WISCONSIN STATE LEGISLATURE COMMITTEE HEARING RECORDS

2005-06
(session year)

Assembly
(Assembly, Senate or Joint)

Committee on Insurance (AC-In)

(Form Updated: 11/20/2008)

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Testimony of
David J Dybdahl, CPCU, ARM
April 21,2005

Packet pt. 01

Re: AB 222

My name is David Dybdahl. I am an internationally recognized expert in environmental insurance. I am here today in opposition of the bill.

I will discuss the prospective effect of AB222 on the environmental insurance market and the residents of the State of Wisconsin.

I have worked in the environmental insurance industry for 25 years. I am a Chartered and Property Casualty Underwriter and I write the textbook chapter on environmental insurance for CPCU students. I am a resident of Middleton, Wisconsin and operate an environmental insurance brokerage firm with offices in New York, Chicago, Los Angles and Middleton. I am in the environmental insurance market place on a daily basis.

I have reviewed the proposed bill AB222 and in my opinion there will be negative unintended consequences that will severely restrict or eliminate the availability of prospective environmental insurance in the estate. Although the environmental insurance market in the state is relatively small and frail, the free market availability of environmental insurance plays an essential role in many parts of the state economy and in the environmental regulatory framework.

As used in AB222, the terms general liability insurance and environmental claims are sufficiently broad to ensnare the majority of prospective environmental insurance policies. A survey of the environmental insurance policies sold in the State of Wisconsin revealed that about half if them specifically contained the words "All Sums" in the insuring agreement and all of the policies had similar language. Therefore virtually all prospective environmental insurance policies would fall under the provisions of the proposed bill.

In my opinion if the State of Wisconsin passed a law that made new environmental insurance underwriters jointly and severally liable for preexisting pollution, without regard for policy terms and exclusions, the insurance market for environmental insurance in the state would quickly disappear. The unintended negative consequences of this law of this proposed law would be dramatic and rapid on businesses, taxpayers and the environmental regulators in the state.

Because AB222 overrides normal insurance industry protocols on policy terms and allocation of claims the impact of this bill on the environmental insurance market would be much more pronounced than merely a price increase for environmental insurance premiums. It is much more likely that the environmental insurance underwriters would abandon the state all together, refusing to issue any environmental insurance polices at all. Market abandonment in environmental insurance has happened in the past with Superfund clean up contractors in states that did not have favorable laws to protect the contractors from Superfund liability as an "operator" of the sites they were cleaning up. In the case of Superfund contractors, the USEPA needed to step in to create a tax payer subsidized contractors indemnity fund that indemnified (insured)contractors for any liabilities they might incur in cleaning up Superfund sites. The Federal government was forced into the hazardous waste contractor insurance business as an unintended negative consequence of the Superfund law. The same thing is a likely unintended consequence of AB222.

If the environmental insurance market place closed its doors to Wisconsin businesses, within one annual renewal cycle of the environmental insurance policies in force, in my opinion the following unintended things would occur.

There would be no underground storage tank insurance on thousands of gas stations in the state. This would require a state sponsored risk sharing pool bail out of the gas station operators in order for them to comply with federal and state laws which require them to provide proof of financial responsibility to operate a under ground storage tank. This fund exists within the state of Wisconsin today. The PECEFA fund is a taxpayer-subsidized source of insurance for underground storage tanks that are for the most part uninsurable. The impact of this bill would be to unwind 10 years worth of work to force UST owners out of a tax subsidized proof of financial responsibility system into the private insurance market. Without the taxpayer bail out to expand the PECEFA fund Wisconsin gas stations could be in mass non-compliance of a federal environmental law, which could lead to the de-certification of the WI DNR authority to administer this law by the USEPA.

With the passage of AB 222 no prospective environmental insurance would be available on landfills and factories. For regulated waste, treatment, storage and disposal facilities the unavailability of environmental insurance would throw them into regulatory noncompliance of proof of financial responsibility laws, potentially threatening the certification of the DNR as the enforcer of Federal environmental laws in this area as well. Without insurance availability many of these regulated sites could be forced to close or pay a $25,000 per day fine under federal law for operating without a permit.

Without access to environmental insurance waste treatment, storage and disposal facilities will also be unable to obtain closure and long- term care insurance for their proof of financial responsibility requirements. This would throw them into regulatory non-compliance with the Resource Conservation and Recovery Act. On a wide spread basis this would also threaten the DNR certification by the EPA for regulatory enforcement of these laws as well.

Environmental engineers and contractors would become uninsurable for their work performed in Wisconsin. Without environmental liability insurance, no financially responsible contractor would work to clean up the Fox River or any other contaminated site in the state without the creation of a state sponsored and funded risk-sharing pool for remedial action contractors. This approach was used by the USEPA in the first seven years of the Federal Superfund program. The EPA worked hard to eliminate their taxpayer funded contractors indemnity fund in 1987. I served on the task force in Washington DC that solved this problem for the USEPA by creating private purchased insurance for Superfund clean up contractors. By reverse engineering the process we used to get engineers and contractors out of the taxpayer funded indemnity program for the US EPA Superfund program an environmental contractors indemnity fund in the State of Wisconsin could be developed. Using $100,000,000 of taxpayer dollars, a fund could be created to provide up to $10,000,000 of coverage for each environmental contracting firm. My firm is the lead insurance consultant for the US Army for their procurements of environmental clean up contractors. From that experience I estimate that $10,000,000 limits of liability will not be sufficient to attract the best environmental remediation contractors to perform the work on the Fox River. They will want more protection from potential liability. Using the same financial ratios that the Wisconsin Insurance Commissioner uses to judge the solvency of insurance companies in the state, $20,000,000 limits could be provided if a $200,000,000 fund was established. Reinsurance capacity to reduce the cash funding requirements would be unavailable because of the AB 222 bill; so all amounts would need to be funded in cash or by an evergreen letter of credit issued by the state.

With the exit from the state of the environmental insurance market, fire and water restoration contractors and even carpet cleaners would be unable to obtain environmental insurance covering mold.

Plumbers, Roofers, Heating and Air Conditioning Contractors, General Contractors, and Home Builders would be unable to obtain environmental insurance covering them for mold, Bankers could become concerned about these firms being uninsured for toxic mold and deny these uninsured firms financing for future projects.

Many of the proposed revisions to sections within s. Ins 3.67, ch. Ins 9 and s. Ins 18 are due to a change in terminology. The term "managed care plan" has been replaced with "defined network plan" in Ch. 609, Stats., established by 2001 Wisconsin Act 16, therefore, necessitating change within the insurance administrative code. In addition many revisions have been made to Ch. Ins 9 to reflect the changes enacted by 2001 Wisconsin Act 16 including modifications reflecting the unique nature of preferred provider plans and changes in the market place since 2001 including regulatory changes that enhance consumer protection enacted by surrounding states.

The proposed rule defines preferred provider plans starting with the definition at s. 609.01, Wis. Stats., and clarifies and interprets the statutory requirements. Insurers offering preferred provider plans cannot require a referral to obtain coverage for care from either a participating or nonparticipating provider. If the preferred provider uses utilization management, including preauthorization or similar methods, for denying access to or coverage of the services of nonparticipating providers without just cause and with such frequency as to indicate a general business practice, such methods shall result in the plan being treated by the Commissioner as a defined network plan and subject to all requirements of a defined network plan. ~~The Commissioner~~ recognizes that the utilization management and preauthorization as appropriate tools for controlling costs of the insurer and may protect enrollees from incurring additional costs for care. ~~Therefore~~ the proposed rule does not prohibit or limit the proper use of utilization management or preauthorization. OCI will, however, track insurers' use of these tools through complaints and market conduct examination to determine if the insurer has developed a pattern, without just cause, for denying coverage. If such a pattern is uncovered then the insurer would be subject to regulation as a defined network plan.

The proposed rule reflects the amendments within Ch. 609, Stats., by delineating unique reporting and other regulatory requirements between insurers that offer preferred provider plans versus other types of defined network plans. Significant provisions that demonstrate the unique regulatory treatment between defined network and preferred provider plans include: defined network plans are required to have quality assurance plans containing standards relating to access to care and continuity and quality of care while preferred provider plans are required to conduct remedial action plans and to develop procedures for remedial action to address quality problems; defined network plans must notify affected enrollees upon the termination of the provider from the plan and preferred providers may contract with another entity or providers to notify the enrollees of the termination, although the preferred provider does remain ultimately responsible for ensuring notifications are

sent; defined network plans must report data similar to HEDIS for consumer information and preferred provider plans do not; both defined network plans and preferred provider plans are required to have sufficient number and type of providers within the network to adequately deliver all covered services, however, defined network plans must comply with all access standards while preferred provider plans need to have at least one participating primary care provider and one participating provider that has an expertise in obstetrics and gynecology that is accepting patients but the preferred provider plan need not offer a choice of participating providers.

In order for preferred provider plans to be regulated under the less rigorous regulatory requirements, the preferred provider plan must comply with the proposed regulatory requirements. Preferred provider plans must provide covered benefits without requiring the enrollee to obtain a referral or directing provider selection through the use of incentives including financial. The Commissioner recognizes that certain covered services may appropriately be best provided through contracted providers, for example the use of "Centers of Excellence" for transplants or cancer treatment. Further the mandated benefit for immunizations requires the insurer to offer as a covered benefit immunizations but the insurer need only cover the benefit when the immunization is given by a participating provider. Finally, some insurers offer services beyond the mandated limits as covered benefits with a greater disparity in coverage and may limit the expanded benefits to services received from participating providers. Therefore, the proposed rule creates a narrow exception to permit specific, limited services to be covered by participating providers with a greater disparity in coverage than when the services are provided by nonparticipating providers including the possibility of coverage only when the services are performed by a participating provider (i.e. immunizations).

The proposed rule requires the insurers offering preferred provider plans that desire to be subject only to the lesser regulatory requirements of preferred provider plans to comply with the following: coverage of the same benefits, unless specifically excepted, with the insurer paying not less than 60% coinsurance and the enrollee paying not more than 40% coinsurance for services performed by a nonparticipating provider. As an alternate, the insurer may pay not less than 50% coinsurance and the enrollee pay not more than 50% coinsurance for the services performed by a nonparticipating provider when the insurer provides the enrollee with a disclosure of limited coverage. Failure of the insurer to offer 60% coinsurance coverage without a disclosure notice or 50% coinsurance coverage with the disclosure notice will result in the insurer being treated as a defined network plan and not eligible for the lesser regulatory standards.

Many of the proposed revisions to sections within s. Ins 3.67, ch. Ins 9 and s. Ins 18 are due to a change in terminology.

The term "managed care plan" has been replaced with "defined network plan" in Ch. 609, Stats., established by 2001 Wisconsin Act 16, therefore, necessitating change within the insurance administrative code. In addition many revisions have been made to Ch. Ins 9 to reflect the changes enacted by 2001 Wisconsin Act 16 including modifications reflecting the unique nature of preferred provider plans and changes in the market place since 2001 including regulatory changes that enhance consumer protection enacted by surrounding states.

The proposed rule defines preferred provider plans starting with the definition at s. 609.01, Wis. Stats., and clarifies and interprets the statutory requirements. Insurers offering preferred provider plans cannot require a referral to obtain coverage for care from either a participating or nonparticipating provider. If the preferred provider uses utilization management, including preauthorization or similar methods, for denying access to or coverage of the services of nonparticipating providers without just cause and with such frequency as to indicate a general business practice, such methods shall result in the plan being treated by the Commissioner as a defined network plan and subject to all requirements of a defined network plan. The proposed rule does not prohibit or limit the proper use of utilization management or preauthorization. OCI will, however, track insurers' use of these tools through complaints and market conduct examination to determine if the insurer has developed a pattern, without just cause, for denying coverage. If such a pattern is uncovered then the insurer would be subject to regulation as a defined network plan.

The proposed rule reflects the amendments within Ch. 609, Stats., by delineating unique reporting and other regulatory requirements between insurers that offer preferred provider plans versus other types of defined network plans. Significant provisions that demonstrate the unique regulatory treatment between defined network and preferred provider plans include:

1. Defined network plans are required to have quality assurance plans containing standards relating to access to care and continuity and quality of care while preferred provider plans are required to conduct remedial action plans and to develop procedures for remedial action to address quality problems;
2. Defined network plans must notify affected enrollees upon the termination of the provider from the plan and preferred providers may contract with another entity or providers to notify the enrollees of the

termination, although the preferred provider does remain ultimately responsible for ensuring notifications are sent;

3. Defined network plans must report data similar to HEDIS for consumer information and preferred provider plans do not;
4. Both defined network plans and preferred provider plans are required to have sufficient number and type of providers within the network to adequately deliver all covered services, however, defined network plans must comply with all access standards while preferred provider plans need to have at least one participating primary care provider and one participating provider that has an expertise in obstetrics and gynecology that is accepting patients but the preferred provider plan need not offer a choice of participating providers.

Preferred provider plans must provide covered benefits without requiring the enrollee to obtain a referral or directing provider selection through the use of incentives including financial. Further the mandated benefit for immunizations requires the insurer to offer as a covered benefit immunizations but the insurer need only cover the benefit when the immunization is given by a participating provider. Finally, some insurers offer services beyond the mandated limits as covered benefits with a greater disparity in coverage and may limit the expanded benefits to services received from participating providers. Therefore, the proposed rule creates a narrow exception to permit specific, limited services to be covered by participating providers with a greater disparity in coverage than when the services are provided by nonparticipating providers including the possibility of coverage only when the services are performed by a participating provider (i.e. immunizations).

The proposed rule requires the insurers offering preferred provider plans that desire to be subject only to the lesser regulatory requirements of preferred provider plans to comply with the following:

1. coverage of the same benefits, unless specifically excepted, with the insurer paying not less than 60% coinsurance and the enrollee paying not more than 40% coinsurance for services performed by a nonparticipating provider.
2. As an alternate, the insurer may pay not less than 50% coinsurance and the enrollee pay not more than 50% coinsurance for the services performed by a nonparticipating provider when the insurer provides the enrollee with a disclosure of limited coverage.

Failure of the insurer to offer 60% coinsurance coverage without a disclosure notice or 50% coinsurance coverage with the disclosure notice will result in the insurer being treated as a defined network plan and not eligible for the lesser regulatory standards.

Additionally, the insurer offering a preferred provider plan that applies a coinsurance percentage when services are performed by nonparticipating providers at a different percentage than the coinsurance percentage that is applied when the services are performed by participating providers shall have the difference be no greater than 30%. If the percent difference is greater than 30% the insurer is required to provide the enrollee with a disclosure notice. If an insurer offering a preferred provider plan applies a deductible that is different for participating providers than for nonparticipating providers, the deductible for the same services when performed by a nonparticipating provider must be no more than 2 times greater or no more than $2000 more than the deductible that is applied when performed by a participating provider. If the insurer applies a deductible for services performed by a nonparticipating provider that is greater than 2 times or is more than $2000 different than the deductible that is applied when performed by participating providers, the insurer is required to provide the enrollee with a disclosure notice. The disclosure notice that is required to be given is contained within the rule and is similar to the notice provided in the state of Illinois.

A preferred provider plan must apply material exclusions, maximum limits or conditions to services regardless if the services are performed by either participating or nonparticipating providers and offers or uses no other incentives than the financial incentives of coinsurance and deductibles described above to encourage its enrollees to use participating providers. The exception to this requirement is for the steering of enrollees to Centers of Excellence for transplants and specified disease treatment services and immunizations pursuant to s. 632.895 (14), Stats., when insurer comply with disclosure requirements at the time the product is marketed, purchased and within the policy form in a prominent location.

Preferred provider plans shall include within the participating provider contracts a provision requiring the participating provider that schedules an elective procedure or other scheduled non-emergent care to fully disclose to the enrollee at the time of scheduling the name of each provider that will or may participate in the delivery of care and whether each provider is a participating or nonparticipating provider. The insurer shall include a disclosure, in a form consistent with the language contained in Appendix D, which informs enrollees of potential financial implications of using

nonparticipating providers and to encourage the enrollee to contact the insurer for assistance in locating an appropriate participating provider.

Preferred provider plans are not required to have a quality assurance program and are instead subject to remedial action plans as mentioned earlier. The remedial action plan requires the insurer offering the preferred provider plan to develop procedures for taking effective and timely remedial actions to address issues arising from access to and continuity of care. The proposed rule requires the remedial action plan to contain at least all of the following:

1. designation of a senior-level staff person responsible for oversight of the plan,
2. a written plan for the oversight of any function that is delegated to other contracted entities,
3. a procedure for periodic review of the insurer's performance or the performance of a contracted entity,
4. periodic and regular review of grievances, complaints and OCI complaints,
5. a written plan for maintaining the confidentiality of protected information,
6. documentation of timely correction of access to and continuity of care issues identified in the plan to include the date the insurer was aware of the issue, the type of issue,
7. the person responsible for the development and management of the plan,
8. the remedial action plan utilized in each situation,
9. the outcome of the action plan, and
10. the established time frame for reevaluation of the issue to ensure resolution and compliance with the remedial action plan

To further clarify the prudent person mandate for coverage of emergency medical care, the proposed rule contains requirements for both insurers offering defined network plans and preferred provider plans that provide emergency medical care treatment as a covered benefit. These insurers shall provide that treatment as though the provider was a participating provider when the enrollee cannot reasonably reach a preferred provider or is admitted for inpatient care even if the care is provided by a nonparticipating provider. The plans must reimburse the provider at the nonparticipating provider rate and apply any deductibles, coinsurance or other costsharing provisions, if applicable, at the participating provider rate.

Defined network plans and preferred provider plans are both required to annually certify compliance with applicable access standards. Defined network plans and preferred providers plans must both provide covered benefits by plan providers with reasonable promptness with respect to geographic location, hours of operation waiting times for appointments in provider offices and after hour's care reflecting

the usual practice in the local area with geographic availability reflecting the usual medical travel times within the community. When the insurer is required to reply to the Office, the insurer must demonstrate that the hours of operation waiting time for appointments and after hours care of the participating providers is reasonable based upon the geographic location and usual medical travel times within that community.

The Commissioner finds that the circumstances of insurers offering group or blanket health insurance policy require that the insurer offering the policy otherwise exempt from Chs. 600 to 646, Stats., under s. 600.01 (1) (b) 3., Stats., in order to provide adequate protection to Wisconsin enrollees and the public those insurers shall comply with s. Ins 9.34 (2) and s. 609.22 (2), Stats., when it covers 100 or more residents of this state under a policy that is otherwise exempt under s. 600.01 (1) (b) 3., Stats.

Finally, the proposed rule includes several new definitions of terms that were requested by the industry to assist in clarifying relationships between insurers and providers and to clarify what entities are subject to specific requirements.

The proposed rule would be enforced under ss. 601.41, 601.64, 601.65, Stats., or ch. 645, Stats., or any other enforcement provision of chs. 600 to 646, Stats. This proposed rule includes a significantly delayed applicability date to give insurers amply time to comply with the various provisions including sufficient time to submit to the OCI forms for approval prior to use.

Additionally, the insurer offering a preferred provider plan that applies a coinsurance percentage when services are performed by nonparticipating providers at a different percentage than the coinsurance percentage that is applied when the services are performed by participating providers shall have the difference be no greater than 30%. If the percent difference is greater than 30% the insurer is required to provide the enrollee with a disclosure notice. If an insurer offering a preferred provider plan applies a deductible that is different for participating providers than for nonparticipating providers, the deductible for the same services when performed by a nonparticipating provider must be no more than 2 times greater or no more than $2000 more than the deductible that is applied when performed by a participating provider. If the insurer applies a deductible for services performed by a nonparticipating provider that is greater than 2 times or is more than $2000 different than the deductible that is applied when performed by participating providers, the insurer is required to provide the enrollee with a disclosure notice. The disclosure notice that is required to be given is contained within the rule and is similar to the notice provided in the state of Illinois.

A preferred provider plan must apply material exclusions, maximum limits or conditions to services regardless if the services are performed by either participating or nonparticipating providers and offers or uses no other incentives than the financial incentives of coinsurance and deductibles described above to encourage its enrollees to use participating providers. The exception to this requirement is for the steering of enrollees to Centers of Excellence for transplants and specified disease treatment services and immunizations pursuant to s. 632.895 (14), Stats., when insurer comply with disclosure requirements at the time the product is marketed, purchased and within the policy form in a prominent location.

Preferred provider plans shall include within the participating provider contracts a provision requiring the participating provider that schedules an elective procedure or other scheduled non-emergent care to fully disclose to the enrollee at the time of scheduling the name of each provider that will or may participate in the delivery of care and whether each provider is a participating or nonparticipating provider. The insurer shall include a disclosure, in a form consistent with the language contained in Appendix D, which informs enrollees of potential financial implications of using nonparticipating providers and to encourage the enrollee to contact the insurer for assistance in locating an appropriate participating provider. The intent of this requirement is to address the frequent complaint from Wisconsin consumers alleging that although the enrollee sought care from a participating surgeon at a participating hospital, the ancillary providers including anesthesiology or other specialist was

nonparticipating and as a result the enrollee incurred large, unexpected medical bills. It is expected that with additional information in advance of the needed service, enrollees will be able to work with insurers and providers to make the best informed medical and financial decisions.

Preferred provider plans are not required to have a quality assurance program and are instead subject to remedial action plans as mentioned earlier. The remedial action plan requires the insurer offering the preferred provider plan to develop procedures for taking effective and timely remedial actions to address issues arising from access to and continuity of care. The proposed rule requires the remedial action plan to contain at least all of the following: designation of a senior-level staff person responsible for oversight of the plan, a written plan for the oversight of any function that is delegated to other contracted entities, a procedure for periodic review of the insurer's performance or the performance of a contracted entity, periodic and regular review of grievances, complaints and OCI complaints, a written plan for maintaining the confidentiality of protected information, documentation of timely correction of access to and continuity of care issues identified in the plan to include the date the insurer was aware of the issue, the type of issue, the person responsible for the development and management of the plan, the remedial action plan utilized in each situation, the outcome of the action plan, and the established time frame for reevaluation of the issue to ensure resolution and compliance with the remedial action plan

Emergency medical care treatment coverage was identified by the Commissioner as another specific type of service for which the Office frequently receives complaints from Wisconsin consumers. This form of regulation is found in the surrounding states and is most similar to the regulation in Iowa. To further clarify the prudent person mandate for coverage of emergency medical care, the proposed rule contains requirements for both insurers offering defined network plans and preferred provider plans that provide emergency medical care treatment as a covered benefit. These insurers shall provide that treatment as though the provider was a participating provider when the enrollee cannot reasonably reach a preferred provider or is admitted for inpatient care even if the care is provided by a nonparticipating provider. The plans must reimburse the provider at the nonparticipating provider rate and apply any deductibles, coinsurance or other costsharing provisions, if applicable, at the participating provider rate.

Defined network plans and preferred provider plans are both required to annually certify compliance with applicable access standards. Defined network plans and preferred providers plans must both provide covered benefits by plan providers with

reasonable promptness with respect to geographic location, hours of operation waiting times for appointments in provider offices and after hour's care reflecting the usual practice in the local area with geographic availability reflecting the usual medical travel times within the community. This requirement is not new and does not require insurers to mandate to participating providers the provider's hours of operation. Rather when the insurer is required to reply to the Office, the insurer must demonstrate that the hours of operation waiting time for appointments and after hours care of the participating providers is reasonable based upon the geographic location and usual medical travel times within that community.

The Commissioner finds that the circumstances of insurers offering group or blanket health insurance policy require that the insurer offering the policy otherwise exempt from Chs. 600 to 646, Stats., under s. 600.01 (1) (b) 3., Stats., in order to provide adequate protection to Wisconsin enrollees and the public those insurers shall comply with s. Ins 9.34 (2) and s. 609.22 (2), Stats., when it covers 100 or more residents of this state under a policy that is otherwise exempt under s. 600.01 (1) (b) 3., Stats.
Finally, the proposed rule includes several new definitions of terms that were requested by the industry to assist in clarifying relationships between insurers and providers and to clarify what entities are subject to specific requirements.

The proposed rule would be enforced under ss. 601.41, 601.64, 601.65, Stats., or ch. 645, Stats., or any other enforcement provision of chs. 600 to 646, Stats. This proposed rule includes a significantly delayed applicability date to give insurers amply time to comply with the various provisions including sufficient time to submit to the OCI forms for approval prior to use.

Wiley Rein & Fielding LLP

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PRIVILEGED & CONFIDENTIAL
PRELIMINARY DRAFT

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2. Each insurer that provided coverage for a policy period and that has a duty to pay any costs of a settlement or judgment under the policy is jointly and severally liable ....

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(a) The insured may elect to file suit against fewer than all insurers providing coverage for the claim, notwithstanding ss. 803.03 and 806.04 (11). ....

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(1) That the costs of preliminary assessments, remedial investigations, risk assessments . . . are defense costs ....

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(1) Within 30 business days after receipt by the insurer of notice of a lost policy, the insurer shall commence and investigation ....

(2) The insurer and the insured shall cooperate with each other in determining the terms of a lost policy ....

(3) An insurer that discovers information tending to show the existence of an insurance policy that applies to the claim ....

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(b) This section applies to all environmental claims specified in par. (a). regardless of the state ....

11. Construction ....

Wiley Rein & Fielding LLP

PRELIMINARY DRAFT: NOT FOR CLIENT DISTRIBUTION

ANALYSIS OF PROPOSED WISCONSIN LEGISLATION

LAURA A. FOGGAN

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 20.370(2)(dj) of the statutes is created to read:

20.370 (2)(dj) Solid waste management – navigable waters. All moneys received under s. 292.71 for activities under ch. 292 related to remedial action in and adjacent to navigable waters.

SECTION 2. 292.71 of the statutes is created to read:

292.71 Fees related to removal of contaminated materials from a navigable water. The department may assess and collect fees from a person responsible, under this chapter or the federal Comprehensive Environmental Response, Compensation, and Liability Act, 42 USC 9601 to 9675, for remedial action involving the removal of at least 10,000 tons of contaminated material from the bed or banks of a navigable water. The

department may not assess a fee under this section that exceeds 25 cents per ton of contaminated material removed from the bed or banks of a navigable water. Fees collected under this section shall be credited to the appropriation account under s. 20.270 (2) (dj).

Comment:

The proposed bill authorizes the collection of certain additional fees from a responsible party for the removal of contaminated materials from navigable water. It is unclear whether such fees would be considered damages under a liability insurance policy.

SECTION 3. 632.28 of the statutes is created to read:

632.28 Environmental claims under general liability insurance policies. (1) DEFINITIONS. In this section:

(a) "All-sums policy" means a general liability insurance policy under which the insurer agrees, using such words as "all sums," "those sums," "the total sum," or similar words, to indemnify or pay on behalf of the insured all sums that the insured becomes legally obligated to pay as a result of a covered risk.

Comment:

The defined term "all-sums policy" serves in this statutory scheme to define those insurance policies under which insurers will, by virtue of the statute, face joint and several liability for 100% of a loss that takes place in part during the policy period. See SECTION 3(3). The definition is troubling in a number of respects. First, and most generally, it advances the misnomer that there exists a type of general liability coverage that is an "all-sums policy." Second, it reads words such as "all sums," "those sums," or "the total sum" out of their context in the insurance contract, ignoring the boundaries provided by other policy language. Third, it equates different policy language such as the words "all sums" with "those sums," "the total sum," or what is vaguely referenced as "similar words." The defined term "all-sums policy" is

confusing and at odds with the meaning the majority of courts have given to the policy language referenced in this provision.

An Oregon statute passed in 2003 relating to liability coverage for environmental claims (hereinafter "the 2003 Oregon Statute") applies to "general liability insurance policies," which the Statute defines as "any contract of insurance that provides coverage for the obligations at law or in equity of an insured for bodily injury, property damage or personal injury to others." ORS SECTION 1.465.475(2). The 2003 Oregon Statute definition of "general liability insurance policy" specifically includes pollution liability insurance policies, general liability policies, and excess and umbrella liability policies, and specifically excludes such policies as "claims-made policies or portions of other policies relating to claims-made policies or specialty line liability coverage such as directors and officers insurance, errors and omissions insurance or other similar policies." ORS SECTION 1.465.475(2).

Unlike the Wisconsin bill, the 2003 Oregon Statute also includes a definition of "policy" as "the written contract or agreement, and all clauses, riders, endorsements and papers that are a part of the contract or agreement, for or effecting insurance." ORS SECTION 1.465.475(5). The 2003 Oregon Statute also includes a definition of "insured" as "any person included as a named insured on a general liability insurance policy who has or had a property interest in a site in Oregon that involves an environmental claim." ORS SECTION 1.465.475(3).

(b) "Environmental claim" means a claim for defense or indemnity that is submitted under a general liability insurance policy by an insured and that is based on the insured's liability or potential liability for bodily injury or property damage arising from the presence of pollutants on the bed or banks of a navigable water in this state as a result of a release of pollutants in this state.

Comment:

The definition of "environmental claim" encompasses the term "pollutant," which is defined in Section 3(1)(e). It is limited to coverage claims under "general liability insurance" policies, and therefore would not appear to compass EIL or other specialty coverages. It requires a "release of pollutants in this state." In addition, the definition of "environmental claim" contains the requirement that pollutants be present on the bed or banks of navigable water in the state of Wisconsin.

Under the 2003 Oregon Statute, "environmental claim" means "a claim for defense or indemnity submitted under a general liability insurance policy by an insured facing, or allegedly facing, potential liability for bodily injury or property damage arising from a release of pollutants onto or into land, air or water." ORS SECTION 1.465.475(1). Contrary, under the Wisconsin bill, an "environmental claim" is limited to liability arising from pollutants on "the bed or banks of a navigable water in the state as a result of a release of pollutants in this state."

(c) "Extended underlying assertion" means an assertion by a governmental entity or other 3rd person that a person who is or was insured under one or more all-sums policies is liable for bodily injury or property damage arising from pollution in this state as a result of a release of pollutants in this state and the injury or damage occurred or is alleged to have occurred partially but not entirely during the policy period of any one all-sums policy.

Comment:

The "extended underlying assertion" definition is apparently intended to be a shorthand reference to pollution claims involving injury or damage taking place for a period of time including but not limited to during the insurance policy period. This definition is confusing in that it is unclear whether it applies to all such claims arising from damage in Wisconsin arising from the release of pollutants in Wisconsin or should be more limited, as with the definition of

"environmental claim to pollution on the bed or banks of navigable water." There is no limitation to the claimant, which may be a governmental entity or other third person. Furthermore, an "assertion" is not defined and could broadly encompass informal, unwritten allegations.

(d) "Governmental entity" means any federal, state, or local government, or any instrumentality of any of them, or any trustee for natural resources designated under 42 USC 9607 (f) (2) or 40 CFR part 300, subpart G.

Comment:

The 2003 Oregon Statute does not define "governmental entity," but rather refers throughout the Statute to the Oregon Department of Environmental Quality and the United States Environmental Protection Agency.

(dm) "Navigable waters" has the meaning given in s. 30.01 (4m).

(e) "Pollutant" means any solid, liquid, or gaseous irritant or contaminant, including smoke, vapor, soot, fumes, acids, alkalies [sic], chemicals, asbestos, petroleum products, lead, products containing lead, and waste.

Comment:

This definition of "pollutant" does not parallel the words of the definition widely used in liability policies. It explicitly references "chemicals, asbestos, petroleum products, lead, products containing lead, and waste."

(f) "Pollution" means the presence of pollutants in or on land, air, or water.

Comment:

The definition of "pollution" reveals that the scope of the terms goes beyond pollution in or on the bed of navigable waters.

The 2003 Oregon Statute does not define the terms "pollutant" or "pollution."

(2) GENERAL INTERPRETATION PROVISIONS. Except as otherwise provided in the policy, all of the following provisions apply to the interpretation of general liability insurance policies under which environmental claims are made:

Comment:

Casting the statutory provisions as "general interpretation principles" appears to be an effort to suggest that they do not retroactively alter insurance contracts, but merely "interpret" them. However, the provisions that follow do substantively alter the meaning and intent of insurance contract terms and therefore present serious state and federal constitutional concerns. Furthermore, the only qualification noted in the bill is that these provisions apply "except as otherwise provided in the policy." This is a narrow statement, which could be understood to allow an "interpretation provision" to override the clear intent of the parties, so long as the policy's exact words did not conflict with the proposed statutory provision.

The 2003 Oregon Statute states that its general interpretation provisions do not apply "if the application of the rule results in an interpretation contrary to the intent of the parties to the general liability insurance policy." ORS SECTION 2.465.480[3](7).

(a) Wisconsin law shall be applied in all cases involving environmental claims, regardless of the state in which the general liability insurance policy under which the claim is or was made was issued or delivered. Nothing in this section shall be interpreted to modify common law rules governing choice of law determinations for claims for defense or indemnity that are submitted under general liability insurance policies and that involve bodily injury or property damage arising from pollution outside this state.

Comment:

The proposed rule is an unnecessary intrusion on the ability of Wisconsin courts to determine the appropriate state law to apply to a coverage dispute. Wisconsin courts apply a "grouping of contacts" approach to choice of law questions, applying the law of the state with the most "significant contacts" with the subject matter, including the place of contracting, the

place of performance, the location of the subject matter, and the place of the parties' business. Belland v. Allstate Ins. Co., 140 Wis.2d 391, 397-98, 410 N.W.2d 611, 613-14 (Ct. App. 1987). The proposed bill improperly assumes that the location of the subject matter always has the most significant contact to a coverage dispute, which may or may not be the case. Id. ("a qualitative analysis of the contracts should be made in light of the policies of the competing jurisdictions"). Wisconsin courts must be allowed to maintain the authority to decide the appropriate law to apply.

By requiring the application of Wisconsin law to all cases involving an environmental claim, unless they arise from pollution outside the state, the statute creates serious concerns about overriding the interests of other states and the authority of other states' courts. What result is intended, for instance, where a Michigan court is determining coverage for a corporation that obtained coverage in Minnesota from a Minnesota insurer for all of its operations, which included a pollution spill that impacted both Minnesota and Wisconsin?

The 2003 Oregon Statute similarly provides for the application of Oregon law "in all cases where the contaminated property to which the action relates is located" in Oregon. ORS SECTION 2.465.480(2)(a). That statute also provides for the application of common law choice of law rules to sites located outside of Oregon.

(b) Any action taken by a governmental entity against, or any agreement by a governmental entity with, an insured in which the governmental entity, in writing, notifies the insured that it considers the insured to be potentially liable for pollution in this state, or directs, requests, or agrees that the insured take action with respect to pollution in this state, is equivalent to a suit or lawsuit as those terms are used in the general liability insurance policy.

Wiley Rein & Fielding LLP

Comment:

The Wisconsin Supreme Court addressed the meaning of "suit" in Johnson Controls, Inc. v. Employers Insurance of Wausau, et al., 264 Wis. 2d 60, 665 N.W.2d 257 (2003). The proposed language provides a meaning of "suit" that is different from Wisconsin court authority. Under the proposed bill, a government agency's written notice to a policyholder of a potential for liability for pollution, absent government compulsion and even absent a formal PRP letter, would initiate an insurer's defense obligations, despite the terms of the liability insurance policy and Wisconsin law regarding the meaning of "suit." Similarly, certain agreements between a government entity and an insured would be deemed "equivalent to a suit or lawsuit as those terms are used" in a policy, although there is no support in the policy or Wisconsin law for such a result.

Note that the provision regarding the meaning of "suit" addresses governmental claims of the policyholder's potential liability for pollution in Wisconsin.

The 2003 Oregon Statute contains a provision that states "any action or agreement by the Department of Environmental Quality or the United States Environmental Protection Agency against or with an insured in which the Department of Environmental Quality or the United States Environmental Protection Agency in writing directs, requests or agrees that an insured take action with respect to contamination within the State of Oregon is equivalent to a suit or lawsuit as those terms are used in any general liability insurance policy." ORS SECTION 2.465.480(2)(b). That statute further specifically defines "suit" or "lawsuit" as including but not limited to "formal judicial proceedings, administrative proceedings and actions taken under Oregon or federal law, including actions taken under administrative oversight of the Department

of Environmental Quality or the United States Environmental Protection Agency pursuant to written voluntary agreements, consent decrees and consent orders." ORS SECTION 2.465.480(1)(a).

(c) The insurer may not deny coverage for any reasonable and necessary fees, costs, and expenses, including costs and expenses of assessments, studies, and investigations, that are incurred by the insured under a voluntary written agreement, consent decree, or consent order between the insured and a governmental entity and as a result of a written direction, request, or agreement by the governmental entity to take action with respect to pollution in this state, on the ground that those expenses constitute voluntary payments by the insured.

Comment:

This provision purports to require that an insurer provide coverage for all costs incurred by the policyholder even absent legal compulsion and without the insurer's consent. This would violate clear terms of many liability policies, which exclude coverage for voluntary payments by a policyholder and provide coverage only for "damages." Moreover, despite the introductory statement in Section (2) that the general interpretation provisions apply "except as otherwise provided in the policy," this paragraph seemingly purports to override "voluntary payments" provisions.

The 2003 Oregon statute contains a provision also requiring coverage for such costs voluntarily incurred by a policyholder, providing that "[i]nsurance coverage for any reasonable and necessary fees, costs and expenses, including remedial investigations, feasibility study costs and expenses, incurred by the insured pursuant to a written voluntary agreement, consent decree or consent order between the insured and either the Department of Environmental Quality or the United States Environmental Protection Agency, when incurred as a result of a written direction, request or agreement by the Department of Environmental Quality or the United States

Environmental Protection Agency to take action with respect to environmental contamination within the State of Oregon, shall not be denied the insured on the ground that such expenses constitute voluntary payments by the insured." ORS SECTION 2.465.480(2)(c).

(3) RULES FOR INTERPRETING ALL-SUMS POLICIES. In the absence of an express provision requiring proration of losses for an environmental claim that is based on an extended underlying assertion, all of the following rules apply to the interpretation of all-sums policies under which environmental claims that are based on extended underlying assertions are made:

Comment:

Again, the bill purports to apply rules for "interpretation" of policies, rather than to alter insurance contract terms. However, the provisions seek to fundamentally alter the risk assured by insurers and impose joint and several liability for damages when any portion of the harm takes place during the policy period. Further, the qualification making the provision inapplicable only in the event of "an express provision requiring proration of losses for an environmental claim that is based on an extended underlying assertion" contains such narrow language that it may be interpreted not to encompass language limiting coverage to damage taking place "during the policy period" or even other insurance clauses. Therefore, this provision may have the affect of retroactively altering the terms of insurance contracts presenting serious state and federal constitutional concerns.

(a) An insurer may not reduce coverage otherwise available to an insured under an all-sums policy because the claim involves bodily injury or property damage that occurred, in part, outside the policy period of that all-sums policy, regardless of whether other valid or collectible insurance is available to the insured for the injury or damage that occurred outside that policy period.

Wiley Rein & Fielding LLP

Comment:

Wisconsin appellate courts have not yet addressed the proper method of allocating continuous and indivisible property damage liability among multiple triggered policies issued by different insurers. See, e.g., Society Ins. v. Town of Franklin, 233 Wis. 2d 207, 218 n. 1 (Ct. App. 2000) ("Because one insurer issued all [of] the policies here, we need not address how liability would be allocated were there multiple insurers."). This provision seeks to impose liability up to the full policy limits on insurers for all harm when any portion of the damage takes place during the period insured regardless of whether the majority of the damage took place outside of the policy period. This provision appears to hold that an insurer cannot allocate damages to uninsured policy periods (including periods where the insured chose to go without coverage or missing policy periods) or prorate the amount of coverage under the policy based on time-on-the risk or other recognized allocation law.

The 2003 Oregon Statute explicitly provides for allocation to a policyholder for periods in which the policyholder "failed to purchase and maintain" coverage for environmental liabilities, which the insurer bears the burden of proving. ORS SECTION 2.465.480 (4)(d), ORS SECTION 2.465.480(b). This is further discussed in the Contribution provisions at (6) CONTRIBUTION AMONG INSURERS below.

(b) If an environmental claim is submitted under one or more all-sums policies and involves bodily injury or property damage that occurred, or that may have occurred, during 2 or more policy periods, all of the following apply:

1. Each insurer that provided coverage for a policy period and that has a duty to defend under the policy is jointly and severally liable to the insured for the full amount of the insured's costs of defending against the extended underlying assertion, subject to any applicable limits of liability.

Comment:

As in (a) above, this provision appears to override policy language and case law providing for each insurer to pay a share of costs in accordance with the risks it assumed. It is not clear whether the restriction to the "applicable limits of liability" refers to a policy's explicit limits of liability for defense costs or a policy's limits of liability generally.

The 2003 Oregon Statute provides that an insurer that "has a duty to pay all sums arising out of a risk covered by the policy, must pay all defense or indemnity costs, or both, proximately arising out of the risk pursuant to the applicable terms of its policy, including its limit of liability, independent and unaffected by other insurance that may provide coverage for the same claim." ORS SECTION 2.465.480(3)(a).

2. Each insurer that provided coverage for a policy period and that has a duty to pay any costs of a settlement or judgment under the policy is jointly and severally liable to the insured for the full amount of the settlement or judgment for the extended underlying assertion, subject to any applicable limits of liability.

Comment:

This provision addresses indemnity as opposed to defense costs, but otherwise parallels Section 3(3)(b)1.

3. The insured may designate a policy period, and the policy or policies providing coverage for that period, including primary, umbrella, and excess coverage, shall provide full coverage, subject to any applicable limits of liability. If the environmental claim is not fully satisfied from policies covering that policy period, the insured may designate the order of other policy periods, and the policy or policies providing coverage for each of those periods, including primary, umbrella, and excess coverage, shall provide full coverage, subject to any applicable limits of liability, in that order until the environmental claim is fully paid.

Comment:

This provision allows an insured to "pick and choose" the policy period that it would like to cover its defense and indemnity costs for environmental injury, regardless of whether a majority of the alleged damage actually occurred outside that policy period. The provision allows the insured to pick the order of policies that it would like to exhaust. Once the policy period is chosen, the provision apparently allows the insured to stack its policies and avoid horizontal exhaustion. Although it is not clear, the provision appears to require the vertical exhaustion of the policy period that the insured picks to apply before the insured can pick another period.

This provision goes much further in imposing a pro-policyholder, coverage-maximizing result than even the Oregon law. The 2003 Oregon Statute provides a method in which the policyholder must choose the policies that respond, based on "(A) The total period of time that an insurer issued a general liability insurance policy to the insured applicable to the environmental claim; (B) The policy limits, including any exclusions to coverage, of each of the general liability insurance policies that provide coverage or payment for the environmental claim; or (C) The policy that provides the most appropriate type of coverage for the type of environmental claim for which the insured is liable or potentially liable." ORS SECTION 2.465.480(3)(b)(A)-(C).

The 2003 Oregon Statute also requires the policyholder to provide notice of the claim to all insurers that issued "all-sums" policies for the applicable periods, stating that, "[i]f an insured who makes an environmental claim under general liability insurance policies that provide that an insurer has a duty to pay all sums arising out of a risk covered by the policy has more than one such general liability insurance policy insurer, the insured shall provide notice of the claim to all

such insurers for whom the insured has current addresses." ORS SECTION 2.465.480(3)(b). Under the 2003 Oregon Statute, the policyholder, if requested by an insurer, must also "provide information regarding other general liability insurance policies held by the insured that would potentially provide coverage for the same environmental claim." ORS SECTION 2.465.480(3)(c).

4. If the insured makes a designation under subd. 3., the coverage available to the insured under a policy providing coverage for a designated policy period, including primary, umbrella, and excess coverage, may not be reduced by the actual or potential availability of coverage for other policy periods.

Comment:

This provision requires payment under any policy that the insured "picks and chooses" without regard to whether the damage mostly occurred outside the policy period and that other policies cover such periods. This provision therefore conflicts with policy provisions limiting coverage to damage "during the policy period" or addressing other insurance. It also conflicts with the majority view of courts nationwide, which provides for allocation of liability where harm occurs in multiple policy periods, requiring an insurer to pay only its fair share.

(4) SUIT ON ENVIRONMENTAL CLAIM. In any lawsuit involving an environmental claim, all of the following apply:

(a) The insured may elect to file suit against fewer than all insurers providing coverage for the claim, notwithstanding ss. 803.03 and 806.04 (11).

Comment:

This provision sets up a situation that will require additional judicial and private resources for subsequent litigation to properly allocate liability among all insurers and the policyholder.

(b) All of the following are rebuttable presumptions:

1. That the costs of preliminary assessments, remedial investigations, risk assessments, feasibility studies, site investigations, or other necessary investigation are defense costs payable by the insurer, subject to the provisions of the general liability insurance policy under which there is coverage for the costs.

Comment:

Unless the policy specifies otherwise, an insurer's defense obligations are expanded to include the insured's preliminary and investigative studies, even if such costs were not incurred to actually defend the suit. This may expand an insurer's potential obligations because the policy may not provide for a limit of liability for such "defense costs."

2. That the costs of removal actions, remedial action, or natural resource damages are indemnity costs and that payment of those costs by the insurer reduces the insurer's applicable limit of liability on the insurer's indemnity obligations, subject to the provisions of the general liability policy under which there is coverage for the costs.

Comment:

The proposed bill expands the scope of an insurer's indemnity obligations, broadening damages to include "removal actions, remedial action, or natural resource damages" which count towards the applicable limit of liability, apparently even if such costs were incurred prior to legal compulsion, unless the insurer can show that such costs are not covered "damages." It would appear to be unnecessary and inappropriate for the bill to address this issue because the Wisconsin Supreme Court in Johnson Controls, Inc. v. Employers Insurance of Wausau, et al., 264 Wis. 2d 60, 665 N.W.2d 257 (2003), held that "an insured's costs of restoring and remediating damaged property, whether the costs are based on remediation efforts by a third party (including the government) or are incurred directly by the insured, are covered damages under the applicable CGL policies, provided that other policy exclusions do not apply."

The 2003 Oregon Statute similarly provides that "[t]here is a rebuttable presumption that payment of the costs of removal actions or feasibility studies, as those terms are defined by rule by the Department of Environmental Quality, are indemnity costs and reduce the insurer's applicable limit of liability on the insurer's indemnity obligations, subject to the provisions of the applicable general liability insurance policy or policies." ORS SECTION 2.465.480(6)(a).

(c) The court shall award to an insured the sum of the costs, disbursements, and expenses, including accounting fees and reasonable attorney fees notwithstanding s. 814.04 (1), necessary to prepare for and participate in an action in which the insured successfully litigates a coverage issue for an environmental claim.

Comment:

This provision provides for the payment of an insured's attorneys fees, in addition to other costs associated in successfully litigating a coverage claim involving an insured's environmental claim. There is support in current Wisconsin law for insureds to recover attorneys fees in litigating coverage claims. See Elliot v. Donahue, 169 Wis.2d 310, 485 N.W. 2d 403 (1992). On the other hand, this approach is contrary to the American Rule, requiring each litigant to bear its own costs and exceptions to that rule should be narrowly read and applied.

(d) 1. An insurer under a general liability insurance policy under which an environmental claim is made that has not entered into a good faith settlement and release of the environmental claim with the insured is liable, up to the amounts stated in the policy, to any governmental entity that seeks to recover against the insured for pollution in this state, irrespective of whether the liability is presently established or is contingent and to become fixed or certain by final judgment.

Comment:

This provision appears to create a direct right of action by any governmental entity against any insurer against whom an environmental claim is made that has not entered a settlement with the insured.

2. An insurer under subd. 1. may be proceeded against directly and may be joined in any action brought by the governmental entity against the insured.

<u>Comment:</u>

The proposed bill authorizes direct actions by a governmental agency to recover from an insurer against whom an environmental claim is made and that has not entered into a good faith settlement with the policyholder. Wisconsin law, by statute, allows tort claimants with a negligence claim a right of direct action against insurers. <u>Decade's Monthly Income & Appreciation Fund by Keierleber v. Whyte</u>, 173 Wis. 2d 665, 671, 495 N.W. 2d 335, 337 (Wis. 1993) (sec. 632.24, Stats provides that "any . . . policy of insurance covering liability to others for negligence makes the insurer liable . . . to the persons entitled to recover against the insured . . . irrespective of whether the liability is presently established or is contingent and to become fixed or certain by final judgment against the insured"). Accordingly, Wisconsin has departed from the general rule prohibiting direct actions against insurers in other settings. This provision would create substantial dislocations, since the insurer is not well-situated to develop the policyholder's defenses to underlying liability.

(5) EFFECT OF SETTLEMENT. An insurer that enters into a good faith settlement and release of an environmental claim, or an insurer that has entered into a good faith settlement and release of an environmental claim before the effective date of this subsection . . . [revisor inserts date], shall not be liable to any person for the claim. Entering into a good faith settlement and release of an environmental claim with an insurer does not reduce or otherwise impair the right of an insured to recover the full balance of its actual loss as provided in this section from an insurer that has not entered into a good faith settlement and release of the claim.

Comment:

This provision appears to protect settling insurers from contribution or other claims. Instead of applying a set off for their share of liability, however, it purports to make other insurers liable for any amount the policyholder compromised in settlement.

(6) CONTRIBUTION AMONG INSURERS. An insurer that pays an environmental claim, or an insurer that paid an environmental claim before the effective date of this subsection . . . [revisor insures date], may seek contribution from any other insurer that is liable or potentially liable for the claim and that has not entered into a good faith settlement and release of the environmental claim with the insured.

Comment:

This provision allows contribution claims against other insurers, except those who have entered into good faith settlements and releases with the insured. It does not address allocation of liability to the policyholder.

The 2003 Oregon Statute allows for an insurer "that has paid an environmental claim [to] seek contribution from any other insurer that is liable or potentially liable." ORS SECTION 2.465.480(4). That section provides that, "[i]f a court determines that the apportionment of recoverable costs between insurers is appropriate, the court shall allocate the covered damages between the insurers . . . based on . . . : (a) The total period of time that each solvent insurer issued a general liability insurance policy to the insured applicable to the environmental claim; (b) The policy limits, including any exclusions to coverage, of each of the general liability insurance policies that provide coverage or payment for the environmental claim for which the insured is liable or potentially liable; (c) The policy that provides the most appropriate type of coverage for the type of environmental claim; and (d) If the insured is an uninsured for any part

of the time period included in the environmental claim, the insured shall be considered an insurer for purposes of allocation." ORS SECTION 2.465.480(4)(a)-(d). The contribution provisions further permit allocation to an insured for uninsured periods for defense costs, providing that "[i]f an insured is an uninsured for any part of the time period included in the environmental claim, an insurer who otherwise has an obligation to pay defense costs may deny that portion of defense costs that would be allocated to the insured under [the contribution provisions] of this section." ORS SECTION 2.465.480(5).

The 2003 Oregon Statute defines an "uninsured" as "an insured who, for any period of time after January 1, 1971, that is included in an environmental claim, failed to purchase and maintain an occurrence-based general liability insurance policy that would have provided coverage for the environmental claim, provided that such insurance was commercially available at such time. A general liability insurance policy is 'commercially available' if the policy can be purchased under the Insurance Code on reasonable commercial terms." ORS SECTION 2.465.480(b). However, the 2003 Oregon Statute provides that, "[n]otwithstanding any other provision of law, an insurer that is a party to an action based on an environmental claim for which a final judgment as to all insurers has not been entered by the trial court on or before the effective date of this 2003 Act and in which a binding settlement has been reached on or before the effective date of this 2003 Act between the insured and at least one insurer that was a party to the action may not seek or obtain contribution from or allocation to: (a) The insured; or (b) Any other insurer that prior to the effective date of this 2003 Act reached a binding settlement with the insured as to the environmental claim." ORS SECTION 5.465.475(3)-(4).

(7) LOST POLICY. **(a) In this subsection, "lost policy" means "all or any part of a general liability insurance policy that is subject to an environmental claim and that is ruined, destroyed, misplaced, or otherwise no longer possessed by the insured.**

Comment:

The 2003 Oregon Statute defines "lost policy" as "any part or all of a general liability insurance policy that is alleged to be ruined, destroyed, misplaced or otherwise no longer possessed by the insured." ORS SECTION 1.465.475(4). The 2003 Oregon Statute further defines "policy" as including "all clauses, rides, endorsements and papers that are part of the contract or agreement, for or effecting insurance." ORS SECTION 1.465.475(5).

(b) If, after a diligent investigation by an insured of the insured's own records, including computer records and the records of past and present agents of the insured, the insured is unable to reconstruct a lost policy, the insured may provide notice of the lost policy to the insurer that the insured believes issued the policy. The notice must be in writing and in sufficient detail to identify the person or entity claiming coverage, including the name of the alleged policyholder, if known and any other material facts concerning the lost policy known to the person providing the notice.

Comment:

The provision does not define a "diligent investigation" of the insured's own records, "including the records of past and present agents of the insured." Furthermore, to provide written notice to any insurer that the insured believes issued a lost policy, and the insured must only provide the identity of the person claiming coverage, the name of the alleged policyholder, if known and any other known material facts. Section 3. 632.28 (7)(b).

The 2003 Oregon Statute similarly provides that "[i]f, after a diligent investigation by an insured or the insured's own records, including computer records and the records of past and present agents of the insured, the insured is unable to reconstruct a lost policy, the insured may provide a notice of a lost policy to an insurer." ORS SECTION 4.465.475(1). The 2003 Oregon

Statute also provides that "notice of a lost policy" means "written notice of the lost policy in sufficient detail to identify the person or entity claiming coverage, including information concerning the name of the alleged policyholder, if known, and material facts concerning the lost –policy known to the alleged policyholder." ORS SECTION 4.465.475(10).

(c) An insurer must thoroughly and promptly investigate a notice of a lost policy and must provide to the insured claiming coverage under the lost policy all facts known or discovered during the investigation concerning the issuance and terms of the policy, including copies of documents establishing the issuance and terms of the policy.

<u>Comment:</u>

This provision imposes on the insurer duties to investigate and to provide the insured with information and documents. There are lesser obligations on the person claiming coverage.

The 2003 Oregon Statute similarly provides that "[a]n insurer must investigate thoroughly and promptly a notice of a lost policy. An insurer fails to investigate thoroughly and promptly if the insurer fails to provided all facts known or discovered during an investigation concerning the issuance and terms of a policy, including copies of documents establishing the issuance and terms of a policy, to the insured claiming coverage under a lost policy." ORS SECTION 4.465.475(2).

(d) For facilitating reconstruction, and determining the terms, of a lost policy, the insurer and the insured must comply with the following minimum standards:

1. Within 30 business days after receipt by the insurer of notice of a lost policy, the insurer shall commence an investigation into the insurer's records, including computer records, to determine whether the insurer issued the lost policy. If the insurer determines that it issued the policy, the insurer shall commence an investigation into the terms and conditions relevant to any environmental claim made under the policy.

<u>Comment:</u>

As noted above, this provision imposes duties on the insurer but not on the person claiming coverage.

The 2003 Oregon Statute contains an identical provision stating "[w]ithin 30 business days after receipt by the insurer of notice of a lost policy, the insurer shall commence an investigation into the insurer's records, including computer records, to determine whether the insurer issued the lost policy. If the insurer determines that it issued the policy, the insurer shall commence an investigation into the terms and conditions relevant to any environmental claim made under the policy." ORS SECTION 4.465.475(3)(a).

2. The insurer and the insured shall cooperate with each other in determining the terms of a lost policy. The insurer and the insured shall provide to each other the facts known or discovered during an investigation, including the identity of any witnesses with knowledge of facts related to the issuance or existence of the lost policy, and shall provide each other with copies of any documents establishing facts related to the lost policy.

Comment:

In this section, both the alleged insured and insurer must cooperate in determining the terms of a lost policy and disclose facts known or discovered during investigation, including the identity of witnesses and any documents establishing facts related to the lost policy.

The 2003 Oregon Statute contains an identical provision, requiring that "[t]he insurer and the insured shall cooperate with each other in determining the terms of a lost policy." ORS SECTION 4.465.475(3)(b). That provision states that "[t]he insurer and the insured: (A) Shall provide to each other the facts known or discsvoered during an investigation, including the idnetify of any witnesses with knowledge of factgs related to the issuaance or existence of a lost policy [and] (B) Shall provide each other with copies of documents establishing facts related to the lost policy." ORS SECTION 4.465.475(3)(b)(A),(B). Unlike the Wisconsin bill, however, the

2003 Oregon Statute provides that the parties "[a]re not required to produce material subject to a legal privilege or confidential claims documents provided to the insurer by another policyholder. ORS SECTION 4.465.475(3)(b)(C).

3. An insurer that discovers information tending to show the existence of an insurance policy that applies to the claim shall provide an accurate copy of the terms of the policy or a reconstruction of the policy. If the insured discovers information tending to show the existence of an insurance policy that applies to the claim, the insurer shall provide an accurate copy of the terms of the policy or a reconstruction of the policy upon the request of the insured.

Comment:

This section erroneously presumes the existence or ability to reconstruct a policy if information "tending to show" its existence is found.

The 2003 Oregon Statute does not require the insurer to provide a copy of the terms of the policy in any instance. Instead, the 2003 Oregon Statute provides "If the insurer or the insured discovers information tending to show the existence of an insurance policy applicable to the claim, the insurer or the insured shall provide an accurate copy of the terms of the policy or a reconstruction of the policy, upon the request of the insurer or the insured." ORS SECTION 4.465.475(3)(c).

4. If the insurer is not able to locate portions of the policy or determine its terms, conditions, or exclusions, the insurer shall provide copies of all insurance policy forms issued by the insurer during the applicable policy period that potentially apply to the environmental claim. The insurer shall identify which of the potentially applicable forms, if any, is most likely to have been issued by the insurer to the insured, or the insurer shall state why it is unable to identify the forms after a good faith search.

Comment:

This provision is not appropriately limited and may impose undue burdens on the insurer.

The 2003 Oregon Statute contains a nearly identical provision that states "[i]f the insurer is not able to locate portions of the policy or determine its terms, conditions or exclusions, the insurer shall provide copies of all insurance policy forms issued by the insurer during the applicable policy period that are potentially applicable to the environmental claim. The insurer shall state which of the potentially applicable forms, if any, is most likely to have been issued by the insurer, or the insurer shall state why it is unable to identify the forms after a good faith search." ORS SECTION 4.465.475(3)(d).

However, unlike the Wisconsin bill, the 2003 Oregon Statute contains further provisions that provide: "(4) Following the minimum standards established in this section does not create a presumption of coverage for an environmental claim once the lost policy has been reconstructed [and that] (5) Following the minimum standards established in this section does not constitute: (a) An admission by an insurer that a policy was issued or effective; or (b) An affirmation that if the policy was issued, it was necessarily in the form produced, unless so stated by the insurer." ORS SECTION 4.465.475(4)-(5).

e. If, based on information discovered in the investigation of a lost policy, the insured can show by a preponderance of the evidence that a general liability insurance policy was issued to the insured by the insurer but cannot produce evidence that tends to show the policy limits applicable to the policy, it shall be assumed that the minimum limits of coverage, including any exclusions to coverage, that the insurer offered during the period in question under such policies apply to the policy purchased by the insured. If, however, the insured produces evidence that tends to show the policy limits applicable to the policy, the insurer has the burden of proof to show by a preponderance of the evidence that different policy limits, including any exclusions to coverage, apply to the policy purchased by the insured.

Comment:

This provision introduces a "preponderance of the evidence" standard for proof of policies. Wisconsin courts have previously applied a "clear and convincing" standard with respect to lost policies. See Menasha Electric and Water, et al. v. American Employers Ins., et al., No. 93-CV-625 (Wis. Cir. Ct. Aug. 14, 1995)(noting that "it's well established that . . . the contents of a lost instrument must be shown with particularity by strong and convincing evidence" and that "[a] party seeking to recover upon a lost instrument must not only prove by clear and convincing evidence the instrument is, or the instrument formally existed, but also that the instrument contains certain language").

If a preponderance of the evidence shows that a policy was issued but the policy limits are unknown, the provision states that the applicable limits shall be the minimum limits that the insurer was offering at the time. This would apparently eliminate the need to show any evidence or policy limits, and creates an unfair and unworkable standard by referring vaguely to the "minimum" limits of coverage. If the insured produces evidence showing policy limits, the provision shifts the burden to the insurer to prove that different policy limits apply. This is inconsistent with the majority view on proof of policy issues.

The 2003 Oregon Statute contains similar language providing "[i]f, based on the information discovered in an investigation of a lost policy, the insured can show by a preponderance of the evidence that a general liability insurance policy was issued to the insured by the insurer, then if: (a) The insured cannot produce evidence that tends to show the policy limits applicable to the policy, it shall be assumed that the minimum limits of coverage, including any exclusions to coverage, offered by the insurer during the period in question were purchased by the insured[;] (b) The insured can produce evidence that tends to show the policy

limits applicable to the policy, then the insurer has the burden of proof to show that a different policy limit, including any exclusions to coverage, should apply." ORS SECTION 4.465.475(6)(a)-(b).

Unlike the Wisconsin bill, the Oregon statute further provides, however, that "[a]n insurer may claim an affirmative defense to a claim that the insurer failed to follow the minimum standards established under this section if the insured fails to cooperate with the insurer in the reconstruction of a lost policy under this section." ORS SECTION 4.465.475(7). The 2003 Oregon Statute also provides that "[v]iolation by an insurer of any provision of this section or any rule adopted under this section is an unfair claim settlement practice under ORS 746.230." ORS SECTION 4.465.475(9).

(8) PUBLIC RIGHTS AND INTEREST. In applying the provisions under this section, any party or court acting under this section shall ensure that public rights and interests are considered for the purpose of furthering the public trust in navigable waters.

Comment:

This provision may be seen as urging that insurers be treated as a deep-pocket to finance clean ups, although the public interest actually will be served through straightforward application of insurance contracts terms.

(9) ENFORCEMENT. Any person who is injured by a violation of this section by an insurer may bring a civil action against the insurer to recover damages together with costs, disbursements, accounting fees, if any, and reasonable attorney fees incurred in bringing the action, notwithstanding s. 814.04 (1).

Comment:

This provision creates a new course of action against insurers.

(10) APPLICABILITY. (a) This section applies to all environmental claims that are not settled or finally adjudicated on or before the effective date of this subsection ... [revisor inserts date], regardless of when the claim arose.

Comment:

This section does not eliminate constitutional and equitable concerns about the retroactive application of provisions of the proposed legislation.

The 2003 Oregon Statute contains a provision stating that the Statute "appl[ies] to all claims, whether arising before, on or after the effective date of th[e] 2003 Act." ORS SECTION 5.465.475(1). The 2003 Oregon Statute further provides that the Statute "do[es] not apply to any claim for which a final judgment, after exhaustion of all appeals, was entered before the effective date of this 2003 Act." ORS SECTION 5.465.475(2).

The 2003 Oregon Statute further provides, however, that "[n]othing in [the Statute] may be construed to require the retrying of any finding of fact made by a jury in a trial of an action based on an environmental claim that was conducted before the effective date of this 2003 Act." ORS SECTION 5.465.475(3).

(b) This section applies to all environmental claims specified in par. (a). regardless of the state in which the general liability insurance policy under which the claim is or was made was issued or delivered.

Comment:

This provision again raises concerns about overriding the interests and rights of other states and courts of other jurisdictions.

The 2003 Oregon Statute does not contain a specific provision stating that the section applies to all claims "regardless of the state in which the general liability insurance policy under

which the claim is or was made was issued or delivered," although the provision generally states that the Statute "appl[ies] to all claims." ORS SECTION 5.465.475(1).

(11) CONSTRUCTION. Nothing in this section shall be construed to raise or support any inference that it is the intention of the legislature to change the common law of this state with respect to the interpretation of general liability insurance policies not subject to this section.

Comment:

This section underscores a serious concern about the selective and inconsistent application of the legislation, which could lead to inconsistent construction of the same policy and inconsistent treatment of policyholders.

(END)