

Anderson Kill & Olick - What's New

INSURANCE NEWS IN BRIEF

Edited by Susannah Crego

we've heard . . .

Insurance News In Brief for the week of January 25, 1999

The United States Supreme Court agrees that the McCarran-Ferguson Act does not protect insurance companies from liability under the federal Racketeer Corrupt Organization Act (RICO). In its unanimous decision in *Humana, Inc. v. Forsyth*, No. 97-303, 1999 U.S. LEXIS 744 (U.S. Jan. 20, 1999), the Court held that beneficiaries of a group health insurance plan may sue the plan for violating RICO. The case involved Humana Insurance, Inc.'s contract with a hospital in Nevada, Humana Hospital Services, under which the insurance company received steep discounts on health plan beneficiaries' medical charges. Humana Insurance's policy provided that it would pay 80% of the beneficiaries' charges, and the beneficiaries would pay 20%. The beneficiaries brought an action alleging RICO violations against Humana because, they said, the discounts that Humana Insurance received were not passed along. The insurance industry argued that RICO could not be applied because, under the McCarran-Ferguson Act, a federal statute of general application cannot be applied to the business of insurance if it would "invalidate, impair, or supersede" any state law regulating insurance. The U.S. Supreme Court found that RICO did not "invalidate, impair, or supersede" Nevada law. "[W]e see no frustration of state policy in the RICO litigation at issue here," wrote the Court. "RICO's private right of action and treble-damages provision appears to complement Nevada's statutory and common law claims for relief." Anderson Kill & Olick filed a friend of the court brief in the case on behalf of United Policyholders, a national policyholder advocacy group. The Supreme Court specifically cited United Policyholders' brief for the proposition that "insurance companies, too, have relied on the statute [RICO] when they were the fraud victim." Please [e-mail](#) us if you would like a copy of the decision or the brief.

Insurance News In Brief for the week of January 18, 1999

PR fiasco? Or SOP (Standard Operating Procedure)? Months after 81-year-old Gertie Witherspoon was stuck and killed by a large truck in Missouri, her family received a claim from the truck's insurance company for damage incurred by the truck!

While driving her car, Mrs. Witherspoon, an octogenarian waitress, suffered a tire blowout and went into a ditch. She staggered out of the ditch, into the road, and was hit by a truck insured by Great West Casualty Co.. Five months later, her family received Great West Casualty Company's claim for \$2,800 in damages caused by the 105-pound Mrs. Witherspoon's "negligent" behavior.

Great West's executive vice president was quoted in the WALL STREET JOURNAL as saying that the pursuit of this claim was risky from a PR standpoint--"It doesn't do anything to help people's impressions of us." [Carl Quintanilla, *An Old Woman Crossed the Road, And*

Litigiousness Sank to New Low, WALL ST. J., Jan. 15, 1999, at B1.]

Great West's claim was short-lived. The day after the story ran in the Wall Street Journal, Old Republic International Corp., Great West's parent, announced that the claim against Mrs. Witherspoon's estate has been withdrawn. "In retrospect, we believe the company's protective function could have been fairly served without recourse to the filing of the small claim. We deeply regret the hurt caused to the Witherspoon family and subsequent notoriety that may have resulted in part by the company's actions." [*Old Republic Responds to Newspaper Articles Regarding Claim Filed by Great West Subsidiary*, PR NEWSWIRE, Jan. 16, 1999]

Insurance News In Brief for the week of January 4, 1999

The Year 2000 is upon us. Or at least, litigation involving the Year 2000 (Y2K) "problem." The first reported action involving an insurance company's obligations to provide insurance coverage for a Y2K problem was filed on December 4, 1998 in the U.S. District Court for the Northern District of Iowa by Cincinnati Insurance Company (Cincinnati). [*Cincinnati Insurance Co. v. Source Data Systems*, No. C-98-144 [MJM] (N.D. Iowa)]

Cincinnati Insurance Company brought the declaratory judgment action seeking a ruling that the insurance policy it sold to Source Data Systems (SDS) does not provide insurance coverage for a lawsuit by a hospital charging that an SDS-installed computer system is not Year 2000 compliant. The hospital is seeking \$1.25 million to cover the cost of replacing the system.

Year 2000 disputes are expected to increase. According to one web site which attempts to track Year 2000 lawsuits, about 25 have been filed to date. [Wendy R. Leibowitz, *Y2K Landscape in 1999*, NAT'L L.J., Dec. 21, 1998, at A16]. For more on the Year 2000 problem, please visit Anderson Kill's new web site devoted to insurance coverage for high-tech loss and liability, including Y2K claims--technoinsurance.com.

Insurance News In Brief for the week of December 21, 1998

If you purchased retrospectively-rated, retrospectively-adjusted, loss adjusted, retrospective overall agreements, retrospective rating agreements, large risk alternative ratings option, deductible, retention and/or any loss sensitive workers' compensation or employers liability insurance policies (or other insurance policy written with, priced with, related to, or combined with, these workers' compensation or employers' liability insurance policies or programs) from one of the Hartford Group between January 1, 1985 and May 7, 1998, your rights under those insurance policies will be affected by a pending class action lawsuit in the United States District Court for the Southern District of Florida, *Afco Industries, Inc., et al. v. Hartford Accident & Indemnity Company, et al.*, Case No. 98-1970-CIV-MORENO. Please note that your general liability insurance policies may be affected too.

If you are within this class of Hartford Group policyholders, you must take action by **FEBRUARY 8, 1999**, or risk the possibility that your rights under your Hartford Group insurance policy have been impacted by the pending class action settlement in this action.

The "Hartford Group" includes: Hartford Fire Insurance Company, Nutmeg Insurance Company, First State Insurance Company, Hartford Accident & Indemnity Company, Hartford Casualty Insurance Company, Hartford Insurance Company of Alabama, Hartford Insurance Company of

Connecticut, Hartford Insurance Company of The Midwest, Hartford Underwriters Insurance Company, New England Reinsurance Company, New England Insurance Company, Pacific Insurance Company, Ltd., Property & Casualty Insurance Company of Hartford, Sentinel Insurance Company, Ltd., Trumbull Insurance Company, and Twin City Fire Insurance Company.

If you have any questions or concerns regarding this matter, please [e-mail](#) us.

Insurance News In Brief for the week of December 14, 1998

The Good Hands people think lawyers are unnecessary. At least, lawyers for victims of accidents with Allstate policyholders. But the Pennsylvania Attorney General's Office thinks Allstate's practice of sending a pamphlet titled "Do I Need An Attorney?" to people who have been in accidents with Allstate policyholders is an unfair claims practice. Last week, the Pennsylvania AG's office filed a civil action charging that Allstate's pamphlet discourages people from obtaining legal advice that could prevent them from losing valuable rights or accepting insufficient claim settlements. The Allstate pamphlet tells accident victims that disputes get settled faster without an attorney, and that, although they aren't Allstate customers, they will receive "quality service" and their own "claim representative."

The action by Pennsylvania is just one of several brought against Allstate in connection with the "Do I Need An Attorney?" pamphlet. Six cases seeking class action status on behalf of the accident victims were filed earlier this year in state courts in Connecticut, Colorado, West Virginia, Texas, Washington, and Illinois.

Other states have had questions about the pamphlet too. Allstate has said that, although New York, Texas, and New Jersey questioned the pamphlet, the three have agreed to changes Allstate made in the wording of mailings, including the "Do I Need an Attorney" pamphlet.

Pennsylvania is seeking a permanent injunction prohibiting Allstate from engaging in such deceptive claims practices. The action also demands that Allstate pay a \$1,000 civil penalty per violation or \$3,000 for each violation involving accident victims age 60 or older.

Insurance News In Brief for the week of November 30, 1998

"Sixteen (years) and what have you got? Another day older and . . ." With apologies to the late Tennessee Ernie Ford, we wonder if someone at E.R. Squibb & Sons is singing that tune following the U.S. Court of Appeals for the Second Circuit's recent decision to vacate a trial court's \$37 million judgment.

The suit filed by E.R. Squibb in federal court in 1984, sought rulings clarifying the responsibilities among the 50 primary and excess insurance company defendants for thousands of claims for DES-related injuries. On appeal, the Second Circuit, on its own, raised the issue of whether the case was properly brought in federal court. The reason? The court was concerned that there might be no diversity jurisdiction because one defendant, Allen Peter Dennis Haycock, was sued in his representational capacity.

The problem arose because Mr. Haycock, a British citizen, served as lead underwriter on one of Squibb's insurance policies underwritten by a group of anonymous Lloyd's of London underwriters or "Names." In order for the case to be heard in federal court against a lead underwriter in a

representative capacity, the Second Circuit held, each and every investor or "Name" must meet the complete diversity requirement. Since the record did not disclose the identities of all of the Names, or their citizenship, the case had to be remanded.

The appeals court did provide the trial court with some guidance. It instructed the trial court to determine whether jurisdiction can be saved by suing Stephen Merrett, another Lloyd's underwriter and British citizen as an individual, rather than as a representative of other Names. If that is not possible, then the court should consider recharacterizing the suit as a class action against the Lloyd's underwriters. [*E.R. Squibb & Sons, Inc. v. Accident & Casualty Co.*, Nos. 97-9468(L); 97-9470(CON); 97-9472(CON); 97-9474(CON); 97-9476(CON); 97-9484(XAP), 1998 U.S. App. LEXIS 30060 (2d Cir. Nov. 25, 1998)]



Insurance News In Brief for the week of November 16, 1998

A picture is worth a thousand words. It may also be worth a lot of money. Owens Financial Group, the owner of property on which old tires were dumped, has brought suit against American International Group (AIG) for false advertising and bad faith because AIG refused to provide the insurance coverage promised in an advertisement.

A months-long advertising campaign by AIG included a photograph of a tire dump. Underneath the photo was the caption: "Dump them, you break the law. Recycle them improperly, you break the law. Meanwhile more times just came in." The ad continues: "Fortunately, AIG specializes in designing the kind of custom coverages you need to cope successfully with changing conditions."

Unfortunately for Owens Financial Group, a tire recycler that purchased AIG insurance policies went bankrupt, leaving 10,000 tons of tires on property in California owned by Owens. When Owens sought insurance coverage from AIG under a pollution legal liability insurance policy, AIG denied coverage, saying that tires are not pollutants as is required under the policy. Then, AIG denied coverage under a commercial general liability insurance policy because the tires were considered to be a pollutant. (Why two policies? AIG required that both policies be purchased, and be purchased at the same time.)

Owens Financial recently brought an action in California against AIG for bad faith and for false advertising. Owens asked the court to direct AIG to pay the costs of cleaning up the tires as well as compensatory damages and interest, attorneys fees and other relief. Koorosh Talieh of AKO's Washington, D.C. office, with Jordan Stanzler, Phyllis E. Andelin and Deborah M. Mongan of the San Francisco office of AKO, represents Owens Financial.

Take a look at our tips on [how to fight your HMO](#)



Insurance News In Brief for the week of November 9, 1998

Anderson Kill & Olick's Rhonda Orin was on National Public Radio's (NPR) Talk of the Nation. Rhonda was a guest on Ray Suarez' show on November 2, 1998. She answered questions from callers and from Ray on getting health maintenance organizations (HMOs) to pay claims. Most of

the callers seemed to have had some problem with their HMO, and even the host confided that he had a problem with his health plan because both he and his son have similar names.

Rhonda's own HMO woes were detailed in her article in the Sunday NEW YORK TIMES on November 8, 1998. Rhonda's family health insurance plan has both a family deductible and an individual deductible. Once the family deductible is met, the insurance company must pay. Although Rhonda's family of five met the family deductible for 1997, the insurance company was still applying the individual deductibles. After a struggle, the insurance company agreed that it did owe her over \$1,000. But, "soo sorry," it couldn't pay her the money because of a broken "accumulator." As Rhonda says, it is no wonder that the insurance company was not rushing to fix the accumulator. As far as Rhonda could tell, it was accumulating her money!

Take a look at our tips on [how to fight your HMO](#)



Insurance News In Brief for the week of November 2, 1998

The U.S. Court of Appeals for the Ninth Circuit, faced with the slippery slope of insurance policy language, held that provisions of the Standard Flood Insurance Policy were ambiguous. Reversing a district court's award of summary judgment to an insurance company, the Court found ambiguous language providing insurance coverage for loss from flood including mudslides, but excluding loss caused by "landslide . . . or any other earth movement except such mudslides (*i.e.* mudflows) or erosion as is covered under the peril of flood."

The Court adopted the doctrine of reasonable expectations in connection with interpretation of the Standard Flood Insurance Policy (The language of the policy is prescribed by the federal National Flood Insurance Act of 1968, 42 U.S.C. §§4001 et seq.). The reasonable expectations doctrine should be applied, said the Court, because the flood insurance policy is a sixteen page, double-columned, fine-print document that is a classic contract of adhesion.

And just what is the doctrine of reasonable expectations? The U.S. Court of Appeals referred to the history of the doctrine provided in 1 Eugene R. Anderson, Jordan S. Stanzler, Lorelie S. Masters, INSURANCE COVERAGE LITIGATION §2.7, at 67--and, quoting that treatise stated: "by honoring the policyholder's reasonable expectations, the court recognizes that which was actually bargained for or negotiated." *McHugh v. United Service Auto. Ass'n*, No. 97-35019, 1998 U.S. App. LEXIS 24272, at *13 (9th Cir. Sept. 28, 1998)]. To order INSURANCE COVERAGE LITIGATION ease [e-mail us](#).



Insurance News In Brief for the week of October 26, 1998

A picture tells the tale. An Aetna videotape discovered during a civil lawsuit provides graphic evidence that insurance companies treat ERISA claims differently from non-ERISA claims. The video buttresses the arguments made by many consumer groups that legislation should be enacted that will allow patients to sue their health maintenance organizations (HMOs).

In the Aetna video, used to train case managers handling long-term disability claims, lawyers

discuss the differences between claims governed by the federal Employee Retirement Security Act (ERISA) and non-ERISA claims. Damages available to those with ERISA claims are extremely limited. One lawyer explains to the video audience that, in a non-ERISA claim under state law, it is important to conduct a "reasonable investigation" because the failure to do so could subject Aetna to a large bad-faith damage award. Courts have held that bad faith claims are limited under ERISA.

An editorial in USA TODAY notes that the threat of litigation gets the attention of insurance companies. USA TODAY concludes the Aetna videotape demonstrates that patients should have the right to sue HMOs. [USA TODAY also presents the insurance industry's viewpoint, written by Richard L. Huber, Chairman and CEO of Aetna. *Today's Debate: Suing Your Health Plan*, USA TODAY, Oct. 19, 1998, at 26A].

Read Anderson Kill & Olick's [Getting Your HMO to Pay: 10 Tips](#).



Insurance News In Brief for the week of October 12, 1998

Marsh & McLennan's latest attempt at gobbling up other insurance brokers may be hitting a snag. Marsh & McLennan, which purchased Johnson & Higgins in 1997, announced in late August that it had agreed to buy the U.K.'s Sedgwick Group for \$2.05 billion. Marsh & McLennan is the world's largest insurance broker in terms of revenue (\$6 billion). But now it seems to some that big broker Marsh & McLennan, which would have 16% of the U.S. market for insurance brokerage, may be too big.

The consolidation in the insurance brokerage market is beginning to worry insurance companies, insurance policyholders, and maybe even the Feds. At the time the purchase was announced, A.M. Best Co. analyst Eric Simpson said insurance companies were concerned about the strength of the two biggest brokerages, Marsh & McLennan and Aon. "As these two gorillas get larger and larger, the insurers fear the loss of focused services and attention, and that they are losing some of their pricing leverage." [Deborah Lohse & Ernest Beck, *Marsh & McLennan Will Buy Sedgwick*, WALL ST. J., Aug. 26, 1998, at A3.]

During the past few weeks, insurance companies and insurance policyholders have stepped up their complaints that consolidation in the insurance brokerage market may mean higher brokerage fees and a more limited range of insurance products. Perhaps in response to those complaints, the Federal Trade Commission has made an unusual second request for more information from Marsh & McLennan in order to determine whether the purchase will violate federal antitrust laws. According to a Marsh & McLennan spokesperson, after the additional information is provided to the FTC, the FTC has 20 days to make its ruling. [Deborah Lohse, *Marsh & McLennan's Planned Purchase of Sedgwick Stirs Increased Concerns*, WALL ST. J., Sept. 29, 1998, at A6].

We'll let you know what happens.



Insurance News In Brief for the week of September 28, 1998

Miniblind manufacturer Jencraft Corp. is entitled to a defense from its liability insurance companies

in pending class action lawsuits that allege that the miniblinds emit lead dust.

A federal court in New Jersey held that Maryland Casualty Company and Northern Insurance Company must defend Jencraft in several class action lawsuits brought by consumers who say the blinds released hazardous lead dust into the environment [*American Alliance Ins. Co. v. Jencraft Corp.*, No. 96-4346, 1998 U.S. Dist. LEXIS 14431 (D.N.J. Sept. 8, 1998)]. The consumers allege violations of various state consumer protection statutes, and fraud, negligence, and breach of warranty claims. The insurance companies argued that these claims were not covered by the insurance policies they sold to Jencraft. The policies required "property damage," they said, and the damages alleged were damages to the miniblinds themselves, which were specifically excluded.

The federal court rejected the insurance companies' efforts to avoid coverage. The court required that the insurance companies defend Jencraft because it was "reasonable to infer" that the consumers' class action suits included property damage claims. The court noted several instances of this "property damage." For example, at least one complaint alleged that the lead dust that spread into the plaintiffs' homes had to be cleaned up using special equipment at a significant cost to the claimants.

For a copy of this decision, please [e-mail](#) us.



Insurance News In Brief for the week of September 21, 1998

More of the story about the Connecticut Insurance Department's "ruling" on the year 2000 (Y2K) problem than you have, we bet.

The Associated Press reported that the Connecticut Insurance Department had issued a "ruling" that "costs associated with the year 2000 computer problem are not covered by insurance policies unless the coverage is specifically requested." [2000 Problem Not Covered, N.Y. TIMES, Sept. 16, 1998, at B10]. This "ruling" reportedly happened after the Insurance Services Office (ISO) sought an opinion. This "ruling" seemed odd. What type of ruling? What were the circumstances under which the Insurance Department made the ruling? So, we asked the Insurance Department.

The Connecticut Insurance Department sent us a press release they issued dated September 17, 1998. The press release says that the story reported was incorrect. No, the Department did not issue a ruling that existing insurance policies do not cover loss or liability from the Y2K problem. "To the contrary, the Connecticut Insurance Department has not been requested to make, and has not made any ruling or decision with respect to specific insurance coverage for claims associated with the year 2000 computer problems."

To date, we haven't seen any news reports of this correction. But now you know what we know. For more information on insurance coverage for technology-related problems and the Y2K problem, visit our technoinsurance.com site. For a copy of the Connecticut Insurance Department press release, [e-mail](#) us.



Insurance News In Brief for the week of September 14, 1998

State Farm will be \$9.5 million poorer as a result of a recent court decision in Idaho. A state court judge in Boise upheld a jury's \$9.5 million punitive damage award against State Farm Mutual Automobile Insurance Company, finding that the insurance company unreasonably delayed payment of a medical claim based on a "completely bogus" outside medical review. [*Robinson v. State Farm Mutual Automobile Insurance Co.*, No. CV OC 94-98099D (Idaho Dist. Ct., 4th Jud. Dist., Cty of Ada, Aug. 6, 1998)]

Cindy Robinson suffered a herniated disk in an automobile accident in early 1992. Two of her doctors reported that the disk problem was caused by the accident. When Ms. Robinson submitted a claim for payment of her medical expenses, the State Farm claims adjuster, based on his own "intuition" determined that her injuries were not related to the accident.

The State Farm adjuster did not deny Ms. Robinson's claim. Instead, he said there was insufficient information to pay it. Exactly what additional information was needed, he did not say. In order to bolster his decision not to pay the claim, the adjuster referred Ms. Robinson's the medical records to an outside utilization review company.

The evidence presented by Ms. Robinson in the case against State Farm was overwhelming that the utilization review company selected by the adjuster was, in the court's words "completely bogus. . . The company did not objectively review medical records, but rather prepared "cookie cutter" reports of stock phrases assembled on a computer." The evidence showed that the reports generated were not objective, but were slanted to favor the denial or reduction of claims. Furthermore, the evidence showed that State Farm management knew that the reports in this case were false.

The result? A jury awarded Ms. Robinson \$2,500 in damages under the insurance policy, \$100,000 in damages for intentional infliction of emotional distress and \$9.5 million in punitive damages. The appellate court upheld the awards.

The words of the court:

The practice of manufacturing evidence to use in defeating a claim being made by the insurance company's own insured is reprehensible. . . State Farm intended by these processes to reduce the amount of money it would have to pay on legitimate claims . . . One buys and pays for first party insurance protection to avoid the very series of hassles and confrontations that State Farm put its insured through in this case.


If you would like a copy of the Memorandum Decision in *Robinson v. State Farm Automobile Insurance Co.*, please [e-mail](#) us.



Insurance News In Brief for the week of August 31, 1998

The head of Action 2000, the U.K.'s task force on the Millennium Bug (the Year 2000 problem or Y2K problem to us Yanks), has reacted strongly to the British insurance industry's attempts to exclude insurance coverage for problems relating to the coming of the year 2000. Gwyneth Flower of Action 2000 says that the insurance industry's position that the problems are


"foreseeable," and thus, not insurable, is unacceptable. "Insurance ought to cover this. After all, you don't want to have an accident with your car but accidents do happen" she said. Kevan Reilly, *Millennium Meltdown; Pounds 32BN Cost of Computer Bug Chaos; Millennium Bug is a Potential Timebomb*, THE MIRROR, Aug. 26, 1998, at 1. For more on the Year 2000 problem, please visit Anderson Kill's new website devoted to insurance coverage for high-tech loss and liability, including Y2K claims--technoinsurance.com.



Insurance News In Brief for the week of August 24, 1998

You may know some things that we do not know about insurance. We would love to hear from you. [Email](#) us your news, including the source of the news, and we will let others know what we've heard from you. (We won't identify you if you don't want to be identified).


For what we've heard about court decisions that have disappeared, visit our [Vacatur Center](#).



Insurance News In Brief for the week of August 17, 1998

State Farm v. David? State Farm v. Rocky Balboa?


A battle of epic proportions has taken place in Utah, and State Farm's tactics during the battle have raised the ire of a court. Although the Third Judicial District Court of Salt Lake County, Utah, reduced a punitive damage award against State Farm in a case involving automobile insurance from \$145 million to \$25 million, the court's opinion includes a litany of State Farm's claims-handling and litigation abuses. To name just a few: (1) engaging in a secret process of using automobile insurance claims handling as a profit center by providing claims adjusters with unlawful incentives to wrongfully deny benefits; (2) falsifying claims files; (3) destroying documents requested in litigation; (4) manipulating testimony by employees; and (5) intimidating opposing claimants, witnesses and attorneys. State Farm's "mad dog" defense tactics required, said the court, "the will of a David against a Goliath, or of a Rocky Balboa against an Apollo Creed, to stay the course and bring litigation such as this to the point where it rests today." [*Campbell v. State Farm Mutual Automobile Insurance Co.*, No. 8909095231, slip op. at 53 (Third Judicial Dist. Ct., Salt Lake Cty., Utah, Aug. 3, 1998)]. For a copy of the decision, please [e-mail](#) us.



Insurance News In Brief for the week of August 10, 1998


Even the police are not safe. Safe from the familiar practice of insurance companies cancelling the insurance policies of policyholders after they make claims. A city in Michigan recently found this out when the insurance company that had been providing them with umbrella liability insurance, Coregis cancelled the city's police liability coverage. Why? Because last year a trial court awarded \$2.8 million to a man who claimed that the city of Hamtramck's police had beaten and kicked him during a 1991 arrest. Coregis did not tell the city why its police liability insurance policy would not be renewed, but city officials and the city's insurance agent believe that the court decision was the reason. Mike Wowk, *In Hamtramck: Insurance Company Cancels City's Police Liability Coverage: Some Believe Decision Stems from \$2.8 Million Lawsuit Settlement*, Detroit News,

Aug. 12, 1998, at S4.



Insurance News In Brief for the week of August 3, 1998


What does "independent" mean? An "independent audit" scheduled for Colorado's Insurance Division will be performed by the law firm of Sonnenschein Nath & Rosenthal, a firm which represents many large insurance companies including Travelers, Aetna, Prudential, and New York Life. The audit will determine whether the Insurance Division follows up on consumer complaints and adequately penalizes insurance companies for unfair practices. The instigator of the push for the audit, Jake Gaffigan, a former Colorado Insurance Division official, charged that Colorado imposed only seven fines against insurance companies in 1996 even though the division had received over 7,000 consumer complaints. Scot J. Paltrow, *Insurance Industry Lawyer Hired to Audit Its Watchdog*, WALL ST. J., June 11, 1998, at B2.



Insurance News In Brief for the week of July 27, 1998

Policyholders (especially UK-based policyholders), take notice. You have been inoculated against the Year 2000 (Y2K) bug! That is the conclusion of a new independent report by British solicitors Cameron McKenna that was prepared for the Association of British Insurers. According to the report, three-quarters of UK businesses would have valid insurance claims under existing insurance policy wordings. Christopher Adams, *Insurers Rush to Cut the Risk Posed By Millennium Bomb*, Financial Times (London), July 21, 1998, at 8. In the U.S., it has been reported that some insurance companies have written to policyholders indicating that Year 2000-related claims under Directors' and Officers' (D&O) liability insurance policies alleging mismanagement will be viewed as any other D&O claim. Gavin Souter, *D&O Silence on Y2K Criticized*, Bus. Ins., July 13, 1998, at 3.

The conclusion that Y2K problems will be covered by existing insurance policy wording may be why many insurance companies, UK-based, as well as U.S.-based insurance companies, are now placing exclusions for Y2K-related losses in their policies. The Insurance Services Office, Inc. has proposed year 2000 exclusions and to date, 44 state insurance departments have approved the ISO filing. For more on insurance coverage for the Y2K problem see [Nicholas J. Zoogman, Randy Paar, and Joshua Gold, Year 2000: Liability and Insurance Coverage Issues](#), Banking on Insurance, Winter 1997) and visit www.technoinsurance.com and [Banking On Insurance, Winter 1998](#).



Insurance News In Brief for the week of July 13, 1998

New York's highest court, the Court of Appeals, reinstated a \$590,000 judgment against an insurance company in a bad faith action, holding for the first time that jurors may consider an insurance company's failure to inform the policyholder of a settlement offer as "evidence of bad faith." *Smith v. General Accident Insurance Co.*, No. 78, 1998 N.Y. LEXIS 1433 (N.Y. June 11, 1998). The court noted that the policyholder had produced evidence that the practice in the insurance industry is to keep the policyholder advised of settlement negotiations when the liability

may exceed policy limits. The failure of the insurance company to follow the industry practice was found to be relevant to the issue of bad faith in this case.

Insurance News In Brief for the week of July 6, 1998

There is a great new book out on insurance coverage litigation, written by experts. A recent book review in LEGAL INFORMATION ALERT, penned by Ellen M. Quinn, Assistant Director for Public Services at Cleveland-Marshall College of Law Library, calls the book "thoroughly researched and heavily footnoted" and "useful to anyone researching in this area." The reviewer continues: "because the book is so well written and well organized, it is easy to locate the sections you want. The authors do a good job of integrating and explaining the jargon of the insurance industry. .."

We modestly point out that this "good overview of the leading issues in insurance coverage litigation" is Eugene R. Anderson, Jordan S. Stanzler & Lorelie S. Masters, INSURANCE COVERAGE LITIGATION (ISBN: 0-471-11036-1), now published by Aspen Publishers, Inc.. To order: (800) 447-1717 or e-mail akodc@andersonkill.com.

For more information on *Insurance Coverage Litigation*, please see our [What's New](#) section.

Insurance News In Brief for the week of June 22, 1998

Cigna's plan to restructure its business suffered a severe set-back. The Pennsylvania Supreme Court refused to hear the appeal of the Commonwealth Court's disapproval of the restructuring plan. *Commonwealth of Pennsylvania Insurance Department v. LaFarge Corp.*, Nos. 131, 132, 133, E.D. Allocatur Docket 1997, 1998 Pa. LEXIS 1129 (Pa. June 5, 1998).

In 1996, the Pennsylvania Insurance Department approved Cigna's plan to split its operations into two holding companies--one with only long-tail liabilities (environmental and asbestos liabilities) and the other with none of the long-tail liabilities. The Commonwealth Court disapproved of the plan in early 1997 and ordered new hearings.

Critics of the reorganization, including Anderson Kill & Olick, contend that the Pennsylvania Supreme Court's refusal to hear the appeal means that the reorganization must be invalidated. A spokesman for Cigna, however, contends that Cigna is not legally obligated to revert to its old structure because the Commonwealth Court's ruling did not order a reversal of the restructuring. A spokeswoman for the Pennsylvania Insurance Department said that the Commissioner has not yet reached a decision on the matter. Deborah Lohse, *Cigna's Finalizing of Restructuring is Dealt a Blow*, WALL ST. J., June 11, 1998, at A6; Dave Lenckus, *New Review For Cigna: Pennsylvania Must Hold New Hearings on Restructuring*, BUS. INS., June 15, 1998, at 1.

If you would like a copy of the decision or if you have any questions or comments, please send your name and address to akodc@andersonkill.com.

Insurance News In Brief for the week of June 15, 1998

The number of business travelers heading to Bermuda may go down. Lloyd's of London is close to admitting captive insurance companies. This may mean that those traditional domiciles of captives, such as Bermuda, the Cayman Islands, and Gibraltar, will see fewer of these specially-created subsidiaries of multinational corporations.

Captive insurance companies have been viewed by corporations as sound alternatives to regular insurance policies purchased from insurance companies and from Lloyd's. [For the less-than-sound, true nature of the non-insurance offered by captive insurance companies, see [AKO POLICYHOLDER ADVISOR, May 1998](#) and [AKO POLICYHOLDER ADVISOR January 1998](#).] Those corporations may view Lloyd's membership favorably. The tax benefits to setting up captive insurance companies have diminished recently and the captives face problems in some countries where they are not allowed to offer insurance and must obtain "fronting" policies from "real" insurance companies.

Lloyd's has traditionally dealt with brokers and not directly with policyholders. This strategy seems to be changing. Lloyd's seems to be seeking new sources of funding. As we reported earlier this year [[INSURANCE NEWS IN BRIEF](#), week of January 5, 1998], the number of corporate Names, or investors, is now greater than the number of individual Names. Captive insurance companies, subsidiaries of corporations, would result in even more corporate investment at Lloyd's. [Christopher Adams, *Lloyd's to Admit Captive Groups*, FINANCIAL TIMES (LONDON), June 4, 1998, at 10]



Insurance News In Brief for the week of June 8, 1998

A lot of tough talk about HMOs. HMOs (health maintenance organizations) have been touted as the best solution for the nation's health care. Increased preventative care and cost reductions are just two of the advertised advantages of HMOs.

Today, the advantages of HMOs are seemingly fewer and the disadvantages more numerous. Patients have difficulty negotiating the maze that is "managed care;" costs do not seem to be coming down; and most significantly, decisions concerning medical care are being made by unseen functionaries at the HMO rather than by the patient's own physician. [For tips on dealing with your HMO see [Getting Your HMO to Pay: Ten Tips](#)]

Last week, Vice President Al Gore spoke at the annual convention of the American Association of Retired Persons (AARP). He used anecdotes to get across his message that the Clinton Administration supports expanding patient rights in the world of managed-care health plans. Gore recounted the story of a woman with breast cancer who desperately battled her HMO seeking care. First, the HMO would let her see only a general surgeon. Later, she had to battle to win payment for chemotherapy. Gore summed up the situation--"That's not managed care, its managed costs." [Jon Jeter, *Gore Targets HMOs in AARP Speech*, WASH. POST, June 4, 1998, at A6.]

A diverse coalition of groups is seeking legislation on the state and federal level that would hold HMOs accountable for their decisions and give consumers more choices. Some of the proposals

would give consumers: the right to appeal denial of claims to an impartial arbiter, the right to sue HMOs for decisions that result in personal injury, the right to have access to medical specialists, right to privacy of medical records, and the right to experimental treatments and drugs.

Insurance News In Brief for the week of June 1, 1998

One year of liability insurance coverage in California = 100% of defense costs. A California appellate court held that defense costs cannot be apportioned when an insurance company breached its duty to defend the policyholder. [*State of California v. Pacific Indemnity Co.*, No. B086001, 1998 Cal. App. LEXIS 448 (Cal. Ct. App. May 21, 1998).]

Legal actions were brought against the State of California for environmental damages that took place over a period of 43 years. During one of those 43 years, the State purchased insurance coverage from Pacific Indemnity Company. Although Pacific Indemnity conceded that it erred when it refused to defend the State, it argued that its duty to defend (and its liability for defense costs) was proportional to its one year of insurance coverage. The California Court of Appeal rejected apportionment because California law requires that an insurance company provide an entire defense of the policyholder unless no claims are potentially covered. The insurance company's argument that its duty to defend should be apportioned with its policyholder was found to be contrary to California law.

Insurance News In Brief for the week of May 25, 1998

A jury in a federal district court in New York, applying New York law, awarded a policyholder \$1.3 million in consequential damages against Chubb Insurance Company for breach of the implied covenant of good faith and fair dealing because Chubb delayed payment of the policyholder's claim for 25 months. *Postel v. Great Northern Insurance Co.*, No. 96-1896 (S.D.N.Y. May 8, 1998).

In November 1993, the policyholder, a retired opera singer, submitted a claim for insurance coverage to her insurance company (part of the Chubb Insurance Group), after her penthouse apartment on New York's Upper East Side was heavily damaged by smoke from a fire in the building. For six months, Chubb paid \$25,000 a month to cover the costs incurred by the policyholder to rent quarters at the Waldorf-Astoria Hotel. Chubb stopped the payments for the alternative living quarters because it contended that the policyholder had had enough time to repair the apartment. It was the end of 1995 before Chubb made any payments for the repair work.

This policyholder victory is unique both procedurally and factually. Procedurally, the case is unique because there will be no appeal. According to Chubb's lawyer, the parties agreed to set the parameters for the jury's verdict in exchange for giving up their appeal rights. Factually, the case is unique because of the high dollar amount of the consequential damages. The consequential damage award was high because of the \$25,000 a month rental value of the policyholder's apartment and the fact that the policyholder was unable to use the apartment for more than four years by the time the case went to trial.

In addition to the \$1.3 million in consequential damages, the policyholder also was awarded the full

amount of the insurance policy, \$2 million.




Insurance News In Brief for the week of May 18, 1998

"Sssh." An insurance company may not have to tell everything it knows. Discovery of information concerning insurance companies has been limited by legislation establishing what is known as a "self-evaluative" privilege in some states. [*Self-Policing in the Insurance Industry Gets an Assist from a State Law*, WALL ST. J., Apr. 23, 1998, at A1.]


Illinois is one of the states with the new "self-evaluative" privilege, which allows insurance companies to obtain confidential treatment of information that may be uncovered during an internal review of the insurance company's employees and business practices. The internal evaluation prepared by the insurance company can be submitted voluntarily to state insurance regulators for their review, but the evaluation may not be admitted into evidence in any subsequent legal proceedings, with certain exceptions. Moreover, the submission of the evaluation to the state insurance regulators does not constitute waiver of the privilege.

The Illinois statute (Section 155.31 of the Illinois Insurance Code) may be the harbinger of a movement by other states to enact such legislation. The American Council of Life Insurance (ACLI) proposed similar model legislation at its 1998 spring meeting. The legislative director of ACLI views the legislation favorably, explaining that it helps promote self-discovery of problems. The Illinois statute allows courts to revoke the privilege if it is used fraudulently.




Insurance News In Brief for the week of May 11, 1998

They are digging for gold. Insurance archaeologists, that is. Insurance archaeologists locate and, if necessary, reconstruct, insurance programs for policyholders. Since liability insurance policies purchased many years ago may provide insurance coverage today, old insurance policies are valuable. But what if the policyholder cannot locate the policies, or does not know where to look? Enter the insurance archeologist. The business of insurance archeology developed over the last 15 years due to the increasing number of so-called "long tail" liabilities, such as environmental and toxic tort liabilities, which may be covered under old insurance policies. Insurance archaeologists began searching basements and warehouses for evidence of insurance policies. Once the policies are identified from direct or indirect evidence, the insurance archeology firm notifies the insurance companies that issued the policies. According to the JOURNAL OF COMMERCE, one archeologist located old policies with a face value of \$8 billion and sent out some 12,000 letters of notification for its client, Browning-Ferris Industries. These insurance sleuths expect to continue producing gold--for themselves, as well as their clients. Potential new clients include beneficiaries of the victims of the Holocaust now seeking insurance proceeds, Cuban refugees whose businesses and homes were confiscated by Castro, and businesses involved in mergers and acquisitions that need to know the extent of their insurance assets. [Gene Linn, *Insurance Archaeologists*, J. OF COM., Apr. 16, 1998, at 5A]



Insurance News In Brief for the week of May 4, 1998


Allstate Insurance Company may be reviewing its insurance policies to see if it has insurance coverage for indoor air pollution (Courts have found insurance coverage for indoor air pollution [Insurance News in Brief, Week of November 24, 1997](#) and [Insurance News in Brief, Week of October 27, 1997, AKO POLICYHOLDER ADVISOR, December 1997](#).) Homeowners recently filed an action against Allstate Insurance Company in a trial court in Pennsylvania, alleging that Allstate did not properly clean their home after an oil burner exploded. Peter and Donna Bendistis' homeowners' insurance policy included coverage for "additional living expenses, debris removal, the cost to treat or remove contaminants or pollutants, [and] payment for necessary medical expenses." After the Bendistis' oil burner exploded, thick soot covered their belongings. Allstate agreed to clean the items, not replace them, despite the fact that the Bendistis' daughter was asthmatic. According to the Bendistis' attorney, the cleaning caused further damage, introducing additional contaminants and odors into the environment. The Bendistises seek damages in excess of \$50,000 for breach of contract, bad faith and negligence. [Victoria Rivkin, *Allstate Sued Over Cleanup of 'Indoor Pollutants,'* LEGAL INTELLIGENCER, Apr. 8, 1998, at 6].



Insurance News In Brief for the week of April 27, 1998

The property/casualty insurance industry may be a bit lighter in the pocket as a result of a recent U.S. Supreme Court decision. In *Atlantic Mutual Insurance Co. v. Commissioner*, No. 97-147, 1998 U.S. LEXIS 2786 (U.S. Apr. 21, 1998), the U.S. Supreme Court unanimously affirmed a decision by the U.S. Court of Appeals for the Third Circuit which approved of the Internal Revenue Service's method of calculating the 1987 tax liability of insurance companies. A spokesman for the insurance industry has stated that the decision could cost the insurance industry "up to \$1 billion or more."


Prior to the Tax Reform Act of 1986, property and casualty insurance companies were allowed to deduct the full amount of claims paid each year and the full amount of reserves. The Act changed the rules, requiring the discounting of reserves, but provided some exemptions. Atlantic Mutual Insurance Company paid its taxes for 1987 based upon one interpretation of the law, but the IRS interpretation resulted in an additional tax of \$519,987. The U.S. Supreme Court sided with the IRS.



Insurance News In Brief for the week of April 20, 1998

Insurance companies are animals. What kind of animals? Squirrels, mules, panthers, sharks. TREASURY AND RISK MANAGEMENT's April issue featured an article reporting on a survey of treasurers, risk managers, and insurance brokers in which they were asked about the personalities of insurance companies. The insurance companies were judged in two categories--underwriting creativity and claims expediency. The survey respondents were also asked to liken their insurance company to a member of the animal kingdom. AIG was characterized as a squirrel "because it likes to collect premiums (nuts) for the payment of claims (winter) but is reluctant to part with them" and Chubb was characterized as a shark "[h]appy to collect premiums, but slow to pay losses, and often only appears to be interested in bigger fish." Other insurance

companies seemed to be a menagerie. One risk manager thought Zurich American was a lion "because it is not only strong and stable but also far-seeing" while another called Zurich a fox that "wants to sneak into the U.S. market and make a presence." [Russ Banham, *The Risk Menagerie*, TREAS. & RISK MGMT., Apr. 1998, at 28]




Insurance News In Brief for the week of April 13, 1998

Or maybe we should say that we "sense" that a policyholder in California is happy that an appellate court found that its insurance company had a duty to defend claims involving the loss of fuel from an underground storage tank [*Charles E. Thomas Co. v. Transamerica Insurance Co.*, No. B11527, 1998 Cal. App. LEXIS 224 (Cal. Ct. App. Mar. 18, 1998)].

The policyholder, Charles E. Thomas Co. (Thomas), designed and installed sensors for detecting leaks in underground fuel storage tanks. A contractor working on a tank punctured the tank, causing it to leak more than 8,000 gallons of fuel. Because the policyholder's sensors did not work, the leak went undetected. The owner of the property on which the tank was installed sued Thomas seeking recovery for damages caused by the punctured tank. Thomas had purchased a comprehensive general liability insurance policy from Transamerica Insurance Company (Transamerica) which excluded: "any loss, cost or expense arising out of any . . . request, demand or order that any insured or others test for, monitor, clean up, remove, contain, treat, detoxify or neutralize, or in any way respond to, or assess the effects of pollutants." Transamerica denied insurance coverage and in the ensuing insurance coverage litigation, the trial court granted Transamerica summary judgment.

The California appellate court reversed, holding that there were potentially covered claims alleged against Thomas. Pollution-related losses which did not arise out of a request that Thomas clean up or remove "pollutants" were not excluded. Since the complaint against Thomas included allegations that the property owner was damaged by non-requested activities, the court found that Transamerica had a duty to defend Thomas. In addition, as a separate ground for reversal, the court found that there was a potential claim for the loss of the diesel fuel itself and that Transamerica had not pointed to any exclusion which would bar insurance coverage for the loss of the fuel.



Insurance News In Brief for the week of March 30, 1998

"Secret justice" is what the April 1998 issue of the ABA Journal calls the practice of keeping the details of litigation beyond the prying eyes of the public [John Gibeaut, *Secret Justice*, ABA J., Apr. 1998, at 50]. According to the ABA Journal, reporter Kirsten B. Mitchell and the Wilmington North Carolina Morning Star were found in civil contempt for obtaining and reporting the details of a secret settlement of an environmental law suit. Judges sealing files and closing courtrooms are examples of the secret justice that is increasingly more common in cases involving large corporations that want to control costs and maintain their public image. All this sounds familiar to insurance policyholder advocates who have battled secrecy in form of the practice of [vacatur](#) for years.

Insurance News In Brief for the week of March 23, 1998

What if TITANIC sunk? At the box office, that is. Or what if GOOD WILL [was] HUNTING for moviegoers? Happily for those two Academy Award winning films, that did not happen. But if it did, insurance policies might have softened the financial blow for the film studio. According to DAILY VARIETY, MGM, Paramount Pictures, and Sony Pictures Entertainment have purchased insurance policies to provide coverage for potential losses if their films lose money. The cost of the insurance is high--3-6% of the amount insured and, as with all insurance policies, there are questions about whether the insurance companies will stand behind the policies when the claims come in. DAILY VARIETY reports that MGM is expected to make a claim on a policy it purchased from CE Heath based upon the performance of the film RED CORNER, but Heath was reportedly trying to roll over the policy into a bigger one, effectively deferring payment on the claim.

Insurance News In Brief for the week of March 16, 1998

Two insurance tales.

- Fact or fiction? Last week's news that a giant asteroid might destroy Earth sometime in the distant future may have sparked interest in a Florida insurance company's "anti-asteroid" insurance coverage. According to the NEW YORK POST, the St. Lawrence Agency has sold about 100 insurance policies for a one time premium of \$19.95. The specialized policies insure against direct hits by asteroid debris and for cirrhosis of the liver arising from "unnecessary panic drinking due to near misses." Of course, insurance coverage for damage from asteroids is already provided under homeowners' insurance policies (falling objects); automobile insurance (comprehensive and glass coverage); health insurance; and life insurance policies.
- Barney, Kermit, "ABC" or ? The January 1997 issue of the AKO POLICYHOLDER ADVISOR featured an article by Gene Anderson and Susannah Crego, [Captive Insurance Companies; Going to Oz--The Culture Shock](#). Forming a captive insurance company is not a good idea, explained the article, using as an example a policyholder that obtained its insurance from a fictitious insurance broker, Barney and Barney. Barney and Barney encouraged the use of the captive insurance company and the policyholder got stuck. The non-fictitious Barney & Barney LLC complained. The AKO POLICYHOLDER ADVISOR apologized in a letter to subscribers and in [Kudos to Barney and Barney](#). A report of the "fictional" contretemps appeared in THE RECORDER, with the article by Jenna Ward titled Maybe Kermit & Kermit Would've Worked Better (Mar. 3, 1998, at 4). As the real Barney & Barney representative who objected to the use of the name said, "the old law school hypotheticals, companies A, B, C, D--are kind of boring, so you want to use some kind of made-up name."

Insurance News In Brief for the week of March 9, 1998

Consolidation in the insurance brokerage industry may mean "destruction." At least for documents such as old insurance policies. One large insurance brokerage, Johnson and Higgins, recently merged with Marsh & McLennan. Johnson and Higgins traditionally maintained documents forever. Marsh and McLennan, some say, has a company policy of destroying documents after five years. Now that the two have consolidated, those "old" J&H documents may be on their way to the dumpsters and shredders.

All insurance policyholders who have employed Johnson & Higgins, or any other insurance brokerage, should request copies of their files. Often, the most complete files relating to a policyholder's insurance coverage are retained only at the brokerage office. With consolidation in the insurance brokerage industry continuing at a rapid pace, the potential loss of insurance files poses a threat to all policyholders.



Insurance News In Brief for the week of March 2, 1998

The outcome in environmental insurance coverage lawsuits often depends upon which state's law is applied by the court. Courts have struggled with the choice of law issue when environmental damage happens in one state, the insurance policy was issued or delivered in another state, and the policyholder is headquartered in yet another state. [For more on the choice of law see Finley Harckham, [*Choice of Law: Has the Value of Your Insurance Been Left to Chance?, AKO POLICYHOLDER ADVISOR, Feb. 1998*](#)].

A federal appeals court was recently faced with a still more difficult situation. The case before it not only included all of the usual complications, but it was also a consolidated case. In *Boardman Petroleum, Inc. v. Federated Mutual Insurance Co.*, No. 96-9270, 1998 U.S. App. LEXIS 2639 (11th Cir. Feb. 19, 1998), the U.S. Court of Appeals for the Eleventh Circuit vacated and remanded a district court's decision in favor of an insurance company and granted summary judgment to the policyholder on the choice of law issue.

The policyholder, Boardman Petroleum, was headquartered in Georgia and owned gas stations in South Carolina which were the subject of litigation alleging environmental damage. The liability insurance policies sold by Federated Mutual Insurance Company did not contain choice-of-law provisions. After Federated disputed Boardman's claim for insurance coverage, Boardman brought an action in a Georgia federal court, and Federated brought an action in a South Carolina federal court. The South Carolina case was transferred to Georgia, and the Georgia court consolidated the two actions.

The policyholder and the insurance company had agreed that, if South Carolina law were applied to the dispute, there was no insurance coverage for the claims. When the federal district court held that South Carolina law applied, the policyholder appealed. Happily for the policyholder, the Eleventh Circuit vacated the district court's ruling. The appeals court held that, when cases are consolidated, the "balancing of interests" analysis should be applied. In analyzing the interests, the court relied on the facts that the policyholder was a Georgia corporation, the insurance policies were delivered in Georgia, and although the property was in South Carolina, the policyholder was responsible for remediating the situation and was based in Georgia. The court held that interests favored the policyholder and that Georgia law be applied. Since there was potential insurance

coverage for the claims against Boardman under Georgia law, the decision that Georgia law applied was a significant victory for the policyholder.




Insurance News In Brief for the week of February 23, 1998

When a policyholder submits a claim to an insurance company, the policyholder is entitled to a fair, unbiased investigation. If the investigation is biased, designed to create a reason for the claim to be denied, the insurance company has breached its duty of good faith and fair dealing. That is what the Texas Supreme Court said when it upheld an award of damages to a policyholder because State Farm Fire and Casualty Company engaged in a biased, "outcome-oriented" investigation which was designed to place the policyholder at the heart of an "arson triangle."

James and Cynthia Simmons and their two young children fell onto hard times in 1985. Due to some down time at work for James, they fell behind on home mortgage payments. Then, someone burglarized their home. The burglar was caught, he confessed, and the insurance claim that the Simmons presented to their homeowners' insurance company, State Farm, was paid. But the unpleasantness continued--the house was vandalized, and, after the Simmons left the home to take the children to Cynthia's mother's home for the summer, the house burned down.

State Farm's reaction when the Simmons filed a claim for the total loss of their home? The claim was labelled "suspicious" because of the earlier theft claim, even though the legitimacy of that earlier claim was unquestionable. State Farm never investigated the possibility that other potential suspects might have started the fire even though the Simmons had identified five people who might have had grudges against them. State Farm stated that it denied the claim because it believed that the Simmons had a strong financial motive to burn their home, even though the amount of the Simmons mortgage exceeded the policy limits on their homeowners' insurance so that the Simmons would have owed money on the mortgage even if they did collect on the insurance policy.


Thirteen years later, the Simmons' luck has finally changed. The Texas Supreme Court has upheld a damage award in their favor against State Farm for breach of the duty of good faith and fair dealing. [*State Farm Fire & Casualty Co. v. Simmons*, No. D-4095, 1998 Tex. LEXIS 30 (Tex. Feb. 13, 1998)] The biased, outcome determinative investigation was sufficient grounds for the award.



Insurance News In Brief for the week of February 16, 1998


\$400 million or more is what some 150 insurance companies owe a policyholder as a result of a court decision involving insurance coverage for cleaning up environmental contamination at a former chemical plant in New Jersey. The court held that the policyholder, Ciba-Geigy Corp., was entitled to insurance coverage under all insurance policies in effect from 1952 until 1984 under the continuous trigger of coverage. Union County New Jersey Superior Court Judge Lawrence Weiss found that Ciba-Geigy Corp. did not expect or intend environmental damage at the site, as the insurance companies had argued. In fact, the evidence demonstrated that Ciba-Geigy made a great effort to clean up and prevent pollution, updating its treatment facilities, looking to qualified

experts to control its waste, and even spending millions to build a pipeline to the ocean after concerns arose over waste water being pumped into the nearby river. The fact that the substances that the policyholder discharged years ago are now known to be pollutants was not enough to demonstrate that the policyholder "expected or intended" the harm. In words hailed by policyholders, Judge Weiss wrote: "Hindsight may be perfect vision, but it would be unrealistic to attribute the knowledge of today to acts that occurred decades before. Therefore, the inquiry regarding a known pollutant requires an analysis of what was known by the insured during the policies in issue." Slip op. at 13. [*In re: Environmental Insurance Declaratory Judgment Actions*, No. L-97515-87 (N.J. Super. Ct. Jan. 28, 1998)]. To receive a hard copy of the slip opinion, please [contact us](#) and include your name and mailing address.



Insurance News In Brief for the week of February 9, 1998

When the National Association of Insurance Commissioners (NAIC) took steps to control the insurance industry nationwide, insurance companies fought back. The companies staged a boycott and refused to pay fees which account for ninety percent of the NAIC's annual budget. In recent years, the NAIC, an alliance of insurance regulators from every state, had expanded investigations into such areas as insurance company solvency, and redlining (the illegal denial of insurance to people in certain neighborhoods, particularly inner-city neighborhoods), and had proposed electronic filing systems that would scrutinize insurance company rates and policy forms. Following the boycott, a "compromise" was reached. Insurance companies paid the fees while the NAIC greatly reduced its expenditures for monitoring sales and claims-handling practices, abandoned the redlining investigation and replaced its staff director. [Scot J. Paltrow, *The Converted; How Insurance Firms Beat Back an Effort for Stricter Controls*, WALL ST. J., Feb. 5, 1998, at A1]



Insurance News In Brief for the week of February 2, 1998


The power of the insurance industry reaches from the courtroom to the state insurance department to the state attorney general's office.

The courtroom. A recent decision by West Virginia's highest court, *Miller v. Fluharty*, No. 23993, 1997 W. Va. LEXIS 289, at *20 n.10 (Dec. 16, 1997), notes that the disparity of bargaining power between insurance companies and policyholders is "apparent in the fact that insurance companies spend over \$1 billion annually in litigation battles against policyholders."

The state insurance department. A front-page WALL STREET JOURNAL article explored the connection between the insurance industry and the Indiana State Insurance Department. [Scot J. Paltrow, *A Matter of Policy; How a State Becomes Popular with Insurers-But Not Consumers*, WALL ST. J., Jan. 14, 1998, at A1.] Indiana's Insurance Department, with a budget of only \$4 million, has received more than 21,000 consumer complaints since 1993, yet has sent only 211 warning letters to 72 insurance companies and has taken disciplinary action against only 11. Only one of those 11 disciplinary actions was in response to consumer complaints.


The state attorney general's office. In Massachusetts, two lawyers that were prosecuted for insurance fraud accused the state Attorney General of being unfairly influenced by the insurance

industry. The lawyers argue that state Attorney General Scott Harshbarger surrendered part of his prosecutorial discretion to the insurance industry because he accepted more than \$1 million a year to fund an insurance fraud division of his office. The money went to pay the salaries and benefits of the assistant attorneys general of the division. [Peter S. Canellos, *Insurance Fraud Case Attacks Mass. System*, BOSTON GLOBE, Jan. 11, 1998, at A1]




Insurance News In Brief for the week of January 26, 1998

A number of states are proposing to make health maintenance organizations (HMOs) liable for insurance coverage and treatment denials. The National Conference of State Legislatures held a conference to debate the issue recently. Presently, patients with claims against employer-sponsored managed care plans have faced the barrier of the federal Employee Retirement Income Security Act (ERISA). Under ERISA, patients cannot sue in state courts for lost wages, pain and suffering, punitive damages, or other relief. They are limited to suing in federal court for the cost of the benefit denied because the federal ERISA preempts state laws. Both managed-care plans and employers are concerned about such legislation, fearing that it will give consumers remedies they presently lack and will raise the cost of health insurance under the plans. Two competing proposals for ERISA reform have been introduced in Congress, one by conservative Republicans Rep. Charlie Norwood of Georgia and Sen. Alfonse D'Amato of New York, the other by Democratic Rep. Fortney H. "Pete" Stark of California. The Norwood-D'Amato bill specifically excludes employers from liability. For tips on what to do if your HMO declines to pay your claim see [Getting Your HMO To Pay](#).



Insurance News In Brief for the week of January 12, 1998

"Policyholder and insurer attorneys alike credit Mr. [Eugene R.] Anderson with leading the assault against the insurance industry's pollution exclusions." This from the January 5, 1998 issue of the weekly insurance trade publication, BUSINESS INSURANCE. In light of the recent decisions by Illinois' highest court in *American States Insurance Co. v. Koloms* [[INSURANCE NEWS IN BRIEF OCT. 27, 1997](#)] and Massachusetts highest court in *Western Alliance Insurance Co. v. Gill* [[INSURANCE NEWS IN BRIEF NOV. 24, 1997](#)] in which the courts held that the so-called "absolute" pollution exclusion does not bar insurance coverage for carbon-monoxide related claims, BUSINESS INSURANCE spotlighted the controversy surrounding the drafting history of the pollution exclusions placed in standard form liability insurance policies in 1970 and 1985. The insurance industry has long argued that the pollution exclusion introduced in 1970 barred insurance coverage for gradual pollution. Policyholders have vehemently objected, arguing that the insurance companies did not receive regulatory approval to bar coverage for gradual pollution. The BUSINESS INSURANCE report by Dave Lenckus details the evidence, including the speeches made by insurance industry executives, memoranda, letters, the hearings held by the West Virginia Insurance Commissioner on the 1970 pollution exclusion, and affidavits later submitted by various former insurance regulators.



Insurance News In Brief for the week of January 5, 1998

Individual Lloyd's investors win in California as their overall number decreases. In an unanimous 3-0 unpublished decision, a California Court of Appeal recently voided the forum selection and choice of law provisions in an agreement entered into by U.S. Names with Lloyd's of London. The Court in *West v. Lloyd's*, No. B095440 (Cal. Ct. App. 2d Appellate Dist., Oct. 21, 1997), *order not to be published in the official reports*, found that the forum selection clause in the agreement violated California's fundamental public policy against waivers of the protections afforded by the California securities laws.

The number of individual Lloyd's investors, known as Names, has dwindled as losses have mounted in recent years. More than 2,000 Names renounced their membership as of the end of 1997, bringing their total number to 6,835 as compared to the 34,000 individual Names in the mid-1980s. Corporate Names, first admitted in 1994, have picked up the slack. Fifty-nine percent of Lloyd's business in 1998 will be covered by the corporate Names. Corporate shareholders are exposed to loss only up to the value of their stock. Their personal fortunes are not available to satisfy policyholder claims as are the personal fortunes of the individual Names.

Insurance News In Brief for the week of December 22, 1997

Santa Claus does not come to town without insurance. Even Santa and his hosts might be sued but--not to worry, insurance is available. According to the HARTFORD COURANT, a one-day insurance policy for Santa costs as little as \$6 a day. One insurance broker in Connecticut said that sometimes a store or a town will not have Santa unless he is insured.

Insurance policies can be purchased for other holiday-related events. For example, a special liability insurance policy may be issued for a Christmas tree lot. \$300,000 in insurance coverage for a premium of \$300. One Christmas tree grower takes some additional precautions. He puts up a sign warning people to watch out for stumps and rocks and he refuses to allow people to use axes or chain saws to chop down trees. They are "just too dangerous."

Insurance News In Brief for the week of December 8, 1997

A big screen portrayal of insurance company claims' handling practices brings in big crowds. The film version of JOHN GRISHAM'S THE RAINMAKER received excellent reviews when it opened across the United States on November 21. The film, directed by Francis Ford Coppola and starring Matt Damon, Claire Danes, Mickey Rourke, Danny DeVito and Jon Voight, pits a young lawyer against an older more experienced lawyer, a policyholder against an insurance company, the "good guys" against the "bad guys."

The plot: Rudy Baylor, a newly-minted lawyer goes to work for an ambulance-chasing personal injury lawyer named Bruiser Stone, played by Mickey Rourke. Stone's right-hand man, Deck Schiflet, played by Danny DeVito, teaches Rudy the ropes and joins Rudy in setting up a law office, even though Deck never managed to pass the bar exam. Rudy's client, Dot Black (Mary Kay Place), is the mother of a man dying of leukemia who is trying to get an insurance company, Great Benefit Insurance Company (defended by Jon Voight), to provide insurance coverage.

Great Benefit Insurance Company flatly rejects the Blacks' claim and the tale of the heroic efforts by Rudy Baylor to uncover the secrets of Great Benefits claims handling operations and to get insurance coverage is on.

What do the critics say?:

Variety, Nov. 17, 1997

"As carefully constructed, handsomely crafted and flavorsomely acted as a top-of-the line production from Hollywood's classical studio era. . . Although highly predictable. . .this story of a young Southern lawyer taking on an evil insurance giant exerts an almost irresistible David and Goliath appeal, and proves absorbing from beginning to end."

Unnamed Critics Who Know Insurance, Nov. 26, 1997

"JOHN GRISHAM'S THE RAINMAKER is a Winner."

"I agree with the NEW YORK TIMES! They didn't have a bad thing to say about it."

"There are some GREAT turns by Jon Voight as the Prince of Darkness on retainer by the predatory insurance company, Mary Kay Place as the persecuted policyholder with a dying son-Randy Travis looking saintly and bleeding on cue, Teresa Wright as a loveable old lady who has kids who can't wait to get their hands on her money, Virginia Madsen as a micro-skirted claims handler who slept her way to lower middle management and Roy Scheider as the only insurance company CEO to wear powder-blue pinstripe suits to court and to arrive on the arm of a statuesque, beehive-coiffed blonde."

"Special mention to Matt Damon for his portrayal of Gene Anderson. He did, indeed, capture the essence of Gene's warmth and fuzziness."

"It has romance, violence, conflict, tears, humor--almost everything a movie needs. I recommend it."



Insurance News In Brief for the week of December 1, 1997

Insurance regulators' views concerning the history of standard form liability insurance policies are getting deserved attention. Back in 1970, the state of Vermont's Insurance Commissioner rejected the insurance industry's proposed new pollution exclusion (often referred to as the "sudden and accidental pollution exclusion" because it does not exclude from coverage pollution that is "sudden and accidental"). Notwithstanding this rejection nor the Vermont law which provides that all insurance policies delivered or issued for delivery in Vermont must be filed and approved, insurance policies were issued that contained the exclusion. Twenty-seven years later, a Vermont trial court has refused to give effect to the exclusion, finding that insurance policies providing coverage for a landfill in Vermont containing the exclusion were invalid and unenforceable. This

discussion may have an effect in other states like Maryland and New Hampshire which declined to approve the "sudden and accidental" pollution exclusion. [Vermont American Corp. v. American Employers Insurance Co., No. S330-6-95 WnCV J.P.M. (Vt., Washington County Super. Ct. Oct. 31, 1997)]

Other states have sought to limit the insurance industry's overly broad application of a more recent addition to the standard form liability insurance policy, the so-called "absolute" pollution exclusion. That newer exclusion was the subject of a cautionary letter issued by the state of Louisiana's chief insurance regulator. Louisiana Insurance Commissioner, James H. "Jim" Brown, conducted a three-year investigation into the use of the exclusion and other similar exclusions first included in insurance policies in 1985. As a result of his investigation, Commissioner Brown warned insurance companies against using the exclusions to deny claims that involve injury or damage caused by lead or asbestos, claims resulting from the proper use of a product, including exposure to fumes, or claims against a policyholder that was not an "intentional active industrial polluter." Insurance companies that continue to use the post-1985 exclusions to deny such claims will be subject to administrative action. [State of Louisiana Advisory Letter No. 97-01 (June 4, 1997)]

For a copy of the advisory letter from the Louisiana Commissioner of Insurance or the court's opinion in *Vermont American Corp. v. American Employers' Insurance Co.*, send an e-mail, including your name and address, to info@andersonkill.com

To contact the office of the Louisiana Commissioner of Insurance, click [here](#).

Insurance News In Brief for the week of November 24, 1997

Add dining (and breathing) in a restaurant to the list of things that one can now do without running afoul of the so-called "absolute" pollution exclusion in Massachusetts. That state now joins Illinois as a state in which the highest court has held that an "absolute" pollution exclusion does not bar insurance coverage for claims resulting from exposure to carbon monoxide. In the Massachusetts case, the policyholder-owner of an Indian restaurant was sued by a patron who suffered injuries from a build up of carbon monoxide. The build up was caused by an oven that was "starved for air" because all of the doors and windows were closed while a kitchen fan was running. The Massachusetts high court, like the Illinois Supreme Court in the *Koloms* case ([Insurance News In Brief, Week of October 27, 1997](#)), agreed that the "absolute" pollution exclusion should not automatically be applied to accidents arising in the course of business just because they involve the release of an "irritant or contaminant." [*Western Alliance Insurance Co. v. Gill*, No. SJC-07506, 1997 Mass. LEXIS 392 (Mass. Nov. 10, 1997)]

Insurance News In Brief for the week of November 10, 1997

In an unusual alliance, American International Group, one of the largest stock insurance companies in the world, has sided with consumer groups, criticizing efforts by mutual insurance companies to sell stock.

Mutual insurance companies are owned by their policyholders, regulated by state law, and if the

companies want to go public, they are required by law to distribute their accumulated profits to the policyholders. With competition in the financial industry fierce, mutual insurance companies have seized on a new way to raise money--change the state law.

Under the changes sought in New York, Massachusetts and at least six other states, a series of holding companies are formed. The policyholders remain the majority owners of the company and so receive no compensation, but they are allowed to purchase a limited amount of stock at a preferential price. Future profits would be shared by the policyholders and the new stockholders.

Consumer advocates such as Ralph Nader and Jason Adkins of the Center for Insurance Research have vehemently opposed the legislation, but it was successfully passed in 15 states and the District of Columbia. Now A.I.G. has come out against the changes, arguing that the changes give the mutual insurance company's management a "takeover-proof structure" in which management is accountable to neither the stock market nor policyholders.

Insurance News In Brief for the week of November 2, 1997

The owners of the Washington Redskins may have to pay an additional \$5.3 million to their workers' compensation insurance company because their insurance policy contained a retrospective rating clause. The U.S. Court of Appeals for the District of Columbia Circuit held last week that the clause allowed the insurance company to adjust the premiums after another court held that the Redskins' players and coaches were entitled to file workers' compensation claims in the District of Columbia rather than in Virginia. Workers' compensation benefits are higher in the District of Columbia than in Virginia and the original insurance premiums had been based on the benefit levels in Virginia. The federal appeals court found that the retrospective rating clause, which allowed the premium to be adjusted until three years after it expired, clearly permitted an adjustment when there was a change in the jurisdiction whose law was available to the employees. [*Hartford Accident & Indemnity Co. v. Pro-Football, Inc.*, No. 96-7215, 1997 U.S. App. LEXIS 29781 (D.C. Cir. Oct. 28, 1997)]

Insurance News In Brief for the week of October 27, 1997

The California Supreme Court denied review of a pro-policyholder Court of Appeals decision. A municipal policyholder that had been self-insured for various years during the time when environmental damages took place was not required to pay a portion of its defense costs. The insurance company that had the duty to defend the policyholder was not entitled to contribution because the policyholder was not an "insurer" and contribution claims are solely matters between "insurers." [*County of San Bernadino v. Pacific Indemnity Co.*, 56 Cal. App. 4th 666, 65 Cal. Rptr. 2d 657 (Cal. Ct. App. 1997), *rev. denied*, No. SO63672 (Cal. Oct. 1, 1997)]

Carbon monoxide claims are covered by insurance policies that contain the so-called "absolute" pollution exclusion. That's what the Illinois Supreme Court said for the second time ten days ago. Owners of a commercial building, the Koloms, were sued when a furnace in the building emitted carbon monoxide and other noxious fumes. The insurance company said the Koloms' claims were not covered because their policy contained what is referred to as an "absolute" pollution exclusion

and what happened was "pollution." The Illinois Supreme Court decided that the exclusion should be limited to those hazards traditionally associated with environmental pollution and should not bar insurance coverage for the damages in this case. In 1996, in the same case, the court also upheld the policyholder's right to insurance coverage but later accepted the insurance company's motion for reconsideration of the case. [*American States Insurance Co. v. Koloms*, No. 81289, 1997 Ill. LEXIS 448 (Ill. Oct. 17, 1997)]



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