TEXAS SURPLUS LINE REPORTER & INSURANCE NEWS

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NEWS IN BRIEF

CORONAVIRUS

Attorney General Ken Paxton's office warned officials in Austin, Dallas and San Antonio to roll back what he termed "unlawful" local emergency orders that impose stricter pandemic restrictions than the state issued. While businesses have the choice of reopening, cities and municipalities do not. The stay-at-home executive order by **Gov. Greg Abbott** lapsed as he began the phased reopening of the Texas economy. Directives by cities instructing residents to wear masks in public and to shelter in place are unlawful, said Paxton.

According to a Reuters report, national governments must help provide insurance cover for future lockdowns, the industry's European Union regulator said on May 11, as the private sector cannot afford to provide such broad coverage on its own. Countries have introduced lockdowns to fight the coronavirus pandemic, forcing companies to close and furlough staff. Businesses are fighting to get insurers to pay business interruption claims as a deep recession beckons. Some U.S. states may retroactively change insurance contracts to pay such claims, and Britain's markets watchdog is asking the courts to clarify wordings in business policies. **Gabriel Bernardino**, chair of the European Insurance and Occupational Pensions Authority, said it would be wrong to retroactively change policies. It is also impossible for insurers to control risks such as business interruption that are not due to damage like floods or fire, he said. "If we really want to build more resilience in our societies against situations like this pandemic, there is clearly a need to have in place mechanisms to cover it," Bernardino told Reuters. "To be honest, I think it's only possible by combining public and private elements. I don't think this is possible for the insurance industry alone to cover it."

Michael Menapace, a Connecticut based insurance attorney and professor at Quinnipac University School of Law issued the following statement as a nonresident scholar of the Insurance Information Institute: "Insurers evaluate individual business interruption claims according to specific policy terms and conditions and the facts known at the time of review. The current government shutdown orders do not trigger the vast majority of standard business interruption policies because those orders do not qualify as direct physical loss to property – a requirement under the policies. Moreover, most policies expressly exclude losses incurred due either to a virus or bacteria because pandemics interrupt nearly all businesses everywhere, all at the same time. The federal government is the only entity with the financial resources to help

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NCOIL webinar addresses financial, legal challenges of retroactive BI proposals

With 553 in live attendance and more tuning in for the replay, an April 24 webcast hosted by the National Council of Insurance Legislators featured facts and figures surrounding business interruption insurance coverage. Rep. Matt Lehman, R-Indiana, president of NCOIL said it was important to share the message with state lawmakers throughout the U.S. Lehman was joined in the video conference by Rutgers law professor Adam Scales, whose research focuses on insurance law and torts; Sean Kevelighan, president and CEO of the Insurance Information Institute, and New Jersey state lawmaker Assemblyman Louis D. Greenwald, D-Camden.

Greenwald serves as the majority leader of the New Jersey Assembly and is a sponsor of A-3844, legislation that would expand business interruption coverage to include the coronavirus as an insured peril under existing business interruption policies.

From the outset, Lehman stated that NCOIL strongly opposes retroactive application of business interruption coverage for coronavirus to insurance policies not heretofore offering such coverage. "Rewriting coverage in the absence of physical damage and expressed exclusions," said Lehman betrays contracts between two parties. Instead, Lehman, who is an insur-

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Appeals court rejects punitives in Prime control-of-well case

Prime Natural Resources saw its court-awarded fortunes dwindle from the May 2017 jury verdict of $41 million, to $19.7 million in trial-court Judge Michael Gomez's adjusted award three months later. Since then, the case moved to the First Court of Appeals in Houston, where a three-judge panel reduced the award further, eliminating the exemplary damages, and remanding the case to the trial court for recalculation of judicial interest. The appeals opinion and judgment order was signed by Judge Richard Hightower on Jan. 23, 2020, then released for publication on Jan. 31. The actual damage award of $1.8 million remained intact.

Remanded to the trial court, the case was settled on May 13, with all parties agreeing to dismiss the lawsuit with prejudice. Details of the settlement were not disclosed in the Harris County Court document.

Prime's lawsuit against Certain Underwriters at Lloyd's (named in the appeal as Syndicates 2020, 1084, 2001, 457, 2791, 2987, 3000, 1221, 5000) and Navigators Insurance Company, UK, stemmed from extensive damage done to its well situated in the Gulf of Mexico 75 miles south of Morgan City, Louisiana, by Hurricane Rita, a storm that made landfall in southwest Louisiana on Sept. 24, 2005. The case was heard in Houston, where Prime is headquartered.

The forces of Rita bent the well about seven feet above the mudline, toppled the platform away from the well and damaged the pipelines. Underwriters paid the company about $4 million under the policy, reserving the right to reimbursement if the loss was overpaid. Prime, however, sought additional payment in order to return the well to production.

At issue in the case was whether the Control of Well coverage in the policy should respond to making the necessary repairs to restore a producing well to its pre-loss production capabilities even though it did not sustain a blowout. Prime

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Insurers prepare for mass tort actions spawned by pandemic

Attorney Steven Badger, partner of the Zelle law firm, said the novel coronavirus has provided plaintiffs with a "mass tort opportunity," as he introduced two other Zelle partners for a webinar on class action and multidistrict litigation. "Personally," said Badger, "this is the most important webinar in the series."

Zelle has offered several webinars for insurance executives and attorneys since March and published several related white papers on the multitude of insurance issues connected to the COVID-19 pandemic. The April 28 webinar was titled Square Peg/Round Hole: Why COVID-19 Coverage Disputes Don't Fit the Template for Class Actions and MDLs. The webinar was attended by more than 300, with the audience including insurance executives, claims professionals, underwriters, product developers, fraud investigators and attorneys.

James R. Martin, partner in Zelle's Washington office, and Dan Millea, a partner in Minneapolis, joined forces to present the arguments against allowing COVID-19 business interruption litigation to proceed as either class action or MDLs. Both attorneys specialize in class actions. Martin's expertise includes antitrust and unfair competition and financial services class action litigation. Millea's expertise includes bad faith and extra-contractual liability and commercial litigation.

Attorneys across the U.S. have begun seeking class action status on behalf of representatives of restaurants and other businesses who were denied insurance cover-

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Lloyd's reputation at risk as COVID19 claims flood in; U.K. regulators seek guidance from courts

London Views
By Len Wilkins
London Correspondent

It takes years to build a reputation but just hours to ruin it.

Ever since Lloyd's paid for losses from the San Francisco earthquake in 1906, it has had a reputation of always paying claims. While the market has paid every valid claim, Lloyd's reputation could be sorely tested over the next few months.

The problem relates to business interruption claims launched by thousands of small and large businesses. Some businesses do have valid cover, but the majority do not.

Lloyd's is not the only part of the London market to be hit by these BI claims and allegations of nonpayment. There seems to be a mixture of confusion, misunderstanding, and panic, with businesses fighting for survival and politicians on both sides of the Atlantic getting involved.

At least there are no concerns about Lloyd's ability to pay. Lloyd's stated that the market is in a strong position to respond to COVID-19 and that it will support its customers and business partners with its resources, which now reach $40 billion with a central solvency ratio of 238 percent.

The U.K. government is concerned about allegations of nonpayment and encouraged the Financial Conduct Authority, which oversees Lloyd's and U.K. insurers, to investigate.

Originally, the FCA said in a letter to the market's CEOs that it saw no "reasonable grounds" to intervene in the BI claims where pandemics were not a feature of the policy. The FCA said that, following discussions with the industry, it understands that most policies have only basic cover and do not cover pandemics; therefore, insurers would have no obligation to pay the COVID-19 claims. The FCA accepted this would be disappointing for policyholders.

Now, however, there has been a dramatic turnaround, and the FCA announced that it intends to seek legal clarity on BI insurance in order to resolve the issue for businesses that are facing uncertainty on their claims. No reason was given for the about face, but the assumption is that businesses' pressure on their political representatives and trade bodies caused the change.

The FCA now emphasizes that, where there is cover for COVID-19, there is an obligation to pay. The FCA

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Attorney reviews tools for investigating claims
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Some frivolous lawsuits reach absurdity
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TWIA board holds quarterly meeting online
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TDI disciplinary actions for April 2020
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Attorney reviews tools to better investigate claims, stop fraud

When insurance companies investigate a possible fraudulent property loss claim, sworn statements in proof of loss, examinations under oath and appraisals are often underutilized as tools by an insurer while investigating the dubious claim, said Matthew Monson, The Monson Law Firm. However, these can be valuable tools that an insurer can use while investigating a claim, Monson told attendees at the Louisiana Department of Insurance Conference 2020 in March in Baton Rouge.

According to Monson, there are some red flags that will help an insurer identify possible claims fraud. At the outset of the claim, signs that it will be a problem include if the insured makes unreasonable demands, a public adjuster or attorney is already retained or, the insured threatens legal action. Other signs that a property claim could be a problem are when the adjuster and insured differ significantly on the scope and amount of loss or when there is an inability to obtain an agreement on the scope of damages.

Other red flags Monson mentioned are emergency repairs/services underway prior to reporting of the claim, pre-existing damages claimed as part of the loss, engagement of contractors or experts who have a history of being difficult to deal with, late reporting of the claim that jeopardizes the investigation, or a lack of documentation to support the damages claimed.

Proofs of loss are often a mere formality for claim payments. Examinations under oath (EUO) are typically used to resolve suspected fraud in claims, and appraisals have been used sparingly to resolve disputes about the amount of the claim, Monson said.

The proof of loss is a formal statement of the insured's claim, and according to Monson, a provision requiring a proof of loss is in nearly all policy forms. The proof of loss requirement appears in the "duties after loss" section of the policy, Monson told attendees. It requires that, upon request, an insured supply detailed information enabling the insurer to investigate and assess the loss.

A sworn statement in a proof of loss quickly gets to the heart of an insured's claim, Monson said. In addition, the sworn statement enables the insurer to obtain information directly from the insured. The sworn statement also enables the insurer to bind the insured and protect against fraud. It compels the insured to commit to a number as a "cap" on a claim, Monson added.

Sworn statements are a great tool to use before conducting an EUO or beginning an appraisal, as it enables the insurer to extract information from an unwilling insured. Sworn statements are also good for committing an insured to a specific number when the insured may have claimed differing amounts and duration for the repairs. The sworn statement is fantastic for proving fraud the insurer may not become aware of until after the claim is paid, Monson told the audience.

Most policies require that the insured return the proof of loss within 30 or 60 days after the request is made by the insurer. The timely return of the proof of loss is a condition precedent to recovery, Monson told attendees. In some jurisdictions, failure to comply is an absolute bar to recovery, he added. But, more courts are trending toward a more liberal approach that requires a showing of prejudice if the proof of loss is not returned, Monson explained. In a standard flood insurance policy, the failure to submit a proof of loss is an absolute bar to recovery.

An insurer can either accept, acknowledge, reject or return a proof of loss.

When a proof of loss is defective, the insurer should reject it and notify the insured, Monson said. The insurer should also provide the insured with a blank form. If a proof is rejected, the insurer should let the insured know the reasons, but shouldn't suggest a claim denial. The insurance company should make clear that the investigation is continuing.

According to Monson, most jurisdictions find that a fraudulent proof of loss bars recovery completely, but the fraud must be material and intentional in order to gain a larger payment. Fraud may also void all coverage under the policy while some jurisdictions hold that recovery is prevented only regarding the part of the submission that is fraudulent.

Examinations under oath (EUO) were addressed by the United States Supreme Court 130 years ago in Claflin v. Commonwealth Insurance Company. Monson explained that the EUO enables an insurer to obtain both claim information and documents in the insured's possession.

The EUO allows for a fair and proper claim evaluation, helps an insurer determine its own policy obligation and enables an insurer to protect itself against fraudulent claims. Monson added that many claims are resolved after an EUO is held.

The request for an EUO is not usually met with open arms, Monson explained. Insureds can become defensive and confused. The insured should be educated as to the process of an EUO. To some, an EUO is considered a device to harass and delay, Monson said. Monson also added that few judges and plaintiff's lawyers are familiar with EUOs and view them as depositions or a mere technicality.

In the event of a loss, the policy language is such that the insurer may examine any insured under oath, while not in the presence of any of the other insureds and at such times as may be reasonably required, about any matter relating to the insurance or the claim, including the insured's books or records. In the event of an examination, an insured's answers must be signed.

The obligation to attend an EUO is contractual and does not arise out of the rules of civil procedure, Monson pointed out. The insured's counsel can be present, but cannot object or instruct an insured not to answer, and the failure to answer all questions may form the basis for denial of a claim. EUOs are taken before litigation as part of an insurer's investigation. The insured has a duty to volunteer information

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TEXAS SURPLUS LINE REPORTER & INSURANCE NEWS

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Will you feel the "change" in time to act?

By Michael G. Manes

I was standing at the receptionist's desk for Pitcher, Penn, and Doyle in Hunt Valley, Maryland, on Nov. 20, 1980. I was scheduled to meet with Don Doyle about a GM Famex Program they managed. The radio broadcast playing in the background announced: "We are interrupting this program to go to Jefferson Island (a few miles from my hometown), Louisiana, for an update." I asked the receptionist to let me listen to this report before calling Mr. Doyle.

A local man was being interviewed about what had happened. He said in the thickest Cajun accent you'll ever hear, "Mais, all of a sudden the lake goes 'woo, woo, woo' like a commode flushing, I got my boat to shore just in time." The receptionist laughed at his broken English and country ways; I celebrated his quick thinking and response in this life threatening event. If she'd been in that boat, she may have drowned planning her next actions instead of instantly reacting to the crisis.

The excerpts below from Wikipedia give a sense of what actually happened:

Lake Peigneur was a 10-foot deep freshwater lake, popular with sportsmen, until an unusual manmade disaster on Nov. 20, 1980, changed its structure and the surrounding land…. Texaco accidently drilled into the Diamond Crystal Company salt mine under the lake…. The resulting whirlpool sucked in the drilling platform, eleven barges, many trees, and 65 acres of the surrounding terrain. So much water drained into those caverns that the flow of the Delcambre Canal that usually empties the lake into Vermillion Bay was reversed, making the canal a temporary inlet.

Although there were no injuries and no human lives lost, three dogs were reported killed. All 55 employees in the mine at the time of the accident were able to escape thanks to well-planned and rehearsed evacuation drills. The crew of the drilling rig fled the platform before it was sucked down into the depths of the lake; a fisherman (the aforementioned Mr. Viator) who was on the lake at the time was able to pilot his boat to shore and escape. Days after the disaster, once the water pressure equalized, nine of the eleven sunken barges popped out of the whirlpool and refloated on the lake's surface.

The event permanently affected the ecosystem of the lake by changing the lake from freshwater to saltwater and increasing the depth of part of the lake.

Get the picture?

Months later, a friend of mine who had spent his entire career in the "oil patch" explained that the tool pusher in charge felt the slightest of movement in the rig and immediately called for evacuation. His experience (scar tissue), sensitivity to the environment and quick thinking saved lives. Lake Peigneur has been transformed, but no one died in the process. We may not control the environment, but we can control our response to what happens in our environment. I now realize the genius of the Scout mantra: Be prepared.

I have been active in or consulting with the insurance industry and independent agency system for 47 years. I've been preaching the gospel of change for over 27 of those years. I've been criticized by many traditionalists and ridiculed by folks who have been blessed by the ways of yesterday. A very successful friend said it best, "Mike, you're preaching to a congregation that doesn't want to be saved."

Recently I've felt some vibrations on the platform that is our industry's marketplace that signal it is time to evacuate from yesterday's world and regroup in and with the marketplace of tomorrow. Most recently, at the beginning of this year, our country and the world took a punch to the gut like no other since Pearl Harbor. Like Mr. Viator, you can head to shore and regroup there or you can stay on the lake that is familiar to you and take your chance on drowning. Consider these challenges to your comfort zone:

-Too many of our agencies have clung to a Father Knows Best Main Street model of yesterday and are not ready to fully transform to the Modern Family marketplace of tomorrow.

-The Greatest Generation is gone, and we Boomers are near the exit. The market we'll serve is now about Gen Xers and Millennials who don't care how we did it in the past.

-The portrait of yesterday's mass market is now a mosaic of many niches. We must meet our clients (who, what, how, when, and) where they are. They won't come to us.

-Decades ago, a new employee was thrown into the market and had to sink or swim. Today's best talent seeks controlled structure with flexibility. This includes a work life balance not promises of riches in the end if you nearly kill yourself getting there.

-Yesterday new employees bought the trust-me promise of opportunity: Do well, and we'll bonus you. Today they want specifics in writing — a clear career path, training, mentoring, specific education, and workplace flexibility, including some office time and some work from home. Rhetoric will not suffice.

-If you're trying to replace an employee who has 45 years of experience with someone of like experience, don't. Find who is right for the future and work with him or her to define and build the role, not as it was but as it will be.

-What you sell today is not nearly as important as what will be needed tomorrow. Flood and health insurance may be government programs tomorrow, and auto insurance may be provided by the manufacturer of the driverless cars we buy. Find and embrace the new products and new markets that are coming. There are future opportunities we can't even yet anticipate.

-From Peter Drucker's WSJ Article (October 21, 1993) The Five Deadly Business Sins, we learn the future is in "price driven costing" – not "cost driven pricing." We must determine what the marketplace is willing to pay and innovate our processes to come in under that price. Customers do not see it as their job to ensure manufacturers a profit.

-Finally, today our world has been changed by a "bug" that none of us fully understands called the coronavirus. It has changed our world, our innocence, our work, our social life, and our sense of security. How has your world changed? How do you adapt to this new world? How do you go forward? Will your future be driven by fear or faith, hope or adventure, or opportunity?

-More importantly, how have your clients and potential clients been changed? Will they depend on you? More or less? Will they hunker down alone?

If you can leverage technology for efficiency (doing things right) and client intimacy for effectiveness (doing the right things), you can survive and prosper. Flexibility and vision will be more important than history and structure. Remember, in

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NCOIL webinar

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ance agent, said NCOIL looks to the federal government to create a federal solution for the millions of businesses whose lost income falls outside policy protections. NCOIL also supports a federal backstop for pandemic coverage to be offered by insurers in the future to protect against future harm caused by the outbreak of diseases.

Scales was frank: "Insurance is generally organized around the concept of physical loss or damage to property. While insurers are loath to indemnify against the risks of someone's business turning sour, they do provide coverage for loss of business income accompanied by property damage. The precise phrasing of this (coverage) can vary from policy to policy; modern policies generally require damage or loss to (the covered) physical property."


Scales

Greenwald's proposal in New Jersey is at odds with Lehman's and Scales's views. The impact of this unprecedented economic slowdown on businesses is in the billions of dollars, Greenwald said. "The appearance is that people have insurance, but when they call upon their insurance, they hear 'Insurance doesn't cover that.' This is harmful to the business community and is a bad appearance for the insurance industry."

The New Jersey lawmaker wants insurers to provide some benefit to their policyholders. He wants insurers' response to be: "This doesn't fall under business interruption; however, you do have this coverage and we can give you some relief under that." While he tries to work this out with insurers in New Jersey, Greenwald said the legislation that would expand all loss of use and business interruption policies is on hold. The New Jersey legislation would provide such coverage for the duration of the declared state of emergency due to the coronavirus and is limited to businesses employing fewer than 100 employees working 25 or more hours weekly.

Greenwald cited examples of health insurers "stepping up" during the pandemic to waive deductibles and co-payments for coronavirus testing. He credited some insurers with "stepping up" to defer payments or return premium to policyholders. Greenwald made it clear that he expects more from the property and casualty insurance industry.

Greenwald predicted that there would be a second wave of the coronavirus before a vaccine is available 18 months from now, and he recommended that the insurance industry craft a policy that would offer coverage for customers in the future in a way that is affordable and makes good sense for small businesses.

Greenwald pointed out that leaving businesses unprotected also leaves government unprotected, as governments greatly depend on revenue derived from business profits and employment, both of which have taken hits during the pandemic. Sufficient funds for government, said Greenwald, protects the ability of government to serve the most vulnerable population in a way that keeps the percentage of vulnerable people from growing.

Triple I's president defended the insurance industry's response to the pandemic, because it applies "forward-thinking solutions to take care of its customers, communities and employees and is acting with urgency during the COVID-19 crisis." Kevelighan called insurers "financial first responders."

Auto insurers across the U.S., said Kevelighan, have returned $10.5 billion to customers through premium relief. Through the Insurance Industry Charitable Foundation, insurers have contributed an estimated $220 million to national and local organizations on the front lines of the pandemic. Property casualty insurers have continued to operate as an essential business to serve their customers, keeping nearly two million employed, even as they make use of virtual processing to protect their employees by maintaining social distancing.


Kevelighan

"The insurance industry is facing challenges as well," said Kevelighan. Even without legislation expanding coverage, the insurance industry will see increased claims, he said, for workers' compensation for health care workers and first responders. Other businesses, such as retailers and restaurants that are continuing to operate, have potentially increased their workers' comp exposures.

At the same time, insurers are anticipating a decrease in workers' comp premium as greater unemployment, decreased manufacturing, and less economic activity drive payroll-based premium down. Insurers' investment income, already in decline due to low interest rates, will decline more, Kevelighan predicted. Beyond the pandemic, insurers are preparing for an active catastrophe year of tornadoes, hurricanes, wildfires and cyberattacks.

A lot has been said of the $860 billion surplus held by insurers at the end of 2019, Kevelighan said. Triple I's economists are estimating a capital loss of $78 billion for the first quarter of 2020. Accounting for the active catastrophe season later in the year, III estimates the yearend surplus will diminish to $717 billion. With $400 billion representing the critical level for the overall industry to maintain before the U.S. starts seeing widespread red flags and systemic issues, Kevelighan said that the industry has about $317 billion available for "unexpected losses." This is an industry-wide number; it does not describe the bottom line of any single insurer.

Proposed legislative solutions, said Kevelighan, fall into two categories: removing the virus/bacteria exclusion from business interruption policies and expanding property policies of small and medium businesses to include business interruption insurance. Only about a third of all small businesses purchase business interruption insurance; broadened to all businesses, the take-up rate for business interruption coverage is about 40 percent, said Kevelighan. Retroactively eliminating the exclusion would cost insurers about $150 billion per month, he said. It would quickly climb to $485 billion in costs for 2020, pushing the industry into a zone that endangers its ability to pay normal and expected claims.

Legislation that would apply business interruption coverage to the small and medium businesses that did not purchase it would increase the monthly cost to the industry to about $380 billion.

Both scenarios of retroactivity would push the insurance industry into multiple insolvencies. "Requiring an insurer to pay for losses it never insured would cause irreparable harm to the industry," Kevelighan said.

The federal government is looking for solutions, Kevelighan said. Congress has implemented some solutions and continues to work on others. In addition to providing forgivable business loans, federal lawmakers are developing a plan that would create the COVID-19 Business and Employee Continuity and Recovery Fund to provide further assistance, he said. Meanwhile, large businesses that might legitimately lay claim to business interruption coverage are having to give back the federal coronavirus relief money, making more available for small businesses, he added.

Kevelighan concluded with key takeaways:

-Global pandemic risks are uninsurable. A pandemic impacts all lines of insurance and many economies around the world at once.

-Retroactive payouts would bankrupt insurers.

-Insurers are actively paying covered claims.

-Policies clearly explain the virus and bacteria exclusions, usually on the declarations page. Insurance that would overcome this exclusion is expensive and extraordinary, said Kevelighan. Wimbledon, for example, purchased this type of coverage at a premium of $2 million, he said.

After Kevelighan presented Triple I's summary of the financial consequences of the legislative proposals to retroactively award business interruption coverage, Scales addressed the legal challenges the industry expects to face in the coming months, some of which have already begun.

Eight states have introduced legislation that would "attach different legal consequences to the content of insurance policies that are in existence right now," Scales

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NCOIL webinar

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said. While it appears that such laws would be ripe for a legal challenge based on impairment of contracts, Scales said such challenges in the past have been somewhat unsuccessful. Despite the clear language of the U.S. Constitution article on contracts, interpretation of the article "has waxed and waned over United States' history."

Federal courts first consider whether the law actually impairs a contract relationship. Then, the courts ask if the state legislature had a sound reason for doing so. There are variations to how this test applies, Scales said. He added that the contract clause has not played a strong role in insurance cases at the federal level because federal courts "lack enthusiasm" for intruding into the state-regulated area of insurance.

Taking a closer look at states' court actions since the specter of these retroactive legislative proposals arose, Scales uncovered some jurisprudence on contract clause challenges through the state courts. State courts, he said, focus on the process of the legislature's consideration. He said state courts review "legislative determination regarding the seriousness and genuineness of the problem." Also intertwined is the court's respect for separation of powers "which might cut a couple different ways," he said.

Where courts have not previously entertained the question of impairment of a contract in a specific way, they may find it prudent to settle the matter as advised by the legislature, he said. There is clear precedent that insurance contracts bearing ambiguity will be resolved in favor of the policyholder, he added.

As an example of the court's deference to legislative will, Scales cited a case involving payment of billed charges under a health policy. After the case was decided in favor of the plaintiff who received a higher benefit from the insurer, one state's legislature passed a law to prevent the same outcome in the future. Hence, claims before the change in law and claims occurring after the change had different outcomes when litigated. How the court's deference to the legislative will may operate in the current situation is an unknown at this time, Scales said.

> *Insurers who defend only on the impairment of the contract might not be successful, said Scales, but they do have other arguments to use.*

Another discernment that will affect court rulings, said Scales, is that courts are protective of judicial prerogative. Where a court has ruled on its interpretation of a contract, it will stick with that decision in future decisions. Scales said that not all states have clear case precedent of what constitutes physical damage as the trigger to business interruption relief under the terms of an insurance policy.

Insurers who defend only on the impairment of the contract might not be successful, said Scales, but they do have other arguments to use. Legislatures that define a serious and genuine problem are expected to narrowly tailor a reasonable solution to that problem, he said. Scales said the present situation would reach the serious problem threshold; he questioned whether the court would consider the solution sufficiently narrow and reasonable.

There is also an equal protection concern in the proposals that carve out small business only for the legislative preemption of the contract, Scales added. "It is difficult to understand why the meanings of the terms of the contract change once a company hits 100 or 150 employees," he said. "This is going to provide fodder for an equal protection-type attack." If the court were to wrap this into the general "reasonableness" requirement, Scales said, it still appears to be "a carve-out for favored interests. That is not a good place for legislatures to be."

Scales shared further insight on the public policy decision facing state lawmakers. He said there has been no correlated event to the economic losses of this pandemic. But, even with the general notion of consumer protection under the ambiguity doctrine, it is "a stretch, in my view, to suggest that businesses always and forever expected coverage of this type," he said.

"Hopefully it's not an actual end-of-the world-event, but in terms of your planning as a business it sure looks like one. In my experience, people tend to discount the likelihood of end-of-the-world events happening. They almost never buy insurance that would be adequate to deal with that situation…. This makes it challenging for policymakers who want to find a way of compelling insurers to participate here," Scales said.

Some policies will respond because the coverage is already contained in the policy, Scales said. But he questioned the wisdom of lawmakers retroactively creating an obligation for insurers to pay what would certainly become policy limits to every policyholder at the same time.

NCOIL's COVID-19 Resource Page on the organization's website includes a recording of this webinar along with links to related public documents and public statements from the Wholesale and Specialty Insurance Association and the U.S. Chamber of Commerce. The website also provides links to the business interruption expanding legislation under consideration in New Jersey, New York, Pennsylvania, Louisiana, Ohio, Massachusetts, South Carolina and Rhode Island.

Investigation tools

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at an EUO, he said. In addition, the insurer has the right to examine insureds out of the presence of each other.

The most common reason for EUOs is suspected fraud, Monson said.

An EUO is also helpful when an insured does not respond to written or oral requests for information, Monson added. EUOs are sometimes the most efficient way to determine the particulars of a claim. In addition, EUOs are a great way to get around a meddling public adjuster or attorney, Monson said.

Some of the areas that can be covered by EUOs are: contested issues, ambiguities, information gaps, losses missing supporting documentation, inconsistencies, fraud, claim exaggeration, insurable interest, background of insured, financial condition, and location at time of loss.

The demand for an EUO must be in writing and sent via certified mail and standard U.S. mail. EUOs should be scheduled unilaterally, according to Monson, but insurers should let the insured know that it can be rescheduled at a convenient time and place. If a time and place are not set, the insured will not be found to have breached a condition of the policy.

The insurer is exercising its right under the policy to conduct the examination, Monson said. The notification for an EUO should include a quote of the policy language requiring the insured's compliance; the date, time, and location of the EUO; a request for records, and the time and place for document production.

Monson told attendees that EUOs often do not proceed as planned because of no shows, lack of knowledge by the insured, or a lack of documents. Again, the insurer should tell the insured that the requirement to sit for an EUO is a condition precedent to coverage, Monson said. Monson reiterated, that some jurisdictions indicate that failure to sit for an EUO is grounds for dismissing a lawsuit while other jurisdictions require a finding of prejudice to the insurer.

In most first party property claims, the fundamental issue is the amount of loss, and most property policies contain an appraisal clause that provides an efficient and cost-effective means of resolving this core dispute. The appraisal clause is great for getting lawyers out of the room and letting the professionals cut to the chase, Monson said.

The language of the appraisal clause states that if the insured and the insurer fail to agree on the amount of the loss, either may demand an appraisal of the loss.

Most residential property policies set out a timeline for the appraisal process. Typically, if an appraisal is demanded, each party will choose a competent and impartial appraiser within 20 days after receiving a written request from the other. The two appraisers will choose an umpire. If the appraisers cannot agree upon an umpire within 15 days, the insured and the insurer may request that the choice be made by a judge of a court of record in the state where the "residence premises" is located.

The appraisers will separately set the amount of loss. If the appraisers submit a written report of an agreement, the amount agreed upon will be the amount of the loss. If the appraisers fail to agree, the appraisers will submit their differences to the umpire. A decision agreed to by any two of the three will set the amount of the loss.

Each party will pay its own appraiser and bear the other expenses of the appraisal and the umpire equally.

There must be an actual dispute as to the amount of loss. A demand for appraisal without proof of differing amount is not sufficient to establish a dispute, Monson said. The insurer should formally deny a premature appraisal demand and request proof of the dispute, Monson added.

The plaintiff bar argues that the appraisal clause is an attempt at binding arbitration and in conflict with the Federal Arbitration Act, Monson said. There are significant differences between the appraisal process and arbitration. Arbitration is a quasi-judicial proceeding with formal hearings and witnesses; whereas, appraisal is an informal process that does not involve the procedural requirements of a court proceeding.

By statute the original public adjuster cannot be the appraiser, as a contingency fee relationship with the insured prevents him from being impartial or disinterested. The original claims adjuster, however, can serve as the insurer's appraiser, but this is not generally done. The mere fact that someone has previously computed the losses as an adjuster does not disqualify him from service as an appraiser. Appraisers must be "disinterested, unprejudiced, honest and competent," Monson said.

In some states, such as Florida, the appraisal process will take jurisdiction away from the courts until the process is complete. In other states, such as Louisiana and Texas, a lawsuit can be filed, but the lawsuit can be stayed until completion of the appraisal process. Appraisal awards will be enforced unless there is evidence of fraud, mistake, duress, or other impeaching circumstances in either the appraisal process or its award, Monson said.

The mistake most often made in the appraisal process is the appraisers trying to agree on the amount of loss and then choosing the umpire if no agreement is reached. The appraisers should agree on an umpire before starting the appraisal. It is often difficult to agree with an opposing appraiser on the choice of umpire once the appraisal process has started, Monson said.

Impartiality is paramount in an umpire, Monson said. Appraisers should consider the use of mediators as an umpire. Insurers should not agree on public adjusters or contractors as umpires, Monson advised. "They are usually biased," he said.

The appraisers are supposed to submit only their differences to umpires, and appraisers should submit all supporting information, photographs, expert reports and prior loss information. The appraisers should go out to the loss location with the umpire.

Insurance companies should always use all of the tools available to them when investigating a possible fraudulent property loss claim, Monson concluded.

In the event a policyholder and his insurer cannot reach agreement under any of these methods, the insured may file a lawsuit. Even then, the insured must comply with terms of the policy. Under the "Suit Against Us" section of the policy, there is a "no action clause" under which the insured is barred from bringing suit against the insurer unless all of the terms of this part of the policy have been met.

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age for lost business income due to the novel coronavirus. Millea said he knew of two instances where attorneys have sought consolidation of pretrial proceedings of actions from several jurisdictions under federal provisions for multidistrict civil actions.

Together, Martin and Millea offered their take on how this should play out.

Class actions and MDLs, said Martin, are used to promote judicial efficiency. They are used to aggregate claims in a single forum with common discovery. The reasons Martin and Millea gave for why the business interruption litigation is unsuited for this judicial efficiency are that there will be individualized fact issues, multiple legal theories, and claims for damages that are available by statute only in some states. "Aggregating these cases in class actions or MDL settings will serve no real benefit for the courts or the claimants," said Martin.

Martin said that class actions serve a legitimate purpose when everyone is harmed in the same way. Allowing smaller claims to be aggregated may be the only sensible means of achieving a just resolution, he said. "It also means that some (class actions) won't have merit," Martin said. Stated more formally in the Zelle white paper that Martin co-authored: "The aggregating nature of the class actions also incentives plaintiffs to pursue lawsuits when the damages are likely too small to justify litigation, but a class action would offer those with small claims the opportunity for meaningful redress. However, class actions can occasionally subject defendants to costly or abusive litigation."

Martin explained that class actions are brought by a single plaintiff on behalf of some defined group or class. In order for the action to proceed on behalf of the class, the court must certify that a class exists. Class actions may seek injunctive relief or damages, or both.

Federal rule provides the prerequisites for defining a class: numerosity, commonality, typicality and adequacy of representation.

"There are a lot of claims out there," said Millea. Business income has been lost, and business owners want to recover it. Millea expects that the action seeking certification would meet the first prerequisite, numerosity.

The commonality hurdle is different, said Millea. There will be variations in policy language and endorsements. "All the (insurance) policies are different," he said. Different state laws will apply. There are multiple market situations; different civil authorities imposed different limitations. Causation might be common among the members of the class, but damages will differ. "Every policyholder will have his own individual losses that need to be proved individually," Millea said.

The typicality and adequacy factors will also be difficult to prove to the court, Millea said. The class plaintiff claims to be typical of the class, he said. What if the representative's policy has a virus exclusion, he questioned, but the other class members do not have the exclusion? Perhaps, said Millea, the class representative has no strength of facts. "He can't represent members who have a better set of facts."

Two additional factors must be met for any class seeking monetary damages: predominance and superiority. Martin and Millea expect that coronavirus class actions will meet neither hurdle.

The predominance standard is tougher than commonality, said Millea. According to Martin's white paper, the plaintiff must show that common questions of law and fact predominate over individual questions and he must present a model of the damages that stem from the defendant's alleged wrongdoing. Millea said there are multiple scenarios among various claimants; he said that individual issues will predominate over common questions.

If class is asserted on a nationwide basis, it will fail, Millea predicted. "Insurance law is state based." The class action will run up against laws that are different from state to state, he said. "There is no way to measure damages on class-wide basis."

To certify a damages seeking class, the court would also have to certify that the class action method is the superior method of adjudicating the claim and that it is manageable. Initially, there may be some subset of declaratory judgment actions that could fit into a class, said Millea. But that would require a critical mass of identical policies, a single insurer defendant, and targeted legal issues. One benefit would be to resolve one or more coverage questions on the same policy form, in the same state.

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Control of well

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had purchased $50 million in coverage for three well locations.

The trial focused on language of the policy that covered damage to the drilling, workover or production equipment caused by windstorm, a provision the plaintiff attorneys read in isolation and alleged ambiguity that should favor their client. Trial testimony lasted nearly three weeks.

The appeals court affirmed the damage award, prejudgment interest at five percent (which continued to accumulate during the appeal) and the $1.4 million in attorney's fees. By keeping the damage award intact, the appeals court sided with Prime on its interpretation of the language of the policy.

The appeals court reversed the "bad faith" and "knowingly" portions of the jury's judgment awarding treble damages and penalty level interest.

The case was remanded to the district court for recalculation of the proper amounts of interest.

Then, on May 13, all parties signed a Joint Agreed Motion to Dismiss with Prejudice. The motion states, "All claims between and among the Parties in the matter have been resolved," and the "Parties entered a settlement agreement and jointly move for dismissal with prejudice.

Appeals court costs were set at $53,296, to be shared equally by Prime and Underwriters, with the named appellants jointly and severally responsible for half of the appellate costs.

Whether this order provides solid precedent for future cases involving damages sought through Control of Well policies when there has been no blowout or seepage remains to be seen. On Page 15 of this 57-page opinion, the court quotes the Southwestern Bell v Mitchell decision rendered by the Texas Supreme Court in 2008: "[U]pon no sound principle do we feel at liberty to perpetuate an error, into which either our predecessors or ourselves may have unadvisedly fallen, merely upon the ground of such erroneous decision having been previously rendered."

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This class, however, said Millea, is too small to exist as a class.

The number of individualized issues defeats the efficiencies of a class action, said Millea. Any class would need to be decertified for determination of damages. The class would devolve into an unmanageable series of minitrials and consume judicial resources. "Class-wide treatment would be worse, not better, than separate actions," said Millea.

According to a published report, Cleveland Attorney Robert Rutter disagrees and sees a class action remedy as appropriate for restaurants shuttered by the coronavirus in Ohio. Rutter, who also owns restaurants, specializes in representing policyholders in lawsuits against their insurers. His bio on his firm's website says he is one of only 25 lawyers in Ohio certified by the state bar association as a specialist in insurance coverage law. His firm, Rutter and Russin, filed the class action in state court after reviewing "60 different insurance forms from hundreds of clients," according to an article published in the Cleveland Scene on April 28.

In the article, Rutter said he is starting with the "low hanging fruit," policies that do not contain virus-exclusion clauses. While he found such polices among those issued by Cincinnati Insurance, Western Reserve Group and State Farm, his firm's initial action is against only Cincinnati Insurance.

The Cleveland Scene quoted Rutter as seeing this initial case as precedent setting: "The first case will dictate what will happen," he said. "If we prevail against Cincinnati, there's really no reason we wouldn't prevail against policies that are similar." The Cleveland Scene article did not indicate the number of restaurants Rutter expects his class action to represent, and he did not return a call from the Reporter asking for this information.

Martin and Millea also took a look at the role MDLs or multidistrict litigation could play in providing federal courts efficiencies as they grapple with what is expected to be a large number of coverage disputes.

MDLs, said Martin, are available only in the federal court system. It is a special procedure in which federal civil cases from different judicial districts are transferred to one court for all pretrial procedures. The cases are then returned to local jurisdictions to be tried or settled. According to Martin, the cases must share a common question of fact; MDL panels do not address questions of law.

"MDLs take a long time," Martin said. He knows of one MDL that is in its seventh year of pretrial discovery. Not all cases brought together are approved for MDL, he added, citing the Chinese drywall cases where the MDL judicial panel in Dallas rejected coordination of declaratory relief actions.

Martin said it would be unusual to put these kinds of cases in MDL. He offered a pie chart of 190 pending MDLs that take in more than 130,000 individual cases. More than half of these cases are products liability and antitrust cases, which bear similar facts.

Millea added that he knows of two MDL applications regarding COVID-19 coverage claims pending so far, one in Illinois and one in Pennsylvania. He expects there may be more. "These will play out over the next few months," Millea said.

The insurance policies of these MDL litigants provide general all risk physical damage, said Millea. He said the plaintiffs are claiming to have suffered property damage and/or business interruption loss. The alternative remedies sought are payment for damages or a declaration of coverage.

Millea said the cases lack commonality of facts. "Can the presence of the virus be assumed or proven on a broad basis, or does every claim differ?" Millea questioned. He said that physical damage involves proof, which must be provided on a business-by-business basis. Interpretation of policy language, said Millea, is purely a legal question, which is outside the purview of the MDL judicial panel. "Policy issues are legal questions," said Millea, "not questions of fact. These are not decided in the MDL process."

The Zelle attorneys reiterated the advice that every claim be investigated. Even with relatively consistent policy forms, any institutional decision to deny with a form letter would become fodder for a class action, said Martin.

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businesses during a widespread global pandemic."

The Big "I" announced that Progressive Insurance donated $2.0 million to establish the Trusted Choice COVID-19 Relief Fund in response to the economic and operational challenges the coronavirus crisis has presented to independent agencies. The grant will be dispersed directly to independent agencies through a Big "I" application process. Applications are available at www.independentagent.com/COVIDRelief. The national association welcomed other insurance carriers and industry partners to support this new 501(c)(3) charitable fund.

MEETINGS/EDUCATION

IIAT's Insurcon, originally slated for June 10-12 in San Antonio, will be held virtually on three consecutive Thursdays in June, starting June 11. Registration is free, courtesy of IIAT's lead underwriters. Once registered, each session can be automatically transferred to the registrant's online calendar with all necessary link information. The schedule of virtual presentations is on IIAT's website, along with separate reservation links to each session. Visit IIAT.org. June 11 presentations include two by **Steve McKee**, brand strategist and author; COVID-19 and Workers' Compensation, by a Texas Mutual representative, and Cybersecurity Best Practices, by **Dustin Mooney**. On June 18, the sessions are What Every Agency Can Learn from Amazon, by **Steve Anderson**; E&O Best Practices, and Turning Your Agency into Fort Knox. June 25 sessions are on Disrupting Disruption, by McKee. All sessions fall within the 10 a.m. to 2 p.m. timeframe;

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a couple ELITExas-only events fall outside this timeframe.

Optimistic that the Jim Millerman Insurance Convention will be held as scheduled on Nov. 5 at the Irving Convention Center, **Tammy Land,** executive director of the Independent Insurance Agents of Dallas, announced that the industry-day event will include virtual golf and clay shoot competitions, designed especially for members who lament the absence of the annual IIADallas spring sporting events cancelled due to the coronavirus. More details to come.

The Texas Surplus Lines Association's 2020 Mid-Year Meeting, originally slated for July 19-22 at the Four Seasons Westlake Village, California, has been canceled. The same meeting site was rescheduled for the 2023 mid-year meeting.

The Insurance Council of Texas hosted a fraud prevention webinar on May 12. Brent Walker, director of the International Association of Special Investigation Units discussed the current P&C fraud trends, as reported through a survey of fraud investigators. He also presented information on the potential impact of the coronavirus on these trends, as economic hardships affect policyholders. The one-hour recording and the presentation slides of the webinar are available free to the public through ICT's Past Webinars link that is normally reserved for members only.

Until further notice, all of the meetings of the Dallas Association of Insurance Professionals will be held on Zoom every second Thursday of the month, starting at 6 p.m. To be added to the series of Zoom meeting invitations, contact **Desiree Binion**, Allied World Insurance Co. Binion is the president of the local FIWT association. DAIP will continue to offer its monthly meetings on Zoom, even after the association's dinner meetings resume at Spring Creek

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Some frivolous lawsuits reach absurdity

While most lawsuits have merit, some frivolous lawsuits stand out because they are so absurd, such as the lady who sued Jelly Belly because there is sugar in the candy beans. The website 247tempo.com searched the archives of various news sites, including CNN, Reuters and NBC, and compiled a list of 25 examples of recent lawsuits that seem ridiculous.

The article, written by John Harrington and Hristina Byrnes, appeared Jan. 29 on 247tempo.com. "While most cases have merit, sometimes the wrongs being sued are not what most people would consider to be unjust," they wrote. Judge for yourself whether or not the 25 lawsuits they selected have merit or are the stuff of late-night comedy.

1. A 69-year-old Dutchman wanted to legally change his age in order to avoid ageism. He thought he was being discriminated against because of his age, which affected his job prospects and success on a dating app. He lost the case.

2. A California woman sued Jelly Belly for using the term "evaporated cane juice" instead of the word "sugar" on its jelly beans' food label. She accused the company of misleading consumers about how much sugar the snack contained. The case was dismissed.

3. A 37-year-old man from Austin, Texas, sued his date for spending the time they were at the movies texting on her phone. He claimed her behavior broke theater rules and affected his movie-watching experience. He withdrew the lawsuit after she agreed to pay him the $17.31 for her cinema ticket.

4. In 2013, a teenager measured a foot-long Subway sandwich and found it to be only 11 inches. Three years later as Subway was settling a class-action lawsuit, promising to make its rolls 12 inches, the only ones set to benefit from the settlement were the attorneys who were to receive $520,000 in fees. The judge threw out the settlement and the case when an activist and legal writer revealed the beneficiaries of the settlement.

5. Two individuals from New York and another from Mississippi, sued Tootsie Roll Industries alleging the company tricked people by underfilling Junior Mints boxes. One-third of the box was empty, they claimed. In a 44-page decision, the judge dismissed the case, writing that a reasonable customer can expect some empty space.

6. A class-action lawsuit accused Red Bull of having misleading ads and making false claims because the energy drink did not give people wings, even figuratively. They did not feel energized. Red Bull settled out of court and agreed to pay $640,000.

7. A Houston firefighter was afraid of fire and reassigned to an office position, so he would not have to come in direct contact with what frightened him, but he wanted to remain in his former job in the fire suppression unit. He claimed that his fear was a disability and that he was discriminated against because of his disability. His case made it to the Texas Supreme Court, which ruled there was no evidence of discrimination because of a disability.

8. A fugitive facing a murder charge kid-

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Frivolous lawsuits

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napped a Kansas couple in 2009. At some point he fell asleep, and the couple escaped. They sued the kidnapper for more than $75,000 in damages, and he, in turn, sued them for breach of contract, claiming he and the couple had a legally binding oral agreement for them to hide him from the police. His case was dismissed.

9. Two McDonald's customers from Florida sued the chain for $5 million because they were made to pay for a quarter pounder without cheese the same price as the sandwich with cheese. A judge dismissed the case reasoning that the plaintiffs could not prove that the price they had to pay caused them any harm.

10. Chinese boy meets pretty girl and marries the girl, but when they have a child, the boy cries foul, saying the baby is "incredibly ugly" and does not look like either parent. He accused the wife of cheating on him, whereupon she admitted to having had several plastic surgeries before they met. He sued alleging she misled him by hiding her cosmetic history. He won the case, and she paid $120,000.

11. A New York woman fell down the stairs at Grand Central subway station, injuring her foot and ankle, after seeing an oversize "scary" poster for the Dexter series. She sued Showtime claiming the poster was "disturbing, provocative, shocking and fear inducing." The judge dismissed the case, saying the network was under no obligation to maintain the stairs at the station nor did the poster create a dangerous condition.

12. In 1993, a man sued Anheuser-Busch for $10,000 for false advertising. He claimed the company's beer ads caused him emotional distress, mental injury and financial loss because the ads depicted beer's ability to enable the drinker to enjoy "scenic tropical settings" with beautiful women and men engaged in "unrestricted merriment" when this was not the case. He lost the lawsuit.

13. A California woman sued the maker of a lip balm alleging that consumers were conned into thinking they could use the entire tube of lip balm, when actually they could only use about 75 percent of the product unless they dug the other 25 percent out of the tube. The court disagreed that the company being sued tried to lie about the quantity of its lip balm and said that a reasonable consumer understands how such dispenser tubes work.

14. A Portland man sued Michael Jordan and Nike for promoting Jordan, seeking $800 million because he looked like Jordan. For 15 years, the man said, he was mistaken for the basketball legend, which caused him permanent injury and emotional pain and suffering. The man dropped the lawsuit without stating a reason.

15. A prison inmate serving time at a correctional center in Virginia for breaking and entering sued himself for $5 million, claiming he violated his religious beliefs and got himself arrested. Having no income, he asked the state to pay because he was a ward of the state. The judge dismissed the case.

16. Last year, a Tennessee man sued Popeyes Louisiana Chicken for $5,000 for running out of its chicken sandwich while he was standing in line. He alleged the food chain wasted his time and deceptively advertised the sandwich. He also sued for damages to his car, which he said was damaged in the restaurant's parking lot. The case is scheduled to go to court in 2020.

17. A California resident threatened a class action against Starbucks, saying customers who ordered cold drinks received less liquid in their cups than advertised because of too much ice. A district judge ruled that even kids know that ice in the cup reduces the amount of liquid and that customers can clearly see the amount of ice in a clear cup and ask for less ice.

18. A French businessman sued Uber for $48 million, claiming that a flaw in the ride-sharing company's app played a role in the dissolution of his marriage. He borrowed his wife's cell phone and used it to log onto the Uber app, but a glitch in the app caused it to continue to send notice of his whereabouts to his wife's phone even after he logged off. Apparently his wife had a problem with some of his movements, and the marriage ended in divorce. The result of the lawsuit is unknown.

19. A 15-year-old boy in Spain sued his mother, claiming he was mistreated after she took his cell phone to get him to study. He sought jail time for his mother and reimbursement for legal expenses. A judge ruled in favor of the mother, saying she was within her rights and acted responsibly.

20. A federal jury awarded two men a total of $24.2 million for getting severely burned by electrical wires when they were teenagers trespassing on railroad property in Pennsylvania. Attorneys for Amtrak and Norfolk Southern claimed the two men, age 17 at the time of the accident, were old enough to know they were putting themselves in danger. The plaintiffs' lawyer conceded his clients were trespassers, but said the property owners were still responsible.

21. A customer sued a Washington, D.C., dry cleaner for $54 million for allegedly misplacing his pants. The court ruled against the customer and ordered him to pay the cleaner's legal fees. The customer,

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Barbecue, to reach all who are unable to physically attend the gatherings so they can benefit from the guest speaker program and keep up with the association's activities.

The Zelle law firm has announced a new date for its Texas Hail and Harvey Seminar and added a day for a COVID-19 Claims Seminar. The new dates for the two-day conference are set for Oct. 27-28. Attendees can attend either or both. An expanded room block is planned for the Hyatt Regency Reunion in Dallas. Anyone who registered for the Hail/Harvey Seminar originally scheduled for April will need to reregister for this event. A networking reception is planned for the evening of Oct. 26. For more information, visit hailseminar.com.

MERGERS/NEW OPERATIONS

On April 22, LP Risk announced it has been acquired by XPT Partners. LP Risk, a full service MGA and surplus lines broker with a wide range of commercial P&C coverages, brings additional Texas presence and expertise to XPT in transportation, general liability, excess/umbrella, property, cargo equipment and more through its Houston, San Antonio and Dallas offices. **Landon Parnell** will continue as president of LP Risk and will take on the new role of leading XPT's National P&C Brokerage Division. This is XPT's sixth investment, preceded by Western Security

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Surplus, WE Love and Associates, SVA Underwriting, Klein and Costa, and Sierra Specialty. The transaction closed on April 22, and LP Risk will continue to operate under its established brand name. XPT was represented in the acquisition by TAG Financial.

Higginbotham and Amerman Insurance Services, an independent broker in San Antonio, have merged operations. The union adds eight commercial and personal property/casualty insurance and employee benefit professionals to Higginbotham's San Antonio office for a combined 38-person group. The partnership is part of Higginbotham's growth strategy that sees it merging with other independent brokers that expand its services to a greater client base. **Matt Amerman,** president of Amerman Insurance, will continue leading his staff as a Higginbotham managing director, along with **Drew Apperson,** managing director of Higginbotham in San Antonio. The two plan to combine office spaces in San Antonio in the coming year.

NAIC

NAIC's Privacy Working Group has resumed discussing comments on the group's markup of the NAIC insurance Information and Privacy Protection Model Act. With lessons being learned from COVID-19, the group will expand its discussion to include updating requirements for health information

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TWIA board holds quarterly meeting online

The Texas Windstorm Insurance Association joined the trend of online board meetings when seven of its eight board members met online to conduct TWIA's regular quarterly meeting on May 12.

A major discussion point of the board was raised by Jerry Fadden, TWIA's CFO, who said the pricing of TWIA's line of credit was increasing. Prices are rising due to COVID-19, he said. Even though the losses associated with the pandemic are unrelated to windstorm coverage, a market result of the pandemic is banks doubling the cost of commitment fees.

Fadden said TWIA's staff tried to shop the $500 million line of credit for the 2020 hurricane season beyond the current vendor, JP Morgan, but there was no interest from other banks. The board approved a resolution to purchase the line of credit at $2.8 million, double the cost of last year's LOC.

For the reinsurance and catastrophe bond pieces of TWIA's required funding, Fadden also expects prices to rise, again, not because of TWIA's book of business. "Overall the reinsurance industry had some disruption due to the impact of COVID," said Fadden. "Most are anticipating losses from business interruption." The result is an increase in the cost of capital.

"It's a difficult market," said Fadden, who remained optimistic for "relatively good pricing in a challenging market."

In other business, the TWIA board reviewed and approved the financial audit conducted by Calhoun, Thomson and Matza, approved the association's investment plan and authorized updated rules to add other traceable forms of applicants, policyholders and agents mailing payments to TWIA. By previous rule, TWIA could accept only the U.S. Postal Service's proof of timely payments.

Board members also requested that the staff facilitate the Actuarial and Underwriting Committee in resuming its review of proposals for independent actuarial services, so an independent actuary can evaluate TWIA's rate adequacy prior to the Aug. 4 board meeting in Galveston. The committee's work was paused due to the impact of the pandemic.

The board also welcomed new board members Peggy Gonzalez, a Brownsville insurance agent, as a first tier coastal representative, and Tim Garrett, a realtor and real estate broker, who fills a non-seacoast territory slot on the board. One non-seacoast position on the board remains vacant.

Gonzalez is vice president of the Hughston Insurance Agency, where she has worked since 1972. She specializes in commercial insurance and holds the CIC, CPCU and CRIS professional designations.

Garrett, a resident of Lubbock, has been a realtor there for over 30 years. He holds the ABR, CRB, CRS, GRI, and MRP professional designations.

TWIA's online meeting was attended by 40 known registrants; however, the meeting could be viewed by the public live on YouTube. Known registrants were permitted to submit questions or comments. The meeting remains available for view through the TWIA website.

Frivolous lawsuits

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an administrative law judge, could not prove the dry cleaner lost his pants, and based his lawsuit on the store's sign indicating "Satisfaction Guaranteed." The case drew national attention as well as sympathy for the defendants, who received funds online for their defense.

22. The mayor of Batman, an oil producing city in southeastern Turkey, said he would sue Warner Bros. and movie director Christopher Nolan for using the name of the city without permission for the film The Dark Knight. The city's mayor wanted compensation from the movie's royalties, claiming the movie's success had negative psychological effects on the city's residents and hurt local businesses trying to register in other countries. The lawsuit was never actually filed.

23. The parents of a Danbury high school student said their son suffered hearing loss after one of his teachers slammed her hand on his desk to wake him during a math class. The family sued the school, the school board and the city. Apparently, the lawsuit fell on deaf ears and collapsed.

24. A woman from Israel sued a well-known television weatherman for a false weather forecast. The weatherman had predicted sunshine, but it rained. Based on the forecast, the woman left her house unprepared for rain. She claimed that she became ill and missed work. She got $1,000 and an apology from the weatherman in an out-of-court settlement.

25. A senior at Memphis High School in Michigan believed his work experience as a paralegal at his mother's law office for one of his classes merited an A+ instead of an A. His family sued to raise the grade to A+, which would have made him valedictorian of his class. The suit also asked that publication of class rankings be blocked until the case was settled. The family lost the case.

London views

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said it is important that claims are assessed and settled quickly and, where there are reasonable grounds to pay part of a claim, but not to make full payment, it expects insurers to make an interim payment.

The FCA statement says it intends to bring to court what it believes are the key relevant cases. Christopher Woolard, interim chief executive of the FCA, said, "Our intended court action is designed to resolve a selected number of key issues causing uncertainty as promptly as possible and to provide greater clarity for all parties, both insureds and insurers. It is clear that decisive action is appropriate given the severity of the potential consequences for customers."

Insurers hope the courts will find little wrong with the market's wordings. The problem is likely to be a misunderstanding of what was covered by the policy. Attempts by politicians to force through uncovered losses are at the moment unsuccessful, and the U.K. government realizes that to do so would just swap the financial problem from one side of the economy to another.

Two law firms said they are gathering companies in Britain for a potential group lawsuit against German insurer Allianz for rejecting BI claims for restaurants and leisure groups on policies that had been arranged by Marsh. Other insurers AXA, Hiscox, RSA, QBE and Zurich already face potential multimillion dollar lawsuits from British pubs, hotels, restaurants and leisure groups alleging that legitimate BI claims were rejected.

While Lloyd's and London insurers believe they have a strong case against these claims, they are concerned about international action. Swiss insurer Helvetia has offered to pay 50 percent of the virus-related BI claims by Swiss restaurant policyholders, despite continuing to insist that the risk is legally excluded from its policies. The offer to pay could be used as an argument for coverage by politicians.

As far as the U.S. is concerned, Standard and Poors issued an opinion that attempts by state legislators to retroactively grant expanded BI coverage for COVID-19 related losses are likely to fail. S&P believes a fierce defense by insurers and concerns over solvency, should legislators be successful, will halt any attempts to create coverage.

Hiscox denies COVID-19 BI claims

Lloyd's managing agent Hiscox specializes in property and casualty insurance aimed at companies and high-net-worth individuals and covers such risks as hacking, kidnapping and satellite damage. The group's overall annual revenues are $3.77 billion.

Hiscox is one of the Lloyd's and London insurers facing BI claims and telling clients that their policies don't cover the pandemic. A group of businesses led by PR firm Media Zoo alleges that Hiscox is trying to avoid paying over $65 million for legitimate BI claims related to business closures as a result of the pandemic.

Media Zoo set up an action group to organize a class action against Hiscox. The action group alleges the firm's policies clearly state they will pay where the interruption to the business was "due to restrictions imposed by a public authority following an occurrence of a notifiable human disease" and has called on the insurers to pay or for the government to step in. So far, over 500 claimants have joined the group, and Media Zoo claims a number of brokers support its work because they believe Hiscox policies covered COVID-19.

Unfortunately, there has been considerable press coverage on these claims recently, which has led to more members joining the action group. The action group is believed to have appointed a lawyer to progress its claims.

Hiscox's response is to deny any liability. Hiscox said it reviews every claim or complaint individually. Hiscox provides BI cover as part of its small commercial package policies. Of these clients around 10 percent buy cover for BI. Hiscox believes that approximately 10,000 of these clients have been directly impacted by mandated government closure to stop the spread of COVID-19. Over 70 percent of these customers have monthly revenues of less than $50,000 in a normal trading environment. Hiscox believes its BI exposure to COVID-19 is limited in Europe, and it has negligible exposure in its U.S. retail business, and in any event, it has substantial reinsurance cover in place.

Hiscox said, "We understand that these are incredibly difficult times for businesses affected by COVID-19. At Hiscox we strive to pay claims that are covered by the policies fairly and quickly.

"However, general business interruption policies across the industry, including Hiscox's, were not designed to cover these extraordinary circumstances. Like terrorism and flood, which have government-backed insurance schemes, pandemics like COVID-19 are simply too large and too systemic for private insurers to cover."

Where Hiscox may have a problem is with event cancellation. It published a realistic disaster scenario which estimates a net loss of $175 million for losses emanating primarily from event cancellation, entertainment and travel, in a global pandemic scenario. Hiscox said it is proactively paying claims for these lines of business, and the claims are progressing in line with its expectations.

While $175 million is a lot of money, it won't break Hiscox's bank.

COVID-19, catastrophe or opportunity?

It's far too early to even consider the

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in three of NAIC's model acts. Proposed changes include broadening application to vendors and others with which insurers share information; extending protections to cover both natural persons and other legal entities; creating new consumer rights, increasing consumer access to their information; shifting from opt-out to opt-in consent for disclosures of information for marketing purposes; adding restrictions on the use of data and provisions regarding insurers' passive collection of information, such as through tracking cookies and web beacons; increasing notice requirements, and others. For more information, visit the NAIC website for updates concerning Models 670, 672 and 55.

MARIT'S READS

Patrick Lencioni's The Ideal Team Player is an easy-to-read fable about how to recognize and cultivate three essential virtues in people: they are humble, hungry and smart. Ideal team players add immediate value in a team environment and require much less coaching and management to contribute in a meaningful way. Lencioni shares four primary applications of the ideal team player model within an organization – hiring, assessing current employees, developing employees who are lacking in one or more of the virtues, and embedding the model into an organization's culture. This is a must read that is perfect for a company-wide book club to stimulate conversation and reinforce teamwork.

-Marit Peters, IIAT president and executive director

Note: In May, Peters hosted a Mornings with Marit that highlights the book she reviewed in March, Fierce Conversations. It is available for replay on YouTube.

SLTX

Premium reported to the Surplus Lines Stamping Office of Texas in April was $741.68 million, topping all previous reports for the month of April. This is a 14.8 percent increase over the same month last year. So far this year, each month's reported premium was the highest ever for that month. Premium year-to-date is $2.4 billion, a 14.6 percent increase compared with the first four months of 2019. The stamping office noted growth in particular of flood and fire and allied lines, as well as growth in the number of filings for exempt commercial purchaser policies. So far, SLTX has recorded 350,818 total filings, which includes 235,679 policy filings. Stamping fee collections through the end of April totaled nearly $3.15 million.

TDI

Through a May 11 bulletin, the Texas Department of Insurance reminded insurers, agents, agencies and adjusters that, even though Texas waived certain licensing requirements for insurance agents and adjusters and extended temporary licenses while testing and fingerprinting sites remained closed, they bear certain responsibilities for temporary agent and emergency adjuster applicants and licensees. As a sponsor for someone with a temporary license, the

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insurer, agent or adjuster is responsible for the acts of the temporary licensee and is expected to review the applicant's background for suitability for licensure. The sponsor is also expected to monitor behavior and provide required training. For more information, contact the Agent and Adjuster Licensing Office at 512-676-6500 or license@tdi.texas.gov.

Due to COVID-19, TDI's Division of Workers' Compensation has canceled its 2020 Texas Workers' Compensation Conference. Registration fees will be refunded in full. Next year's conference is slated for June 28-30, 2021, at the Hyatt Regency Austin.

Commissioner Kent Sullivan issued a bulletin to all Texas insurers reminding them that Texas law limits their authority to use credit scoring in rates, rating classifications and underwriting rules for a consumer whose credit information has been directly influenced by temporary job loss, as those occurring during the pandemic. An insurer may consider only credit information not affected by the temporary loss of employment or must assign a neutral credit score. TDI encouraged insurers to accept verbal requests for credit score exceptions in lieu of written ones, as prescribed by law.

In a May 11 bulletin, TDI encouraged health insurers, health maintenance organizations, and utilization review agents to extend prior authorizations for elective procedures authorized prior to the March 22 executive order directing a postponement of those procedures. Based on the go ahead of **Gov. Greg Abbott**, issued April 17, TDI requests that all prior authorizations for elective surgeries and referrals for specialists, therapy, counseling services and other medically necessary services disrupted by the stay-at-home order be extended and provide insureds and health providers with written notice of the updated authorizations. The notices may be sent electronically. Providers remain responsible for completing documentation required for reimbursement. This bulletin does not apply to one-time service authorizations already completed, new requests for authorization, or pharmacy prior authorizations.

TDI's Division of Workers' Compensation is accepting public comment until June 8 on whether rules in 28 TAC Chapters 126-128 still have reason to exist or should be repealed, readopted or readopted with amendments. Written comments may be sent to rulecomments@tdi.texas.gov. **Kara Mace**, deputy commissioner of legal services said TDI may consider such suggestions in future rulemaking.

TDI's Division of Workers' Comp reminded system participants that maximum medical improvement and impairment rating evaluations are not permitted through telemedicine. Otherwise, in accordance with an emergency rule issued by TDI on April 13, physical medicine and rehabilitation services provided by a licensed health care provider on or after April 13, through telemedicine or telehealth services, shall be reimbursed using the applicable Medicare codes. Medicare's distant site practitioner requirements do not apply.

London views

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likely costs of COVID-19, but already regulators worry about potential exposures, while insurers look at increased revenues.

Market gossip suggests COVID-19 will produce the biggest insurance loss in history – over $100 billion. Others are less pessimistic.

Lloyd's CEO John Neal recently wrote in the UK's Financial Times that COVID-19 is "no doubt the largest insurance challenge the industry has ever faced" and it will be "tens of billions, if not hundreds of billions, of loss that will be discussed over time." The eventual losses will take a long time to resolve, said Neal, and will be shared very widely among the worldwide insurance and reinsurance industry, not just Lloyd's.

Neal urged the industry to get mechanisms in place quickly so that, if there is a dispute, it doesn't go on for months or longer. He also is concerned about the possibility of a second wave of COVID-19 cases and said that there needs to be dialogue between the government and insurers about how any second wave of COVID-19 cases could be covered. "We've got weeks, not months, to resolve some of these immediate issues." He concluded that the 2020 calendar year will see a "notable loss."

Lloyd's expects claims from COVID-19 to affect both the 2019 and 2020 years of account, with 2019 having more significant claims. Lloyd's will publish shortly market figures for the period.

Lloyd's is not the only insurer worried about COVID-19. London market insurance companies listened carefully to the initial estimates from the ABI (Association of British Insurers), which indicate that its members expect to pay out over $1.6 billion in claims to support businesses and individuals affected by COVID-19. This figure covers payments on business interruption, travel insurance, wedding policies and canceled school trips.

The $1.6 billion is made up of $1.3 billion of BI claims and a record $0.3 billion in cancellation claims on travel insurance, and $25 million spread across wedding insurance, school trips and events. Like Lloyd's, the ABI believes few policyholders have COVID-19 cover.

COVID-19 is going to cause havoc across the industry. It is expected to boost the current hardening of rates across the board. There is a school of thought in the market which believes rates on big-ticket insurance could surge. For the first three months of the year, London underwriters saw market rates rise by single digits and low double digits. The belief is that rates could jump by 20 percent as the COVID-19 effect feeds through at the beginning of 2021 onward.

To take on new business, insurers will need capital. Ironically, one of those raising money is Hiscox, which has raised almost $500 million by issuing extra shares at a discount of 6.1 percent.

Hiscox said it expects opportunities for profitable growth in wholesale and reinsurance markets as a result of capital contraction and rate improvement across the market following the uncertainty caused by the COVID-19 pandemic. The proceeds raised from the share issue will allow Hiscox to take advantage of future growth opportunities and rate improvement in the U.S. wholesale and reinsurance markets, as well as position the group to withstand a range of downside scenarios. Hiscox also is buying $100 million of additional reinsurance to protect against natural catastrophe, especially U.S. wind.

Along with Hiscox, Australian insurer QBE is going to raise $1.3 billion, and others are expected to look for opportunities to expand.

At least some insurers see an encouraging future.

London market to help create pandemic backstop

Lloyd's has joined other market bodies in creating a government funded backstop to cover future pandemics.

The market's aim is to set up Pandemic Re, a government funded backstop that would pay for major pandemic losses. The talks involve the U.K. finance ministry, market regulators and insurance participants such as Lloyd's, the Association of British Insurers, the London and International Brokers Association and the British Insurance Brokers Association.

The first step is to produce preliminary estimates of the impact of COVID-19 on the insurance community. Some hope to do this in May, but other members consider this too early. The U.K. already has two backstops, one for flood (Flood Re) and the other for terrorism risks (Pool Re).

Since many SMEs are unwilling to purchase BI cover, the U.K. government feels a Pandemic Re is vital. Without it, pandemic cover would be limited, expensive and unattractive to buyers.

The proposed Pandemic Re would be expected to operate on similar terms as Flood Re and Pool Re. The primary carrier would issue policies to buyers and then be reinsured for losses above an agreed figure by the government. Insurers charge a fee to the policyholder of around $325 and insurers pay an annual levy of around $235 million into Flood Re. Pool Re has a similar system, but with each insurer fixing the rate for terrorism cover.

Electronic trading target unchanged

With all the chaos over COVID-19, it's difficult to remember that there is still insurance business being transacted in the London market. There is a curious difference in that, prior to lockdown, a broker would negotiate a risk face-to-face and then use the electronic placing system; whereas, now electronic placing rules the roost.

Lloyd's recently issued Market Bulletin Y5276, which gives the electronic placement targets for the second quarter of 2020. The bulletin says that effective April 1, 2020, the target for electronic placing is to continue at 80 percent of all risks.

Lloyd's is working with representatives from the LMA Operations Committee to agree on appropriate submission/quote targets for the second half of the year. Consequently, another bulletin is expected to be issued at the beginning of June.

Largest ever new syndicate at Lloyd's

American International Group Inc. recently announced the launch of Lloyd's Syndicate 2019. This landmark syndicate is the largest ever syndicate to be launched through Lloyd's. It will exclusively reinsure risks from AIG's Private Client Group. PCG is an industry-recognized brand with a leading market position in the high net worth segment.

AIG said it has received significant capital support from high-quality investors and capacity providers, which is a testament to the quality and growth potential of the PCG franchise. In combination with its existing Lloyd's operations, AIG will now operate the ninth largest managing agency in the Lloyd's market, in terms of capacity.

For Lloyd's and the third-party investors and capital providers, Syndicate 2019 represents an opportunity to access the highly attractive High Net Worth segment.

Peter Zaffino, AIG's president and global chief operating officer, said that Syndicate 2019 is "a unique and industry-defining structure between AIG and the oldest insurance market in the world."

Syndicate 2019 will be managed by Talbot Underwriting Limited, the managing agency AIG acquired in 2018 as part of the Validus transaction.

Manes

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turbulence, rigid pine trees snap and flexible willow trees and well-rooted, strong oaks prevail. Are you ready for tomorrow? Really?

MICHAEL G. MANES is the owner of Manes and Associates, a New Iberia-based consulting business focusing on planning, sales and operations, and change. He has over 47 years of insurance industry experience, including serving as an instructor of Risk and Insurance at Louisiana State University.

TDI Final Disciplinary Actions April 2020*

Date	Name & City	Action Taken	Violation
4/14/2020	DirectPath LCC, Birmingham, Ala.	Fined $10,000[C]	Allowed unlicensed and unappointed individuals to submit long-term applications to Unum Insurance Group
4/30/2020	Elephant Insurance Company, Henrico, Va.	Fined $80,000[C]	Several violations found in a targeted market conduct examination
4/30/2020	Envolve Pharmacy Solutions Inc., Fresno, Calif.	Fined $120,000[C]	Failed to provide prescribing health care providers reasonable opportunities to treating physician to discuss patient treatment plans and clinical basis for adverse determination; sent adverse determination notices without principal reason for adverse determination; failed to include professional specialty of the health care provider that made the adverse determination; sent adverse determination notice one day late
4/28/2020	Geoffrey Wayne Leininger, Plano	General lines agent license and personal lines property and casualty agent license revoked	Failed to notify TDI of regulatory actions taken against him in Washington, Louisiana and California; engaged in fraudulent and dishonest acts; failed to notify TDI of change in mailing address

***Except for consent orders, actions may be appealed to State District Court.**
[C]Consent order: Parties waived rights to other procedures.

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