CPCU SOCIETY INSURING YOUR SUCCESS

Consulting, Litigation, and Expert Witness Section Quarterly

CLEWS

Volume 13 Number 4 December 2006

From the Chairman

by Daniel C. Free, J.D., CPCU, ARM

Daniel C. Free, J.D., CPCU, ARM, is president and general counsel of Insurance Audit & Inspection Company, an independent insurance and risk management consulting organization founded in 1901 by his great-grandfather. He is past president of the Society of Risk Management Consultants (SRMC), an international association of independent insurance advisors.

Free is also a founding member of the CPCU Society's CLEW Section.

It was a packed house as CLEW and Claims Section members presented "A Ring of Fire" at the 2006 CPCU Society Annual Meeting and Seminars.

By now, we hope you heard that your CLEW Section once again came home with gold level recognition in the Circle of Excellence. Our success is a direct result of the efforts of many members of our section. As I began to study the submission, I thought I had a fairly good mental inventory of the various things we had done during the past year to advance the interests of the CPCU Society and our profession. Before I got too far into the documents, it became clear to me that there were far more section members volunteering their time and effort nationally and within the chapters than what I had first thought. Thanks to everyone—not only for your participation in the activities that led to the award—but also for letting us know what you did and when you did it. Special thanks go to **Vincent "Chip" Boylan Jr., CPCU,** for assembling all of the information for the submission, which was no small feat.

For many of you that are new to the CLEW Section, we all hope that you enjoy this newsletter and make good use of the information found on our web page. Try to take a few minutes to look at the newsletter archives, where you will find a number of interesting articles from previous issues. You may also wish to check out the page on Blogs of Interest put together by **George M. Wallace, J.D., CPCU,** which, in turn, takes you to some links to online web logs hosted by your fellow insurance professionals and attorneys. We encourage you to log on to the CLEW web page regularly. It enhances the value of your membership and we are always looking for new things to add to it.

This newsletter provides an excellent opportunity for you if you are interested in publishing articles. The articles in this issue and in the archives will give you an idea of the scope and length of the works best suited to this type of publication. Feel free to contact our newsletter editor, **Jean E. Lucey, CPCU,** to discuss your ideas.

Finally, have you ever been forced to sit through some CE class that was just plain boring? I am not referring to any of the excellent programs presented under the auspices of the CPCU Society, but we all know that there are some less-than-interesting programs out there. If you have found yourself in this situation, then you absolutely owe it to yourself to come to one of your CLEW Section's mock trials. Oh sure, they're educational and approved for CE credits. But then, so are some humdrum ones you'll come upon when checking your state's list of approved offerings. Here's a major difference: our mock trials are also a hoot!

Our most recent production was at the CPCU Society's 2006 Annual Meeting and Seminars in Nashville. Entitled, "A Ring of Fire," it was a first-ever combined effort of the CLEW and Claims Sections. The facts revolved around a suspected arsonist, who is acquitted of the criminal charges, and then sues her insurance company for failure to pay her claim. She

Continued on page 2

From the Chairman

Continued from page 1

obtains a runaway jury verdict, but not without the unwitting assistance of the insurance company's hapless claims adjuster.

The "CPCU Players" had some new cast members from the Claims Section who are unforgettably funny people. We don't have much time to rehearse, so the characters' lines are mostly ad lib. As I watched the trial, I did not see a single cast member who kept a straight face throughout, and it was obvious that the audience loved it. The next time you need hours, sign up for a CLEW Section mock trial. ■

■ *Attendees of this year's mock trial were entertained while learning details of an arson case.*

From the Editor

by Jean E. Lucey, CPCU

■ **Jean E. Lucey, CPCU,** earned her undergraduate degree (English) and graduate degree (Library Science) through the State University of New York at Albany. After a brief stint as a public school librarian, she spent six years at an independent insurance agency outside of Albany, during which time she obtained her broker's license and learned that insurance could be interesting.

Upon moving to Boston in 1979, because of a career opportunity for her husband, she was delighted to find there actually exists an Insurance Library Association of Boston. Serving as director since 1980, Lucey attained her CPCU designation in 1986. She is a member of the CPCU Society's Consulting, Litigation, & Expert Witness Section Committee. The Boston Board of Fire Underwriters honored her as "Insurance Person of the Year" in 1995.

Lucey continues to learn on the job every day through constant exposure to insurance literature and the myriad of questions asked by people working in the insurance industry as well as lawyers, consultants, accountants, bankers, academics, consumers, and students.

Daniel C. Free, J.D., CPCU, ARM, is a serious kind of guy, despite any impression you may have formed of him in the course of attending CLEW Section mock trials. So when he tells you that the section newsletter is an excellent forum in which to publish original articles, he means it. Feel free to contact me at jlucey@insurancelibrary.org if you have already written something and would like to submit it, or if you would like to brainstorm some ideas.

CLEW member **Paul J. McGee, CPCU, ARe,** is not only an extremely accomplished practitioner and instructor, he is also one of the most genuinely nice people that I know. I think that this shines through the profile of him that is included in this newsletter. Had he attended Boston College Law School after his other schooling, he would be what is known in the Boston area as a "Triple Eagle." The insurance industry is indeed better off because that did not happen.

James Zemp, J.D., CPCU, did pursue a career in law, and he pursues that career with the utmost conscientiousness and zeal, while retaining his courteous and pleasant demeanor—a balancing act that seems unattainable by many (including myself at times!). I think that when you read his suggestions concerning the drafting of laws, you will gain an enhanced understanding of that process and how it may be facilitated when reasonable people work together.

Companies big and small have elected to go into bankruptcy for many reasons, not all related to long-tail insurance claims such as that associated with asbestos. Are workers compensation premiums owed to insurers granted any special status in such proceedings? We seem to have a definitive answer to that question from the United States Supreme Court.

Just because you say you're not liable in any particular situation and get your customers to agree doesn't mean you're safe from lawsuits, as a riding stable in Connecticut learned. This lesson has relevance for many types of businesses.

We are again most appreciative of **Donald S. Malecki, CPCU,** for providing input in the form of a thoughtful and well-informed real-life answer to a real-life question. ■

CLEW Section Member Profile: Paul J. McGee, CPCU, ARe

Personal and Business

Although my birth record will show that I was born in Cambridge, MA, I actually grew up in a district of Boston known as Brighton, not to be confused with Brighton, England. Being a graduate of both Boston College High School class of 1950, and Boston College class of 1954, I am what is known as a "Double Eagle." The U.S. Marine Corps owned me for the next four years, followed by four years of active reserve service, at which point in time I was honorably discharged as a captain. Looking back, I think that my service in the Marines had a significant influence in the maturing process of my life.

After active military service, I joined the Employers Group of Boston in March 1958 as an underwriting trainee, progressing through the various ranks within the casualty organization as a regional office underwriter and ultimately being named as an underwriting manager in the home office in 1963. In February 1966, I was transferred to the newly formed Professional Reinsurance Department of the Employers (now known as OneBeacon), and was named assistant manager in 1967. My duties included the production and underwriting of Treaty Reinsurance business through intermediaries.

In September 1975, I joined Boston Reinsurance Corporation, an underwriting management company, as a senior vice president with responsibilities for the production and underwriting of both domestic and international treaty reinsurance. These responsibilities also included the negotiation and placement of ceded reinsurance.

The most demanding era of my corporate life began in March 1982 when I became president of Paul J. McGee Associates, Inc. in Boston, MA. As the senior person at McGee Associates, I had responsibility for all aspects of a Treaty and Facultative Underwriting management company. Assisted by a team of competent, professional people, these responsibilities included oversight of production, underwriting, accounting, claims handling, and negotiation plus the placement of ceded reinsurance, arising from a $20 million book of both domestic and international business.

For a brief period of time in the early 1990s, I had my first taste of the world of reinsurance consultancy, offering hands-on reinsurance services to insurance and reinsurance companies, and regulators. This service included, but was not limited to, reinsurance audits, contract review, reinsurance placement advice, and regulatory related examinations.

Following this challenging time as a consultant, I joined a subsidiary of the The Hartford known as Horizon Management Group in September 1995.

Horizon is charged with the responsibility of managing all aspects of a major reinsurance company in run-off. My duties included overseeing the scheduling and conduct of on-site audits of ceding companies and providing expert counseling and assistance to claims, accounting, and legal personnel in the conduct of daily affairs. In addition, I worked closely with counsel in providing expert positions on matters in dispute through arbitration or litigation, and advising claims personnel on reinsurance coverage issues. In addition, I conducted reinsurance educational programs for employees in Hartford and Boston.

Since retiring from the Hartford in 2004, I have aligned myself with Buxbaum, Loggia and Associates, an insurance and reinsurance consulting firm based in Fullerton, CA. This firm is staffed with insurance and reinsurance professionals well prepared to assist clients in solutions to insurance and reinsurance matters through audits and inspections, commutation discussions, expert witness, and arbitration support. At Buxbaum, Loggia, I am engaged in all of these disciplines. The most rewarding aspect of this work is the ability to share my knowledge and experience, gained from some 40 years in the reinsurance business, with clients who are in serious need of help. It is gratifying to realize that your counsel and efforts have played a role in smoothing fractured relationships and lead to reasonable solutions among reasonable people.

Family

I am the father of six children, Joan, Cathy, Pauline, Madeline, Michael, and Timothy. My wife, Jane, and I are living in Norwood, MA, where I am active as an elected town meeting member and chairman of the Cable Commission.

Memberships and Professional Activities

Throughout my career, I have stressed the importance of education and professionalism. Knowing this, it is not surprising to learn that I have not only been active in the CPCU Society but also in professional education.

After receiving my CPCU designation in 1977, I served as the president of the CPCU Society's Boston Chapter, and on the national level, a national director and chairman of the Reinsurance Section. Presently, I belong to both the CLEW and Reinsurance Sections.

As an educator, I have been a course leader for the Associate in Reinsurance (ARe) designation—receiving the designation myself in 1991—and for many years I have presented and continue to present a self-designed program known as Introduction to Reinsurance at the Insurance Library Association of Boston, and under the auspices of the CPCU Society at various chapters throughout the United States.

Continued on page 4

CLEW Section Member Profile: Paul J. McGee, CPCU, ARe

Continued from page 3

As an arbitrator certified by ARIAS•U.S.—the AIDA Reinsurance and Insurance Arbitration Society—and a graduate of the program on negotiation at Harvard Law School, I feel my years of experience in the reinsurance industry can be of significant value in the resolution of reinsurance disputes in a fair and equitable manner.

My growing concern is that the reinsurance dispute resolution arena is continuing to move away from maximizing the talents and knowledge of reinsurance "business people" as consultants or arbitrators. The increasing emphasis on legal practitioners in all phases of disputes will lead, in my view, to the ultimate yet unintended result that disputes will be resolved more on contemporary, persuasive legal arguments and to a lesser degree along the lines that the parties to the reinsurance agreements had intended. ■

Paul J. McGee, CPCU, ARe
can be reached at:
76 Lane Drive
Norwood, MA 02062
Phone: (781) 551-9705
Fax: (781) 762-1804

Federal Judicial Center

by Jean E. Lucey, CPCU

Editor's Note: In a previous issue of this newsletter, I imparted some information about the Federal Judicial Center. I reiterate my subjective (as contrasted with expert!) opinion that the work of this organization is well worth investigation. You can find it at www.fjc.gov/. Following is a summary of its publication policy, along with a synopsis of one of the many items available on its web site. Items cover a wide range of court-related subjects and comprise a wide range of formats—this one summarized here is among the smallest.

Publications

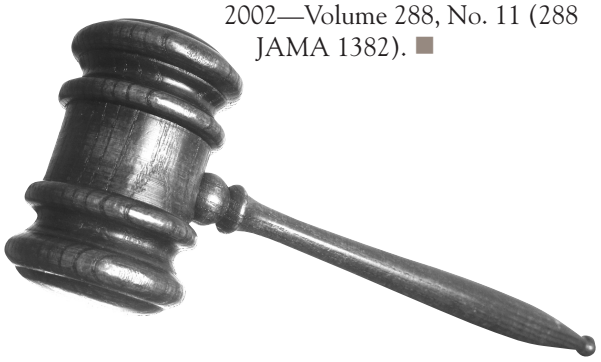
The catalog contains records of publications the Federal Judicial Center (FJC) has produced since its creation in 1967, including all titles currently in print and many older titles. Included are reports of research and analysis done by or for the Center, monographs on substantive legal subjects, manuals, and desk references for judges and court staff. Most FJC publications are available in depository libraries and federal court libraries. In addition to formal reports and studies, the catalog includes unpublished reports, memoranda, and other work produced by Center researchers. Unless otherwise noted, FJC publications are not copyrighted and may be photocopied, reproduced, or posted to Internet and intranet sites without the Center's permission, although acknowledgment of the Center's authorship would be appreciated.

Inconsistency in Evidentiary Standards for Medical Testimony: Disorder in the Courts

Jerome P. Kassirer; Joe S. Cecil
September 18, 2002, 6 pages
(In Print: Available for Distribution)

The Supreme Court, based on three decisions over the past decade, now requires judges to examine the underlying basis of all testimony to ensure that only expert testimony supported by valid methods if inquiry is introduced as evidence in litigation. Under these standards, expert testimony in the courtroom, including medical testimony, is supposed to meet the same standards of intellectual rigor that professionals use outside the courtroom. If expert testimony does not meet this standard, the courts are expected to exclude the testimony and may dismiss the case without trial. In this article, the authors review cases that illustrate inconsistencies in the courts' approach to medical expert testimony. They argue that while there may be good reasons to require evidence of a higher quality and quantity that a physician would require in ordinary clinical decision making, as some courts have done, this practice is not faithful to the mandate of the Supreme Court.

Reprinted from *JAMA*, September 18, 2002—Volume 288, No. 11 (288 JAMA 1382). ■



Laws Are Like Sausages!

by James Zemp, J.D., CPCU

- **James (Jack) Zemp, J.D., CPCU,** joined Rath, Young and Pignatelli's Insurance and Health Practices as a senior associate in June 2005. He is admitted to practice in New Hampshire and Massachusetts. Previously, Zemp served as attorney and counselor for the New Hampshire Insurance Department, where he advised the commissioner on legal and policy issues, wrote regulations, and served as the Department's hearings officer. Before joining the State, Zemp was in the private sector since 1989 working with insurers and other corporate clients on legal, risk, and business issues. He advised groups domestically and abroad on complex claims and coverage issues involving property and casualty, medical malpractice, employment practices, workers compensation, and life and health lines of insurance. Zemp graduated from Franklin Pierce Law Center in 1994. He became a Chartered Property Casualty Underwriter in 1996. In 1999, he received his master of business administration from the Carroll School at Boston College, and was inducted into Beta Gamma Sigma honor society. He graduated from the University of North Carolina at Chapel Hill with a bachelor of arts degree in 1987. In 2001, he was a Ph.D. candidate and course instructor in insurance and risk management at the University of Georgia.

Editor's Note: Those laws we often have a need to read and understand are not created in a vacuum (we hope!). Here's the perspective of a person who has been directly involved in the drafting process.

"Laws are like sausages, it is better not to see them being made."

—Otto von Bismarck (1815–1898)

This quote probably captures how many of you feel about drafting and implementing laws—it's best not to even think about it. Actually, writing laws really is not that bad. I discovered this when I joined the New Hampshire Insurance Department as general counsel in 2002, and it holds true in my private practice today. Up until these jobs, my experience was much like yours, working for insurance companies, (primarily in claims and consulting) with no real background drafting and implementing laws.

When I had to write my first insurance law, I quickly realized that there were many helpful resources. There are modal laws, other states' laws, and drafts offered by those representing industry and consumers. Also indispensable to the process were those people from the State Insurance Department, state representatives, senators, and their research staffs. With all of this help so readily available, writing laws is actually less daunting than one might think. For those who are curious, or may even be willing to give it a try, here are a few tips on how to write and implement insurance laws.

"I choose a block of marble and chop off whatever I don't need."

—Auguste Rodin (1840-1917)

With my apologies to the great sculptor Rodin, this is good advice for drafting laws as well. The trick is to start with a good "block" of resource material. Fortunately, there are many sources. First, as previously mentioned, there are model laws and regulations. For insurance, two good sources for models are the National Association of Insurance Commissioners (NAIC) and the National Association of Insurance Legislators (NCOIL).

Both the NAIC and NCOIL meet quarterly to draft, debate, and adopt model insurance laws and regulations. At the NAIC, for instance, the gathering includes state insurance commissioners and their staffs as well as industry representatives and consumer advocates. The NAIC models, notes, drafts, and meeting minutes are then made available to State Insurance Departments and others who are seeking ways to tackle a similar issue. You can order these models and proceedings through the NAIC.org or NCOIL.org web sites or for the NAIC, use online legal research engines such as Lexis or Westlaw.

If a model is not available, or if it does not quite fit what you need, other good sources are the laws and regulations from other states. One advantage of having the 50 states regulate insurance (contrasted with a federal regulator) is that those who are drafting a law in one state can often find good approaches in another.

This underscores that writing laws is an evolutionary process, where many thoughtful and knowledgeable people across the country monitor, discuss, and contribute ideas, in an effort to improve the overall body of insurance law. Sure, the result may mean inconsistencies among states' laws. But, within these inconsistencies, you will often identify issues unresolved in the model—and the richest source for finding better alternatives.

A draft law must of course account for local interests and concerns. The governor, state legislators, or the commissioner of insurance often are the ones to express these local interests.

Continued on page 6

Laws Are Like Sausages!

Continued from page 5

However, many times the sources for such concerns are consumers or industry representatives who discover an issue or inconsistency within the law or insurance marketplace, and look to the Department of Insurance for clarification or correction. They may only express a general concern, or they may be willing to be engaged in the process by participating in a working group or helping formulate draft language.

For example, in 2003, members of the insurance brokerage community brought concerns to the New Hampshire Insurance Department about the state's anti-rebating laws. The law—which was based in NAIC language adopted by New Hampshire and 46 other jurisdictions in the 1940s—broadly precluded an agent, broker, or insurer from giving, for free or at a discount, anything of valuable consideration as an inducement to buy or retain insurance, which is not mentioned in the insurance contract.

> ***. . . today's marketplace thrives in part through producers and insurers offering value-added services for the benefit of the client.***

After reviewing other states' laws and conducting several roundtable discussions with local interested parties, the New Hampshire Department of Insurance recognized that the old law needed changing. It recognized that today's marketplace thrives in part through producers and insurers offering value-added services for the benefit of the client. Permitting these services encourages competition in today's marketplace, and provides a means for the producer or insurer to better meet customer needs. Accordingly, the drafted amendments, which were subsequently adopted by the state legislature, added exceptions to the anti-rebating statute. Now, producers and insurers may offer value-added services, for free or a discount, as long as those services are (1) part of the insurance or producer contract, (2) directly related to the firm's servicing of that contract, or (3) provide risk control for the benefit of the client. See N.H. Rev. Stat. Ann § RSA 402:41.

One last thing to keep in mind:

"When ideas fail, words come in very handy."

—Goethe (1749–1832)

When drafting a law, often the best way to provide clarity is to reduce the law down to as few words as possible. Good ideas usually can be expressed simply. A sure sign that a law is flawed is that it does not communicate clearly what it does.

This trouble will often haunt you. During the legislative process, legislators (rightfully) will test the thinking underlying the law. If the law has deficiencies, there is often a tendency to add words or meaning that may, in fact, cause more confusion after it's enacted.

The best strategy to avoid this is to test your ideas and build a consensus among interested parties. This requires a lot more listening than talking. I'm a huge fan of working groups, where those who have divergent interests can offer their thoughts. In these groups, open discussion is key.

By airing and testing ideas, you will find underlying principles that will direct you in your drafting. These will also help you communicate what the law does and build consensus, not only among those in your working group, but with the state lawmakers as well. With such principled consensus, the draft is well on the way to becoming a law. You have made the sausage, and can feel good about the process. ■

Supreme Court Denies Priority Status for Unpaid Workers Compensation Premiums

by Daniel S. Bleck and Scott H. Moskol

Editor's Note: This item is somewhat more substantial than those that typically appear in our section newsletters. It elucidates a somewhat complicated situation, and one in which many may, unfortunately, come to be involved with in one capacity or another.

This article was previously published in the September 2006 issue of *The Insurance Coverage Law Bulletin* and is reprinted here with permission.

- **Daniel S. Bleck** practices in the commercial law section in the Boston office of Mintz, Levin, Cohn, Ferris, Glovsky and Popeo, P.C., and is a member of the firm's insurance/bankruptcy group.

- **Scott H. Moskol** also practices in the commercial law section in Mintz Levin's Boston office, and is a member of the firm's insurance/bankruptcy group.

Author's note: The authors acknowledge the help and assistance of **Kim Marrkand**, the chair of the firm's insurance/reinsurance group and a member of the firm's insurance/bankruptcy group, in the preparation of this article.

The views expressed in the article are those of the authors and not necessarily those of Mintz Levin or its clients.

In a recent decision, the United States Supreme Court clarified an important issue to workers compensation insurers holding that pre-petition unpaid workers compensation premiums are not entitled to priority status under the Bankruptcy Code. *Howard Delivery Service, Inc., et. al. v Zurich American Insurance Co.*, 126 S. Ct. 2105 (2006). This decision forecloses any disagreement among the circuit courts that unpaid workers compensation premiums are entitled to priority status in a bankruptcy proceeding. In light of *Howard*, such claims are now considered merely general unsecured claims. Had the Supreme Court afforded priority status to such claims, they would have been paid prior to the claims of general unsecured creditors. Generally, priority expense claims receive a significant, if not a one hundred percent (100 percent) distribution, as opposed to general unsecured claims, which, in many circumstances, receive only pennies on the dollar. In a decision delivered by Justice Ginsberg, joined by five other Justices (Chief Justice John Roberts Jr. and Justices John Paul Stevens, Antonin Scalia, Clarence Thomas, and Stephen Breyer) the Supreme Court's ruling not only brings consistency to this issue, but also provides opportunities to workers compensation insurers to avoid forfeiture of payment of their premiums by financially troubled insureds.

In *Howard*, Zurich issued various workers compensation policies for Howard Delivery Services, Inc., a freight trucking business. In 2002, Howard filed for chapter 11 bankruptcy protection, while still owing Zurich approximately $400,000 in unpaid workers compensation premiums. Zurich sought priority status for its claim, asserting that the unpaid premiums qualified as "contributions to an employee benefit plan," which were thus entitled to priority status under Section 507(a)(5) of the Bankruptcy Code. The Bankruptcy Code provides a waterfall of how claims will be paid in a bankruptcy proceeding. Generally, with certain exceptions, holders of secured claims will be paid first and in full to the extent of the value of their underlying collateral. A claim may be secured by either real or personal property, or both. Following secured claims, a debtor's estate will pay administrative claims. Administrative claims are claims incurred by a debtor subsequent to the filing of the petition in which the debtor received some benefit from the post-petition rendering of either goods or services. Usually, administrative claims are paid in full as well.

The majority of claims in a typical bankruptcy case are classified as general unsecured claims—such claims are not secured by any form of collateral and typically will be paid a percentage of its full claim value. Congress, in enacting the Bankruptcy Code, recognized that certain types of unsecured claims should be paid in full prior to other types of claims. Thus, the Bankruptcy Code establishes a list of so-called "priority claims," which are paid in full or nearly in full and ahead of other general unsecured claims. Examples of priority claims include claims for unpaid wages and salaries, contributions to an employee benefit plan, or claims for taxes. For certain types of priority claims, the Bankruptcy Code establishes a monetary limit with any remaining portion of the claim above the cap being treated as a general unsecured claim. For example, Sections 507(a)(4) and (a)(5) address the wage and fringe benefit claims against a debtor employer. Section 507(a)(4) provides that individuals or corporations will be granted priority status for wage-related claims that are earned within 180 days of the filing of the bankruptcy or the cessation of the debtor's business, whichever occurs earlier, up to a maximum amount of $10,000. Section 507(a)(5) complements 507(a)(4) by elevating priority status to claims for contributions to an "employee benefit

Continued on page 8

Supreme Court Denies Priority Status for Unpaid Workers Compensation Premiums

Continued from page 7

plan" arising from services rendered within the 180-day period up to the $10,000 maximum amount noted above less any amounts provided for under Section 507(a)(4).

In the bankruptcy proceeding, Zurich sought priority status for the unpaid premiums owing to it, asserting that these past due premiums qualified as contributions to an employee benefit plan and thus were entitled to priority under Section 507(a)(5) of the Bankruptcy Code. The Bankruptcy Court, however, denied Zurich's request for a priority claim finding that the premiums were not bargained-for benefits furnished in lieu of increased wages and thus did not fall within Section 507(a)(5). The District Court affirmed the decision of the Bankruptcy Court while the Court of Appeals for the Fourth Circuit reversed in a 2-to-1 *per curiam* opinion. Although the Fourth Circuit agreed on the outcome, the majority disagreed as to the rationale. One judge found that Section 507(a)(5) unambiguously provided priority status to unpaid workers compensation premium. Another judge, concurring in the judgment, found that the term "employee benefit plan" contained in the statute was ambiguous and, instead, turned to legislative history to conclude that Congress likely intended that past due workers compensation premiums should be granted priority status. In his dissent, Judge Neimeyer relied on what he deemed to be the plain meaning of the statute, but read it to mean that past due workers compensation premiums should not be granted priority status.

The Supreme Court granted *certiorari* to resolve a split among the circuit courts. In determining that Zurich's claims were not entitled to priority status, the Supreme Court focused its analysis on whether an unpaid workers compensation premium is equivalent to a contribution to an "employee benefit plan." The majority decision found that workers compensation plans are considerably different than other types of employee benefit plans and thus denied Zurich's request.

The Supreme Court initially noted that Congress had not defined the term "employee benefit plan"; accordingly the Court reviewed the "essential character" of workers compensation regimes and compared these plans to other employee benefit plans. In denying priority status to workers compensation insurers, the Supreme Court differentiated workers compensation plans from other employee benefit plans on a number of grounds.

First, as opposed to other types of benefits that run solely to the employee's benefit—such as pension plans and group health, life, and disability insurance—workers compensation programs run to the benefit of both the employee and employer. In exchange for the no-fault fixed payment workers compensation administrative system, the employer is relieved of all liability and uncertainty from an employee's claim against it in the tort system. Although the Court recognized that workers compensation programs provide some benefit to employees (i.e., such plans assure payments for injuries incurred on the job) the Court believed that the overriding benefit inures to the employer. The Court concluded that "[i]n exchange for no-fault liability, employers gain immunity from tort actions that might yield damages many times higher than awards payable under workers compensation schedules. Although the question is close, we conclude that premiums paid for workers compensation insurance are more appropriately bracketed with premiums paid for other liability insurance, e.g., motor vehicle, fire, or theft insurance, than with contributions made to secure employee retirement, health, and disability benefits."

Second, the Court distinguished workers compensation benefits from other "employee benefits plans" because so-called fringe benefits are either voluntary or bargained-for while workers compensation benefits are not; state laws, with limited exceptions, require employers to participate in workers compensation arrangements. The Court was very careful in stating that this was simply a factor in its analysis by noting that a workers compensation carrier's claim for unpaid premiums would not gain priority status in those states where workers compensation coverage is not mandatory. The Court hedged this factor by stating that "[w]e simply count it a factor relevant to our assessment that States overwhelmingly prescribe and regulate insurance coverage for on-the-job accidents, while commonly leaving pension, health, and life insurance plans to private ordering."

Finally, the Supreme Court looked to the overriding policy of the Bankruptcy Code, which requires equal distribution among creditors. Expanding the definition of "employee benefit plans" to provide a preferred status to workers compensation insurers would, the Court believed, effectively erode the priority amount available to employees in connection with other unpaid wages and employee benefits, an outcome the Court rejected. As noted above, there is a cap of $10,000 for wage-related priority claims; thus an expansion of the definition of "employee benefit plan" would decrease the amounts available for other types of "employee benefit" claims.

The Court was also unwilling to look to other statutes, namely the Employee Retirement Income Security Act of 1974 ("ERISA"), to assist in the interpretation of what is meant by an employee benefit plan. While Zurich argued that ERISA expressly included workers compensation plans in the definition of an "employee benefit plan," the Court declined to rely upon ERISA for guidance, concluding that ERISA was not enacted with bankruptcy goals in mind. The Court in rejecting the ERISA argument, appeared to take a strict construction approach: "We follow the lead of an earlier decision, *United States v Reorganized CF&I Fabricators of Utah, Inc.*, 518 U.S. 213, 219 (1996), in noting that '[h]ere and there in the Bankruptcy Code Congress has included specific directions that establish the significance for bankruptcy

law of a term used elsewhere in the federal statutes.' Id. At 219-220. No such directions are contained in Section 507(a)(5), and we have no warrant to write them into the text." Curiously, if the majority followed the strict construction approach throughout its entire opinion, it may have reached the exact same conclusion of the dissenting justices.

A strong dissent was written by Justice Kennedy, in which Justices David Souter and Samuel Alito joined. Each of these justices believed that the Court was required to apply a strict interpretation of the Bankruptcy Code (as the majority had done in addressing the ERISA argument). In the dissenting opinion, the justices noted that, because workers compensation plans benefit both employees, as well as employers, this should end the inquiry. As the dissent highlights, there is no requirement in the Bankruptcy Code that, to qualify as an employee benefit plan, a court needs to weigh who benefits more from such a benefit, the employer or the employee.

Additionally the dissent countered that even if the definition of an "employee benefit plan" is ambiguous, ERISA provides "considerable support" to Zurich's arguments. The dissent notes that the term "employee benefit plan" "is not a general phrase but something closer to a term of art, with a meaning that seems unlikely to change based on statutory context."

The dissent also countered the majority view that priorities should be construed narrowly to limit their availability by commenting that "[t]he bankruptcy priorities . . . should not be read simply to give priorities to as few creditors as possible. They should be interpreted in accord with the principle of equal treatment of like claims. In any event, the priority provisions should not be read so narrowly as to conflict with their plain meaning."

This decision once again highlights the struggles courts face in dealing with insurance issues in any bankruptcy proceeding. Here, in a decision that the Court itself characterized as a "close call," as in other bankruptcy cases involving insurers, the majority opinion tipped the balance in favor of the debtor insured, notwithstanding that, as the dissenting opinion demonstrated, there is no requirement under the Bankruptcy Code to balance the benefits between the employers and employees. Going forward, workers compensation insurers may want to consider taking the following steps. First, a workers compensation insurer should closely monitor the financial viability of its insureds. No longer can the insurer rely on the prospect of receiving a priority claim in a bankruptcy proceeding for its unpaid pre-petition workers compensation premiums. Based on the *Howard* decision, unpaid workers compensation premiums will only be treated as general unsecured claims in an insured's bankruptcy and thus the insurer bears the risk of receiving pennies on the dollar for its claim. An insurer needs to be aware of its accounts and be flexible in terms of considering options for an insured with a large arrearage of unpaid premiums.

Second, regardless of the financial viability of its insureds, the insurer should consider requiring the insured to provide collateral to support its obligations under any workers compensation policy, including posting a bond or a letter of credit at the time of the initial writing of the policy. Often times, upon the inception of a workers compensation policy, the insurer may request that unpaid amounts—whether they be regular premiums, retrospective premiums, deductibles, or any other unpaid amount owing to the insurer under the terms of the policy, be secured. Thus, if the insured is unable to make the required payments under the policies, the insurer can look to the security for payment, whether it is a letter of credit, a bond, or other form of security. To the extent the insurer finds an insured with past due arrearages, it may consider asking for collateral from its insured to secure any and all amounts due and owing to it (although there may be some risk that this security will be avoided in a subsequent bankruptcy filing). If an insured were to file for bankruptcy, letters of credit generally are seen as being a "better" form of security. Since most courts hold that letters of credit are not part of the debtor's bankruptcy estate, the insurer is not required to obtain court relief to draw down on the letter of credit—all the insurer needs to do is follow the requirements contained in the letter of credit. As opposed to a letter of credit, various courts have held that a debtor does possess an interest in a bond securing unpaid obligations and, thus, it is prudent to obtain bankruptcy court authorization prior to enforcing the insurer's right against a bond to pay the outstanding amounts owed under a policy. Regardless of the form of security, however, the insurer will be in a better position vis-à-vis other unsecured creditors if it can look to any form of security for payment of unpaid premiums.

Finally, at the time of the renewal of any workers compensation plans, an insurer should insist that any unpaid premiums be paid currently (to the extent no bankruptcy proceeding is pending and, for retrospectively rated programs the loss data is available) before the insurer agrees to the renewal of any such policies. If a bankruptcy is pending at the time of such renewal, the insurer should be careful that it does not condition renewal on payment of any pre-petition amounts outstanding, as a court might find such a demand to be a violation of the automatic stay. Although the *Howard* decision has changed the landscape of insurers' options in a bankruptcy, by taking various steps prior to the bankruptcy filing the insurer can avoid having its unpaid claim being treated as a mere general unsecured claim. As all situations in this area are factually unique, however, consultation with a bankruptcy professional is recommended when deciding upon which course of action to take in this regard. ■

No Horsing Around, Connecticut High Court Tosses Liability Waiver

Editor's Note: I could not readily quantify the number of riding stables in operation throughout the states, but we can be certain there are thousands of them. If any stable operators think that they can rely upon signed waivers to escape liability, it should be suggested that they'd better think again. Here's a summary of a case in point, reprinted with permission from the October 26, 2006, issue of *Insurance Journal* (East).

A release from liability that a horseback riding farm requires all of its customers to sign violates public policy and is not enforceable, the Connecticut Supreme Court recently ruled.

The high court, citing a similar case involving a snow tubing liability waiver, ruled that a recreational liability waiver must be judged in the "totality of the circumstances of any given case against the backdrop of current societal expectations," including whether the recreational activity is one people expect to be safe, whether the operator is in the best position to ensure safety, and whether the customer has any choice in the waiver.

Williams and Mona Raymond, owners of Wind Swept Farm LLC, had all of their customers sign the waiver. The plaintiff, Jessica Reardon, signed the release prior to her horseback riding lesson with the defendants and even identified herself on the release as an "[e]xperienced [r]ider" and as someone who had "[r]idden [horses] frequently" several years earlier.

During the course of her lesson, the horse provided by the defendants became excited, bucked back and forth suddenly and without warning, threw the plaintiff to the ground, causing her serious injuries.

The plaintiff brought an action in August 2003, alleging that she had been injured due to the defendants' negligence. Among other things, she maintained that the defendants knew of the horse's propensity to buck yet failed to warn [the plaintiff] and they failed properly to hire and train their riding instructor.

In their defense, the Raymonds contended that the plaintiff had assumed the risk and legal responsibility for any injury and her claims were barred due to the fact that she signed the waiver/release. The trial court agreed, ruling that the waiver was enforceable, and granting summary judgment for the Raymonds.

On appeal, plaintiff Reardon claimed that the release should be void as a matter of public policy in light of the court's previous decision in *Hanks v Powder Ridge Restaurant Corp.*, supra, 276 Conn. 314. This time, the Supreme Court agreed with her.

In *Hanks*, a case about a release involving snow tubing, the court concluded that the enforcement of an exculpatory document might violate public policy if certain conditions are met. The court concluded that "[t]he ultimate determination of what constitutes the public interest must be made considering the totality of the circumstances of any given case against the backdrop of current societal expectations."

In the *Hanks* snow tubing decision, the court placed particular emphasis on: the societal expectation that family-oriented activities will be reasonably safe; the illogic of relieving the party with greater expertise from the burden of proper maintenance of the snow tubing run; and the fact that the release was a standardized adhesion contract, lacking equal bargaining power between the parties, and offered to the plaintiff on a "take it or leave it" basis.

The Supreme Court found the situation in the horseback riding case similar to that in *Hanks*. The Raymonds provided the facilities, the instructors, and the equipment, and their facilities were open to the general public regardless of an individual's ability level. Indeed, the defendants acknowledged that, although the release required riders to indicate their experience level, it also anticipated a range in skills from between "[n]ever ridden" to "[e]xperienced [r]ider," and that the facility routinely had patrons of varying ability levels.

The court said that there is a "reasonable societal expectation that a recreational activity that is under the control of the provider and is open to all individuals, regardless of experience or ability level, will be reasonably safe."

Additionally, as in *Hanks*, the court found that the plaintiff "lacked the knowledge, experience, and authority to discern whether, much less ensure that, the defendants' [facilities or equipment] were maintained in a reasonably safe condition." Although the plaintiff characterized herself as an experienced rider, she was in no greater position than the average rider to assess all the safety issues connected with the defendants' enterprise. It was the defendants, not their customers, who had the "expertise and opportunity to foresee and control hazards, and to guard against the negligence of their agents and employees. They alone [could] properly maintain and inspect their premises, and train their employees in risk management."

The high court was also bothered by the fact that the release was mandatory. There was no opportunity for the plaintiff to negotiate the terms. If she didn't like the terms of the release, her only option was to not participate in the activity.

In addition, the court said the waiver was an attempt to extend the plaintiff's assumption of risk beyond what the state legislature set forth. Current statute says that an operator of a horseback riding facility can be liable for injuries caused by its own negligence.

The court acknowledged that there are certain risks that are inherent to horseback riding as a recreational activity, one of which may be that horses move

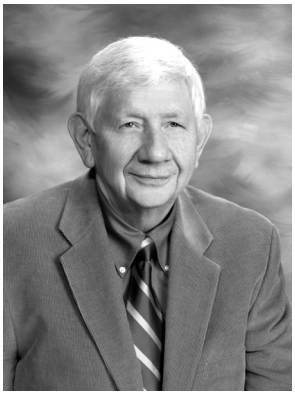
unexpectedly. However this "does not change the fact that an operator's negligence may contribute greatly to that risk." For example, the defendants may have negligently paired the plaintiff with an inappropriate horse given the length of time since she last had ridden or negligently paired the plaintiff with an instructor who had not properly been trained on how to handle the horse in question. The court said both of these scenarios "present factual questions that, at trial, may reveal that the defendants' negligence, and not an inherent risk of the activity, was to blame for the plaintiff's injuries."

Accordingly, the court said it was unable to conclude that horseback riding is so different from snow tubing that the release should be enforced as a matter of law.

The case, *Reardon v Wind Swept Farm LLC*, was handed down September 29, 2006. ■

Q&A with Donald S. Malecki, CPCU

by Donald S. Malecki, CPCU



Donald S. Malecki, CPCU, is a principal at Malecki Deimling Nielander & Associates L.L.C., based in Erlanger, KY. During his 45-year career, he has worked as a broker, consultant, archivist-historian, teacher, underwriter, and insurance company claims consultant; and as publisher of *Malecki on Insurance,* a highly regarded monthly newsletter.

We have a situation where an entity purchased a property policy. The Declarations page states that the property insurance is blanket for an amount of $7.2 million. Typed on the Declarations page also, is Item 002 Blanket Building and Personal Property per Statement of Values on File with X Insurance Company.

The next six pages of the Declarations list the locations of the buildings throughout the community. The locations are listed as 002-001, 002-002, 002-003, as so forth. No values are listed on any of the buildings at these locations. The statement that the item 002 values are on file appears to be the Schedule of Values. The producer had the general manager sign the Statement of Values.

The coinsurance is 100 percent. However, on the back of the first Declarations page are the typewritten words: Blanket Options, Agreed Amount expiration date June 30, 2007.

The Statement/Schedule of Values is an ACORD form 139. It has a column heading of 100 percent values, under which each of the buildings is identified as being the 100 percent values.

As luck would have it, lightning struck one of the buildings and with fire following, it was destroyed. The estimated cost to rebuild this building is $2.7 million. The scheduled value on file with the insurer, however, is $1.2 million.

The issue, as we see it, is that the insurer is maintaining the policy as a scheduled one, whereas we believe it is blanket. Quite frankly, we do not believe there is such a thing as a blanket policy with scheduled values. We, therefore, are taking the position that the policy is a blanket one and that we can apply the entire policy limit of $7.2 million to the loss.

Are we correct in our thinking?

Based on your explanation, yes, you are correct that the policy limit is $7.2 million. With the Agreed Amount applicable, the coinsurance is suspended. The Statement of Values is used by underwriters to calculate the blanket (average) rate.

There are three kinds of blanket insurance covering direct property loss; that is, not involving blanket business income coverage: (1) vertical coverage, applying two or more items of property, such as building and business personal property in a single "fire division" (a building or section of a building cut off from other buildings or sections by adequate clear space or approved fire wall); (2) horizontal coverage, applying to a single kind of property in two or more fire divisions at one or more locations; and (3) a combination of (1) and (2), e.g., two or more buildings or business personal property. Actually, there are four kinds of property that can be grouped under a single blanket item or in a single fire division or separately rated building: building or structure; business personal property; personal property of others; and tenant improvements and betterments.

An entity with property in two or more fire divisions or locations can provide horizontal coverage, applying to similar property (buildings, business personal property, property of others, or tenant's improvements and betterments) at all or selected locations. If the locations are widely enough separated so that the largest conceivable loss will not exceed the blanket limit of insurance, the advantage of blanket coverage is most obvious.

Continued on page 12

Q&A with Donald S. Malecki, CPCU

Continued from page 11

Where one amount is applicable to any loss, a policyholder, assuming it is otherwise in compliance with coinsurance (which is suspended with an agreed amount provision), can collect the full amount of its loss, even in your case; that is, when the value of the property destroyed is more than the value declared on the Statement of Values.

The fact that the insurer is disputing this loss is not unusual, particularly when the replacement value of the damaged or destroyed property is considerably more than the amount declared in the Statement of Values. In fact, there are some reported cases in this area with mixed results.

In *Reliance Ins. Co. v Orleans Parish School Board,* et al., 322 F. Supp. 803, the U.S. court of appeals, 5th circuit, found that a policy with a form attached listed as "School Form-Blanket" was a blanket policy. It initially covered some 350 items of property but, at the time of the loss under consideration, contained more than 40 endorsements showing additions and deletions of specific property items, each with a specified amount added or deleted. The insurer argued, without success, that reference to the individual values on the endorsements was evidence of the policy's intent to provide scheduled rather than blanket coverage for the amounts shown in the schedule.

But in *Rich Maid Kitchens v Penna. Lumbermen's Mutual Ins. Co.,* 641 F. Supp. 297, the question of whether a policy was for a single blanket amount or applied separately to each of five property locations listed in the policy was resolved by the U.S. district court, E.D. Pa. in favor of separate scheduled items. On one of the policy's pages appeared the words "PA. BLANKET" and in the space for identification of covered property was shown "as per attached." Stapled to the form was a schedule listing five locations, each showing a separate amount; a total amount; and a set of average rates used to compute the premium.

A key factor in this case, however, was the producer's testimony that in his opinion the coverage was intended to apply to each of the five locations separately. Whether, absent that testimony, the court's decision would have been the same will never be known.

To restrict limits available, the policy in your case could have been issued with a limit applicable to buildings and a separate limit for business personal property. Some insurers also include a so-called "margin clause" above the property's value as listed on the Statement of Values. One such endorsement will then pay 115 percent of the total values. Margin clauses are somewhat of a compromise, covering for less than the blanket amount but more than the value noted on the Statement of Values. The policies need to be read carefully to determine if they have been amended with such clauses. It does not take long when insurers, seeing such a clause to exist, will incorporate it into their policies. ■

CLEWS is published four times a year by and for the members of the Consulting, Litigation, & Expert Witness Section of the CPCU Society.
http://clews.cpcusociety.org

***CLEWS* Editor**
Jean E. Lucey, CPCU
Insurance Library Association of Boston
E-mail: jlucey@insurancelibrary.org

CLEW Section Chairman
Daniel C. Free, J.D., CPCU, ARM
Insurance Audit & Inspection Company
E-mail: dfree@insuranceaudit.com

Sections Manager
John Kelly, CPCU
CPCU Society

Managing Editor
Michele A. Ianetti, AIT
CPCU Society

Production Editor
Joan Satchell
CPCU Society

Design
Susan B. Leps
CPCU Society

CPCU Society
720 Providence Road
Malvern, PA 19355
(800) 932-CPCU
www.cpcusociety.org

CPCU Society INSURING YOUR SUCCESS

Consulting, Litigation, and Expert Witness Section Quarterly

CLEWS

Volume 13 Number 4 December 2006

CPCU Society
720 Providence Road
Malvern, PA 19355
www.cpcusociety.org

PRSRT STD
U.S. POSTAGE
PAID
BARTON & COONEY