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Claims Interest Group

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Claims Quorum

Message from the Chair

by Barbara Wolf Levine, CPCU, J.D.

Barbara Wolf Levine, CPCU, J.D., is CEO of Exam Coordinators Network, which provides nationwide medical evaluation services. She has held this position since 1999. Levine earned her CPCU in 1996. She previously worked as a claims attorney at State Farm from 1987 to 1998. She earned her B.S. in political science from Tufts University and her law degree from the University of Florida Levin College of Law. She is a practicing attorney licensed by the state of Florida and a member of the Florida Bar Association.

Having just returned from the CPCU Society Leadership Summit in Miami, Florida, I am filled with excitement about leading the Claims Interest Group throughout 2012 and beyond. I have the great fortune to be working with **James Beckley** as "Incoming Chair."

The summit was held in Miami, Florida, on April 26-28, 2012, at the beautiful Doral Resort and Spa. It was the first meeting since the affiliation between The Institutes and the Society. I was curious about the role interest groups would play subsequent to the merger. I was happy to learn that The Institutes consider the interest groups experts in their subject matters. The interest groups will continue to be responsible for developing educational content for the CPCU Society Annual Meetings and Seminars, as well as for providing content and ideas for ongoing webinars.

The Claims Interest Group Committee accomplished a lot during the three hours in which we met. We discussed and finalized many of the details for the Annual Meeting and Seminars, which are scheduled to occur on September 8-11, 2012, in Washington, D.C., at the Marriott Wardman Park. The Claims Interest Group seminar is going to be held on Sunday, September 9, 2012, from 2:45 p.m.–4:45 p.m. The seminar is called "Social Media in Claims Adjusting," and it will be moderated by **Kimberly Riordin, CPCU.** Panel members include our past chairman, **Tony Nix,** as well as two prominent attorneys in the field—**Matthew J. Smith** of Smith, Rolfes & Skavdahl in Cincinnati Ohio, and **Ron Kurzman,** partner and litigation consultant at Magna Legal Services in New York. Registration for the meeting has recently opened.

Our Claims Interest Group luncheon will also take place on September 9, 2012, from 11:30 a.m.–1:00 p.m. Traditionally, this event has been heavily attended. The Claims Interest Group is known for providing outstanding door prizes, including iPads, and sponsoring up to five students to attend the luncheon in order to find out what claims are all about. The generous funding of Insurance Services Office, Inc. (ISO) has allowed us to provide consistently outstanding programs, and this year is no exception. We are pleased to present "Building a Weather Ready Nation" with **Dr. Edward R. Johnson.** We hope you will join us there.

For those of you considering national service, now is an excellent time to submit your applications. We are going to have several openings on our committee, and we are looking for some outstanding professionals to join us. For more information, please contact James Beckley at jbeckley@aaic.com or me at blevine@ecnime.com.

I wish everyone a wonderful and safe summer! I look forward to seeing you all in September. ■

What's in This Issue

Editor's Notebook

Donald O. Johnson, JD, LLM, CPCU

Donald O. Johnson, CPCU, JD, LLM, is the founder of D. O. Johnson Law Office, PC, in Philadelphia. He has more than fifteen years' experience in commercial litigation and counseling and has represented clients in state and federal courts. His practice has concentrated primarily on insurance coverage and bad-faith claims handling litigation involving commercial property and commercial liability policies. Don also serves as general counsel of the National African-American Insurance Association.

I sadly announce that **Charles W. Stoll, CPCU, AIC, RPA,** recently resigned from his position as editor of the *Claims Quorum* (CQ) because of the evolution and growth of his professional responsibilities. In February 2010, Chuck began as the assistant editor under **Marcia A. Sweeney, CPCU, AIC, ARM, ARe, AIS,** when Marcia returned to CQ to take over as interim editor. Chuck assumed the role of CQ editor in 2011 and continued the tradition of editorial excellence. Although he has stepped down as CQ editor, Chuck will remain active in the Claims Interest Group (CIG). Chuck, on behalf of all of your section members, thank you for your outstanding service to the CIG.

As Chuck's assistant editor, I have assumed the role of interim editor to ensure that the CIG continues to publish a high-quality newsletter in a timely fashion. In this issue, you will find these interesting articles:

Randy J. Maniloff, JD, and **Joshua A. Mooney, JD,** contributed an excerpt from their annual article on the Top 10 Liability Insurance Cases of Year.

Matthew J. Smith's article, "Arbitration: The 'I'm Not Dead Yet' Alternative Dispute Resolution Program" discusses the continued relevance of arbitration and identifies several variations on the general framework.

I authored an article, "Claims Adjuster Depositions: Prepare for an Away Game," that recognizes certain advantages that opposing counsel has when deposing claims adjusters and suggests actions that the attorney defending the adjuster can take to level the playing field.

Kevin Quinley's article, "Five Steps After Your Next Claims Audit," recommends several follow-up actions that may help claims professionals after a claims audit has been conducted.

We invite CIG members and nonmembers to submit claims-related articles for publication consideration. If you have an article that you would like to have published, or if you know someone else who would like to do so, please send the article to me at donjohnson@dojlaw.com. As always, our goal is to provide meaningful information to claims professionals. ■

The Claims Interest Group newsletter is published by the CPCU Society's Claims Interest Group.

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Two Thousand and Unleaven: A Flat Year for Insurance Coverage

11th Annual Review of the Year's Ten Most Significant Coverage Decisions
4th Annual "Coverage for Dummies and Inane Observations"

by Randy J. Maniloff, JD, and Joshua A. Mooney, JD, White and Williams LLP

Randy J. Maniloff, JD, is a partner in the Business Insurance Practice Group at White and Williams, LLP, in Philadelphia. He writes frequently on insurance coverage topics for a variety of industry publications (including, for the eleventh time, this review for Mealey's Litigation Report: Insurance of the year's ten most significant insurance coverage decisions). In February, Maniloff published the second edition of General Liability Insurance Coverage: Key Issues in Every State, a book that addresses the law in all fifty states and the District of Columbia on twenty-one key liability insurance coverage issues (Oxford University Press; co-authored with Professor Jeffrey Stempel of the University of Nevada - Las Vegas Boyd School of Law).

Joshua A. Mooney, JD, is counsel in the Business Insurance Practice Group and Intellectual Property Group at White and Williams, LLP, in Philadelphia. His practice focuses primarily on representing insurers in coverage litigation and bad-faith matters under commercial general liability and various professional liability policies. Many of his cases involve complex and emerging issues under insurance law, including invasion of privacy rights and new media, greenwashing, intellectual property, construction defect, additional insured coverage, and contractual indemnification.

Editor's note: (1) Over the past few years, *Claims Quorum* (CQ) has had the opportunity to publish a summary of attorneys Randy J. Maniloff and Joshua A. Mooney's annual article on the top ten insurance coverage cases of the year. This CQ article is a shorter version of the original twenty-four-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 LLP. (2) Due to space considerations, we have chosen four of the ten case discussions. The entire article can be requested from 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 or its clients. (4) All uses herein of the first person are references to Maniloff.

Everyone is entitled to an off-day once in a while. Even those who are the best at what they do put up a clunker now and then. I mean, [Andrew] Lloyd Webber gave us Cats, didn't he?

And that is not unlike what 2011 was for insurance coverage. In most years, with courts issuing thousands of decisions addressing insurance coverage issues, finding many that could qualify as one of the ten most significant is like putting a hot knife through butter. The pool of candidates is an embarrassment of riches. There are usually two dozen or so decisions that could all lay claim to being one of the year's ten most significant. The harder task is to scrutinize this list and, using the factors discussed below, cull it down to only the ten that qualify as the pick of the litter.

But 2011 was different. Instead of the usual abundance of decisions that could be best in show, there were barely ten in total. It was the pick of the litter box. There is little doubt that, in the eleven years of preparing this annual insurance coverage hit parade, the eleventh year of the third millennium had the least to offer in the way of significant judicial decisions. While a list of ten standouts was capable of being created, doing so was no easy task. It was like choosing the ten best episodes of The Love Boat. And some of the coverage decisions that were chosen as one of the year's ten most significant would not have made the cut in a more bountiful year.

For insurance coverage, 2011 was the year that coughed up a fur ball. But at least we have our memories of the time we knew what happiness was. Look, a new day has begun.

4th Annual "Coverage for Dummies and Inane Observations"

Reading a lot of insurance coverage cases makes you realize that some people do really dumb stuff. Their shocking behavior causes injury, and not long after, a lawsuit is filed against them. The tomfool then makes an insurance claim. Somehow they still know enough to do that. For the past three years, this annual insurance coverage best-of has included a special report—"Coverage for Dummies." "Dummies" has been a look at several examples from the past year of attempts by individuals to secure insurance coverage for the frailty and imperfection of the human brain.

In addition, the entertainment value of coverage cases isn't limited to this window into the world of the common-sense

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challenged. Coverage cases also have this way of including all sorts of interesting tidbits. While perhaps not important or relevant to anything, and sometimes just plain inane, their out-of-the-ordinary quality makes them something that ought to be shared. The Insurance Coverage Top 10 is committed to not allowing these decisions to simply disappear into the bowels of Lexis. In no particular order, here is "Coverage for Dummies and Inane Observations" for 2011:

1. Hawaii federal court rejected the opportunity to be the first in the country to address whether dog poop on another's property is "property damage." Now *that's* a doodie to defend case. *See State Farm Fire & Cas. v. Cabatbat*, No. 09-532, 2011 U.S. Dist. LEXIS 14560 (D. Hawaii February 11, 2011).

2. A teeny weenie misunderstanding between neighbors who speak English as a second language as to the difference between "cutting" and "trimming" trees. Oops. *See State Farm Fire & Cas. Co. v. Kwing On Ng*, No. 64515-3-I, 2011 Wash. App. LEXIS 722 (Wash. Ct. App. Mar. 28, 2011).

3. Bad idea to light a pilot light in an oven that does not have one. *See Nationwide Mut. Fire Ins. Co. v. Parker's Propane Gas Company*, No. 299068, 2011 Mich. App. LEXIS 1694 (Mich. Ct. App. Sept. 27, 2011).

4. Also in the bad-idea-with-matches category: bartender poured Bacardi 151 onto the surface of a bar and lit it. The alcohol exploded and engulfed a patron in flames. *Brother Jimmy's BBQ, Inc. v. American International Group, Inc.*, No. 105077/09, 2011 NY Slip Op. 31295U (N.Y. Super. Ct. May 17, 2011).

5. Restaurant sought coverage for claims that it kept tips charged to customers' credit cards and that its managers had their fingers in the tip jar. *See New Orleans Deli & Dining, LLC v. Continental Cas. Co.*, No. 10-4642, 2011 U.S. Dist. LEXIS 111928 (E.D. La. Sept. 28, 2011).

6. Michigan federal court addressed coverage for insured for claims that he hired an underage woman to assist him with testing sex toys that he was designing for, get this… the military. *See Keely v. Fire Ins. Exchange*, No. 10-13707, 2011 U.S. Dist. LEXIS 69500 (E.D. Mich. June 28, 2011).

7. Insurer not liable for injuries sustained by the housekeeper when she tripped over Buddy – the family's Shitzu puppy. Buddy's other misdeed: getting underneath the blankets when the housekeeper was trying to change the beds. Court held: "[P]laintiffs could not make a showing that Buddy presented an unreasonable risk of harm to Ms. Williams." *See Williams v. Farm Bureau Ins. Cos.*, No. 2011 CA 0487, 2011 La. App. LEXIS 1340 (La. Ct. App. Nov. 9, 2011).

8. Bad idea to bring a rifle to a school board meeting—even in West Virginia. *See Taylor v. Erie Ins. Prop. & Cas. Co.*, No. 2:10-1300, 2011 U.S. Dist. LEXIS 44520 (S.D.W.Va. Apr. 25, 2011).

9. Connecticut trial court addressed coverage for woman for claims that she served a ginger cake containing marijuana. Hey, wait a minute, Martha Stewart lives in Connecticut. *See Safeco Ins. Co. v. Glass*, No. CV106007133, 2011 Conn. Super. LEXIS 874 (Conn. Super. Ct. April 8, 2011).

10. Proof that *Owens-Illinois* has no limits on its attempted use. New Jersey appellate court rejected the continuous trigger for viewing pornography in the workplace. We've come a long way since asbestos. *See General Security National Ins. Co. v. N.J. Intergovernmental Ins. Fund*, No. A-5591-08T1, 2011 N.J. Super. Unpub. LEXIS 2288 (N.J. Sup. Ct. App. Div. Aug. 25, 2011).

11. The real Travelers succeeds in shutting down insurance advertising site Travellers.com. So much for my idea to register Heartford.com. *See The Travelers Indemnity Co. v. Travellers.com*, No. 10-448, 2011 U.S. Dist. LEXIS 136447 (E.D. Va. Nov. 28, 2011).

12. Minnesota federal court addressed coverage for claims against a real estate agent that showed a house—and that's not all he showed— while its owners were out of the country. Warning: Purell required. *See Safeco Ins. Co. v. Skar*, No. 10-4789, 2011 U.S. Dist. LEXIS 82548 (D. Minn. July 27, 2011).

13. Michigan appeals court addressed coverage for thirteen year old that placed opposing basketball player in a headlock and then threw him to gym floor, causing him to suffer an acute head injury with associated seizures, two hematomas on his head, soft tissue injuries, a bruised and/or fractured iliac crest of his hip bone, photophobia and post-concussion syndrome. The same conduct by Michael Jordan would not have drawn a foul. *See Auto Club Group Ins. Assoc. v. Andrzejewski*, No. 297551, 2011 Mich. App. LEXIS 888 (Mich. Ct. App. May 17, 2011).

14. Seventh Circuit Court of Appeals, in addressing coverage for construction defects, confirmed that the Titanic's sinking was an accident. *See Continental Cas. Co. v. Sycamore Springs Homeowners Assoc.*, 652 F.3d 804 (7th Cir. 2011).

15. A fight-between-neighbors coverage case as good as any you'll find: Among lots of other unfriendly things, one neighbor shined spotlights on the other's property that were of such high intensity that they interfered with the targeted neighbors' sleeping patterns and presented a danger to

the Native Hawaiian shearwater birds in the area. *See Hartford Underwriters Ins. Co. v. Masters*, Nos. 10-629 and 11-174, 2011 U.S. Dist. LEXIS 59306 (D. Hawaii June 2, 2011).

16. Elevator maintenance company performed work at a hospital and disposed of used hydraulic fluid in fifteen-gallon plastic barrels that previously contained—and were still labeled for—surgical cleaning solutions. You can see where this is going. As many as 3,650 patients may have had surgical procedures using instruments that had been washed in hydraulic fluid. *See Mitsui Sumitomo Ins. Co. of Am. v. Automatic Elevator Co.*, No. 09-480, 2011 U.S. Dist. LEXIS 103165 (M.D.N.C. Sept. 13, 2011).

17. Friendly ritual between buddies of hitting each other in the groin goes just a little too far. As mom always said, it's all fun and games—until someone suffers a hematocele on the right scrotum. *See State Farm Gen. Ins. Co. v. Frake*, 197 Cal.App. 4th 568 (2011).

18. When you intentionally hit someone with your car, even if you just slowly roll forward into them, you cannot avoid the "intentional act" exclusion by maintaining that "it was nothing" and concluding that any sober person could and would have moved. Oh, did I mention, the victim was missing part of one leg and using crutches? *See Hurst v. Southern Farm Bureau Cas. Ins. Co.*, No. 11-162, 2011 Ark. App. LEXIS 701 (Ark. App. Ct. Nov. 2, 2011).

19. Court addressed coverage for injury to a patron of the Lucky Lounge who alleged that, while being ejected from the back door, he fell down several concrete steps, landed on his head, lost consciousness and began bleeding from his ear. Lucky Lounge employees allegedly returned inside and left him bleeding and unconscious on the sidewalk. *See Indemnity Ins. Corp. v. Austin Lucky Lounge, LP*, __ N.E.2d __ (Ind. Ct. App. 2011). It should be called the Lucky To Be Alive Lounge.

20. Quote of the year from a coverage case: "This is a difficult case. The main problem with this case is that it centers on an insurance policy that is terribly written." And, with that, the judge was just getting warmed up in providing his thoughts about the policy. *See Unitedhealth Group, Inc. v. Columbia Cas. Co.*, No. 05-CV-1289, 2011 U.S. Dist. LEXIS 148422 (D. Minn. Dec. 27, 2011).

How the Ten Most Significant Insurance Coverage Decisions Are Chosen

As always, I am grateful to *Mealey's Litigation Report: Insurance* and editor Gina Cappello for the opportunity to make the case for the ten most significant insurance coverage decisions from the year gone by. 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 an issue; (iii) are part of a new trend; (iv) involve a burgeoning issue; or (v) provide a novel policy interpretation. Admittedly, some of these criteria overlap.

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 reasons why many unquestionably important decisions are not selected are because other states do not need guidance on the particular issue, or the decision is tied to something unique about the particular state. Therefore, a decision may be hugely important for its own state—indeed, it may even be the *most important* decision of the year for that state—but nonetheless may very likely be passed over as one of the year's ten most significant if it has little chance of being called upon in the future by other states confronting the issue. When it comes to selecting the year's ten most significant insurance coverage decisions, the potential to have future influence *nationally* is everything.

For example, in 2011 Maryland's highest court held that an insurer seeking to disclaim coverage on the basis of late notice under a claims-made policy must prove that it was prejudiced. *See Sherwood Brands, Inc. v. Great Am. Ins. Co.*, 13 A.3d 1268 (Md. 2011). The requirement for late notice prejudice under a claims-made policy is very unique. But because the decision is tied to a Maryland statute, it is unlikely to have any national influence. Also on the subject of late notice, Nevada's highest court held in 2011 that an insurer must show prejudice before it may properly deny coverage to an insured under an "occurrence" policy based on late notice. *See Las Vegas Metro Police Dep't v. Coregis Ins. Co.*, 256 P.3d 958 (Nev. 2011). This decision provided much needed clarification on the late notice issue in Nevada. But given that the court's conclusion is the long-held majority view, with no shortage of decisions nationally addressing the issue, *Las Vegas Metro* is hardly the stuff of a decision that other courts around the country will run to for guidance. Thus, neither of these late notice coverage decisions was selected—or even considered—for inclusion as one of 2011's ten most significant.

Another example of an important decision in 2011 left on the Top 10 sidelines was the Supreme Court of New Jersey's decision in *Abouzaid v. Mansard Gardens Associates, LLC*, 23 A.3d 338 (N.J. 2011). *Abouzaid* may have important ramifications for the Garden State's duty to defend standard. But given that duty to defend standards are so state specific,

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not to mention that New Jersey's duty to defend rules are a world unto themselves, *Abouzaid* was not selected for inclusion as one of 2011's ten most significant coverage decisions.

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. But just because the selection process has no accountability or checks and balances whatsoever does not mean that it wants for deliberativeness. To the contrary, the process is very deliberate. It resembles that famous picture of the baldish guy who is using a giant magnifying glass to scrutinize hanging chads on a ballot during the Florida recount in the 2000 presidential election. That's how much careful consideration goes into choosing the year's ten most significant insurance coverage decisions. So there is plenty of deliberation. It's just that only one person is deliberating.

The Ten Most Significant Insurance Coverage Decisions of 2011

Below are the ten most significant insurance coverage decisions of 2011 (listed in the order that they were decided):

- *Great American E & S Ins. Co. v. Quintairos, Prieto, Wood & Boyer, P.A.*—Seven Mississippi Rush: state's appeals court allows excess insurer to get two hands on negligent defense counsel.

- *Michael Taylor Designs, Inc. v. Travelers Prop. Cas. Co. of Amer.*—Northern District of California held that the sale of "cheap, synthetic knock-offs"—i.e., counterfeits—can constitute "personal and advertising injury." For real.

- *Union Carbide Corp. v. Affiliated FM Ins. Co.*—New York's highest court applied a simple approach to a complex follow-form program. Will other courts now follow form?

- *Schmitz v. Great Amer. Assurance Co.*—Perplexcess Insurer: Supreme Court of Missouri handled drop-down in a way that will leave excess insurers' chins, err, dropped-down.

- *State Farm Fire and Cas. Co. v. Vogelgesang*—From Hawaii: macadamia nuts, coconuts and proof that coverage for construction defects has become just plain nuts. District Court demonstrated how so.

- *DeMarco v. Travelers Ins. Co.*—Rhode Island Supreme Court

explained insurer's duty to settle when faced with the "Sisyphean challenge" (we had to look that up too) of having multiple claims against an insured that collectively exceed the policy limit.

- *Mosser Construction, Inc. v. The Travelers Indem. Co.*—Sixth Circuit held that the meaning of "subcontractor," in the "subcontractor exception" to the "your work" exclusion, was ambiguous. Imagine that—something about construction defect coverage found to be ambiguous. Memo to ISO: something to mull over.

- *AES Corp. v. Steadfast Ins. Co.*—Supreme Court of Virginia gave a chilly reception to insured seeking coverage for global warming response costs.

- *Lennar Corp. v. Transamerica Insurance Co.*—Arizona appeals court adopted a novel solution to the dispute over payment for an insured's independent counsel fees—and created the second-ever insurance coverage superhero in the process.

- *Norfolk & Dedham Mutual Fire Ins. Co. v. Cleary Consultants, Inc.*—New England claim chatter: Massachusetts appeals court converted a CGL policy to an Employment Practices Liability policy.

Discussion of the Ten Most Significant Insurance Coverage Decisions of 2011

Editor's note: Twenty pages of discussion about the ten cases appear in the original article. We have chosen to include the discussion on four of the cases for our *CQ* readers. Please feel free to contact the author for the complete article or for the discussion about any particular case listed.

Michael Taylor Designs, Inc. v. Travelers Prop. Cas. Co. of Amer., 761 F. Supp. 2d 904 (N.D. Cal. 2011)

Coverage for counterfeiting actions is not contemplated under the "personal and advertising injury" section of a commercial general liability policy. However, traffickers around the country of counterfeit name-brand merchandise, such as Uggs®, The Northface®, or Gucci®, to name just a few, may use the Northern District of California's decision in *Michael Taylor Designs, Inc. v. Travelers Prop. Cas. Co. of Amer.* to argue that their actions do constitute "personal and advertising injury," under the theory that the sale of counterfeits inherently results in disparagement.

Because counterfeit merchandise is manufactured to imitate a well-known product in all details of construction and appearance, consumers may unknowingly believe they are purchasing genuine merchandise when, in fact, they are not. Alternatively, consumers may knowingly purchase counterfeit items because the items may be had at dramatically lower prices than the real thing. Either way, intellectual property holders often claim damage through trademark dilution and loss of goodwill, materialized either because (1) when a customer has unknowingly purchased a counterfeit product of inferior quality, the customer will blame the intellectual property holder for the product's ultimate failure, or (2) even when a customer knowingly has purchased a counterfeit product of inferior quality, third parties will not realize this fact and will blame the product's failings on the genuine product and the intellectual property holder. In both instances, the intellectual property holder will likely claim that its reputation and the reputation of its product have been injured.

In *Michael Taylor Designs, Inc. v. Travelers Prop. Cas. Co. of Amer.*, the District Court for the Northern District of California held that such claims are sufficient to implicate defense and liability coverage under the definition of "personal and advertising injury," concluding that such claims constitute ones for disparagement.

The insured, Michael Taylor Designs, Inc. ("MTD"), was a furniture retailer sued for allegedly infringing the trade dress of one of its former suppliers by offering "cheap synthetic knockoffs" of that supplier's high-end wicker furniture products. The underlying complaint alleged that MTD had a business relationship with furniture designer Ivy Rosequist in which MTD acted as the exclusive sales agent for Rosequist's high-end line of wicker furniture. *See* 761 F. Supp. 2d at 907. The relationship soured when MTD began selling synthetic wicker products that Rosequist contended were unlawful copies of her designs. *Id.*

Rosequist thereafter filed a two-count complaint against MTD, alleging breach of contract and violation of the Lanham Act. *Id.* Rosequist's Lanham Act claim alleged that MTD had distributed promotional materials to its customers that contained photographs of Rosequist's distinctive and high-quality furniture, but that MTD then pulled a "bait-and-switch" by selling in its showroom "cheap synthetic knock-offs" of Rosequist's merchandise, running the risk that consumers would be confused and misled as to the origin of the knock-off items. *Id.* Rosequist claimed MTD's actions would "dilute and tarnish" her trade dress. *Id.* The complaint later was amended to include a claim for relief entitled "Slander of Goods/Slander of Title," which repeatedly alleged that MTD had "disparaged the quality and origin" of Rosequist's goods. Id. at 908.

The Travelers policy at issue contained a "Web Xtend Liability" endorsement, which deleted that part of the definition for "personal and advertising injury" that would have provided coverage for trade dress infringement, and instead provided

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coverage only for "[o]ral, written or electronic publication of material that slanders or libels a person or organization or disparages a person's or organization's goods, products or services." *Id.* at 907, 910-11. The primary question presented to the court, therefore, was not whether trade dress infringement was alleged, but, instead, whether "the factual allegations of the original complaint filed against MTD were sufficient to give rise to a duty to defend, despite the claims having been couched in language of trade dress infringement rather than in terms of disparagement." *Id.* at 907. Because the complaint alleged that the counterfeit merchandise would harm the reputations of both Rosequist and her products, the court held that the factual allegations were sufficient to implicate the duty to defend.

Specifically, the complaint alleged that:

- "The promotional materials widely circulated by Michael Taylor Designs, Inc., for the patrons of Westweek include [sic] photographs of [Rosequist's] actual furniture (which Michael Taylor Designs, Inc., has removed from its showroom and is no longer selling), compounding the high risk that customers will visit Michael Taylor Designs, Inc., looking for [Rosequist's] furniture, *only to be unknowingly steered* instead to cheap imitation knock-offs."
- "Consumers are likely to be confused and will naturally assume that the knock-offs currently being displayed in Michael Taylor Design's showrooms are plaintiff's products."
- "Defendant's action, unless enjoined, will cause irreparable harm and injury to plaintiff and to consumers, in that it will substantially dilute and *tarnish plaintiff's established trade dress* and mislead consumers about the true origins and nature of the cheap synthetic knockoffs."

Id. at 910-11 (emphasis in original).

Concluding that these allegations were sufficient to allege disparagement, the court explained that "the very essence of the injury [Rosequist was] alleging was damage to the reputation of Rosequist's products that would result from consumers encountering 'cheap synthetic knock-offs' and believing them to be products manufactured and marketed by Rosequist." *Id.* at 911. In so holding, the court rejected a common argument that the sale of knock-off merchandise cannot constitute disparagement because imitation is a form a flattery, not disparagement. Given Rosequist's claim for loss of reputation, the court held that in situations of trafficking counterfeit merchandise, there was no authority that "advertising an inferior item as if it were the product of another invariably falls outside disparagement." *Id.* at 911. That the claim was couched as a trade dress violation—and not a disparagement claim—also mattered little: "[b]ecause Rosequist was expressly alleging that the reputation of her goods was harmed by MTD's conduct, the mere fact that it was labeled as trade dress infringement does not preclude the possibility of a disparagement claim." *Id.* at 912. "The express 'disparagement' in the amended complaint arises from consumers allegedly being led to believe that Rosequist had designed and was distributing the 'cheap synthetic knock-offs' displayed in MTD's showrooms." *Id.*

The effect of this case bears watching. Because intellectual property holders almost universally claim loss of reputation and goodwill in counterfeiting actions, the reasoning of the *Michael Taylor Designs* court may have opened the door for coverage to a line of cases for which defense and liability coverage was never contemplated. Needless to say, the defense costs alone in intellectual property cases can be monumental.

Union Carbide Corp. v. Affiliated FM Ins. Co., 947 N.E.2d 111 (N.Y. 2011)

The New York Court of Appeals's 2011 decision in *Union Carbide* is poised to have influence in the world of coverage for asbestos and hazardous waste claims. The decision concerns the amount of limits of liability available under a three-year policy and the limits created (or not) by a policy's two month extension (a so-called "stub" period). When it comes to coverage for asbestos and hazardous waste, where the damages at issue can be gargantuan, the dollar amount of coverage available, usually under long-ago expired policies, is often a paramount issue. And since such claim scenarios usually involve some three-year policies (popular back in the day), with stub issues also not entirely uncommon, *Union Carbide* is likely to be a case considered by other courts for its treatment of such issues. Not to mention that the New York Court of Appeals is no slouch when it comes to respectability.

But *Union Carbide's* inclusion as one of 2011's ten most significant is for broader reasons than just how to calculate the limits of liability available under a three-year policy and a stub period. Rather, its significance is tied to the manner, in general, in which the court addressed the relationship between primary and excess policies—a situation that, of course, has far wider ramifications than simply the worlds of asbestos and hazardous waste.

Union Carbide was hit hard by asbestos bodily injury claims, claiming that it paid over $1.5 billion in defense costs, settlements, and judgments. *Union Carbide* at 112. It was insured under a primary policy, issued for a three-year duration, and subject to a $5 million limit of liability. *Id.* It was not disputed that the limit of liability was an "annual aggregate," and, as such, a separate $5 million limit applied to each twelve months of the three-year policy. *Id.*

Union Carbide was also covered under successive layers of excess insurance. *Id.* The fifth excess layer, covering losses between $70 million and $100 million, was a brief subscription form policy that incorporated by reference the terms of the underlying policy pursuant to a "follow-the-form" clause. Id. The excess policy

was issued for a three-year period, and its $30 million in coverage was described in the declarations as being for each occurrence and in the aggregate. *Id.*

At issue before New York's highest court was whether the fifth layer excess policy, by its term "$30,0000,000 … in the aggregate," meant that the maximum coverage available for all three years was $30 million or, alternatively, three times $30 million, i.e., $30 million for each of the three years. *Union Carbide* at 113. The insurers argued that "$30,000,000 ... in the aggregate," "can mean only that $30 million is the maximum that may be paid under the policy[.] … They stress that the follow-the-form clause, which incorporates the [primary] policy by reference, is expressly made 'subject to the declarations set forth below' and that those declarations, unlike the [primary] policy, speak of an 'aggregate,' not an 'annual aggregate,' limit of liability." *Id.* Conversely, Union Carbide argued that "under the follow-the-form clause, the conditions in the [primary] policy are part of the subscription form policy, and that one of those conditions is that the 'aggregate' limit shall be annualized." *Id.*

The court held that Union Carbide's interpretation must prevail. While noting that the insurers' interpretation of "aggregate" "might be plausible in many contexts" the court's decision was dictated by its view of the meaning of "follow-the form" clauses:

> [H]ere the follow-the-form clause should prevail. Such clauses serve the important purpose of allowing an insured, like UCC, that deals with many insurers for the same risk to obtain uniform coverage, and to know, without a minute policy-by-policy analysis, the nature and extent of that coverage. It is implausible that an insured with as large and complicated an insurance program as UCC would have bargained for policies that differed, as between primary and excess layers, in the time over which policy limits were spread.

Id. Hence, the excess policy's $30 million limit, like the primary's, was subject to a separate limit for each twelve-month period—obviously making for a huge difference in the amount of coverage available under the policy.

It is not uncommon for excess policies to "follow form" to primary policies but, at the same time, for there to also exist differences between such policies. The takeaway from *Union Carbide v. Affiliated FM* is this: even if an excess insurer can show that its policy does not follow form on all points, if it is a close call and/or if the excess insurer's argument could be viewed as technical, a court may conclude that an excess policy still follows form based on the follow-form concept. A court may conclude, like *Union Carbide*, that it is just not plausible for an insured to have bargained for policies that differed as between primary and excess layers. Of course, in a different case, an excess insurer that is seeking to follow form to a primary policy may benefit from Union Carbide's view of the follow-form principle.

DeMarco v. Travelers Ins. Co., 26 A.3d 585 (R.I. 2011)

Generally, an insurer may face extra-contractual damages where it had an opportunity to settle an underlying claim against its insured within the policy limits, failed to do so, and the insured ultimately is held liable for damages in excess of the policy's limits. As a matter of first impression under Rhode Island law—and a situation without much national guidance—the Supreme Court of Rhode Island addressed an insurer's duties when the insured is faced with multiple claims that collectively exceed the applicable policy's limits, and one such claimant seeks to settle its claims for the policy's limits, leaving the insured exposed as to the other claims.

In *DeMarco v. Travelers Ins. Co.*, Wayne DeMarco was seriously injured in a collision while traveling as a passenger in a motor vehicle owned by the insured, Virginia Transportation Corp. ("Virginia Transport"), and driven by the company's owner, Leo Doire, when the

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vehicle veered off the road and struck two utility poles. *See* 26 A.3d at 587. A second passenger, Paul Woscyna, also was seriously injured; in addition, the public utility Narragansett Electric Company ("NEC") sustained property damage as a result of damage to its utility poles. *Id.*

At the time of the collision, the vehicle was insured by Travelers under a policy with limits of $1 million. *Id.* DeMarco's attorney immediately and repeatedly demanded the full limits of the Traveler's policy in return for a full release of Doire and Virginia Transport (collectively, the "Insureds"), citing the Supreme Court of Rhode Island's decision in *Asermely v. Allstate Ins. Co.*, 728 A.2d 461 (R.I. 1999), which imposes upon an insurer a duty to act in the best interests of its insured and those to whom the insured may assign its rights. *Id.* at 589-91. Travelers, however, refused to settle or make a counteroffer, stating that it could not settle with DeMarco and leave its insureds exposed to the Woscyna and NEC claims. *Id.* Woscyna alone had demanded $859,000 in settlement of his claims. Id. at 590. In response to DeMarco's demands, Travelers consistently maintained the position that it needed only to offer the full policy limits and have the three claimants fight over how the money was to be divided. *Id.* at 591-93. Travelers then sought to commence an impleader action. *Id.*

In the meantime, the DeMarco claim went to trial, at which time Travelers offered for the first time to settle the claim for $500,000, plus $150,000 from the Insureds' own funds. *Id.* at 594-95. DeMarco rejected the offer and obtained a verdict for approximately $2.8 million. *Id.* at 595. The Insureds then demanded that, under *Asermely*, Travelers pay the full amount of the verdict, plus costs for its independent counsel, on the ground that the Insureds had demanded that Travelers settle the DeMarco claim for the full policy limits and that Traveler's refusal to negotiate on the basis that there were multiple claims merely was a pretext for delaying any potential settlement. *Id.* at 596-98. Ultimately, DeMarco and Woscyna settled their claims with the Insureds for $550,000 and $450,000, respectively. The Insured then assigned its extra-contractual claim against Travelers to DeMarco, who commenced an action against Travelers. *Id.* at 599-600. The trial court granted summary judgment in DeMarco's favor; the Supreme Court of Rhode Island affirmed in part and reversed in part—holding that Travelers had a fiduciary duty to negotiate, but whether it acted reasonably was a question of fact ill-suited for summary disposition. *Id.* at 605.

Under *Asermely*, an insurer has a duty to act in the best interests of its insured. *Id.* at 606-07. Moreover, if an insurer

"has been afforded reasonable notice and if a plaintiff has made a reasonable written offer to a defendant's insurer to settle within the policy limits, the insurer is obligated to seriously consider such an offer. If the insurer declines to settle the case within the policy limits, it does so at its peril in the event that a trial results in a judgment that exceeds the policy limits, including interest." *Id.* at 607 (quoting Asermely). Travelers argued that Asermely applies only where there is a single claimant for the policy proceeds and where that claimant offers to settle within the policy limits; Travelers contended that Asermely "does not apply in a situation (such as the case at bar presents) where there are multiple claimants whose combined claims exceed the policy limits." *Id.* at 605. The DeMarco court disagreed.

The court held that an insurer has an "'affirmative duty to engage in timely and meaningful settlement negotiations' in spite of the sometimes Sisyphean challenge that reaching a global settlement within the policy limits represents." *Id.* at 613. An insurer must perform "everything it reasonably could to minimize the amount of [the insured's] direct liability," even if such an action still will result in some exposure:

> It is clear that an insurer may have to engage in a much more complex assessment of whether and how to settle claims in order to meet its duty to protect its insured's best interests in the face of multiple claims, the aggregate of which exceeds the policy limits. However, it is also clear that such complexities do not relieve an insurer of its "affirmative duty to engage in timely and meaningful settlement negotiations" in spite of the sometimes Sisyphean challenge that reaching a global settlement within the policy limits represents. There undoubtedly will be some instances where an insured will still face direct liability even in the face of the fact that the insurer acted in the insured's best interests; even in such a situation, however, the critical issue to be determined is whether or not the insurer did everything it reasonably could to minimize the amount of that direct liability.

Id. at 613.

Thus, the court held that "when an insurer is faced with multiple claimants with claims that in the aggregate exceed the policy limits, the insurer has a fiduciary duty to engage in timely and meaningful settlement negotiations in a purposeful attempt to bring about settlement of as many claims as is possible, such that the insurer will thereby relieve its insured of as much of the insured's potential liability as is reasonably possible given the policy limits and the surrounding circumstances." *Id.* at 613-14 (citations omitted). In doing so, the court explained that the insurer must:

- "negotiate as if there were no policy limits applicable to the claims and as if the insurer alone would be liable for the entire amount of any excess judgment"; and
- "exercise its best professional judgment throughout this process, always keeping in mind the best interests of its insured and the necessity of minimizing its insured's possible eventual direct liability[.]"

Violation of this duty, moreover, may be demonstrated at a lower threshold than that required for bad faith. The court explained that "in order to show that an insurer has violated its fiduciary duty in a multiple claimant case, the insured (or a party to whom the rights of the insured have been assigned) need not demonstrate that the insurer acted in bad faith but only that the insurer did not act reasonably and in its insured's best interests in light of the surrounding circumstances." *Id.* In the case before it, the court held that whether Travelers had satisfied its *Asermely* duty was best left to the trier of fact and reversed the trial court's grant of summary judgment against Travelers. *Id.* at 615.

The critical issue to take away from *DeMarco* is that, where there is a demand to settle a claim within policy limits, the general rules that apply to this one-claim situation are not suspended because such demand, when added to the demands of other claimants, now collectively exceed the limits of the applicable policy.

Norfolk & Dedham Mutual Fire Ins. Co. v. Cleary Consultants, Inc., __ N.E.2d __, 2011 Mass. App. LEXIS 1561 (Mass. Ct. App. Dec. 16, 2011)

When it comes to coverage for "bodily injury" to an employee of the insured, ISO's CG 00 01 commercial general liability form leaves little doubt that none is available. For many reasons, this is an exposure that has long been precluded from the scope of coverage available under a CGL policy. Yet, despite the obvious desire for insurers to exclude employee "bodily injury" coverage, Part B of the ISO CGL form does not contain an exclusion for "personal and advertising injury" to an employee of the insured. I have long found this differential treatment between the two coverage parts to be curious. And I'm obviously not the only one—since many insurers frequently endorse Part B of their CGL policies with exclusions for "personal and advertising injury" to: "(1) A person arising out of any: (a) Refusal to employ that person; (b) Termination of that person's employment; or (c) Employment-related practices, policies, acts, or omissions, such as coercion, demotion, evaluation, reassignment, discipline, defamation, harassment, humiliation, discrimination or malicious prosecution directed at that person." *E.g.*, *see* Form CG 21 47 12 07.

So, if insurers have little appetite for Part B "employee" exposure in the first place, and given the availability of such coverage under an Employment Practices Liability policy—where the exposure can be more specifically underwritten and priced—why has ISO not simply incorporated the CG 21 47 exclusions into its Form CG 00 01 terms and conditions?

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Maybe the answer is that the potentially covered "employee" Personal Injury scenarios are viewed as limited. In other words, perhaps the potential for Part B "employee" coverage is seen by some insurers as a tolerable risk. If that's the case, then the end-of-year decision from the Massachusetts Court of Appeals in *Norfolk & Dedham Mutual Fire Ins. Co. v. Cleary Consultants, Inc.* should give those insurers that have, for now, been willing to take on Part B "employee" risk, something to ponder. *Cleary Consultants* demonstrates the breadth of employment practices liability coverage that could be provided by insurers that fail—intentionally or inadvertently—to endorse their CGL policies with an exclusion for employment-related practices. Even the court made this observation.

At issue in *Cleary Consultants* was coverage for an employer for employee-on-employee sexual harassment. In other words, the case involved the type of claim for which an employer would ordinarily purchase an Employment Practices Liability policy.

Rebecca Towers, a recruiter, filed a claim against her employer, Cleary Consultants, and her immediate supervisor, Jonah Adelman, with the Massachusetts Commission Against Discrimination. *Cleary Consultants at *3.* The court summarized Towers's complaint as follows:

> From the start of and throughout her employment, Adelman made sexually explicit, inappropriate, and unwelcome comments to Towers, over her protestations. Adelman inquired about her divorce and expressed amazement that her ex-husband would have let "such a beautiful girl" go. Adelman told her about his sex life and asked about hers; and he brushed off her expressed desire not to discuss her personal life with him by saying that if she stayed close to him, he would make sure she was a success and would be able to take care of her children.

Id. at *3-4.

This is actually the G-rated version of the facts. The court went on to describe Adelman's communications with Towers in much more graphic terms, as well as the fact that Adelman caused Towers to be exposed to sexually explicit material. *Id.* at *4-5.

Mary Cleary's response to Towers's complaints is unlikely to win any awards in the category of how to appropriately respond to a sexual harassment situation:

> Towers complained to Cleary about Adelman's behavior. Towers's first complaint was made after one week or so of employment, during the final week of May, 2006. Towers told Cleary that Adelman made her feel uncomfortable and described the inappropriate comments made by him. Cleary's response was to laugh and to instruct Towers to ignore Adelman's behavior, stating that he made Cleary money, and that was why she kept him. She also stated that Towers was "a very attractive girl and, in this business, [she] should use that to [her] advantage." Later, in June, 2006, Towers asked if she could work from home in order "to avoid the discomfort caused by [Adelman's] inappropriate conduct." Cleary denied her request, saying in so many words, "Jonah may be rough around the edges, but he's harmless. He will teach you a lot. Just try to ignore the other stuff." When Towers again complained in September, 2006—this time stating that she was being exposed to pornographic material—Cleary downplayed Adelman's conduct as simply being "immature" and emphasized his skills as a recruiter.

Id. at *5-6. Finally, after Towers complained to Adelman that his conduct caused her significant distress, he responded that she could not give one hundred percent to the job because she was a single parent. Adelman told Towers, who had been working from home because her daughter was ill, not to bother coming back. Towers considered herself terminated and did not return to work. *Id.* at *6.

After some back-and-forth between Cleary and its CGL insurer, Norfolk & Dedham Mutual Fire Ins. Co., Norfolk agreed to defend Cleary, against the Massachusetts Commission Against Discrimination claim, under a reservation of rights. Norfolk's main issue was that "the complaint stated a claim for discrimination and could not reasonably be construed to 'adumbrate' a claim for invasion of privacy because it contained no allegation that Adelman had published his offensive comments about Towers to others, as required under the terms of the personal and advertising injury coverage of the policy." *Id.* at *8.

Towers then filed an amended complaint, which was obviously drafted for purposes of triggering coverage under the Norfolk policy. Towers added allegations that, among other things, Adelman speculated about her sex life, which was witnessed and overheard by her co-workers; Adelman's inappropriate conduct deeply embarrassed her; Adelman invaded her right to privacy and slandered her reputation by circulating his humiliating, vulgar, false, and demeaning statements among co-workers. *Id.* at *11.

The trial court concluded that the facts alleged by Towers qualified as invasion of privacy and defamation to satisfy the definition of "personal and advertising injury" in the policy. However, the trial court also concluded that the actions of the Cleary defendants fell within the exclusions for injury caused by or at the direction of the insured with the knowledge that the act would violate the rights of another and would inflict "personal and advertising injury" and injury arising out of oral or written publication of material, if done by or at the direction of the insured with knowledge of its falsity. *Id.* at *11-12.

The Massachusetts appeals court reversed summary judgment in favor of Norfolk. Putting aside how it concluded that the exclusions were not applicable, which is not the point for purposes of this discussion, the court held that the complaint alleged an invasion of privacy. The court looked to the Massachusetts Invasion of Privacy statute, which requires that a person allege an unreasonable, substantial, and serious interference with his or her privacy. *Id.* at *18-19. Using this as the test, the *Cleary* court held:

> From the inception of the case, Towers alleged that Adelman repeatedly made offensive sexual comments about her appearance and her relationships. He questioned her about her sex life during her marriage and after her divorce, and ridiculed her choice of boyfriend by using an offensive, derogatory term to question the boyfriend's sexuality and Towers's attraction to him. These allegations should have been understood by Norfolk as raising a claim for invasion of privacy. ***
>
> We reject any suggestion that, for the most part, Adelman's comments were not published to others, as required for coverage to attach, and that any remaining comments were too benign to form a basis for a claim of invasion of privacy. The amended complaint specifically alleges that Adelman's speculations about Towers's sex life were witnessed and overheard by her coworkers, and that he circulated humiliating, vulgar, false, and demeaning statements among her coworkers. Indeed, even prior to amendment, Towers's allegations created the distinct possibility that her claims involved *public* humiliation, and any conceivable doubt on that score soon was dispelled by the Schlemann affidavit. Schlemann averred that he had witnessed Adelman harassing Towers "on many occasions," and then gave "[e]xamples," which, by definition, should have been understood by Norfolk to be illustrative and not exclusive.

Id. at *20-21 (emphasis in original).

In general, the facts of *Cleary*—a male employee making comments of a sexual nature to a female subordinate or co-worker—are hardly unusual. To the contrary, while Adelman's conduct may have been worse than some other office Casanovas, *Cleary* involves a fairly typical sexual harassment claim. What makes this case remarkable is that, for purposes of insurance coverage, the Massachusetts Court of Appeals equated a sexual harassment claim with a right of privacy claim to implicate coverage under Coverage Part B of the policy.

In doing so, the Massachusetts appeals court in *Cleary* may have provided a road map for underlying plaintiffs to secure coverage for garden-variety sexual harassment claims from insureds that have a garden-variety CGL policy—but not an EPL policy. And this is hardly an unusual inventory of many company's insurance assets. Indeed, the *Cleary* court itself noted that "unlike other commercial liability insurance policies, [the Norfolk policy] made no attempt to exclude personal and advertising injury associated with discrimination against or harassment of an employee." *Id.* at *16-17 (several citations to examples omitted).

Insurers that have heretofore eschewed endorsing Coverage Part B with Form CG 21 47—which serves to preclude coverage for, among other things, employee harassment claims—may want to study Cleary and be certain that they are comfortable with the employment-practices exposure that they may be providing in their CGL policies. ■

Claims Adjuster Depositions: Preparing for an Away Game

by Donald O. Johnson, CPCU, J.D., LL.M.

In insurance coverage litigation, claims adjusters often are deposed because they are involved in frontline determinations about coverage and valuation issues. The objectives of such depositions are: (1) to investigate the facts surrounding the insurer's handling of the claim—the reasons articulated for making the relevant coverage and/or valuation decisions and the methods that the insurer used to reach those decisions; (2) to elicit testimony that supports potential theories of the insured's case and that rules out others; (3) to evaluate the claims adjuster and memorialize his or her testimony; and (4) to obtain helpful testimony for use in negotiations, in motions, and/or at trial.

Some experienced claims adjusters have been through the process many times and may feel relatively comfortable being deposed. At the other end of the spectrum are claims adjusters with little or no deposition experience. All claims adjusters, no matter what their experience level is, will benefit from this brief examination of the deposition process because it recognizes that the attorney taking an adjuster's deposition has home field advantage.

The Attorney Taking the Deposition Has Many Advantages

An attorney taking a claims adjuster's deposition has some obvious advantages over the claims adjuster because of the attorney's greater familiarity with the deposition process, control of the areas of examination, knowledge of the insured's potential theories of the case and the testimony needed to support each potential theory.

Beyond these advantages, the examining attorney benefits from the fact that the scope of the examination in a deposition is much broader than at trial. During a deposition, unlike at trial, an attorney is allowed to ask questions that do not directly seek admissible evidence as long as the questions might lead to the discovery of admissible evidence. This allows the attorney to ask questions in some areas that a claims adjuster might have thought were out of bounds and, thus, might not have answers prepared.

Further advantages that the attorney taking the deposition enjoys are the use of leading questions and the requirement, except in very limited circumstances, that a deponent must answer the attorney's questions.[1] The use of leading questions allows the attorney taking the deposition to exert more control over a claims adjuster's answers and to introduce into deposition questions language favorable to the insured's position in an effort to have the claims adjuster expressly or impliedly adopt that language in his or her answers. The requirement that a deponent answer the attorney's questions increases the attorney's control of the examination and should prevent a claims adjuster from sidestepping difficult questions if the examining attorney insists upon receiving responsive answers.

Throughout a deposition, the attorney taking the deposition will have opportunities to use his or her superior knowledge of other rules of evidence and civil procedure to gain an advantage over the adjuster. For example, early in a claims adjuster's deposition, the attorney taking the deposition typically will attempt to learn which evidence the insurer thinks is important in the case. Hence, among other things, the attorney usually will ask a claims adjuster which documents he or she reviewed in preparation for the deposition. Sometimes this question results in an objection and an instruction not to answer the question. The basis for the objection and the instruction generally is the assertion that answering the question would require the disclosure of attorney work product (for example, the attorney's mental impressions about the case) because the claims adjuster only reviewed documents that the attorney defending the deposition gave him or her.

To get around the objection and the instruction not to answer, the examining attorney may ask the claims adjuster whether any of the documents that the adjuster reviewed refreshed his or her memory about the facts of the case. If the claims adjuster answers, "Yes," under the rules of evidence, the examining attorney can require the claims adjuster to identify the documents that refreshed his or her memory, notwithstanding the fact that the attorney representing the adjuster may have shown the documents to the adjuster during deposition preparation.

The Attorney Defending the Deponent Can Provide Only Limited Assistance

Claims adjusters can improve their deposition performance by being aware of the extent of the assistance that his or her counsel can provide during the deposition. This is crucial because deposition witnesses sometimes overestimate how much assistance their counsel can provide, which can lead to such things as erratic behavior by a surprised witness and loss of confidence in his or her counsel.

Deposition testimony is supposed to proceed like trial testimony. The attorney defending a claims adjuster can make objections to specific questions but the adjuster, like any other deponent, has to answer the questions notwithstanding the objections, except in the limited circumstances under which an instruction not to answer is permissible.

After the attorney taking the deposition completes his or her examination, the attorney defending the deposition also may assist the claims adjuster and his client—the insurer—by conducting a direct examination of the claims adjuster to allow the adjuster to correct

unintentional errors in his or her earlier testimony, clarify confusing testimony, and introduce testimony necessary to support the insurer's theories of the case and/or to undercut the insured's theories of the case. Such examinations are conducted on an as-needed basis.

Beyond this, the attorney representing the claims adjuster can do little to assist the adjuster during the deposition. During breaks in the deposition, some attorneys will offer guidance to the witness they are defending. However, this can be problematic because, when the deposition resumes, the attorney taking the deposition may ask the witness what he or she discussed with his or her counsel during the break, which, in some circumstances in some jurisdictions, may require the disclosure of the substance of the conversation.

Thorough Deposition Preparation is the Best Way to Try to Level the Playing Field

Because of the defending attorney's limited power during a deposition, the greatest service that he or she can provide to a claims adjuster is to thoroughly prepare the adjuster for the deposition ahead of time. Thorough deposition preparation provides claims adjusters with the information needed to understand how their depositions are likely to proceed and how to handle anticipated situations calmly and as effectively as possible.

During the deposition preparation of a claims adjuster, the attorney who will defend the deponent should, among other things:

- Explain basic deposition procedure
- Have the adjuster describe his or her personal knowledge about the facts of the case
- Review all relevant documents with the adjuster
- Explain what the opposing party's theories of the case appear to be
- Explain the difference between open-ended and leading questions, how leading questions can be used to try to put words into a deponent's mouth, and how to avoid adopting any slanted terminology that the examining attorney may use
- Provide available information about the opposing attorney's known deposition tactics
- Explain the objections that the defending attorney will be allowed to make and their significance
- Explain the limited circumstances under which the adjuster's attorney can instruct the adjuster not to answer a question from opposing counsel
- Discuss appropriate deponent demeanor
- Emphasize the importance of giving truthful answers to questions and the high cost of making intentional misrepresentations;
- Give examples of proper ways of answering deposition questions
- Instruct the adjuster to refrain from such things as volunteering information that the examining attorney has not asked for and speculating about matters about which the deponent has no personal knowledge.

After the attorney defending the claims adjuster has prepared the adjuster with regard to the foregoing topics, the attorney should discuss with the adjuster the subject areas anticipated to be addressed during the deposition and prepare the adjuster to be able to answer questions in each area. A typical list of areas in which a claims adjuster may be examined during a deposition are:

- His or her education, work history, claims handling experience and prior depositions
- His or her deposition preparation
- Claims department chain of command
- Oral and written communications between the insurer and the insured
- Communications between the insurer and third parties related to the claim (for example, contractors, medical service providers, brokers, reinsurers, and so forth)
- Internal insurer communications relative to the claim
- Specific actions taken by the claims adjuster and other insurer personnel when handling the claim (for example,, coverage analysis and valuation) and the reasons such actions were taken
- Actions that the insurer didn't take and the reasons for not taking them
- Other areas of inquiry addressed in interrogatories and document requests served in the case and in prior depositions taken of other witnesses

Preparing for a deposition in this manner takes time but it gives claims adjusters the best chance of offsetting some of the systemic advantages that the attorneys taking their depositions have. On the other hand, failing to properly prepare for a deposition will result in poor deposition performances by inexperienced claims adjusters and less than optimal performances by seasoned claims adjusters, all of which will translate into poor litigation results for insurers and unnecessarily increased claims costs. Given these alternatives, the wise choice for insurers is to try to level the playing field to the extent possible by properly preparing the claims adjusters for their depositions and reducing the home field advantage that the attorneys taking the depositions enjoy. ■

Endnote

1 An attorney defending a deposition witness may instruct the witness not to answer a question only if it is necessary to: (1) preserve a privilege, such as the attorney-client privilege or attorney work product; (2) enforce a court order limiting the testimony; or (3) make a motion to terminate or limit the scope and manner of taking the deposition because the deposition is being conducted in bad faith or in a manner to annoy, embarrass or oppress the witness or a party.

Arbitration: The "I'm Not Dead Yet" Alternative Dispute Resolution Program

by Matthew J. Smith, Esq.

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The hit Monty Python Broadway musical *Spamalot* contained the humorous song "I'm Not Dead Yet." For those of us who have worked in insurance claims for more than just the past decade or two, the same may well be said of arbitration. What was the "hot property" of alternative dispute resolution (ADR) in the 1980's has become nearly forgotten in the new millennium. For the right claim, however, arbitration remains a very viable alternative to litigation or to other types of ADR, such as mediation.

Black's Law Dictionary defines arbitration as, "The reference of a dispute to an impartial third person" or, "Abiding by the judgment of a selected person in a disputed matter to avoid delay, expense and ordinary litigation."

The theoretical purpose of arbitration is to avoid or limit litigation, provide the parties with an expedited resolution process, and while doing so, decrease court docket backlogs and create a less adversarial method of resolving the dispute. As with most forms of ADR, arbitration is normally not governed by specific laws, statutes, or rules of procedure, and it affords parties more freedom in determining the method of arbitration most appropriate to the issues at hand.

This is not to say arbitration is without regulation. The Uniform Arbitration Act was originally adopted by the National Conference of Commissioners on Uniform State Laws in 1955, and subsequently amended in 1956 and 2000. Many local courts, both at the state and federal level, have also adopted arbitration proceedings as part of their ADR programs, and many professions, including architects, stockbrokers, and bankers, have now incorporated arbitration proceedings into contractual agreements.

Additionally, the American Arbitration Association (AAA) operates both nationally and internationally, providing a framework for arbitrations. AAA offers set rules and guidelines for arbitration proceedings, will provide listings of skilled and competent arbitrators, and may provide office facilities specifically geared for conducting arbitration hearings in major cities.

The reason arbitration has historically been so popular is that it affords a much more flexible format than traditional litigation, summary jury trials, or even mediation. Although contractual terms must be reviewed in most situations and especially when a lawsuit is pending, the parties may define their own terms for arbitration, including whether the decision is binding or merely advisory, whether the matter is submitted to one arbitrator or a panel, and whether all issues or specific issues (such as determining liability or the amount of damages) are subject to arbitration,.

Frequently, parties may decide, within the arbitration format, how the actual hearing will be conducted. Matters such as opening statements, closing arguments, the type of exhibits to be utilized, and whether witnesses will appear and give personal testimony may be subject to negotiation and agreement between the parties.

Too often, even experienced attorneys and claims professionals overlook alternatives within the arbitration format of ADR. A traditional arbitration involves one or more arbitrators issuing a decision, similar to a judge or jury, based upon the issues presented. The use of arbitration as an ADR format, however, allows you to be creative and consider some important alternatives, which may actually be more appropriate for resolving the disputed issue. Some examples are discussed here:

Baseball Style—Owing to its use in major league baseball, this form of arbitration forces both sides to very realistically evaluate their case and damages. Normally, these arbitrations are conducted with one arbitrator, and the parties agree several days in advance to submit sealed envelopes to each other, and to the arbitrator, on behalf of their respective clients. It is agreed the arbitrator will not open the envelopes until he or she reaches a decision. In advance of the arbitration, however, the parties open respective envelopes containing the plaintiff's demand for settlement and the defendant's highest offer of settlement. Typically, the parties will agree if the figures overlap (which is unlikely), or reach a compromise if the figures are within a relatively close range, and the arbitration will be cancelled. However, if the parties cannot reach an agreement, the arbitrator hears the evidence and reaches his or her own independent decision.

This is an example of what happens next: An arbitrator returns a verdict of $75,000.00. The arbitrator then opens the two envelopes. If the plaintiff's demand was $200,000.00 and the defendant's offer was $50,000.00, the amount awarded to the plaintiff is $50,000.00, not the

$75,000.00 awarded by the arbitrator. The number closest to the arbitrator's verdict is the figure that is ultimately paid on the claim. This is why baseball-style arbitration forces both parties to *very* realistically evaluate their cases in order to try to get as close as possible to the arbitrator's fair and impartial decision.

High-Low Agreements—The parties may also submit a matter to arbitration with the understanding that the arbitrator's verdict will set the final amount of the claim, but with a guaranteed capped low or high, as agreed to by the parties. This assures the plaintiff of a minimum amount of recovery and makes certain, even in arbitration, there is not a "runaway" verdict, which is unacceptable to the defendant or their insurer.

Normally, the baseball-style and high-low agreements are only successful if the arbitration is agreed to in advance by all parties to be fully binding.

Formal or Casual—No, I am not referring to what you wear to the hearing. Arbitrations can be conducted with the same level of formality and dignity as a courtroom proceeding or may be extremely informal, conducted around a conference table, with no one under oath, and the parties simply sharing information and submitting documents to the arbitrator(s). Many arbitrations are similar to mediations, with the exception that a mediator has no final authority. The arbitrator does have final authority on either an advisory basis or a binding basis, depending on the parties' agreement. Careful consideration should be given to what format best meets the needs of the parties and the issues at hand. There are occasions when litigants need to feel they have had their "day in court" and a more trial-like arbitration may fulfill those needs. In other situations, for example, when a spouse or child has died, a more relaxed and understanding discussion format with less "pressure" may be more conducive to resolving the dispute.

Arbitration Without Attorneys—Heaven Forbid!" Yes, it is possible for the parties or their representatives to arbitrate a case without attorneys even being present. There are clearly advantages to having attorneys present because, presumably, they possess advocacy skills and can help guide the parties in the arbitration hearing. However, there is no formal requirement that an attorney present a case at arbitration, and often it may be advisable to consider whether nonattorneys are a better choice on an arbitration panel. In complicated construction matters or business income loss claims, it may be appropriate to have a panel of arbitrators but to include one attorney, a professional engineer, and a forensic accountant. Again, arbitration affords the flexibility and adaptability to make certain the parties feel they have been treated fairly and their case has been heard by those who are most competent to judge and decide the issues at hand.

In its best use, arbitration is prompter, more efficient, more amicable, and less costly than a jury trial; and it avoids the always feared aberrant jury decision.

However, there are risks associated with arbitration. If the arbitration decision is based on a serious error of fact or law and the arbitration is binding, there is no appeal process to correct the error. If the parties do not resort to arbitration early on, and if the attorneys do not wisely control the cost, an arbitration may be nonbinding and more costly than a trial. Also, if the arbitration is nonbinding, the opposing counsel and party may now know the best evidence and will have used the arbitration to secure a "trial run" to improve their case before it actually goes before the judge or jury.

Taking care early on to address key factors will help to avoid many, if not all, issues. First, decide sooner rather than later if the case is suitable for arbitration. If it is, structure the case and discovery for arbitration, especially if it is binding in nature. Experience has shown that arbitration is best when it is binding; otherwise, you may well be wasting your client's or your company's time and money. Also, do not be afraid to be innovative. Design the arbitration in a style that works best for the facts and circumstances of the dispute or claim at issue.

Once you have agreed to arbitration, play an active role in the selection of the arbitrator or arbitration panel. Do not simply rely on published lists, retired judges, or recommendations from counsel. Interview the arbitrators and have a pre-arbitration meeting with all counsel and the arbitrator(s) in advance to set the ground rules, expectations, timing, and other issues. This will ensure the arbitration goes smoothly and everyone is entering the arbitration with the same expectations.

It is also important to inform the nonattorney or claims-professional parties to the arbitration of what to expect. Do not assume they understand what the arbitration process entails or what will occur at the arbitration hearing. Discuss this with them in advance and secure their agreement regarding the format, time, and goals of the arbitration.

Finally, learn from the process. Whether you win or lose, speak to the members of the arbitration panel or the arbitrator. Find out from them what worked, what did not, and what factors were crucial to making their decision. Seek specific guidance from them regarding matters such as the style and length of the arbitration, the manner and format in which the evidence and witnesses were presented, and what specific information the arbitrators may not have received, but would like to have considered before making their final decision.

In the final analysis, do not give up or assume arbitration is dead. Consider arbitration a valuable tool in the ADR process, and at all times, learn, adapt, and improve your claims handling or legal representation skills through the use of effective ADR. ■

Five Steps to Take After Your Next Claims Audit

by Kevin Quinley, CPCU, AIC, ARM

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Handshakes and smiles abound as you bid adieu to the claim audit team leaving your office after a four-day stint. "Have a smooth flight back," you add, privately thinking, "Don't let the door hit you on the way out!"

Ah, claim audits. Can't live with them, can't live without them. At times, it seems that everyone wants to put your operation and its claim files under the magnifying glass: reinsurers, excess carriers, state insurance departments, agents and brokers, and the home office. Claim audits can be a huge distraction—sort of like trying to compete in the Indy 500 while having to pull off to the side of the track periodically for a mandatory state motor vehicle inspection. Love them or loathe them, they are a necessary part of life in any claim operation. You can't wish them away (though you might want to).

After auditors leave, many react by breathing a sigh of relief. There is an understandable and a natural tendency to think, "Well, glad that's over. Now we can get back to our real jobs, our real work!" Although that thought is understandable, claim management must not close the mental books so soon. Savvy claim managers and supervisors should adopt follow-up action items that come after any claims audit. Here are five recommended steps:

1. **Request a copy of the audit report.** Given all the time the auditors spent on site, you should be curious about their findings. Granted, you may get some hint or flavor of that in a "wrap-up" meeting. Sometimes, though, in face-to-face exchanges, auditors will exercise restraint or tone down criticisms that may surface more emphatically in written reports. Presumably, the aim of a wrap-up meeting is to avoid surprises, but they can still happen. People are often more willing to put criticisms on paper than to confront them awkwardly in a conversation. This is not necessarily due to auditor duplicity. In fairness to the auditors, they may sometimes have observations and recommendations that come to them later, upon reflection and after crunching numbers related to the audit. Still, as a best practice, a wise claim manager will ask the auditors at the end of the wrap-up meeting, "Will we be surprised by anything in your report?" and "Are there any other findings, observations, or recommendations that we haven't discussed?"

   Moral: ask for a copy of whatever report the auditor writes. Caution: some (many) auditors will not honor this request, but there is no harm in asking. The reasons for their declining are varied. Some companies simply have a policy not to release such a work product.[1] Perhaps the audit is for internal use only. Reinsurers may use the claim audit to make decisions on underwriting or renewing treaty business with a ceding company or to price a reinsurance quote. Other companies may feel uncomfortable releasing unvarnished findings or believe that if they have to share the report, the auditors will use discretion and not be as candid. For whatever reason, the party doing the audit may balk at releasing a copy of its findings.

   Fortune favors the bold; do not let the possibility of being rebuffed deter you from asking. The worst that can happen is that the auditors say no, and you may be pleasantly surprised by the auditors' saying yes. If they agree to provide a copy, follow up promptly with a letter or an e-mail, which will serve as a friendly reminder.

2. **Thank the auditors for their time and effort during the visit.** Wish them smooth travels on their flight or drive back home. If the auditors were from a business partner (such as a reinsurer or broker), tell them how you value the business partnership. Acknowledge that no claims operation is perfect and that any claims unit is open to improvement. Remind them in a friendly way of any promise they made to share a copy of the audit report with you. Indicate a willingness to listen to all improvement suggestions constructively and with an open mind.

3. **Calendar or diary the audit report request for follow-up** in a reasonable number of days, say, thirty to forty-five. Keep this as a recurring or an open action item on your diary or to-do list until you receive a copy of the audit report. You may need to follow up, perhaps more than once.

4. **Once you get the audit report, read it closely.** Do not treat it as mere "credenza decoration." Compare the audit report with the notes you took during the wrap-up meeting. Are there any inconsistencies? Does the report contain any new criticisms that did not surface in the wrap-up meeting? Depending on the audit report's findings and conclusions, you may also wish to write a response or a rebuttal. This may be especially true if there are damaging observations or findings that you feel are significantly off base.

   If the report is going to be shared with key constituencies—such as the department head, the board of directors, the home office, the audit committee, or senior management—a written response may be important. Before investing the time, though, speak with the boss about the advisability of a written rebuttal. Sometimes a rebuttal only "adds fuel to the fire," especially if it's possible that no one will take much notice of the audit recommendations. It is a natural impulse for any claims person to want to set the record straight if he or she feels an injustice has been done. Nevertheless, avoid drawing more attention to adverse findings by virtue of a heated response.

5. **Use the claim audit as an opportunity to learn and to improve** your claim operation. Turn a negative into a positive—an opportunity for growth, improvement, and learning. That really should be the point of any audit. Admittedly, it's tough to be impartial about your own claim operation. Often, it takes an outsider to give objective observations and advice. Your professional capacity to grow and to take your claims unit to the next level will suffer if you adopt a closed-minded attitude toward every claim audit. So cut the cynicism about claim audits, take a deep breath, and view them as opportunities to get better.

Who knows, as you become more adept in navigating the receiving end of claim audits, you may one day find yourself in a new role: that of *claims auditor!* ■

Endnote

1. If the audit results are negative or critical and you now have a copy of that report, the latter may be discoverable in case of, say, bad-faith litigation. Still sure you want a copy?

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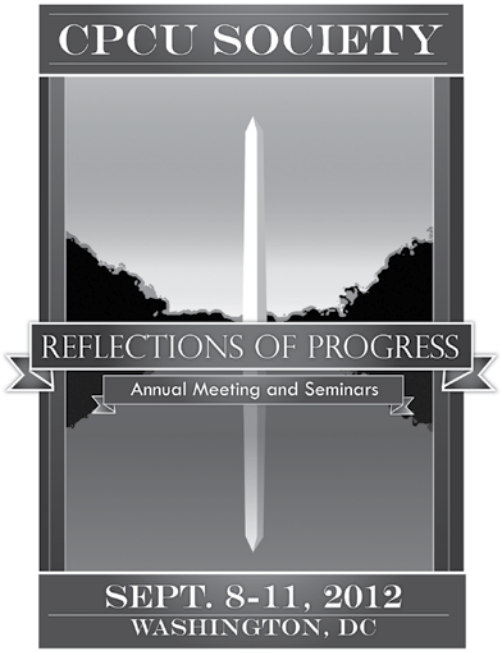

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