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Recent Case Developments

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RECENT CASE DEVELOPMENTS

Jeffrey W. Stempel*

WASHINGTON SUPREME COURT REJECTS ALLOCATION OF RESPONSIBILITY FOR POLLUTION DAMAGES BETWEEN INSURED AND UNINSURED YEARS

B & L Trucking & Constr. Co., Inc. v. Northern Ins. Co. of N.Y., 951
P.2d 250 (Wash. 1998).

When tort claims against a policyholder involve damages spanning several years, the damage claims may also span several different liability insurers. In such cases, policyholders argue that any policy "triggered" by the presence of liability-creating injury during the policy period should be responsible for providing defense and indemnity for the claim, so long as the insurers collectively responsible for coverage are not required to pay more to the policyholder than the amount of liability loss. Where the policy limits of the triggered policies exceed the amount of liability, policyholders argue that insurers may seek contribution from one another but should not be permitted to reduce their own coverage responsibility because of the presence of other triggered insurers or periods where the policyholder was uninsured. A number of courts have adopted the policyholder's view of coverage in multiyear tort cases. *See, e.g., Keene Corp. v. Insurance Co. of N. Am.*, 667 F.2d 1034 (D.C. Cir. 1981); *Montrose Chem. Corp. v. Admiral Ins. Co.*, 913 P.2d 878, 901 (Cal. 1995); *Armstrong World Indus., Inc. v. Aetna Cas. & Sur. Co.*, 52 Cal. Rptr. 2d 690, 705 (Cal. Ct. App. 1996).

Insurers conversely argue that where multiple policy periods are involved, courts should pro-rate the coverage responsibility of the insurers, with the most popular allocation method being the time period in which each insurer was on the risk. Where there are periods of self-insurance or no insurance, insurers seek to have policyholders pay a pro-rated share of the costs of liability coverage. Several courts have adopted this view. *See, e.g., Stonewall Ins. Co. v. Asbestos Claims Mgmt. Corp.*, 73 F.3d 1178 (2d Cir. 1995) (applying New York law, but refusing to allocate responsibility to

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policyholder during years when insurance was unavailable due to asbestos claims exclusion made nonnegotiable in standard liability policies); *Sharon Steel Corp. v. Aetna Cas. & Sur. Co.*, 931 P.2d 127 (Utah 1997); *Northern States Power Co. v. Fidelity & Cas. Co. of N.Y.*, 523 N.W.2d 657 (Minn. 1994); *see also* *Owens-Illinois, Inc. v. United Ins. Co.*, 650 A.2d 974 (N.J. 1994) (endorsing allocation and policyholder bearing of costs for uninsured periods and suggesting temporal proration as default formula but refusing to adopt per se formula if it is possible to determine percentage of injury that took place during different coverage periods). For a more in extensive discussion of the allocation controversy and its case law, *see* JEFFREY W. STEMPEL, *INTERPRETATION OF INSURANCE CONTRACTS* § T3.4 (1994 & Supp. 1998).

The Washington Supreme Court recently rejected allocation of liability responsibility by time on the risk and also strongly disagreed with the rationale supporting pro-rata allocation in a case involving wetlands pollution and a subsequently ordered remediation. In 1978, Policyholder William Fjetland purchased the B & L Landfill near Tacoma Bay. The landfill was the recipient of slag hauled from nearby log yards until 1980, when the landfill was closed due to its proximity to area wetlands. But the damage was done—or in process—in that contaminants leached from the slag at the outset and continued for years. Arsenic contamination in the Tacoma tideflats area was attributed to the leaching slag and remediation costs were imposed on the owners of the landfill and others pursuant to the Comprehensive Environmental Response, Compensation, and Liability Act of 1980 (“CERCLA” or “Superfund”).

Policyholder Fjetland’s insurers commenced a declaratory judgment action resulting in a finding that Fjetland was not liable for pollution prior to January 1981 (apparently because the contaminants had not leached from the landfill to third-party property prior to that date) and that the pollution damage was expected by Fjetland as of June 1982, thus making damage after that date “expected or intended from the standpoint of the insured” and therefore excluded from coverage under the terms of the standard commercial general liability (CGL policy). The date of the cleanup order was April 29, 1987. The trial court determined that the period for which the responsibility for the liability claims would be allocated was January 1981 to April 1987.

Thus, there were seven annual increments of pollution/CERCLA cleanup over which responsibility was to be allocated. Fjetland was insured by a Northern insurance policy in effect from August 1980 to August 1983 and another Northern policy from August 1983 to August 1984. The trial court thus found Fjetland to have coverage from Northern for the 1980-81 policy period (when the pollution liability started) and the 1981-82 policy period (when the pollution was still causing injury to other property) up to the point

when Fjetland began to expect pollution damage from the slag in the landfill. The trial court then allocated coverage responsibility according to the time on the risk and found Northern to be responsible for 2/7ths of the liability, with Fjetland holding responsibility for the remaining 5/7ths of the matter (for all policy periods or portions thereof after the June 1982 realization of the ongoing pollution damage).

The Washington Court of Appeals reversed, rejecting the allocation method. In its February 1998 decision, the Washington Supreme Court similarly rejected not only the trial court's allocation calculation but strongly rejected the rationale of allocation to the policyholder altogether. However, three of the eight deciding judges dissented and endorsed allocation prorata by time on the risk. *B & L Trucking* thus provides a current illustration in microcosm of the pro and con views of allocation.

The *B & L Trucking* majority specifically endorsed the approach of *Gruol Constr. Co. v. Insurance Co. of N. Am.*, 524 P.2d 427 (Wash. 1974), a well-known case applying a continuous trigger of coverage to claims against a builder for negligent construction resulting in years of "dry rot" that proceeded unseen prior to detection in a home. Endorsing *Gruol's* continuous trigger and broad view of coverage-triggering injury, the *B & L Trucking Court* stated:

The *Gruol Court* held when an insured sustains damages of a continuing nature, its insurers are jointly and severally liable. All insurers providing coverage during any portion of the total time period of the continuing damage were held liable for the total amount of the continuing property damage. We agree with Fjetland that *Gruol* stands for the proposition that all insurers on the risk during the time of ongoing damage have a joint and several obligation to provide full coverage for all damages. . . . In other words, when damage occurs during a policy period, that policy is triggered.

B & L Trucking, 951 P.2d at 254.

[I]n a continuing damage situation, each insurer is held jointly and severally liable for the full amount of damage, regardless of the amount that occurred during its policy period.

Id. at 254 n.4.

We [have] accepted that when damage is continuing, all triggered policies provide full coverage. Northern's argument that it can be held liable only for property damage occurring during the policy

period is misguided. this argument addresses only which policies are triggered, not whether costs should be allocated.

* * *

The jury's finding that Fjetland "expected" damage after June 1982 precludes the policies after that date from being triggered. It does not, as the dissent urges, preclude Northern's liability under the triggered policies for continuing damage.

Id. at 255.

The *B & L Trucking* Court rejected the argument of the insurers (and the dissenters) that failure to apportion damage over the seven annual policy periods of pollution liability would essentially mandate coverage for periods when he was not insured. On the contrary, the majority found that Fjetland had effective insurance in force and triggered for 1980-81 and 1981-82 and that Fjetland was entitled to coverage up to those policy period limits for occurrences taking place in those two years irrespective of whether coverage was available in other years.

Although the *B & L Trucking* Court and others refer to this as "joint and several liability" for triggered policies, the term is unfortunate and misleading. In fact, *B & L* and similar cases simply say that a triggered carrier is responsible for coverage according to the terms of its policy without any reduction in coverage liability simply because the injury triggering coverage also took place in other years triggering other policies. The "joint & several" liability discussed in *B & L* and other cases rejecting allocation is not a real tort law joint and several liability where each tortfeasor (even the one that is one percent at fault) is responsible to pay all of the plaintiff's damage under a judgement. Under *B & L Trucking* and other cases rejecting prorata allocation among insurers or between insurer and policyholder, a triggered insurer is never responsible for more than its policy limits (absent a bad faith judgment) even where the policyholder's liability is far greater. This is quite different than the joint and several liability of tort law, where a torfeasor responsible for only 10 percent of the negligence may be required to pay 100 percent of a plaintiff's damages. See JEFFREY W. STEMPEL, INTERPRETATION OF INSURANCE CONTRACTS § T3.4 (1994 & Supp. 1998) ("joint and several liability" a misnomer).

In particular, the *B & L Trucking* Court found any proration of coverage responsibility and consequent reduction of Northern's 1980 and 1981 coverage responsibility unwarranted because "if Northern intended solely to be liable on a pro rata basis, it could have included that language in its policy." Rather, "Northern drafted the policy language; it cannot now argue

its own drafting is unfair. . . . We will not add language to the policy that the insurer did not include. Instead, Northern agreed to pay 'all sums' arising out of an 'occurrence' which, by its own policy definition, may take place over a period of time." *B & L Trucking*, 951 P.2d at 256-57.

The three dissenting justices attacked the nonapportionment result in part on public policy grounds, arguing that "the majority's imposition of 'joint and several' liability requires Northern to provide coverage for years after that date, when property damage was expected by the insured." *Id.* at 258. However, the dissent's perspective seems to misperceive the issue. According to the case report of the trial jury's finding, the pollution that created liability was not expected prior to June 1982 even though the pre-1982 pollution continued to do damage for years afterward. In this type of situation, it is not at all unusual for a tortfeasor to have coverage for injuries taking place for negligence of years gone by even though the damage takes place well after the policyholder has become aware that its past negligence brings or may well bring a particular kind of harm.

For example, in the asbestos cases, many of the claims were made years after the industry itself was aware of the dangers of the product. However, courts generally held that coverage for asbestos makers was not negated by the intentional act exclusion because the injurious exposure of the claimant to asbestos took place as much as perhaps decades earlier when the tortfeasor had no expectation of causing injury through sale and use of the product.

A more common insurance situation also illustrates problems with the dissent's characterization of the majority's anti-allocation decision as one that permits the policyholder to recover for expected losses and thus permits an impermissible introduction of moral hazard into liability insurance. Consider the "garden variety" lawsuit where an insured tortfeasor is negligent by, for example, running into a pedestrian and the pedestrian has years of medical expense and expenditures for rehabilitation and care. In these situations, the liability insurance policy (usually an automobile insurance policy) in effect at the time of the insured's infliction of injury on another remains responsible through the ensuing years of ongoing damage until policy limits are exhausted. Nothing is thought improper about this "long tail" of payments under the original policy.

Insurers raise an interesting fairness argument for proration by pointing out that in continuous trigger states such as Washington, many policies may be regarded as triggered. Without apportionment of the coverage responsibilities, argue the insurers, the insured enjoys a windfall of more coverage than is reasonable. However, this argument appears inconsistent with the language of the occurrence policy itself, which provides for triggering of the policy if there is injury during the policy period for which the insured policyholder is liable. Even though the typical liability policy also

states that it will pay for "damage" that "occurs during the policy period", the treatment of ongoing damages from a policy period injury such as the hypothetical automobile accident case previously discussed demonstrates that prior to the asbestos and pollution coverage cases that spawned the pro-rata allocation debate insurers never expected to stop paying under a triggered policy simply because the calendar had turned a page.

So long as courts do not make erroneous trigger decisions (e.g., confusing an injury during a policy period with continued progression of an injury that took place during an earlier policy period) there would appear to be nothing untoward with requiring a triggered policy to be responsible for the financial consequences of the triggering injury up to its limits. Where the nature of the liability-creating tort triggers injury in different policy years, this is a product of the policy language and the insuring agreement rather than "joint and several" liability. Requiring triggered insurers to provide policy proceeds without any reduction due to proration thus seems merely reasonable enforcement of reasonably clear contract language so long as the court does not inaccurately treat continuing deterioration of the claimant's person or property from the original injury as a new injury triggering coverage.

The problem, of course, is that cases such as asbestos and pollution present difficult problems of proof, making it difficult or impossible to know exactly when an injury took place. However, under the available facts in such cases, it does not seem unreasonable to find multiyear triggering of policies for workers who were exposed to asbestos particles for several years while working in a shipyard or for a landowner whose property was adjacent to a continuously leaking landfill.

In the ongoing debate about allocation, the *B & L Trucking* opinion will undoubtedly be important because it both endorses a broad view of coverage-triggering injury under the CGL, and endorses the continuous trigger. This officially places the Washington Supreme Court on record as supporting the important *Gruol Construction* opinion rendered 25 years ago by the Washington Court of Appeals and frequently cited by policyholder attorneys, and roundly rejects the rationale of apportionment of coverage liability among the years during which damage occurs, particularly where this has the effect of making the policyholder responsible for otherwise insured liability claims or where apportionment among insurers reduces each insurer's own policy limits of responsibility.

Despite its potential significance, however, *B & L Trucking* can be viewed as a case where the discussion of the allocation issue was unnecessary. Rather than being characterized as an allocation case, *B & L Trucking* can be seen as a case concerning when a liability insurer's responsibility for ongoing damage can be terminated. Recall that the 1980-81 and 1981-82 Northern CGL policies were triggered. Assume that only the 1981-82 policy existed.

Once triggered, this policy would presumably be required to pay its policy limits to indemnify Fjetland for CERCLA clean-up liability. Even if after the trigger, the risk becomes uninsurable, this should have no effect on the triggered policy's responsibility to defend and indemnify the covered occurrence that predates the uninsurability. Whether subsequent insurance policies must pay is not so much a question of allocation as one of end point—at what point do coverage responsibilities end? For a triggered insurer, the coverage responsibility ends when the triggered policy is exhausted regardless of the insurer's conduct or risk management practices after trigger. Viewed in this way, the *B & L Trucking* decision could have been rendered by simply deciding that a triggered insurer is not relieved of coverage responsibilities for ongoing damage merely because the policy period has ended. The end of the policy period may preclude any other triggering occurrences but it does not relieve the insurer of responsibility for the already triggered coverage responsibility. In this sense, *B & L Trucking* as recharacterized could be viewed as uneventful and could perhaps have avoided venturing into a lengthy examination about allocation in general.

The *B & L Trucking* case also noted that apportioning coverage responsibility across years during which there is no coverage also tends to violate the language and purpose of the CGL as well as disappointing the expectations of the policyholder in that the policyholder receives less from the insurer than what it paid for in premiums merely because the liability creating tort spans more than one policy period. Although insurers are understandably upset when multi-year torts and continuous trigger precedents expand the number of policies on the risk, insureds argue that this does not justify reducing the policyholder's protection. In a pollution tort that spans decades, the impact of apportionment could dramatically reduce or effectively eliminate coverage purchased by the policyholder, a result the *B & L Trucking* majority regarded as distinctly unfair.

APPLYING SECOND CIRCUIT'S RULE FAVORING PRO-RATA
ALLOCATION OF COVERAGE RESPONSIBILITY, FEDERAL DISTRICT
COURT HOLDS OLIN RESPONSIBLE FOR HALF THE COSTS OF
POLLUTION CLEAN-UP DUE TO 14 YEARS OF SELF-INSURANCE

Olin Corp. v. Insurance Co. of N. Am., 986 F. Supp. 841 (S.D.N.Y. 1997).

In *Stonewall Ins. Co. v. Asbestos Claims Mgmt. Corp.*, 73 F.3d 1178 (2d Cir. 1995), a case discussed in connection with *B & L Trucking*, *supra*, the United States Court of Appeals for the Second Circuit applying New York

law held that in cases of multiyear triggering of liability insurance, the coverage responsibility must be pro-rated by time on the risk and that this included pro-rating the years during which the policyholder was uninsured or self-insured. However, the *Stonewall* court refused to impose responsibility on the insured via proration for years during which it was impossible to purchase insurance coverage for asbestos claims. The New York law applied in *Stonewall* has not been definitively pronounced by New York State's highest court. Under the balance of power between state and federal courts, federal courts ruling on matters of state law apply the law as enunciated by the state's highest court and attempt to discern or "predict" state law on novel questions based on lower court decisions and general legal principles. Thus, *Stonewall* may not be the definitive word on New York allocation of coverage responsibility for multiyear torts but neither has the New York Court of Appeals (New York's highest court; unlike other states, New York trial courts are called the "Supreme" court) suggested any rejection of *Stonewall*'s approach, making it likely that the New York high court will eventually expressly adopt the *Stonewall* view of pro-rata allocation.

Left open after *Stonewall* is the showing a policyholder must make to prove unavailability of insurance in order to avoid proration of coverage responsibility to the policyholder. In *Olin*, a pollution liability coverage matter, the federal trial court in Manhattan held that the *Stonewall* exception to pro-rata allocation "applies only where insurance is unavailable in the marketplace." *Olin*, 986 F. Supp. at 844.

The case arose out of an EPA order requiring Olin to cleanup a fertilizer plant site near Williamston, North Carolina. An earlier opinion sets forth the underlying facts in some detail. See *Olin Corp. v. Insurance Co. of N. Am.*, 972 F. Supp. 189 (S.D.N.Y. 1997). After jury trial, it was determined that "there was injury to property covered by insurance for the years 1958 through 1985." *Olin*, 986 F. Supp. at 842. However, Olin was self-insured for the 1971 through 1985 period.

Olin argued that under *Stonewall* it had been deprived of the opportunity to obtain insurance because of the presence of the "sudden and accidental" pollution exclusion in post-1970 liability policies. Under New York law, this exclusion permits pollution coverage only if the pollution liability stems from an abrupt or rapid discharge rather than the gradual release of pollutants that took place at the Olin plant in North Carolina. However, the court found that this standard exclusion in the Comprehensive or Commercial General Liability Policy (CGL) did not make insurance unavailable because Olin could have purchased environmental liability (EIL) insurance beginning at least as early as 1980 and that Olin could have kept in force this claims-made form of insurance, which would have provided insurance to Olin.

As a consequence of its failure to purchase five years' worth of EIL insurance, Olin will be required to shoulder 14 years worth of the 27-year pollution period at its plant. Applied to the \$400,000 cleanup cost, this makes Olin responsible for more than \$200,000 at this facility. Other facilities in dispute in this insurance coverage declaratory judgment action commenced by Olin could ultimately be the subject of additional jury trials regarding the timing of pollution and the knowledge of the polluter but it is also quite possible that disputes over the other facilities will be informally settled by Olin and INA now that the court has ruled, although further appeal is of course possible as well. According to the Court:

Due to the nature of gradual pollution, and under the framework which we have used in this case, this was not a situation where there was one injury with consequential damages. This was a situation where there were continual instances of injuries, each of which would be sufficient to be a separate trigger for liability under a policy if the policy were in effect during the particular year.

We start with the proposition that the insurance company is normally liable only for injury occurring during the time covered by the insurance under a general comprehensive liability policy. If the injury or the occurrence does in fact happen during the period of the policy, then there is coverage. If it occurs or happens after the conclusion of an insurer's policy period, it is not the responsibility of that insurance company. This case involves annual policies, and thus, if the occurrence or injury did not happen during the year of coverage, it is not covered by that policy.

* * *

We know that the nature of gradual pollution does not permit us to literally learn what particular injury occurs in a particular year leading to what particular monetary amount of damages. So proration is necessary.

Id at 843. Therefore, the Court stated:

I am holding that the proration in a case such as was involved in the Williamston, North Carolina site, this proration should take place over all the years of the injury. I am further holding that the insurance company is to pay its share of the years in which insurance coverage existed. I am further holding that Olin will be required to

accept responsibility for the years in which injury occurred and in which it did not have insurance in effect.

Id. at 845.

Olin and *Stonewall* thus provide a current and interesting counterpoint to the Washington Supreme Court's view of allocation in *B & L Trucking*. A policyholder's attorney might take issue with *Olin*'s approach regarding *Olin*'s failure to purchase EIL insurance from 1980 on. Most claims-made policies, including EIL policies, provide for a retroactive date that prohibits coverage for claims based on events occurring prior to the retroactive date. Many claims-made policies also contain language seeking to exclude any claims that arise from events predating the inception of the claims-made policy. Either of these provisions in an EIL policy could preclude coverage for the 1971-1980 period and perhaps for some or all of the 1980-85 period as well. The *Olin* Court's opinion is unclear regarding whether in such a case *Olin* would have been required to pay half the cleanup costs even if it had faithfully maintained EIL insurance during the 1980 to 1985 period.

ARGUABLE MANIFESTATION OF AIDS PRIOR TO INCEPTION OF
DISABILITY IS INSUFFICIENT TO PERMIT RESCISSION BECAUSE OF
BOTH AMBIGUOUS POLICY LANGUAGE AND STATE STATUTES
REGULATING INCONTESTABILITY

Estate of John Doe v. Paul Revere Ins. Group, 948 P.2d 1103 (Haw. 1997).

Dentist John Doe (a pseudonym used to protect the privacy of the plaintiff in this coverage action) applied for disability insurance with Paul Revere in October 1985. He completed a pre-printed application, and was issued a policy on October 22, 1985. In November 1991, Doe sought benefits for total disability due to HIV infection. Revere made three monthly benefit payments, stopped, and demanded a refund, claiming the AIDS-related disability was not covered due to its manifestation prior to the issuance of the policy. Doe died in September 1997 and the coverage claim was pursued by this estate.

In his 1985 application, Doe fully disclosed his history of doctor visits and made his medical records available to the insurer by signing a release. However, Revere did not obtain records of Doe's visits to Dr. E. Blossom Wang during 1983 when Doe complained of swelling of the lymph glands, occasional diarrhea, and fatigue, which Dr. Wang diagnosed as amebiasis (a parasitic infection) or Lymphadenopathy (disease of the lymph nodes), which

could have resulted from any number of factors, including allergies, mononucleosis, or Hodgkin's disease as well as AIDS. Doe also had an abnormal decrease of white blood corpuscles. Although Dr. Wang's examination revealed some concern about Doe's T cells, extensive lab tests led the physician to conclude that Doe did not have AIDS. Referral to an infectious disease specialist revealed no diagnosis of AIDS. Both Wang and the specialist essentially concluded that, at least in 1983, Doe was healthy. In January and July 1985, further examination and testing by Wang showed significant improvement for Doe and suggested Doe "looked well physically and had no complaints".

Although Doe's disability policy had been in effect more than six years prior to his disability claim, Revere challenged the claim as one resulting from a pre-existing condition that should have been disclosed to the insurer. However, the Revere policy stated that it became incontestable after two years. In addition, Hawaii Revised Statutes § 432:10A-105(2)(A)(1993) provided that all accident or sickness policies must include the following language:

After three years from the date of issue of this policy, no misstatements, except fraudulent misstatements, made by the applicant in the application of this policy shall be used to void this policy or to deny a claim for loss incurred or disability (as defined in the policy) commencing after the expiration of the three-year period.

No claim of loss incurred or disability (as defined in the policy) commencing three years from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this policy.

[policies with rights of continuation for premium payment may contain the following provision in lieu of the forgoing:]
"Incontestable: After this policy has been in force for a period of three years during the lifetime of the insured (excluding any period during which the insured is disabled), it shall become incontestable as to the statements contained in the application."

Estate of John Doe, 948 P.2d at 1113 (citing HAW. REV. STAT. § 431:10A-105 (1993)). The Hawaii law making policies incontestable for any statements made in connection with the application and underwriting is similar to those of virtually all states for life, health, and disability policies. See *Oglesby v.*

Penn Mut. Life Ins. Co., 889 F. Supp. 770, 774 (D. Del. 1995) (47 states with such legislation).

Despite the policy language and the Hawaii law, Revere sought to avoid coverage, arguing that the pre-existing condition language of the policy permitted it to rescind coverage if the insured had an undisclosed prior condition materially affecting the risk that had "manifested" itself prior to the issuance of the policy. Reasoning retroactively on the basis of the 1983 medical records which it appeared not to have sought to obtain prior to the issuance of the policy, Revere argued that it could rescind even where there had been no fraud or concealment if the AIDS was sufficiently manifest in 1983.

The Hawaii Supreme Court rejected Revere's argument on both contractual and statutory grounds. Regarding the insurance policy, the Court found Revere's language hopelessly ambiguous, referring to it as "an oxymoron" and a 'hall of mirrors'. Regarding the statute, the Court read the law as requiring the insurer to provide coverage where it had failed to clearly exclude a particular cause of disability and where there was no evidence of policyholder fraud in obtaining the policy.

Although *Doe* is a significant victory for the policyholder, it is important to note that *Doe* would permit an insurer to specifically exclude from life, health, or disability coverage specific causes of loss. For example, an insurer could state that it provides disability insurance so long as the disability is not caused in whole or in part by AIDS, other sexually transmitted diseases, cancer, heart or lung disease of any type, automobile accidents, industrial accidents, homicide, etc. The resulting policy would be something far less comprehensive than what we normally think of as insurance but it would apparently be permitted under the rationale of the Hawaii Court.

In addition, the actual facts of the claim in *Doe* are not particularly damning to Doe. Only with 20-20 hindsight can the 1983 medical records be seen as showing the onset of AIDS (although when viewing these records prior to October 1985, two insurers other than Revere had declined the risk). There was no fraud by Doe and he worked for six years after issuance of the policy, paying premiums throughout this time. Even after his total disability, Doe lived an additional six years. However much the 1983 medical records might have raised a red flag, Doe was clearly not at death's door when he sought insurance.

Although the *Doe* opinion is quite critical of Revere's policy language and implicitly critical of Revere's underwriting and payment practices, *Doe* is considerably less dramatic than *Amex Life Assurance Co. v. Superior Court*, 930 P.2d 1264 (Cal. 1997) (discussed at greater length below), in which the California Supreme Court ruled that a claim for life insurance was incontestable even though the life insurance applicant knew he was HIV-

positive and intentionally arranged for an imposter to take his physical examination. There, the California Court read the application narrowly to find no literal misstatement to the insurer negating the incontestability clause despite the obvious fraud upon the insurer.

LIFE INSURANCE INCONTESTABLE DESPITE FRAUD BY INSURED
WHO APPLIED KNOWING HE WAS HIV-POSITIVE AND USED
IMPOSTER FOR PHYSICAL EXAM

Amex Life Assurance Co. v. Superior Court, 930 P.2d 1264 (Cal. 1997).

Jose Morales “knew he was HIV (human immunodeficiency virus) positive when he applied for life insurance. He lied on the application form and sent an imposter to take the mandatory medical examination.” Despite this almost classic example of defrauding an insurer, the California Supreme Court ruled that Morales’s beneficiary was entitled to collect the policy proceeds. More than two years elapsed from the issuance of the policy and the insured’s death and the policy contained a two-year incontestability clause. According to the Court, California law treats incontestability clauses as being in the nature of a “statute of repose”, forever extinguishing the insurer’s opportunity to rescind coverage on grounds of fraud or any other available defense within the time prior to the vesting of incontestability. Furthermore, the Court found that the truth about the imposter was “long available” to the insurer and could have been discovered and used well before the two-year period expired.

The Court rejected an imposter defense urged by the insurer. The Court distinguished cases where such a defense had been recognized based on differing facts or law. For states treating incontestability as a statute of repose, the common thread appears to be that the insurer must have issued a policy to someone who is not the named insured rather than merely having issued the policy to the named insured on the basis of fraud. The insurer agreed to insure Morales but simply was fooled into thinking that Morales met its underwriting criteria. By contrast, if Morales had pretended to be a healthy John Smith, the resulting policy issued to Smith would not be liable to pay upon Morales’s death. Although this seems something like Monty Python reasoning, it comports with formal contract law. A policy issued to John Smith would not be a contract between the insurer and Morales. However, a contract issued to Morales under false pretenses was still a contract between Morales and the insurer—albeit a contract procured by fraud. But the Court reasoned that the insurance contract specified that if the

insurer did not discover and act upon the false pretenses within two years, it must honor the contract, whatever the reprehensible behavior that led to its formation. However, the incontestability provisions of most life insurance policies are statutorily mandated and the Amex Life decision has the practical effect of rewarding the life insurance applicant for knowing and calculated fraud.

WORDING OF POLICY APPLICATION LANGUAGE REGARDING PRE-EXISTING CONDITIONS KEY IN DETERMINING WHETHER APPLICANT'S INCOMPLETE DISCLOSURE SUFFICIENT TO WARRANT DENIAL OF MEDICAL BENEFITS; FLORIDA SUPREME COURT RESOLVES CONFLICT OF INTERMEDIATE COURTS IN PLACING GREATER EMPHASIS ON APPLICANT STATE OF MIND AND POLICY WORDING RATHER THAN OBJECTIVE MATERIALITY OR QUALITY OF INFORMATION CONVEYED IN APPLICATION

Allen Green v. Life & Health of Am., 704 So. 2d 1386 (Fla. 1998).

In March 1991, Harold Green applied for a home health care benefits policy from Life & Health of America. Among other things, the application asked whether Green or his wife had been told during the past five years that they had any of a list of enumerated conditions, including kidney failure and "chronic obstructive lung disease." Green checked "no" and signed the application, which contained a statement that the answers he had given were "full, true and complete to the best of my knowledge and belief" and that the statements were representations and not warranties. (An untrue warranty acts under the common law to void the policy, even if the warranty does not relate to the risk insured or the actual cause of a loss. A representation by contrast vitiates coverage only if it is material to the risk, or in some states, material to the actual cause of law in coverage litigation over a claim. The modern trend in insurance law, by both statute and judicial decision, has been to treat statements made by applicants or policyholders as representations so that a nonfraudulent inaccuracy will not void coverage unless it relates to the risk or loss).

The insurer issued the policy, apparently without obtaining and reviewing Green's medical records. A year later, Green filed a claim (the precise nature of the current disability claim was not noted in the Supreme Court's opinion). Thereupon, the insurer reviewed Green's medical records and "discovered that he suffered from chronic renal failure. As a result, Life & Health rescinded the policy and returned all of the previously paid premiums." *Id.* at 1388.

Green sued for benefits and prevailed, although he died shortly after the onset of the litigation. The deposition of Green's treating physician and other discovery suggested that layman Green may have known that he had sluggish kidneys but had not been told by his doctor that he suffered from "chronic renal failure". The lower court found it "undisputed" that "Green had no knowledge of his condition and any misrepresentation was therefore unintentional." *Id.* at 1389.

However, the insurer prevailed at trial and before the intermediate court of appeals on the basis of prior Florida precedent that approved rescission for applicant misrepresentation even when the misstatement was innocent and the insurance application contained the "to the best of my knowledge and belief" type language contained in Green's application. *See, e.g., Continental Assurance Co. v. Carroll*, 485 So. 2d 406 (Fla. 1986); *Life Ins. Co. of Va. v. Shifflet*, 201 So. 2d 715 (Fla. 1967) (under then applicable statute, all misrepresentations material to the acceptance of risk will invalidate an insurance policy even if made in good faith; "knowledge and belief" language in the Carroll's policy not deemed to modify this absolute rule). However, there also existed recent contrary law in federal court decisions applying Florida law. *See, e.g., William Penn Life Ins. Co. v. Sands*, 912 F.2d 1359 (11th Cir. 1990); *Carter v. United of Omaha Life Insurance*, 685 So. 2d 1 (Fla. Dist. Ct. App. 1996) (holding that where the insurer uses the less draconian "knowledge and belief" language, this lower standard for judging misrepresentation and rescission applies, permitting the policyholder to recover so long as he or she answered the application truthfully based on his or her actual knowledge and belief).

In *Green*, the Florida Supreme Court moved away from the absolute rule of *Carroll* and *Shifflet* and adopted the *Carter* approach: where the insurer's own application hinges the veracity of the applicant's statements on knowledge and belief, even a material untruth in the application will not void coverage if innocently made. The *Green* Court noted:

It is well settled that, as a general rule, "parties are free to 'contract-out' or 'contract around' state or federal law with regard to an insurance contract, so long as there is nothing void as to public policy or statutory law about such a contract."

Green, 704 So.2d at 1390 (quoting *King v. Allstate Ins. Co.*, 906 F.2d 1537, 1540 (11th Cir. 1990)).

Although contracting around the default rules of the law is normally done by the insurer to advantage the insurer, which directs the arrangement and drafts the contract language, the *Green* Court found that the insurer was

logically bound by chosen language which favors the insured, as occurred in the *Green* case.

After *Green*, health, life, and disability insurers operating in Florida will presumably revise their application forms to remove "knowledge and belief" or "good faith" language and will instead provide that any material misrepresentation or inaccuracy in the application will provide grounds for rescinding the policy.

MINNESOTA HOLDS THAT CAR RENTAL COMPANY MAY BY CONTRACT MAKE RENTER'S AUTO INSURANCE POLICY PRIMARILY RESPONSIBLE FOR ACCIDENT COVERAGE; RENTAL COMPANY POLICY OR SELF-INSURANCE IS PRIMARY AS IT IS "CLOSEST TO THE RISK" OF RENTAL MISHAP

Hertz Corporation v. State Farm Mutual Insurance Co., 573 N.W.2d 686 (Minn. 1998).

Hertz's rental car operations in Minnesota sought to provide pursuant to the car rental agreement that Hertz would be liable for auto liability claims arising out of the rental only to the extent that the renter or operator of the rented vehicle does not have other automobile liability insurance. Hertz had earlier obtained authorization to operate as a self-insurer pursuant to the terms of the Minnesota No-Fault Automobile Insurance Act, Minn. Stat. §§ 65B.41-.71 (1996). State Farm challenged the Hertz contract as violative of the Act and prevailed before the state Supreme Court. Said the Court:

A self-insured car rental agency does not meet its obligations as an automobile owner under the No-Fault Act by thrusting upon the renter its responsibility to provide liability coverage—that is, by providing liability coverage only in the event that the renter is without liability coverage.

[The Act's provisions] do not on their face require that an automobile owner maintain coverage that is not contingent upon the presence of other coverage. Nevertheless, it is inconsistent with the general purpose of the No-Fault Act to read the statute in a manner advocated by Hertz. Hertz's interpretation of the Act would create a practical exemption to the broad statutory mandate that all automobile owners carry liability insurance, an exemption nowhere evident in the language of the statute.

Id. at 688-89.

The Court thus interpreted the state no-fault statute to require that all users of automobiles provide primary coverage through either purchase of a policy or approved self-insurance, rejecting Hertz's argument that this requirement violated Hertz's freedom of contract to structure its rental agreements to place the burden of insurance upon the renter.

In addition, the Court required that the Hertz self-insurance program must provide primary coverage and that the renter's policy would provide secondary liability coverage. Minnesota law requires that the insurance policy "closest to the risk" be primary for purposes of coordination of benefits. If the policy closest to the risk is insufficient to satisfy the liability claim, the secondary policy is triggered for additional coverage. *See Interstate Fire & Cas. Co. v. Auto-Owners Ins. Co.*, 433 N.W.2d 82 (Minn. 1988). In making this determination, *Hertz v. State Farm* and other Minnesota cases examine which policy most specifically describes or contemplates the "accident-causing instrumentality" and "[w]hich premium is reflective of the greater contemplated exposure". *Hertz*, 573 N.W.2d at 691.

Applying these factors to this case, the Hertz self-insurance policy specifically describes the rental vehicle involved in the accident because Hertz is the owner and its self-insurance is specifically available to cover the vehicle at issue, while Powers' [the renter] State Farm policy only describes Powers' personal automobile. . . . because Hertz chose to self-insure, it avoided the payment of premiums to cover its liability. However, it is clear that Powers' State Farm policy did not contemplate primary coverage for more than damage to a rental vehicle, and its premiums are reflective of that fact. . . . the State Farm policy specifically states that its non-owned vehicle coverage is excess and incidental to any other policy covering the vehicle. While Hertz attempts to shift primacy to the State Farm policy through its rental agreement, Hertz's self insurance must provide liability coverage for damages caused by the use of vehicles it owns and offers for rent. Therefore, Hertz's self-insurance coverage is primary even under common law principles.

Id.

Two Justices concurred specially, suggesting they disagreed with the majority's common law analysis but finding a statutory amendment that became effective a day prior to the rental at issue in the case to be dispositive. Justice Alan Page, widely known for his prior career as a star NFL defensive lineman for the Minnesota Vikings and Chicago Bears, was the lone dissenter, arguing that the majority approach would not provide increased coverage but

would merely require Hertz to absorb more of the cost of rental car accidents, with the increased cost "likely to be passed on by Hertz to all of its rental car customers. There is no sound reason why individual renters should not be required to bear the cost of their own liability insurance protection."

Despite its appealing law & economics argument, the Page dissent appears to underestimate the reduction in auto insurance protection effected by the Hertz rental agreement, which would "not grant any defense or indemnity protection under [the agreement if the renter is] covered by any valid and collectible automobile liability insurance, whether primary, excess or contingent, with limits at least equal to the minimum required by the applicable state financial responsibility law." *Id.* at 687. In Minnesota, like most states, the minimum required by no-fault is low—\$10,000 per person and \$30,000 per accident of liability coverage—hardly enough to provide full compensation in the event of a serious automobile accident. Consequently, enforcement of the Hertz provision would appear to open the door to rental car accidents in which the third party victim would be able to pursue only the relatively shallow pocket of a minimum level no-fault policy but be effectively barred from full compensation absent active fault by Hertz (e.g., faulty car maintenance contributing to the hypothetical accident) or a tortfeasor renter with sufficient personal assets to pay the claim. Consequently, the *Hertz v. State Farm* decision would appear not merely to shift coverage burdens but to expand available automobile liability coverage generally.

RECENT FEDERAL DISTRICT COURT DECISIONS HIGHLIGHT VARIANT ISSUES IN INSURANCE ARBITRATIONS

In re National Broadcasting Company, Inc. and NBC Europe, Inc., No. M-77, 1998 U.S. Dist. LEXIS 385, 1998 WL 19994 (S.D.N.Y. Jan. 21, 1998).

Clarendon National Insurance Co. v. TIG Reinsurance Company, No. 97 Civ. 5911, 1998 U.S. Dist. LEXIS 191, 1998 WL 12110 (S.D.N.Y. Jan. 12, 1998).

Two recent decisions by noted federal district judge Robert W. Sweet bring focus to two seldom litigated but potentially important aspects of insurance arbitration. In *Application of NBC*, the issue was whether 28 U.S.C. § 1782, which authorizes the issuance of documentary or testimonial subpoenas for "use in a proceeding in a foreign or international tribunal" applies to private commercial arbitration. The *NBC* Court's review of the

statute's history led it to conclude that Section 1782 applies only to publically operated tribunals and not to private arbitrations such as the International Chamber of Commerce arbitration at issue in *NBC*. *Accord In re Medway Power Ltd.*, 985 F. Supp. 402 (S.D.N.Y. 1997); *contra In re Technostroyexport*, 853 F. Supp. 695 (S.D.N.Y. 1994).

In *Clarendon National Insurance*, the court reviewed a reinsurance arbitration award and largely confirmed the award but remanded a portion of the arbitrator's determination on the ground that this particular aspect of the award exceeded the scope of the arbitrator's authority established by the arbitration clause. The arbitrators had awarded interest to the prevailing party based on the damage award even though the arbitration clause had plainly provided that any award of interest would be calculated pursuant to a Memorandum of Understanding the parties executed when the disputants settled most issues between them and submitted the remaining issues to arbitration. The *Clarendon National* Court found some uncertainty in the law regarding the power of a reviewing court to confirm or remand a portion of an arbitration award rather than the entire award but resolved the issue in favor of partial vacating and remand of the infirm component of the award on grounds of judicial and arbitral economy as well as deference to the portion of the arbitrators' award that was entitled to prompt confirmation.