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Claims Interest Group

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Claims Quorum

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Message from the Chair

by Tony D. Nix, CPCU, CIFI

Tony D. Nix, CPCU, CIFI, is a special investigations unit (SIU) team manager for State Farm in Atlanta, Ga., and has been employed with State Farm for 27 years. He obtained his bachelor's degree in management from the University of West Georgia in 1980, and earned his CPCU designation in 1999 and his CIFI (Certified Insurance Fraud Investigator) designation in 2000. Nix has served on the Claims Interest Group Committee for the last six years and is an active member of the CPCU Society's Atlanta Chapter, with prior service as director, secretary, president elect and president.

With 2009 officially "in the books," everywhere you turn television and radio shows are doing "Year in Review" specials. While some are more entertaining than others, I do find it interesting to reflect on the top stories of the year. The amount of activity that takes place during any given year never ceases to amaze me. Well, the Claims Interest Group Committee is no exception.

2009 was a very active year for our interest group (IG), as demonstrated by the Claims' Circle of Excellence (COE) submission being awarded "Gold with Distinction" at the CPCU Society Annual Meeting and Seminars in Denver. Our submission consisted of more than 120 pages of documentation that captured the various activities the Claims Interest Group and its committee members participated in during the year. I commend everyone who took the time to submit information to our COE subcommittee for inclusion in our submission. The percentage of participation is increasing every year, and I hope to see that trend continue. I encourage you to go to the Claims Interest Group Web site if you have any questions about how you can contribute to our 2010 COE submission.

Obviously, I do not have the luxury of reviewing the 127-page submission in its entirety in this column. So, as an alternative, here follows some of the key accomplishments, activities and happenings for 2009:

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What's in This Issue

Message from the Chair

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- I would like to thank **Keithley D. Mulvihill, CPCU, J.D.,** for his contributions as the editor of the *Claims Quorum* for the last couple of years. He consistently produced a product that has been both informative and relevant to CPCU Society members. Keith has stepped down as editor, but I hope he remains an active member of the Claims IG Committee.
- I want to welcome back **Marcia A. Sweeney, CPCU, ARM, AIC, ARe,** as editor of the *Claims Quorum*. She brings a great deal of experience to this role on the committee. Marcia has been an active member of the Claims IG Committee for several terms, and I look forward to working with her in the development and publishing of our newsletter.
- At the Annual Meeting and Seminars in Denver, **Arthur F. Beckman, CPCU, CLU, ChFC, AIM,** was given the 2009 Claims IG MVP Award for his contributions as webmaster. Since Art assumed this responsibility, the Claims IG Web site has undergone needed updates and improvements. The fact that the site now serves as a resource to all CPCU Society members is a direct result of Art's efforts. As Claims IG chair, I thank him for his dedication and commitment to serving the CPCU Society. I encourage everyone to regularly visit the Web site and submit content to Art for future publication on the site.

Arthur F. Beckman, CPCU, CLU, ChFC, AIM (left), receives the 2009 Claims Interest Group MVP Award from Tony D. Nix, CPCU, CIFI.

- Recognizing a membership need for online training, the Claims IG presented two webinars that were well attended and received positive feedback on content and instructor quality. I want to thank our webinar subcommittee members, **James W. Beckley, CPCU, AIC, AIM; L. Jane Densch, CPCU, AIC, AIS, ARe, ARP, CPIW;** and **Cecelia T. Foy-Dorsett, CPCU, AIC,** for their work in this area. Stay tuned, as I know they have more webinars in the planning stage for 2010.
- During the Annual Meeting and Seminars, the Claims IG presented two seminars: "Embracing Change in Control of Litigation Expenses" and "Medicare Secondary Payer Mandatory Reporting Requirements — What Insurers and Self-Insurers Need to Know." Both programs provided timely and relevant material. Review of the evaluations submitted by the attendees shows that the programs were well received and well attended. Thanks to **Robert Riccobono, CPCU; Barbara Wolf Levine, CPCU, J.D.;** and **John A. Giknis, CPCU,** for their excellent efforts in putting these programs together.
- The Claims IG Committee had two new members join its ranks. While on the committee for only a short time, **Charles W. Stroll Jr., CPCU,** and **Theresa L. Young, CPCU, AIC, API, AIM,** have become active members on the committee, and I look forward to working more with them in the future.
- In our 2009 Annual Meeting and Seminars "luncheon attendance competition" with the Underwriting Interest Group, I must admit that we fell short. The Underwriting IG managed to get three more attendees at its luncheon than we did at ours. While I think the books may have been cooked (☺), we still had a great event with an interesting speaker. **David Warner,** of National Renewable Energy Laboratory, provided an overview on real-world applications of renewable energy. I thank Jane Densch for organizing the lunch event.

Claims Interest Group Luncheon attendees learned about renewal energy at the Annual Meeting and Seminars in Denver.

As you can see from the information above, the Claims IG continues to be one of the most active interest groups in the CPCU Society. We have already begun planning for the 2010 Annual Meeting and Seminars in Orlando. Our mid-year Claims IG business meeting will be held in Phoenix, Ariz., April 29–May 1, at the Leadership Summit. If you have never attended the Leadership Summit, I highly recommend you register for the CPCU Society Center for Leadership programs that will be presented. And if you do find yourself in Phoenix at the Summit, feel free to drop in to the Claims IG Committee meeting that will be held on Saturday, May 1.

As a good friend of mine always says, "You only get out of something what you are willing to put into it." I challenge each of you to find ways to become active in the Claims IG and your local chapter. I hope that we all find 2010 to be a very good year! ■

'Thriller — 9th Annual Review of the Year's Ten Most Significant Insurance Coverage Decisions'

2nd Annual 'Coverage for Dummies'

by Randy J. Maniloff, J.D., and Sarah Damiani

Randy J. Maniloff, J.D., is a partner in the Business Insurance Practice Group at White and Williams LLP in Philadelphia. Maniloff writes frequently on insurance coverage topics for a variety of industry publications (including, for the ninth time, a review of the year's 10 most significant insurance coverage decisions for *Mealey's Litigation Report: Insurance*).

Sarah Damiani is a third-year student at Temple University Beasley School of Law and a research assistant at White and Williams LLP. She is assisting Randy J. Maniloff, J.D., and Jeffrey Stempel, J.D., of the University of Nevada Las Vegas Boyd School of Law, with a forthcoming book, to be published in late 2010.

Editor's note: (1) Over the past few years, *Claims Quorum (CQ)* has had the opportunity to publish a summary of attorney **Randy J. Maniloff's** annual article on the top 10 insurance cases of the year. This *CQ* article is a shorter version of the original 53-page article, recently published in *Mealey's Litigation Report: Insurance*. It has been edited and is being reprinted with the permission of White and Williams LLC. © 2009 White and Williams LLC. (2) Due to space considerations, for *CQ* readers we have chosen three of the 10 case discussions. The entire article can be requested from co-author Randy Maniloff via e-mail at maniloffr@whiteandwilliams.com. (3) The views expressed herein are solely those of the authors and not necessarily those of White and Williams LLC or its clients. (4) All uses herein of the first person are references to Maniloff.

Sure, Michael Jackson was as peculiar as New Jersey's duty to defend rules; as shocking as an insurer winning a bad faith case in West Virginia; as ambiguous as every word in an insurance policy (as some see it); as addicted to prescription medications as policyholders are to repeating that ambiguities in a policy must be construed against the insurer; and maybe even a walking criminal act exclusion. But despite a few oddities, Michael Jackson was also as talented as anyone who can figure out choice of law for a coverage action by applying Restatement (Second) of Conflict of Laws § 188, as modified by § 193, based on the factors set out in § 6, unless comment b to § 193 applies. And, of course, Michael's death was as tragic as the birth of the continuous trigger.

Not many people know this, but in the early 1980s Michael Jackson had grown tired of a lifetime in the music industry and was looking for a new challenge. His was a career into which he had been born. And because of that he had always wanted to chart his own course. A fire had long been burning in Michael's belly to get into the insurance claims business. By 1982, it was an inferno that he could no longer control. The time had come for him to pursue his dream. Michael broke the news to Quincy Jones that the recording sessions for *Thriller* were off. Jones, who had just had a homeowner's claim denied, and was in a foul mood toward insurance companies, convinced Michael that the insurance industry was no place for someone so sensitive.

So, with a heavy heart Michael went into the studio and recorded "Thriller." And as everyone knows, it went on to become the number one selling album of all time. But despite "Thriller" providing Michael with unimaginable wealth and fame, he was never able to stop thinking about the career in claims that never was. All agree that Michael was a tortured soul. And there has been much speculation why. This is it.

As Michael lay awake at night during that post-"Thriller" period, thinking about concurrent causation and the pollution exclusion, it was inevitable that "Beat It," his new and wildly successful song, would come on the bedside clock radio. And as he listened to himself telling a wanna-be tough guy to avoid a fight he can't win, a different set of lyrics ran through his head. But he kept them bottled-up inside. It was only after his untimely and tragic death, when his Neverland Ranch was being cleaned out, that a folded-up piece of loose leaf paper was discovered deep in the back of a desk drawer. On it were scribbled the lyrics of "Beat It" that Michael had long dreamed to sing:

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We told you don't you ever make a claim around here;
Don't wanna see your Acord, you better not mess up our fiscal year;
There's disclaimer in our eyes and our letter's very clear;
So beat it, just beat it.

You better file somewhere else, better do what you can;
You ain't gonna see no money, in your lifespan;
You wanna push back, but we're the size of Hoover Dam;
We tell you beat it, but you seem to have no attention span.

Just beat it, beat it, don't get on our balance sheet-it;
Our bank account will not be depleted;
Showin' how funky and strong is our fight;
It doesn't matter if we're not exactly right,
We still won't pay for your dog bite;
Just beat it, beat it;
Our money's so well secreted.

We're out to get you, better get another quote while you can;
Don't wanna be uninsured, for your mini van;
You wanna stay covered, and not end up as broke as Ed McMahon;
So beat it, just beat it.

We're here to show you that we're really not scared;
If you get water in your basement that ain't no time to be unprepared;
And if we finally pay your claim, you'll have an uninsured share;
So beat it, we need to stay a billionaire.

Just beat it, beat it;
We will not be defeated;
We'll keep you off our balance sheet-it;
Don't make us have to repeat it;
Just beat it, beat it, beat it, beat it.

Thriller — 9th Annual Review of the Year's Ten Most Significant Insurance Coverage Decisions is dedicated to the memory of Michael Jackson — coverage guy at heart.

Opening Act —2nd Annual 'Coverage for Dummies'

As anyone who reads insurance coverage cases knows — some people do really dumb stuff. For that matter, even people who do not read insurance coverage cases know that some people do really dumb stuff. Look at Balloon Boy's dad. This not-to-be-believed behavior causes injury, a lawsuit is filed and then comes the inevitable insurance claim. The results are mixed, but more often than not courts do not allow these tomfools to pass the buck.

Last year's review of the ten most significant insurance coverage decisions included "Coverage for Dummies: The Top Ten" — a special report chronicling the year's "best of" cases in this category. "Dummies" was very popular based on the e-mails and other feedback that I received. Nonetheless, I wasn't sure whether to reprise it for 2009 or try to think of something even more sophomoric. But then *Cornett Management Co. v. Fireman's Fund Insurance Co.*, 332 F. App'x 146 (4th Cir. 2009) (applying West Virginia law) was decided. And that's when I realized that "Coverage for Dummies" was coming back for an encore.

At issue in *Cornett* was coverage for a Hooters franchise for sexual harassment claims by two female employees who alleged that they were individually called into the restaurant supervisor's office and advised that a customer had reported a stolen change purse. The women were instructed to listen to a male voice on a telephone, identifying himself as a police officer, directing them to strip naked in front of the manager. The women were threatened with arrest if they did not comply. The women complied. The telephone call was revealed to be a crank. The women filed suit. Hooter's sought coverage.

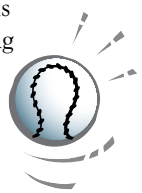
The Fourth Circuit concluded that the Employment-Related Practices Exclusion, contained in the restaurant's commercial general liability policy, precluded coverage for the women's claims. Amazing you say? Yes. But even more amazing is that not long ago a Kansas appeals court addressed coverage for this exact same scheme. *LDF Food Group v. Liberty Mut. Fire Ins. Co.*, 146 P.3d 1088 (Kan. Ct. App. 2006).

In no particular order, here are the nine other decisions from 2009 that best demonstrated the frailty and imperfection of the human brain:

(1) Insurer not entitled to discovery of records from insured's wife's psychologist in an attempt to prove that no coverage was owed to insured-husband for eye injuries sustained by his wife when he threw a carrot at her. What's up doc? *See Safeco Ins. Co. of Am. v. Vecsey*, 259 F.R.D. 23 (D. Conn. 2009) (records protected by the psychologist-patient privilege).

(2) No coverage owed to a convenience store, under its commercial general liability policy, for injuries caused by a clerk who struck a customer in the head with a baseball bat after the customer attempted to cancel a purchase. And I thought I took my job seriously. *See Essex Ins. Co. v. Quick Stop Mart, Inc.*, No. 07-CV-1909, 2009 U.S. Dist. Lexis 21268 (E.D. Pa. Mar. 16, 2009) (coverage precluded by assault and battery exclusion).

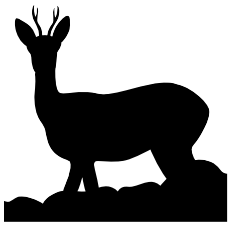
(3) Consideration of coverage for insured, under homeowner's policy, for injuries caused by hitting a person with his automobile, then exiting the vehicle and striking the victim three times with a golf club, breaking three ribs — all in



response to the victim entering the insured's property to retrieve a baseball accidentally hit onto the insured's property by the victim's son. When did the national pastime become the Ultimate Fighting Championship? *See Farmers Auto. Ins. Ass'n. v. Danner,* No. 4-08-0905, 2009 Ill. App. Lexis 992 (Ill. App. Ct. Sept. 3, 2009) (case remanded to trial court to consider applicability of the policy's expected or intended exclusion to an amended complaint).

(4) No coverage owed to a prostitute, for injuries she caused in an accident while driving a truck loaned to her by a customer, as the truck was owned by the customer's employer and she was determined not to be a permissive user under the employer's commercial automobile policy. *See Crawford v. St. Paul Fire & Marine Ins. Co.*, No. C058676, 2009 Cal. App. Unpub. Lexis 8011 (Cal. Ct. App. Oct. 6, 2009).

(5) Consideration of coverage under homeowner's policies, for serious bodily injuries sustained by motorists that drove off the road after swerving to avoid hitting a target deer that a group of high school friends had placed 15 to 30 yards beyond the crest of a hill, at night, in the middle of an unlit two-lane roadway with a speed limit of 55 m.p.h. *See Allstate Ins. Co. v. Campbell,* No. 09AP-306, 2009 Ohio App. Lexis 5096 (Ohio Ct. App. Nov. 17, 2009) (question of fact whether the boys intended to cause injury because they stated that their purpose was to observe the reactions of motorists suddenly confronted with an obstruction directly in front of them). Let's hope they can study their own reactions to suddenly being confronted with an obstruction directly in front of them — bars.



(6) Coverage owed to insured under (presumably) homeowner's policy, for injury caused by firing a paintball at his opponent, as a post-game congratulatory gesture, and striking him in the eye after he had removed his protective eye gear. Mom was right — You won't be satisfied until you poke someone's eye out. *See Tenn. Farmers Mut. Ins. Co. v. Neill,* No. M2008-02056-COA-R3-CV, 2009 Tenn. App. Lexis 308 (Tenn. Ct. App. June 2, 2009) (intended or expected acts exclusion not applicable because the insured did not intend to cause harm).

(7) No coverage owed to convenience store clerk under a Business Owner's liability policy, for injury caused by the accidental discharge of a .22 rifle that he was holding while dancing around and posing for his friends' camera phones. Mr. DeMille, I'm ready to act like an idiot. *Employers Mut. Cas. Co. v. Al-Mashhadi,* No. 08-CV-15276, 2009 U.S. Dist. Lexis 75442 (E.D. Mich. Aug. 24, 2009) (clerk not an "insured" because he was not acting within the scope of his employment at the time of the shooting).

(8) Consideration of coverage for insured, under homeowner's policy, for injuries caused by shooting his ex-wife's new husband, in a fight that started with the two men throwing each other's cellular phones. Can you hear me now? *Alfa Mut. Ins. Co. v. Bone,* 13 So. 3d 369 (Ala. 2009) (case remanded to trial court following a determination that certification of appeal had been improperly granted).

(9) Coverage owed to high school student-insured, under homeowner's policy, for injuries caused to a fellow shop class student, during horseplay that followed the insured pulling a shop stool out from under the victim as a practical joke. An oldie but a goodie. *RAM Mut. Ins. Co. v. Meyer,* 768 N.W.2d 399 (Minn. Ct. App. 2009) (intentional act exclusion not applicable because the insured did not act with the requisite willfulness or egregiousness).

The Ten Most Significant Insurance Coverage Decisions of 2009

In general, the most important consideration for selecting a case as one of the year's ten most significant is its potential ability to influence other courts nationally. That being said, the most common reason why many unquestionably important decisions are not selected is because other states are not lacking for guidance on the particular issue. Therefore, a decision may be hugely important for its own state, but is nonetheless very likely to be passed over

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as one of the year's ten most significant because it has little chance of being called upon in the future by other states confronting the issue.

As I remind readers every year, the process for selecting the year's ten most significant insurance coverage decisions is highly subjective, not in the least bit scientific and in no way democratic. So if you think a decision should have made the list, but didn't, I probably wouldn't argue with you too much. But just because the selection process has no accountability or checks and balances whatsoever does not mean that it wants for deliberativeness. A lot of deliberation goes into the process. It's just that only one person is deliberating.

Below are the ten most significant insurance coverage decisions of 2009 (listed in the order that they were decided). Some are thrillers, off the wall or just plain bad.

- ***Addison Insurance Co. v. Fay*** — Land of Blago, er Lincoln, turned number of occurrences on its hair, er head.
- ***Callahan & Sons, Inc. v. Worcester Insurance Co.*** — Cain and Abel of Coverage Issues: Supreme Judicial Court of Massachusetts on the seldom addressed issue of recovery of attorneys fees in an "insurer v. insurer" declaratory judgment action.
- ***Idaho Counties Risk Management Program Underwriters v. Northland Insurance Cos.*** — CSI-daho: One of the first state top courts addressed the trigger of coverage arguments made in ever-increasing DNA exoneration cases.
- ***Essex Insurance Co. v. Bloomsouth Flooring Corp.*** — First Circuit sniffed out a likely Chinese drywall coverage issue — Does a permeating odor qualify as "property damage?"
- ***Nazario v. Lobster House*** — Insurance Claws: New Jersey Appellate Division placed insurers in boiling water for failure to obtain their insured's consent to being defended under a reservation of rights.
- ***QBE Insurance Corp. v. Austin Co.*** — Alabama Getaway, Getaway: State's high court denied an insurer's request to intervene in an underlying action to address coverage issues. But the court provided useful guidance for insurers in the future.
- ***Health Care Industry Liability Insurance Program v. Momence Meadows Nursing Home*** — Qui Tam Slam: Seventh Circuit shut the door on coverage under a commercial general liability policy for False Claims Act liability — just in time for the inevitable Stimulus Package fraud claims.
- ***State Farm General Insurance Co. v. Mintarsih*** — Follow that Buss: California Court of Appeal addressed coverage for attorney's fees awarded to an underlying plaintiff for securing uncovered damages.
- ***North American Capacity Insurance Co. v. Claremont Liability Insurance Co.*** — No Cash For Flunkers: California Court of Appeal, addressing coverage for construction defects, penalized a contractor insured that did not follow the ABCs, 123s of risk management.
- ***Baughman v. United States Liability Ins. Co.*** — A Dud in the Swamps of Jersey: District Court raised the temperature on the pollution exclusion, finding that exposure to mercury, at a former thermometer manufacturing facility, was not traditional environmental pollution.

Discussion of the Ten Most Significant Insurance Coverage Decisions of 2009

Editor's note: There are 44 pages of discussion on the 10 cases in the original article. We have chosen the discussion on three of the cases for our *CQ* readers. Please feel free to contact the author for the complete article or the discussion on any particular case listed.

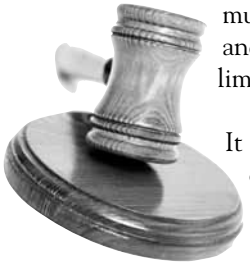
Addison Insurance Co. v. Fay, 905 N.E.2d 747 (Ill. 2009)

Ordinarily a "number of occurrences" decision, as important as it may be, is not material for the annual insurance coverage hit parade. The decisions are legion — by my count the issue has been addressed by about 40 states. Further, the cases are extremely fact specific. The upshot of this combination is that any newly decided case addressing number of occurrences is unlikely to have much of an impact (if any) on future courts addressing the issue.

And that is just one reason why it is surprising that the Supreme Court of Illinois's number of occurrences decision in *Addison Insurance Co. v. Fay* is included as a top ten coverage decision of 2009. Another is that, when it comes to number of occurrences, Illinois's top court has been there and done that — and it wasn't even that long ago. *See Nicor Inc. v. Associated Elec. & Gas Ins. Servs., Ltd.*, 860 N.E.2d 280 (Ill. 2006).

Most number of occurrences decisions involve the court deciding whether to adopt the "cause" test (look to the cause of the damage) or the "effect" test (look to the number of claims or injuries) for purposes of making the number of occurrences calculation. The "cause" test is the majority rule nationally. *Liberty Mut. Ins. Co. v. Pella Corp.*, 631 F. Supp.2d 1125, 1135 (S.D. Iowa 2009). In general, and this is by no means a certainty, a court's adoption of the "cause" test frequently leads to a single occurrence determination.

What makes *Fay* significant is that, despite the Illinois Supreme Court's adoption of the "cause" test just three years earlier in *Nicor*, and despite *Fay* involving a paradigm set of facts that would ordinarily lead a "cause" state to find a single occurrence, the Supreme Court in *Fay* nonetheless concluded that



multiple occurrences, and, hence, multiple limits, applied.

It is not unusual for coverage cases to involve tragic facts. Sadly, after a while, you can't help but become immune to them. But the facts in *Fay* are tough to take, no matter how hardened of a coverage veteran you are. On an evening in April 1997 teenage friends Everett Hodgins and Justice Carr left Hodgins's home to go fishing in a nearby lake. *Fay*, 905 N.E.2d at 749. A storm swept in, and in an attempt to get to Carr's house to escape the storm, the two boys used a shortcut through property owned by Donald Parrish. *Id.* at 750. Parish used the property to operate a business and was insured by Addison Insurance Company. *Id.* at 749. On a part of the property close to the shortcut that the boys frequently took was an excavation pit that was filled with water. *Id.* at 750. Because the sand and clay around the pit was saturated with water, it created a dangerous "quick condition," meaning that the water prevented the soil from supporting a load of weight. *Id.* at 749. The two boys became trapped. *Id.* Their bodies were found three days later in the wet clay and sand surrounding the pit. *Fay*, 905 N.E.2d at 749. The doctor performing the autopsy concluded that the primary cause of the boys' deaths was hypothermia. *Id.*

Although investigators could not determine the exact manner and timing of the serious of events leading to the boys' deaths, they did determine that when Carr reached the water-filled pit, he attempted to jump across the water, but became trapped in the pit. *Id.* at 750. In an attempt to get Carr out of the pit, Hodgins also became trapped. *Id.* Investigators could not conclude the amount of time that elapsed between Carr becoming trapped and Hodgins becoming trapped, or even whether Hodgins was with Carr when he became trapped. *Id.*

Addison and the boys' estates agreed to settle the claims in an amount equal to Parish's policy limits, but disagreed which policy limit applied. *Id.* The policy contained a "General Aggregate Limit" of $2 million and an "Each Occurrence" limit of $1 million. *Id.* Addison filed a declaratory judgment action seeking a determination that the boys' deaths constituted a single occurrence. *Id.* The trial court found that the boys' deaths constituted two occurrences. *Fay*, 905 N.E.2d at 750. The appellate court reversed, and the issue came before the Illinois Supreme Court. *Id.*

At the outset, the Supreme Court could not escape its recent decision in *Nicor* — adopting the "cause" test, but with the caveat that "where each asserted loss is the result of a separate and intervening human act, whether negligent or intentional, or each act increased the insured's exposure to liability, Illinois law will deem each such loss to have arisen from a separate occurrence." *Id.* at 754 (quoting *Nicor*, 860 N.E.2d at 280). Based on this test, Addison maintained that, because the cause of both boys' injuries was Donald Parrish's sole negligent act of failing to properly secure and control his property, both injuries were caused by a single occurrence. *Id.* at 754.

Despite what appeared to have been classic single occurrence facts under a "cause" test, the Illinois Supreme Court concluded otherwise. *Id.* at 755. The court expressed its concern that such a decision would lead to an inadequate amount of coverage. *Id.* Indeed, the court did not even attempt to hide that it was embarking upon an outcome determinative decision:

> [I]n light of these facts, applying *Nicor* in the way Addison suggests leads to an unreasonable interpretation of Parrish's insurance policy. Focusing on the sole negligent omission of failing to secure the property would allow two injuries, days or even weeks apart, to be considered one occurrence. The defendants raised this concern in the trial court. If several injuries suffered over the course of several weeks could be bundled into a single occurrence, the likelihood that damages would exceed a per-occurrence limit is significant, as demonstrated by the damages in the instant case. Purchasers of insurance such as Parrish would be left unprotected by their insurance policy, and liable for any amount above the per-occurrence limit. In accepting a per-occurrence limit, Parrish could not have intended to expose himself to greater liability by allowing multiple injuries, sustained over an open-ended time period, to be subject to a single, per-occurrence limit.
>
> As a result, in situations where a continuous negligent omission results in insurable injuries, some limiting principle must be applied.
>
> *Fay,* 905 N.E.2d at 755.

To avoid this untenable situation, the *Fay* Court introduced two new considerations to the number of occurrence equation. First, the court adopted a "time and space" test — "if cause and result are simultaneous, or so closely linked in time and space as to be considered by the average person as one event, then the injuries will be deemed the result of one occurrence." *Id.* at 756 (quoting *Doria v. Ins. Co. of N. Am.*, 509 A.2d 220, 224 (N.J. Super. App. Div. 1986). "The insured's negligence consisted of an omission, the failure to maintain the property. Where negligence is the result of an ongoing omission rather than separate affirmative acts, a time and space test effectively limits what would otherwise potentially be a limitless bundling of injuries into a single occurrence." *Id.*

Next, the *Fay* Court held that, once the boys' estates provided the necessary facts

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to establish coverage and the value of the loss, the burden then shifted to the insurer to prove that the event or events giving rise to the damage constituted a single occurrence. *Id.* at 753. The court reached this conclusion despite acknowledging that it has long been established law in Illinois that the insured bears the burden of proving coverage under an insurance policy. *Id.* at 752.

Examining the facts surrounding the boys' deaths, the court determined that Addison could not meet its burden of proving that their injuries were so closely linked in time and space as to be considered one event: The boys did not become trapped simultaneously and it could not be determined how closely in time the boys became trapped nor how closely in time the boys died. *Id.* at 756.

Because of Addison's failure to meet this burden, the court held that the two boys' deaths constituted separate occurrences. *Fay*, 905 N.E.2d at 757. As a result, the claims were subject to the policy's $2 million general aggregate and not capped at the $1 million occurrence limit. *Id.*

As noted above, a review of number of occurrences decisions nationally demonstrates that application of the "cause" test frequently leads to a determination that a single occurrence applies. But Fay has provided a blueprint for courts, constrained to follow the "cause" test, but desirous of providing the additional limits that would be available if multiple occurrences applied.

Essex Insurance Co. v. Bloomsouth Flooring Corp., 562 F.3d 399 (1st Cir. 2009)

Chinese drywall is no flash in the wok. While it is certainly not the proverbial next asbestos, neither is it the next Y2K. Claims are mounting and the Multi-District Litigation pending in New Orleans is proceeding at a rapid clip. The litigation has placed a host of legal issues on the table. Recent issues of *Mealey's Litigation Reports: Construction Defects* have reported on some settlements, as well as defendants invoking the economic loss rule to prevent tort recovery; builders allegedly tricking homeowners into settling without providing all of the facts; a default judgment entered against a Chinese-based drywall manufacturer; debate over application of a state's right to repair law to Chinese drywall claims; and class certification issues.

In addition, studies are underway (and some results are in) to determine if the presence of Chinese drywall in homes causes property damage and bodily injury. The Consumer Product Safety Commission (CPSC) recently concluded that there is a "strong association" between chemicals emitted by Chinese drywall and corrosion of metals. The CPSC also concluded that, while the hydrogen sulfide and formaldehyde levels detected in 51 studied homes containing Chinese drywall were at concentrations below irritant levels, the additive or synergistic effects of these and other compounds in the subject homes could cause irritant effects. The Formaldehyde Council, a trade group, begged to differ. Melanie Trottman & M.P. McQueen, *CPSC Ties Drywall, Corrosion, The Wall Street Journal*, Nov. 24, 2009.

Given that so many defendants in Chinese drywall cases are smallish size contractors, it is very likely that the ability of homeowners to recover some of their losses, even if they establish liability, will be tied to the availability of insurance for such defendants. On this subject, there has been more sizzle than steak. While lots of commentators have identified and hypothesized about the likely coverage issues, judicial decisions setting out the actual parameters of coverage for Chinese drywall claims have been elusive. And it may remain that way for some time — until coverage actions are filed (of which there have only been a few so far) and work their way through the system.

Some of the most critical issues surrounding coverage for Chinese drywall will be: trigger, the pollution exclusion and "business risk" exclusions. Given that the treatment of all three of these issues varies widely between states, it is natural to expect that the extent of coverage for Chinese drywall will likewise run the gamut. But this much is certain — even if courts are ultimately generous in providing coverage for Chinese drywall, the amount available will be a drop in the bucket compared to Towers-Perrin's oft-cited projection of $15 billion to $25 billion for the total Chinese drywall bill. The simple fact remains that, because many of the defendants in the litigation are small size contractors, those that even have insurance likely have minimal limits, such as $1 million per occurrence, with such limit probably subject to a general or products-completed operations aggregate limit of the same amount or perhaps $2,000,000 (and multiple occurrences may not apply anyway). In other words, many homeowners are likely to be disappointed when comparing their damages to their recoveries.

It is still too early for any concrete judicial guidance on Chinese dry wall coverage issues. However, given how much has been made of the so-called rotten egg smell allegedly given off by Chinese drywall, the First Circuit's decision in *Essex Insurance Co. v. BloomSouth Flooring Corp.* — addressing whether odor can constitute a physical injury to property — may prove relevant in future coverage disputes.

The case arose as follows. In 2000, Suffolk Construction Corporation subcontracted with BloomSouth Flooring Corporation to install carpet tile and related materials in the offices of Boston Financial Data Services (BFDS). *Essex,* 562 F.3d at 401. BloomSouth subsequently subcontracted out the supply and installation of the carpet to two other companies. *Id.*

The carpet was installed in Spring 2001. *Id.* Sometime thereafter BFDS employees moved into the building and noticed an odor that they described as a "locker room" smell, a "sour chemical" smell or a "playdough" smell. *Id.* Some employees complained that the odor caused ill effects, including headaches. *Id.* BFDS notified Suffolk of the problem. *Id.* One of BloomSouth's subcontractors scraped up the original carpet adhesive in an effort to eliminate the odor. *Id.* Such effort failed, and the odor spread to other areas of the building. *Essex,* 562 F.3d at 401. Tests on the flooring to determine the cause of the odor were inconclusive. *Id.* at 402.

BloomSouth was insured under commercial general liability policies issued by Essex Insurance Company, naming Suffolk as an additional insured. *Id.* BFDS demanded that Suffolk remove the carpet and eliminate the smell. *Id.* Suffolk demanded that BloomSouth respond to BFDS, and BloomSouth refused. *Id.*

As a result, Suffolk paid BFDS nearly $1.5 million for remediation efforts. *Id.* Suffolk then notified Essex of BFDS's claim and demanded that, as an additional insured under the BloomSouth policies, Essex defend and indemnify it. *Essex,* 562 F.3d at 402. Essex denied Suffolk's claim. *Id.*

Suffolk filed an action against BloomSouth for negligence, breach of contract, indemnity and related claims, and Essex filed a declaratory judgment action against BloomSouth and Suffolk. *Id.* Essex sought a declaration that it was not required to defend or indemnify Suffolk for the BFDS claims nor BloomSouth for the Suffolk action. *Id.* The trial court granted Essex's motion for summary judgment, holding that certain business risk exclusions relieved Essex of its policy obligations. *Id.*

The First Circuit reviewed the trial court's decision de novo. Although the parties did not address directly whether odor constituted "physical damage to tangible property," instead focusing on whether one of the exclusions applied, the court noted that the odor, as physical damage, was a threshold issue that required analysis prior to making any decision regarding the applicability of the exclusions. *Id.* at 404.

Because the Massachusetts Supreme Judicial Court had not yet decided whether an odor could constitute a physical injury, the First Circuit noted that its decision would be "an informed prophecy of what the court would do." *Essex,* 562 F.3d at 404 (internal quotation omitted). The insureds identified unpublished Massachusetts decisions that they argued stood for the proposition that odor could constitute physical injury under Massachusetts law. *Id.*

First, *Matzner v. Seaco Insurance Co.*, No. 96-0498-B, 1998 Mass. Super. Lexis 407, at *13 (Mass. Super. Ct. Aug. 12, 1998) held that "carbon monoxide contamination constitute[d] a 'direct physical loss of or damage to' property." *Id.* at 405. Second, *Arbeiter v. Cambridge Mutual Fire Insurance Co.*, No. 94-00837, 1996 Mass. Super. Lexis 661, at *3 (Mass. Super. Ct. Mar. 15, 1996) found "that fumes are physical loss which attach to the property." *Id.*

Essex responded to the insureds' reliance on these cases by making three arguments. *Id.* First, the odor could not constitute physical injury because the underlying claims referenced injury to the "air," not injury to "tangible" property. *Id.* The First Circuit quickly dismissed this contention, noting that Suffolk alleged that the odor "permeated the building." *Essex,* 562 F.3d at 405. Second, Essex argued that odor simply cannot constitute physical injury to property, but failed to cite any authority in support of this position. *Id.* As a result the First Circuit rejected Essex's argument given the authority of *Matzner* and *Arbeiter.* *Id.* at 405-06.

Third, Essex argued that, even if it were incorrect on the first two points, case law suggests that, at the very least, in order for odor to constitute physical injury, the odor must have persisted even after the source of the odor was removed. *Id.* at 405. According to Essex, there was no persistent odor because it did not remain once the carpet was removed. *Id.* The First Circuit found that, although Essex may be correct that the odor must be permeating, the "underlying complaint explicitly assert[ed] that the odor 'permeated the building.'" *Id.* at 406.

The First Circuit ultimately held "that odor can constitute physical injury to property under Massachusetts law, and also that allegations that an unwanted odor permeated the building and resulted in a loss of use of the building are reasonably susceptible to an interpretation that physical injury to property has been claimed." *Essex,* 562 F.3d at 406.

Nazario v. Lobster House, Nos. A-3025-07T1, A-3043-07T1, 2009 N.J. Super. Unpub. Lexis 1069 (N.J. Super. App. Div. May 5, 2009)

New Jersey's duty to defend seems to suffer from schizophrenia. On one hand, it could be argued that it is the most restrictive in the country for insureds. After all, *Burd v. Sussex Mutual Insurance Co.*, 267 A.2d 7 (N.J. 1970) affords insurers the right, in many cases, to decline to provide a defense and instead convert its defense obligation to one of reimbursement of defense costs at the

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conclusion of the case. "[T]he practical effect of *Burd* is that an insured must initially assume the costs of defense itself, subject to reimbursement by the insurer if it prevails on the coverage question." *Trustees of Princeton University v. Aetna Cas. & Sur. Co.*, 680 A.2d 783, 787 (N.J. Super. App. Div. 1996) (quoting *Hartford Accident Indem. Co. v. Aetna Life & Cas. Ins. Co.*, 483 A.2d 402, 407 n.3 (N.J. 1984)). Further, such reimbursement obligation can then be limited, admittedly when feasible, solely to those costs that were incurred to defend covered claims. *See SL Indus. Inc. v. Am. Motorists Ins. Co.*, 607 A.2d 1266 (N.J. 1992). Based on these principles, insureds frequently view the Garden State's duty to defend as standing in contrast to the rule, applied just about everywhere else in the nation, that the duty to defend is broader than the duty to indemnify.

On the other hand, it could just as easily be argued that New Jersey's duty to defend is the most expansive in the country for insureds. Even before *Burd* was hatched, the Supreme Court of New Jersey held in *Merchants Indemnity Corp. v. Eggleston*, 179 A.2d 505 (N.J. 1962) that an insurer that wishes to defend its insured, under a reservation of rights, can do so only if it obtains its insured's consent. In other words, an insurer that wishes to take the common course of action of appointing panel counsel to defend its insured, while at the same time sending its insured a reservation of rights letter setting out reasons why, notwithstanding providing a defense, the insurer may not have an obligation to pay some or all of any damages awarded, must advise the insured of its right to object to being defended in such a matter.

New Jersey courts have imposed a simple sanction on insurers that fail to obtain their insured's consent to being defended under a reservation of rights — loss of the insurer's ability to assert an otherwise applicable defense to coverage. *See Certain Underwriters at Lloyd's, London v. Frederick*, No. A-3234-04T2, 2006 N.J. Super. Unpub. Lexis 2763 (N.J. Super. Ct. App. Div. Apr. 4, 2006); *Selective Ins. Co. v. Allstate Ins. Co.*, No. A-6061-02T2, 2006 N.J. Super. Unpub. Lexis 238 (N.J. Super. Ct. App. Div. Mar. 10, 2006); *Pa. Nat'l Mut. Cas. Ins. Co. v. South State, Inc.*, No. 07-2989, 2008 U.S. Dist. Lexis 98456 (D.N.J. Dec. 3, 2008).

Despite the fact that *Eggleston* has been on the books since the same year as the Cuban Missile Crisis, not to mention imposing an obligation on insurers with the most serious of all consequences for their failure to comply, some insurers have not been aware of the decision. Consequently, they have not obtained their insured's consent to being defended under a reservation of rights and paid dearly for it. One insurer's failure to be aware of such a long-standing decision recently left a New Jersey appellate court incredulous. It had the following to say — just before concluding that the insurer was estopped from denying coverage because its reservation of rights did not comport with *Eggleston*, "Borrowing from my own experience, every once in a while you see something and you scratch your head and you wonder why a carrier that's in the business of doing this type of thing would not know how to do it appropriately. It's not particularly difficult, but those things happen I guess." *Allstate Ins. Co.*, 2006 N.J. Super. Unpub. Lexis 238, at *19.

How it is that a decision as significant as *Eggleston* managed to fly under the radar for so long is a mystery. But *Eggleston's* days as a stealth coverage issue appear over, as evidenced by the spate of decisions over the past four years that have applied it to preclude an insurer from asserting an otherwise applicable coverage defense. In 2009 the New Jersey Appellate Division added one more decision to that list. But what makes this most recent entry particularly noteworthy is the court's rejection of the specific arguments presented by insurers in an effort to avoid the consequences of *Eggleston*.

Nazario v. Lobster House involved coverage for bodily injury sustained by an employee of a door company when he fell from a ladder while installing overhead garage doors at the Cape May, New Jersey, warehouse facility of Cold Spring Fish and Supply Company. *Lobster House*, 2009 N.J. Super. Unpub. Lexis 1069, at *6. Cold Spring sought coverage from its two primary liability insurers — Essex Insurance Company and Sirius America Insurance Company. *Id.* at *2. Essex and Sirius both appointed counsel to defend Cold Spring under a reservation of rights and each insurer filed declaratory judgment actions against Cold Spring seeking a judicial determination that it was not entitled to coverage. *Id.* at *2-3.

The trial court ruled that the terms and conditions of the Essex and Sirius policies did not provide coverage to Cold Spring for the underlying tort action. *Id.* at *4. Coverage was precluded under the Sirius policy because it did not extend to Cold Spring's wholesale warehouse operations. Coverage was precluded under the Essex policy on account of an exclusion for negligent hiring and independent contractors and subcontractors. *Id.* at *15-16.

But despite the trial court's decisions concerning the lack of coverage — at least under the provisions of the Essex and Sirius policies — the court also concluded that both insurers' reservation of rights letters were ineffective because they failed to inform Cold Spring that their offers to defend could be accepted or rejected. *Id.* at *4. As a result, the policy provisions were tossed aside and the insurers were estopped to disclaim coverage. *Lobster House*, 2009 N.J. Super. Unpub. Lexis 1069, at *4. Appeals were taken to the Appellate Division. *Id.* at *6.

The New Jersey Appellate Division was just as unsympathetic to the insurers' position as the trial court. The appellate court began its analysis by setting out several quotations from *Eggleston*. Most notably: "If an insurer 'wishes to control the defense and simultaneously reserve a right to dispute liability, it can do so only with the consent of the insured.' Agreements may be 'inferred from an insured's failure to reject an offer to defend upon those terms, but to spell out acquiescence by silence, *the letter must fairly inform the insured that the offer may be accepted or rejected.*'" *Id.* at *12 (emphasis added and citation omitted) (quoting Eggleston, 179 A.2d at 512).

Seeing the writing on the wall, that the appellate court had every intention to follow *Eggleston*, the insurers focused on the trial court's statement that "prejudice is presumed by the absence of control of the litigation." *Id.* at *19. The insurers argued that it could be demonstrated that Cold Spring suffered no prejudice as a result of being represented by counsel chosen by the insurers. *Id.* They pointed out that Cold Spring retained personal counsel to serve as defense counsel and to monitor the action on its behalf, with such personal counsel also filing third party pleadings and attending depositions. *Id.* As such, the insurers argued that a *rebuttable* presumption of prejudice should have been applied. *Lobster House*, 2009 N.J. Super. Unpub. Lexis 1069, at *19. Further, Sirius pointed out that its defense was not based on a policy exclusion, but, rather, a complete lack of coverage - the Sirius policy did not extend to Cold Spring's wholesale warehouse operations. *Id.* at *19-20.

However, the Appellate Division was not persuaded that prejudice was even a consideration under Eggleston:

> Because Essex and Sirius actively assumed defense of the claim but did not disclaim liability or reserve its rights through "appropriate measures" as set forth in *Eggleston,* we affirm the trial judge's finding that both insurers are estopped from denying coverage.
>
> We find nothing in *Eggleston* or its progeny which suggests that the insured must prove actual prejudice to create coverage, or that the carrier may prove lack of prejudice to avoid coverage by estoppel, when a fully informed written consent is lacking. The control of the litigation without proper consent equates to creating the coverage without qualification under *Eggleston.*

Id. at *20-21.

The significance of *Lobster House* is this: The insured was represented by personal counsel, who apparently cooperated with the insurers' retained counsel. In addition, there was a complete lack of coverage under the Sirius policy. Nonetheless, the insurers' were still estopped from denying coverage. By applying *Eggleston*, even under these facts, and rejecting a prejudice consideration, the court seemingly adopted strict liability for insurers that fail to obtain their insured's consent to being defended under a reservation of rights. The moral of the story for insurers is simple. The safest way to stay out of boiling water is to follow *Eggleston* when undertaking an insured's defense. If *Lobster House* is the law, this appears to be easier than attempting to prove *Eggleston's* inapplicability. ■

Extreme Claims Makeover — Building a Good Faith, Market Conduct Compliant Culture

by Kevin M. Quinley, CPCU, AIC, ARM, ARe

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"Extreme Makeover" was an ABC television series that depicted ordinary men and women undergoing drastic physical changes in diet, hairstyle and wardrobe. Insurance and claim departments may never be featured on TV, but many of them may be due for their own version of an extreme makeover. As one indicator, a recent study by Wolters Kluwer Financial Services lists the top 10 reasons that property-casualty insurance companies fail to achieve compliance on market conduct examinations. What is striking is that half of the top 10 transgressions involve claim-handling lapses.[1]

The five claims-related market conduct violations are:

- Failure to acknowledge, pay or deny claims within specified time frames.
- Failure to pay claims properly (sales, tax, loss of use).
- Improper claim file documentation.
- Failure to communicate in writing a delay in claim settlement.
- Using unlicensed claim adjusters or appraisers.

A market conduct examination is about as much fun as a colonoscopy. And it may be as infrequent, depending on how often an insurer or claim outfit hits the radar screen of state regulators. Periodic complaints will earn an insurer one of these exams. Even "virginal" insurers with spotless complaint records may still receive periodic efforts by state insurance department auditors to check under the hood and kick the tires.

Market Conduct 'Colonoscopies'

We can compare market conduct exams to colonoscopies in other ways. In both instances, you feel better when they are over. Fear of the unknown — not knowing what will be found — can be a source of angst. In both cases, you are relieved if you get a clean bill of health. Both may make you swallow stuff that you would otherwise prefer not to ingest.

However, while health insurance usually covers colonoscopies, no such policies cover the cost of market conduct examinations. In fact, insurers pay for the privilege of undergoing market conduct exams. (It would be interesting to compare the length and frequency of market conduct exams of insurers based in Duluth versus those based in, say, South Florida or Maui.)

One positive emerges from the Wolters Kluwer study: It offers a template for building a compliance culture within an insurance company and claim department. It's like the old joke where a guy goes to his doctor, raises his arm over his head and says, "Doc, it hurts when I do this." The doctor's reply: "Don't do that!"

Staying off the radar screens of state insurance departments may be as straightforward as embracing good-faith claim practices, avoiding bad-faith hot-spots, knowing the difference between the two, training staff in these areas, keeping customers happy and complying with the areas state regulators see as claim-handling hot buttons. These steps will not guarantee immunity from market conduct examinations, but they heighten the odds of emerging from such an examination smelling like a proverbial rose.

Building a Compliance Culture

Building a compliance culture is a claim management challenge. It is not a flavor-of-the-month initiative. There must be more than lip service. There must be an ongoing, recurring and sustained commitment from top management all the way through the organization. One way to reinforce the importance of market conduct compliance is to incorporate key criteria into annual and interim performance evaluations.

Stronger still is to link compliance with sound practices to compensation. Tracking and monitoring compliance with market conduct criteria is essential. As the management guru **Tom Peters** says, "That which gets measured gets done." If you don't measure it, it likely will not get done. If hitting or not hitting targets pertaining to good claim practices has no impact on adjuster raises and no impact on bonus or contingent income, adjusters may be indifferent to best practice criteria.

Another way to build a compliance culture is to periodically audit for compliance. This may involve monthly, quarterly or semiannual assessments of randomly pulled files (both open and closed) to gauge or "grade" conformity to sound adjusting processes.

It is all fine and well to talk about "culture." Defining it is another, tougher, matter. Is it like pornography, hard to define but "I know it when I see it"? One way to define culture is to explain what it is not. A culture of good faith and market conduct compliance means that it is not a "flavor of the month" management initiative or campaign. It is not something done with motivational speeches, posters and coffee mugs that will soon hold spare pencils. It is ***not*** a one-and-done, check-it-off-a-list phenomenon.

It is an ongoing commitment, from the top vice president of claims in the home office to the rankest newbie adjuster. If you woke up someone from the claims department at 3:30 a.m. and asked him what core values the unit held, he would tell you that good faith and market conduct compliance are bedrock. ***That*** is culture!

A commitment to a good-faith market compliant culture starts with, but does not end at, the organization's very top. Certainly the chief executive officer and "C-suite" officers must buy into good-faith practices and market conduct compliance. They must do this in both verbal and visible ways that go beyond a one-shot campaign.

Along with this may come the decision to appoint an ethics ombudsman and to draft an organizational credo. The latter should reflect a commitment to good-faith claim practices and to ethical behavior. However, merely appointing someone to a post and offering a high-sounding credo will, by itself, avail a claim operation of nothing. These are necessary but not sufficient conditions. The risk is that the commitment to good-faith and market conduct compliance becomes a "paper" program, existing to placate internal and external constituencies but observed more in the breach than in practice. Some organizations, for example, offer an anonymous toll-free number that can be used by any "whistleblower" employee to report deviations from ethical behavior. This could be an early warning sign to flag bad-faith claim practices or deviations from market conduct standards.

Top claim management and leadership must not only "talk the talk" but also "walk the walk" when it comes to good-faith claim handling and adherence to market conduct standards. This commitment must filter down throughout the organization, claim department and work team.

Nuts and Bolts Action Plans

Claim offices should establish standards for prompt acknowledgement, payment or denial of claims. Timeliness standards should start with examining the local state's fair/unfair claim practice statutes. Many of these will contain deadlines for an insurance company to acknowledge, pay or deny claims.

Claim file documentation is another area of focus by state insurance commission market conduct examiners. Examiners want to see the adjuster's notes and generally trace the narrative of a claim's life cycle. Other auditors seek a sense of the adjuster's thought processes in claim file notes. This helps shed light on claim practices, reserve practices, settlement offers and case evaluations. (Of course, claim file notes can also provide evidence of bad faith, especially if they reflect dubious claim practices or derogatory comments about a policyholder, claimant, lawyer, etc.)

While we all understand the reason auditors want to see claim file notes, documentation often receives scant attention. The reasons for this are perhaps understandable. An adjuster's scarcest resource is time. Often, in the hustle and bustle of a busy work day, an adjuster can either spend time documenting a file or spend time investigating, evaluating and negotiating activities that move cases forward. Given that choice, it is often a "no-brainer" for adjusters to opt to spend time on substantive claim-file advancement activities instead of meticulously recording what happened blow-by-blow or recording their thought processes for posterity. (Often, adjusters privately suspect that the reason auditors are so obsessed with file documentation is because they want a shortcut to orient them and avoid having to slog through a claim file page by page.)

This may be unfair since auditors realize that brisk turnover frequently (and unfortunately) characterizes claim departments. File hand-offs are common. Having thorough, self-explanatory file notes gets a "successor" adjuster up to speed on any inherited file. As a result, insurance claim departments and third party administrators (TPA's) should stress claim file documentation. It is not necessarily an either/or choice; good

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adjusters strive — and sound claim practice supports — a balance between documenting and doing.

Let us turn to failure to communicate in writing a delay for claim payment. Many legitimate reasons exist as to why a claim payment to a policyholder may be delayed. Perhaps the insured has not submitted a Proof of Loss. Maybe a question exists over the extent of damage or whether property can be fixed versus requiring replacement. Maybe — through no fault of the adjuster — the claim investigation is stalled due to the unavailability of a key witness or official report. Adjusters must be meticulous in not only keeping policyholders "in the loop" of communications but also making sure that communication takes a written form.

Claim management must develop and enforce company-wide communication standards, identifying for adjusters: (a) The time lag which qualifies as "delayed payment" under a given state's regulations and (b) Requirements that adjusters notify and explain in writing the reason(s) for any delay. Management should audit and spot-check compliance. Adherence to this communication — both frequency and form — must be incorporated into adjusters' performance evaluation criteria. Management should prepare and use case studies of successful and unsuccessful communication as training modules. In the "unsuccessful" discussion, claim managers and supervisors can illustrate how communication failures can alienate policyholders, make claim settlement more difficult, spawn bad-faith claims and invite consumer complaints that might trigger market conduct exams.

Management can likewise address emphatically the challenge of adjuster licensing. In some organizations and departments, this responsibility may fall to the claims manager or supervisor. In other firms, it may fall to the legal/regulatory department. The point is that management must task someone with tracking the claim staff's license status. (If the claim outfit operates solely in a state which does not require adjuster licensing, this is a moot point.)

Using unlicensed adjusters does not by itself mean that the adjuster is unqualified to handle a loss. There are superb adjusters who — for various reasons — have had licenses lapse. There are likely licensed adjusters who, despite the licensing, would do a bumbling job. Nevertheless, keeping licensing current is sound practice. First, it avoids market conduct penalties that a state insurance department can levy. Second, using unlicensed adjusters can look bad to the company in the event of E&O or bad-faith litigation.

This hits home in cases where I have served as an expert witness. Plaintiff attorneys like to probe the licensing status of claim staff to make the case before juries that, "Company X was so incompetent and irresponsible that it didn't even bother to provide licensed personnel." Using unlicensed adjusters gives plaintiff attorneys one more tool to use to try to inflame juror passions against insurance company defendants.

Investing and Divesting

Maria Lopez is a claim professional from the Cleveland, Ohio, area. She says that two keys to building a good-faith and market-compliant culture are to invest and divest. First, she says companies should "send a message by investing in people." By this, she means training them the moment employment commences for at least a week, using a dedicated training department.

Suggested topics include the history of insurance and the company, the image of the insurance industry as a whole, why customer service is crucial and how it can be accomplished." Then, Lopez says, "do good-faith training." She also thinks claim units should keep a close eye on caseloads per employee so that staff can focus on good-faith handling. Lopez says the second aspect is to divest, adding that companies should "divest leaders who cannot embrace a good-faith/compliance path."

Transforming "ordinary" claim departments from being good to great will not depend on diets, Botox or a new Versace wardrobe. Attention to building a good-faith market conduct compliant culture will, however, position claim teams for an extreme makeover in a positive direction and propel them to the claims equivalent of prime time! ■

Reference

(1) Cited in "Top 10 Ways Insurers Are Non-Compliant," *American Agent & Broker,* November 2009, p. 9.

The Hazards of the Company Picnic — Claims for Employee Social Events

by Jesse A. Baird, CPCU, MBA, AIC

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Anyone in the business of insurance claims has attended his or her share of work-related social events. Though the focus on cost-cutting has grown more intense in recent years, businesses continue to host festivities that reward hard work, increase morale and help employees get to know each other. While these soirees are intended to take adjusters away from their claim files, there is always the risk that the event will result in one. At picnics and parties, as in any human endeavor, accidents happen and people are sometimes injured. If a mishap occurs, is the employer liable? Will workers compensation coverage apply? How should adjusters approach such claims?

Sports activities, company picnics, holiday dinners and team-building outings create two risks for employers. First is the possibility that employees might cause harm to nonemployees. Given that the venues for social events are often public, casual and not within the control of the employer, the potential for property damage, injuries from sporting or vehicle accidents, and sexual harassment claims is significant. The second risk for employers is that a workers compensation claim will be made for an injury sustained at such an event. This is an important issue not only for workers compensation adjusters, but also for property-casualty adjusters handling subrogation or who need to determine if workers compensation exclusions apply.

The legal issues involved in determining who is liable for injuries at employee events constitute a gray area of employment law. Standards for liability also vary among states, creating another layer of complexity. However, basic principles do exist, and these should be the starting point for adjusters, regardless of the jurisdiction where the festive misadventure occurred.

When determining whether employee conduct at a social event will result in liability for an employer, the primary issue is whether the social event was within the course and scope of employment of the person involved in the incident. In other words, was the person working when the accident occurred? Though state laws vary, two basic standards apply in deciding whether an employee is within the course and scope of employment. The first issue is whether participation was required by the employer; the second is whether the employer benefitted from the event.

Whether the employee is required to participate is a crucial issue in deciding liability. If an employee is required to take part in an event as a condition of employment, then he or she is clearly within the course and scope of employment, the employer is generally liable for damages to third-parties and workers compensation applies. However, if involvement in the event is voluntary, the employer often escapes liability. In an Illinois case, a man was burned by a portable stove at a company holiday party. The court held that since attendance at the party was voluntary, no claim could be made for workers compensation benefits.[1]

Similarly, in a California case, a police officer was injured while playing an off-duty pickup basketball game. He made a claim for workers compensation on the grounds that he was required to stay in good physical condition to fulfill his duties as a police officer. Because of this, he argued workers compensation should cover any injury resulting from cardiovascular exercise regardless of where and how it occurred. The workers compensation judge, indulging in the generosity for which Golden State benches are notorious, found that the injury in fact occurred during the course of the officer's employment and that workers compensation applied. The judge decided essentially that the officer was working any time the officer's heart rate climbed due to a voluntary activity.

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The appellate court overturned the decision, finding that an injury is not covered by workers compensation unless the activity was "expressly or impliedly required".[2] The court found that an employee who is injured during voluntary, off-duty participation in a recreational, social or athletic activity is not entitled to workers compensation benefits unless the employee can show that his or her participation was — in either explicit or implicit fashion — required by his or her employer.[3]

It may help to provide a hypothetical example. Since this writer's favorite workers compensation adjuster is author **Franz Kafka,** who worked for much of his life at the Workers Accident Insurance Institute for the Kingdom of Bohemia, I will call our hypothetical employee "Franz." Perhaps not coincidentally, workers compensation systems in some jurisdictions have been described as "Kafkaesque" — and in the sense that the word means "marked by a senseless, disorienting often menacing complexity,"[4] it is hard to disagree.

Imagine Franz is attending the company picnic of his employer, Workers Accident Insurance, and injures himself and a bystander while playing Frisbee. If Franz's boss told him it was part of his job to attend the picnic, or if his boss implied that attending the picnic would improve his standing within the company or would be a factor in evaluating his job performance, Workers Accident Insurance is liable and workers compensation applies. However, if Franz's boss invited him to participate but made it clear that he is not required to attend, the first hurdle is cleared and it is possible that Workers Accident Insurance may not be liable to Franz or to the bystander. It is important not to overstate the strength of this defense, however, since in many jurisdictions it is the *minimum* required for an employer to avoid liability.

The next question becomes whether Workers Accident Insurance benefited

from Franz's attendance at the picnic. If the employer achieved any positive business result from the event at which the injury occurred, the employer may in fact be liable, *even when attendance is voluntary*. This means that the event doesn't even have to be organized by the employer for liability to apply — a manager could ask employees to attend an event thrown by a third-party vendor, for example, and the sales relationships that result could provide enough benefit to the employer for the employee to be found legally within the course and scope of employment.

Whether an employer benefits from a social event is another gray area subject to broad interpretation. However, it is likely that an employer benefits from an event when:

- The employer requires employees to attend the event. Franz's boss tells him he must attend the picnic.
- The employer pays employees for their participation. Franz earns overtime for attending the picnic on a weekend.
- The event takes place on company property and/or during business hours. Franz attends the picnic at Workers Accident Insurance's Prague headquarters (assuming hypothetically it has large and well-groomed grounds) during normally scheduled work hours.
- Company business takes place at the event, including employee recognition or socializing with clients. At the picnic, Franz and his peers are given awards for achievement or a speaker is brought in by Workers Accident Insurance to discuss insurance issues.
- The employer paid for the activity.[5] Workers Accident Insurance rented the gazebo at the park, purchased the food for the picnic and paid for the Frisbee involved in Franz's mishap.

Examples of actual cases serve only to illustrate the challenge of defining employer benefit in specific circumstances. For example, in one case an employee returning home from a summer picnic caused a fatal car accident. The employee's heirs argued that the employer benefited from increased employee morale resulting from the picnic and should therefore be liable for wrongful death. However, the court held that increased morale alone was insufficient to establish liability and that in fact the employer did not benefit since attendance was voluntary, there were no award presentations, there was no opportunity for work-related education, and the event bore no relationship to the attending employee's continued employment, performance evaluation or promotional opportunities.[6]

On the other hand, just because none of these criteria applies does not mean there is no liability against the employer. For example, a Pennsylvania court held an employer liable for workers compensation benefits to the heirs of a man who drowned at an annual company picnic. Even though the company did not require or pay the man to attend, it advertised the event with posters in the workplace and provided the food. The judge ruled that the annual picnic benefitted the employer by fostering good employee relationships, and as a result, the family of the deceased was entitled to workers compensation benefits.[7] Claim people

should be aware that states have varying ideas about the importance of employee relationships to business results, and that this could result in employer liability.

In addition, if business-related activities occur at an event, simply making the event voluntary may not be enough protection for an employer. In an Ohio case, an employee was injured during a company picnic. (Company picnics are apparently quite dangerous.) The Ohio Supreme Court held that the employee's attendance was "logically related to his employment" since the employer sponsored, paid for and supervised the event. Further, the employer's purpose in organizing the picnic was to provide employees with an outing to improve employee relations.[8] The employee won his workers compensation suit against his employer.

It is usually clear whether an employer requires an employee to attend an event or not. However, in jurisdictions where any gathering of employees is seen to convey a benefit to the employer, perhaps the only general conclusion that can be drawn is the potential breadth of the employer-benefit argument. However, there are questions adjusters should ask when determining employer liability:

- Did the business plan and organize the event, or did volunteer employee committees do so?
- Was company ownership inferred by having the employer named as the sponsor on posters and flyers promoting the event, or by having the event identified as an "annual custom"?
- Was there reason for employees to believe they must participate?
- Was there reason for employees to believe that attending would improve their standing within the company, would be a factor in evaluating their job performance, or would increase opportunity for promotion, sales incentives or leads?
- Were employees reimbursed for expenses incurred in attending the function, or was a sports team sponsored by the business?
- Were work-related activities conducted in connection with the social event?

Answering these questions will help an adjuster determine whether an employer is liable for damages from an incident at an employee event. For those hosting work social events, the best course of action is to prevent picnics from descending into Kafkaesque, menacing complexity in the first place through loss prevention: choose safe activities, remind employees to remain professional and refrain from serving alcohol. Above all, one should remain alert at company picnics. However, even the most meticulous loss prevention cannot guarantee that an employee or bystander will not have a claim. Though picnics, sports and parties are fun, these types of claims remind us that when it comes to liability when we are with our bosses and co-workers, we are always at work. ■

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Circle of Excellence — Gold with Distinction

by Eric J. Sieber, CPCU, AIC, RPA

Eric J. Sieber, CPCU, AIC, RPA, is the owner of Sieber Claims Investigation in Rancho Cucamonga, Calif. His 33 years in claims includes extensive experience in trial preparation investigation of personal and commercial casualty claims. He specializes in handling severe casualty claims, fraud investigation, trial preparation and jury debriefing investigations. Sieber currently is a member of the CPCU Society's Claims Interest Group Committee, the California Association of Independent Insurance Adjusters and the California Association of Licensed Investigators. He is also an associate member of the Association of Certified Fraud Examiners.

For the third straight year in a row, the Claims Interest Group achieved the highest interest group Circle of Excellence (COE) Program recognition — Gold with Distinction. Many thanks go to the involvement of scores of individuals, which resulted in a 127-page COE submission.

Our achieving Gold with Distinction was also the very rewarding result of a great deal of reorganization undertaken by the COE Committee members — **Robert Riccobono, CPCU; Karen Hope, CPCU;** and me. Previously, this overwhelming COE submittal process was singularly handled by **Barbara Wolf Levine, CPCU, J.D.** When the time came to hand off this responsibility, it was determined that a committee with redundant copies of records would be the best way to manage the process, especially considering the risk of losing data that typically is submitted over the course of an entire year. There are various ways such a situation could arise, including the loss of a key committee member or a crashing hard drive. Consequently, it was decided that a committee of three would be involved in processing all submissions. We then tried out a few ideas on how to divide up the required work, ultimately settling on each committee member storing all submissions and then collaborating, with the use of a spreadsheet, on where to apply each submission for credit towards COE.

We then utilized the skills of able Claims IG Webmaster **Arthur F. Beckman, CPCU, CLU, ChFC, AIM,** to streamline the online form for making submissions to the committee. In the past, submissions were often faxed to Barbara, creating the need for duplicate data entry on her part. Our goal was to utilize electronic data as much as possible to avoid that work. Art revised and streamlined the submission process, even to the point where anyone desiring to make a submission could simply go directly to a special section of the Claims Web site (http://claims.cpcusociety.org/page/COESubmission/) to file his or her submission with just a few "clicks" and a small amount of detail typing.

On the online submission page, options were created so that anyone desiring to make a submission could simply click to reach the appropriate form, each one tailored to a section, for example, "Instructed a CPCU or IIA insurance class," of the COE Detail Form. Just fill in a bit of data, click, hit "Submit" and your work is done. What had been a rather tedious process — trying to decide where to enter the data — for each submitter is now quite simple. On the other end, rather than the COE Committee having to look over a long form to pick out a single item, it now receives a brief form with only the salient data included.

"Try it, you'll like it" is what Mikey's brothers used to tell him in the Life cereal television ad back in the 70s; take it from me, try this and you'll like it, too! There's even an online tutorial available on submitting the COE documentation. Check it out by going to our Web site, http://claims.cpcusociety.org. ■

Tony D. Nix, CPCU, CIFI, (back row, fourth from the right) represented the Claims Interest Group at the Circle of Excellence Luncheon in Denver, Colo. He is shown here with other interest group representatives; Marvin Kelly, CPCU, MBA, 2008–2009 CPCU Society president and chairman, first row, fourth from left; and James R. Marks, CPCU, CAE, AIM, chief executive officer, first row, first on left.

The Institutes — 2009 Synopsis

by Donna J. Popow, CPCU, J.D., AIC

Donna J. Popow, CPCU, J.D., AIC, is senior director of knowledge resources and ethics counsel for the American Institute for CPCU/ Insurance Institute of America (the Institutes) in Malvern, Pa. The Institutes are not-for-profit organizations offering educational programs, professional certification and research to people who practice or have an interest in risk management and/ or property-casualty insurance. Popow has responsibility for all aspects of claims education, including the Associate in Claims designation program and the Introduction to Claims certificate program. She can be reached at popow@cpcuiia.org.

Conferment Update

The American Institute for CPCU honored 1,002 new graduates of the Chartered Property Casualty Underwriter (CPCU®) program at the 2009 CPCU conferment ceremony in Denver, Colo. The profile of the class reveals the following:

- The youngest designee is 23, and the oldest, 85.
- Men represent 57 percent of the designees, and women, 43 percent.
- New designees come from 43 of the 50 states.
- Graduates also come from Aruba, Bermuda, Canada, China, Guyana, India, Japan, Netherlands Antilles, Pakistan, Peru, South Korea and the United Kingdom.

Designees come from a wide variety of job functions. Our survey showed that nearly 60 percent work in claims, commercial underwriting, and sales and marketing.

Improving the CPCU Experience

In August 2009, the Institutes announced that the CPCU experience requirement was changing from three years to two years. The new two-year experience requirement applies to all CPCU students and candidates who qualify for the class of 2010 and beyond, regardless of when the individual began the program.

Exams for the following courses will change from short essay to objective format beginning with the January 15–March 15, 2010, testing window:

- CPCU 520 — Insurance Operations, Regulation, and Statutory Accounting.
- CPCU 530 — The Legal Environment of Insurance.
- CPCU 540 — Finance for Risk Management and Insurance Professionals.

President's CPCU Scholarship

During these tough economic times, we are all facing challenges. The Institutes responded by creating the President's CPCU Scholarship. Each year, the Institutes will award CPCU scholarships to eligible company employees to make it easier for companies to invest in their top performers. The scholarship is also available to eligible college and university students to help them gain a competitive advantage in a tight labor market. A maximum of 100 scholarships will be awarded per year. Textbooks, course guides, exam registration fees and SMART Study Aids are included in the scholarship.

To nominate someone for the President's CPCU Scholarship, or for more information, contact **Kathy Hinkle** at (610) 644-2100, ext. 7849, or e-mail hinkle@cpcuiia.org.

Enterprise-Wide Risk Management (ERM) Course

The Institutes, through its Center for the Advancement of Risk Management Education (CARME), have joined with the Risk and Insurance Management Society (RIMS) to create a new enterprise-wide risk management (ERM) course. Designed for practitioners with strong risk management and business backgrounds, this new advanced ERM curriculum teaches executives with risk management responsibilities how to optimize risk-taking to meet strategic goals and the practical steps to follow to develop and implement an ERM program.

The ERM course consists of three sections: ERM, Strategy and Exposure Spaces; Integrating Risk Management into Organizational Strategy and ERM as a Project — Building the Business Case. This unique course combines self-study with a hands-on seminar. The self-study component (available in print or online) provides participants with a practical toolkit to initiate and implement a strategic ERM program.

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The Institutes — 2009 Synopsis

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An exam covering the course material assesses understanding. The seminar, conducted by RIMS, gives participants an opportunity to work with trained instructors and fellow practitioners as they learn how to best implement ERM in their organizations.

Promoting CPCU through Regional Sales Executives

Sales executives represent the Institutes and promote CPCU and other Institute educational programs on a business-to-business basis, primarily during company and agent/broker visits. The primary emphasis of the sales executives' efforts is on serving the corporate customer and related company-wide initiatives. The sales executives seek out meetings with line-of-business managers to help the Institutes identify and respond to the core insurance technical knowledge needs of our business customers. Once a need has been identified and a mutually agreeable solution has been developed, the respective line-of-business managers are able to assist the Institutes with content delivery across the entire organization.

We strongly encourage CPCU Society members to continue to work with our sales executives, as so many have done in the past, to set up and participate in these important visits with line-of-business managers at insurance companies, large insurance agencies, brokerage firms and risk management organizations.

Please e-mail Karen Lawrence, marketing and sales coordinator, at lawrence@cpcuiia.org, for the contact information of your regional sales executive. ■

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