



Evaluating Insurance Overcharges: Should Your Company Pursue Claims Against Brokers and Carriers?

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The recent suit by New York Attorney General Eliot Spitzer alleging price-fixing and deceptive practices by broker Marsh McLennan and major insurers is prompting many corporate policyholders to examine whether they too are being overcharged. While this can often be determined without too much trouble, it brings up a more complicated question:

Should a wronged company risk enormous expense and time in pursuing claims against brokers and insurers when the outcome and collectibility of judgments are uncertain?

Here are the issues corporate counsel should consider:

Does my company have a claim?

Upon initiating an investigation of their insurance purchases over the past few years, many companies will recognize immediate signs of overcharging. For example, clients of this firm, which limits its practice to insurance policy enforcement on behalf of corporate policyholders, have reported in recent days discovery of the following red flags that may well shed light on your situation:

- **Unexplained premium increases:** As the anniversary date of a policy approaches, the broker tells the insured to prepare senior executives and the board for rate increases – and indeed, they arrive on schedule. If there is a loss history or adverse underwriting criteria to explain this increase, expectation management is prudent. In the absence of explanatory factors it's a red flag.
- **No new markets:** When there's a wholesale retreat from high-risk business, carriers still willing to write business coverage can charge what they wish. If rates have increased substantially, look for the absence of carriers willing to quote in prior years. If the playing field is substantially similar and premiums are up, this should be viewed as a red flag.
- **Brokers as unwilling advocates:** When a carrier refuses to pay a legitimate claim, the broker should be willing to fight for coverage for the corporate policyholder – even to the

point of damaging a relationship with an underwriter. Failure to do so means the broker perceives the underwriter relationship as more important than providing their client companies with the best possible coverage at an equitable price. Lukewarm broker response to an unjustified claim denial is a red flag.

- Vague engagement agreements: If a broker’s engagement agreement includes statements like, “From time to time, we may receive compensation from other sources in connection with this placement” or “The client fee paid pursuant to this engagement may not be the exclusive source of broker compensation,” this is a red flag indicating the possibility of broker-carrier financial relationships diluting or defeating the broker’s duty of loyalty to the client.
- Broker recalcitrance: When in doubt about the extent of broker compensation paid by carriers, call the broker and ask. The broker loyal to the policyholder will provide straight answers. The broker with something to hide is more likely to equivocate – a red flag.

To investigate whether there is a basis for claiming carrier or broker liability, corporate counsel should ask personnel in Finance or Risk Management to provide copies of the broker’s engagement agreement, all communications with brokers and carriers for the past several years, all policies placed and all claim-related communications. Then counsel should interview the key company personnel who interact with the broker, and finally the broker him or herself.

How Likely Is a Recovery?

If a company has evidence that broker-carrier misconduct has led to overcharging, to undisclosed broker compensation or to some compromise in the scope of coverage, three initial questions emerge:

- What is the extent of damages?
- Do statutes of limitations apply?
- Is the judgment collectible?

The extent of damages can be quite easy to determine in the case of broker overcharging. If comparable coverage was available from other sources than the carrier presented by the broker as the putative low bid, the policyholder’s damages are measured by the difference between what it paid and the price at which comparable coverage was available. Undisclosed broker compensation and compromises to the scope of coverage are difficult to quantify in the absence of a denied claim. Corporate counsel and risk managers have to determine if the claim would have been covered had the broker acted in the policyholder’s best interest.

The first step in the investigation is to review documents reflecting placements of coverage and communications about placement to and from the broker. Then review documents relating to unpaid claims, looking for signs that the broker did not aggressively advocate the company’s position. Finally, speak with people from Finance and Risk Management. Knowing now that the company might have been a victim of price-fixing, can they think of any harm to the company from brokers and carriers in recent years? This investigation should give corporate counsel a general idea as to the existence and amount of provable damages.

The first line of defense to claims of fraud (against carriers and brokers) and malpractice (against brokers) are the statutes of limitations. Thus it is important to look for signs of prior knowledge by company employees – past and present – of disloyalty or misconduct by brokers or carriers. Look for past employees in Risk Management who have gone to work for the company’s broker of record. Find out if they may have a motive to testify that they knew years ago that the broker received volume-based commissions from carriers with which the company was placed. Watch in particular for the character of any broker disclosure: Was it vague and uninformative?

If a corporate policyholder can prove liability and damages, the evidence indicates a judgment would be collectible.

Public agencies and regulators have brought the current litigation to stop deceptive practices and impose fines. While fines and penalties could be significant, it is not in the interest of politically ambitious public servants to drive any otherwise solvent broker or insurer out of business. Fines

and penalties from this first wave of litigation will hurt but they are unlikely to force any insurance company or insurance broker to the brink of bankruptcy.

The next wave of litigation will include private suits by policyholders seeking to recover past overcharges from brokers and insurers, based on fraud, malpractice and related theories. If the first and second waves of litigation generate enough likely recovery from brokers or carriers, a third may arrive in the form of broker and insurer suits against each other for contribution and indemnity. Brokers and insurers could suffer far more significant financial consequences from these suits, both in damages and defense costs.

But unless private suits against carriers and brokers generate damages claims beyond overcharging and inflated commissions, this litigation seems unlikely to drive any company into liquidation. Marsh recently lost roughly a third of its market value on a single day, corresponding to an analyst report that roughly a third of its earnings per share represent contingent commissions. Thus the stock market can be counted on to reflect investors' view of the true value of Marsh stock without future receipt of contingent commissions. So long as damages to corporate policyholders are limited to the difference between what Marsh was paid and the actual value of its services, Marsh may suffer, but it is unlikely to tank and leave clients uncompensated.

Note that the largest brokers purchase errors and omissions insurance coverage triggered at very high levels of loss. Typically, a large broker self-insures millions of dollars in liability exposure per malpractice claim asserted. Moreover, fraud liability is not insurable in most states, meaning that large brokers are self-insured for this liability as well. Excess malpractice insurance may help soften the blow of an avalanche of fraud and malpractice claims against Marsh and comparable brokers, but it is unlikely to shoulder the bulk of the burden except in the most catastrophic loss scenarios.

Is This Kind Of Claim Best Left To Class Litigation?

Achieving class certification in federal court (where litigation brought by some corporate policyholder seeking to represent similarly-situated corporate policyholders would likely be brought) requires a factual showing satisfying (1) all four prerequisites of Federal Rule of Civil Procedure 23(a) (the proposed class is numerous, there is a common nucleus of operative fact among the claims of proposed class members, the proposed class representative’s claims are typical of those of the proposed class, and the proposed class representative’s counsel can adequately represent the class); and (2) one of the four alternative requirements of Rule 23(b) (risk of prejudice if separate actions are filed, separate judgments would adversely affect class members, defendant has wronged a class in a manner susceptible to injunctive relief, and common questions predominate over separate ones).

Undoubtedly, a large number of corporate policyholders have been harmed by the alleged deceptive practices. Should a corporation step up claiming to represent these potential plaintiffs, its counsel likely will have insufficient experience and skill to adequately represent a class. But damages claims against brokers and insurers based on facts likely to differ from policyholder to policyholder render the device of class litigation poorly suited to this kind of matter.

More fundamentally, litigation brought by public agents like the New York Attorney General seeks to enjoin the deceptive practices alleged in the recent suit. Insurance regulators seem poised to follow, as witnessed by the investigation by California Insurance Commissioner John Garamendi.

There is no compelling reason to aggregate private party damages claims to stop deceptive practices by insurers and brokers because public litigation is already doing so.

Nor would class litigation by corporate policyholders over deceptive practices achieve the economy of scale that characterizes consumer class litigation. When a single class member’s claim totals \$200, or even \$20,000, having a class represented by a single law firm paid by a percentage of the recoveries makes economic sense. This rationale evaporates when class members have factually dissimilar claims over larger sums of money which they wish to exert control, and which can be litigated by their chosen counsel on an hourly basis for less than the 30% or 40% fee charged by class counsel.

If brokers and agents prove to have been overcompensated in placing consumer insurance, and such claims are now under investigation in New York and elsewhere, class litigation may well be appropriate. For claims of corporate policyholders, however, class certification seems unlikely and the desirability of class certification seems questionable.

What Will It Cost?

Many of the claims of corporate policyholders against the handful of large brokers for damages suffered from undisclosed and deceptive practices, including contingent commissions, will share common features. Aggregating such claims in firms handling a number of them **can** achieve an economy of scale, by reducing the time necessary to learn the general factual background of the topic, by more easily sharing documents and information obtained from the major brokers in discovery and by gaining strength in numbers that can translate into bargaining power forcing these cases into settlements rather than expensive trials.

A workable benchmark for estimating the expense of enforcing these claims is the 30% rule. For claims of damages of \$1 million or more, hourly counsel should never end up costing more than 30% of anticipated recoveries (i.e., roughly what contingency counsel would have received). Where counsel engaged on an hourly basis handles more than one of these cases, the aggregation of effort and experience should produce results for less than 30% of recoveries.

Do Not Delay

Statutes of limitations are ticking. Many events and alleged disclosures will not come to light until after corporate investigations are well under way. Companies should act quickly. Waiting for the situation to develop, without investigating and pursuing claims, may mean that relief ultimately is unavailable.

Corporate counsel and risk managers should also use this period to re-examine the role of insurance as part of the company's risk management strategy. With carriers on the defense, this could be an excellent opportunity to renegotiate policy terms, expanding coverage and potentially reducing premiums.

About David Wood

David Wood is a co-founder of Wood & Bender, one of the nation's leading law firms in the fast-growing area of insurance policy enforcement. With nearly two decades of experience in the insurance industry, Wood devotes his practice to evaluating and enforcing business insurance claims, evaluating and enforcing enforcement actions against brokers, and handling litigation aimed at accessing insurance. The firm is headquartered in Southern California, and represents corporate clients in coverage disputes and litigation throughout the nation.