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Fee-Falling *(Proving Up Brandt Fee Requests)*

FOCUS COLUMN

By Ken Moscaret, Esq.

Every policyholder coverage litigator in California knows that a policyholder is entitled to recover some attorney fees under *Brandt v. Superior Court*, 37 Cal.3d 813 (1985), after winning a "bad faith" lawsuit against an insurance carrier. What they may not realize, though, is that since *Cassim v. Allstate Insurance Co.*, 33 Cal.4th 780 (2004), the actual amount of the *Brandt* fee award will depend on whether plaintiff-policyholder's counsel worked on an hourly or contingency fee basis in the bad faith lawsuit.

In *Cassim*, the California Supreme Court re-affirmed a policyholder's right to *Brandt* fees. *Cassim* dealt with a situation where plaintiff-policyholder's counsel was handling the case on contingency. A majority of the California Supreme Court in *Cassim* adopted a new, multi-step formula for computing *Brandt* fees in contingency fee cases. That formula was not without controversy. One dissenter in *Cassim*, Justice Marvin Baxter, remarked that his colleagues had "complicated" the entire *Brandt* fee process compared to what had existed before.

Essentially, under *Cassim*, a plaintiff-policyholder's counsel on contingency has to be able to segregate their time in the successful bad faith lawsuit into three separate hypothetical "baskets." The first basket is for all hours billed for legal work solely related to proving the breach of contract claim. The second basket is for all legal work solely for proving the tortious bad faith claim. The third basket is for everything else, which necessarily means all legal work related to *both* the contract and tort claims, i.e., overlapping, intertwined "mixed" legal work.

Under *Cassim*, the trial court has to make some apportionment of the

third basket, assigning a portion of the third-basket hours to the contract claim and the rest to the tort claim. Unfortunately, the Supreme Court in *Cassim* did not articulate a formula for making that apportionment. It is at the trial court's discretion. The only requirement is that some hours have to be assigned by the trial court to the contract claim and other hours to the tort claim. It cannot be all-or-nothing. Once that is done, the trial court adds up all of the first-basket hours for pure contract work, plus that portion of third-basket hours allocated to contract work. None of the tort claim hours are recoverable.

Plaintiff-policyholder's counsel will note that this apportionment approach differs from another California Supreme Court case, *Buss vs. Superior Court*, 16 Cal. 4th 35 (1997). In *Buss*, the Supreme Court said that where an insurance carrier is defending a lawsuit against its policyholder that contains both covered and non-covered claims, any legal work that overlaps and is necessary to both the covered and non-covered claims must be paid by the carrier. No apportionment is necessary. Such legal work would be analogous to third-basket hours in *Brandt* fee cases, i.e., mixed, intertwined legal work. However, in *Cassim*, the Supreme Court mandated some apportionment of mixed work in bad faith lawsuits on contingency.

After the allocation among the three baskets is finished, the trial court next computes a fraction. The numerator of that fraction is the total number of hours for contract work from basket one and part of basket three. The denominator is the total hours from all three baskets, meaning, for the entire case. The ensuing fraction equals some percentage, say, 30 percent.

The *Brandt* fee award in a contingency case under *Cassim* is calculated by multiplying that percentage fraction by the dollar contingency fee that plaintiff-policyholder's counsel is entitled to receive under their retainer agreement with their client. For example, suppose the policyholder recovers compensatory damages of $1 million at trial, and plaintiff-policyholder's counsel is entitled to a 40 percent contingency fee, or $400,000. Assume the *Brandt* fee percentage is 30 percent. In that example, the actual *Brandt* fee award is $120,000 (30 percent of $400,000).

Under the *Cassim* formula, there are a lot of math steps. Also, plaintiff-policyholder's counsel working on contingency had better be recording their actual hours billed on the case internally. Otherwise they will not be able to make the requisite three-basket segregation of hours spent on contract versus tort claims under *Cassim*.

Savvy coverage counsel for insurance carriers realize that the more they can persuade the trial court to allocate hours into the second (purely tort) basket, and to allocate a greater portion of the third-basket hours toward tort than contract, the smaller the percentage fraction will end up being (i.e., because the numerator will be a smaller number). That tactic will reduce the entire *Brandt* fee award in a contingency case. Savvy carriers' coverage counsel may attack hard on the entire time allocation process, and on the quality (or not) of plaintiff-policyholder's counsel's record-keeping.

There is some good news, though, for plaintiff-policyholder's counsel who work on a straight hourly basis in bad faith lawsuits. Neither the California Supreme Court nor any California appellate case has yet held that the *Cassim* approach applies to hourly rate bad faith cases. Some commentators have suggested that at least some elements of the *Cassim* approach will still apply in hourly cases, e.g., the three-basket allocation process. See, e.g., California Practice Guide, "Insurance Litigation" (The Rutter Group 2007). But other elements of the *Cassim* formula make no sense in an hourly case, e.g., multiplying the ensuing percentage fraction by the dollar contingency fee earned.

One recent appellate decision addressed if and how *Cassim* applies in hourly bad faith cases. In *Jordan v. Allstate Insurance Co.*, 148 Cal. App. 4th 1062 (2007), the 2nd Appellate District said that to get a *Brandt* fee award, a policyholder must plead and prove four prima facie elements: the amount of recoverable insurance policy (i.e., contract) benefits; that the carrier acted unreasonably and in bad faith; the amount of attorney fees paid or incurred by the policyholder in proving their contract claim; and the reasonableness of those attorney fees. The *Jordan* court noted that the strict *Cassim* approach might not apply if plaintiff-policyholder's counsel was

working on an hourly basis, instead of contingency.

The *Jordan* court recognized that there could well be legal work that was intertwined and overlapping between contract and tort claims. In that event, the court said that "a fair and equitable apportionment would be appropriate." Turning to the mechanism for making that apportionment, the court said that the apportionment process might be simpler if there were hourly billing, because it would involve an allocation of "already designated legal work and the billing therefore."

In other words, if plaintiff-policyholder's counsel maintained detailed, contemporaneous hourly time records in the bad faith case, which clearly described which legal work related to contract versus tort claims, then apportionment might be easier for a trial judge. Perhaps some variation on the three-basket approach would still be used to separate purely contract work, purely tort work and mixed contract-tort work. Some "fair and equitable" apportionment would still be made for the mixed work in the third basket.

The *Jordan* court acknowledged, though, that there could be a wrinkle. Many disputed fact issues regarding the contract claim might also relate to the tort claim. There might still end up being a lot of mixed work even with hourly billing, in which case the trial judge could encounter a large third basket that needed to be apportioned.

Plaintiff-policyholder's counsel should remember that the policyholder has the burden to apportion legal work between contract versus tort claims. As for the actual prove-up procedure, plaintiff-policyholder's counsel can testify as a fact witness as to which of their own time entries in the bad faith lawsuit belong in each of the three baskets. See *Diamond Woodworks, Inc. v. Argonaut Insurance Co.*, 109 Cal. App. 4th 1020 (2003). Alternatively, expert testimony can be used to do that.

Finally, plaintiff-policyholder's counsel must also remember that the *Brandt* fee prove-up process does not end with apportionment. Once the apportionment has been made, the fourth prong of the *Jordan* test comes into play, namely, proof that the all of the contract-related hours are

reasonable. In the policyholder's battle against the insurance carrier over apportionment, the reasonableness element can be overlooked. This fourth step can entail proof of reasonable hourly rates, reasonable hours billed, efficient case staffing and delegation of work, proper billing practices, and the like. An aggressive insurance carrier may challenge the *Brandt* fee request on one or more of those grounds.

Expert testimony is frequently used to establish the reasonableness of a *Brandt* fee request, because it can attest to the fact that plaintiff-policyholder counsel's rates, fees and billing practices are reasonable and consistent with prevailing rates and practices in the local legal community. Also, the insurance carrier may employ a legal-bill auditor as their own fee expert to challenge the reasonableness of the *Brandt* fees, in which case plaintiff-policyholder's counsel may want a rebuttal fee expert.

Brandt fees are still alive and well in California after *Cassim*, but there is now more "devil in the details" than ever before. A plaintiff-policyholder's counsel who wins their bad faith case at trial should savor their victory while they can, because a fresh, new, equally contentious battle may await them once they submit their *Brandt* fee request.

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Delegating Duty *(Higher-Rate Attorneys Can Be More Appropriate Billers)*

FOCUS COLUMN

By Ken Moscaret, Esq.

You may have heard the attorney billing adage "Make the biller fit the task." If not, you're definitely going to hear it if your law firm is defending a corporate client as its independently selected defense counsel in a business lawsuit and an insurance carrier is paying your firm's legal bills.

Billing Objections

Insurance carriers typically object to legal billings when the corporate policyholder's defense firm does not appear to have delegated enough work to less-expensive associates and paralegals. It's called "lack of delegation to appropriate billers." Although the need for delegation of work on a case is valid, the reality of it often depends on how you go about determining who is an appropriate biller in a given situation.

For example, insurance carriers (as well as corporate clients) don't want to pay for a partner's time when a less-expensive associate can complete a task satisfactorily or for an associate's time when a paralegal is equally capable. Insurance billing guidelines for defense counsel usually contain a provision to that effect. Conversely, though, corporate policyholders' defense counsel does not want to let the insurance carrier dictate internal case management decisions if the carrier has no right to control the defense (as, for example, in a *Cumis* situation or under an "indemnity" insurance policy).

As an attorney-fee expert witness for many years, I frequently have seen disagreements erupt between insurance carriers and corporate policyholders' defense counsel over the appropriate delegation of legal work on a case. However, as I have found in most billing disputes between insurance carriers and

corporate policyholder defense firms, the issue of appropriate delegation of work is never as simple as insurance carriers would like to believe - especially in large, complex cases.

California Case Law

As a starting point, the case law in California courts on this issue is mixed, with published decisions typically coming from the federal courts. For example, the 9th Circuit, in *Davis v. City and County of San Francisco*, 976 F.2d 1536 (9th Cir. 1992 - later modified on other grounds), said that a fee-applicant attorney can be awarded the same hourly rate for all the different tasks he or she performed on a case, in the trial court's discretion. Then, again, in *MacDougal v. Catalyst Nightclub*, 58 F. Supp. 2d 1101 (N.D. Cal. 1999), the district court found that a senior attorney had billed many hours at his senior-attorney rate for tasks usually performed by less-expensive associates or even nonattorneys at lower rates. The court considered this an exercise of "poor billing judgment."

Generally speaking - and there may be exceptions to this - the courts are more inclined to view basic legal research, preparation of routine written discovery requests, drafting of ordinary court pleadings and motions, and other such tasks as more appropriately delegated to associates in a law firm. On the other hand, some associates are clearly more capable than others. There is no reasonable requirement that every task be delegated to the least-expensive associates, namely first-year and second-year attorneys. Brand-new attorneys may not be competent and experienced enough to complete every associate task in a satisfactory fashion.

Hence, delegating associate work to more experienced midlevel or senior associates, even at their higher hourly rates, would be reasonable for a corporate policyholder's defense counsel to do in some instances. In the end, insurance carriers might have to pay only for associates, though not necessarily the lowest-priced associates.

Determining Appropriateness

On some occasions, having a partner complete a task that otherwise could be assigned to an associate may truly be more cost-effective, even though the partner's hourly rate may be twice as high as the associate's. In my experience, insurance carriers have a hard time accepting that notion. They tend to fixate on hourly rates first and foremost, because hourly rates are a much easier cost indicator for carriers to understand than the more open-ended question of how many hours a partner might bill versus an associate to complete the same task.

For example, an experienced partner who has defended a particular type of large, complex case before might be able to prepare persuasive court motions much more quickly than an associate who has to conduct research first. I have seen instances in large, complex lawsuits in which a partner took on more billable tasks in the case than usual, simply because those tasks required an intimate, detailed working knowledge of opposing counsel, the trial judge and all the key witnesses. The partner had that knowledge. The associates working on the case did not.

As any business litigator knows, the key to beating an opponent in court is not always found in the law books; it can come from interacting directly and repeatedly with the other key players in the case and learning their strengths, weaknesses and predispositions. As a general rule for business litigation, partners tend to have a breadth and depth of close personal contact with all the key players in a case that associates do not. That produces valuable intuitive knowledge, which can be the difference between winning and losing a case.

Hence, a partner on a large, complex case may be better-positioned to prepare important court briefs, take key depositions or perform other tasks that ordinarily might be assigned to associates, if that partner can weave all of his or her knowledge into the work product. Keep in mind, however, that the partner needs to demonstrate to the court's satisfaction that he or she was indeed the most efficient biller for those tasks.

An insurance carrier's preconceived notion that associates always are going to be cheaper does not apply to every case, especially not to larger, more complex ones. Large, complex cases probably have even more tasks that

partners can demonstrate were more reasonable for them to perform, given the greater degree of difficulty involved in such cases. Because every case is different, a partner needs to be able to explain why doing the particular work in question was more reasonable for him or her.

Partner Benefits

Unless business litigation changes substantially, partners tend to have the better overall vantage point on the entire case. Partners more likely have a 30,000-foot view of the case, and most associates remain at ground level. The partner's expansive outlook can render him or her the more appropriate biller for certain tasks.

If your law firm is litigating the issue of delegation of work against an insurance carrier in front of a judge, jury or arbitrator, the law-firm partners who billed on the case need to be prepared to show, with concrete examples, why partners were better-suited to do some of the work on the case and why associates were more appropriate for other work. If possible, the partners who did the work should try to quantify some examples of time savings on the defense fees. For example, if a partner can testify that, because of her prior experience in defending that type of case, she was able to prepare a motion in five hours that would have taken a capable associate 15 hours, even at twice the associate's hourly rate, then that is a quantifiable dollar savings that the trier of fact should know about.

Additionally, if certain tasks in a large, complex case truly required the special skill, knowledge and experience that a partner more likely has, the law firm must be able to articulate that for the trier of fact. In a previous article, I mentioned a case in which four in-depth legal specialties were necessary in order to defend a corporate policyholder effectively in a $12 million complex business lawsuit. In that case, having one or two partners with those specialties do the lion's share of the defense work themselves at higher partner rates was appropriate.

The bottom line is that decisions about how to delegate the legal work on a business lawsuit are reflective not only of who is going to control the defense of the corporate policyholder but also of the practical judgment of defense counsel.

A corporate policyholder's defense counsel should attempt to ensure that "the biller fit the task," but the insurance carrier also must recognize that the most appropriate biller is not always the least-expensive one.

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Calibrating Staffing *(Overcoming Carrier Challenges to Case Staffing)*

FOCUS COLUMN

By Ken Moscaret, Esq.

Your law firm is defending a corporate client as its handpicked defense counsel in a large, complex lawsuit, with an insurance carrier paying your firm's legal bills. This is a big case, so your firm staffs it with a small core team of partners, associates and paralegals in order to divide the labor. As the defense fees climb, you begin receiving letters from the insurance carrier objecting to the number of timekeepers billing on the case. Those letters allege overstaffing and threaten to disallow a substantial portion of the defense fees on those grounds.

The insurance carrier doesn't appear to appreciate that your firm has been forced to play tough defense in this business lawsuit against an aggressive, unreasonable plaintiff who refuses to settle. Dozens of depositions have been taken, and tens of thousands of pages of evidentiary documents have been produced. Opposing counsel has several attorneys working on the case. Given all of this, how do you disabuse the insurance carrier of their overstaffing claims against your firm?

Justifying Levels

As an attorney-fee expert witness for many years, I have frequently seen insurance carriers and corporate policyholders' defense counsel spar over the proper number of timekeepers on a case. Insurance carriers often balk at paying a portion of the defense fees until that issue is resolved.

If your law firm is going to find itself litigating the issue of reasonable staffing in front of a judge, jury, or arbitrator, you need to be able to persuasively explain and justify the staffing levels on the case. Proper case staffing is part of efficient case management, which every law firm should try to achieve. However, where case staffing is concerned, appearances may be different than reality.

First, from a tactical standpoint, you may want to imagine the issue from the vantage point of a typical insurance claims person for a moment. Claims persons start out in knee-jerk fashion, wanting your law firm to adhere to the insurance company's billing guidelines. Those billing guidelines are typically a one-size-fits-all set of billing rules. Insurance billing guidelines may not distinguish between a routine business lawsuit and a big, complex lawsuit.

Hence, the insurance claims person may have a cookie-cutter view of your case that reflects the oversimplicity of insurance billing guidelines. That may be neither the correct, nor the most sophisticated approach for them to take, but it is the reality of dealing with insurance carriers on defense fees.

Insurance billing guidelines typically limit the staffing on defense cases to one, or perhaps two, attorneys. Hence the bar on case staffing is set very low in the minds of insurance claims persons from the outset.

Because of that mindset, a corporate policyholder's defense counsel may encounter automatic resistance in large, complex business lawsuits, where even two attorneys may not be enough to handle every aspect and activity in the case (especially where broad discovery wars break out, as often happens in big, complex cases). The corporate policyholder's defense counsel should explain to the insurance carrier why rigid application of the billing guidelines to the staffing of a big, complex case is impractical at best, and bad faith at worst.

Next, the corporate policyholder's defense counsel may want to consider communicating more frequently about case developments with the insurance carrier's claims person in order to lay the groundwork for greater staffing levels later on, even in instances where the policyholder, not the carrier, gets to control the defense. Sometimes, claims persons react badly and push back against increased staffing levels on defense counsel's invoices simply because they feel surprised. Nobody who pays legal bills likes surprises, especially insurance carriers.

Nevertheless, even if the corporate policyholder's defense counsel has tried to get an insurance carrier to see the light and acknowledge the staffing realities of a large, complex case, they may still face objections from the carrier to using more than one or two attorneys on the case. At that point, the defense counsel will have no alternative but to meet the carrier's objections head-on if they are

going to protect the interests of their corporate policyholder client.

Defending Attacks

If the dispute goes before a judge, jury, or arbitrator, the insurance carrier's first point of attack against the staffing levels may be to highlight the total number of law firm timekeepers who touched the case, however slightly. Those individuals will be shown on the defense counsel's invoices. If there are more timekeepers than the insurance billing guidelines allow, the carrier will cite that fact to establish overstaffing (assuming that the billing guidelines are found to be enforceable by the court against defense counsel in the first place).

However, insurance carriers often overlook the fact that the total number of timekeepers on a case is not determinative of proper staffing in and of itself. Rather, the focus should be on efficient levels of staffing. If a small, core team of timekeepers has billed a substantial majority of the hours defending the case, then that is strong evidence of tight, efficient staffing. As a general rule, you want as few timekeepers as possible doing as much of the work as possible. If this is not the case, then the law firm will have some explaining to do.

Second, the insurance carrier may attack the mix of different timekeepers on the case, citing the relative balance of partners, associates and paralegals in an attempt to show that the staffing levels were unnecessarily top-heavy. The criticism will turn on the allegation that there were too many expensive partners and too few less-expensive associates and paralegals. While carriers will probably make more headway with this particular argument in routine business lawsuits, it becomes problematic for them in a large, complex case that requires specialized knowledge and experience in more than one substantive area of the law.

I recently testified for a corporate policyholder in an insurance coverage arbitration where the defense of the underlying litigation ($12 million in damages were at issue) required expertise in banking law, equipment leasing law, bankruptcy law, and business litigation. Rarely will one attorney in a law firm be able to wear all those different hats. Typically, those who do will be partners, not associates. Hence, it might be very reasonable from a staffing standpoint to have two or more partners on the core litigation team for such a case, perhaps

supported by a few associates and paralegals, no matter what insurance billing guidelines might say.

Third, the insurance carrier may also try to show that there were too many so-called "transient timekeepers" on the case. "Transient timekeepers" is a term used by insurance industry legal-bill auditors for those timekeepers who do not bill steady, consistent hours throughout the entire case from start to finish. Instead, they bill sporadically or in very small amounts.

Pruning Transience

The automatic assumption by insurance carriers, not surprisingly, is that transient timekeepers contribute little or nothing to the defense of the underlying case, and that their time should therefore be disallowed. The insurance carrier will argue that too many timekeepers were coming on and off the case, supposedly to do nothing more than meet their respective monthly billing quotas instead of making a real contribution.

Sporadic or minor timekeepers cannot simply be dismissed, however, without first examining what they did and why they did it. Simplistic appearances can be deceiving. Sometimes their involvement has a perfectly necessary, reasonable explanation. For example, sporadic billings by some of the timekeepers on a large, complex case involving lots of depositions and document productions may be due to the need to bring more attorneys and paralegals onto the case temporarily during the discovery phase. Those same timekeepers may not have been necessary back in the earlier pleading stage.

In large, complex cases that ebb and flow, there are often no other practical alternatives to "just-in-time" staffing, especially if an aggressive, hard-charging plaintiff is driving the discovery process. Some timekeepers are simply not going to be needed from start to finish on a case. That does not mean, however, that they aren't making a legitimate contribution to it.

The insurance carrier may also reflexively try to disallow any minor timekeepers, such as those who only billed for office conferences on a case. I have seen situations where a senior partner in a law firm billed only a few hours on the entire case, only to be immediately labeled a disallowable transient timekeeper by the carrier. However, it turned out that the core litigation team

consulted that eminent senior partner in their firm for a few hours about trial strategy and tactics instead of spending many more hours on library research to get the same answers. By tapping the internal knowledge base inside their own law firm, the core team took the more sensible, efficient approach. The senior partner's conferencing time should definitely be billable.

The bottom line is that reasonable case staffing is in the eye of the beholder. Therefore, the corporate policyholder's defense counsel will want to make sure to communicate clearly and sensibly its vision of case staffing to the court.

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Salvaging Payment *(Winning Cumis Hourly Rate Battles)*

FOCUS COLUMN

By Ken Moscaret, Esq.

You are defending one of your law firm's corporate clients in a business lawsuit in which an insurance carrier has a duty to defend the client. This is because the insurance carrier issued a reservation of rights, then agreed to let your law firm handle the defense of the corporate policyholder, instead of referring the matter to the usual panel defense counsel. The insurance carrier will pay your defense fees while reserving the right to contest coverage later on. That happens often in business litigation. So far, so good.

You wonder what hourly rate the insurance carrier is willing to pay your law firm. You're soon shocked to learn how low the proposed rate is, far below your firm's regular market rate. The question is, Do you have to accept the carrier's low rate in order to keep the case? Not necessarily.

Independent Counsel

In many instances, liability insurance carriers have to allow their corporate policyholders to retain their own independently selected defense counsel. When a carrier has a duty to defend, issues a reservation of rights, and would face a conflict if the carrier's panel counsel handled the case, Civil Code Section 2860 permits independent defense counsel to handle the case for the policyholder (dubbed *Cumis* counsel after a 1984 California appellate decision). The insurance carrier has to pay to the extent prescribed in Section 2860.

Once independent defense counsel has been authorized, the first battle is typically over the hourly rate to be paid by the insurance carrier to the

policyholder's hand-picked defense counsel. For example, large corporate policyholders are often represented in day-to-day litigation matters by major law firms with high hourly rates. Those corporate policyholders may be much more comfortable retaining their own regular outside counsel to act as independent defense counsel, because they know, trust and work with them continually. It's not that the insurance carrier's panel counsel aren't capable; it's just that familiarity takes precedence, especially in high-stakes business litigation.

Just as major law firms handling litigation matters for large corporate clients generally charge high hourly rates, panel counsel usually charge much lower rates to insurance carriers. That rate differential can amount to hundreds of dollars per hour. In a *Cumis* situation, then, somebody ends up having to absorb that differential. The question is, Who - the policyholder or the carrier? Disputes over this issue get resolved by mandatory binding arbitration under Section 2860.

The Going Rates

Today, an insurance carrier commonly pays a maximum of $250 per hour as the panel counsel partner rate for defending a lawsuit. By comparison, a big-firm litigation partner defending a corporate client in a noninsurance case might charge twice that much (or more). Under Section 2860, the insurance carrier is trying to impose the considerably lower panel counsel rate on independent defense counsel as a rate cap.

Insurance carriers don't get to impose panel counsel rates on independent defense counsel automatically, however. In a Section 2860 arbitration, insurance carriers are first required to make a specific evidentiary showing regarding their relevant panel counsel rates before that can happen. That evidentiary showing under the statute and the burden of proof that underlies it form the battleground over the rate cap issue at *Cumis* arbitration.

The carrier has the burden of proof on the rate cap. If the carrier can present sufficient evidence and meet the burden of proof, then independent

defense counsel has to accept lower panel counsel rates and look to the corporate policyholder client to pay the differential. Conversely, if the carrier falls short on the burden of proof, then the Section 2860 rate cap is avoided, and independent counsel becomes entitled to prevailing market rates from the carrier - the same rates as those charged by other local attorneys of comparable skill, experience and reputation for handling similar cases. Independent counsel has to offer expert testimony on that latter issue, just as in any other case for which a reasonable (that is, market) rate must be determined.

Section 2860(c) is the key statutory provision. It says, in relevant part, that "the insurer's obligation to pay fees to the independent counsel selected by the policyholder is limited to the rates which are actually paid by the insurer to attorneys retained by it in the ordinary course of business in the defense of similar actions in the community where the claim arose or is being defended." In my experience, this is a multipart burden of proof that forces the insurance carrier to jump through several evidentiary hoops in order to win at arbitration on the rate cap issue.

I have seen all the points of view on the Section 2860 rate cap. Over the years, I have lectured on the subject to insurance carriers, their claims staffs and their outside coverage counsel. I have advised policyholders' counsel about it. I have even trained retired judges who act as *Cumis* arbitrators about what the statutory language means. The bottom line, in my experience, is that there is more to the statutory language than meets the eye. The insurance carrier ends up having the uphill battle at arbitration. Why? Because of the burden of proof.

All business litigators understand the importance of the burden of proof, but, as a procedural issue, it can be overshadowed by the facts of the case. Litigators are trained to focus on, analyze and respond to the facts. Facts can be sexy and dramatic; the burden of proof is dull by comparison. Yet some cases are won or lost on the burden of proof alone. The Section 2860 rate cap issue is a prime example of that.

The statutory language quoted above means that the insurance carrier

has to produce enough evidence at arbitration to prove that it has a record of having hired and paid competent panel counsel to defend similar lawsuits in the same community as the current lawsuit. Sounds simple, right? But insurance carriers often fall short, for a couple of reasons.

Reasons for Failure

First, unless an insurance carrier is able to produce evidence from its claims files information from other cases regarding rates paid to panel counsel, it will not be able to demonstrate that it has a record of having hired and paid panel counsel to defend other similar lawsuits. I have seen insurance carriers try to tell an arbitrator, in effect, "This lower rate is what we would pay our own panel counsel if we had to defend such a case." Such a statement amounts to mere speculation about the future. It does not meet the carrier's burden of showing what it has done.

Second, I have seen some insurance carriers who were able to present evidence that they had paid lower rates to their panel counsel to defend other lawsuits in the same community. However, on closer inspection, those other lawsuits turned out to be too dissimilar to the current lawsuit to qualify under Section 2860. Hence, the carrier could not meet its burden of showing that it has defended similar actions before at lower panel counsel rates.

For example, defending a bodily injury/negligence lawsuit is not the same as defending a business torts lawsuit (such as under the advertising injury coverage in a commercial general liability policy). Both may be civil litigation, but they involve different factual and legal issues. It's about as similar as comparing apples and oranges. Yet I have heard insurance carriers claim at arbitration that "our personal injury panel counsel would be just as capable of defending a business lawsuit, too." Maybe so, but that's not good enough under the language of Section 2860.

Choosing an Arbitrator

All of this leads to a very important tactical consideration that the corporate policyholder's independent defense counsel must keep in mind if they find themselves headed for *Cumis* arbitration against their client's insurance carrier. Section 2860 says that any disputes regarding rates (or regarding the defense fees themselves, for that matter) must be resolved by a single arbitrator in a final, binding arbitration. Hence, the choice of arbitrator is crucial.

Corporate policyholder's counsel should select an arbitrator who (1) understands the multipart burden of proof that Section 2860 imposes on the insurance carrier in order to qualify for the rate cap and (2) strictly holds the insurance carrier to the burden in every respect. In other words, an arbitrator who has respect for the burden of proof itself from a purely procedural standpoint, no matter which party has to carry it. Not all arbitrators do.

Finally, although Section 2860 does not explicitly address it, many *Cumis* arbitrations go way beyond rate cap issues to encompass broader disputes regarding the reasonableness and necessity of independent counsel's defense billings. Many, if not most, arbitrators allow the parties to present evidence regarding the reasonableness of the hours billed, the propriety of the independent counsel's billing practices generally, the enforceability (or not) of any insurance billing guidelines, and other nuts-and-bolts fee and billing issues.

At a *Cumis* arbitration, the insurance carrier frequently presents expert testimony on all the rate and fee issues. Independent defense counsel may wish to do the same, in addition to offering fact testimony from the working attorneys on the case at their law firm.

Section 2860 was intended by the state Legislature to be a compromise statute. In return for insurance carriers giving up control of the defense in some instances, they could limit how much they paid to independent defense counsel. However, in order to avail themselves of the benefits of the statute regarding defense rates and defense fees, insurance carriers must understand fully what is expected of them at *Cumis* arbitration.

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Billing Guidelines *(How to Neutralize Insurance Billing Guidelines)*

FOCUS COLUMN

By Ken Moscaret, Esq.

The good news is that you recently acquired a new corporate client whom your law firm is defending in a lawsuit and the client's insurance policy will cover the defense fees. The bad news is that you just received the insurance company's billing guidelines, telling you what you can and cannot bill for.

Any litigator who has defended business lawsuits under an insurance policy probably has encountered insurance billing guidelines by now (they are sometimes called "litigation management guidelines"). They have become a fixture in the defense arena. All the major national insurance companies have them. Insurance billing guidelines aren't going to go away, so defense counsel need to know when they are enforceable by the insurance company, as well as under what circumstances they may be unenforceable.

Billing guidelines aren't just confined to the insurance industry. Many, perhaps most, large corporate law departments use them with their own outside counsel, as do many large governmental entities. As an attorney-fee expert witness for many years, I have encountered many sets of billing guidelines. I find the insurance variety to be more restrictive than the corporate or governmental varieties, but every version is aimed at trying to exert more power over legal billings.

Billing guidelines are a manifestation of a desire for control. When insurance companies are paying the legal bills, they (understandably) don't want to be viewed by their policyholders and defense counsel as an "open checkbook." On the other hand, policyholders want to do whatever it takes

to defeat the legal claims against them in any lawsuit they are defending, and their defense counsel want to be free to make their own subjective, professional judgments about how best to accomplish that while still getting paid. Hence, a tug-of-war ensues.

Defense law firms react differently to insurance billing guidelines, depending on their relationship with the insurance company involved. First, defense firms that customarily act as preferred "panel" counsel for insurance companies accept the fact that insurance billing guidelines are part of their contractual relationship with the insurance company, and they comply with them.

On the other hand, independent defense counsel retained directly by the policyholder, not by the insurance company, owe their first loyalty to their client. Independent counsel have no contractual relationship with the insurance company. Nevertheless, if their client is being covered under a "duty to defend" insurance policy (for example, commercial general liability policy) governed by the *Cumis* statute, Civil Code Section 2860, independent defense counsel may owe certain reporting and disclosure duties to the insurance company, whether they like it or not.

However, in a third scenario, when the insurance policy requires the policyholder to defend itself and get reimbursed for defense fees by the insurance company (such as in an "indemnity" policy), independent defense counsel selected by the policyholder may believe they owe nothing at all to the insurance company. That may not be correct. The insurance company will argue, if the indemnity policy has a "duty to cooperate" provision, that the policyholder's independent counsel cannot completely ignore the insurance company.

Thus, an inherent tension always exists between the insurance company and the policyholder's independent defense counsel. Insurance billing guidelines can bring that tension to a head. Part of the problem is that very little appellate case law in California specifically addresses insurance billing guidelines. Most such disputes never even reach the appellate courts. Fee disputes under Civil Code Section 2860 frequently encompass disputes

over insurance billing guidelines but always are decided by nonappealable mandatory binding arbitration under the statute.

The one California appellate case that is usually cited, *Dynamic Concepts v. Truck Insurance Exchange*, 61 Cal.App.4th 999 (1998), says in a dictum footnote that "insurer-imposed restrictions [for example, in billing guidelines] on discovery or other litigation costs may well violate the insurer's duty to defend as well as the attorneys' ethical responsibilities to exercise their independent professional judgment in rendering legal services." However, the court found that the insurance company had not actually restricted defense counsel in that case.

Given the lack of case authority on this subject, I fall back on my own practical experiences when I encounter a set of insurance billing guidelines. If I happen to be a fee expert on the corporate-policyholder side of an insurance-coverage/bad-faith lawsuit or a *Cumis* arbitration, I look for certain factors to assess whether the billing guidelines will be enforceable at trial or arbitration.

First, insurance billing guidelines should not be enforceable unless and until the independent defense counsel has received a copy of them from the insurance company, which constitutes "actual notice" of the guidelines. Billing guidelines to the independent defense counsel do not always happen in a timely fashion. Thus, if an insurance company's claims department forgets to send out its billing guidelines to independent defense counsel at the beginning of the lawsuit (when they are supposed to), the insurance company should not be allowed to enforce the billing guidelines retroactively later on. That's just basic fairness. I testified before an arbitration panel once that did not enforce insurance billing guidelines before the actual notice date.

Second, despite the independent defense counsel's not having a regular working relationship with the insurance company, they should try to communicate periodically with them about the case. Insurance billing guidelines typically require some reporting. Regardless, the independent defense counsel try to keep the insurance company periodically apprised of

case progress, so long as the former is looking to the latter to pay the legal bills.

I testified in a case in which arbitrators admonished the independent defense counsel for not communicating at all with the insurance company, even when the policyholder was defending itself under an indemnity policy that gave the company no right to control the defense. Experienced arbitrators recognize a distinction between "communication" and "control." Independent defense counsel that exhibit a "stick-it" attitude toward the insurance company that is paying the legal bills will not win over arbitrators. Arbitrators will be impressed, on the other hand, when the independent defense counsel at least can show that they made an effort to meet the insurance company halfway.

Third, I have seen independent defense counsel become frustrated, even "handcuffed" in their defense efforts, by insurance company claims that staff do not respond to their requests in a timely fashion. Insurance billing guidelines typically require that even independent defense counsel seek prior approval for certain defense expenditures; otherwise, they run the risk of not getting paid. However, those same guidelines typically don't say how quickly the insurance company must respond to the independent defense counsel's requests.

Anyone who has dealt with insurance companies knows that staff turnover in the claims department is fairly common, because insurance companies constantly try to streamline their claims operations to cut costs and make them more efficient. Thus, it's not rare for independent defense counsel who have taken the time to develop a good working relationship with one claims person to have to start over from scratch dealing with a new one. In fact, insurance-claims staff turnover may occur more than once on the same case. This is very aggravating for the defense counsel.

If insurance billing guidelines expressly say that independent defense counsel must get prior approval for certain expenditures, then insurance billing guidelines also can and should be interpreted by judges and arbitrators to require that insurance-claims staff must respond in a timely

fashion to the independent defense counsel's requests or be deemed to have waived any objections.

Judges and arbitrators might consider that a fair trade-off. If the independent defense counsel is trying to meet the insurance company halfway, then insurance-company claims staff has no reason not to respond within 48 hours, especially if the request is urgent. I once saw a situation where counsel was preparing for trial, attempting to communicate with the claims person whom they had dealt with on the case for a year, received no response to their requests for several weeks, then finally learned that the claims person had left the insurance company. The lawyer was the last to find out.

Insurance companies should take a lesson from some of the law firms that work for them. Many law firms expect their attorneys to return client telephone calls no later than the next business day. Law-firm attorneys are very busy people, handling many cases, yet they have to make time to respond to their clients' inquiries. Policyholders are like clients to insurance companies. Insurance claims people may be very busy, too, but if they don't make responding to an independent defense counsel's requests a priority, they should forfeit any objections later on; otherwise, the policyholder's defense in the case could be prejudiced by delays in decision making.

Fourth and finally, insurance billing guidelines can and should be interpreted by judges and arbitrators to say that the insurance company cannot unreasonably withhold consent to independent defense counsel's requests. In my experience, insurance billing guidelines typically do not include such language. Such a provision might give insurance-claims staff pause before saying "no" when an independent defense counsel presents a strong argument for approval. I have seen disputes arise because a claims person did not possess a sufficient litigation background to appreciate an independent defense counsel's requests, especially in large, complex lawsuits to be tried to a jury. Hence, they simply refused the independent defense counsel's requests in a knee-jerk fashion based solely on cost,

without really understanding the litigation strategy behind the request. That could prejudice the insured's defense at trial, as well as frustrate the independent defense counsel.

Because insurance billing guidelines are here to stay, they should be enforceable only to the extent that they are not too one-sided or restrictive. At the same time, independent defense counsel should recognize that, regardless of what they may think of those billing guidelines or insurance companies themselves, communicating (at least to some extent) with the insurance company works to their advantage, come trial or arbitration.

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