maintenance, use, or entrustment to others of any "auto" owned or operated by or rented or loaned to any insured, did not apply to it. The textual argument for BP's position was that "any," as used in the Auto Exclusion, should be read not to mean "all," but, rather, "the." The insurer countered that the Auto Exclusion "cannot be interpreted to allow coverage to an innocent insured when all automotive liability coverage of any insured is specifically disallowed." *BP America* at \*\*11. The Supreme Court of Oklahoma sided with the insurer:

The overwhelming number of courts, addressing policy language similar to that at issue here, determines, as a matter of law, that the term "any insured" in an exclusionary clause is unambiguous and expresses a definite and certain intent to deny coverage to all insureds—even to innocent parties. These jurisdictions recognize that to impose liability on the insurer would raise coverage where none was intended and no premium was collected.

*BP America* at \*\*11–\*\*12.



"Furthermore, adopting the position advanced by the insured would require that we unilaterally convert a general liability policy—without motor vehicle coverage—into an automotive liability policy. This we will not do." *BP America* at \*\*18.

The *BP America* court next addressed whether the inclusion of a severability clause in the liability policy renders the Auto Exclusion ambiguous. The policy's severability ("Separation of Insureds") clause provided as follows:

Except with respect to the Limits of Insurance, and any rights or duties specifically assigned in this Coverage Part to the first Named Insured, this insurance applies:

- a. As if each Named Insured were the only Named Insured; and
- b. Separately as to each insured against whom claim is made or 'suit' is brought.

*BP America* at \*\*20.

BP America argued that, even if the Auto Exclusion is clear when read in isolation, the inclusion in the policy of a severability clause renders the exclusion ambiguous:

The assertion rests on an argument that if, under the severability clause, each insured is treated as having a separate policy, only the negligent insured should be denied coverage.

*BP America* at \*\*21.

While noting that the majority/minority split is not as dramatic on the severability issue as the interpretation of the exclusion, *BP America* nonetheless concluded that "most courts addressing the issue of whether a severability clause will render a clear and unambiguous exclusionary provision doubtful determine that the clear language of the exclusion must prevail." *BP America* at \*\*26.

Failure to so hold results in the specific terms of the exclusionary clause being overridden by a more general severability provision. Furthermore, it requires the court to ignore and treat as superfluous, the term "any" in the policy language. It also ignores the purpose of the severability clause—to afford each insured a full measure of coverage up to the policy limits, rather than to negate bargained-for and plainly-worded exclusions.

*BP America* at \*\*24.

The majority view is that, in the context of exclusionary language relating to "any insured," the severability clause's only effect is to alter the meaning of the term "the insured" to reflect who is seeking coverage. *BP America* at \*\*26.

Cases that address the distinction between the phrases "any insured" or "an insured" and "the insured," as used

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in a policy exclusion, are not unique, as evidenced by *BP America* citing nearly 60 of them from around the country in reaching its decision. And as for the potential effect of a policy's severability clause on the exclusion, *BP America* cited approximately 50 cases nationally. Obviously, these are staggering numbers of cases to be cited by a court in its analysis of a single issue. Therein lies the significance of the Supreme Court of Oklahoma's decision in *BP America*.

The phrase "any insured" is seen in a variety of policy exclusions. As a result, the question whether an exclusion containing this phrase applies to so-called "innocent insureds" arises with regularity. But despite the exclusion's clear meaning, some insurers might still eschew coverage litigation when their case rests on the seemingly technical distinction between the phrase "any insured" and "the insured." Not to mention that all policyholders speak Latin and are quick to invoke *contra proferentem*—the rule of construction that if the policy language is ambiguous, it must be construed against the insurer, as its drafter. However, given the results of the comprehensive survey of this issue undertaken by the Supreme Court of Oklahoma in *BP America*, some insurers that were otherwise hesitant to pursue litigation based on this distinction may now be more comfortable doing so.<sup>4</sup>

## ***Hooters of Augusta, Inc. v American Global Insurance Company*, 2005 U.S. App. LEXIS 26765 (11th Cir.)**

Junk faxes cause insurance coverage disputes. That much is clear. Whether they cause "advertising injury" is much less certain. The availability of coverage for liability for sending junk faxes (i.e., violating the Telephone Consumer Protection Act) under the "advertising injury" portion of a commercial general liability policy has been the subject of numerous decisions since 2002. Courts have bounced back and forth on this issue.



*Hooters* was not the most significant junk fax coverage decision handed down in 2005. In fact, from the standpoint of potential precedent, it was arguably the least significant. However, because it was the latest decision at the time of this writing, it was selected to demonstrate the current state of this coverage issue.

The court addressed coverage for *Hooters* for its liability for sending unsolicited fax advertisements in violation of the Telephone Consumer Protection Act (TCPA), 42 U.S.C. §227. *Hooters* had purchased advertising space on weekly flyers faxed to a database of Atlanta businesses. One of the faxes was sent to an Augusta attorney. He sued *Hooters* for violation of the TCPA and was granted class certification. The TCPA made it unlawful "to use any telephone facsimile machine, computer, or other device to send an unsolicited advertisement to a telephone facsimile machine." The TCPA allowed for an award of \$500 in damages for each violation, trebled, in the court's discretion, if the defendant willfully or knowingly violated the statute. *Hooters* at \*2–\*4.

A jury returned a verdict against *Hooters* for knowingly and willfully violating the TCPA. The court exercised its discretion to treble the damages and entered judgment against *Hooters* for nearly \$12 million. Following a settlement that reduced the judgment to \$9 million and certain procedural maneuvers that led to the coverage litigation, the district court found coverage and entered a final judgment in the amount of \$5 million (the policy limit) plus post-judgment interest. *Hooters* at \*5–\*6.<sup>5</sup>

The Eleventh Circuit addressed whether *Hooters*'s TCPA liability qualified as "advertising injury," defined in relevant part under an umbrella liability policy as "oral or written publication of material that violates a person's right of privacy." *Hooters* at \*7. The court held that it did:

American Global first argues that *Hooters*'s conduct violated no right of "privacy" because a fax sent in violation of the TCPA would not constitute a common-law tort for invasion of privacy under Georgia law. American Global's reading may be one reasonable interpretation, but, undeniably, it is at least as reasonable to interpret "privacy" more broadly to include aspects of privacy protected by other sources of law, including state privacy statutes and federal law. Indeed, the statutory notion of being free from intrusive and unsolicited facsimile transmissions is at least arguably embodied in the common law right to privacy under Georgia law. An essential element of the right to privacy, Georgia's courts have recognized, is "the right 'to be let alone,'" or "the right to seclusion or solitude." Notably, the insurance policy contains no language explicitly limiting the scope of the term "privacy" or, for that matter, alerting non-expert policyholders that coverage depends on the source of law underlying the relevant privacy right.

*Hooters* at \*9–\*10 (citation omitted).

While the *Hooters* court did not address whether invasion of privacy means violation of a right to secrecy of personal information or intrusion into a private

domain, this is the issue on which TCPA coverage decisions often turn. For this reason, *Hooters* is unlikely to carry as much weight in the future as such decisions as *Capital Associates* and *Swiderski Electronics*, where this issue was addressed.

Tort reform advocates are fond of pointing out that the asbestos system is run amok because most of the plaintiffs are *not truly injured*. Not truly injured. It doesn't get more *not truly injured* than plaintiffs in an underlying TCPA suit. But as long as insurance dollars are available to fund statutory damages under the TCPA, there is no reason to expect this make-believe tort to go away anytime soon. Speaking of which, ISO has responded to this license to print money by adopting Form CG 00 67 03 05, which excludes coverage for advertising injury arising out of violation of the TCPA, CAN-SPAM Act of 2003, or any statute, ordinance, or regulation that prohibits or limits the sending, transmission, communication, or distribution of material or information.

Incidentally, while preparing the write-up of this case, I took a peek at Hooters's web site (for research purposes) and found an interesting position statement by the company in defense of criticism that its business concept exploits women. The company states, in part:

Claims that Hooters exploits attractive women are as ridiculous as saying the NFL exploits men who are big and fast. Hooters Girls have the same right to use their natural female sex appeal to earn a living as do super models Cindy Crawford and Naomi Campbell. To Hooters, the women's rights movement is important because it guarantees women have the right to choose their own careers, be it a Supreme Court Justice or Hooters Girl.

[www.hooters.com/company/about\\_hooters](http://www.hooters.com/company/about_hooters).

It certainly isn't everyday that one sees the words *Supreme Court Justice* and *Hooters Girl* in the same sentence. ■

## Endnotes

1. From the jokes page on [qualityininsurance.com](http://qualityininsurance.com).
2. In *Dillon Companies, Inc. v Royal Indemnity Company*, 369 F. Supp. 2d 1277 (D. Kan. 2005) the court interpreted the phrase "acts or omissions" in a manner that suggests that even the use of ISO's July 2004 additional insured endorsements is no guarantee that disputes over this issue will not continue.
3. *American Casualty Co. v General Star Indemnity Co.*, 125 Cal. App. 4th 1510 (2005); *Garamendi v Golden Eagle Insurance Co.*, 2005 Cal. App. Unpub. LEXIS 7082; *AIU Insurance Company v Clarendon America Insurance Company*, 2005 Cal. App. Unpub. LEXIS 2285; *LaFarge Midwest v Frankenmuth Mutual Insurance Co.*, 2005 Mich. App. LEXIS 1947; *Mikula v Miller Brewing Co.*, 701 N.W.2d 613 (Wis. App. 2005); *City of St. Paul v Penn-America Ins. Co.*, 2005 U.S. Dist. LEXIS 14975 (D. Minn. 2005); *Ingalls Shipbuilding v Fed. Ins. Co.*, 410 F.3d 214 (5th Cir. 2005); *Meridian Mut. Ins. Co. v Cont'l. Bus. Ctr.*, 2005 U.S. Dist. LEXIS 6406 (E.D. Pa. 2005); *Dillon Cos. v Royal Indem. Co.*, 369 F. Supp. 2d 1277 (D. Kan. 2005); *Landpen Co., L.P. v Maryland Casualty Co.*, 2005 U.S. Dist. LEXIS 2145 (S.D.N.Y. 2005); *Koala Miami Realty Holding Co. v Valiant Ins. Co.*, 2005 Fla. App. LEXIS 14844; and *Roy Anderson Corp. v Transcon. Ins. Co.*, 358 F. Supp. 2d 553 (S.D. Miss. 2005).
4. For an example of another decision from 2005 that addressed the phrase "any insured," as well as the impact of a severability of interests provision, see *United National Insurance Company v Union Pacific Railroad Company*, United States District Court for the Southern District of Texas, No. H-04-0614 (May 27, 2005, Memorandum and Order) (employee exclusion).
5. The Eleventh Circuit reversed the district court's conclusion that the policy provided coverage for post-judgment interest. The court concluded that the obligation to pay post-judgment interest was tied to the duty to defend, which, for American Global, never materialized, because the underlying litigation was already concluded when the primary coverage was exhausted. *Hooters* at \*24-\*28.



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