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RECENT CASE DEVELOPMENTS

Jeffrey W. Stempel*

ABSENT EXPRESS AGREEMENT, INSURER NOT PERMITTED TO USE ARBITRATION AWARD AGAINST POLICYHOLDER; CGL POLICY MAY BE REQUIRED TO COVER CLAIMS FRAMED IN BREACH OF CONTRACT LANGUAGE RATHER THAN TORT LANGUAGE

Vandenberg v. Superior Court, 982 P.2d 229 (Cal. 1999).

The California Supreme Court dealt two blows to insurers, one by a unanimous vote in its recent Vandenberg decision. The court held: (1) absent express agreement in the arbitration clause, an insurer could not use an arbitration award unfavorable to the policyholder to gain “offensive” collateral estoppel against the policyholder in a subsequent coverage dispute; and (2) despite the general admonition that liability insurance covers tort claims rather than contract claims, a commercial general liability (“CGL”) policy does not necessarily bar coverage for claims against the policyholder that are framed as breach of contract claims. See Vandenberg, 982 P.2d at 234.

Policyholder Vandenberg operated an automobile sales and servicing facility from 1958 to 1988 on land leased from Eugene and Kathryn Boyd. See id. In 1988, Vandenberg discontinued the business and the land was again possessed by the Boyds. See id. Subsequently, the Boyds discovered pollution damage on the land and sued Vandenberg, alleging that Vandenberg’s installation and operation of waste oil storage tanks on the land created the pollution. See id. at 235. For the years in question,

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Vandenberg was insured by several companies through standard CGL insurance. See id. One insurer, USF&G, agreed to defend. See id. As part of a complex settlement arrangement, the pollution damage to the land was remediated (with USF&G footing much of the bill, at least as an initial matter). See id. The Boyds and Vandenberg arbitrated between themselves issues relating to whether Vandenberg’s oil waste activity constituted a breach of the lease. See id. The coverage dispute was treated as a separate matter for litigation. See id.

After an extensive arbitration proceeding, the arbitrator found in favor of the Boyds and against Vandenberg, awarding more than $4 million in damages. See id. In particular, the arbitrator found that the bulk of pollution damage to the land resulted from the underground waste storage tanks and was caused in part by Vandenberg’s improper installation, maintenance and use of the tanks. See id. The arbitrator also found that the discharge of pollutants from the tanks had taken place gradually over a number of years. See id.

On the basis of the arbitrator’s findings, Vandenberg’s CGL insurers rejected his request for indemnification, prompting Vandenberg to sue seeking coverage. See id. The insurers moved for judgment in their favor on the basis of the arbitration findings. See id. In particular, the insurers argued that the arbitrator’s finding that the oil waste pollution took place over several years made it impossible for Vandenberg to obtain coverage for the matter pursuant to the “sudden and accidental” pollution clause contained in the policies. See id. at 235-36. In addition, the insurers (particularly those without a qualified pollution exclusion in the policy) argued that because the arbitrator had awarded damages to the Boyds for “breach of lease,” the damages owed by Vandenberg to the third party claimants were contractual rather than tortious and thus outside the scope of CGL coverage. See id. at 236.

This type of motion for summary judgment by the insurers sought to make “offensive” use of “collateral estoppel,” or issue preclusion. The doctrine of issue preclusion (more commonly referred to as collateral estoppel) provides that a fact that is fully and fairly litigated may be binding in subsequent proceedings against a party who was part of the earlier factual determination. Issue preclusion may apply where: (1) the fact in question is the same in both cases; (2) where it was actually litigated in the earlier action; (3) where the proceeding was fair and the fact fully and completely litigated, and (4) where the fact in question was a necessary part of the earlier tribunal’s decision.
Ordinarily, issue preclusion is invoked on the basis of a prior judicial opinion rather than on the basis of a prior arbitration hearing or similar form of alternative dispute resolution. In addition, the most common form of issue preclusion is to prevent a party from the earlier action (or those in close association with the party) from bringing again charges that were rejected in the first action. For example, one partner in a stock brokerage firm may sue a lawyer for malpractice. If the lawyer wins the claim, he or she may generally use the decision as a basis for dismissing a second claim by another partner in the same brokerage firm or by the brokerage firm itself.¹

This is generally referred to as “defensive” collateral estoppel (issue preclusion) because the party invoking issue preclusion is using the result of the first matter to bar a relitigation of the issue on which the defending party prevailed in the prior action.

For many years, defensive issue preclusion was not only the most common form of collateral estoppel but was also viewed more favorably by the law than offensive issue preclusion. As the example above illustrates, defensive issue preclusion can be used against someone who was not part of the earlier action so long the party that was in the first action had a similar incentive to litigate the point and had the actual opportunity to fully and fairly litigate the point. Thus, the defensive use of issue preclusion need not be “mutual” – the winning party can use its win on the issue to prevent strangers to the first litigation from challenging the earlier determination, so long as the first litigation was fair and actually decided an issue that was necessary to resolution of the first claim.

By contrast, offensive collateral estoppel takes place where a stranger to the first proceeding seeks to use the first proceeding’s determination of an issue to prevent the losing party in the first case from contesting the issue in a second proceeding brought by this stranger to the first case. For example, the second partner of the brokerage in the example previously

¹ The lawyer certainly may use the first result to preclude a second claim by a partner who sued in the first action, even if the partner’s legal arguments for recovery are different – but this is barred under the doctrine of “res judicata” or “claim preclusion,” which precludes relitigation of the same dispute between the same parties. Claim preclusion was not at issue in Vandenberg because Case 1, the arbitration dispute, was Boyd v. Vandenberg (on the breach of lease/damage to property claim). Case 2, the litigation dispute, was Insurance Companies v. Vandenberg (regarding coverage).
given might try to win a summary judgment motion against the law firm if
the law firm lost the first case against a different partner in the brokerage
firm. For years, such offensive collateral estoppel was frowned upon
where the party seeking offensive use was not involved in the prior
litigation. This view has been relaxed in recent years—"mutuality" is not
required for offensive use of collateral estoppel—but courts generally give
offensive collateral estoppel greater scrutiny. To gain offensive issue
preclusion, the movant must ordinarily demonstrate that this is fair and
consistent with the state's public policy.

The status of arbitration and collateral estoppel has been a matter of
some controversy. Because arbitration is not a judicial proceeding,
arbitration results were not historically considered to give rise to issue
preclusion. During the past twenty years, as social policy endorsed
arbitration and other forms of alternative dispute resolution (ADR), many
courts moved away from this view and found that an arbitration award
could result in either offensive or defensive collateral estoppel depending
on the facts and circumstances of the case. As the Vandenberg court itself
observed:

We realize that some commentators and most other
courts addressing the issue, have taken a contrary
approach [to the Vandenberg majority]. The
predominant view is that unless the arbitral parties
agreed otherwise, a judicially confirmed private
arbitration award will have collateral estoppel effect,
even in favor of nonparties to the arbitration, if the
arbitrator actually and necessarily decided the issue
sought to be foreclosed and the party against whom
estoppel is invoked had full incentive and opportunity to
litigate the matter.

Id. at 240; see, e.g., Witowksi v. Welch, 173 F.3d 192, 198, 205 (3d Cir.
1999) (applying federal and Pennsylvania law); Mandich v. Watters, 970
F.2d 462, 465-67 (8th Cir. 1992) (applying Minnesota law); Cities Service
Co. v. Gulf Oil Corp., 980 P.2d 116, 123-30 (Okla. 1999) (applying federal
and Oklahoma law). For example, in many states, an arbitration decision
may be accorded preclusive effect as to a fact if the arbitration made a firm
determination of a fact necessarily at issue and was fair, thorough, and
hotly contested. The chances for preclusion are greater where the
arbitration involves a matter that the parties knew would likely be at issue
with other parties in subsequent proceedings.
In *Vandenbarg*, the California Supreme Court embraced the more traditional wariness of arbitration to some extent. The court held that arbitration, a form of ADR chosen by contract, cannot automatically be given the issue preclusion effect that would accompany a court judgment. See *Vandenbarg*, 982 P.2d at 239. Because the parties to an arbitration clause agree only that they will arbitrate a particular matter, the court reasoned that it would be unfair to make the results of the arbitration binding as to each issue in the arbitration – at least when strangers to the arbitration attempt to use the results against one of the parties to the arbitration. See id. at 239-40.

According to the court, an arbitration determination is not a proper basis for offensive collateral estoppel for a variety of reasons. First, arbitration awards are subject only to limited and deferential judicial review. See id. at 239. A commercial arbitration\(^2\) award will not be vacated unless there has been bias, corruption, gross unfairness in the proceeding (such as giving a party insufficient time to prepare a case or barring crucial witness testimony), or the award exceeds the scope of the agreement.\(^3\) Under federal law, an arbitration award may be overturned in rare cases where the arbitrator demonstrates “manifest disregard” of the law.\(^4\) But this is normally interpreted to mean that the arbitrator expressly refused to follow applicable law, not merely that the arbitrator erred in applying the law. As a result, arbitration is not given the type of searching appellate scrutiny applied to trial court decisions. Furthermore, California law appears to make it even less likely that an award could be vacated for manifest disregard of the law. The *Vandenbarg* court cited favorably an old California decision stating that “arbitrators are not bound to award on

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2. Commercial arbitration, which includes arbitration of tort claims and need not involve business entities per se, is distinguished from labor arbitration, which involves resolution of management-union disputes. Labor arbitration differs somewhat from commercial arbitration in terms of procedure and standard of review. A labor arbitrator’s award is arguably accorded even more generous judicial review and will be affirmed so long as the award “draws its essence from the collective bargaining agreement.” United Steelworkers of Am. v. Enterprise Wheel & Car Corp., 363 U.S. 593, 597 (1960). Commercial arbitration is controlled by federal law where the arbitration clause is one reflecting a transaction involving interstate commerce. Absent interstate commerce, arbitration is controlled by state law, which is largely congruent with federal law.


4. See, e.g., Sheet Metal Workers Int'l Ass'n v. Kinney Air Conditioning Co., 756 F.2d 742, 746 (9th Cir. 1985) (applying federal common law of arbitration).
principles of dry law, but may decide on principles of equity and good conscience, and make their award *ex aequo et bono* [according to what is just and good].” *Vandenberg*, 982 P.2d at 239 (citations omitted).

Second, according to the *Vandenberg* court:

[a]n agreement to arbitrate particular claims reflects each party's conclusion that the immediate stakes make it preferable to avoid the delay and expense of court proceedings, and instead to resolve the matter between themselves without resort to the judicial process. Under such circumstances, each party is willing to risk that the arbitration will result in a ‘final’ and ‘binding’ defeat with respect to the submitted claims, even though the party would have won in court, and even though the arbitrator's errors must be accepted without opportunity for review. But this does not mean each arbitral party also consents that issues decided against him by this informal, imprecise method may bind him, in the same manner as a court trial, in all future disputes, regardless of the stakes, against all adversaries, known and unknown.

*Id.* (citation omitted). Because of this reality, the court found it unfair to accord collateral estoppel effect to facts determined by an arbitrator unless the parties had specifically agreed that this would be the case when they entered into the arbitration agreement. *See id.* at 240.

Third, the policies behind collateral estoppel for court decisions have less weight when applied to arbitration results. The rationale for the doctrine of issue preclusion is to prevent a losing litigant from having the proverbial second bite at the apple but also to conserve judicial resources. The *Vandenberg* court reasoned that conservation of judicial resources was not really an issue because by definition the judiciary has expended little or no effort in the course of an arbitration, which takes place outside the judicial system. *See id.* However, courts may be involved, even heavily involved, in prearbitration motions seeking to force or prohibit an arbitration where one of the parties attempts to avoid the arbitration clause.

The *Vandenberg* court concluded: “the policies underlying the doctrine of collateral estoppel must yield to the contractual basis of private arbitration, i.e., the principle that the scope and effect of the arbitration are for the parties themselves to decide.” *Id.* at 240.

*Vandenberg*’s issue preclusion assessment can be criticized as insufficiently supportive of arbitration results, but it can also be defended
on the facts of the case itself. Vandenberg involved a “post-dispute” arbitration agreement, one that arose after a controversy was apparent to all concerned - the Boyds, Vandenberg, and their respective insurers. An agreement between the Boyds and Vandenberg to arbitrate just the disputes between them in order to expedite matters is by implication not one designed to resolve all the coverage questions that may be lurking in the background. The context of the Boyd-Vandenberg arbitration strongly appears to be one directed toward only the Boyd-Vandenberg dispute, not to disputes between Vandenberg and his insurers.

On the other hand, it should hardly have been a surprise to Vandenberg that the insurers would invoke the pollution exclusion and hope to convince a court that the oil waste pollution was insufficiently “sudden” to be covered. Thus, policyholder Vandenberg had a strong incentive to fight any implication in the arbitration that the oil waste pollution was gradual or intentional.

However, insurance law may view facts differently than tort or contract law. For example, a party may be liable in tort for reckless conduct, but does not necessarily “expect or intend” injury within the meaning of the “occurrence” definition of an insurance policy. Thus, an arbitrator’s determination that a party “should have known” that its conduct would cause injury does not necessarily result in a successful, expected or intended defense against a policyholder. Similarly, an arbitrator may find that pollution occurred over many years. But if the pollutants were released sporadically in a series of unforeseen and abrupt bursts of damage to storage tanks, the events could qualify as “sudden and accidental” discharges eligible for coverage. Further, in a jurisdiction that requires only that a “sudden and accidental” discharge be unintentional rather than abrupt, the policyholder might obtain coverage even if the arbitrator had correctly found the pollution discharges to span many years.

Put another way, perhaps the California Supreme Court could have protected the policyholder without setting forth such a seemingly broad rule disfavoring collateral estoppel based on arbitration results. To qualify for collateral estoppel effect, the matter in question must involve the “same” issue and be “necessary” to the decision. The issue of whether Vandenberg polluted the Boyd land during the course of the lease is not exactly the same issue as whether the pollution was “sudden and accidental” within the meaning of the qualified pollution exclusion. Although the arbitrator needed to determine whether Vandenberg polluted and injured the Boyd property, the arbitrator did not necessarily need to make any findings as to the time and manner of the pollution. Thus, the
California Supreme Court could have adopted the majority approach to issue preclusion based on an arbitration finding, but instead found the test for collateral estoppel was not satisfied in Vandenberg's particular case.

In California or other states that might endorse Vandenberg, its analysis would probably control and prevent collateral estoppel if a party to a mandated arbitration attempted to make offensive use of issue preclusion. For example, most states require arbitration of disputes concerning first-party automobile insurance benefits. Should the results of these determinations be given preclusive effect? Defensively? Offensively? Presumably, the California Supreme Court would find that such mandated proceedings are intended to have a narrow scope (deciding the first-party claim) and will not be accorded collateral estoppel effect if used offensively. But defensive use of such arbitration determinations may subsequently find more favor in California simply because defensive collateral estoppel is generally regarded with less suspicion.

Vandenberg's application is less clear regarding "predispute" arbitration agreements – those in which the parties agree to arbitrate when making a contract without having any particular dispute between them at the time of contracting. These common forms of arbitration clauses generally state that the parties to the contract agree to arbitrate "all disputes arising out of the contract." Some broad clauses may even obligate the parties to arbitrate disputes "relating to" the contract. When parties arbitrate pursuant to this sort of broad agreement, should they be regarded as having consented to accord collateral estoppel impact to the resulting arbitration award?

Vandenberg is silent on the question and predicting California law for broadly worded predispute arbitration agreements is uncertain. On the one hand, a broadly worded clause suggests that a party willing to arbitrate a wide range of disputes is willing to have the arbitration create collateral estoppel for a wide range of determinations. On the other hand, such broad arbitration clauses have a boilerplate quality, are made without either party appreciating the potential collateral estoppel impact, and often

6. See, e.g., Smith v. Smith Cogeneration Int'l, Inc., 198 F.3d 88 (2d Cir. 1999) (applying federal common law of arbitration; reviewing one such clause). My Lexis search of 1999 cases (conducted April 4, 2000) finds more than 100 cases examining clauses of this type, a reflection of the popularity of this arbitration clause language.
result from contracts of adhesion between parties of quite disparate sophistication, wealth, and bargaining power. Consequently, one should be wary of interpreting *Vandenbergs* to give a green light to issue preclusion if the arbitration agreement is broadly worded.

However, in light of *Vandenbergs*, a party drafting an arbitration agreement that implicates California law may want to specifically address collateral estoppel questions in the arbitration clause itself. *Vandenbergs* suggests that the California Supreme Court would enforce an arbitration clause that specifically states that matters determined in an arbitration shall have preclusive effect. Conversely, *Vandenbergs* clearly establishes that an arbitration clause that states that matters determined in the arbitration will not have preclusive effect in subsequent proceedings will be enforced under California law to prohibit collateral estoppel.

Of perhaps particular interest to parties drafting arbitration agreements after *Vandenbergs*, and to insurers and policyholders, is the fact that the *Vandenbergs* court rejected issue preclusion in part on the facts of the case because it was inconsistent with the “reasonable expectations of the arbitral parties.” See *Vandenbergs*, 982 P.2d at 241. The reasonable expectations principle is, of course, more commonly regarded as a part of contract and insurance law rather than procedural law. *Vandenbergs* suggests some solicitude for this factor by the California Supreme Court.

On the more specifically insurance related issue before it, the *Vandenbergs* court held that the mere fact that an arbitration award or third-party claim was denominated a breach of contract did not conclusively determine whether CGL coverage was available for the claim. See id. at 244. The court acknowledged that liability insurance exists to cover fortuitous losses and not losses that were under the effective control of the policyholder. See id. Consequently, liability insurance is generally regarded as providing coverage for tort claims but not contract claims. The theory is that a breach of contract is not fortuitous but results from intentional nonperformance by the breaching party. See id. at 244 n.12 (citing cases). Although this is true as a general matter,

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7. Two Justices dissented from the *Vandenbergs* majority on the question of collateral estoppel. These Justices would have given issue preclusion effect to the arbitrator’s finding that the oil waste discharge was gradual and took place over many years. Thus, there are at least two votes on the Court favoring issue preclusion if the party arguing a subsequent case can differentiate its case and arbitration agreement from *Vandenbergs* on the facts.
Coverage under a CGL insurance policy is not based upon the fortuity of the form of action chosen by the injured party. Thus, as the Court of Appeal stated, determination of coverage must be made individually by considering 'the nature of [the] property, the injury, and the risk that caused the injury, in light of the particular provisions of each applicable insurance policy.'

Id. at 243-44 (quoting California Court of Appeal opinion).

The Vandenberg court noted that "the same act may constitute both a breach of contract and a tort. Predicating coverage upon an injured party's choice of remedy or the form of action sought is not the law of this state."

Id. at 245 (citations omitted). "[T]he legal theory asserted by the claimant is immaterial to the determination of whether the risk is covered." Id. (quoting 9 COUCH, COUCH ON INSURANCE §126:3, 126-28 (3d ed. 1997)). Vandenberg also found support for its analysis in two frequently cited insurance industry authorities: DONALD S. MALECKI & ARTHUR L. FLITNER, COMMERCIAL GENERAL LIABILITY 6 (6th ed. 1997) and George Tinker, Comprehensive General Liability Insurance — Perspective and Overview, 25 FED. INS. COUNSEL. Q. 217, 265 (1975). See Vandenberg, 982 P.2d at 246.

Although the Vandenberg court's decision on the "breach of lease" issue was a victory for the policyholder in that particular case, it is not clear that its holding will always benefit policyholders. If, as Vandenberg declared, the key to coverage is the essential nature of the claim rather than the third-party's framing of the claim, this principle is something of a two-way street. On the one hand, it may permit a policyholder like Vandenberg to recover if it is sued for despoiling land or other tort-like damage under the rubric of breaching a lease. On the other hand, it may permit an insurer to deny coverage where the claim is framed as a tort action but the underlying offense can be shown not to be fortuitous within the meaning of CGL.

Thus, on questions of indemnity, Vandenberg may be a precedent cited equally by both insurers and policyholders in the future. Vandenberg may also impact determinations of the duty to defend. Most likely, however, Vandenberg will not adversely affect policyholders on these questions because duty to defend jurisprudence focuses primarily (almost exclusively in many states) on the language of a third-party complaint.
against the policyholder. Where the language of the complaint makes out a covered claim, the insurer must defend even if the claims are outlandish and defy common sense. Presumably, Vandenberg does nothing to change this aspect of duty to defend law in California. Where the third party pleads a claim as something covered (e.g., a tort) rather than as something uncovered (e.g., a breach of contract), the CGL carrier must defend until it can establish as a matter of fact that the claim falls outside coverage. In Vandenberg itself, USF&G defended the matter for some time and undoubtedly at considerable expense until it challenged indemnity coverage after the arbitration was concluded. After a matter has been defended, Vandenberg can in theory be used to oppose providing indemnity for a judgment against the policyholder that is labeled one of tort if the facts of the case establish that the matter giving rise to liability was not fortuitous or otherwise covered.

DENIAL OF AIDS COVERAGE IN HEALTH POLICY DOES NOT VIOLATE AGE DISCRIMINATION ACT; McCARRAN-FERGUSON ACT FURTHER PRECLUDES POLICYHOLDER’S CLAIM

Doe v. Mutual of Omaha, 179 F.3d 557 (7th Cir. 1999), reh’g denied, No. 98-4112, 1999 U.S. App. LEXIS 18360 (7th Cir. Aug. 3, 1999).

The AIDS crisis that emerged in the 1980’s prompted many insurers to consider AIDS risk in underwriting and to refuse coverage for AIDS-related disease in health and disability policies. The Americans with Disabilities Act (“ADA”), 42 U.S.C. §§12182(a) – 12213, was passed in 1990 to address the problem of disability discrimination. Since passage of the ADA, there has been debate over whether the statute requires health insurance coverage of AIDS or AIDS-related illnesses, with courts divided on the issue. The Court of Appeals for the Seventh Circuit (covering the

8. At one time, the CGL language on this point was more explicit, stating that the policy would defend the policyholder against even claims that were “groundless, false, or fraudulent.” See, e.g., St. Paul Cos. v. Talladega Nursing Home, Inc., 606 F.2d 631, 633 (5th Cir. 1979) (applying Alabama law; reviewing this type of clause).
states of Illinois, Indiana, and Wisconsin) recently found that the ADA did not bar such insurance restrictions.

Plaintiffs Doe and Smith (pseudonyms to protect their privacy) purchased individual health insurance policies from Mutual of Omaha. See Doe, 179 F.3d at 558. The policies placed significant limits on the amount of benefits available to individuals suffering from AIDS or AIDS-related conditions ("ARC") by capping the amount of coverage available at a $25,000 lifetime maximum for Smith and a $100,000 lifetime maximum for Doe. See id. The policies' overall limit was $1 million. See id. Plaintiffs contended this was disability discrimination in violation of the ADA. See id. The federal trial court in Chicago agreed and found this to be a violation of the ADA. See id. at 557. On appeal, the appellate court rejected the contention and found no ADA violation in the insurer's establishment of disease-specific limits on coverage. See id. at 565.

Mutual of Omaha sold health insurance policies to the applicants that provided for up to $1 million in coverage for health problems other than AIDS or ARC, which had a lifetime benefit limit of $25,000 and $100,000, respectively. See id. at 558. The insurer stipulated that AIDS was a disability covered under the ADA and that it cannot show that its AIDS caps were "consistent with sound actuarial principles, actual or reasonably anticipated experience, bona fide risk classification, or state law." Id. Mutual of Omaha defended solely on the basis of its argument that the ADA does not regulate the substantive coverage of insurance policies. See id.

The ADA states that "no individual shall be discriminated against on the basis of disability in the full and equal enjoyment of the goods, services, facilities, privileges, advantages, or accommodations of any place of public accommodation" by the owner of the operation. See 42 U.S.C. §12182(a). The sale of an insurance policy can be said to be the sale of a good or service. However, the Seventh Circuit panel, in an opinion by Chief Judge Richard Posner (joined by fellow University of Chicago law professor Frank Easterbrook), found that the ADA language at issue had a "core meaning" of prohibiting a business from refusing to deal with the disabled. See 179 F.3d at 559. According to the panel majority, the ADA does not prevent the business from differentiating its products in a way that may impact upon the disabled:

[A] dentist cannot refuse to fill a cavity of a person with AIDS unless he demonstrates a direct threat to safety or health, and an insurance company cannot (at least without pleading a special defense [discussed later in the
opinion]) refuse to sell an insurance policy to a person with AIDS. Mutual of Omaha does not refuse to sell insurance policies to such persons — it was happy to sell health insurance policies to the two plaintiffs. But because of the AIDS caps, the policies have less value to persons with AIDS than they would have to persons with other, equally expensive diseases or disabilities. This does not make the offer to sell illusory, for people with AIDS have medical needs unrelated to AIDS, and the policies give such people as much coverage for those needs as the policies give people who don’t have AIDS.

Id. at 559 (citations omitted). Continued the court:

The common sense of the [ADA] statute is that the content of the goods or services offered by a place of public accommodation is not regulated. A camera store may not refuse to sell cameras to a disabled person, but it is not required to stock cameras specially designed for such persons. Had Congress proposed to impose so enormous a burden on the retail sector of the economy and so vast a supervisory responsibility on the federal courts, we think it would have made its intention clearer and would at least have imposed some standards. It is hardly a feasible judicial function to decide . . . how many Braille books the Borders or Barnes and Noble bookstore chains should stock in each of their stores.

Id. at 560.

The Doe majority also concluded that prohibiting AIDS caps for insurers willing to write health policies would make little sense when insurers retained the right to refuse to cover any pre-existing conditions related to AIDS or HIV-positive status, where “the insurer can in effect cap his AIDS-related coverage at $0.” Id. at 559. Consequently, the court did not find it counter to the ADA for the insurer to attach some limits on AIDS-related coverage since the insurer has substantial power to refuse to insure HIV-positive applicants altogether. See id. In making this argument, however, the majority overlooked an important distinction: a refusal to cover preexisting conditions does not preclude coverage for that condition per se — even expensive coverage — should the condition develop after the policy is in effect. Thus, the majority’s decision permits insurers to not only refuse to write coverage for persons that already have AIDS but also allows health insurers to limit or exclude coverage should the HIV-
free policyholder develop AIDS complications at some later date. As a practical matter, the distinction may mean a large difference in the number of ultimately covered persons and benefit dollars ultimately provided. Of course, one can find the preexisting condition point of the court’s opinion unconvincing but still agree with the *Doe* decision as a whole.

The panel majority further found that an insurer’s attempt to limit its AIDS exposure would be useless unless the limitation extended to the types of opportunistic diseases most associated with the onset of AIDS. See *id.* at 561. According to the court:

A refusal to sell insurance to a blind person is not the same thing as a provision in the policy that if the insured becomes blind, the insurer will not pay the expense of his learning Braille. We find nothing in the language or history of the statute to suggest that the latter refusal would be unlawful.

*Id.* at 562. Continued the court:

There is, as we have pointed out, a difference between refusing to sell a health-insurance policy at all to a person with AIDS, or charging him a higher price for such a policy, or attaching a condition obviously designed to deter people with AIDS from buying the policy (such as refusing to cover such a person for a broken leg), on the one hand, and on the other, offering insurance policies that contain caps for various diseases some of which may also be disabilities within the meaning of the Americans with Disabilities Act.

*Id.* at 563.

The *Doe* majority buttressed its holding by noting that other appellate cases had given similar construction to the ADA, even though several district court cases, including the trial court in *Doe*, had found disparate AIDS caps to violate the ADA. See *id.*; see, e.g., *Ford v. Schering-Plough Corp.*, 145 F.3d 601, 612-14 (3d Cir. 1998); *Parker v. Met. Life Ins. Co.*, 121 F.3d 1006, 1010-14 (6th Cir. 1997) (en banc); *Vaughn v. Sullivan*, 83 F.3d 907, 912-13 (7th Cir. 1996). These cases essentially state that disparate benefit structures do not violate the ADA merely because they fall more adversely upon disabled persons so long as the disparate benefit schedule is not directed at disabilities per se.

In addition to its holding regarding the ADA, the *Doe* majority observed that even if its construction of the ADA “is wrong, the [*Doe*] suit
must fail anyway, because it is barred by the McCarran-Ferguson Act.”
Doe, 179 F.3d at 563. According to the court:
That Act, so far as bears on this case, forbids construing a federal statute to ‘impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . unless such Act specifically relates to the business of insurance.’ . . . Direct conflict with state law is not required to trigger this prohibition; it is enough if the interpretation would ‘interfere with a State’s administrative regime.’ The interpretation of section 302(a) of the Americans with Disabilities Act for which the Plaintiffs contend would do this. State regulation of insurance is comprehensive and includes rate and coverage issues, so if federal courts are now to determine whether caps on disabling conditions (by no means limited to AIDS) are actuarially sound and consistent with principles of state law they will be stepping on the toes of state insurance commissioners.
Id. at 563-64 (citations omitted). Continued the court:
[R]equiring a federal court to decide whether an insurance policy is consistent with state law – obviously would interfere with the administration of the state law.
The states are not indifferent to who enforces their laws.
Id. at 564 (citations omitted).
In dissent, Judge Terence Evans noted the breadth of the ADA’s prohibition of discrimination and disagreed that enforcing a broad ADA prohibition would either involve courts in micromanaging the economy or run afoul of the McCarran-Ferguson Act. See id. at 565 (Evans, J., dissenting). Judge Evans viewed the ADA as like other civil rights laws that are enforced to vindicate the rights of the protected class rather than to meddle in markets or state regulatory systems. “[W]e are not being asked to regulate [insurance policy] content; we are being asked to decide whether an insurer can discriminate against people with AIDS, refusing to pay for them the same expenses it would pay if they did not have AIDS. The ADA assigns to courts the task of passing judgment on such conduct.”
Id.
Judge Evans also took issue with Judge Posner’s analogies of a business’s outright refusal to deal with disabled customers:
While I agree that the ADA would not require a store owner to alter its inventory, I think the analogy misses the mark. The better analogy would be that of a store which lets disabled customers in the door, but then refuses to sell them anything but inferior cameras.

* * *

[The ADA’s] ‘safe harbor’ [allowing insurers to make distinctions for reasons of actuarial soundness] would allow Mutual of Omaha to treat insureds with AIDS differently than those without AIDS if the discrimination were consistent with Illinois law or could be justified by actuarial principles or claims experience. But Mutual of Omaha conceded that its AIDS and ARC caps do not fall under the ADA’s safe harbor protection.

The parties stipulated that the very same affliction (e.g., pneumonia) may be both AIDS-related and not AIDS-related and that, in such cases, coverage depends solely on whether the patient has AIDS. In my view that is more than enough to trigger an ADA violation.

_Id._

Judge Evans further attacked the majority result as creating a situation where reasonable policyholders would have great difficulty determining the confines of coverage due to the vagueness of the term “AIDS-related condition.” _See id._

The policies don’t even hint at what illnesses or afflictions might fall within the ARC exclusion. Nor has the medical community embraced an accepted definition for what “conditions” are “AIDS-related.” The practical effect of all this, as Mutual of Omaha concedes, is that coverage for certain expenses would be approved or denied based solely on whether the insured had AIDS. _See id._

On the McCarran-Ferguson Act issue, Judge Evans further disagreed with the majority because Mutual of Omaha’s stipulations had removed the issue of possible actuarial justification from the case. _See id._ at 566. Consequently, reasoned Judge Evans, enforcement of the ADA to strike down the caps at issue in the two policies before the court would not impermissibly alter or interfere with state regulation. _See id._ But Judge Evans on this point seems to overlook the need for an appellate ruling to provide a consistent set for rules to govern a large number and wide array
of current and future cases. Although Mutual of Omaha’s willingness to stipulate on the actuarial issues may have removed those issues from that case, the potential conflict between underwriting practice and the ADA is one that the federal courts would need to address in any event.

Both the majority and dissenting opinions set forth thoughtful and strong arguments. Not surprisingly, the unsuccessful plaintiff policyholders petitioned for rehearing before the entire Seventh Circuit. It is perhaps similarly unsurprising that the full circuit court of twelve judges split seven to five on the issue of whether to grant a rehearing of the Doe case before the full court. Predictably, dissenting Judge Evans wanted rehearing. See id. at 557. He was joined by Judges Joel Flaum, Kenneth Ripple, Illana Diamond Rovner, and Diane Wood. See id. Supporting Judges Posner and Easterbrook in opposition to rehearing were Judges William Bauer, Richard Cudahy, John Coffey, Daniel Manion, and Michael Kanne. See id.

Although the bulk of other cases on the issue, particularly appellate opinions, accord with the Doe majority rather than with the dissent, there is sharp division on the issue among federal judges. For example, the Seventh Circuit was closely divided on the issue. Although generally, the more “conservative” members of the court supported the Doe majority while the more “liberal” members of the court voted to grant rehearing, the split is not uniformly ideological, either in the Seventh Circuit or other courts. Presumably, the United States Supreme Court will be compelled to hear and decide a case such as Doe in order to finally resolve the tension between the ADA and disability-restricted health coverage. To date, however, the Supreme Court has avoided the issue, denying certiorari in cases that have presented the opportunity to rule on the issue.

**VIRGINIA SUPREME COURT OVERTURNS $100 MILLION PUNITIVE DAMAGES VERDICT IN DISCRIMINATION CASE ON GROUND HOUSING RIGHTS ORGANIZATION LACKED STANDING TO BRING SUIT**


The Virginia Supreme Court tossed out a punitive damages verdict that had startled the insurance industry – but did so based on the technicalities
of standing doctrine rather than on the merits of the suit, which alleged discrimination in the availability of homeowners insurance.

Housing Opportunities Made Equal, Inc. ("HOME"), a fair housing organization, sued Nationwide Mutual Insurance Company and Nationwide Mutual Fire Insurance Company for alleged discriminatory practices in the marketing and sales of homeowners insurance to blacks in the Richmond area. See 523 S.E.2d at 219. HOME’s case asserted that Nationwide had adopted an intentional strategy of avoiding black neighborhoods and black customers. See id. At trial, HOME presented evidence of a marketing and advertising policy that could be construed as avoidance of sales to black customers and also produced evidence of bias in Nationwide’s underwriting, pricing, location of agents, hiring policies, and training policies. See id. at 220. HOME also used “testers” — agents for HOME who shopped for insurance and encountered barriers from Nationwide’s agents. See id. at 221. HOME argued that this quilt of conduct demonstrated race bias by Nationwide. See id. at 219. A jury apparently agreed, awarding $500,000 in compensatory damages and $100 million in punitive damages to HOME. See id.

HOME made claims under both Virginia common law and the state Fair Housing Law. See id. After the verdict, Nationwide appealed, arguing that HOME did not have standing to bring a lawsuit since HOME itself was not a policyholder or actual applicant for insurance. See id. at 222. The Virginia Supreme Court agreed and reversed the decision in its entirety, eradicating the verdict against Nationwide. See id. at 226.

Standing doctrine requires that a claimant have a tangible stake in the controversy so that there will be sufficient concrete adversity to facilitate adjudication. The standing doctrine is designed to avoid putting courts in the position of rendering advisory opinions and to limit the possibility of manufactured litigation.

Standing doctrine is most developed in the federal courts because Article III of the Constitution requires that the judicial power of the United States be limited to “cases” or “controversies.” See U.S. CONST. Art. III, § 2, cl. 1. Federal courts are generally considered to be stricter about standing requirements than most state courts. Some states, most notably Massachusetts, expressly permit courts to issue advisory opinions prior to a controversy actually materializing.

In both federal and state court, much of the standing litigation involves claims against the government, where separation of powers concerns generally prompt courts toward a stricter view of standing so that the judiciary will not be required to pass on executive or legislative branch
conduct unless the case genuinely demands it and is not merely a vehicle for airing political grievances.

Virginia's common law standing doctrine is, however, "more restrictive than its federal counterpart." See 523 S.E.2d at 224 (citing Nicholas v. Lawrence, 171 S.E. 673 (Va. 1933) (to have standing, litigant "must show that he has an immediate, pecuniary and substantial interest in the litigation, and not a remote or indirect interest."). More recently, the Virginia high court stated that a litigant must have a "direct interest" in the matter at issue and that

it is not sufficient that the sole interest of the petitioner is to advance some perceived public right or to redress some anticipated public injury . . . . The word ‘aggrieved’ in a statute contemplates a substantial grievance and means a denial of some personal or property right . . . or imposition of a burden or obligation upon the petitioner different from that suffered by the public generally.

Virginia Beach Beautification Comm'n v. Board of Zoning Appeals, 344 S.E.2d 899, 902-03 (Va. 1986).

In addition, the HOME court noted that "Virginia is not a class-action state" and does not consider an entity to have standing to sue in a representative capacity by asserting the rights of another, unless so authorized by statute. See HOME, 523 S.E.2d at 225.

In light of these precedents, it is probably not surprising that the court found HOME not to have common law standing to pursue its claims as an entity on behalf of black residents of the Richmond area who alleged wrongful impediments to obtaining insurance. However, the Fair Housing Law provides that an "aggrieved person" may bring an action against discriminatory housing practices where the person claims she has been injured or will be injured by the discriminatory practices.

HOME argued for standing because the alleged discrimination had resulted in "frustration of its mission, the diversion of its resources, and the discrimination practiced against its 'tester/agents.'" Id. at 224. The majority found these bases for standing to be insufficiently substantial, personal, and concrete. See id. For example, the majority found HOME's assertion of damage to its cause of nondiscrimination in housing to be too indirect and attenuated and that HOME had not suffered any injury not suffered by the public in general. See id. at 225. The court also found no standing claim could be founded on discrimination toward testers. See id.
at 226. The court reasoned that the testers suffered no real loss since they were not genuinely shopping for homeowner’s insurance. See id.

The majority used state common law to determine who was an “aggrieved person” under the statute. See id. at 224. Three dissenting justices argued that the statute evidenced legislative intent to provide standing on a less restrictive basis than does state common law. According to the dissent, the “statutory standard is less restrictive than the common law and, therefore, the common law cannot be used to provide a definition for the term ‘injured’ because the Virginia Fair Housing Law expressly expands the scope of persons who can incur a legally cognizable injury.” Id. at 234.

The dissenters also viewed the majority opinion as gutting the state’s fair housing statute, stating:

Significantly, and most disturbing, the majority is unable to explain how a housing organization could ever have standing to pursue a claim under the Virginia Fair Housing Law.

The effect of the majority’s construction of the word ‘injured’ is to render meaningless the General Assembly’s 1991 amendment of the Virginia Fair Housing Law to include housing organizations within the definition of ‘person’. . . . The majority has effectively repealed those portions of the Virginia Fair Housing Law which relate to fair housing organizations such as HOME.

Id. at 233-34. The dissent was additionally troubled that the majority had so sweepingly vaporized the lower court decision and granted no deference to the trial court’s determination that HOME had standing to bring the claim, even though issues of injury would appear to be at least somewhat fact-sensitive. See id.

The court subsequently withdrew its decision, finding no standing and granted rehearing, which may indicate that the Court has experienced a change of perspective and that it will ultimately reach the merits of the claim. Irrespective of which side is correct regarding the intricacies of standing doctrine under Virginia law, the initial HOME decision is of significant practical importance, particularly if the court continues to deny standing. Most immediately, it saves a prominent insurer from a large judgment and probably produced a collective sigh of relief across the industry. However, the insurance company won this round on the basis of
what laypersons would call a "technicality" or "loophole." There remains the stark fact that a jury believed Nationwide had discriminated and deserved to be punished with a nine-figure punitive damages judgment. Because of the standing basis for the Supreme Court's decision, it did not disturb the fact findings or other legal conclusions of the court below. In states with less restrictive standing law than Virginia, civil rights groups may be encouraged to continue litigation against perceived discriminatory practices. In its next opinion in *HOME*, the Virginia high court may well address the subsequent issues of discrimination.

PREPONDERANCE OF THE EVIDENCE STANDARD – RATHER THAN CLEAR AND CONVINCING EVIDENCE STANDARD – GOVERNS ISSUE OF BAD FAITH UNDER STATE STATUTE DESIGNED TO ENCOURAGE INSURERS TO ACT REASONABLY OVER SMALL CLAIMS


Nationwide Insurance did not win everything it sought from the Virginia Supreme Court thus far this year. In a decision rendered the same day as *HOME*, discussed above, the court affirmed a finding of bad faith against Nationwide in a small claims matter.

Twelve-year-old Joel St. John was injured in an auto accident. *See* 259 Va. at 73. An examination by a chiropractor revealed significant injuries that were treated by the chiropractor over several weeks, resulting in a medical claim of $1,960 under the family's auto policy with Nationwide. *See id.* at 74. The insurer referred the claim to another chiropractor for review. *See id.* Based on the review, Nationwide agreed to pay only $378.50 of Joel's medical expenses. *See id.* The St. John family sued for benefits and invoked a state law providing that in claims of $2,500 or less, the policyholder may obtain double damages and counsel fees if the "denial, refusal or failure to pay was not made in good faith." *Id.* at 75, n. 1 (*citing* VA. INS. CODE §8.01-66.1(A)).

Nationwide appealed the trial court's decision, awarding Joel the full amount of his chiropractic bill, doubling the amount, and allowing recovery of fees. Although both sides agreed that the standard for determining bad faith was whether the refusal to pay was reasonable, the parties disagreed as to the quantum of proof required to prove reasonableness. Nationwide argued that a finding of bad faith should be
made by clear and convincing evidence before statutory penalties apply. The court disagreed, holding that proof of bad faith (i.e., lack of a reasonable basis for denying the claim or questioning the amount) was sufficient when made by a preponderance of the evidence.

Although the Virginia standard for common law bad faith claims is "clear and convincing evidence," the court found this case to be governed by a lower evidentiary threshold of "preponderance of the evidence" because of its statutory source. See St. John, 259 Va. at 76. The purpose of the statute and the intent of the legislature was to make it possible for policyholders to vindicate small claims by making it less onerous to pursue litigation and to remove the insurer's incentive to merely delay payment and force the policyholder to trial. See id. at 75. The higher evidentiary burden was viewed as inconsistent with this purpose and held not to govern this class of small, statutory bad faith claims. See id. at 76.

On the facts of the case, the trial court and supreme court ruled against Nationwide because the basis of its denial was uncertainty over whether all of Joel's medical expenses were caused by the auto accident. See id. at 77. Prior to trial, however, "Nationwide had no medical evidence that the injuries were not caused by the May 14, 1994 accident . . . . Nevertheless, Nationwide refused to pay the remaining balance of Joel's medical bills and thus forced the matter to proceed to a trial." Id. at 78.

In dissent, Justice Compton argued that the common law clear and convincing evidentiary standard for bad faith should govern because the common law and the statute are designed for the same purpose of encouraging good faith contract performance. See id. at 80. He stated that "it makes no sense in this insurance contract action alleging bad faith to adopt a preponderance of the evidence standard of proof. Bad faith means the same in any insurance contract context, no matter under what circumstances the lack of good faith is sought to be proved." Id.
INDIANA SUPREME COURT APPROVES INSURER USE OF IN-HOUSE COUNSEL TO DEFEND POLICYHOLDERS FROM THIRD-PARTY CLAIMS BUT FORBIDS CAPTIVE LAW FIRMS FROM PORTRAYING THEMSELVES AS OUTSIDE COUNSEL


In recent years, there has been considerable focus on the legal ethics of representation of policyholders pursuant to liability policies. Recently, the Indiana Supreme Court weighed in on aspects of the issue. The court's assessment was largely consistent with decisions in other states. In general, insurers have successfully resisted legal attacks on their use of in-house counsel to represent policyholders against third-party tort claims under standard liability policies.

This case started like most liability claims. David and Marcia Wills asserted tort claims against Elaine Mellenger and Betty Suter. See 717 N.E.2d at 153. Suter was insured by Celina Insurance Group, who appointed in-house counsel Keith Faber to defend Suter in the Wills action. See id. After being apprised of Faber's house counsel status, Suter consented to the representation. See id. The Wills moved to disqualify Faber, asserting that his representation of Suter would be unauthorized practice of law. See id. While the case was pending, Cincinnati Insurance sought to intervene because of the possible impact of the case on Cincinnati's practice of representing policyholders in the area through Berlon & Timmel, which Cincinnati characterized as a "captive law firm." See id. Berlon & Timmel "is staffed exclusively by employees of Cincinnati who represent only Cincinnati's insureds and Cincinnati itself." Id.

The Wills' disqualification motion succeeded before the trial court, which ruled that insurer Celina engaged in unauthorized practice of law by giving its policyholders legal representation through in-house counsel. See id. at 153-54. The trial court further viewed the in-house lawyer as assisting unauthorized practice by the non-law firm insurance company, a violation of Indiana Rule of Professional Conduct 5.5(b). 9 See id. at 154.

The trial court also found Cincinnati’s use of the name Berlon & Timmel to be an unauthorized practice of law and a deceptive practice that would lead policyholders to erroneously think that they were being represented by outside counsel. See id.

The Indiana Supreme Court reversed the trial court on the issue of unauthorized practice, with regard to both Celina’s in-house counsel and Cincinnati’s captive firm, but affirmed the trial court ruling that an insurer’s captive law firm could not do business under a name that suggested that it was an outside law firm apart from the insurer’s organization. See id. at 153.

The Indiana Supreme Court began its analysis with an overview of the types of arguments that have been employed to suggest unauthorized practice by staff counsel and captive firms. See id. at 156. The court also summarized legal developments on the issue to date, specifically noting that eight states and the ABA have, in ethics opinions, concluded that practice through in-house counsel does not in and of itself constitute unauthorized practice. In two states, challenges to policyholder representation have been successful: in Kentucky based on potential conflict of interest between insurer and policyholder; and in North Carolina based on a state statutory bar to practice of law by a corporation.

The court found that Celina’s notice to its policyholder had been sufficient to alert the insured to the situation and was not misleading. See Wills, 717 N.E.2d at 156. In disclosing the in-house status of Attorney Faber, Celina had apparently informed the policyholder that the assigned attorney's primary loyalty was to the policyholder and that confidences between policyholder and attorney could not be shared with the insurer. See id.

As to unauthorized practice, the court found that in-house counsel was generally accepted and that counsel’s legal services for the company were clearly authorized under the Rules of Professional Conduct. See id. at 159.

10. See id. at 155, n.3 (citing to ABA Opinion) and n. 4 (citing to ethics opinions in Alabama, Arizona, Colorado, Illinois, Michigan, New Jersey, New York, Texas and Virginia). The Indiana Supreme Court also noted case law largely favorable to use of in-house counsel. See id. at 155, n. 5.
11. See American Ins. Ass’n v. Kentucky Bar Ass’n, 917 S.W.2d 568 (Ky. 1996).
Although the situation is more complicated when the company lawyer is representing a customer of the company, the court found this to be permissible because the rendering of legal service was done by an attorney who was subject to the control of the policyholder client rather than the nonlawyer company. See id. at 160. For example, the court noted that under agency law principles, "where the law requires a license, agency law doctrine permits an unlicensed legal entity to employ licensed agents to perform those acts requiring a license." Id.

The court further found that there was no inherently problematic conflict between insurer, policyholder, and counsel. See id. The court acknowledged, however, that conflict might well arise in specific cases but found this no reason to issue a blanket prohibition on the use of staff counsel for representation. "If a conflict arises, it will have to be handled, and there are a variety of means to do that... Any abuses can be handled on a case-by-case basis rather than by adoption of the broad prohibition the [third-party claimants] Wills seek." Id. at 161.

The court did not specifically adopt the "two-client" model of the insurer-counsel-policyholder relationship, but suggested as much by referring to the insurer as a "co-client" of counsel. See id. Most states follow the so-called "one-client" model, which provides that the policyholder is the sole client of counsel and that the insurer is a nonclient third-party paying the legal fees. Of course, the insurer is also an entity with a contractual right to control the litigation under the terms of most liability policies that have a "duty to defend" obligation. Consequently, the one-client/two-client debate cannot be viewed in bipolar and stark terms.13

On the matter of the captive law firm, the court concluded:

We agree with the trial court that the use of the name Berlon & Timmel implies independence and that the ordinary person would assume 'Berlon & Timmel' to be some form of outside counsel. As a result, it is 'misleading' as to identity, responsibility, or status of

the attorneys practicing under the name. [However,] the trial court’s finding that Cincinnati should close its Indianapolis office was too broad. It is sufficient that the Indiana attorneys practicing under the name Berlon & Timmel take immediate action to discontinue use of Berlon & Timmel or any other name suggesting a legal entity other than Cincinnati to describe their practice as employees of Cincinnati.

Wills, 717 N.E. 2d at 164-65.

Against the four-judge majority, there was a lone dissent, which focused heavily on concerns about conflict of interest, lawyer independence, and lawyer professionalism under in-house arrangements of the sort at issue.\textsuperscript{14} Although acknowledging that outside counsel are of course subject to economic incentives to do the client’s bidding even when it runs afoul of ethical rules, the dissent found the danger considerably more pronounced when the lawyer was an employee subject to employer control over job security, income, and career advancement. \textit{See id.} at 183.

The dissent also found the situation to constitute unauthorized practice since the insurer was providing legal services to an entity other than the insurance company itself.\textsuperscript{15}

\begin{itemize}
\item \textsuperscript{14} Quoting Dean Kronman, the dissent observed:
  
  \textit{Id.} at 183 (quoting ANTHONY T. KRONMAN, THE LOST LAWYER: FAILING IDEALS OF THE LEGAL PROFESSION 379 (1993)). Justice Dickson continued: “Not only do non-lawyers own interests in insurance companies, but also, once house counsel are allowed to represent insureds, non-lawyers, particularly corporate directors and officers, inevitably may control and decide matters related to the legal practice of the salaried attorneys. \textit{Id.} at 183 (Dickson, J., dissenting).

\item \textsuperscript{15} \textit{See id.} at 178 (citing GEOFFREY C. HAZARD, JR. & SUSAN P. KONIAR, THE LAW AND ETHICS OF LAWYERING 903 (1990) (“The corporation is engaged in unauthorized practice if its lawyers provide legal assistance to others, such as the corporation’s customers. However, the corporation can provide legal assistance to itself without thereby engaging in practice of law”)).
\end{itemize}
NEW YORK COURT OF APPEALS PERMITS POLICYHOLDERS OF "VANISHING PREMIUM" LIFE INSURANCE TO PLEAD CAUSE OF ACTION FOR DECEPTIVE PRACTICES PURSUANT TO STATUTE BUT REJECTS COMMON LAW FRAUD CLAIM


A current litigation issue involves a life insurance product that was popular during the 1980’s – “vanishing premium” life insurance. These products were a form of “universal” life insurance, a life insurance policy in which premiums were designed to exceed the amount strictly required to pay for the death benefit purchased by the policyholder. The additional premium dollars were to be invested by the insurer, with return on investment reinvested to pay future premiums. The idea was that after a few years of paying premiums, the return on investment would equal the present value of required future premiums so that no further premium payments would be required to maintain the policy. Universal life is described as a “cash value” insurance policy that combines “pure” life insurance (where the premium charged matches the mortality risk in light of the death benefit) and an investment component that seeks to accumulate the funds to pay future premiums.16

In traditional cash value policies, any return on premium in excess of that required to immediately pay for coverage is returned to the

16. Universal life is thus distinguished from traditional “whole” life, in which the policyholder pays a level premium throughout the time of the policy. During the early years of the policy when the mortality risk is lower (because the policyholder is younger and less likely to die), the premium is higher than required to pay for a given policy year’s death benefit. During the later years of the policy (when the policyholder is older and more likely to die, ultimately certain to die), the premium is lower than would otherwise be required for a given policy year’s detriment. In effect, higher than required premiums during the early years of the policy subsidize lower than required premiums during the later years of the policy. See 1999 N.Y. LEXIS 3932 at *9-*12. Whole life is traditionally contrasted with term insurance, in which the premium charged is linked to the death benefit offered and mortality risk entailed during the immediate policy period. See generally Jay M. Zitter, Annotation, Divorce and Separation: Method of Valuation of Life Insurance Policies In Connection With Trial Court’s Division of Property, 54 A.L.R.4th 1203 (2000).
policyholder in the form of dividends or interest. Early cash value policies featured conservative investments by insurers. High interest rates during the 1980’s made these unattractive products due to low return. In response, insurers began offering universal life policies in which the policyholder’s accumulated money is tied to the current rate of interest. According to the Gaidon court:

Carriers marketed interest rate-sensitive insurance under a host of premium payment options, including the ‘vanishing premium’ plan. Under this plan, the policyholder pays higher than normal premiums in the early years of the policy, resulting in a quicker accumulation of premium dollars for investment purposes. These policies are marketed on the premise that enough cash value will accumulate so that at a fixed date future administrative and insurance costs will be covered and the policyholder relieved of any further out-of-pocket premium obligations.

In the late 1980s, however, sharply declining interest rates ‘upset the economics’ of these widely marketed policies. Accumulated cash values became insufficient to pay expected future insurance and administrative costs. By the early 1990’s, many consumers who purchased such policies were required to continue out-of-pocket payment to keep their policies in force. And the lawsuits followed.

1999 N.Y. LEXIS 3932 at *11-*12 (citations omitted).17

17. In an interesting irony of the case, the Court of Appeals frequently cited Daniel R. Fischel & Robert S. Stillman, The Law and Economics of Vanishing Premium Life Insurance, 22 Del. J. Corp. L. 1 (1997) as authority concerning the nature of insurance and the background of the controversy. Fischel, a University of Chicago law professor and law/economics expert witness, had successfully sued Gaidon attorney Melyvn Weiss’s prominent law firm, alleging that firm attempted to defame him in retaliation for past opposition in litigation. The suit was ultimately settled. The Fischel & Stillman article is sympathetic to the insurance industry regarding the vanishing premium litigation explosion (e.g., “Declining interest rates, not deceptive sales practices, are responsible for the failure of vanishing premium life insurance policies to perform as well as initially hoped.” Id. at 32). It was undoubtedly brought to the court’s attention by insurers. But the court majority citing the article approved continued prosecution of a significant part of the Gaidon claim.
Specifically, class representative plaintiff Gaidon and others bought insurance from Guardian Life in the 1980's, allegedly on the strength of what proved to be false representations that they would absolutely be relieved of premiums after a few years. See id. at *4. The plaintiffs also alleged that Guardian artificially inflated its current dividend rates "despite waning profits [on the invested premium] because it wanted to continue depicting competitive vanishing rates." Id. However, on a separate page, accompanying insurer illustrations of various payment and investment return options, Guardian disclaimed:

Figures depending on dividends are neither estimated nor guaranteed, but are based on the current year's dividend scale.

The current year's dividend scale reflects current company claims, expense and investment experience and taxes under current laws. Actual future dividends may be higher or lower than those illustrated depending on the company's actual future experience. Id. at *4-*5. In addition, the policies when delivered contained a statement saying that divisible surplus would be determined on an annual basis and that dividends would "reflect Guardian's mortality, expense, and investment experience." Id. at *5.

By the 1990s, it was clear that declining interest rates made it impossible for the life premiums to vanish too quickly. In 1995, Guardian informed plaintiffs that premiums would not vanish at all and would need to be continually paid for the foreseeable future to keep policies in force. In 1996, plaintiffs sued insurers Guardian. In a separate suit, another class of policyholders sued Mutual of New York (MONY) over similar vanishing premium policies. Plaintiffs asserted several causes of action, including breach of contract, negligence, and unjust enrichment. The two causes of action reviewed by the New York Court of Appeals in Gaidon were (1) violation of New York’s General Business Law §349 and (2) common law fraud. Defendants moved to dismiss these causes of action for failure to state a claim. See id. at *15. The court granted the defense

18. The action was commenced as a class action, but at the time of the Gaidon decision by the New York Court of Appeals, there had not been a determination as to whether the proffered class would be certified and whether the matter would be permitted to proceed on a class action basis.
motion as to fraud, but permitted the actions to continue under the statute. See id. at *27-*28.

Under New York General Business Law §349, a defendant is liable if it has engaged "in an act or practice that is deceptive or misleading in a material way" that causes resulting injury to the plaintiff. See id. at *14 (citing N.Y. C.L.S. GEN. BUS. §349 (1999)). According to the court:

Plaintiffs have alleged, in essence, that defendants lured them into purchasing policies by using illustrations that created unrealistic expectations as to the prospects of premium disappearance upon a strategically chosen 'vanishing date.' This vanishing date, plaintiffs allege, was misleading, as based on the premise that interest rates would continue at a high, unprecedented rate for, in some cases, twenty or more years – a premise that defendants allegedly knew to be unlikely.

Id. at *14-*15.

On this issue, plaintiffs were assisted by the New York Attorney General, who filed an amicus brief against dismissal of the Section 349 claims. See id. at *15. Under the rules of procedure, a motion to dismiss – which was filed in the claim against Guardian – accepts as true the allegations of the complaint, at least for purposes of deciding the motion. Thus, if the defendants' motions were granted, the court would have been in effect holding that even where significant deception took place, the state statute attacking deceptive practices was inapplicable. The Attorney General took the position "that a matter-of-law finding that the practices [allegedly committed by the insurers] were not deceptive or misleading would undermine the State's power to redress consumer practices that do not rise to the level of common law fraud." Id.

The MONY action involved a summary judgment motion. Summary judgment is similar to a motion to dismiss in that the court does not resolve legitimately contested questions of fact and renders a decision as a matter of law. However, in the case of summary judgment, considerable discovery may be conducted and there is often a large factual record. Further, the court may determine that some facts are clearly established by the record and not subject to reasonable dispute. The court was obviously disturbed by aspects of the MONY record that tended to suggest plaintiffs' allegations had factual support:

The record contains a sales training videotape that is revealing. It instructs agents how to 'cause the vanish to occur whenever your client wants to see it.' Also,
vanishing premium policies were marketed with slogans such as 'Pay one and done,' '4 Pay/No Pay,' 'Pay One Vanish,' 'Accelerated Vanish,' and 'How to get lifetime insurance protection with payments that are . . . GOING, GOING, GONE.'

*Id.* at *18*. The court also noted that other courts had "sustained deceptive trade practices causes of action under statutes similar to New York's."19

However, the court was persuaded by the defense argument that plaintiffs had failed to plead a claim for which relief could be granted on grounds of common law fraud, although a number of court decisions have sustained such actions.20 The court found that

plaintiffs have not met the threshold elements to support a fraud claim - 'misrepresentation or material omission.' The elements of fraud are narrowly defined, requiring proof by clear and convincing evidence. Not every misrepresentation or omission rises to the level of fraud. An omission or misrepresentation may be so trifling as to be legally inconsequential or so egregious as to be fraudulent, or even criminal. Or it may fall somewhere in between, as it does here.

*Id.* at *26* (citations and footnote omitted).

Judge Bellacosa, in lone dissent, agreed that plaintiffs had not pleaded a common law fraud claim, but further argued that the sales practices in question were at most puffery and aggressive selling that should not be actionable under New York General Business Law Section 349. *See id.* at *44-*45.

The *Gaidon* decision illustrates the sometimes key differences between attempting to prove traditional fraud (which requires a material misrepresentation) and litigating fraudlike claims under deceptive practices statutes, which may permit recovery were the conduct attacked was not an outright lie but may have been deceptive in whole or part.

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20. *See id.* at *25-*26 (citing Greenberg v. Life Ins. Co. of Va., 177 F.3d 507 (6th Cir. 1999); Myers v. Guardian Life Ins. Co. of Am., 5 F. Supp. 2d 423 (N.D. Miss. 1998)).
NEVADA EMPLOYERS ARE NOT IMMUNIZED FROM SUIT FOR INDEMNITY BY POWER COMPANY BUT SCOPE OF POWER COMPANY’S INDEMNITY RIGHTS LIMITED BY COURT’S STATUTORY INTERPRETATION


A Nevada statute provides that a power company subject to a personal injury judgment make seek indemnity from other tortfeasors contributing to the injury. Does the power company’s right of indemnity extend even to indemnity claims against the injured plaintiff’s employer, an entity normally exempt from employee claims under terms of state workers’ compensation law? The Nevada Supreme Court recently answered the question in the affirmative, but refused to permit the power company to sue the employer for indemnity in the particular case in question on the ground that the particular statutory right of indemnity applied only where the incident involved “overhead” power lines rather than the ground-level power lines that were the source of the injury-causing electricity. *See* 989 P.2d at 879-80.

Raymond Haggerty was a maintenance engineer employee of the Horseshoe Club, a casino in downtown Las Vegas. *See id.* at 872. While working, Haggerty entered a room in the basement of the Horseshoe that contained electrical equipment. *See id.* The vault that normally secured high-voltage power lines in the room was unlocked, permitting Haggerty to enter the vault to inspect a vent. *See id.* While in the vault, Haggerty’s shoulder came in contact with high voltage equipment owned by Nevada Power. *See id.* Haggerty suffered substantial injuries. *See id.* Although precluded from suing the Horseshoe, Haggerty sued Nevada Power for alleged negligence. *See id.* at 873. Nevada Power then filed a third-party complaint to seek indemnity from the Horseshoe on the ground that the employer’s negligent maintenance of the area was a substantial factor contributing to the Haggerty injury. *See id.* In particular, Nevada Power alleged that it should have been informed of employee access and the padlock on the vault should not have been removed, allegedly by the employer. *See id.*

Nevada Revised Statutes Sections 455.200 through 455.250 provide that a person working in the vicinity of high voltage overhead power lines must notify the power company before commencing the work. *See id.* Where failure to follow the statute results in injuries and claims against the
power company, the power company may sue for indemnity against the party that failed to notify the utility. See id. at 874. Nevada Power sought to use this statute to force Horseshoe to share in any judgment Haggerty might obtain. See id. In addition, Haggerty had applied for and received workers' compensation benefits from Horseshoe pursuant to the Nevada Industrial Insurance Act (NIIA), the state's workers' compensation law. See id.

Horseshoe argued that the power company's indemnity claim should be barred as a matter of law under NIIA, which (like workers compensation laws generally) provides employer immunity against tort litigation as the quid pro quo for the employer's strict liability for workplace injuries under the workers compensation law (under workers' compensation principles, the fault of both employer and employee is immaterial but the amounts payable to the employee are determined by a schedule of benefits rather than by ad hoc jury awards). See id. The Nevada Supreme Court disagreed with Horseshoe's assertion of immunity, essentially deciding that the indemnity provisions of the overhead power line statute overrode the immunity provisions of the workers' compensation law. See id. at 877. Horseshoe had argued that this was contrary to the legislature's intent in passing these laws. See id. at 874. The court found that "[t]here is no legislative history in Nevada to support either position" and instead decided the case reasoning from the structure and purpose of the statutes in light of precedent from other jurisdictions. See id. at 876. Reviewing analogous precedent from other states, the Nevada Supreme Court noted that a right of indemnity had been held to overcome the workers compensation immunity in Texas, Arizona, Oklahoma, and Georgia. See Haggerty, 989 P.2d at 875-76. The only contrary precedent noted by the Haggerty court was from Colorado. See id. at 876. 

As to structure and purpose, the court reasoned that the employer
retained immunity from litigation by workers and that this would not be
unduly undermined by an indemnity action by the power company. See id.
at 877. In return, subjecting employers to the power line indemnity statute
would encourage employers to comply with the law and to notify the
power company before working around overhead power lines. See id. The
court also followed the general rule of statutory construction that posits
that a specific statutory provision (power company indemnity) should be
given precedence over a general statute (employer immunity from suit
pursuant to the workers compensation system). See id.

The court further noted that the power line indemnity statute was
enacted more recently than the workers compensation law. See id. Under
traditional rules of statutory construction, the more recent statute takes
precedence under the theory that (1) this evidences the most recent will of
the legislature, and (2) that the legislature was constructively aware of the
preexisting workers’ compensation law, but said nothing in the more
recent law to preserve employer immunity in the face of the newly-created
power company right of indemnity. See id. According to the Haggerty
court, permitting the indemnity action was “a more harmonious resolution
of the conflict between the two statutes than gutting the power line statute
in favor of the workers’ compensation laws.” Id.

Nevada Power’s victory on the statutory conflict was quickly erased
by the second half of the Haggerty opinion, which held that the statute did
not apply in the instant litigation because Haggerty was not injured by an
“overhead” power line. See id. at 880. The statute imposes duties of
notice and a right of indemnity only for “overhead” power lines. See id. at
878. The court held that the power lines in the Horseshoe facility that
injured Haggerty were at best on-ground power lines and were arguably
even underground power lines since the accident occurred in the basement
of the casino building. See id.

The relevant Nevada statute defines an overhead line as “a bare or
insulated electrical conductor installed above ground.” NEV. REV. STAT.
455.200(2) (2000). Horseshoe, amicus curiae the Nevada Self-Insurers
Association, had argued that “above ground” means “in the air,” while
Nevada Power argued that “above ground” meant unburied. See id. at
877. The court found either definition to be reasonable, which meant that
the term was ambiguous and must therefore be construed “in line with
what reason and public policy would indicate the legislature intended.” Id.
at 878 (citation omitted). Again reviewing at the language, purpose, and
structure of the power line law, the Haggerty court concluded that the
statute connoted power lines suspended outdoors and above ground. See id. at 879. According to the court, the legislature must have held this conception or the notification requirement would be hopelessly broad, requiring notice whenever anyone was working around any power company lines or transformers:

If the overhead power line statutes were construed to apply in this situation, then each time a Horseshoe employee conducted work in the electrical room of the building, the Horseshoe might be required to contact Nevada Power, whether or not the employee was actually working in the vault where the high voltage power lines are located, because the proximity of the room and the vault could come within the parameters of the statute. Under the statute, Nevada Power could also charge a fee for supervising the work to ensure no one came into contact with the high voltage equipment. Given the number of times this would occur on a weekly basis, it is unlikely that the legislature intended such a result, since the employees could more easily be protected by Nevada Power restricting access to its equipment. Indeed, applying NRS 455.240 to Nevada Power's indoor equipment would be more likely to undermine worker safety, since there would be no incentive for Nevada Power to maintain safety measures to protect people and property from accidental contact where Nevada Power knew such contact was likely to occur. The statutory intent is better served by not imposing the provisions of the overhead power line laws to high voltage electrical equipment located within a building.

Id. at 879.

Two Justices dissented regarding both the issue of statutory conflict and the definition of overhead power lines. See id. at 880. (Agosti, J., with Leavitt, J., dissenting). The dissent argued that although the term "above ground" most logically means "not buried" and that the power lines in the Horseshoe were certainly above the ground upon which Haggerty worked. Further, the dissent argued for a definition of overhead power line that would make the statute more widely applicable in order to promote worker safety. See id. at 880-81. The dissent's approach to statutory interpretation relied upon yet another canon of statutory construction —
“statutes with a protective purpose should be liberally construed in order to effectuate the intended protection.” *Id.* at 881.

The dissent also objected to the majority opinion on a number of jurisprudential grounds. According to the dissent, the issue of the meaning of “overhead” was not raised in the court below but appeared for the first time on appeal, suggesting that a remand was in order to permit the lower court to give initial consideration to this legal issue. *See id.* In addition, the dissent found no support in the record for the majority statement that Nevada Power could routinely charge fees for supervising work near power lines and suggested that the majority had improperly based its decision in part on matters not in the record. *See id.* Most important, the dissent characterized the majority holding that the power line statute overcomes the workers’ compensation law as an unwarranted advisory opinion because the majority had determined that under the facts of the case Haggerty was not injured by an overhead power line. *See id.* at 880. The power line statute was thus inapplicable and there was no need to decide whether it trumped the workers compensation immunity of the employer. *See id.* at 880.

**IN-HOME BABYSITTING FALLS WITHIN “BUSINESS PURSUITS” EXCLUSION IN HOMEOWNER’S POLICY; COVERAGE DENIED FOR SUIT ARISING OUT OF INJURY TO CHILD IN HOME**


Alisa Dwello was a working mother with a seven-year-old daughter. *See 990 P.2d at 191.* She arranged for her neighbor, Patty Kenyon, to care for the girl while Dwello worked. *See id.* Kenyon generally watched the child in her home ten hours per day, five days a week for $50.00. *See id.* The charges were, to say the least, modest, but accounted for forty percent of Kenyon’s monthly income. *See id.* Unfortunately, the arrangement took a tragic turn when Kenyon’s dog attacked the child, severely injuring her face, head, and eye. *See id.*

Dwello sued Kenyon for negligence in failing to adequately protect the girl and failing to warn of the dog’s dangerous propensities (it had apparently bitten others before). *See id.* The Kenyons tendered the complaint to their homeowner’s insurer, American Reliance. *See id.* The insurer refused to defend and commenced a declaratory judgment action.
against the Kenyons, claiming the matter fell outside of coverage because the injury arose out of business activity by the Kenyons, which was specifically excluded from the standard homeowners' policy. See id. When the Kenyons filed for bankruptcy, Dwello was permitted to intervene against American Reliance in the declaratory judgment action. See id.

After a one-day bench trial, the trial court found for the insurer, a decision which the Nevada Supreme Court unanimously affirmed. See id. The exclusion in the policy provided that the liability coverage did not extend to bodily injury or property damage “[a]rising out of your business pursuits. This also includes your occasional or part-time business pursuits.” Id.

The Nevada Supreme Court found this language undeniably clear in limiting coverage. See id. at 192. The Kenyons had argued that they would have watched the child for free if necessary because of the neighbor relationship, and that the exclusion did not apply because Kenyon was not generally operating a child care business (she was not licensed and did not advertise), but watched only the one child as an accommodation to Dwello. See id. Notwithstanding the cut-rate charges, the court rejected the Kenyon position on the ground that the childcare in question was provided for a fee and was substantial and ongoing. See id.

According to the court, the business pursuits exclusion in the policy “is clear and unambiguous.” Id. Notwithstanding this pronouncement, the Nevada Supreme Court suggested that it would not read the business pursuits exclusion to exempt from coverage all claims arising out of babysitting. See id. Noting that other state courts were divided on whether in-home babysitting fell within the business exclusion, Dwello expressly adopted the approach of the New Jersey courts in Carroll v. Boyce, 640 A.2d 298 (N.J. App. Div. 1994) and used a two factor test which asks: (1) whether the business pursuit “involves a continuity or customary engagement in the activity” and (2) “whether the activity involves a profit motive.” Id. Under the facts of the Dwello case, these conditions of continuity and profit made the exclusion applicable.

On one hand, Dwello may be part of what seems to be an increasing tendency of courts to apply the business pursuits exclusion to in-home babysitting. On the other hand, the court’s adoption of a fact-based inquiry into continuity and profit makes these cases resistant to summary judgment, which is not helpful to insurers. Although the trial below was only one day, it was nonetheless a trial. Further, cases like Dwello and Carroll, to some extent, beg the question of what courts will do when
confronted with cases that arise from a teenager’s episodic babysitting of neighborhood children. Will a court consider this continuity if there is repeat babysitting but it is not substantial or regularized? Will a court consider it a “profit motive” if the teenager charges, but the parents view the activity primarily as a service for neighbors or a means of inculcating responsibility in the child? This seems unclear and suggests that courts will continue to differ at the margin over the application of the business pursuits exclusion to babysitting. Furthermore, as long as the exclusion is styled as one of “business” pursuits, some courts will fairly ask whether the reasonable construction of “business” really extends to children’s activities. For example, does a lemonade stand in the driveway fall within the exclusion? *Dwello* was an easy case because it involved regularized adult activity rather than a child’s lemonade stand or babysitting.

In response, insurers could perhaps achieve greater efficacy of the exclusion by adding that the exclusion applies to for-profit activities “no matter how infrequent and regardless of motive.” Insurers might also add language such as: “Whenever compensation is received for activity in the home, this exclusion applies to the activity.” Although this may seem like overkill for an exclusion that has been deemed clear and unambiguous, additional language may be helpful for insurers. Cases like *Dwello* suggest that courts do not literally mean that the exclusion is ambiguous in all cases or they would not engage in the “continuity and profit motive” analysis but would instead simply exclude coverage whenever there is remunerative activity.

In any event, the practical effect of the state of the law on this point is to suggest that anyone offering even occasional in-home child care would be wise to talk to his or her agent about obtaining express coverage through an endorsement to the policy. In the alternative, families with teenage babysitters should probably insist that the teenager go to the home of the other child rather than permitting the other child to be dropped off at the home of the teenager. In this way, the situs of any unfortunate injury will be the cared-for child’s own home, which is not receiving any revenue from the babysitting.