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New Punitives Ruling Means New Battles

By Marcia Coyle

The Supreme Court's April 7 ruling on punitive damages, greeted with relief and enthusiasm by corporate defendants, opens new battlegrounds in litigation seeking those awards. The ruling significantly expanded the High Court's prior attempts to guide lower courts and lawyers on when punitive damages awards may run afoul of the Constitution. *State Farm Mutual Automobile Insurance Co. v. Campbell*, No. 01-1289.

The 6-3 decision in *State Farm* threw out a $145 million punitive damages award won by Curtis Campbell in a bad-faith action against the auto insurer. Compensatory damages totaled $1 million.

"This is not the end," said Lori S. Nugent, head of the punitive damages practice in the Chicago office of Cozen O'Connor. "Justice Scalia was absolutely right when he said that there will be many decisions in the future on punitive damages. And there should be."

Groundwork

The Court majority was not breaking new ground in the ruling, supporters and opponents said, but was elaborating on previous guidelines. In a series of rulings beginning in 1989, the Court has expressed growing concern and increased skepticism about punitive awards that are dramatically out of proportion to compensatory awards. In 1996, the Court for the

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Can the Innocent Survive Rescission?

The Innocent-Insured Exception to the Wrongful-Acts Exclusion

By Donald R. McMinn

Professional liability policies typically exclude coverage for claims arising out of an insured's knowing, wrongful acts, but, in recognition of the fact that a single policy may extend coverage to multiple insureds working together in association, insurance companies sell the policies with language reinstating coverage for innocent insureds, those of the insureds who had no knowledge of the allegedly wrongful acts of their colleagues. Recently, this innocent-insured coverage has received scrutiny. In two decisions involving professional liability policies, courts have granted an insurer summary judgment, finding that the material misrepresentation regarding prior conduct of a member of an insured firm was grounds for rescinding the coverage of all of the insureds, including those who were innocent and unaware of the wrongdoing. *TIG Ins. Co. v. Robertson, Cecil, King & Pruitt*, No. 1:01CV00143, 2003 WL 253167 (W.D. Va. Jan. 31, 2003); *First American Title Ins. Co. v. Lawson*, 798 A.2d 661 (N.J. Super. Ct. App. Div.), *appeal granted*, 807 A.2d 191 (N.J. 2002). These decisions stand in marked contrast to recent decisions on similar issues by courts in Massachusetts and New York, confirming that innocent insureds are entitled to coverage following the exposure of a co-worker's covert wrongdoing. *See In re Perrone*, 284 B.R. 315, 320 (Bankr. D. Mass. 2002); *Fuchsberg & Fuchsberg v. Chicago Ins. Co.*, No. 00 Civ. 3118 DLC, 2001 WL 484013, at * 7 (S.D.N.Y May 7, 2001), *aff'd sub nom. Fuchsberg & Fuchsberg v. Galizia*, 300 F.3d 105 (2d Cir. 2002); *Holloway v. Sacks & Sacks, Esqs.*, 713 N.Y.S.2d 162, 164 (N.Y. App. Div. 2000).

Covert Wrongdoing By a Co-Worker

In *Robertson*, the insurer, TIG, issued a policy to a law firm upon a renewal application completed by one of the firm's partners, King. King had answered in the negative to a question asking if "any attorney [was] aware of any claims made ... wrongful acts, errors or omissions that could result in a professional liability claim" or was aware of the reasonable foreseeability of such a claim being made. *Id.* at *1. When King answered in the negative, he had indeed misappropriated client funds, but none of the clients or

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anyone at the firm (or elsewhere) was aware of this fact. King's actions subsequently were uncovered, and clients brought claims against the firm and its remaining partners (King had died). TIG declined coverage.

In seeking to avoid coverage, TIG argued that King, as the miscreant, had had knowledge of the falsity of his response to the questions on the renewal application, and that his misrepresentation was grounds either for rescission or for a declaration of a lack of coverage for the claims. The firm opposed TIG. While acknowledging the policy's exclusion for claims arising out of a "dishonest, fraudulent, criminal, malicious or knowingly wrongful act," the firm argued that it and the other partners were entitled to coverage pursuant to the express exception from this exclusion for insureds who were unaware of, and had not participated in, the wrongful acts of the co-insured. *Id.* at *3. Although not discussed in the opinion, it appears the insureds must have raised the existence of this innocent-insured exception in support of an argument that, in the light of the parties' mutual intent to cover innocent insureds for claims arising out of the unknown, wrongful acts of a co-insured, the non-disclosure of those wrongful acts at policy renewal would not support rescission. The court decided in TIG's favor, reasoning that partners are responsible for each other's conduct and that because the partners had the greatest opportunity to discover King's wrongful conduct, they, rather than the insurer, who relied on the application, should bear the loss. *Id.* at *4.

Guilty in New Jersey

The Appellate Division of the Superior Court of New Jersey faced similar circumstances in *First American Title Insurance Company v. London*, a case currently pending before the New Jersey Supreme Court. 798 A.2d 661. In *First American*, two members of a three-person firm engaged in a check-kiting scheme to conceal the abuse of client trust funds; the third member, whose office was in another jurisdiction, apparently was unaware of these wrongful acts. 798 A.2d at 664-65. One of the miscreants was responsible for completing the insurance application, as well as subsequent warranties, and in response to questions concerning an awareness either of claims against the firm or circumstances that could lead to claims, answered in the negative. *Id.* at 665-66. The trial court denied the insurer's summary judgment motion seeking rescission or a declaration of no coverage, holding, among other grounds, that rescission should not lie as against the innocent insured. *Id.* at 671. The Appellate Division reversed, holding that because the miscreant was authorized by the firm to complete the application, partnership law finds the miscreant's statements binding on the firm and the innocent partner, "subjecting [them] to the equitable remedy of rescission." *Id.* As in *Robertson*, the court found the innocence of the remaining partner "of no consequence" despite the equitable nature of the rescission remedy and the presence of a contract term explicitly preserving coverage for innocent insureds (evidencing the parties' intent to provide coverage for innocent insureds), which it did not address. *Id.* at 672.

Innocent in Other States

Courts in New York and Massachusetts have approached the subject differently, allowing coverage to the innocent insured whose co-insured or employee has committed wrongful acts resulting in claims against the innocent insured. The *Perrone* court expressly recognized that an objectively reasonable insured would expect coverage under a professional liability policy for claims arising out of wrongful acts of which he or she was unaware at the time the policy was issued. *In re Perrone*, 284 B.R. at 320. As long as the insureds seeking coverage had no knowledge of the co-insured's or employee's wrongful acts at the time of application or renewal, these courts did not accept the carriers' nondisclosure arguments. For instance, as part of the *Perrone*

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Investigating Fraudulent Claims, Part 2

(This article is part of an ongoing series)

By Anthony J. Golowski II

The first article in this series (*Insurance Coverage Law Bulletin* Volume 21, Number 1, February 2003) provided an overview of upcoming articles, and addressed the issue of fraud at the inception of an insurance claim. This second installment focuses on insurance carriers' analysis of fraudulent claims and the use of forensic experts to defend against claims. It also addresses the issue of fraudulent enhancement of otherwise valid claims.

Introduction

When a claim has been noted as containing, or potentially containing, fraudulent elements, it is usually referred to the carrier's Special Investigation Unit (SIU). A carrier's SIU is generally charged with investigating fraudulent claims, working with specially trained, outside counsel, and, where required, making referrals to the appropriate criminal, civil or administrative agencies.

As discussed in the first article, the most successful investigations occur when all involved departments of a carrier collaborate with the carriers' SIU attorney to provide the most thorough and complete investigation and defense possible. For example, in the case of a suspected fraudulent claim, a carrier's Claims Department should obtain all routine information necessary to process the claim, including Loss Notice, Sworn Proof of Loss, and a recorded statement, even if the matter is initially referred to the SIU. After obtaining oral and documentary evidence, the Claims Department should make that information available to the SIU, which can, in turn, attempt to verify it or confirm the fraudulent nature of same during the course of its investigation. All of this information should then be turned over to the SIU attorney for complete analysis. If the carrier deems that an Examination Under Oath (EUO) is appropriate, the attorney will then have the necessary information to conduct a concise, targeted EUO to uncover the true facts of the case. Acquisition of as much information as possible makes it easier for retained counsel to determine, with a high degree of confidence, whether a claim is fraudulent. If a claim is not deemed fraudulent, or if any fraudulent statements are immaterial, the claim can be promptly processed and paid. If, based on discovery, the claim is deemed fraudulent and the misrepresentations are material, the claim should be denied.

Making the Case for Fraud

Developing the information necessary to confirm the fraudulent nature of claims is the most important part of all insurance claim investigations. Depending upon carriers' internal procedures, all contact with SIU attorneys may occur through the SIU or the claims representative and they may each forward information to the SIU attorney.

The term "SIU attorney," for the purposes of this article, refers to outside counsel retained by SIU departments, who have special expertise in analyzing fraudulent insurance claims, not an attorney employed by the carrier. This author's company is one such firm routinely retained by carriers' SIUs to assist with in-depth investigations and defense of fraudulent claims. The scope of representation at such firms ranges from consultation on claims, in-depth analysis and investigation, conducting EUOs, and/or defending carriers in the event that litigation is instituted.

Confidentiality

In New Jersey, an SIU may take advantage of certain statutory confidentiality provisions during the course of its investigation. By statute (the New Jersey Insurance Fraud Prevention Act N.J.S.A. 17:33A-1, *et seq.*), certain information developed by the SIU may be deemed confidential during the course of insurance fraud investigations. It is important to note that, when sharing information, both Claim Departments and SIUs should direct the flow of information directly to their SIU attorney(s). If communicated directly, the information may be transmitted under the attorney/client privilege. As long as no outside agencies or entities are copied on the correspondence, the privilege will not be waived. The information may eventually be turned over to the insured, but such production could be at a time, or under circumstances, favorable to the carrier.

Outside Experts

While claims representatives and SIU investigators each have their respective information-gathering duties, the unique nature of individual claims often requires the assistance of outside experts. In many cases, a forensic expert's input is crucial to a carrier's analysis, and ultimate determination, on a claim. A carrier's primary responsibility is to pay valid claims and to deny those deemed invalid. Forensic experts help carriers make that ultimate determination. In defense cases, this author routinely works with three specific types of experts to defend a variety of potentially fraudulent claims. They include accountants, doctors, and vehicle theft/arson experts.

Accounting experts are frequently used and can be invaluable to the investigation and defense of cases involving premium fraud. These experts (who are required in cases involving allegations of accounting malpractice) also can assist with business interruption claims. In cases involving premium fraud, having an expert's review and analysis of an insured's books and records can be a tremendous source of discovery. While an attorney may have an accounting, financial or tax background, he or she cannot prepare an expert report. The expert report needs to be generated by a qualified professional in the respective field. Working together, the attorney and the accountant should review the insured's books and records and elicit relevant facts and information, so that the expert may generate a report including the necessary evidence to prove the carrier's case. Some examples of invaluable accountant services

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include: analysis of payroll and financial information in commercial claims involving workers compensation premiums; review of accounting services and the standard of care in cases wrongfully alleging accounting malpractice; and analysis of payroll, financial and tax information in cases of business interruption loss.

Accounting Experts

In a thorough investigation, it is best for the SIU attorney and the accountant to work with the carrier's representative in developing the defenses to the claim. It is important to note that there are tactical reasons for an accounting expert to be retained by the SIU attorney rather than the provider. These reasons relate to the privilege of communications between the attorney and the accountant, and maintaining the confidentiality of such communications.

Medical Professionals

Medical professionals are a second category of invaluable experts who can be tapped for help with certain claim analyses. Their knowledge can be particularly useful in analyzing claims for bodily injury damages and for medical benefits, such as personal injury protection (PIP). Medical professionals are typically retained by carriers to conduct independent medical examinations (IMEs) or to provide "peer reviews." IMEs are an important part of the evaluation and potential defense of a claim. Statements obtained by an examining physician often provide counsel with a basis for cross-examining claimants and for defending against claims. The importance of IMEs should not be underestimated. At the same time, an IME alone may not be sufficient evidence for a carrier to prevail in arbitration or litigation. While carriers routinely refer claimants to physicians for IMEs, they do not typically avail themselves of the other services that physicians can provide. For example, medical professionals can provide information regarding appropriate billing practices, standards of care, and formal legal requirements imposed upon practicing physicians by entities such as a state's Board of Medical Examiners or Board of Chiropractic Examiners. Judges, jurors and arbitrators routinely accord great weight to a claimant's treating physician. In some jurisdictions, there may even be a "treating physician rule" that requires that deference be given to a claimant's treating physician.

An expert's peer review may provide a defense in one area that has a domino effect in defending other areas of the claim. For example, some carriers have begun routinely requesting peer reviews of magnetic resonance imaging (MRI) test results. For reasons ranging from liberal interpretation to allegedly interchangeable terms to outright fraud by MRI providers, carriers have encountered cases where MRI test results consistently indicate the presence of herniated discs. When the underlying MRI films have been referred to radiologists retained by these carriers to provide peer review, the subsequent reviews have frequently revealed that no such herniation exists. Obtaining these opinions and establishing the lack of herniated disc can potentially save carriers thousands of dollars in damages per bodily injury lawsuit and can save additional thousands of dollars in the event they are called upon to pay claimants' medical bills.

In high-volume medical practices, such as those that specialize in the treatment of PIP claimants, groups of medical professional often collaborate their services. For example, a chiropractor may refer a patient to an MRI facility, a physical therapist, a neurologist (for diagnostic testing) and a pain management specialist. Some or all of the treatment provided by each medical professional may be allegedly justified by the results of an incorrect or misread MRI. While testing and treatment may be rendered in good faith by an innocent physician, in other cases it is readily apparent, from the lack of objective and circumstantial indicia and the results of other diagnostic testing, that claimants did not actually require much of the treatment and testing rendered. Establishing these facts can serve a three-fold purpose: reducing damage awards in bodily injury lawsuits, reducing medical expense awards in PIP suits or suits for medical expenses, and alerting the SIU and Claim Department to groups of physicians whose collaborative actions should be investigated in other cases.

In addition to peer reviews and IMEs, a medical expert can provide carriers with personal knowledge regarding the requirements (such as record-keeping, delegation of duties, and scope of practice) of the governing administrative agency. In New Jersey, for instance, there are regulations governing the practices of medicine and chiropractic, which are promulgated by the Board of Medical Examiners and the Board of Chiropractic Examiners, respectively. A physician specializing in one of those disciplines is often the best candidate to review a colleague's services, the medical necessity of those services, and the propriety of billing for such services. The carrier should be aware that although certain medical modalities may be rendered to a patient, those same modalities might not be billable if the appropriate regulatory agency has deemed those treatments to be of little or no medical value. Whether based on a belief that the treatment is appropriate or in an attempt to increase billings, doctors and chiropractors routinely per-

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form and submit bills for certain modalities even though those modalities are not eligible for payment. In-house and outside audit agencies routinely will assess those charges for "fee schedule" purposes, but they will not address the issue of medical validity. A carrier and its SIU attorney should be made aware of those modalities which lack medical validity and are not eligible for payment. This knowledge can potentially save carriers thousands of dollars in medical fees per claim.

Vehicle Theft/Arson Experts

The third category of invaluable experts for investigating insurance fraud cases is in vehicle theft/arson. These people are usually former law enforcement officers or insurance investigators who have specific training in vehicle theft and arson cases. They can provide detailed analysis of whether a vehicle was or could potentially have been stolen under the circumstances described by the insured. They have detailed and extensive knowledge regarding automobiles and commercial vehicles relating to doors, keys, and locking systems, ignition and steering issues, and vehicle security features, among other things.

The detailed reports provided by these experts frequently help carriers construct an ironclad defense to fraudulent vehicle theft claims. In addition, most claimants and sometimes even their attorneys have no knowledge that these professionals exist, and are not familiar with the complex reports they generate and the terminology contained therein. The vehicle theft expert should have thorough knowledge of older vehicles as well as up-to-date information on current changes in vehicles and their security features. Their reports not only assist in defending staged theft claims but can also serve as the cornerstone of governmental prosecutions for insurance fraud. While these reports are generally commissioned by the carrier during the investigative stage, it is imperative that the carrier retain an SIU attorney who is familiar with such reports, the terminology and technology addressed therein, and is able to elicit from the expert, in layman's terms, the testimony necessary to prove before a jury that the insured has, in fact, submitted a fraudulent claim.

A vehicle theft forensic expert may also have experience in investigating arson cases. If not, a separate expert may be retained. Arson experts provide carriers with Cause and Origin reports that clearly state, if determinable, the origin of fires, the causes thereof, and analyses of those facts as they relate to the claims in question. Cause and Origin reports are extremely helpful in investigating, analyzing and potentially defending claims for arson damages to personal and commercial property.

A vehicle theft forensic expert may also have experience in investigating arson cases.

Fraudulent Enhancement

Earlier in this article, fraudulent enhancement of otherwise valid claims was addressed. Each of the case types referenced above could readily be the subject of a fraudulent enhancement of an otherwise valid claim. For example, in the case of business interruption claims, an insured may claim an extensive loss that is not justified by its books and records. While the loss itself may have been a valid event, the insured may attempt to use that valid event as a springboard for the submission of a fraudulently enhanced claim. In personal and commercial property claims (whether real property, durable goods and/or inventory) an insured may attempt to utilize an initially valid loss as the catalyst for a fraudulently enhanced claim.

Based upon case experience, this author can attest to the value of using qualified experts to successfully defend fraudulent claims. In one such claim, an insured whose abandoned house was destroyed by fire claimed to have lost in excess of $100,000 of personal property in the fire. The forensic expert report confirmed that the house was empty at the time of loss and that the $100,000 property claim submitted by the insured was fraudulent. Expert analysis has also led to successful defense against fraudulent business interruption cases where insureds presented inflated sales and income information, and business theft claims where insureds fraudulently inflated the amount of inventory that was allegedly stolen.

While some claims involved losses that were legitimate, the insureds attempted to inflate the value of their claims in order to obtain additional benefits. Depending upon the language of the carriers' underlying policies, carriers may be able to deny claims in their entirety (both the valid and invalid portions) as a result of insureds' commission of fraud in connection with claims. In defending the cases noted above, it was imperative to have knowledge of the underlying policy and its terms and conditions,

...carriers may be able to deny claims in their entirety (both the valid and invalid portions)...

and to apply that knowledge to the facts provided by the claims personnel, the SIU investigators and the forensic experts.

When confronted with such complete and detailed defense, fraudulent claimants are left with little or no ability to prove their claims or to prevail in court. By filing counterclaims, where appropriate, carriers can not only defend against claims, but may also be entitled to recover damages from insureds based upon their filing of fraudulent claims. One of the greatest deterrents to insurance fraud is for carriers to actually end up collecting damages from the insureds who submitted fraudulent claims.

New Punitives Ruling

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first time struck down a punitive award as grossly excessive, $2 million compared with $4000 in compensatories. *BMW of North America Inc. v. Gore*, 517 U.S. 559 (1996). The Justices also set out three "guideposts" for weighing a punitive award. Courts must look at:

- The degree of reprehensibility of the defendant's conduct;
- The ratio between the actual or potential harm suffered by the plaintiff and the punitive damages award. The court suggested a ratio that was exceeded by nearly one-third of the punitive damages awards in the nation's biggest jury verdicts of 2001 and 2002, according to *The National Law Journal's* Top 100 Verdict surveys for those years.
- The difference between the punitive damages awarded by the jury and the civil penalties authorized or imposed in comparable cases.

The elaboration of the first two guideposts formed the basis for the reversal of the $145 million punitive award. It also laid the groundwork for future court battles.

Future Court Battles: What to Expect

"Each one of these issues, from a litigation perspective, will be hard-fought going forward," said Arvin Maskin of New York's Weil, Gotshal & Manges, who filed an amicus brief for the Washington Legal Foundation supporting State Farm. "Every time the Court refines them, people are going to be busy construing them, and there will be extra litigation." At the heart of the *State Farm* ruling, by Justice Anthony M. Kennedy, are the two R's in the first two guideposts. They are reprehensibility and ratio.

Reprehensibility

In fleshing out reprehensibility, Kennedy took on one of the biggest issues pressed by corporate defendants for years: When can a court consider a defendant's out-of-state conduct in evaluating his or her reprehensibility?

In the *State Farm* case, the trial court had allowed Campbell to introduce evidence that the company's decision to take his auto accident case to trial instead of settling it for the policy limits, as offered by the injured third parties, was the result of a national scheme to cap payouts on claims companywide.

The Utah Supreme Court, on appeal, noted some examples of the insurer's "most egregious and malicious behavior." These included a 20-year-plus policy of encouraging adjusters to pay less than market value for claims, and rewarding them when they did; challenging the contents of files; and lying to customers. A State Farm official had ordered an adjuster to change the file's accident report to lessen Campbell's liability for a car accident.

State Farm argued in the high court that the lower courts improperly relied on out-of-state conduct, some of which was not similar to what happened in the Campbell case, and some of which was legal in other states. The high court majority agreed.

While saying that State Farm's handling of Campbell's case "merits no praise," Kennedy wrote: "Lawful out-of-state conduct may be probative when it demonstrates the deliberateness and culpability of the defendant's action in the state where it is tortuous, but that conduct must have a nexus to the specific harm suffered by the plaintiff. A jury must be instructed, furthermore, that it may not use evidence of out-of-state conduct to punish a defendant for action that was lawful in the jurisdiction where it occurred."

The lower courts, he wrote, awarded punitive damages against State Farm to punish and deter conduct that bore no relation to Campbell's harm. "A defendant's dissimilar acts, independent from the acts upon which liability was premised, may not serve as the basis for punitive damages. A defendant should be punished for the conduct that harmed the plaintiff, not for being an unsavory individual or business," said Kennedy.

If punitive damages are not confined to the conduct of a defendant toward the plaintiff, the defendant can be punished again and again for the same thing," said Victor E. Schwartz of the Shook, Hardy & Bacon Washington office, who filed a brief supporting State Farm on behalf of the Product Liability Advisory Council.

"Certainly, looking at what State Farm did all around the country, one could say that was reprehensible," said Schwartz. "But the Court said that was unconstitutional because it strayed from conduct that was directed toward the plaintiff. They [the Court] drew a red line on not allowing punitive damages cases to turn into a trial of the defendant in general, as to whether it was a bad company. This has major implications for pharmaceutical companies, [and] automakers, tobacco, asbestos and insurance companies."

Kennedy's language will be the "battleground going forward," said Cozen O'Connor's Nugent. "I think plaintiffs will use some of the language to encourage trial courts to permit entry of evidence," she said. "And defense counsel need to be very aggressive in reminding the court of the constitutional parameters."

The Ratio Issue

The second key "R" in the *State Farm* decision and the second battlefront is the ratio between the punitive and compensatory damages. Kennedy said the Court has always refused to set a bright-line maximum ratio for punitives, and would not set one in the *State Farm* case. But both sides agreed that the Court approached such a line.

In *The National Law Journal's* Top 100 verdicts for the past 2 years, 31% of the total punitive awards had more than a single-digit ratio to compensatory awards. In 2001, 24% of the 38 punitive awards had double-digit ratios with a high of 500 to 1. In 2002, it was 39% of the 41 punitive awards, with a high of 1145 to 1. Cases included wrongful death, and sexual harassment.

Higher ratios, Kennedy wrote, may be upheld where "a particularly egregious act has resulted in only a small amount of economic damages." But he said the converse is also true. "When compensatory damages are substantial, then a lesser ratio, perhaps only equal to compensatory damages, can reach the outermost limit of the due process

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Marcia Coyle is a staff reporter for *The National Law Journal,* in which this article first appeared.

CASE BRIEFS

Insurer Must Seek Rescission Before Third-Party Files Claim

In the case of *USAA v. Pegos,* 2003 (Cal. App. Lexis 445) (Cal. Ct. App.), March 25, 2003, the California Court of Appeal addressed the question of whether an insurance carrier can rescind an automobile liability insurance policy after the insured injures another person. The court held that the insurance carrier could not do so. As the court stated:

"Unless it has conducted a reasonable investigation as to the insurability of its insured, an insurance company may not rescind an automobile insurance policy based upon the material misrepresentations of its insured *after the insured injures a third party* ... This requirement is to protect the public from injury by the insured's acts rather than to reward a dishonest insured." (For in-depth information on rescission, see the article entitled "Can the Innocent Survive Rescission?" beginning on page 1.

The court acknowledged that material misrepresentations of fact made in connection with an application for insurance constitute a ground for rescission. However, the court recognized that an insurance carrier cannot successfully defend a claim upon the ground of its own failure to reasonably investigate the insured's application. The court noted that an insurer's duty to investigate derives "principally from the public policy underlying California's Financial Responsibility Law and the 'quasi-public' nature of the insurance business." The court also noted that both of these public policy considerations mandate the conclusion that the failure of an insurer to reasonably investigate the insurability within a reasonable time after issuance of the policy "results in the loss of the carrier's right to rescind, as opposed to its right to cancel, the policy." As the court further explained, if the carrier had not timely rescinded the policy "prior to an accident in which the insured negligently injures a third person, the policy necessarily remains in effect at least through the time of the accident; the insurer cannot thereafter rescind, but only cancel the policy." The court premised its holding in significant part upon the "quasi-public" nature of an insurance contract. It stated: "The reasonable expectation of the public is that insurance companies provide them with insurance. This expectation would be frustrated if the courts allowed an insurance company to 'perpetually postpone the investigation of insurability and concurrently retain its right to rescind [the insurance policy] until the injured person secures a judgment against the insured and sues the carrier.' " The court emphasized that a contrary rule would "defeat the public's expectation for insurance companies" and allow an insurer to avoid investigating until there is an accident or injury, thereby "allowing the insurance company to collect premiums ... without the risk associated with the policy in violation of its public obligations as an insurance company." The court also noted that as a practical matter, a contrary rule would mislead an insured into believing that he or she was covered, when, in fact, he or she might not be, thereby discouraging the insured from obtaining insurance that actually does provide coverage. While the court's ruling was with respect to an automobile policy, the court's focus on the "quasi-public" nature of an insurance contract indicates that the ruling is not so limited and may, in fact, extend to any third-party insurance policy.

Ralph S. Hubbard III, Lugenbuhl, Wheaton, Peck, Rankin & Hubbard, New Orleans; and **Kirk Pasich**, Howrey Simon Arnold & White, LLP, Menlo Park, CA, wrote this month's Case Briefs. Both are members of this newsletter's Board of Editors.

Can Failure to Include a Special Endorsement Justify Reformation of the Policy?

In *Illinois Central Railroad Company v. Dupont,* No. 02-30613 (5th Cir. 4/01/03), 2003 WL 1704649, the U.S. Court of Appeals for the Fifth Circuit affirmed a lower court's grant of summary judgment in favor of an insurer, holding that the failure to include a special endorsement in the policy, even if required by regulations, cannot give rise to a reformation of the policy deeming the endorsement to be a part of the policy.

Underwriters Insurance Company ("Underwriters") issued a business automobile policy to Denmar Logging, Inc. ("Denmar"). Illinois Central Railroad Co. ("Railroad") sued Denmar after an accident in which one of Denmar's contract drivers collided with a Railroad train. Underwriters intervened in the suit seeking a declaratory judgment that its policy did not cover the accident. Underwriters moved for summary judgment on the grounds that the policy only covered one truck owned by Denmar. The Railroad argued that by virtue of a regulation promulgated under the Motor Carrier Act of 1980, Denmar was required to have a special endorsement in its insurance policy. The endorsement, known as the MCS-90, provides that the insurer will pay within the policy limits any judgment recovered against the insured motor carrier for liability resulting from the carriers' negligence, whether or not the vehicle involved in the accident is specifically described in the policy. The Railroad argued that the endorsement should be deemed a part of the policy because of the regulation.

The district court granted summary judgment in favor of Underwriters, holding that Denmar was exempt from the regulation requiring the endorsement because Denmar was hauling an "agricultural commodity" not subject to regulation, and that even if the endorsement was required, the Railroad was not entitled to a reformation of the policy. The Fifth Circuit affirmed on the latter grounds without resolving whether the regulation even applied to Denmar.

The Fifth Circuit refused to reform the policy to deem the endorsement to be a part of the policy. The Fifth Circuit noted that even if the endorsement was required, the regulations are directed at the motor carrier, not its insurer. The Fifth Circuit did not interpret the regulations as imposing a duty on the