RECENT DEVELOPMENTS IN INSURANCE COVERAGE

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I. INTRODUCTION

Damian J. Arguello

In this update, the ICLC committee covers a lot of ground, from insurance coverage for mass shootings, consent to settle clauses and the bad faith implications for an insurer, the application of the notice/prejudice rule in California to choice of law and consent to settle provisions, and whether interstate compacts might streamline the delivery of insurance products much needed by consumers or allow insurers to sidestep the state regulatory process to the detriment of consumers.

II. MASS SHOOTINGS AND INSURANCE COVERAGE

William Reed and Christopher Mosley

A. *Introduction*

In the month of August 2019 alone, at least 53 people died in mass shootings in the United States, including a massacre in a Walmart in El Paso, Texas, an indiscriminate shooting rampage at passing cars in Odessa, Texas, and gunfire in a busy entertainment district in Dayton, Ohio.[1] Although there is no settled legal definition for "mass shooting," using the most inclusive definition (at least four victims injured in any setting), the Gun Violence Archive reports 417 mass shooting events in 2019.[2]

Traditionally, insurance coverage did not intersect heavily with gun ownership and mass shootings. The rarity of these events, laws limiting liability, and exclusions to preclude such coverage combined to allow insurers to take a hands-off approach to mass shooting risks. But with the increased number of mass shooting events in recent years, significant damages, a changing liability landscape, and new coverages, insurers and policyholders are squarely addressing such risks.

The stakes are high and getting higher for insurers and policyholders. The 2007 Virginia Tech shooting led to an estimated $48.2 million in

1. Neil Vigdor, *53 People Died in Mass Shootings in August Alone in the U.S.*, N.Y. Times, Aug. 31, 2019, https://www.nytimes.com/2019/08/31/us/us-mass-shootings.html.

2. Mass Shootings in 2019, https://www.gunviolencearchive.org/reports/mass-shooting?year=2019.

litigation and recovery costs.[3] On October 3, 2019, news outlets reported that the Las Vegas shooting resulted in a settlement in which MGM Resorts International agreed to pay victims up to $800 million.[4]

Regardless of where they occur, mass shootings may result in a wide range of damages, losses, and expenses both to victims and to impacted businesses. The risk lies at the intersection of the scope of liability, coverage for liability, and coverage for direct damages. This article surveys recent developments in case law and expanding insurance coverage options.

B. *Insurance Response to Mass Shootings*

1. Scope of Liability

While the perpetrators of mass shootings are liable to victims, they typically do not offer a source of recovery. That often leaves victims to look to businesses connected to the crime in some way for recovery, such as the gun manufacturer, a security company, or the place where the shooting occurred. In the past, the risk of liability for these businesses was low. But that is changing as mass shootings arguably become a more foreseeable risk.

The landscape is changing for businesses that become the venue of a shooting. In most jurisdictions, a business owner is not liable to a person injured by the criminal acts of a third party unless the criminal act was foreseeable.[5] Traditionally, courts found the threat posed by mass shooters to be so unexpected and remote that, as a matter of law, no rational juror could find that a landowner should have foreseen or known about it.[6]

As mass shooting incidents become more commonplace, the assessment of foreseeability and causation has begun to shift. In 2019, a Colorado court made an analytical leap and concluded that a mass shooting was not unforeseeable as a matter of law and that the business owner's negligence could have been a substantial factor in causing the harm, which opened the door to premises liability.[7] The case stemmed from a shooting spree at a Planned Parenthood location in Colorado Springs. The court concluded the risk was not unknown as a matter of law because, among other reasons, the number of threats against abortion providers, active shooter trainings, and staff con-

3. Paul Marshall, *Insurance Coverage for Active Shooter Risks*, Risk Mgmt., Sept. 4, 2018, http://www.rmmagazine.com/2018/09/04/insurance-coverage-for-active-shooter-risks.

4. *See, e.g.*, Khristopher J. Brooks, *MGM Settles Las Vegas Shooting Case for as Much as $800 Million*, CBSNews.com, Oct. 3, 2019, https://www.cbsnews.com/news/las-vegas-shooting-settlement-mgm-settles-las-vegas-shooting-case-for-735-million-to-800-million.

5. Restatement (Second) of Torts § 344, cmt. f (Am. Law Inst. 1965).

6. *See* Lopez v. McDonald's Corp., 238 Cal. Rptr. 436, 441 (Ct. App. 1987) (describing a mass shooting as a "once-in-a-lifetime" event).

7. Wagner v. Planned Parenthood Fed'n of Am., Inc., 2019 WL 989316, ¶ 43 (Colo. Ct. App. Feb. 21, 2019), *cert. granted in part sub nom.* Rocky Mountain Planned Parenthood, Inc. v. Wagner, 2019 WL 4263833 (Colo. Sept. 9, 2019).

cerns about the lack of security.[8] On a related causation question, the court concluded that the lower court erred in ruling that the shooter's actions has such a predominant effect in causing the harm that they eliminated as a matter of law the possibility that the business owner's alleged negligence was a substantial factor in causing the harm.[9] The dissent disagreed, noting that after the 2012 Aurora theater shooting, courts found the shooter's actions were the predominant cause of the plaintiff's injuries, which negated the causation element of a negligence claim against others.[10] The Colorado Supreme Court granted certiorari on the question of whether a mass shooter "is necessarily the predominant cause of harm to the victims of his attack."[11]

Faced with increasing likelihood of liability, business owners are exploring avenues of immunity from claims resulting from mass shooting incidents. Gun manufacturers have enjoyed immunity from such suits since Congress's 2005 enactment of the Protection of Lawful Commerce in Arms Act ("PLCAA"), which provided that manufacturers and sellers of firearms and ammunition "are not, and should not, be liable for the harm caused by those who criminally or unlawfully misuse firearm products ... that function as designed and intended."[12] Absent a statutory violation in the sale or marketing of a gun, the PLCAA has proved to be an effective firewall against liability. Most recently, in *Prescott v. Slide Fire Solutions, LP*, a case arising out the 2017 Las Vegas shooting, the court found that PLCAA immunity extended to the manufacturer of the bump stocks used by the shooter to increase the fire rate and the resulting harm inflicted on the victims.[13]

MGM resort, the site of the shooting, also claimed immunity, albeit under a different law. Taking the unusual step of filing a declaratory judgment action against the shooting victims, MGM sought protection under the Support Anti-Terrorism by Fostering Effective Technologies (SAFETY) Act.[14] Enacted as part of the Homeland Security of 2002, Public Law 107-296, the SAFETY Act[15] was intended to ensure that companies would not let the considerable liability risks associated with a potential terrorist attack

8. *Id.* ¶ 40.
9. *Id.* ¶ 43.
10. *Id.* ¶ 57 (citing Nowlan v. Cinemark Holdings, Inc., 2016 WL 4092468, at *3 (D. Colo. June 24, 2016), and Phillips v. Lucky Gunner, LLC, 84 F. Supp. 3d 1216, 1228 (D. Colo. 2015)). It is noteworthy that another decision stemming from the Aurora theater shooting reflected a shift in thinking on the foreseeability question since the 1980s *Lopez* case: "what was 'so unlikely to occur within the setting of modern life' as to be unforeseeable in 1984 was not necessarily so unlikely by 2012." Axelrod v. Cinemark Holdings, Inc., 65 F. Supp. 3d 1093, 1099 (D. Colo. 2014) (citing *Lopez*, 238 Cal. Rptr. at 441).
11. *Rocky Mountain Planned Parenthood*, 2019 WL 4263833.
12. 15 U.S.C. § 7901(a)(5).
13. 341 F. Supp. 3d 1175, 1191 (D. Nev. 2018).
14. MGM Resorts Int'l v. Acosta, No. 2:18-cv-01288 (D. Nev. July 13, 2018), https://media.lasvegasnow.com/nxsglobal/lasvegasnow/document_dev/2018/07/16/MGM%20Lawsuit_1531784831785_48790338_ver1.0.pdf.
15. 6 U.S.C. §§ 441–444.

deter them from creating or using technologies that could help protect the public, and immunizes certified businesses from claims arising out of an act of terrorism when SAFETY Act covered technologies have been deployed. After a public relations backlash, MGM opted for mediation and ultimately settled the case, leaving unanswered whether the SAFETY Act would apply to the venue of a mass shooter scenario.

2. Existing Coverage Under Liability Policies

Residential, umbrella, and commercial liability policies contain familiar limitations that often preclude coverage for a shooting. The limitations appearing most commonly in the case law are: (1) exclusions for intentional harm[16]; (2) criminal act exclusions[17]; and (3) assault and battery exclusions.

The assault and battery exclusion is less common in liability policies and has produced recent decisions. In *Nautilus Insurance Co. v. EJIII Development Co.*,[18] the court analyzed insurance coverage for a shooting that occurred at a Waffle House. The policy contained an assault and battery exclusion applicable to bodily injury arising out of "[a]ctual or alleged assault or battery," "[p]hysical altercation" or "[a]ny act or omission in connection with the prevention or suppression of such acts, including the failure to provide adequate security."[19] The court found that it was "clear" that the suit was the result of an alleged assault and battery or physical altercation, holding that the exclusion unambiguously applied and rejecting the policyholder's argument that the exclusion was inapplicable to a "professional liability" coverage extension.[20]

3. Existing and Developing Coverage for Direct Damages

Apart from the individual victims of mass shooting events, the commercial or public settings of many of these events suffer distinct and direct damages. For these types of damages, an organization may look for coverage in policies for commercial property, business interruption, workers' compensation, or even directors and officers.

16. In mass shooting situations, courts generally do not hesitate to find intent to injure from the insured assailant's actions and deny coverage on that basis. Donegal Mut. Ins. Co. v. Baumhammers, 938 A.2d 286 (Pa. 2007) (finding no coverage for insured who went on two hour shooting spree, killing 5 people in three different townships); *see also* Steven Plitt et al., Couch on Insurance § 101:22 (3d ed. 2006) ("In general, it is against public policy for an insurance contract to provide coverage for the intentional or willful misconduct of an insured."). But courts typically find that intent is not imputed to innocent insureds. *See* Nationwide Mut. Fire Ins. Co. v. Pipher, 140 F.3d 222, 225–26 (3d Cir. 1998).

17. Injury resulting from a criminal act invokes the criminal act exclusion and precludes coverage as a matter of law. Liebenstein v. Allstate Ins. Co., 517 N.W.2d 73, 75 (Minn. Ct. App. 1994).

18. 2018 WL 3524639 (N.D. Ga. July 19, 2018).

19. *Id.* at *1.

20. *Id.* at *3.

A burgeoning area of coverage is specific protection for mass shooting events, in specialized policies or endorsements that often combine elements of traditional liability and property coverage. Traditional policies were not designed with the particular circumstance of a mass shooting event in mind. Invariably there are gaps even after combining coverages for liability, property, business interruption, and workers' compensation. That has led to specially designed named-perils policies for mass shooting events that straddle the traditional divide between first party and third party coverage. One underwriter has noted that demand for Deadly Weapon Protection policies doubled from 2017 to 2018.[21]

Some damages suffered by these organizations are direct and straightforward, such as a property damaged by gunfire. Other damages present more nuanced coverage questions. One site of a shooting event recovered (through litigation against its security company's insurer) on a theory of the loss of use of the property as a nightclub due to the revocation of its liquor license following a shooting.[22] Categories of damages insureds have suffered also include clean-up and other extra expense, costs of additional security and security upgrades, crisis management costs, business interruption and event cancellation losses, workers' compensation claims, medical costs, mental health counseling fees, and funeral expenses.[23] Three issues that arise frequently—preventative risk assessment, replacement of buildings, and upgraded security systems—present difficult insurance coverage issues.

Preventative risk assessment:

> By its nature, most insurance coverage is reactive. But, unlike an earthquake or a hurricane, a mass shooting event is a man-made disaster and steps can be taken to reduce the likelihood it will occur. Coverage for risk assessment and training is not available under most traditional commercial property or business interruption policies.
>
> Perhaps that is why coverage for prevention is quickly becoming one of the hallmarks of mass shooting event policies. ... After the Parkland attack, Florida's Palm Beach County School District acquired active shooter coverage specifically because it wanted the risk assessment and training service, according to Dianne Howard, the district's director of risk and benefits management.[24]

21. Graham Buck, *How Risk Management Pros Are Working to Stop the Next Mass Shooter*, Risk & Ins., Oct. 15, 2018, http://riskandinsurance.com/removing-the-target-for-mass-shooters (Beazley underwriter reporting that the number of clients buying Deadly Weapon Protection policies has more than doubled).

22. Thee Sombrero, Inc. v. Scottsdale Ins. Co., 239 Cal. Rptr. 3d 416, 422 (Ct. App. 2018).

23. *See, e.g.*, *The Insurance Coverage Aftermath of Mass Shooting Events*, In-House Def. Q. 58, Fall 2016 (noting possible workers comp claims, business interruption, property damage, and business interruption for nearby businesses).

24. *Mass Shootings*, *supra* note 1, at 22 (citing Jonathan Berr, *Schools Are Now Buying Insurance Against Mass Shootings*, CBSNews.com, June 8, 2018, https://www.cbsnews.com/news/schools-are-now-buying-insurance-against-mass-shootings).

Replacement of facilities:

> Although mass shooting events typically do not destroy buildings, the tragedies that unfolded within often do destroy the value of those facilities for the survivors and the community. ... [M]any of the communities in which these tragedies occur have decided it is worth the investment to demolish or renovate the building where the attack happened. Whether characterized as stigma damage or property damage (loss of use), it is difficult to find coverage for replacement of a building for primarily emotional reasons. Not even active shooter policies would typically cover this cost.[25]

Communities such as Newtown, Connecticut and Parkland, Florida have replaced buildings with taxpayer funds.[26] "Yet, determined risk managers are working with insurers to develop new products that at least offer matching funds for the cost of rebuild triggered by 'emotional duress.'"[27]

Upgraded security systems:

> Another expense that has fallen on the locations where shootings occur (or locations taking preventative measures) is the cost of upgrading security systems.[28] Understandably, risk managers want to do everything possible to decrease the chances of another mass shooting event. But upgrading security is a category of expense that does not typically fall within traditional property coverage. First, the security system itself may not have been damaged in the attack; rather than being destroyed, it is deemed to be insufficient. Second, even if the security system is damaged, most property policies are designed to replace damaged property with new property of similar quality. A substantially upgraded system may fall outside this coverage and be characterized as a betterment rather than a reasonable replacement.[29]

This area of coverage is contemplated in some active shooter policies that provide protection and help for preventative measures.

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25. *Id.* (citing Autumn Heisler, *When the Emotional Toll of a Mass Shooting Requires a Building to Be Torn Down, How Can Risk Managers Foot the Bill?*, Risk & Insurance, Sept. 28, 2018, http://riskandinsurance.com/after-a-mass-shooting-what-happens-to-the-building/ ("A typical active shooter policy would be focused on medical expenses, funeral costs, public relations firms, security firms and the like. It would not cover the demolition or rebuild of the building.").

26. Berr, *supra* note 24.

27. *Mass Shootings*, *supra* note 1, at 23 (citing Autumn Heisler, *When the Emotional Toll of a Mass Shooting Requires a Building to Be Torn Down, How Can Risk Managers Foot the Bill?*, Risk & Insurance, Sept. 28, 2018, http://riskandinsurance.com/after-a-mass-shooting-what-happens-to-the-building).

28. *Mass Shootings*, *supra* note 1, at 23 (citing *Facing Litigation, Organizations Buy into Active Shooter Insurance*, Security Mag. (Dec. 3, 2018) https://www.securitymagazine.com/blogs/14-security-blog/post/89648-facing-litigation-organizations-buy-into-active-shooter-insurance).

29. *Id.*

C. *Conclusion*

In the past year, the risk of liability for organizations connected to a mass shooting has expanded as the sadly common events are seen as more foreseeable, and attempts to immunize businesses other than gun manufacturers have not yet succeeded. Common exclusions in liability policies typically preclude coverage and traditional property policies are not designed to handle all the types of damages implicated. The risk of liability to victims, as well as the growing direct and indirect costs of mass shooting events, have led to increased demand for specialized mass shooting policies that combine elements of traditional liability and property policies.

III. BAD FAITH LAW

Laura Meyer Gregory

A. *Is an Insurer in Bad Faith When It Did Not Settle a Claim Against Its Insured, Because Its Policy Required the Insured to Consent to the Settlement and He Would Not?*

Massachusetts' highest court has decided that an insurer did not violate Massachusetts statutes requiring insurers to settle claims in which liability has become reasonably clear, when it did not settle a claim because its policy required the insured's consent to settle a claim and the insured refused to provide that consent.[30] Specifically, the Court considered whether an insurer's failure to settle a claim due to the insured's refusal to consent to the settlement violated the statute requiring an insurer to "to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear" and whether such consent-to-settle provisions are against public policy.[31]

The Massachusetts Supreme Judicial Court took this case from the Appeals Court *sua sponte* and solicited amicus briefs regarding the following:

> Whether a liability insurer violated its duty, under G. L. c. 176D, § 3 (9) (f), to effectuate a prompt, fair, and equitable settlement of a claim in which liability had become reasonably clear, where the insured refused to consent to a settlement and the insurance policy provided that the insurer would not settle any claim without the informed consent of the insured; whether such a provision is unenforceable as against public policy.[32]

Five Amici Curiae briefs were filed.[33]

30. Rawan v. Cont'l Cas. Co., 136 N.E.3d 327 (Mass. 2019).
31. Mass. Gen. Laws ch. 176D, § 3(9)(f).
32. Docket at #2, *Rawan*, No. SJC-12691 (Feb. 15, 2019).
33. Amici Curiae briefs were filed on behalf of the American Council of Engineering Companies of Massachusetts, the Massachusetts Chapter of the American Institutes of Architects,

This case arose out of the insured's structural engineering work for the plaintiffs in the design and construction of their residence.[34] The homeowners sued the insured engineer for negligence, breach of contract, and violation of Massachusetts Unfair Trade Practices statute, M.G.L. c. 93A.[35] The insurance policy issued to the engineer provided that the insurer would "not settle any claim without the informed consent" of the engineer.[36]

After two settlement offers were rejected, the insured engineer refused to settle, instead seeking to go to trial.[37] Ultimately, the jury found against the insured and awarded $400,000 to the plaintiffs and also issued an "advisory verdict" finding the engineer had committed unfair business practices and awarding an additional $20,000 in damages, which the court later increased to $40,000 based on its determination that the insured had acted either knowingly or recklessly.[38] The judgment was paid in full, with the insurer paying its policy limits (reduced by defense costs) and the insured paying the remainder.[39]

The plaintiffs alleged bad faith by Continental Casualty Company ("Continental"), the insurer of the engineer, claiming violation of the Massachusetts Unfair Claims Settlement Practices Act by "[f]ailing to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear."[40]

The trial court found in the insurer's favor, on summary judgment.[41] The Court determined that Continental counseled the insured engineer that the claims against him had substantial merit and that a judgment in excess of the policy limits could result, but the insured steadfastly refused to agree to increase the offer over the $100,000 that had been offered and rejected twice previously and refused any further settlement negotiations.[42] In these circumstances, the trial court concluded that "Continental's hands were tied, and it was legally precluded from making other efforts to settle the case. Accordingly, Continental cannot be found liable for violating c. 176D [the Unfair Claims Practices Act], and, by extension, c. 93A [the Unfair

the Professional Liability Foundation Ltd., the Boston Bar Association, the American Property and Casualty Insurance Association, Medical Professional Liability Association, the Massachusetts Insurance Federation, and the Massachusetts Defense Lawyers Association.

34. *Rawan*, 136 N.E.3d at 330.
35. *Id.*
36. *Id.*
37. *Id.*
38. *Id.* at 334.
39. *Id.*
40. Mass. Gen. Laws ch. 176D, § 3(9)(f).
41. *Rawan*, 136 N.E.3d at 330.
42. Brief of Appellants, Douglas M. Rawan & Kristen Rawan, at ADD. 2–3, https://www.ma-appellatecourts.org/pdf/SJC-12691/SJC-12691_01_Appellant_Rawan_Brief.pdf.

Trade Practices Act], because it engaged in all the settlement practiced which its insured … authorized."[43]

This case appears to be the first case to address whether an insurer's failure to settle a claim due to its compliance with the provision in the insurance contract requiring the insured's consent-to-settle a claim violates public policy or is an unfair claims practice. Such consent-to-settle provisions are common in professional liability, employment practices liability, and directors' and officers' policies.[44] And, like Massachusetts, the majority of states have enacted some form of the model Unfair Claims Settlement Practices Act promulgated by the National Association of Insurance Commissioners.[45]

The plaintiffs' counsel argued to the Massachusetts Supreme Judicial Court that these consent-to-settle clauses are against public policy.[46] Specifically, plaintiffs claimed that the statute requiring an insurer to "effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear," is violated by a consent-to-settle clause.[47]

Such consent-to-settle clauses are not new, having been present in case law in Massachusetts going back nearly forty years.[48] A typical clause requiring that the insured consent in order for a settlement funded by the insurer to occur provides that the insurer "shall . . . not settle any claim without the written consent of the named insured which consent shall not be unreasonably withheld."[49] The consent-to-settle clause in *Rawan* did not include a reasonableness component. Additionally, the *Rawan* policy did not include a so-called "hammer clause," which is included in most policies that contain consent-to-settle clauses. The hammer clause limits the insurer's risk and requires the insured to bear at least a portion of the risk of a judgment against the insured in excess of the amount that the case could have settled for had the insured provided consent. The hammer clause at issue in *Freedman* was:

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43. *Id.*

44. *See*, *e.g.*, Clauson v. New England Ins. Co., 83 F. Supp. 2d 278, 281 (D.R.I. 2000). In *Clauson*, the court recognized that most legal malpractice policies contain clauses requiring the insured's consent in order for the insurer to settle. It stated that these clauses "are included in professional liability policies in recognition of the fact that settlement of claims may adversely and unjustifiably affect the insured's professional reputation." *Id.* (citing R. Long, Law of Liability Insurance, § 12C.08[8] (1998)).

45. *See* Unfair Claims Settlement Practices Act, § 4D (NAIC 1997), https://www.naic.org/store/free/MDL-900.pdf ("Not attempting in good faith to effectuate prompt, fair and equitable settlement of claims submitted in which liability has become reasonably clear" it is an unfair claim practice).

46. *Rawan*, 136 N.E.3d at 337.

47. *Id.*

48. *See*, *e.g.*, Van Dyke v. St. Paul Fire & Marine Ins. Co., 448 N.E.2d 357 (Mass. 1983); Mut. Ins. Co. v. Murphy, 630 F. Supp. 2d 158, 170 (D. Mass. 2009); *see also* 14 Steven Plitt et al., Couch on Insurance § 203:10 (2019 supp.) and cases cited therein.

49. Freedman v. United Nat'l Ins. Co., 2011 WL 781919, at *1 (C.D. Cal. Mar. 1, 2011).

> If however, the named insured refuses to consent to a settlement recommended by [Insurer] and elects to contest the claim or continue legal proceedings in connection with such claim, [Insurer's] liability for the claim shall not exceed the amount for which the claim could have been settled, including claims expenses up to the date of such refusal, or the applicable limits of liability, whichever is less.[50]

A similar clause was noted as "standard" for professional liability policies by the court in *Transit Casualty Co. v. Spink Corp*.[51] The court in *Security Insurance Co. of Hartford v. Schipporeit, Inc.*,[52] discussed the application of a hammer clause stating:

> If an insured is presented with an opportunity to dispose of a claim and the insurer recommends that the claim be resolved, the insured may refuse to accept the insurer's recommendation only at his peril. The risk of loss over and above the proposed settlement passes to the insured. But the term "settlement" in this provision makes sense only if it means a full and final disposition of a claim, and that assumes that a release of liability will be issued.[53]

The policy at issue in *Rawan* does not include a hammer clause. The Rawans argued that the consent-to-settle clause without a "hammer" clause defeats the letter and spirit of Massachusetts Unfair Claims Practices Act[54] and therefor violates public policy. The Rawans suggested that it would not be violative of public policy if the consent-to-settle clause was accompanied by a hammer clause, a mandatory arbitration clause, or other process to address a disagreement between insurer and insured regarding settlement.[55]

As noted above, consent-to-settle clauses are common in professional liability policies. Further, as noted by the *Rawan* amici, the ability of an insured to obtain a policy that allows them to control settlement can be determinative of whether they obtain insurance, if they are not obligated to purchase insurance, and certainly will impact on future insurance rates, available public information, and potentially on their professional reputation.[56] For example, provisions allowing the insured to control settlement were not allowed in Florida medical malpractice policies until the law was

50. *Id.*
51. 156 Cal. Rptr. 360, 363 (Ct. App. 1979) (disapproved of on other grounds by Commercial Union Assurance Companies v. Safeway Stores, Inc., 164 Cal. Rptr. 709 (Ct. App. 1980)).
52. 69 F.3d 1377, 1383 (7th Cir. 1995).
53. *Id.*
54. Brief of Appellants, *supra* note 42, at 32.
55. *Id.*
56. *See* Brief of Amici Curiae American Property and Casualty Insurance Association, Medical Professional Liability Association, and Massachusetts Insurance Federation at 18–20, https://www.ma-appellatecourts.org/pdf/SJC-12691/SJC-12691_19_Amicus_American_Property_and_Casualty_Brief.pdf.

changed in 2011.[57] Prior to that time many doctors chose not to obtain malpractice coverage, with one of the reasons cited being insurers settling cases that the doctor believed were frivolous.[58] Further, prior to the revision of the law, the *Florida Bar Journal* outlined the following potential impacts of the "settlement of a medical malpractice case on a physician's livelihood and reputation, including (1) future insurance rates, (2) insurability, (3) the possibility of a 'strike,' (4) the potential for excess exposure, (5) reports to the administrative agencies, and (6) the potential for adverse publicity."[59]

On December 16, 2019, the Massachusetts Supreme Judicial Court issued a decision upholding consent-to-settle provisions requiring the insured's consent in order to settle a case against them, finding that such provisions are not against Massachusetts public policy.[60]

> A consent-to-settle provision in an insurance policy does not violate an insurer's duty to effectuate a prompt, fair, and equitable settlement under G.L. c. 176D, § 3(9) (f). However, a consent-to-settle provision is not a carte blanche for an insurer to engage in unfair or deceptive conduct with a third-party claimant merely because the insured declines to reach a settlement. An insurer still owes a duty to conduct a reasonable investigation and engage in good faith settlement attempts consistent with its duty to both its insured and the claimant.[61]

The Court outlined several bases for its decision, including: (1) professional liability policy are voluntary, not mandatory; (2) professional liability policies with consent to settle clauses predate the Massachusetts Unfair Claims Practices Act (G.L. c. 176D) and its revision to allow third parties to bring suit against insurers for violation of the act; and (3) consent-to-settle clauses serve valuable purposes—protecting professional's reputation and good will and encouraging professionals to purchase insurance, thereby creating more funding for third-party claims.

The Court further rejected the claimant's argument that consent-to-settle clauses should only be allowed when paired with hammer clauses, stating that there was not a specific legislative mandate to do so and without such a mandate the Court would not redraft voluntary insurance policies.[62] Further, the Court acknowledged that "The hammer clause also will diminish the incentive professionals have to purchase this voluntary

57. Fla. Stat. §627.4147.

58. Bob LaMendola, *Uninsured Doctors on Rise in S. Florida*, S. Fla. Sun Sentinel (July 27, 2008), https://www.sun-sentinel.com/news/fl-xpm-2008-07-27-0807260139-story.html.

59. Robert L. Rubin, *Legal, Practical, and Ethical Considerations of Medical Malpractice Settlements*, Fla. Bar J., Jan. 2009, https://www.floridabar.org/the-florida-bar-journal/legal-practical-and-ethical-considerations-of-medical-malpractice-settlements.

60. Rawan v. Cont'l Cas. Co., 136 N.E.3d 327, 327 (Mass. 2019).

61. *Id.* at 343.

62. *Id.* at 341 n.7.

insurance, which … serves a valuable purpose: it benefits third parties by providing deeper pockets for recovery."[63]

The court went on to hold that the existence of a consent-to-settle clause did not eliminate the insurer's obligations to act in good faith towards both its insured and the third-party claimant, stating:

> [t]he determination whether an insurer has complied with its dual obligations, despite the existence of a consent-to-settle clause, is a factual one to be measured in terms of the insurer's good faith efforts and transparency toward both its insured and a third-party claimant. These efforts would include a thorough investigation of the facts, a careful attempt to determine the value of a claim, good faith efforts to convince the insured to settle for such an amount, and the absence of misleading, improper, or 'extortionate' conduct towards the third-party claimant.[64]

Whether state law allows a plaintiff/claimant to bring a claim directly against the insurer for bad faith on a third party claim will greatly impact on the application of bad faith law in the context of consent-to-settle clauses. Massachusetts law provides for a direct cause of action by a claimant/plaintiff against an insurer for failing to settle a claim, but other states do not. Further, some jurisdictions and courts emphasize protecting insureds, while others emphasize protecting innocent third parties. It will be interesting to see whether other states follow the lead of the Massachusetts Supreme Judicial Court and rule that a policyholder's refusal to settle pursuant to a policy with a consent-to-settle clause offers the insurer some shelter from application of the Unfair Claims Handling Practices Act.

IV. CHOICE OF LAW

Timothy M. Thornton, Jr.

A. *California Finds Notice-Prejudice Rule Is a Fundamental Public Policy for Choice of Law Analysis*

In *Pitzer College v. Indiana Harbor Insurance Co.*,[65] the California Supreme Court answered certified questions from the Ninth Circuit regarding choice of law and California's late notice prejudice rule. It held that the notice-prejudice rule was a fundamental public policy for analysis of choice of law provisions.[66] And it further held that the notice prejudice rule applies to a consent to payment provision in first party coverage.[67] But it also held

63. *Id.*
64. *Id.* at 341 (citations omitted).
65. 447 P.3d 669 (Cal. 2019).
66. *Id.* at 676.
67. *Id.* at 679.

that the notice prejudice rule did not apply to a consent to payment provision in third party coverage.[68]

In *Pitzer* the insured college discovered darkened soil during construction of a new dormitory.[69] It determined that environmental remediation would be required.[70] The college was concerned about completing the construction of the dormitory before the beginning of the following academic year.[71] It conferred with experts to determine the least expensive and most expeditious option to remediate the site.[72]

The college gave notice to the insurer three months after it completed remediation and six months after discovery of the darkened dirt.[73] The insurer denied coverage eight months after that for failure to given notice as soon as practicable and failure to obtain consent before beginning the remediation process. [74]

The insurance policy was described as a pollution remediation policy. The policy agreed to pay on behalf of the insured for "remediation expense" and related "legal expense" resulting from any "pollution condition" at a "covered location" for "a claim first made against the insured during the policy which the insured has or will become legally obligated to pay," or "that is first discovered during the policy period" and reported to the insurer.[75] The court outlined three pertinent provisions for its analysis. First a notice provision that required the college to give notice of any pollution condition as soon as practicable.[76] Second a consent provision that required the college to obtain the insurer's written consent before incurring expenses, making payments, assuming obligations or beginning remediation.[77] Third, a choice of law provision stipulated the New York law governed all matters arising under the policy.[78]

The college sued the insurer for declaratory relief and breach of contract. The federal district court granted summary judgment to the insurer.[79] The college appealed to the Ninth Circuit. The Ninth Circuit certified questions to the California Supreme Court.[80]

The court first addressed the choice of law issue. California applies *Restatement of Conflict of Laws*, Second, section 187 in determining the

68. *Id.*
69. *Id.* at 672.
70. *Id.*
71. *Id.*
72. *Id.*
73. *Id.*
74. *Id.*
75. *Id.* at 679.
76. *Id.* at 671.
77. *Id.*
78. *Id.*
79. *Id.* at 672–73.
80. *Id.* at 673.

enforceability of contractual choice of law provisions. Under section 187 a choice of law provision, such as that found in the insurance contract at issue, applied unless (1) it conflicts with a state's fundamental public policy, and (2) that state has a materially greater interest in determining the issue than the state stipulated in the choice of law provision.[81]

Under the second part of this test, the court must determine if the state designated in the choice of law provision has a substantial relationship to the parties or their transaction; or if there is any other reasonable basis for the parties' choice of law.[82] If the answer to these two inquiries is in the negative, the court will not enforce the provision. But if the answer to either of these inquiries is positive, the court must then determine if California has a "materially greater interest" than the designated state in determining the issue. If the answer to that inquiry is yes, then the choice of law will not be enforced.[83]

Since the parties agreed that there was a reasonable basis to select New York law, the court turned to the second question—that is, whether California's notice-prejudice rule is a "fundamental" public policy.[84] The court previously had stated that the notice-prejudice rule was the public policy of the state but had never stated it was a "fundamental" public policy.[85]

First the court defined a "fundamental" public policy. Such a policy need not be established by a statute, or constitution or principle of contractual unconscionability. The court stated its goal in this analysis as protecting those with inferior bargaining power in the insurance contract. "A policy such as the notice-prejudice rule may be considered fundamental because it is connected to fundamental fairness in the negotiation process."[86] The court identified three essential reasons for this rule: (1) the adhesive nature of insurance contracts; (2) the public policy objective of compensating tort victims; and (3) the inequity of an insurer receiving a windfall due to a technicality.[87] These justifications were in line with justifications other courts have used in determining that certain rules were fundamental public policy.

The first reason provided by the court for establishing the notice-prejudice rule as a fundamental policy is that it could not be contractually waived, therefore restricting the freedom to contract.[88] Second, the rule protects insureds against inequitable results arising from insurers' superior bargaining power.[89] The court has recognized insurance contracts as

81. *Id.*
82. *Id.*
83. *Id.*
84. *Id.* at 674.
85. *Id.*
86. *Id.* at 674.
87. *Id.* at 674–75.
88. *Id.* at 675.
89. *Id.*

"inherently unbalanced" and "adhesive" placing the insurer in a "superior bargaining position."[90] Third the rule protects the public from bearing the costs of harms that an insurance policy covers but for the late notice.[91]

The insurer argued that public policy must be articulated in constitutional or statutory provisions. The court disagreed finding that a contract or provision can be contrary to public policy despite the Legislature's silence on the issue.[92] The court found that this fundamental public policy brought with it "no potential for tort liability" but instead prevented a windfall benefitting the insurer.[93] It found this consistent with the court's prior holding that the covenant of good faith and fair dealing is not a fundamental policy of the state.[94]

The court held that California's notice-prejudice rule is a fundamental public policy of the state. The court left it to the Ninth Circuit to decide whether California had "a materially greater interest than New York in determining the coverage issue, such that the contract's choice of law would be unenforceable because it is contrary to [California] public policy."[95]

New York common law had historically followed a strict late notice rule, with no requirement that the insurer show prejudice to enforce a late notice condition. Further, under New York law, delays of one or two months were routinely held unreasonable. In 2009 the New York legislature amended section 3420 of the New York Insurance Law. As amended the law required that liability insurance policies covering bodily injury or destruction of property, "issued or delivered" in New York, contain a provision that "failure to give any notice … within the time prescribed therein shall not invalidate any claim made by the insured, injured person, or any other claimant, unless the failure to provide timely notice has prejudiced the insurer … ."[96] The statute is more detailed and complicated, including a shifting burden of proof on the issue of prejudice, if notice is given more than two years late. However, for policies not issued or delivered in New York , the common law strict late notice rule still pertains. Therefore, that is the rule that would have applied here if New York law was applied under the choice of law provision, because this policy was not issued or delivered in New York.

The California Supreme Court then considered whether the consent provision was subject to the notice-prejudice rule.[97] That provision stated

90. *Id.*
91. *Id.*
92. *Id.* at 676.
93. *Id.*
94. *Id.*
95. *Id.* at 677 (citation omitted).
96. N.Y. Ins. Law § 3420(a)(4).
97. *Pitzer*, 447 P.3d at 677.

that in the absence of an emergency "no costs, charges, or expenses shall be incurred … without the Company's written consent which shall not be unreasonably withheld."[98]

The insurer argued that the consent provision prevents unnecessary expenditures by the insured, allows the insurer to approve and control costs, protects subrogation rights, and avoids potential destruction of evidence.[99] The court found that all of these spoke to minimizing prejudice to the insurer, and supported applying the notice-prejudice rule here.[100] The court found that the notice-prejudice rule made "good sense" for consent to payment provisions in first party policies.[101]

However, as to third party coverage, the court determined that the notice-prejudice rule should not apply to consent to payment or "no voluntary payment" provisions.[102] Such a provision serves a role beyond the prompt notice requirement. In the third party liability context the court held that the insurer is invested with complete control and direction of the defense.[103] The decision to pay any remediation costs outside the civil action context "'raises a judgment call left solely to the insurer.'"[104] In this third party context these provisions ensure that insurers promptly accept a tender of defense and gain control over defense and settlement of the claim. The insurer's duties to defend and settle a lawsuit are crucial to its coverage obligations. Because the right to control defense and settlement is paramount in the third party coverage context courts refuse to apply the notice prejudice rule to the consent to payment provisions. This "protects against coverage by fait accompli."[105]

In the first party context, California courts had not addressed whether to apply the notice-prejudice rule to a consent to payment provision.[106] Since there is no claim of liability to defend, and therefore no need for unimpaired control over claims handling, the reasons that pertain as to the third party context do not apply to the first party context. Therefore failure to obtain consent is not inherently prejudicial and the logic of the notice prejudice rule should apply in the first party context. The court therefore held that the notice-prejudice rule applied to consent to payment provisions in first party policies.[107]

98. *Id.*
99. *Id.*
100. *Id.* at 678.
101. *Id.*
102. *Id.* at 678–79.
103. *Id.* at 679.
104. *Id.* at 678.
105. *Id.*
106. *Id.* at 679.
107. *Id.*

The college and the insurer also disputed whether the coverage in question was first party or third party.[108] The insurer argued it was third party coverage since it addressed remediation to the extent required by federal, state or local laws or by a legally executed state voluntary program. The college argued that the second insuring agreement provision—promising to pay remediation expense resulting from a pollution condition first discovered during the policy period—was a first party coverage, not a third party coverage. The Supreme Court left this question also to the Ninth Circuit.[109] This raises the possibility that the notice prejudice rule might be applied to the consent provision as applied to one clause of an insuring agreement but not to another clause in an insuring agreement.

This decision of the California Supreme Court as to the choice of law implications of the notice-prejudice fundamental public policy issue raises questions about what other common law rules might be considered fundamental public policy that could overcome a choice of law provision. For example, would California public policy against insurability of punitive damages trump punitive damages coverage under a "punitive damages wrap?" And, as another example, is the right to *Cumis* counsel a fundamental public policy? If so, how would this affect a choice of law provision?

V. INTERSTATE COMPACTS

Damian J. Arguello

Interstate Compacts—Useful Shortcut or End-Run around Regulatory Oversight?

A. *Introduction*

A case currently pending before the Colorado Supreme Court involving the use of an interstate compact involving 44 states[110] to streamline the introduction of insurance products in member states raises significant concerns about the efficacy of such compacts in protecting insurance consumers against insurance company overreach. While the legal arguments are framed to address constitutional separation of powers issues, the broader practical issues are equally compelling for insurance law practitioners. Thus, the case bears watching.

108. *Id.*

109. *Id.*

110. As of August 31, 2017, all states have joined except California, Delaware, Florida, New York, North Dakota, and South Dakota. Amica Life Ins. Co. v. Wertz, 272 F. Supp. 3d 1239, 1242 n.1 (D. Colo. 2017).

B. *Statutory Background*

The following background, case facts, and procedural history are taken largely from the September 11, 2017 opinion of Judge William Martinez of the District of Colorado. In 2004, the Colorado General Assembly adopted the Interstate Insurance Product Regulation Compact ("Compact") at Colorado Revised Statutes § 24-60-3001.[111] The Compact created the Interstate Insurance Product Regulation Commission ("Commission"), a joint public agency with one representative from each compacting state.[112] The Compact authorizes the Commission to promulgate "Uniform Standards" for insurance products "which shall have the force and effect of law and shall be binding in the Compacting States."[113] The Compact is limited to certain insurance products, specifically "individual and group annuity, life insurance, disability income, and long-term [care] insurance products."[114]

Essentially, the Commission acts as a national quasi-insurance commission to streamline the approval and use of proffered insurance products nationwide. Under the Compact, insurance companies submit proposed insurance products to the Commission for approval under the Uniform Standards.[115] If approved, the insurance company may sell that product in any Compact member state in which the insurer is authorized to do business.[116]

While the Compact facilitates the streamlined adoption of insurance products in member states, it is not an automatic process. Instead, the Commission must follow "a rulemaking process that conforms to the Model State Administrative Procedure Act of 1981 as amended, as may be appropriate to the operations of the Commission."[117] Further, "[b]efore the Commission adopts a Uniform Standard, the Commission shall give written notice to the relevant state legislative committee(s) in each Compacting State responsible for insurance issues of its intention to adopt the Uniform Standard."[118]

Having received such perfunctory notice, a member state can opt out of a Uniform Standard "either by legislation or regulation duly promulgated by the Insurance Department under the Compacting State's Administrative Procedure Act."[119] The opt-out is prospective only, and does not void insurance products sold after a Uniform Standard become effective but

111. *Id.* at 1242 (internal citations omitted).
112. *Id.*
113. *Id.*
114. *Id.*
115. *Id.*
116. *Id.*
117. *Id.*
118. *Id.*
119. *Id.*

before the state opts out.[120] If the member state does not opt out after receiving notice, the proposed Uniform Standard automatically becomes effective ninety days after promulgation "or such later date as the Commission may determine."[121]

There is a process to correct any overreaching under the Compact. If the Commission exceeds the scope of the purposes of the Compact or its associated powers, then the Commission's action "shall be invalid and have no force and effect."[122] Further, any person may challenge a Uniform Standard by filing a judicial action within thirty days of promulgation.[123] However, the Compact directs the reviewing court to "give deference to the actions of the Commission" and find a Uniform Standard unlawful only if it is an unreasonable exercise of the Commission's authority.[124]

Against this legislative backdrop the district court was asked to decide whether the two-year suicide clause in a term life insurance policy sold under the Compact was enforceable in light of Colorado's one-year suicide clause statute. As noted, Colorado adopted the Compact in 2004, effective August 4, 2005.[125] The Colorado General Assembly Legislature designated the insurance commissioner as Colorado's representative to the Commission.[126]

On January 24, 2007, the Commission published notice of its intent to adopt Individual Term Life Insurance Product ("ITLIP") Standards.[127] Allegedly, on May 1, 2007, the Commission notified the chairs, ranking members, and members of the Colorado General Assembly's House Business Affairs and Labor Committee and Senate Business Labor and Technology Committee of the pending ITLIP Standards.[128] The ITLIP Standards to be adopted declared that any suicide exclusion in an approved policy can be no longer than two years from the date the policy issues.[129] Colorado did not opt out of that Uniform Standard.[130]

The Commission formally adopted the ITLIP Standards on June 1, 2007, with an effective date of September 6, 2007.[131] However, Colorado Revised Statute § 10-7-109, which has been in effect in some form

120. *Id.*
121. *Id.*
122. *Id.* at 1242–43.
123. *Id.* at 1243.
124. *Id.*
125. *Id.*
126. *Id.*
127. *Id.*
128. *Id.*
129. *Id.*
130. *Id.*
131. *Id.*

since 1913, essentially precludes an insurer from denying coverage for an insured's suicide after "the first policy year of any life insurance policy.[132]

C. *Fisher's Policy, His Suicide, and Wertz's Claim*

In October 2011, the Commission approved Amica Life Insurance Company's individual term life insurance product.[133] Consistent with the ITLIP Standards, that policy excluded death benefits if the insured committed suicide within two years of the policy's issuance.[134]

On January 28, 2014, Amica issued such a policy to Martin Fisher. About fourteen months later, Fisher, a Colorado resident, committed suicide.[135] Amica denied coverage for the claim by Michael Wertz, Fisher's named beneficiary, who claimed that C.R.S. § 10-7-109 prohibited denial of coverage if suicide occurs after the first policy year.[136] Amica disagreed and brought a declaratory judgment action in June 2015.[137]

Amica moved for summary judgment, arguing that Colorado's adoption of the Compact meant the Commission's Uniform Standards have the force and effect of law, and therefore that the ITLIP Standards apply.[138] Wertz countered that the Compact or its application violates the Colorado Constitution because it effectively is an unconstitutional delegation of legislative power, violates separation-of-powers principles, and violates the guarantees of equal protection and freedom from special legislation.[139] Amica responded by arguing that the Compact's notice and opt-out provisions provided the necessary safeguard to the Compact's constitutionality.[140]

On September 11, 2017, the district court initially granted Amica's summary judgment motion in part but, as relevant here, certified the following question to the Colorado Supreme Court:

> Does the Colorado Constitution empower the Colorado Legislature to enter into the Interstate Insurance Product Regulation Compact, Colo. Rev. Stat. § 24–60–3001, considering that: (a) the Compact will not be approved by the United States Congress; (b) the Compact creates an administrative body with power to promulgate rules and regulations with the force of law in Colorado; and (c) such rules and regulations supersede any Colorado statute to the extent of a conflict between the rule or regulation and the Colorado statute?[141]

132. Colo. Rev. Stat. § 10-7-109.
133. *Amica*, 272 F. Supp. 3d at 1243.
134. *Id.*
135. *Id.* at 1243–44.
136. *Id.* at 1244.
137. *Id.*
138. *Id.*
139. *Id.*
140. *Id.*
141. *Id.* at 1255.

Three weeks later, the Colorado Supreme Court declined to accept the certified question.[142] Consequently, on October 19, 2018, the district court concluded that the Uniform Standards were not unconstitutional and superseded the statutory one-year suicide clause and granted summary judgment for Amica.[143]

Wertz appealed to the Tenth Circuit, which certified the following question to the Colorado Supreme Court on July 24, 2019: "May the Colorado General Assembly delegate power to amend statutes to an interstate administrative agency?"[144] On August 7, 2019, the Colorado Supreme Court agreed to address the following, restated question: "May the Colorado General Assembly delegate power to an interstate administrative commission to approve insurance policies sold in Colorado under a standard that differs from Colorado statute?"[145]

As of this writing, the Colorado Supreme Court appeal has been fully briefed, including a brief filed by amicus curiae the National Association of Insurance Commissioners and the Interstate Product Regulation Commission, in support of Amica.

D. *Discussion*

Setting aside the legal arguments by the parties for and against, which will not be repeated here, this case raises interesting questions. Does the Compact and its process facilitate a streamlined process of bringing insurance products to the marketplace, addressing issues common to the member states? Or does it, as Wertz claims, allow insurers and any other regulated industry to "avoid unfavorable state law by lobbying for an interstate compact and funding the regulatory body as a means to self-regulate."[146]

As every insurance law practitioner knows, the regulatory processes governing the introduction of new insurance products and policies in the various states can be burdensome. Different insurance departments and legislatures have their various processes, even given the uniformity enable by model acts and regulations promulgated by the National Association of Insurance Commissioners ("NAIC"). In general, the regulatory process of approving such new products has relaxed in recent decades, but nevertheless remains a time-consuming endeavor. Given that a primary purpose of insurance regulators is to protect insurance consumers, such a deliberative process might well be deemed desirable. Conversely, given that the various state insurance departments likely share similar concerns about new

142. Amica Life Ins. Co. v. Wertz, 350 F. Supp. 3d 978, 981 (D. Colo. 2018).
143. *Id*. at 999–1003.
144. No. 18-1455, Document: 010110202390 (filed July 24, 2019).
145. *In re* Amica Life v. Wertz, No. 19SA143 (D. Colo. Aug. 7, 2019), https://www.courts.state.co.us/Courts/Supreme_Court/Case_Announcements/Files/2019/320C888.19.19.pdf.
146. Opening Brief at 14, *In re* Amica Life v. Wertz, No. 19SA143.

products that insurers seek to introduce to the marketplace, an interstate compact seems like an efficient way to achieve the departments' common goals, including consumer protection.

As both sides recognize, the role of interstate compacts has long been a central one in the Republic, allowing states to effectively contract with each other to address common issues, such as boundaries, water rights, etc. To a certain point, the very purpose of such compacts is to supersede individual state laws and regulations in favor of a common goal.[147]

In the *Wertz* case, the fact that the Compact has promulgated a general standard that allegedly supersedes a very specifically enacted consumer protection is troubling and problematic. This is made more concerning by the fact that the notice and opt-out provisions, practically speaking, do not facilitate a broad public comment solicitation to the same extent that proposed laws and regulations from the Colorado General Assembly and the Division of Insurance would.

It will be interesting to see how the Colorado Supreme Court decides this case—on narrow legal grounds or on broader public policy considerations. If Amica and the *amici* prevail, will it embolden insurers to use the Compact to sidestep individual state regulations, expanding the use of the Compact or similar arrangements in other lines of insurance? Will any states move to restrict the application of compacts in the insurance world or take any measures to yield greater transparency? Or is the issue simply too arcane to garner much attention given scarce resources? Stay tuned.

147. *See* Answering Brief at 36, *In re* Amica Life v. Wertz, No. 19SA143 (arguing that the "effectiveness" of such compacts "depends on their ability to bind the compacting states. Therefore, a reasonable and necessary implication of the fact that interstate compacts establishing interstate bodies are permissible under the Colorado Constitution is that such statutes may empower those interstate bodies to promulgate rules and regulations that have the force and effect of law in the compact states to the extent provided for in the compact.").