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Chairman's Corner: Coaching Ethics

by Robert E. McHenry, CPCU, AIC, AIS

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"Ethics, noun [U]:
The study of what is morally right and wrong, or a set of beliefs about what is morally right and wrong."

—Cambridge Dictionaries online.com

The spring 2008 fastpitch softball season started several weeks ago here in Florida. I am privileged to be coaching my seventh season. More importantly I've been coaching claims people for nearly 33 years (or 66 softball seasons). It has never mattered if the player or adjuster was my favorite. The person got honest feedback, direction, help, encouragement, and/or an ethics lesson.

Most states have some type of bad-faith action available. Coaching ethical and legal behaviors will prevent or defeat these causes of action. Does the adjuster action conform to the fair claims practices in your state? If the answer is yes, then the action is legal and most likely ethical. Teach your coworker where to find the practices and get a copy of them. Go over the document, highlight the key areas, and answer any questions.

The "does it feel right?" test. This is an example of being legal, yet not necessarily ethical. Teaching claims representatives to follow the myriad cases and common law is just part of your coaching duties. Strong moral examples must be part of the training. It used to be legal in Ohio to withhold property damage payments until the injury is settled. But it "didn't feel right." (Unfair claims practices changed this quite some time ago—33 years, remember.) So we paid to repair the claimant vehicle as soon as possible.

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We frequently see the same attorney names year after year and case after case. In other words, sooner or later an adjuster will have to deal with that counselor again. Ethical behavior should go both ways. Instruct the adjuster to be fair. A thorough review of the positives and negatives of the case can do this. Have them discuss the attributes with the attorney. If the adjuster does not believe part of the claimant's story, it is ethical to say so and also why. This does not mean to play all of your cards at once. Yet it does mean not to play cards you don't have.

People make mistakes. Coach the adjuster to give an insured or claimant a second chance. Common sense and experience may show the story, price, or injury cannot possibly be correct. Teach your co-worker to tell the first or third party what could happen if there is no merit to the claim. Then the ball is in their court. If the person changes to a more plausible scenario, the adjuster knows he or she was right and ethical. If the person persists then there are two possibilities. One is the claim representative is mistaken.

Use an outside coach. Florida and other states require continuing education hours every two years in ethics. Go with the adjuster and take the classes together. Discuss what you both learned. (If **Elise M. Farnham, CPCU,** is the instructor, by all means attend!) Different perspectives help us build our own ethical database.

My team is "Maximum Fastpitch." Our record was 34 wins and 12 losses. Coach, what record will you have teaching ethics? ■

"Reputation is what folks think you are. Personality is what you seem to be. Character is what you really are."

—Anonymous

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Photo courtesy of the Philadelphia Convention & Visitors Bureau and Jim McWilliams.

Insurance-Palooza

Seventh Annual Look at the Year's 10 Most Significant Coverage Decisions

by Randy J. Maniloff

Randy J. Maniloff is a partner in the Business Insurance Practice Group at White and Williams, LLP in Philadelphia. He concentrates his practice in the representation of insurers in coverage disputes over various types of claims. Maniloff writes frequently on insurance coverage topics for a variety of industry publications, and his views on such issues have been quoted by numerous media, including *The Wall Street Journal, The New York Times, USA Today,* Associated Press, and Dow Jones Newswires.

Editor's notes: Maniloff's analysis of the top 10 cases has been edited because of space limitations. We have included a detailed analysis of four of the cases that were judged to be of most interest to our readers. The unedited version of the article can be obtained from the author, maniloffr@whiteandwhilliams.com. This article originally appeared in *Mealey's Litigation Report: Insurance,* January 10, 2008.

The views expressed herein are solely those of the author and are not necessarily those of his firm or its clients. The author expresses his gratitude to firm associate Jennifer Wojciechowski for her invaluable contributions to this article.

It is a rare day that a court is called upon to address the availability of insurance coverage for a claim for alienation of affections. But in 2007, this solar eclipse of a coverage issue saw the light not just once, but twice. If you don't think that's a long shot, then how about this—both decisions came from South Dakota (the state's supreme court and the Eighth Circuit applying South Dakota law[1]). Those are Powerball odds. And I thought the only thing that people in South Dakota did for fun was visit Mt. Rushmore. (South Dakotans—you can send hate mail to maniloffr@whiteandwilliams.com.)

That's the kind of year 2007 was for insurance coverage—the typical landscape of important decisions dotted with entertaining and attention-grabbing ones, e.g., see *Bobby Knight v Indiana Insurance Company* (who else), 871 N.E.2d 357 (Ind. App. 2007) (No coverage for Indiana University's famously bad-tempered basketball coach for, what else, assaulting an assistant coach); *Woo v Fireman's Fund Insurance Company*, 164 P.3d 454 (Wash. 2007) (Coverage available for an oral surgeon that played a practical joke on a surgical assistant—inserting novelty boar tusks into her mouth while she was under anesthesia for a procedure and then photographing her with her eyes pried open); *Bituminous Casualty Corp. v Kenway Contracting Inc.*, 2007 Ky. LEXIS 129 (Coverage available for a contractor hired to tear down a carport but mistakenly tore down half the house. Oops. "[Employee] testified that he knew something was wrong when [supervisor] got out of his truck and placed both hands to his head." Id. at *4.); *Underwriters at Lloyd's London v Frederick Yale*, 2007 Conn. Super. LEXIS 1586 (examining the applicability of an "athletic and sports exclusion," the court held that there is "a genuine issue of material fact as to whether professional wrestling constitutes an entertainment event, as opposed to an athletic or sporting event."); and *United Sugars Corp. v St. Paul Fire and Marine Insurance Company*, 2007 Minn. App. Unpub. LEXIS 660 (Coverage addressed for cookie dough adulterated with bee parts and cigarette butts. Not exactly mix-ins you'll see at Cold Stone Creamery.)

None of these decisions made the list of the year's 10 most significant (or even came close for that matter). As Sanjaya proved last year, attention-grabbing can only get you so far in the voting.

The selection process operates throughout the year to identify coverage decisions (usually, but not always, from state high courts) that (i) involve a frequently occurring claim scenario that has not been the subject of many, or clear-cut, decisions; (ii) alter a previously held view on a coverage issue; (iii) are part of a new trend; or (iv) involve a burgeoning coverage issue.

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The process for selecting the year's 10 most significant insurance coverage decisions is highly subjective, shrouded in secrecy, has no accountability, and follows strict tradition. It's not unlike how a new Pope is chosen, except no white smoke comes out of a chimney when I'm finished.

The following are the 10 most significant insurance coverage decisions of 2007 (listed in the order that they were decided):

Swank Enterprises, Inc. v All Purposes Services, Ltd.
Montana Supreme Court gave additional insureds their coveted seat at the grown-ups table.

Cinergy Corporation v Associated Electric & Gas Insurance Services, Ltd.
Indiana Supreme Court told policyholders the inconvenient truth about coverage for global warming compliance costs.

Continental Casualty Company v Employers Insurance Company of Wausau
New York trial court let out a roar in the mousetrap of insurance coverage issues—asbestos. Honorable mention to *In the Matter of: The Liquidation of Integrity Insurance Company*—New Jersey Supreme Court interpreted the term "absolute" straight-up, left claimants on the rocks, and had reinsurers doing the twist concerning incurred but not reported asbestos claims covered by an insolvent insurer.

Home Depot U.S.A., Inc. v Ohio Casualty Insurance Company
You must do it. And we can't help. Texas District Court provided no assistance to Home Depot in its effort to build a case for coverage as an additional insured. The court provide a reminder on the importance of providing timely notice of such claims.

Vanderbrook v Unitrin Preferred Ins. Co. *(In re Katrina Canal Breaches)*
Fifth Circuit was Waterloo for policyholders seeking coverage for flood damage caused by Hurricane Katrina.

Allmerica Financial Corporation v Certain Underwriters at Lloyd's London
Supreme Judicial Court of Massachusetts tried to clear up the dirty water in the relationship between primary and excess insurers.

Catholic Mutual Relief Society v Roman Catholic Archdiocese of San Diego
Supreme Court of California addressed the sometimes Al Capone's vault of coverage issues—discovery of reinsurance information.

Lamar Homes, Inc. v Mid-Continent Casualty Company
Texas Supreme Court addressed coverage for construction defects and settled the biggest battle over a home since the Alamo. In addition, everything is bigger in Texas and that now includes the consequences for an insurer that breached its duty to defend.

Bradley Ventures, Inc. v Farm Bureau Mutual Insurance Company
Supreme Court of Arkansas handed policyholders a get out of jail free card when seeking coverage after a guilty plea.

Essex Insurance Co. v H & H Land Development Corporation
At last, a court addressed the Montrose Endorsement. Insurers reaction to this Georgia District Court decision—Uga.

The remainder of this article is devoted to a detailed summary of the four most interesting cases.

Cinergy Corporation, et al. v Associated Electric & Gas Insurance Services, Ltd., 865 N.E.2d 571 (Ind. 2007)
The potential for global warming insurance issues got a shot in the arm in 2007 when the United States Supreme Court decided *Massachusetts, et al. v Environmental Protection Agency, et al.*, 127 S. Ct. 1438 (2007). In *Massachusetts v EPA*, the U.S. high court held that "greenhouse gases fit well within the Clean Air Act's capacious definition of 'air pollutant,' [and] that EPA has the statutory authority to regulate the emission of such gases from new motor vehicles." *Id.* at 1462. "Under the clear terms of the Clean Air Act, EPA can avoid taking further action only if it determines that greenhouse gases do not contribute to climate change or if it provides some reasonable explanation as to why it cannot or will not exercise its discretion to determine whether they do." *Id.*

Take away point for insurance purposes—if manufacturers are at some time in the future obligated to upgrade their facilities to meet emission standards for greenhouses gases—no doubt an expensive undertaking—they will likely seek coverage for such costs from their general liability insurers. While these claims are no doubt a ways off, the Indiana Supreme Court addressed this fundamental coverage issue in *Cinergy Corporation, et al. v Associated Electric & Gas Insurance Services, Ltd.*

In *Cinergy*, the Indiana Supreme Court addressed whether coverage was owed by an insurer, AEGIS, to various power companies for a complaint filed against them by the United States, three states and several environmental organizations pursuant to the federal Clean Air Act, alleging failure to obtain permits and discharge of excess emissions from power plants, allegedly resulting in wide-spread harm to public health and the environment. *Cinergy* at 573.

The Indiana Supreme Court turned to the language of the AEGIS policy for its decision and held as follows:

> The responsibility of AEGIS under its policies for "ultimate net loss," including the power companies' defense costs, is conditioned by the requirement that such loss be for damages because of bodily injury or property damage "caused by an occurrence." Under all three policies

> the term "occurrence" means "an accident, event, or continuous or repeated exposure to conditions." Due to this occurrence requirement, the policy thus applies only if damages claimed by the power companies, the costs associated with the installation of equipment to contain further excess emissions, constitute damages because of bodily injury or property damage ***caused by*** an accident, event, or exposure to conditions. The clear and unmistakable import of the phrase "caused by" is that the accident, event, or exposure to conditions must have preceded the damages claimed—here, the costs of installing emission control equipment.

Id. (emphasis in original). "We cannot read the policy requirement that covered damages result from the happening of an occurrence to mean that coverage extends to damages that result from the prevention of an occurrence." *Id.*

While the *Cinergy* court reached its decision by resort to the AEGIS policy language, and, specifically, the policy's "occurrence" requirement contained in the Insuring Agreement, it was also guided by out-of-state decisions that relied on a different aspect of the Insuring Agreement. In *A.Y. McDonald Industries v Ins. Co. of North America*, 475 N.W.2d 607 (Iowa 1991) and *AIU Insurance Company v Superior Court*, 799 P.2d 1253 (Cal. 1990), both courts concluded that the costs to pay for preventive measures taken in advance of pollution are not incurred because of property damage.

The *Cinergy* court tried its best to find coverage for the cost to install the new equipment ("Notwithstanding our preference to construe ambiguous insurance policy language strictly and against the insurer. . . ." *Id.*), but was ultimately constrained by an inconvenient truth (". . .we discern no ambiguity here that would permit the occurrence requirement reasonably to be understood to allow coverage for damages in the form of installation costs for government-mandated equipment intended to reduce future emissions of pollutants and to prevent future environmental harm." *Id.*). It didn't take long for an Indiana court to rely on *Cinergy* to deny coverage for the costs to install emission control equipment. See *Newman Manufacturing, Inc. v Transcontinental Insurance Company*, 871 N.E.2d 396 (Ind. App. 2007).[2]

Continental Casualty Company, et al. v Employers Insurance Company of Wausau, et al., 839 N.Y.S.2d 403 (2007)

It has been reported that the worst of the asbestos liability crisis is now behind the insurance industry.[3] But even if new filings are down and some courts are now looking at claims with an overdue jaundiced eye, there are still enough claims and potential coverage disputes in the system to keep the longest-running insurance coverage show going well into the future.

The asbestos beast has an insatiable appetite for money. And the large number of asbestos defendants that have declared bankruptcy stand as a warning to companies that are unable to satisfy it. By necessity, this forces asbestos defendants to leave no stone unturned in their search for insurance dollars. Along those lines, there has been much talk in coverage circles over the past several years about asbestos defendants attempting to re-open previously-thought-to-be exhausted insurance policies by arguing that the claims paid under them were for asbestos-related "operations" and not "products liability" or "completed operations." Translation—since operations claims (unlike products and completed operations) were usually not subject to an aggregate limit, the policies are not exhausted after all. Whoa, Nelly, as Keith Jackson would say.

Putting aside a mountain of procedural issues, the heart of the coverage dispute was as follows. Robert A. Keasbey Company was a small New York state insulating company founded in 1885. Keasbey used asbestos materials in insulating contracting operations at various job sites in New York, New Jersey, and Connecticut. The work involved cutting, sawing, mixing, and removing of asbestos containing materials, which led to exposure of asbestos by individuals at the job site. *Keasbey* at 409-410. Lo and behold, Keasbey became the subject of claims by 20,000 individuals alleging asbestos-related personal injuries. *Id.* at 407.

Keasbey's insurers defended the company against the personal injury actions and eventually exhausted a long list of primary policies. Keasbey's excess carriers also made payments of over $100 million. But when it comes to asbestos, no amount of money ever seems to be enough. The attorneys for the asbestos claimants asserted that most of the claims against Keasbey related to exposure during Keasbey's asbestos installation activities. Thus, they argued that the products/completed operations aggregate limits

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did not apply to these allegedly non-products claims. *Id.* at 408. If they did, it was undisputed that the products aggregates of the primary policies were exhausted. *Id.* at 412.

But the plaintiffs maintained that the *Keasbey* claims fell under the premises/operations coverage of the primary and excess policies, which were not subject to aggregate limits, but, rather, only a per occurrence limit. The result—the actual value of Keasbey's insurance coverage was alleged to be greater than the policies' aggregate limits *and could even be perpetual*. It was estimated that approximately $100 million to $250 million (on top of the enormous sums already paid) turned on the issue. *Id.* at 408.

The New York trial court concluded that the claims at issue were for "operations," and, thus, not subject to aggregate limits:

> Here, the claims by all of the claimants in the underlying actions were that they were injured away from the premises of defendant Keasbey. Plaintiffs have not demonstrated that the injuries occurred after relinquishment of the asbestos products or after the operations were complete. To the contrary, the evidence has shown that the injuries happened while the installation operations of defendant Keasbey were ongoing, which were covered under the operations coverage provisions of the subject insurance policies[.] *Id.* at 411 (extraneous text omitted).

To achieve the alchemy that comes from re-characterization of asbestos claims from products to operations is in fact a two-step process. Even if it is determined that the claims are for un-aggregated operations, the totality of such claims may still be subject to the policy's per occurrence limit (if all claims are deemed to be the same occurrence). If so, the policies would still be exhausted, just on a different basis.

Therefore, the second hurdle for insureds or claimants seeking the benefits of re-characterization is to secure an interpretation of the policy that each claimant's exposure to asbestos constitutes a separate occurrence, and, hence is subject to a separate occurrence limit (hence, the *Keasbey* court's characterization of the policies' limits being perpetual). Here too the *Keasbey* claimants were successful:

> [H]ere the events that led to the injuries to members of the defendant class all took place at various work sites over the course of many years. Thus, the class defendants are entitled to a declaration that each individual class members' exposure to conditions resulting in bodily injury constitutes a separate occurrence under the "occurrence" definition and "per-occurrence" limits of the subject insurance policies. *Id.* at 419.

Lamar Homes, Inc. v Mid-Continent Casualty Company, et al., 2007 Tex. LEXIS 797

Not long ago it was big news when a state supreme court issued a decision addressing the scope of coverage for construction defects. Those days are long gone as these decisions have now reached ho-hum status. Indeed, by my count, in 2007 alone there were six decisions issued by state supreme courts addressing coverage for construction defects.[4] Last year had plenty too. And you'd be hard-pressed to keep up with the staggering number of construction defect coverage decisions coming from trial and intermediate appellate courts.

For this reason, a coverage decision of this type seems an unlikely candidate for inclusion as one of the year's 10 most significant. However, an exception can be made for the right case, and the Supreme Court of Texas's decision in *Lamar Homes v Mid-Continent Casualty Company* was just such case.

First, Texas's size makes it a candidate for a significant number of coverage disputes over construction defects. Indeed, the supreme court noted at the outset of its opinion that similar issues were pending in six separate petitions for review before it. And there's no doubt that Texas Court of Appeals decisions addressing coverage for construction defects had been all over the place. Clarification from the Texas high court was sorely needed. In addition, when a coverage case includes 11 *amicus* parties, it has to be taken seriously for selection as one of the year's 10 most significant, even if the issue is not groundbreaking. The *Lamar Homes* court also addressed an important duty to defend issue.

Lamar Homes involved coverage for defects in a new home purchased by the DiMares from Lamar. Several years after the purchase of the home, the DiMares encountered problems that they attributed to their foundation. The DiMares sued Lamar and its subcontractor

for the defects. Lamar sought coverage from Mid-Continent Casualty Company under a commercial general liability policy. Mid-Continent refused to defend, Lamar filed a declaratory judgment action and the parties were off to the races. *Lamar Homes* at *2-3.

The coverage dispute reached the Texas Supreme Court on the following certified questions from the Fifth Circuit:

1. When a homebuyer sues his general contractor for construction defects and alleges only damage to or loss of use of the home itself, do such allegations allege an "accident" or "occurrence" sufficient to trigger the duty to defend or indemnify under a CGL policy?

2. When a homebuyer sues his general contractor for construction defects and alleges only damage to or loss of use of the home itself, do such allegations allege "property damage" sufficient to trigger the duty to defend or indemnify under a CGL policy? *Lamar Homes* at *1-2.

A third certified question, and one that will have consequences far beyond the construction defect arena, asked whether the Texas "Prompt Payment of Claims" statute, formerly codified as Article 21.55 of the Texas Insurance Code, applies to an insurer's breach of the duty to defend.

Mid-Continent made the arguments often advanced by insurers in these types of cases: a CGL policy's purpose is to protect the insured from claims for tort liability; and defective work cannot be an "occurrence" because it is not accidental. In other words, a general contractor should expect that faulty workmanship will result in damage to the project itself. And if an injury is expected, it is not accidental.

The Texas Supreme Court concluded that the insurer made a false assumption when it concluded that an accident can never exist apart from a tort claim. Citing to a law review article, the court noted that the author observed that "the argument has some intuitive appeal but conclude[d]: Yet, on even a moment's reflection, we all understand that contracts are broken, many times, for reasons that we would call 'accidental.' The wrong number of boxes was shipped because someone made a mistake in the counting." *Id.* at *12-13, quoting Ellen S. Pryor, *The Economic Loss Rule and Liability Insurance*, 48 ARIZ. L. REV. 905, 917 (2006), quoting *Anthem Electronics, Inc. v Pacific Employers Ins. Co.*, 302 F.3d 1049, 1056 (9th Cir. 2002). In addition, the Texas high court noted that no one alleged that Lamar intended or expected its work or its subcontractors' work to damage the DiMares' home. *Lamar Homes* at *17.

> Contrary to the carrier's contentions, the CGL policy makes no distinction between tort and contract damages. The insuring agreement does not mention torts, contracts, or economic losses; nor do these terms appear in the definitions of "property damage" or "occurrence." The CGL's insuring agreement simply asks whether "property damage" has been caused by an "occurrence." Therefore, any preconceived notion that a CGL policy is only for tort liability must yield to the policy's actual language. *Id.* at *27.

Much more could be said about how the court addressed these issues, including the majority's point-counterpoint with the dissent's arguments. However, better to get to the real issue in the case. Lamar conceded that the "your work" exclusion would have eliminated coverage, but for the exclusion's "subcontractor exception." *Id.* at *21. Thus, by concluding that faulty workmanship that results in damage to the project itself is an "occurrence," the court was able to reach the "subcontractor exception" to the "your work" exclusion. This exception purportedly provides coverage in those instances in which the faulty workmanship was caused by the insured's subcontractor. Compare that to the decisions holding that faulty workmanship that results in damage to the project itself is not an "occurrence," which then stops the case in its tracks, thereby never allowing the insured to reach the "subcontractor exception" to the "your work" exclusion. The

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applicability of the "subcontractor exception" to the "your work" exclusion is often what is at the center of construction defect coverage cases.

It's remarkable how much coverage litigation is taking place over what are essentially the same basic issues. What's more, the disputes concern contract-based claims under policies issued to companies that often have the word "contractor" in their name. In other words, there is nothing surprising about the types of claims being made. Yet they continue to confound courts and defy consensus.

Essex Insurance Co. v H & H Land Development Corporation, 2007 U.S. Dist. LEXIS 89904 (M.D. Ga.)
Insurance Services Office, Inc. adopted the so-called Montrose Endorsement in 1999, and in 2001 it became part of ISO's bread and butter commercial general liability terms and conditions (Form CG 00 01 10 01, *et seq.*). In brief terms, the endorsement was drafted to respond to the California Supreme Court's decision in *Montrose Chemical Corporation v Admiral Insurance Corporation*, 913 P.2d 878 (Cal. 1995), which held that the insured's knowledge of "bodily injury" or "property damage," prior to the policy period, did not preclude coverage, so long as the imposition of liability upon the insured had not been established. "[T]he loss-in-progress rule will not defeat coverage for a claimed loss where it had yet to be established, at the time the insurer entered into the contract of insurance with the policyholder, that the insured had a legal obligation to pay damages to a third party in connection with a loss." *Montrose* at 906.

However, under the Montrose Endorsement, the insuring agreement was amended to provide that there is no coverage for "bodily injury" or "property damage" if, prior to the policy period, the insured knew of its existence. In other words, under the policy provision drafted to respond to *Montrose*, "known loss" is based simply on the insured's knowledge of the existence of bodily injury or property damage, and is not tied to the insured's potential liability for such injury or damage.

In 2007, the long wait for decisions addressing the Montrose Endorsement ended. In both cases the endorsement was strictly construed and did not preclude coverage on the basis of known loss because the property damage for which coverage was being sought was not the *same* property damage that was known by the insured to exist prior to the policy period.

This is not to say that the Montrose Endorsement won't achieve its purpose. But so far, in order for the endorsement to operate to exclude coverage, courts have required a close relationship between the damage known by the insured to exist before the policy period and the damage for which coverage is being sought. *Very close*, in fact, when you consider that in *Regency Roofing*, the water damage that was clearly known by the insured to exist before the inception of the policies was simply a continuation of the same damage, but in a different form—mold. ■

Endnotes

1. See *State Farm Fire & Casualty Co. v Harbert,* 2007 S.D. LEXIS 175 (No coverage available because injury caused by alienation of affections was "expected or intended" and to insure for alienation of affects is also contrary to South Dakota public policy); and *Pins v State Farm Fire & Casualty Co.,* 476 F.3d 581 (8th Cir. 2007) (S.D. law) (No coverage available because injury caused by alienation of affections was "expected or intended").
2. For a more in-depth look at Cinergy, see Michael D. Lichtenstein and Adam B. Lavinthal, "*Cinergy v AEGIS:* Are Climate Change Costs Insured by CGL Policies?," *Environmental Claims Journal,* Volume 19, Number 3, July-September 2007 at 186.
3. See the Insurance Information Institute's June 2007 "Asbestos Liability" report, available at http://www.iii.org/media/hottopics/insurance/asbestos, citing to a March 2007 report by A.M. Best.
4. *Lamar Homes, Inc. v Mid-Continent Casualty Company et al.,* 2007 Tex. LEXIS 797; *Supreme Servs. & Specialty Co. v Sonny Greer, Inc.,* 958 So. 2d 634 (La. 2007); *Travelers Indem. Co. of Am. v Moore & Assoc.,* 216 S.W.3d 302 (Tenn. 2007); *Webster v Acadia Ins. Co.,* 2007 N.H. LEXIS 185; *Bituminous Cas. Corp. v Kenway Contr., Inc.,* 2007 Ky. LEXIS 129; *Blair v Mid-Continent Cas. Co.,* 167 P.3d 888 (Mont. 2007).

Libel and Slander Claims: "There Is Always a Biological Advantage of Delivering the Truth"[1]

by Ken Carmichael, CPCU

Ken Carmichael, CPCU, has been a State Farm Auto employee for more than 15 years and was a State Farm National Catastrophe Employee for 18 months. While on the Catastrophe Team, his responsibilities included estimating, investigating, and settling first-party property damage claims for both the auto and fire (passed fire certification test) companies. This job required 12-hour days, six days a week. Currently he is responsible for resolving first- and third-party auto claims.

Carmichael serves on the CPCU Society's Claims Interest Group Committee, is a subcommittee member for the Claims Interest Group web site, and is a member of the CPCU Society's Michiana Chapter.

Unless you have been out of the country the past couple of months, there is no doubt you have heard about the scandal that has rocked our nation's pastime: the steroids debacle.

I was watching ESPN at my health club recently and a number of reporters and athletes including John Smoltz and Curt Schilling (both pitchers) were surprised that Roger Clemens, a seven-time Cy Young award winner as his league's best pitcher, two more awards than any other pitcher, did not immediately file a defamation suit regarding his alleged steroid use while with the New York Yankees. At first, Clemens appeared to be relying on the media as opposed to the court system to tell his side of the story. "I want to state clearly and without qualification I did not take steroids, human growth hormones, or any banned substances at any time in my baseball career or, in fact, my entire life."[2] But that strategy was not working as well as hoped. A reporter for the *NY Daily News* offered the following: "It's not that Clemens doesn't look sincere and sound believable on the video (he released a Christmas "video card" denying he used banned substances) when he reaffirms his earlier statement of denial that he ever used steroids. It's just that if you consider the circumstantial evidence logically, Clemens looks guilty, and it's up to him to give people a legitimate reason to believe otherwise."[3]

Perhaps one reason for the delay in bringing suit was that because he is in the public eye, Clemens is held to a very different and much more demanding burden of proof if he chooses to defend himself in court. Being a well-known sports personality and therefore a "public figure," Clemens' libel and slander lawsuit has a different threshold to meet than the average person. Because of a 1964 U.S. Supreme Court decision, *New York Times v Sullivan*, Roger Clemens must prove that his trainer's statement was made with "actual malice." In other words, the person making the statement knew the statement to be false, or issued the statement with reckless disregards as to its truth and it published to a third party."[4] This threshold, actual malice, is very tough to prove to a jury especially since this appears to be a case of one witness's word against another's. Rusty Hardin, Roger Clemens' attorney, feels otherwise: "McNamee made the allegations with actual malice, knowing they were false."[5] So far, no witnesses have come forth to either confirm or deny the trainer's allegations of steroid use by Roger Clemens.

In addition, his attorney surely advised him of the risks of the litigation process. Clemens will be required to respond to interrogatories and provide sworn deposition testimony as part of the lawsuit process. The lawyers defending McNamee, Roger Clemens' former trainer, would undoubtedly ask some very tough questions during the discovery process. Not only does Clemens open himself to questions under oath about the use of steroids and other substances, he may open his entire character to a whole variety of other issues as well (e.g., have you cheated on your taxes, have you been faithful to your spouse, did you use any illegal drugs while in high school and college, etc.).

The Mitchell Report seems like such strong evidence against Clemens; one wonders why would he file suit? He knows that the report and the evidence contained in it will likely be admitted as evidence if the suit goes to trial. Keep in mind, however, that McNamee's version of the facts appears to be essentially uncorroborated—there were no other witnesses when Clemens was allegedly taking steroids. Clemens likely filed suit because he feels his story is a lot

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Libel and Slander Claims: "There Is Always a Biological Advantage of Delivering the Truth"

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more credible than McNamee's. Sports writers have pointed out, however, that "McNamee accused another New York Yankees pitcher, Andy Petite, who was playing at the same time as Clemens, of using growth hormones and he admitted his guilt; this puts Roger Clemens in a bad situation since they were teammates."[6]

What is libel and slander? According to Expertlaw.com, "slander involves the making of defamatory statements by a non-fixed representation—usually in an oral representation. Libel involves making defamatory statements in a printed or fixed medium, such as a magazine or newspaper."[7] "Publication is a critical element to defamation or disparagement, and simply means that the false statements (either by speech, written, or visual) have been made to third parties other than the person or organization whose reputation, goods, products, or services are allegedly harmed."[8]

The lawsuit raises interesting insurance coverage issues. Since Clemens filed a suit against his former trainer who evidently was employed by the Yankees, would the New York Yankees' liability policy provide a defense and indemnity to McNamee? The ISO Commercial General Liability policy (Part B) does provide coverage for third-party personal injury liability for an employee's libel and slander against another person, but it does not cover intentional injuries. Therefore, it appears the New York Yankees would provide a defense for McNamee's actions; however, if Clemens could prove to a jury that McNamee acted with "actual malice" and the jury awarded damages because of this arguably intentional act, it appears the Yankees would not be liable for the verdict. Consequently, McNamee would have to pay the award because of the intentional act exclusion in the ISO CGL policy or be forced to seek coverage under his personal homeowner's policy or any personal business policy.

What is the most common defense in a libel and slander law suit? "Most states provide that truth is a complete defense in any libel case."[9] Even if McNamee is not able to rely on truth as an absolute defense, he can argue that he should not be held liable because he acted for the public good (e.g., awards should not be based on the use of illegal substances or kids should not be enamored by Clemens alleged steroid use).

Proving liability in a case like this one is extremely difficult since Clemens will be held to the public figure standard. In plaintiff's favor however, is the fact that libel and slander cases put the defendant at high risk because if a jury finds liability, substantial damages are likely to be awarded particularly given Clemens' reputation and future earnings potential. In addition, a trial would potentially allow Clemens to restore his good name.

Roger Clemens can send his video Christmas cards to friends and family, he can blog his opinion on the Internet, and appear on *60 Minutes*, but many wonder how true his statements are if it took him this long to file a legal action against his co-employee. Moreover, his truthfulness has come into question just based on his public statements to date. Analysts of his *60 Minutes* interview noticed that Clemens swallowed hard, looked down, and licked and pursed his lips when answering questions—all signs, they said, that he might not have been telling the truth. Attorney Hardin should advise his client that he'll need to learn Spence's fourth component of his 10 steps of how to successfully "argue and win" (i.e., the biological advantage of delivering the truth) if Clemens wants to prevail at trial. If anything, Clemens realizes now is the time to stand up for his rights through the legal system. You can tell this given the recent phone conversation he had with McNamee (who did not realize it was being taped). Clemens' voice sounded agitated, accusatory, and high pitched when talking to McNamee about his allegations.

It sure seems like some athletes took illegal steps to enhance in order to set baseball records. In my opinion, any records set by alleged steroid users should be stripped from them until juries determine the accusations to be false. Unlike other suspected steroid users, however, Roger Clemens intends to never have an asterisk by any of his records. ■

Endnotes

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What's in a Name? For Claim Professionals, Plenty!

by Kevin M. Quinley, CPCU

Kevin M. Quinley, CPCU, is an insurance claim executive and author. He has helped thousands of claim professionals boost their productivity.

Receive a *free* monthly productivity newsletter, *Claims Caffeine,* by e-mailing claims_caffeine-subscribe@yahoogroups.com or kquinley@cox.net. Read his new blog, The Claims Coach at http://claimscoach.blogspot.com.

"What's in a name? That which we call a rose by any other name would smell as sweet."

—Juliet from Romeo and Juliet (II, ii, 1-2)

Clearly, Shakespeare's Juliet had never served a stint as a claims adjuster. She was a smooth one with words, however. Even claim veterans stumble and bumble. Last Friday I was e-mailing a request for a settlement check on a resolved product liability claim in Texas and incorrectly referred to my client as *Bridget* when her name is *Gretchen*. (Background: for years, this client's in-house risk manager was our claims contact; her name was Bridget. She found love and happiness in Australia, though, and left the corporate world for Oz years ago.) That is no alibi, though.

Her successor was named Gretchen. I knew that. Should have known that. Terrific lady and client. Old habits die hard and brain cells die off as you age. At the end of a long day and week, though, yours truly had a brain cramp (not covered by any HMO and not listed in DSM III) and referred to the client as *Bridget*. To help matters, I cc'd the client in on the e-mail. Ouch!

She called me on it. What could I say? Throwing myself on the mercy of the court/client, I apologized and told her that—as penance for the transgression—she could call me "Kelvin" or "The Idiot" for three days—her choice. Fortunately, she was a good sport about the whole thing and assured me that she "was just messing with me." Not every client is going to be so good-natured about it.

It prompted me thinking, though, about the role of names in claims handling and customer relations. The take-away is that names are vitally important to people. Make sure you get them right (do as I say and not as I sometimes do!). Adjusters and claim professionals need to build good, strong, interpersonal relationships to succeed in their jobs. One way to do this is to sweat the details and get names right. This involves not just calling a Gretchen Bridget, but also taking time to try to pronounce names correctly. Adjusters will likely have some claimants, insureds, and clients with odd names. Take time to ask the person how to pronounce the name. What works for me is something like, "Ms. XXX, I want to be sure I pronounce your name right, so can you help me?"

Just because you are sweating those details does not mean that others will necessarily get your name right. Reciprocity may be elusive here. As a Quinley, I have been called Quincy, Quinney, Quigley, Kelvin, Calvin, and other terms likely best gone unmentioned in this article (let's keep our PG family rating). Perhaps I have been referred to by the initials S.O.B. as much as by the initials CPCU.

As a neophyte adjuster at Crawford & Company, one day I returned to the claim office from taking a statement (this was at a time when adjusters actually did such things), only to find the staff laughing, hooting, and hollering over my arrival. When I asked, "What's the deal?" my coworkers responded that while I was out on the road, a claimant had phoned, complaining about her adjuster and the paltry settlement he offered. She said she could not recall the guy's name but that "He was a little red-headed white dude!" From then on, the claim staff jokingly referred to me as "The Little Red-Headed White Dude." I could not shake the moniker, as I explored claim office openings and transfer opportunities in garden spots such as Three Mile Island, Juneau, Alaska, and Kurdistan.[1]

People who forget names can erode their credibility. Recall Vice Presidential candidate Adm. James Stockdale

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What's in a Name? For Claim Professionals, Plenty!

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beginning one of his campaign debates with the rhetorical question, "Who am I and why am I here?" Voters were not impressed. Maybe they could not answer Stockdale's rhetorical question, either.

Occasionally our claim office receives feedback surveys from defense law firms that we employ. I applaud this discipline and wish it were more widespread (the subject of another article, perhaps). One of my right-hand people is a very talented claims professional whose last name is Khin, a somewhat unusual name I grant. She has received law firm feedback surveys that butchered her name—Kihn, Kine, King, you name it. She was not impressed. "Gee, if they can't get the name right, what does that say about the law firm's client orientation?" The laudable gesture of sending a feedback survey is undercut by the failure to get the client's name right.

As a freshman on my high-school cross-country team, the cheerleaders couldn't remember my name amidst the team's fast-legged and much better looking luminaries, of which I most certainly was not one. So on the "Spirit Posters" hung in the cafeteria they wrote, "Go—Little Red!" Those friends who knew me and knew I was on the cross-country team whooped and hollered about me being—much to my mortification—"Little Red." (A taller carrot-topped runner was known as "Big Red.")

Regardless of whether you are dealing with clients, insureds, claimants, witnesses, coworkers—pay attention to names. Strive to not only call people by the right name, but take pains to get the spelling and pronunciation right. Before calling someone by his or her first name, pause. Some people might find that off-putting, too familiar, and presumptuous. Others may welcome it. (One tip: do they call you by your first name?) Do not hesitate to ask, "Mr. Jones, do you mind if I call you Jim?"

Moral: Sweat the details, especially if you "are not good with names." Many people fall into this category. There are many mnemonic tricks and memory devices to help people remember names—I just can't remember them all for purposes of this article. (For seven specific tips advocated by CareerBuilder.com check out http://www.cnn.com/2005/US/Careers/07/22/names). Your effectiveness not only as a claim adjuster but as a claim professional—and professional networker—is enhanced if you pay attention to names.

To each person, the sound of his or her name is the sweetest sound he or she will hear, though I used to joke that, until the age of 13, I thought my name was "Turn it Down!" because that is what my parents used to yell at me all the time while I played my Monkees albums on the stereo.

Don't turn it down, though. Instead, tune in . . . to proper names. Sweat the details. Get the name right. ■

Endnote

1. Now, I just wish my (remaining strands of) hair was still red. I'm more likely to be called a Silverback than Carrot-Top.

From the Editor

by Keithley D. Mulvihill, J.D., CPCU

Keithley D. Mulvihill, J.D., CPCU, is a resident partner in the Pittsburgh, Pennsylvania office of Rawle & Henderson LLP, a regional defense firm headquartered in Philadelphia. Mulvihill graduated from the University of Pittsburgh School of Law in 1981. He obtained his CPCU in 2000. Mulvihill's practice focuses on defense of product liability matters, including toxic tort cases, insurance coverage, and general defense matters including professional liability. He is active in the CPCU Society's Allegheny Chapter and regularly provides an update on recent developments in insurance law for the chapter's newsletter.

As with life itself, the only constant in the claims business is change, and this edition of *Claims Quarterly (CQ)* brings some changes. With this edition of CQ we begin a new editorial cycle and I begin my time as the new editor. In addition, what was known as the Claims Section is now formally the Claims Interest Group.

While many things will change, the one thing I hope will not change is the quality of information provided by CQ. We hope to be able to build on the excellence provided by my immediate predecessor, **Robert M. Kelso, J.D., CPCU,** and his predecessor, long-time editor, **Marcia Sweeney, CPCU,** both of whom continue to be active as part of our editorial team.

Like all of the Claims Interest Group programs, CQ has traditionally provided quality resources to help claims professionals effectively meet the day-to-day challenges of working in the ever-changing, ever-challenging claims environment. One of the biggest challenges in assembling a publication like this one is that claims professionals work in such a wide variety of settings (company claims, TPAs, independent adjusters, attorneys) and deal with such widely varying issues (first- and third-party auto, general liability, property, personal and commercial lines). Our goal continues to be to provide resources that will be useful in as many of those settings as possible. To do that, CQ provides a mix of articles covering the legal, technical, ethical, and sometimes personal aspects of claims handling.

One significant area of claims handling that we have not addressed recently but which is becoming increasingly more significant for claims professionals is subrogation. This issue includes an article reviewing recent trends in handling of subrogation claims in which subrogation has gone from something of an afterthought at most carriers to an important source of revenue. The article by subrogation attorney **Jeffrey M. Baill, Esq.,** also suggests ways to continue to improve that source of revenue. Subrogation is also an area of interest because many front-line claims handlers are called upon to defend against subrogation claims. As such, it is a topic that is important for claims professionals to be aware of at all levels.

This issue also includes what has become our annual survey/summary of the 10 most significant insurance coverage court decisions in 2007 by coverage attorney, **Randy J. Maniloff.** Despite years of court decisions and what seem on their face to be clear rules for interpreting policy terms, coverage disputes continue to be a fertile ground for our courts making it vital to remain current on the latest trends.

One area of truly breathtaking change in the claims profession is technology. Not only are there constant changes in the use and application of technology but the law regarding technology continues to evolve as well (e.g., the Federal Rules of Civil Procedure were amended in 2006 to require substantially greater attention to retention and production of electronically maintained documents). Over the course of the coming year, we hope to provide information on technology-related issues.

Finally, we are always on the lookout for timely and interesting articles. If you are interested in suggesting a topic or would like to submit an article, please contact me or one of the other members of the editorial team directly. ■

A Modern History of Subrogation

by Jeffrey M. Baill, Esq.

■ **Jeffrey M. Baill, Esq,** is a partner in the Minneapolis, Minnesota law firm of Yost and Baill. Baill specializes in subrogation litigation on behalf of insurance carriers. He is a founder and past president of the National Association of Subrogation Professionals and has spoken at numerous seminars and educational programs covering all aspects of subrogation.

Editor's note: This article originally appeared in the November 2007 issue of *Claims* magazine and is reprinted here with permission.

In 1980, when I began practicing law, one of the only things I felt confident about was the location of a subrogation file at an insurance claims professional's desk. Back then, most subrogation at a property and casualty company was handled by the front-line claims person. The subrogation files were usually located at the very bottom of the very highest pile on their desk.

There were many reasons for this situation. Claims people were judged by how fast they handled their claims. There was pressure to resolve the insured claims in a prompt and efficient manner. Third-party claims were expected to be processed effectively. The subrogation file was the lowest priority. Most claims people were not evaluated on how they handled these claims. The concept of benchmarking subrogation results for individual claims people or subrogation companywide was almost nonexistent.

On a management level, subrogation was also an afterthought. Executives rarely discussed the topic, let alone make strategic plans to improve results. Subrogation education was almost nonexistent. Because it is hard to find data on the subject, which was rarely gathered, I can only state anecdotally that results for the recovery of subrogation dollars were lackluster.

A Necessary Change

Today, subrogation results at most companies and in most lines of business are completely different. My perception is that things began to change in the mid-'90s during one of the cyclical downturns in the insurance business. Many executives took a closer look at revenue sources for the business. Insurance companies have three main sources of revenue: premiums, investment, and subrogation.

The premium dollar is a very expensive proposition. A company must support an underwriting staff, sales force, marketing expenses, agent expenses, and other costs to compete with all the other carriers to bring in the premium dollar. Investment dollars are, on average, a prisoner of the market. When the market is doing well, most companies' portfolios are growing. When the market is bad, everyone suffers. Investment departments at one company may do better than at another, but on the whole, within a range, results seem to trend the same direction industrywide.

Subrogation dollars do not have the same cost as the premium dollar. A trained staff is required. Some infrastructure is required along with technology. The subrogation dollar is out there, owned by the company. The question is, can the company put together an effective structure that results in the efficient collection of those dollars? Subrogation is not subject to the fluctuations in the market like investments are. In addition, subrogation does not have all of the expenses that the premium dollar requires. The cost per dollar makes the subrogation dollar a relatively low-cost way to improve a company's financial performance.

This analysis seemed to hit home during a time frame when the industry was struggling with performance. Executives around the country began to see subrogation as a profit center where a real difference could be made on the company's bottom line. Major trends across the industry began to take shape.

The Move Toward Dedicated Subrogation Units

The single most significant difference in organizational structure occurred when companies began the creation of regional and national subrogation units. These units solved many structural problems. No longer could a front-line claims person bury a subrogation file at the bottom of his or her pile. These files would now be removed completely from the pile. The new subrogation unit personnel would have one responsibility—recover money. They could be benchmarked on many different levels: how much money they were collecting; how many subrogation files were opened; how many demands were made, etc. Recoveries may track like a roller coaster ride, especially on the larger files. On the other hand, activities should remain more predictable. Management had an ability to evaluate their internal subrogation performance, beyond the dollars.

In addition to the structural benefit of removing subrogation files from the responsibility of front-line claims people, other benefits are possible. The subrogation unit over time will build expertise in the art of recovery. Subrogation is plaintiffs' work. There is a plaintiff's mindset necessary to be effective. One must creatively look for all potential opportunities to recover. There are personality traits that are more effective in subrogation personnel. Strategic hires can be made and people with complimentary skill sets can staff subrogation departments.

In addition to the right people being in the department, the designated subrogation staff will develop and become more effective as their level of experience builds. The unit can take advantage of training dedicated toward plaintiffs issues. Eventually, the subrogation unit will be a source of expertise that can be used for more than their own internal purposes, including a resource for the entire company on recovery issues.

Subrogation units allow companies to track similar events. An example of this is the litigation against Firestone and Ford related to exploding tires on certain vehicles. When a company has a dedicated subrogation unit in place, it is easier to track same or similar claims against tortfeasors. This allows for a sharing of knowledge on these claims to make the claims people involved "experts" on these claims. They will know how to handle them in the most efficient way without having to recreate the wheel every time another similar claim arrives.

Finally, the subrogation units have begun to serve as subrogation advocates throughout the company. This is extremely important in light of the unintended outcome of subrogation reorganization.

A Formula for Success

Virtually every company that has reorganized into a more centralized subrogation operation has found one element of its structure that cannot be changed. Subrogation units are still dependent on front-line staff for three things: identification, investigation, and transfer.

Identification is the most important of the three. Front-line staff must identify subrogation potential immediately. This is especially true in property and workers compensation scenarios. With the advent of the doctrine of spoliation, subrogation will be prohibited by the courts if the proper notification isn't made to potential tortfeasors. It is, therefore, more important than ever to identify subrogation claims early on.

Twenty years ago, the concept of spoliation was not widespread. In those days, we would investigate a loss, clean up the site, save a few artifacts, and then put other parties on notice. The courts around the country ultimately decided this was unfair and created the doctrine of spoliation. This doctrine holds that a tortfeasor is harmed when they do not have an opportunity to examine a loss site before it is disturbed. The sanctions for spoliation are severe and many times result in cases being dismissed.

Spoliation has a huge effect on subrogation. Insurers faced with a loss with subrogation potential must place all potential tortfeasors on notice and coordinate the examination of a loss site. This usually requires the input and direction of attorneys and experts. If subrogation is not recognized immediately, in many cases the right of recovery may be lost. Therefore, many subrogation units spend a great deal of time developing and implementing strategies to continually train front-line staff of the need to recognize subrogation potential when a loss is reported. If subrogation is not recognized early, it may be lost forever.

The second key component still remaining on the shoulders of most front-line claims people is the duty to investigate. A lack of an early investigation usually results in all subrogation rights disappearing. Once again, this requires training on how a subrogation investigation should proceed. Subrogation units are often involved in training claims staff on investigative issues. Many companies have put in place technological methods of informing subrogation units early on about large losses. This allows the subrogation unit to give input into the investigation much sooner in the process.

The third key is the transfer of files with subrogation potential to the subrogation units. Before recent improvements in technology, this was more of a problem than today. When companies had one paper file, it was difficult to open a subrogation file until the adjustment was completed. Today, most companies can open a subrogation file while the adjustment is ongoing because of the use of electronic files. However, some companies still struggle with ways to make sure files with subrogation potential actually make it to the subrogation department.

Many companies today have put in place audit procedures to try to ascertain where the system breaks down in terms of subrogation referrals. The single biggest culprit appears to be the failure to identify subrogation potential. Companies use many different approaches to shore up this hole in the process. What is clear is that there is no one-time solution to the issue. Subrogation identification requires constant training and prodding to be effective. This is where the subrogation advocate concept comes into play. The subrogation units should be advocating for subrogation awareness throughout the company. This group will provide the continual reminder of what needs to be done to facilitate quality subrogation results.

Joining Forces

One of the most significant changes in the subrogation field occurred in the fall of 1998. A small group of people came together to create the National Association of Subrogation Professionals. This non-profit trade association was formed with the following mission statement:

> The NASP mission is to enhance the stature and effectiveness of subrogation and recovery professionals through education, training, and the exchange of information.

Over the years NASP has grown to more than 2,300 members. NASP has an annual conference with more than 75 subrogation educational programs divided into tracks: auto, property, subrogation management, workers compensation, health, specialty, etc. In addition, NASP has created a certification program for people within the field to demonstrate their professionalism. The program (Certified Subrogation and Recovery Professional) includes a 428-page training manual covering 14 chapters of material. It is the most comprehensive training manual for subrogation that exists.

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NASP has also sponsored industrywide benchmarking studies so companies can get an idea of how effective they are compared to industry averages. These benchmarking studies were the first time companies could access this data, as no one else had prepared this type of apples-to-apples comparison before. The benchmarking studies also include best practice examples from the industry.

NASP has just hired an education director to launch a new Subro College Training Program. Initially, this program will be taken on the road to train people new to subrogation on the ins and outs of the field. Eventually, the program will expand to an advanced curriculum for experienced personnel. Since very few companies have dedicated subrogation training programs, and many states require continuing education credits for claims people, Subro College will fill a void for the industry.

None of this would have been possible 25 years ago. NASP exists because insurance companies today realize the potential subrogation can have on the bottom line of the income statement. The difference between high performers and average performers, as demonstrated in the NASP benchmarking studies, results in millions of dollars left on the table for many companies.

Today is truly an exciting time to be involved in subrogation. There is a real opportunity for a group of people to make a significant difference within a company. This was not the case 25 years ago. Back then, subrogation departments, where they existed, were often dumping grounds for low-performing staff. Many companies are now putting their best and brightest into subrogation because the results can have a dramatic effect on a company's bottom line. ■

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