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# REDEFINING THE INSURER'S DUTY TO DEFEND

*by Susan Randall**

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## INTRODUCTION

This Article contends that a liability insurer's duty to defend arises only if the policy covers the conduct at issue in the litigation against the insured. This contention is unremarkable as a matter of policy interpretation and as a matter of common sense. In fact, however, the proposition that coverage determines the duty to defend is controversial, contradicting the almost universal "complaint rule." In virtually every jurisdiction, the allegations of the complaint against a liability insured determine an insurer's defense obligation. The virtues of the rule are simplicity and protection of insureds' interests in receiving a defense: the complaint provides an easy way to assess an insurer's obligation, particularly where coverage is questionable and may depend on the resolution of the litigation against an insured. If the complaint alleges a covered claim, the insurer must defend. The importance of an insurer-provided defense has led courts to broaden the complaint rule, so that in most jurisdictions, information extrinsic to the complaint which indicates coverage may also trigger a duty to defend. The focus of the rules on protecting an insured's right to a defense is so unswerving that this rule works in only one direction: an insurer may not deny a defense if information extrinsic to the complaint demonstrates that there is no coverage under the policy. In many jurisdictions, an insurer may not avoid a defense obligation by obtaining a declaratory judgment on coverage, and simple rejection of the defense carries substantial penalties, often including indemnification (regardless of coverage) and possible bad faith liability.

These rules guarantee that in most instances, insureds under liability policies will get the benefit of an insurer-provided defense, an important right for which insureds pay substantial premiums. But the single-minded focus on protecting an insured's right to a paid defense obscures the adverse consequences of rules which render the duty to defend nearly absolute. First, the rules increase the likelihood that an insured will be sued. Because the complaint measures an insurer's duty, plaintiff's counsel can manipulate the pleadings to trigger the defense obligation, even in cases which are clearly not covered under the policy. The existence of liability insurance drives tort litigation; a defendant whose insurer can be involved in a litigation is a more attractive target and more likely to be sued than a defendant whose insurer cannot be involved. Second, although individual insureds may benefit economically by receiving an insurer-provided defense, the complaint rule works to the economic detriment of insureds as a class by raising insurance costs. The complaint rule raises costs in at least two ways, by increasing the incidence of lawsuits, and by

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requiring a defense in cases not covered by the applicable policies. Defense costs represent a significant expense for insurers, and these costs are passed onto insurance consumers. Finally, the complaint rule increases the possibility of conflicts of interest in insurance defense. An insurer must defend even where it believes there is no coverage under the policy. As many courts have articulated the rule, an insurer has a duty to defend until it can confine the case to noncovered claims. This formulation is a recipe for conflicts of interest. The insurer's primary concern is demonstrating noncoverage; the insured's interest lies in avoiding liability, or at least limiting it to a covered claim.

Each of the problems cited above is serious. Taken individually, each warrants reconsideration of the existing rules defining an insurer's duty to defend; conflicts of interest in insurance defense, for example, has generated an enormous body of commentary,[1] advancing various solutions,

1. *See, e.g.*, Michael A. Berch and Rebecca White Berch, *Will the Real Counsel for the Insured Please Rise?*, 19 ARIZ. ST. L.J. 27 (1987); Karon O. Bowdre, *Conflicts of Interest Between Insurer and Insured: Ethical Traps for the Unsuspecting Defense Counsel*, 17 AM. J. TRIAL ADVOC. 101 (1993); Bruce L. Gelman, *The Insurance Company or the Insured: Where Does Defense Counsel's Loyalty Really Lie?*, 70 U. DET. MERCY L. REV. 215 (1992); Eric M. Holmes, *A Conflicts-of-Interest Roadmap for Insurance Defense Counsel: Walking an Ethical Tightrope Without a Net*, 26 WILLAMETTE L. REV. 1 (1989); John F. Larkin, *Ethical Considerations for Attorneys Acting as Insurance Defense Counsel*, 518 PLI/Lit. 381 (1995); Ronald E. Mallen, *A New Definition of Insurance Defense Counsel*, 378 PLI/Comm. 123 (1986); John K. Morris, *Conflicts of Interest in Defending Under Liability Insurance Policies: A Proposed Solution*, 1981 UTAH L. REV. 457 (1981); Thomas V. Murray and Diane M. Bringus, *Insurance Defense Counsel--Conflicts of Interest*, FICC QUAR. 283 (Spring 1991); Richard L. Neumeier, *Serving Two Masters: Problems Facing Insurance Defense Counsel and Some Proposed Solutions*, 77 MASS. L. REV. 66 (1992); Robert E. O'Malley, *Ethics Principles for the Insurer, the Insured, and Defense Counsel: The Eternal Triangle Reformed*, 66 TUL. L. REV. 511 (1991); Karla J. Pierce, *Conflict of Interest: Representing the Insured and the Insurer When Liability Exceeds Coverage--An Ethical Enigma*, 9 MISS. C. L. REV. 341 (1990); Douglas R. Richmond, *Lost in the Eternal Triangle of Insurance Defense Ethics*, 9 GEO. J. LEGAL ETHICS 475 (1996); Douglas R. Richmond, *Walking a Tightrope: The Tripartite Relationship Between Insurer, Insured, and Insurance Defense Counsel*, 73 NEB. L. REV. 265 (1994); Charles Silver and Kent Syverud, *The Professional Responsibilities of Insurance Defense Lawyers*, 45 DUKE L.J. 255 (1995); Charles Silver, *Does Insurance Defense Counsel Represent the Company or the Insured?*, 72 TEX. L. REV. 1583 (1994); Earl M. Sutherland, *One Client, One Defense: Revisiting CHI with the Alaska Rules of Professional Conduct*, 11 ALASKA L. REV. 1 (1994); Willis R. Tribler, *Coverage Disputes: Attorneys in the Middle*, 17 BRIEF 39 (1988); Alan I. Widiss, *Abrogating the Right and Duty of Liability Insurers to Defend Their Insureds: The Case for Separating the Obligation to Indemnify from the Defense of Insureds*, 51 OHIO ST. L.J. 917 (1990); Brooke Wunnicke, *The Eternal Triangle: Standards of Ethical Representation by the Insurance Defense Lawyer*, 31 FOR THE DEFENSE 7 (1989).

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ranging from changes in the rules of professional responsibility,[2] to accommodation of the choices of insurer, insured, and counsel by honoring retainer agreements,[3] to radical restructuring of insurance through creation of separate policies to cover defense expenses.[4] Taken together, the problems of increased litigation, costs, and conflicts of interest arising out of the complaint rule compel such reconsideration.

This Article suggests that the traditional approach to the duty to defend inappropriately balances the competing interests. The traditional approach favors an individual insured's immediate interest in an insurer-provided defense over the interests of individual insureds in avoiding conflicts of interest and insureds as a class in minimizing insurance costs and avoiding litigation. The traditional approach promotes conflicts of interest in insurance defense by requiring a defense in cases where the interests of the insurer and insured in the litigation diverge. Judicial and legislative efforts to resolve these conflicts are costly, and the resolutions inadequate. Some jurisdictions require separate counsel for insurer and insured in such instances, a solution which undercuts interests in controlling insurance costs. Other jurisdictions hold that such conflicts do not necessitate separate counsel, threatening the insured's interests in controlling the litigation and avoiding liability (particularly noncovered liability), often without the insured's awareness.

To strike a more appropriate balance, this Article proposes that the traditional rules be restructured to permit insurers to reject the defense of insureds where facts extrinsic to the complaint indicate noncoverage. One way to accomplish this reform would be revision of declaratory judgment procedures where necessary to permit preliminary adjudication of coverage. This approach carries a number of potential problems, including potential prejudice to the insured[5] or the plaintiff in the underlying action,[6] and substantial expenditure of judicial resources.

2. Much of the commentary cited *supra* note 1, addresses the rules of professional responsibility and offers practical advice on avoiding, identifying, and handling conflicts.

3. Charles Silver and Kent Syverud, *supra* note 1, propose this solution.

4. Alan I. Widiss, *supra* note 1, advances this suggested resolution of the conflicts of interest issues posed by insurance defense relationships.

5. Potential prejudice to an insured may result from being forced to litigate two actions simultaneously, the declaratory judgment action on coverage and the underlying action. Resolution of facts in a declaratory judgment action may also prejudice an insured's defense in the underlying action.

6. Potential prejudice to a plaintiff may result in cases where the court stays the underlying action pending resolution of the coverage issue, delaying resolution of the plaintiff's claim.

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Another possible approach involves permitting insurers to make unilateral coverage determinations and to accept or reject the defense on that basis. This seems a radical suggestion given the current focus on protection of insureds' interests. However, a number of factors support this potential reform. First, there is remarkably little justification advanced for the complaint rule in the case law or commentary, other than its simplicity and the difficulty, in some cases, of assessing coverage before resolution of the underlying dispute. Second, an emerging line of authority permits insurers to determine their duty to defend based on facts. Third, although insurer error or overreaching are always possible, an insurer has substantial incentives to make correct coverage determinations and afford a defense in appropriate cases.

Section I explains the complaint rule and examines its operation, pointing out the problems arising from its application. Section II examines policy language relating to the insurer's defense obligation and judicial rationales for the complaint rule. Standard policy provisions contemplate a defense only if the policy covers the insured/defendant's conduct. The case law frequently provides no reasons (other than precedential) for application of the complaint rule; the proffered justifications of simplicity and timing are not compelling in many cases. Section II concludes accordingly that the complaint rule should be modified to permit consideration of facts extrinsic to the complaint, whether they trigger or negate coverage. Section III proposes an alternative method for assessing the duty to defend based on actual facts rather than complaint allegations. Section III demonstrates that an insurer often has, or can obtain, information necessary to assess coverage. It also demonstrates that existing incentives to make correct coverage determinations will prevent insurer overreaching and that existing penalties for insurer misconduct will adequately protect insureds' interests.

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## I. THE DUTY TO DEFEND UNDER THE COMPLAINT RULE[7]

The traditional starting point for assessing a liability insurer's duty to defend is the complaint rule. Known variously as the four corners rule,[8] the eight corners rule,[9] the exclusive pleading rule,[10] and the scope of the allegations test,[11] the complaint rule requires an insurer to defend any lawsuit in which the complaint alleges a claim covered by the policy or indicates a "potentiality" that the claim could be covered or potentially

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7. For discussions of the duty to defend, *see, e.g.,* Robert J. Federman & Suzanne R. Ruder, Gray *Turns to Black: Further Expansion of Duties to Defend the Insured,* FED'N INS. COUNS. Q. 351 (Summer 1985); James M. Fischer, *Broadening the Insurer's Duty to Defend: How* Gray v. Zurich Insurance Co. *Transformed Liability Insurance Into Litigation Insurance,* 25 U.C. DAVIS L. REV. 141 (1991); David S. Garbett, *The Duty to Defend Clause in a Liability Insurance Policy: Should the Exclusive Pleading Test Be Replaced?,* 36 U. MIAMI L. REV. 235 (1982); Andrew Janquitto, *Insurer's Duty to Defend in Maryland,* 18 U. BALT. L. REV. 1 (1988); Margo A. Metzner, *The Duty to Defend,* PRACTICING LAW INSTITUTE, COMMERCIAL LAW AND PRACTICE COURSE HANDBOOK SERIES (1987); Kenneth L. Miller and Christina L. Nargolwala, *The Insurer's Duty to Defend: Overview, Recent Developments and Ethical Considerations,* PRACTICING LAW INSTITUTE, LITIGATION AND ADMINISTRATIVE PRACTICE COURSE HANDBOOK SERIES (1993); Frank Revere and Arthur J. Chapman, *Insurer's Duty to Defend,* 13 PAC. L.J. 889 (1982); Gary A. Schlessinger, *The Evolution of the Rule Determining an Insurer's Duty to Defend,* 6 ENVTL. CLAIMS J. 327 (1994); Jeffrey Silberfeld, *Duty to Defend Under CGL Policies,* PRACTICING LAW INSTITUTE, COMMERCIAL LAW AND PRACTICE COURSE HANDBOOK (1987); Deborah M. Neyens, Comment, *Expanding the Insurer's Duty to Defend in Iowa:* First Newton National Bank v. General Casualty Co. of Wisconsin, 74 IOWA L. REV. 969 (1989); Clifford A. Platt, Note, *The Insurer's Duty to Defend: New York Folds the Four Corners of the Complaint Rule in* Fitzpatrick v. American Honda Motor Co., 13 PACE L. REV. 141 (1993).

8. *See, e.g.,* City of Englewood v. Commercial Union Assur. Co., 1996 WL 385698 (Colo. App. July 11, 1996); Ramos v. National Cas. Co., 642 N.Y.S.2d 290 (App. Div. 1996); NL Ind., Inc. v. Commercial Union Ins. Co., 926 F. Supp. 446 (D. N.J. 1996); EDO Corp. v. Newark Ins. Co., 898 F. Supp. 952 (D. Conn. 1995); State Farm Fire & Cas. Co. v. Helminiak, 659 N.E.2d 385 (Ohio C.P. 1995); Britamco Underwriters, Inc. v. Stokes, 881 F. Supp. 196 ( E.D. Pa. 1995).

9. Texas courts call the rule the "eight corners" rule: the four corners of the policy plus the four corners of the complaint. *See, e.g.,* Potomac Ins. Co. of Illinois v. Peppers, 890 F. Supp. 634, 637 (S.D. Tex. 1995); Cullen/Frost Bank of Dallas v. Commonwealth Lloyd's Ins. Co., 852 S.W.2d 252, 255 (Tex. Ct. App. 1993).

10. Maryland courts use this term. Maryland Cas. Co. v. Armco, Inc., 643 F. Supp. 430 (D. Md. 1986), *aff'd* 822 F.2d 1343 (4th Cir. 1987), *cert denied,* 108 S. Ct. 703 (1988); Aetna Cas. & Sur. Co. v. Cochran, 651 A.2d 859 (Md. Ct. App. 1995); Mount Vernon Fire Ins. Co. v. Scottsdale Ins. Co., 638 A.2d 1196 (Md. Ct. Spec. App. 1994).

11. Ohio courts use this term. Willoughby Hills v. Cincinnati Ins. Co., 459 N.E.2d 555 (Ohio 1984).

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covered by the policy.[12] Under the complaint rule, the existence of the duty to defend is ascertained, whether by the insurer or by a court in a declaratory judgment proceeding, by comparing the complaint and the policy language.[13] A common modification of the rule requires the insurer also to consider facts extrinsic to the complaint which indicate coverage of

12. *See, e.g.*, Gray v. Zurich Ins. Co., 419 P.2d 168 (Cal. 1966).

13. Some courts prohibit reference to any information outside the complaint. *See, e.g.*, Great Northern Nekoosa Corp. v. Aetna Cas. & Sur. Co., 1996 U.S. Dist. LEXIS 5250 (N.D. Miss. Apr. 8, 1996) ("The traditional test is that the obligation of a liability insurer is to be determined by the allegations of the complaint or declaration. Moreover, a divergence may exist between the facts as alleged in the petition and actual facts as they are known to or reasonably ascertainable by the insurer, in which latter case the insurer has a duty to defend, notwithstanding a policy exclusion."); Potomac Ins. Co. of Illinois v. Peppers, 890 F. Supp. 634, 637-38 (S.D. Tex. 1995) (citing numerous Texas courts for proposition that "The duty to defend is not affected by the facts of the case ascertained before, during, or after the suit."); National Fire & Marine Ins. Co. v. Picazio, 583 F. Supp. 624, 628 (D. Conn. 1983) (insurer cannot avoid duty to defend by reference to information extrinsic to complaint); Sauer v. Home Indemn. Co., 841 P.2d 176, 180 (Alaska 1992) ("[E]ven though facts extrinsic to the pleadings may show that there will be no ultimate liability under the policy, if the complaint on its face alleges facts which, standing alone, give rise to a possible finding of liability covered by the policy, the insured has a contractual right to a proper defense at the expense of the insurer."); Fun Spree Vacations Inc. v. Orion Ins. Co., 659 So. 2d 419 (Fla. Dist. Ct. App. 1993); Western World Ins. Co., Inc. v. Paradise Pools & Spas, Inc., 633 So.2d 790 (La. App. 1994) (duty to defend measured by allegations of complaint, even though insurer may have determined no coverage on basis of known or ascertainable fact); Commercial Union Ins. Co. v. Royal Ins. Co., 658 A.2d 1081 (Me. 1995) (declining to create exception to pleading comparison test where uncontroverted facts extrinsic to complaint established lack of coverage under policy); Eastern Shore Fin. v. Donegal Mut. Ins. Co., 581 A.2d 452 (Md. App. 1990), *cert denied sub nom.* Insley v. Old Guard Mut. Ins. Co., 586 A.2d 13 (Md. 1991) (declining to adopt a rule permitting evidence extrinsic to complaint to trigger defense obligation); Foundation Reserve Ins. Co., Inc. v. Mullenix, 642 P.2d 604, 606 (N.M. 1982) (duty of insurer to defend where complaint alleges covered claim even though insurer's investigation reveals noncoverage); American Cas. Co. v. Corum, 910 P.2d 1151 (Or. Ct. App. 1996) ("[A]n insurer can consider only the complaint and should be able to determine from the face of the complaint whether to accept or reject the tender of the defense."); Ledford v. Gutoski, 877 P.2d 80 (Or. 1994) (court rejected insured's argument that insurer had a duty to defend based on possibility of liability for unintentional acts, where complaint alleged only intentional acts); Angelone v. Union Mut. Ins. Co., 319 A.2d 344 (R.I. 1974); Employers' Fire Ins. Co. v. Chester K. Beals, 240 A.2d 397 (R.I. 1968) ("In this state. . . a liability insurer's duty to defend is predicated not upon information in its possession which indicates or even proves non-coverage, but instead upon the allegations in the complaint filed against the insured; in other words, when a complaint contains a statement of facts which bring the case within or potentially within the risk coverage of the policy, the insurer has an unequivocal duty to defend.").

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the claim.[14] A few jurisdictions permit judicial consideration of facts which negate the duty to defend.[15]

Several hypothetical cases will illustrate the operation of the rule and the problems it engenders.[16] The first two hypotheticals involve complaint allegations which conflict with known facts. The last involves uncertainty about the actual facts underlying the lawsuit.

> An insured under a homeowners policy tenders the defense of a lawsuit against him to his insurer. The complaint alleges that the insured negligently injured the plaintiff, causing substantial injuries. The insurer's investigation of the claim reveals that the insured attacked and beat the plaintiff, without provocation; that the insured admitted his intention to harm the plaintiff; that the insured has been convicted of criminal assault and battery. The homeowners policy excludes coverage for intentional acts[17] and for liability arising out of criminal conduct.[18] The policy promises to defend the insured in lawsuits for "bodily injury" " to which this insurance applies".[19]

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14. Other courts permit use of extrinsic information which supports the duty to defend. *See, e.g.*, Chantel Assoc. v. Mount Vernon Fire Ins. Co., 656 A.2d 779, 784 (Md. 1995); Employers Nat'l Ins. Co. v. Breaux, 516 N.W. 2d 188, 190 (Minn. Ct. App. 1994); Fitzpatrick v. American Honda Motor Co., Inc., 575 N.E.2d 90, 92 (N.Y. 1991); McMahan & Baker, Inc. v. Continental Cas. Co., 843 P.2d 1133, 1137 (Wash. Ct. App. 1993).

15. *See infra* notes 106-09.

16. These hypotheticals involve the common fact pattern in which the defendant's conduct can be characterized as either intentional or negligent.

17. This is a standard exclusion in liability policies. The Insurance Services Office standard Commercial General Liability Policy, for example, provides:

> This insurance does not apply to:
>
> a. Expected or Intended Injury
>
> "Bodily injury" or "property damage" expected or intended from the standpoint of the insured. . . .

Insurance Services Office, Commercial General Liability Coverage Form (1992).

18. Some policies contain additional limitations such as this, to counter the possibility that courts will define "intent" narrowly and find coverage for acts which appear to be intentional. *See, e.g.*, Horace Mann Ins. Co. v. Barbara B., 846 P.2d 792 (Cal. 1993), and discussion *infra* note 49, and accompanying text.

19. Standard Homeowners policies provide in pertinent part:

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> An insured under the same standard homeowners policy tenders a lawsuit against him to the insurer. This lawsuit alleges that the insured wilfully assaulted plaintiff, intentionally causing him serious bodily injury. The insurer's investigation shows that while the insured did in fact injure the plaintiff, he did so negligently. There is no evidence to support the complaint's allegations of an intentional tort.
>
> An insured under the same homeowners policy is faced with a complaint alleging negligence and/or intentional conduct and tenders the defense to the insurer. The underlying facts are unclear: it is uncertain whether the insured defendant's conduct is properly characterized as intentional or negligent.

From a purely practical perspective, without considering the impact of the complaint rule, an insurer's options in each hypothetical include:

- Reject the defense unilaterally.
- Obtain a declaratory judgment as to whether it should accept or reject the defense.
- Accept the defense conditionally, reserving the right to contest coverage later.[20]

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> If a claim is made or a suit is brought against an "insured" for damages because of "bodily injury" or "property damage" caused by an "occurrence" to which this coverage applies, we will:
>
> 1. pay up to our limit of liability for the damages for which the "insured" is legally liable. . . .
> 2. provide a defense at our expense by counsel of our choice, even if the suit is groundless, false, or fraudulent.

Insurance Services Office, Homeowners 3 Special Form, reprinted in ABA, ANNOTATIONS TO THE HOMEOWNERS POLICY (2d ed. 1990).

20. A reservation of rights is a unilateral notice to the insured that an insurer undertakes the defense of the underlying litigation conditionally, reserving the right to contest coverage later. Nonwaiver agreements, used less frequently, are bilateral agreements with the same effect: the insured agrees to accept a conditional defense with the understanding that the insurer may later raise defenses to coverage.

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- Accept the defense unconditionally, without reserving the right to contest coverage.

In the final hypothetical, an additional response is possible:

- Conduct further investigation of the facts to assess the defense obligation.

Given the lack of coverage in the first hypothetical, an insurer's most reasonable response would be to reject the defense unilaterally or to obtain a declaratory judgment permitting it to reject the defense. In the second hypothetical, the appropriate insurer response would be to accept the tender of the defense unconditionally, since coverage is clear.[21] In the third hypothetical, an insurer's most reasonable response would be to conduct further investigation to ascertain its obligations. In each case, however, the complaint rule, and the procedures which have developed around it, dictate an insurer's choice among these alternatives and subvert an insurer's appropriate coverage-based responses.

The insurer in the first hypothetical cannot merely reject the defense. Because the complaint rule prohibits consideration of information outside the complaint to avoid the defense obligation,[22] the insurer in the first hypothetical would subject itself to substantial risks by rejecting the defense, despite the lack of coverage. Simple rejection of the defense constitutes a breach of the duty to defend, as measured by the complaint rule, subjecting the insurer to liability for defense costs,[23] and in many jurisdictions, for indemnification as well.[24] The breach may also give rise

21. This discussion assumes that a reasonable insurer would accept the defense of its insured where its policy provides coverage and reject it in the absence of coverage. Although the assumption appears to be reasonable, it is obviously not universally accepted: the complaint rule itself operates in contravention of this assumption. The assumption that the duty to defend follows coverage is discussed and supported in Section II.A. *infra*.

22. *See supra* note 13.

23. *See generally* Milton Roberts, Annotation, *Insurer's Tort Liability for Consequential or Punitive Damages for Wrongful Failure or Refusal to Defend Insured*, 20 A.L.R.4th 23 (1983).

24. In a substantial minority of jurisdictions, an insurer who breaches its duty to defend is estopped from raising defenses to coverage. *See, e.g.*, Underwriters at Lloyds v. Denali Seafoods Inc., 927 F.2d 459, 462-65 (9th Cir. 1991) (applying Washington law); St. Paul Fire & Marine Ins. Co. v. Vigilant Ins. Co., 919 F.2d 235, 240 (4th Cir. 1990) (applying North Carolina law); Jones v. Southern Marine & Aviation Underwriters, Inc., 888 F. 2d 358, 363 (5th Cir. 1989) (applying Mississippi law); Rhodes v. Chicago Ins. Co., 719 F.2d 116, 120 n.5 (5th Cir. 1983) (applying Texas law); Solo Cup Co. v. Federal Ins. Co., 619 F.2d 1178, 1184 (7th Cir. 1980); Sauer v. Home Indemn. Co., 841 P.2d 176, 183 (Alaska

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to liability for bad faith.[25] Additionally, the insurer may be responsible for the insured's expenses in prosecuting the breach of contract action.[26]

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1992); Missionaries of Co. of the Mary, Inc. v. Aetna Cas. & Sur. Co., 230 A.2d 21 (Conn. 1967); Clemmons v. Travelers Ins. Co., 88 Ill. 2d 469, 479 (1981); Sims v. Illinois Nat'l Cas. Co., 193 N.E.2d 123 (Ill. App. 1963); Nixon v. Liberty Mut. Ins. Co., 120 S.E.2d 430, 434 (N.C. 1961); Coanicut Marine Servs., Inc. v. Insurance Co. of N. Am., 511 A.2d 967, 971 (R.I. 1986).

The imposition of liability for indemnity as a penalty for breach of the duty to defend may not be defensible. Contract damages include those costs flowing from the breach. Except perhaps in the circumstance where an insured cannot afford a defense and a default judgment is entered, or where an insured can afford only incompetent counsel, an adverse judgment is not a consequence of the insurer's rejection of the defense. The majority of jurisdictions which have considered the question do not estop an insurer from contesting coverage based on a breach of the duty to defend. In such jurisdictions, damages against an insurer include only those amounts traceable to the breach. *See, e.g.*, Colonial Oil Indus., Inc. v. Underwriters, 1995 U.S. Dist. LEXIS 17439 (S.D. Ga. 1995) (applying Georgia law); Servants of the Paraclete, Inc. v. Great Am. Ins. Co., 866 F. Supp. 1560 (D. N.M. 1994) (applying New Mexico law); Johnson v. Studyvin, 828 F. Supp. 877 (D. Kan. 1993); Cincinnati Ins. Co. v. Vance, 730 S.W.2d 521 (Ky. 1987); Sentinel Ins. Co. v. First Ins. Co. of Hawaii, 875 P.2d 894, 912-13 (Haw. 1994) ("[A] blanket application of coverage by waiver or estoppel, based upon the failure to provide a defense, subverts any meaningful distinction between the duty to defend and the separate duty to indemnify and, in many cases, serves no more than to punish the insurer for breach of a contractual duty."); Hirst v. St. Paul Fire & Marine Ins. Co., 683 P.2d 440, 447 (Idaho Ct. App. 1984) ("We question the propriety of utilizing a form of estoppel as a punitive measure against an insurer for breach of a contractual duty to defend. Rather, we believe that the sanction for that breach should be governed by ordinary principles of contract law"); Polaroid Corp. v. Travelers Indem. Co., 610 N.E.2d 912 (Mass. 1993); Servidone Const. Corp. v. Security Ins. Co., 477 N.E.2d 441, 444 (N.Y. 1985).

25. Many jurisdictions permit the award of tort and punitive damages for failure to provide a defense. Such extracontractual awards are based on an insurer's breach of an implied covenant of good faith and fair dealing, an obligation imposed by law and not by private contractual agreement. For an overview of bad faith liability in the context of third party insurance, see STEPHEN S. ASHLEY, BAD FAITH LIABILITY (1987).

26. The common law "American Rule" prohibits a party's recovery of attorney's fees incurred in prosecuting a breach of contract action. Where an insurer breaches the duty to defend, however, courts often award insureds attorney's fees incurred in establishing the duty, based on the quasi-fiduciary relationship of the liability insurer and insured. *See, e.g.*, American Family Ins. Co. v. Dewald, 597 F.2d 1148, 1151(8th Cir. 1979); Gibson v. Farm Family Mut. Ins. Co., 673 A.2d 1350, 1354 (Me. 1996); Wheeler v. Reese, 835 P.2d 572, 577 (Colo. App. 1992) (insurer liable for attorney's fees from insured's successful action for breach of duty to defend); Olympic S.S. Co. v. Centennial Ins. Co., 811 P.2d 673 (Wash. 1991); Elliott v. Donahue, 485 N.W.2d 403 (Wis. 1992); *contra* Zurich Ins. Co. v. Killer Music, Inc., 998 F.2d 674, 680 (9th Cir. 1993) (applying California law); Garick v. Northland Ins. Co., 469 N.W.2d 709 (Minn. 1991). Some jurisdictions have provided by statute for the insured's recovery of attorney's fees for establishing coverage. NEB. REV. STAT. § 44-359 (1992); OKLA. STAT. 36 § 3629(B) (1992); OR. REV. STAT. § 743.114 (1991). Some courts condition the insured's recovery of attorney's fees on a showing of the

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As to the possibility of a declaratory judgment, some jurisdictions prohibit an insurer's institution of a declaratory judgment proceeding on policy coverage before the conclusion of the underlying lawsuit.[27] To do otherwise may prejudice the insured by requiring simultaneous defense of the declaratory judgment action and the underlying action, or, if the underlying action is stayed, by resolving factual issues in the underlying litigation.[28] If the underlying action is stayed, the plaintiff may also be

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insurer's bad faith. *See, e.g.*, Farmers Ins. Exch. v. Call, 712 P.2d 231 (Utah 1985). *See generally* Jane M. Draper, *Insured's Right to Recover Attorneys' Fees Incurred in Declaratory Judgment Action to Determine Existence of Coverage Under Liability Policy,* 87 A.L.R. 3d 429 (1978).

27. *See, e.g.*, Fuisz v. Selective Ins. Co., 61 F.3d 238, 247 (4th Cir. 1995) (coverage issue not appropriate for disposition in declaratory judgment action); Hecla Mining Co. v. New Hampshire Ins. Co., 811 P.2d 1083 (Colo. 1991) (appropriate course of action for insurer which believes no coverage under policy is to defend under reservation of rights or file declaratory judgment action after underlying action complete); United States Fidelity & Guar. Co. v. Wilkin Insulation Co., 550 N.E.2d 1032, 1041, *aff'd,* 578 N.E.2d 926 (Ill. 1991); Foundation Reserve Ins. Co., Inc. v. Mullenix, 642 P.2d 604 (N.M. 1982) (insurer may not obtain declaratory judgment on coverage issue where same facts will be addressed in underlying action); North Pacific Ins. Co. v. Wilson's Distrib. Serv., Inc., 908 P.2d 827 (Or. 1995) (duty to defend may not be negated by declaratory judgment prior to conclusion of underlying action); Commonwealth County Mut. Ins. Co. v. Moctezuma, 900 S.W.2d 798, 800 (Tex. Ct. App. 1995).

In contrast, North Dakota's rules specifically provide for the resolution of coverage issues in declaratory judgment proceedings. Pertinent provisions of NDCC 32-23-06 state: ". . .the court shall. . .enter a declaratory judgment. . .in an action brought by or against an insurance company to determine liability of the insurance company to the insured to defend, or duty to defend. . . ." In Blackburn, Nickels & Smith, Inc. v. Nat'l Farmers Union Property & Cas. Co., 452 N.W.2d 319, 323 (N.D.1990), the North Dakota Supreme Court held this statute required "the trial court to render a declaratory judgment to determine both coverage and duty to defend, whether or not the insured's liability has been determined."

28. *See, e.g.*, Montrose Chem. v. Superior Court, 861 P.2d 1153 (Cal. 1993) ("To eliminate the risk of inconsistent factual determinations that could prejudice the insured, a stay of the declaratory relief action pending resolution of the third party suit is appropriate when the coverage question turns on facts to be litigated in the underlying action (citations omitted). For example, when the third party seeks damages on account of the insured's negligence, and the insurer seeks to avoid providing a defense by arguing that its insured harmed the third party by intentional conduct, the potential that the insurer's proof will prejudice its insured in the underlying litigation is obvious. This is the classic situation in which the declaratory relief action should be stayed."); Connecticut Gen'l Life Ins. Co. v. AAA Waterproofing Inc., 911 P.2d 684 (Colo. Ct. App. 1995); Murphy v. Urso, 430 N.E.2d 1079, 1084-85 (Ill. 1981); North Pacific Ins. Co. v. Wilson's Distributing Service, Inc., 908 P.2d 827, 832 (Or. Ct. App. 1995) (insurer may not pursue declaratory judgment action which puts insured in position of having to abandon denial of liability in underlying action in order to demonstrate coverage under the policy); Employers' Fire Ins. Co. v. Chester K. Beals, 240 A.2d 397, 402 (R.I. 1968) ("[T]o allow insurance companies to litigate issues which are identical with ones to be tried later during the injury suit would be tantamount to

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harmed by delayed resolution of the plaintiff's claim.[29] Other jurisdictions permit declaratory judgments, but only regarding the duty to defend – which the court must assess under the complaint rule.[30] Some jurisdictions permit declaratory judgment actions concerning the duty to defend only where the issue is a policy defense (such as invalidity of the policy for nonpayment of premiums, timing of the occurrence placing it outside the policy period, or an insured's failure to give timely notice or to cooperate) rather than a coverage defense.[31]

The fourth option, an unconditional defense, would estop the insurer's later contest of coverage.[32] Thus, under the complaint rule, the insurer's only viable option in the first hypothetical is acceptance of the defense under a reservation of rights.

Despite clear coverage in the second hypothetical, a strong version of the complaint rule, under which the insurer may consider only the complaint and not any evidence extrinsic to it, permits the insurer to reject the defense.[33] Many jurisdictions, however, utilize a modified version of

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permitting insurance companies to assume unfairly the control and command of the tort litigation (citations omitted). To do otherwise would surely jeopardize the injured party's right to direct, control and manage the course of his injury suit.")

29. *See supra* note 6.

30. *See, e.g.*, Transcontinental Ins. Co. v. Ice Sys. of Am., Inc., 874 F. Supp. 947 (M.D. Fla. 1994); Western World Ins. Co. v. Paradise Pools & Spas, Inc., 633 So. 2d 790, 793 (La. Ct. App. 1994); Lumbermens Mut. Cas. Co. v. Belleville Indus., 555 N.E.2d 568, 575 (Mass. 1990); Blackburn, Nichols & Smith, Inc. v. National Farmers Union Property & Cas. Co., 452 N.W.2d 319, 322-23 (N.D. 1990); Erie Ins. Exch. v. Claypoole, 673 A.2d 348, 355 (Pa. 1996) ("In [declaratory judgment] actions, the allegations raised in the underlying complaint along fix the insurer's duty to defend."); North Star Mut. Ins. Co. v. Kneen, 484 N.W.2d 908, 911-12 (S.D. 1992); Travelers Ins. Co. v. North Seattle Christian and Missionary Alliance, 650 P.2d 250 (Wash. Ct. App. 1982) (duty to defend rendered meaningless if insurer permitted to avoid its duty to defend through declaratory judgment action demonstrating that complaint allegations are groundless, false or fraudulent).

31. *See, e.g.*, Madden v. Continental Cas. Co., 1996 WL 266512 (Ark. App. 1996); Cold Storage Co., 373 A.2d 247 (Me. 1977).

32. *See, e.g.*, Alliance Ins. Co. v. Collela, 995 F.2d 944, 945 (9th Cir. 1993); Knox-Tenn Rental Co. v. Home Ins. Co., 833 F. Supp. 665, 671 (E.D. Tenn. 1992); Sauer v. Home Indem. Co., 841 P.2d 176, 182 (Alaska 1992); Ogden v. U.S. Fidelity & Guar. Co., 932 S.W.2d 169, 1714 (Ariz. Ct. App. 1996); Stonewall Ins. Co. v. City of Palos Verde Estates, 46 Cal. App. 4th 1810, 1838-39 (1996); American Gen'l Fire & Cas. Co. v. Progressive Cas. Co., 199 P.2d 1113, 1117 (N.M. 1990). Some jurisdictions utilize a different rule. *See, e.g.*, AIG Hawaii Ins. Co. v. Smith, 891 P.2d 261, 264 (Haw. 1995) (insurance company may initially assume unconditional defense while it performs coverage investigation and may thereafter reserve rights).

33. A number of jurisdictions endorse this result. *See supra* note 13. Pennsylvania is a notable example. Despite the decision of a federal court predicting that Pennsylvania courts would require an insurer to defend a claim where the complaint could be "reasonably

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the rule, under which an insurer must consider facts supporting coverage in assessing its defense obligation.[34] In these jurisdictions, the insurer would be required to assume the defense of its insured. As in the first hypothetical, however, the insurer's likely response would be a defense under a reservation of rights: if the complaint allegations can in fact be proved, there is no coverage, and a reservation of rights preserves the insurer's ability to raise coverage issues.

In the third hypothetical, the majority rule requires acceptance of the defense. Even if additional investigation revealed noncoverage, the result would not change: extrinsic information may trigger, but not defeat, the defense obligation.[35] The insurer must determine its obligation to defend based on the complaint. If the complaint alleges covered negligence, the insurer must defend, regardless of the facts further investigation might reveal. If the complaint alleges intentional conduct, the insurer must defend if there is any possibility that a claim based in negligence could be asserted or proved.[36] Given uncertainties surrounding the facts, an insurer faced with either possibility will defend under a reservation of rights.

In the first and second hypotheticals, the complaint rule contradicts the resolution of the duty to defend based on coverage. In the third hypothetical, the complaint rule prevents resolution of the defense issue based on coverage. The third hypothetical presents greater complications than the first and second. Most courts require resolution of any doubts about the insurer's duty to defend against the insurer.[37] This approach

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amended" to state a claim compensable under the insured defendant's policy, Safeguard Scientifics v. Liberty Mut. Ins. Co., 766 F. Supp. 324 (E.D. Pa. 1991), *rev'd in part on other grounds*, 961 F.2d 209 (3d Cir. 1992), all Pennsylvania state courts considering the issue have continued to apply the four corners rule. Aetna Cas. & Sur. Co. v. Roe, 650 A.2d 94, 98 (Pa. Super. Ct. 1994) ("The insurer's obligation is fixed solely by the allegations in the underlying complaints"); Britamco Underwriters, Inc. v. Grzeskiewicz, 639 A.2d 1208 (Pa. Super. Ct. 1994); Britamco Underwriters, Inc. v. Weiner, 636 A.2d 649 (Pa. Super. Ct. 1994); American States Ins. Co. v. Maryland Cas. Co., 628 A.2d 880 (Pa. Super. Ct. 1993); Stidham v. Millvale Sportsmen's Club, 618 A.2d 945, *app. denied*, 637 A.2d 290 (Pa. 1993); Heffernan & Co. v. Hartford Ins. Co. of Am., 614 A.2d 295 (Pa. Super. Ct. 1992); Biborosch v. Transamerica Ins. Co., 603 A.2d 1050, *app. denied*, 615 A.2d 1310 (Pa. 1992). *See also* I.C.D. Indus., Inc. v. Federal Ins. Co., 879 F. Supp. 480, 488 (E.D. Pa. 1995) ("This Court, too, concludes that the 'four corners of the complaint' rule is the correct statement of Pennsylvania law and respectfully declines to follow the Safeguard Scientifics approach.").

34. *See supra* note 14.

35. *See supra* note 14.

36. *See, e.g.*, Gray v. Zurich Ins. Co., 419 P.2d 168 (Cal. 1966).

37. For an early example, see Lee v. Aetna Cas. & Surety Co., 178 F.2d 750, (2d Cir. 1949), in which Chief Judge Learned Hand, faced with a complaint alleging injuries caused

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seems reasonable in the context of insurance law generally, where the ambiguity doctrine[38] routinely results in decisions against the insurer. In this instance, however, courts use the ambiguity doctrine in the context of factual rather than verbal ambiguities. As posed by a majority of courts, the issue in duty to defend cases is not whether a specific ambiguous provision covers a particular factual occurrence, but whether it is possible that a lawsuit in its infancy may, at some point, implicate the policy coverage. Many courts also construe ambiguities in the complaint against the insurer.[39] In other words, courts resolve factual doubts concerning coverage and doubts surrounding the complaint in favor of the duty to defend. Such use of the ambiguity doctrine clearly expands its boundaries. In the normal situation, *contra proferentum* (construction against the drafter) applies because the insurer drafted the policy and accordingly bears responsibility for any ambiguity it contains. But the insurer bears no responsibility for factual uncertainties, and no responsibility for ambiguities in the pleadings.

Thus, the complaint rule and accompanying procedures force conditional defenses. In turn, these defenses create substantial legal complications.[40] Typically, the attorney retained by the insurer to defend its insured represents both the insured and insurer, each of whom has substantial interests in the litigation.[41] Such dual representation is generally

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by plaintiff's fall into defendant's elevator shaft and a policy which excluded coverage for bodily injury arising out of the "use" of an elevator, concluded: "[w]hether the insurer ought to defend such an action at least until it appears that the claim is not covered by the policy is not free from doubt; but it seems to us that we should resolve the doubt in favor of the insured." *Id.* at 752.

38. According to basic canons of insurance policy interpretation, any ambiguity in the policy of insurance is construed against the drafter, the insurer. For general discussions of the doctrine, see, e.g., ROBERT H. JERRY, II, UNDERSTANDING INSURANCE LAW, § 25A (2d ed. 1996); ROBERT E. KEETON AND ALAN I. WIDISS, INSURANCE LAW: A GUIDE TO FUNDAMENTAL PRINCIPLES, LEGAL DOCTRINES, AND COMMERCIAL PRACTICES, § 6.3(a) (1988).

39. *See, e.g.*, Ledford v. Gutoski, 877 P.2d 80, 83 (Or. 1994) ("Any ambiguity with respect to whether the allegations could be covered is resolved in favor of the insured.").

40. The courts' discussions of the duty to defend promote conflicts by requiring a defense until the insurer can confine the claim to noncovered elements. For example, *see supra* note 36 and accompanying text.

41. Problems for defense counsel abound. In addition to difficulties dealing with conflicts, *see supra* notes 1-4 and accompanying text, counsel are at serious risk for malpractice lawsuits by the insurer as well as the insured. Because defense counsel represents both insurer and insured, many jurisdictions permit an insurer to sue defense counsel for malpractice. *See, e.g.*, Glenn v. Fleming, 781 P.2d 1107 (Kan. Ct. App. 1989); Friesens v. Larson, 438 N.W.2d 444 (Minn. Ct. App. 1989), *rev'd on other grounds*, 443

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permitted by both the Model Rules of Professional Conduct[42] and the Model Code of Professional Responsibility.[43] If, however, the interests of the insurer and insured actually or potentially conflict, dual representation is prohibited.[44] In many jurisdictions, a reservation of rights defense may in itself create a conflict of interest[45] sufficient to mandate single-client status

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N.W.2d 830 (Minn. 1989); Nationwide Mut. Ins. Co. v. Winslow, 382 S.E.2d 872 (N.C. Ct. App. 1989).

42. The American Bar Association presented the Model Rules to the states in 1983. Forty-one states and the District of Columbia have adopted legal ethical rules based on the Model Rules. The Model Rules do not specifically address issues relating to insurance defense. *See* ABA Standing Committee on Ethics and Professional Responsibility, Formal Op. 96-403, "Obligation of a Lawyer Representing an Insured Who Objects to a Proposed Settlement within Policy Limits" (August 2, 1996) ("The Model Rules of Professional Conduct offer virtually no guidance as to whether a lawyer retained and paid by an insurer to defend its insured represents the insured, the insurer, or both."). Rule 1.7 articulates the general rule concerning conflicts of interest, permitting dual representation if the lawyer reasonably believes the representation will not be adversely affected and the client consents after consultation. Rule 1.8(f) permits payment for representation of a client by one other than the client where the client consents after consultation and there is no interference with the lawyer's independent judgment or the attorney-client relationship.

43. The ABA Model Code of Professional Responsibility, promulgated in 1969, survives in California, Massachusetts, New York, Oregon and Vermont, none of which have adopted the Model Rules. Disciplinary Rule 5-105(C) permits multiple representation if the lawyer can adequately represent each client and each consents after full disclosure. *See also* Oregon State Bar Ass'n Bd of Governors, Formal Op. No. 1991-121 (1991) ("As a general proposition, an attorney who represents an insured in an insurance defense case has two clients: the insurer and the insured.").

44. *See* Rule 1.7, Disciplinary Rule 5-105(C). If a lawyer has already undertaken the representation of both, each must consent to continued representation; if either refuses, the lawyer must withdraw from representation of both. Some commentators take the position that defense counsel automatically continues in the representation of the insured only. This possibility appears to be limited by the Model Rules. Rule 1.7, Comment 2 states "Where more than one client is involved and the lawyer withdraws because a conflict arises after representation, whether the lawyer may continue to represent any of the clients is determined by Rule 1.9 which prohibits continued representation unless the parties consent after consultation." Presumably, an attorney could continue to represent the insured only if both insured and insurer consented to that arrangement after consultation.

45. *See, e.g.*, Kansas Bankers Surety Co. v. Lynass, 920 F.2d 546, 549 (8th Cir. 1990) (applying South Dakota law); Fireman's Fund Ins. Co. v. Waste Management of Wisconsin, Inc., 777 F.2d 366 (7th Cir. 1985); New York State Urban Dev. Corp. v. VSL Corp., 738 F.2d 61 (2d Cir. 1984); CHI of Alaska, Inc. v. Employers Reinsurance Corp., 844 P.2d 113, 116-18 (Alaska 1993); San Diego Navy Fed. Credit Union v. Cumis Ins. Soc'y, 162 Cal. App. 3d 358, 364-69, 208 Cal. Rptr. 494, 498-502 (Cal. Ct. App. 1984); Missouri *ex rel* Rimco, Inc. v. Dowd, 858 S.W.2d 307, 308 (Mo. Ct. App. 1993) ("A reservation of rights may chill a zealous defense based on the insurer's assessment of the liability and it presents a possible conflict of interest because the insurer may be more concerned with developing

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for the insured;[46] the insurer becomes a third-party payor and must retain its own representation. In jurisdictions where a conditional defense does not automatically create a conflict as a matter of law, there is in fact a conflict. A reservation of rights defense significantly misaligns the interests of insurer and insured, creating a conflict in fact if not in law.[47]

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facts showing noncoverage than facts defeating liability."). The Cumis rule has been limited by statute in California. California Civil Code § 2860(b) provides:

> For purposes of this section, a conflict of interest does not exist as to allegations or facts for which the insurer denies coverage; however, when an insurer reserves its rights on a given issue and the outcome of that coverage issue can be controlled by counsel first retained by the insurer for the defense of the claim, a conflict of interest may exist.

*Id.*

Other jurisdictions hold that a reservation of rights creates a potential conflict of interest. In Alabama and Washington, the potential conflict of interest that arises under a reservation of rights requires "an enhanced obligation of good faith" on the part of the insurer and appointed counsel towards the insured. *See, e.g.*, L & S Roofing Supply Co. v. St. Paul Fire & Marine Ins. Co., 521 So. 2d 1298, 1303-4 (Ala. 1987); Tank v. State Farm Fire & Cas. Co., 715 P.2d 1133, 1137 (Wash. 1986). Some courts recognize the threat to the insured's interests and permit the insured to settle independently of the insurer (in direct contravention of the policy conditions) where the insurer offers a reservation of rights defense. *See, e.g.*, Lozier v. Auto Owners Ins. Co., 1992 U.S. App. LEXIS 749 (9th Cir. 1992); Cay Divers, Inc. v. Raven, 812 F.2d 866, 870 (3d Cir. 1987); United Servs. Auto. Ass'n v. Morris, 741 P.2d 246, 252-54 (Ariz. 1987); Pruyn v. Agricultural Ins. Co., 36 Cal. App. 4th 500, 509, 42 Cal. Rptr. 2d 295 (Cal. Ct. App. 1995); Miller v. Shugart, 316 N.W.2d 729 (Minn. 1982).

46. *See, e.g.*, William Barker, *The Right and Duty to Defend: Conflicts of Interest and Insurer Control of the Defense,* Litigating the Coverage Claim: Denial of Coverage and the Duty to Defend, 1991 ABA Sec. Tort & Ins. Prac. 195.

Other circumstances may conceivably result in the opposition of insurer/insured interests, such as a request for damages in excess of policy limits or a claim for punitive damages. Because inflated prayers for relief and unwarranted claims for punitive damages have become routine, courts do not disturb the dual representation in such instances. *See, e.g.*, Bogard v. Employers Cas. Co., 164 Cal. App. 3d 602, 210 Cal. Rptr. 578 (1985); Parker v. Agricultural Ins. Co., 109 Misc. 2d 678, 440 N.Y.S.2d 964 (1981) ("Indisputably the great bulk of litigation involving insureds, wherein punitive damages may be routinely tacked on to the ad damnum clause, may be predictably, regularly and properly defended and controlled by the insurer."); Scalettar v. Hartford, 1985 Daily Wash. L. Rep. 1635 (Super. Ct. 1985); Zieman Mfg. Co. v. St. Paul Fire & Marine Ins. Co., 724 F.2d 1343 (9th Cir. 1983); *contra* Nandorf, Inc. v. CNA Ins. Co., 479 N.E.2d 988 (Ill. App. Ct. 1985).

47. Where the insurer defends conditionally under a reservation of rights or a nonwaiver agreement, the interests of the insurer and insured are opposed, as Figure 1 illustrates, creating a conflict of interest. Most significantly, the insurer's optimal outcome is also the worst possible outcome for the insured.

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FIGURE 1. Preferred Outcomes: Conditional Defense (Claim within Policy Limits)

| Insurer | Insured |
|---|---|
| 1. Judgment for plaintiff on noncovered claim | 1. Settlement |
| 2. Judgment for insured | 2. Judgment for insured |
| 3. Settlement | 3. Judgment for plaintiff on covered claim |
| 4. Judgment for plaintiff on covered claim | 4. Judgment for plaintiff on noncovered claim |

The ordering of preferences may vary depending on the relative costs of defense and settlement and the risk of an adverse judgment. If a plaintiff's judgment is likely and projected defense costs substantial, the insurer may prefer settlement over other options. The insured's preferences are unlikely to vary, with one exception. Although insureds generally prefer to avoid litigation, professional insureds sued for malpractice may prefer litigation as a possible means of protecting professional reputation. Regardless of these possible variations, however, the reservation of rights ineluctably pits insurer's interests against insured's. A claim in excess of policy limits magnifies the divergence of interests, as illustrated in Figure 2.

FIGURE 2. Preferred Outcomes: Conditional Defense (Claim in Excess of Policy Limits)

| Insurer | Insured |
|---|---|
| 1. Judgment for plaintiff on noncovered claim | 1. Settlement within limits |
| 2. Judgment for insured | 2. Judgment for insured |
| 3. Settlement | 3. Judgment for plaintiff on covered claim within limits |
| 4. Judgment for plaintiff on covered claim | 4. Settlement above limits |
| | 5. Judgment for plaintiff on covered claim above limits<br>Judgment for plaintiff on noncovered claim |

In contrast, unconditional defenses align the interests of insured and insurer. The interests of insurer and insured differ only minimally, as illustrated by Figure 3, and may not differ at all. For example, depending on the relative costs of defense and settlement and the risk of an adverse judgment, the insurer may prefer settlement to litigation. Alternatively, an insured may prefer litigation to settlement, as in the case of professional insureds with reputational interests at stake.

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In the first hypothetical, the insurer's knowledge that it does not provide coverage for the insured's conduct is irrelevant. The insurer must undertake the defense in the absence of coverage. Moreover, because there is no coverage, the insurer will defend conditionally, creating a conflict of interest between insurer and insured, increasing the cost and complexity of the defense. If the jurisdiction does not treat a conditional defense as a conflict, the insured's interests are jeopardized; the insurer's control of the defense affords an opportunity to slant the litigation towards the noncovered intentional claim rather than the lesser, covered negligence claim.

In the second hypothetical, the insurer will reject the defense of a covered claim under a strict complaint rule; under the modified complaint rule, which requires consideration of facts supporting coverage, the insurer will defend. However, it is likely that the insurer will do so conditionally, giving rise to the conflicts of interest noted above. Such false conflicts of

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FIGURE 3. Preferred Outcomes: Unconditional Defense (Claim within Policy Limits)

| Insurer | Insured |
|---|---|
| 1. Judgment for insured | 1. Settlement |
| 2. Settlement | 2. Judgment for insured |
| 3. Judgment for plaintiff | 3. Judgment for plaintiff |

Even where plaintiff's claim exceeds policy limits, the interests of insurer and insured basically converge, as Figure 4 shows.

FIGURE 4. PREFERRED OUTCOMES: UNCONDITIONAL DEFENSE (CLAIM IN EXCESS OF POLICY LIMITS)

| Insurer | Insured |
|---|---|
| 1. Judgment for insured | 1. Settlement within limits |
| 2. Settlement | 2. Judgment for insured |
| 3. Judgment for plaintiff | 3. Judgment for plaintiff within limits |
| | 4. Settlement above limits |
| | 5. Judgment for plaintiff above limits |

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interest, in covered cases where the insurer should be involved, prevent an insurer's participation in settlement negotiations, preclude the insurer's ability to assure that the insured is represented by competent counsel, and eliminate the insurer's control over or participation in defense expenses and strategies. Conversely, in those jurisdictions which do not view a reservation of rights as creating a conflict of interest, the insured's interests may suffer: the insurer's control over the litigation may permit it to slant the case towards noncoverage.

The anomalous results generated by the complaint rule are no less than remarkable. A strong version of the complaint rule permits insurers to take advantage of pleadings and deny a defense in a covered case. Weaker versions of the complaint rule give insurers an incentive to defend conditionally in a covered case. All versions of the rule require insurers to assume a defense in noncovered cases if the complaint alleges a covered claim. The result is the proliferation of unnecessary conflicts of interest. The facts of several recent cases illustrate that these anomalous results are not confined to hypothetical cases:

> An insurer rejected the defense of its insureds, a chiropractor and the professional corporation encompassing his practice, in an action based on the chiropractor's surreptitious recording of private conversations between plaintiffs, a therapist who rented office space from the insured, and her patients, one of whom was the insured's wife. Under the Business Owners Policy, only actions within the scope of the insured's employment were covered, and the insurer concluded that the policy provided no coverage for the claims. The insured settled and filed a declaratory judgment action against the insurer. The court found that the insurer's defense obligation had been triggered by the complaint's allegation that the insured had acted as an agent of the corporation. The breach of the duty to defend obligated the insurer to pay defense costs and the settlement, despite the court's admission that the insurer "appear[s] to have a meritorious argument that no coverage exists."[48]

48. Michaud v. Merrimack Mut. Fire Ins. Co., 1994 U.S. Dist. LEXIS 19930, at *23 (R. I. 1994).

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An insurer was required to defend its insured under an educator's liability policy in an action based on the insured's sexual molestation of his thirteen year-old student. The policy excluded coverage for intentional actions and for civil suits arising out of criminal acts. Although the insured had pleaded nolo contendere to violating the state Penal Code, the court found a duty to defend because the complaint alleged "nonsexual" acts related to the seduction of the victim which negligently caused her emotional distress.[49]

The pleadings alleged that the driver of a vehicle involved in an accident had the named insured's permission to use the vehicle. Based on the pleadings, the insurer had a duty to defend, despite its correct factual conclusion that no permission had actually been given.[50]

In an action involving polychlorinated biphenyl (PCB) pollution of New Bedford Harbor, a federal district court certified to the Supreme Judicial Court of Massachusetts the following question: whether an insurer, whose duty to defend was triggered by the complaint but who would be liable at most for only a small fraction of the damages which might be awarded, could terminate its duty to defend prior to the conclusion of the underlying action. The district court noted: "[E]ach of the insurers herein has incurred more than one million dollars in legal costs in providing a defense of its clients in the underlying actions. Even so, . . . there appears virtually no evidence that any significant contribution to the pollution at issue in the underlying case flowed from incidents which were 'sudden and accidental' [and thus covered under the policy]."[51] According to the Supreme Judicial Court, an insurer has a duty to defend where the complaint alleges a covered claim, even if "it is apparent from the event that gave rise

49. Horace Mann Ins. Co. v. Barbara B., 846 P.2d 792 (Cal. 1993).
50. Colon v. Aetna Life & Cas. Ins. Co., 484 N.E.2d 1040 (N.Y. 1985).
51. Lumbermens Mut. Cas. Co. v. Belleville Ind., 555 N.E.2d 568, 574 (Mass. 1990).

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to the underlying claim that the loss is not covered by the insurance policy."[52]

In addition to the anomalous results generated by the complaint rule, there are a number of fundamental difficulties in its application. First, under the complaint rule, the plaintiff's counsel has virtually complete control over the contractual obligations of an insurer to its insured. Skillful pleading by plaintiff's counsel can involve the insurer in the litigation, even in the absence of coverage, with significant strategic advantages accruing to the plaintiff.[53] That the plaintiffs' bar manipulates pleadings to involve insurers in noncovered cases is beyond dispute.[54] Once the insurer is involved, defense costs and the insurer's fiduciary responsibilities to the insured regarding settlement[55] jointly impose pressures on the insurer to settle, regardless of coverage questions. On the other hand, inept pleading

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52. *Id.* at 575.

53. As in *Michaud*, 1994 U.S. Dist. LEXIS 19930, where the insurer funded the settlement and paid defense costs in the absence of coverage as a result of its breach of the duty to defend.

54. Numerous reported cases document counsel's amendment of the pleadings specifically to allege a covered claim and trigger the insurer's defense obligation. *See, e.g.*, Western Heritage Ins. Co. v. River Entertainment, 998 F.2d 311 (5th Cir. 1993) (complaint amended to exclude reference to alcohol or to intoxication of insured's patron to avoid application of liquor liability exclusion, triggering defense obligation despite noncoverage); Thornton v. Paul, 384 N.E.2d 335 (Ill. 1978) (The court noted that all facts, with exception of amended complaint, indicated claim based on intentional battery, that plaintiff's counsel was aware that defendant's act constituted battery, and that amended complaint filed solely to bring the action within insurance coverage. The court concluded: "There is no explanation for the procedures followed other than the desire of plaintiff's counsel to maneuver the insurer into a position where it would be obligated to pay the judgment and estopped from raising the defense of noncoverage."); Brohawn v. Transamerica Ins. Co., 347 A.2d 842, 846 (Md. 1975) (plaintiff's counsel amended complaint by adding allegations of negligence to create a potential for coverage and involve Brohawn's liability insurer); Lawrence v. Northwest Cas. Co., 311 P.2d 670 (Wash. 1957) (complaint initially alleging insured's assault and battery amended to allege negligence); *see also* Nikolai v. Farmers Alliance Mut. Ins. Co., 830 P.2d 1070 (Colo. App. Ct. 1991) (plaintiff's counsel withdrew negligence claims from complaint alleging sexual assault when notified of insurer's intent to commence declaratory judgment action on coverage and subsequently amended complaint to reinstate negligence claims following appellate ruling that insured's state of mind in sexual assault cases poses a factual question which triggers the duty to defend). Given standardization of insurance policies, it is quite possible in most cases to draft initial pleadings which will ensure the involvement of defendant's insurance company.

55. *See* Jerry, *supra* note 38, at § 112, for a discussion of the insurer's settlement obligations.

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by the plaintiff's counsel may preclude the defense obligation in a covered case.[56]

Second, the complaint is not a particularly useful tool for assessing the defense obligation. The complaint often provides very little information regarding a claim. Notice pleading under Federal Rule of Civil Procedure 8 and similar state rules[57] requires only that the complaint set out a "short and plain statement of the claim showing that the [claimant] is entitled to relief,"[58] and that pleadings "shall be simple, concise, and direct."[59] Recognition of the complaint's limited notice function has prompted a number of courts to look beyond the complaint in assessing the duty to defend.[60] Other courts, however, continue to adhere to the complaint rule despite problems created by notice pleading. In discussing the insurer's duty to defend under notice pleading, the U.S. District Court in Idaho, for example, stated:

> The duty to defend arises upon the filing of a complaint whose allegations, in whole or in part, read

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56. A common example involves environmental pollution cases where the pleadings trigger the pollution exclusion, but actual facts suggest that the exception to the pollution exclusion, for "sudden and accidental" discharges, may apply.

57. Most states currently follow the example of the Federal Rules and allow notice pleading. Alabama, Alaska, Arizona, Colorado, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Kansas, Kentucky, Maine, Massachusetts, Minnesota, Missouri, Montana, Nevada, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Rhode Island, South Dakota, Tennessee, Utah, Vermont, Washington, West Virginia, Wisconsin, and Wyoming use notice pleading, modeled after the federal rule. JACK H. FRIEDENTHAL ET AL., CIVIL PROCEDURE § 5.1, at 239 (1985).

58. FED. R. CIV. P. 8(a)(2).

59. FED. R. CIV. P. 8(e)(1).

60. *See, e.g.*, Kepner v. Western Fire Ins. Co., 509 P.2d 222 (Ariz. 1973). The Court of Special Appeals in Maryland discussed the history of the complaint rule (known in Maryland as the "exclusive pleading rule," *see supra* note 10) at length, concluding that the adoption of notice pleading had resulted in abandonment, in whole or part, of the rule. Eastern Shore Fin. Resources, Ltd. v. Donegal Mut. Ins. Co., 581 A.2d 452 (Md. 1990). The court noted that:

> The Exclusive Pleading Rule necessarily rests on the assumption that it is in fact possible to determine from the allegations of the complaint whether the claim falls within the policy coverage. . . . Where "notice pleading" was adopted, however, that critical underpinning of the rule became structurally (and logically) unsound.

*Id.* at 460. Because Maryland had not adopted strict notice pleading, the court declined to relax the complaint rule, noting that "resort to extrinsic evidence to supplement or replace the complaint is not without its own set of problems." *Id.* at 461.

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> broadly, reveal a potential for liability that would be covered by the insured's policy. The problem which faces the insurers when a claim is made is determining if there is a potential for liability. However, . . .since the advent of notice pleading there will likely be broad ambiguous claims made against the insured making it more difficult for the insurer to determine whether the insurance policy covers the claims. . . . [W]here there is doubt as to whether a theory of recovery within the policy coverage has been pleaded in the underlying complaint, the insurer must defend regardless of potential defenses arising under the policy or potential defenses arising under the substantive law under which the claim is brought against the insured.[61]

Finally, perhaps because of its universal acceptance, courts utilize the complaint rule without providing any real justification for doing so. A typical analysis of the duty to defend consists of the court's recitation of the complaint rule, the statement that the duty to defend is broader than, separate from, and independent of the duty to indemnify, and a description of the policy's coverage. The sheer weight of the precedents may account for this phenomenon; one commentator has recently suggested that overwhelming demands on the judiciary and the relatively arcane nature of insurance law may account for the heavy and largely uncritical reliance on formal doctrine in insurance cases.[62] This observation may be particularly apt in the case of the complaint rule. The next section turns first to an examination of policy language concerning the duty to defend, and then to a discussion of explicit and implicit rationales for the complaint rule and the procedures which have developed around it.

## II. THE COMPLAINT RULE

Very little in the case law or commentary convincingly defends the complaint rule. In fact, many decisions offer no rationale other than precedential for the rule. Many omit any discussion of policy language.[63]

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61. Idaho v. Bunker Hill Co., 647 F. Supp. 1064, 1068 (D. Idaho 1986).

62. Peter Nash Swisher, *Judicial Interpretations of Insurance Contract Disputes: Toward a Realistic Middle Ground Approach,* 57 OHIO ST. L. J. 543, 555-65 (1996).

63. Where courts do in fact analyze policy language, they often omit the portion of the defense provision which conditions the duty to defend on coverage. *See, e.g.*, Foundation Reserve Ins. Co., Inc. v. Mullenix, 642 P.2d 604 (N.M. 1982) ("The provision of the policy relating to the duty of the insurer to defend under the terms of the insurance policy reads: '[T]he company shall: (a) defend any suit against the insured . . . even if such suit is

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In many ways, the duty to defend has become a duty imposed not by contract but by law; considerations of public policy motivate many judicial opinions concerning the duty to defend.[64] This section examines policy language and the courts' failure to discuss or analyze it, and the basic (mostly implicit) rationales for the complaint rule. The Section demonstrates that the complaint rule is indefensible where facts concerning coverage are available.

### *A. Policy Language*

Liability insurance policies typically provide that the insurer will defend its insured in lawsuits for damages covered by the policy. For example, the standard Commercial Liability policy reads as follows:

> We will pay those sums that the insured becomes legally obligated to pay as damages because of "bodily injury" or "property damage" to which this insurance applies. We will have the right and duty to defend any "suit" seeking those damages.[65]

The Personal Auto policy similarly provides:

> We will pay damages for "bodily injury" or "property damage" for which any "insured" becomes legally responsible because of an auto accident. . . . We will settle or defend, as we consider appropriate, any claim or suit asking for these damages. In addition to our limit of liability, we will pay all defense costs we incur. . . . [W]e have no duty to defend any suit or settle any claim for "bodily injury" or "property damage" not covered under this policy.[66]

Homeowners policies also limit the duty to indemnify and defend to covered lawsuits:

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groundless, false or fraudulent'". The omitted portion of the provision limits the defense obligation to suits seeking damages for covered injuries.)

64. *See* Fischer, *supra* note 7 at 150.

65. Commercial General Liability Coverage Form, Insurance Services Office, Inc. (1992).

66. Personal Automobile Insurance Policy, Insurance Services Office, Inc. (1988).

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> If a claim is made or a suit is brought against an "insured" for damages because of "bodily injury" or "property damage" caused by an "occurrence" to which this coverage applies, we will . . .
>
> 1. Pay up to our limit of liability for the damages for which the "insured" is legally liable. . . and
> 2. Provide a defense at our expense by counsel of our choice, even if the suit is groundless, false, or fraudulent.[67]

Policy language suggests that coverage alone triggers the duty to defend. Typical policies, like those quoted above, indicate clearly that both the duty to indemnify and the duty to defend are dependent on coverage under the policy.[68] In each policy, the duty to defend and the duty to indemnify are subject to the same limiting language which makes coverage a prerequisite. The Commercial Liability policy requires indemnification only for damages "because of 'bodily injury' or 'property damage' *to which this insurance applies*," and a defense for "any 'suit' seeking *those damages*," referring back to the limiting language of the indemnity provision. The Personal Auto policy is quite similar, reinforcing the point with a final sentence stating that coverage determines the duty to defend: "[W]e have no duty to defend any suit or settle any claim for 'bodily injury' or 'property damage' not covered under this policy."[69] The Homeowners policy is structured differently, with the limiting language set out first, followed by the statement of the duty to indemnify, in subpart (1) and the duty to indemnify, in subpart (2), but the import is the same.

It is, of course, possible to argue that policy language supports the complaint rule. The fact that some policies refer to the defense of lawsuits "seeking" damages to which the insurance applies, or "asking" for covered damages, permits an inference that the language of the complaint controls an insurer's duty to defend. Such an argument garners support from the insurance law doctrine which protects an insured's reasonable expectations concerning coverage. An insured might reasonably expect, under this policy language, to receive an insurer-provided defense in any action

67. Homeowners Policy 03, reproduced in Alliance of American Insurers, POLICY KIT: SAMPLE INSURANCE FORMS AND ENDORSEMENTS (1991).

68. Declaratory judgment procedures in some jurisdictions make this connection clear. Some jurisdictions permit the insurer to obtain a declaratory judgment that there is no coverage under the policy and accordingly no duty to defend. *See supra* note 27.

69. Personal Automobile Insurance Policy, *supra* note 66.

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which alleged a covered claim, regardless of the actual facts.[70] The first and second provisions above, which require a defense in lawsuits "seeking" or "asking for" damages for injuries "to which this insurance applies," might suggest a defense obligation measured by the complaint. Alternatively, if the policy language can reasonably be read as requiring reference either to the complaint or the facts, it is ambiguous, and *contra proferentum* requires construction against the insurer.[71]

As a matter of common sense, however, it is clear that the duty to defend is necessarily related to coverage. The point is especially clear in an extreme example: no one would expect an auto insurer to undertake the defense of its insured in a professional malpractice action.[72] Similarly, it would be unusual to construe identical limiting language in the policies differently for defense and coverage obligations. The current majority practice of utilizing allegations to determine the duty to defend, and actual facts to determine the duty to indemnify, in *all* cases, contravenes the most plausible construction of the policy language and undercuts accepted

70. As articulated by Robert E. Keeton in a two-part law review article published in 1970, "the objectively reasonable expectations of applicants and intended beneficiaries regarding the terms of insurance contracts will be honored even though painstaking study of the policy provisions would have negated those expectations." Robert E. Keeton, *Insurance Law Rights at Variance with Policy Provisions: Part One,* 83 HARV. L. REV. 961, 967 (1970); Robert E. Keeton, *Insurance Law Rights at Variance with Policy Provisions: Part Two,* 83 HARV. L. REV. 1281 (1970). For an extreme example, see Fire Ins. Exch. v. Jiminez, 184 Cal. App. 3d 437, 229 Cal. Rptr. 83 (Cal. Ct. App. 1986), in which an insured tendered the defense of a personal injury action involving his commercial property to his homeowners insurer. The homeowners policy covered only the insured's residence, and excluded coverage for business pursuits. The trial court found a duty to defend based on the insured's reasonable expectations. The court held that the duty to defend provision did not adequately convey to the insured the limits on the duty. According to the trial court,

> [t]he only exception to this general statement [that the Company shall have the right and duty to defend. . . any suit against the insured seeking damages on account of such bodily injury. . . even if any of the allegations of the suit are groundless, false or fraudulent.] is the word "such" which modifies "bodily injury." Since the claim by Metzger in the underlying personal injury suit is for bodily injury, it is the opinion of the court that as a matter of fact this language quoted above would not place a reasonable person on notice that the Company does not have a duty to defend a lawsuit even if the liability coverage of the policy would not cover a judgment against the defendant.

*Id.* at n.1. The court of appeals reversed.

71. Under this doctrine, any ambiguity in the policy is construed against the insurer. *See supra* note 38.

72. *But see Fire Ins. Exch.*, 229 Cal. Rptr. at 84, n.1.

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methods of contract interpretation. The most plausible construction of the provisions is that actual coverage controls both duties. In other words, it is unreasonable to expect that the allegations, in the face of contrary facts, control an insurer's duty to defend, or to read identical limiting language as referring in one instance to allegations and in another to facts.[73]

Similarly, *contra proferentum* does not support the complaint rule: in many jurisdictions, there is no ambiguity to construe against the insurer if the alternative construction of the policy language is unreasonable.[74] Because insureds do not really contract for and cannot reasonably expect a near-absolute duty to defend, the most reasonable reading of the policy is that the defense obligation depends on the facts of coverage. Furthermore, using ambiguity doctrine to determine the duty to defend may create an anomaly. In some instances, it will be to an insured's advantage to assess the duty to defend based on allegations;[75] in others, it will be to an insured's advantage to assess the duty based on facts.[76] Thus, use of the ambiguity doctrine precludes the possibility of a general rule; the determinant of the defense obligation will change depending on whether assessment according to facts or allegations benefits the insured.

Finally, the language of some policies does not permit the inference, either through the reasonable expectations doctrine or the ambiguity doctrine, that the complaint determines the duty to defend. The final sentence of the quoted portion of the Personal Auto Policy above clearly limits the defense obligation to covered cases: "[W]e have no duty to defend any suit or settle any claim for 'bodily injury' or 'property damage' not covered under this policy." The third provision above, from the standard Homeowners policy, is similar in its effect. It refers only to the

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73. Kenneth S. Abraham launches a broader attack on the reasonable expectations doctrine in the context of the duty to defend, concluding that the expansive duty to defend arises from judicial concerns about the substance of coverage rather than with protecting the insured's expectations. He argues that most insureds have no expectations based on policy language because they do not read the policy. He notes further that any readers would not understand the duty to defend provision well enough to be misled by it and if they did read carefully, they would also understand the limitations on the duty. Kenneth S. Abraham, DISTRIBUTING RISK at 111.

74. *See* Jerry, *supra* note 38 at § 25A(b).

75. For example, in many cases involving sexual harassment, abuse, or molestation, the complaint alleges negligent infliction of emotional distress to avoid the intentional act exclusion. It is to the insured's advantage to rely on the allegations in such cases, because courts generally agree that abuse and molestation are by definition intentional acts excluded from coverage both by policy language and public policy. *See, e.g.*, *supra* note 49 and accompanying text.

76. *See supra* note 56.

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facts of coverage, without suggesting that the duty to defend should be gauged based on the complaint. Under that policy language, the duty to defend arises if a claim is made against the insured "for damages because of 'bodily injury' or 'property damage' caused by an 'occurrence' to which this coverage applies."[77]

The promise to defend "groundless, false, or fraudulent" suits, contained in many early policies and some modern policies such as the Homeowners policy cited in the preceding paragraph,[78] has suggested to many courts that the duty to defend is virtually absolute and the complaint determines the duty.[79] Even where policies do not contain this language, recent decisions often adopt early judicial recitations of the language as a rule.[80] If a lawsuit is truly groundless, there are no facts by which to assess coverage. In this limited instance, the duty to defend must be determined by the allegations of the complaint. If, however, there is a factual basis for the lawsuit, this provision does not apply.[81] To utilize the "groundless,

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77. *See supra* note 54.

78. *See supra* text accompanying note 67.

79. *See, e.g.*, Preferred Risk Ins. Co. v. Gill, 507 N.E.2d 1118 (Ohio 1987). The Ohio Supreme Court in that case sharply distinguished policies which promise to defend "groundless, false or fraudulent suits" and policies which do not:

> We hold, therefore, where the insurer does not agree to defend groundless, false or fraudulent claims, an insurer's duty to defend does not depend solely on the allegations of the underlying tort complaint. Absent such an agreement, the insurer has no duty to defend or indemnify its insured where the insurer demonstrates in good faith in the declaratory judgment action that the act of the insured was . . . outside the policy coverage.

*Id.* at 1123; *see also* Travelers Ins. Co. v. North Seattle Christian and Missionary Alliance, 650 P.2d 250, 254 (Wash. 1982) ("This agreement to defend [even if allegations are groundless, false or fraudulent] is a valuable provision of the policy that exists independently of the agreement to pay a judgment. The provision would be rendered virtually meaningless if Travelers were allowed to avoid its duty to defend by using a declaratory judgment action to prove that the allegations in the. . .actions were groundless, false or fraudulent.").

80. In many ways, the duty to defend has become a matter of public policy rather than contract: early policy language, by dint of repetition, has hardened into a rule.

81. The decision of the United States District for the Southern District of Georgia explained: "If the true facts reveal no coverage, then, notwithstanding the grant of coverage's promise to defend even groundless lawsuits, the insurer nevertheless can safely decline to defend." Colonial Oil Indus., Inc. v. Underwriters, 1995 U.S. Dist. LEXIS 17439 (S.D. Ga. 1995). *See also* Bolden v. Economy Preferred Ins. Co., 1994 Ohio App. LEXIS 2007 (1994), in which the court commented on the decision of the Ohio Supreme Court in

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false or fraudulent" language in a broader context, to create an absolute duty to defend, cannot be justified by policy language or public policy.

### B. *"The duty to defend is broader than, separate from, and independent of, the duty to indemnify."*

The articulated basis for most decisions involving the duty to defend is a series of maxims derived from precedent. Cases and commentaries routinely recite, in one form or another, that the duty to defend is broader than, independent of, and separate from the duty to indemnify when they find that an insurer must defend its insured.[82] These related maxims contain a bit of truth, but at least as a matter of contract, they are more wrong than right, and more significantly, they do very little to advance an understanding of the duty to defend or to assess its existence in a particular case. In the words of Oliver Wendell Holmes, "It is not the first use, but rather the tiresome repetition of inadequate catch words, . . . phrases which

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*Preferred Risk v. Gill*, 507 N.E.2d at 118. The court noted that the insurer agreed to defend groundless, false or fraudulent suits, but commented that

> [P]receding that language is the following language: "caused by an occurrence to which this coverage applies. . . ." Thus, it must first be determined whether or not the complaint alleges bodily injury to which coverage applies. If coverage applied, appellee (insurer) would then be bound to defend a claim, even if it were groundless, false or fraudulent. However, if coverage did not apply, then appellee would have no duty to defend.

Id. at *4-5.

82. Virtually every case includes such a recitation, as do the treatises and commentaries. The Court of Appeals of New York explicitly identified these maxims as the basis for the complaint rule in a recent opinion:

> The rationale underlying the cases in which the "four corners of the complaint" rule was delineated and applied [citations omitted] is based on the oft-stated principle that the duty to defend is broader than the duty to indemnify. [citations omitted] In other words, as the rule has developed, an insurer may be contractually bound to defend even though it may not ultimately be bound to pay, either because its insured is not factually or legally liable or because the occurrence is later proven to be outside the policy's coverage. It follows logically from this principle that an insurer's duty to defend is called into play whenever the pleadings allege an act or omission within the policy's coverage.

Fitzpatrick v. American Honda Motor Co., Inc., 575 N.E.2d 90, 92 (N.Y. 1991).

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originally were contributions, but which, by their very felicity, delay further analysis for fifty years."[83]

In a limited sense, it is true that the duty to defend is broader than and independent of the duty to indemnify. Litigation of a covered claim may be concluded favorably for the insured, with the result that the insurer, although required to defend, has no judgment to indemnify. The more salient point, however, is that the two duties are related, both dependent on coverage under the policy. Indemnity is conditioned on coverage and a judgment against the insured; defense is conditioned on coverage alone. In other words, contrary to the maxims, the duty to defend and the duty to indemnify are coextensive *except* where the insured prevails in a covered lawsuit.[84]

One likely reason for the misunderstanding of the insurer's defense obligation is the courts' tendency to conflate coverage and indemnity.[85] This confusion permits the following flawed syllogism: if the duty to indemnify is equivalent to coverage under the policy, and the duty to defend is broader than the duty to indemnify, then the duty to defend exists despite a lack of coverage. The problem, of course, is that the duty to indemnify, like the duty to defend, is dependent on coverage rather than coextensive with it. For example, the policy may provide coverage for an occurrence which does not produce a lawsuit or which produces a lawsuit concluded favorably for the insured. In both instances, the issue of coverage is independent of the duty to indemnify.

Even assuming these maxims were correct statements in a broad sense, they cannot further analysis of the duty to defend in particular cases. The maxims merely address the relationship between two conditional obligations, indemnity and defense, the first of which is unknown at the time the second must be assessed. The maxims alone cannot generate conclusions about the existence of either duty in a particular case: the fact that the duty to defend is broader than the duty to indemnify does not, and cannot, indicate whether the duty to defend arises. Rather, the maxims

83. OLIVER WENDELL HOLMES, COLLECTED LEGAL PAPERS 230-31 (1921).

84. This is true as a matter of contract, but in many cases, it is apparent that the courts assess the duty to defend based on considerations of public policy rather than contract. It is also apparent, however, that public policy considerations in many cases, particularly where the complaint rule creates unnecessary conflicts of interest, yield the same result as contract language. *See infra* Section III.A.2.

85. Language in many opinions suggests that the courts perceive coverage and the duty to indemnify as equivalents. *See, e.g.*, Seymour Mfg. Co., Inc. v. Commercial Union Ins. Co., 665 N.E.2d 891, 892 (Ind. 1996) ("[T]he duty to defend is broader than an insurance company's coverage liability or its duty to indemnify.").

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merely impart a generalized sense that the insurer's obligation to defend is expansive, without specifying its parameters. The adverse impact of the maxims, however, is enormous: they support a duty to defend in *all* cases tendered to a liability insurer.

### *C. Timing and Efficiency*

The timing of the decision to accept or reject the defense is sometimes explicitly offered as a rationale for the complaint rule.[86] More often, it implicitly justifies a rule for which the proffered support (the maxims discussed above) fails. The duty to defend must be assessed at the outset of litigation, when the court has not yet determined the facts; in contrast, the duty to indemnify arises only at the conclusion of litigation when a judgment has been entered. Since the complaint initiates the lawsuit, it is an obvious vehicle for assessing the duty to defend in the absence of a developed factual record. Courts and commentators have also justified the complaint rule by noting its simplicity. In order to assess its duty, an insurer need only review the complaint and the policy.[87]

It is clear, however, that neither timing nor efficiency really justifies use of the complaint rule. The necessity of making an early determination about the duty to defend cannot justify focusing solely on the complaint where facts concerning coverage are available. Many jurisdictions recognize this point to a limited degree. Under the rules in many jurisdictions, an insurer must consider facts extrinsic to the complaint which indicate coverage and thus trigger the duty to defend.[88] If, however, extrinsic facts indicate no coverage, the insurer's duty to defend depends solely on the complaint and the policy.[89] Timing alone cannot account for these rules; it is also apparent that the rules do not necessarily promote efficiency. The configuration of these rules suggests, rather, that the

86. Some courts and commentators explicitly identify timing as the rationale for the complaint rule. *See, e.g.*, Gray v. Zurich Ins. Co., 419 P.2d 168 (Cal. 1966); Fresno Economy Import Used Cars, Inc. v. United States Fidelity & Guar. Co., 142 Cal. Rptr. 681, 685 (Cal. App. 1977) ("[T]he duty to defend is broader than the obligation to indemnify. This results from the difficulty in determining whether the third party suit falls within the indemnification coverage before the suit is resolved."); Fischer, *supra* note 7, at 142-43. Professor Fischer's article identifies timing as the "traditional explanation" for the courts' requiring insurers to defend claims for which there is no duty to indemnify, but recognizes that timing alone cannot justify the expansive duty to defend.

87. *See, e.g.*, Gary A. Schlessinger, *The Evolution of an Insurer's Duty to Defend,* 6 ENVTL. CLAIMS J. 327, 327-28 (1994).

88. *See supra* text accompanying note 14.

89. A limited number of jurisdictions permit judicial consideration of facts which negate the duty to defend. *See infra* notes 106-09.

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motivation for using the complaint rule is limiting an insurer's discretion to deny its insured a defense.

### *D. The Real Reason for the Complaint Rule*

Two related difficulties in assessing an insurer's defense obligation account for the complaint rule. First, at the time the duty to defend must be determined, no legal record of facts exists. The underlying action will produce a factual record which may impact on coverage[90] as well as liability, but only a declaratory judgment action can supply such a record prior to the conclusion of the underlying action. Because of problems inherent in the use of declaratory judgment proceedings in this context,[91] many jurisdictions limit their availability.[92]

Second, courts are reluctant to permit insurers to make unilateral factual assessments impacting the duty to defend. A decision of the Massachusetts Court of Appeals illustrates the concern. After discussing the options where the complaint suggests coverage but the facts indicate otherwise, the court noted:

> What is not permitted is that an insurer shall escape its duty to defend the insured against a liability arising on the face of the complaint and policy, by dint of its own assertion that there is no coverage in fact: the insurer then stands in breach of its duty even if the third party fails in the end to support any such claim of liability by adequate proof (citation omitted).[93]

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90. The resolution of the underlying action often will not resolve the coverage question. A general verdict may not indicate whether there is or is not coverage, and some jurisdictions do not favor the use of special questions to the jury in cases where insurance coverage is at issue. *See, e.g.*, Gray v. Zurich Ins. Co., 419 P.2d 168, 178, n.18 (Cal. 1966); Cowan v. Insurance Co. of North America, 318 N.E.2d 315, 326 (Ill. 1974); *but see* American Home Assur. Co. v. Evans, 589 F. Supp. 1276, 1279-87 (E.D. Mich. 1984), *vacated on other grounds*, 791 F.2d 61 (6th Cir. 1986).

91. Judicial determination of coverage prior to the conclusion of the underlying lawsuit for purposes of determining the duty to defend presents a number of problems, including delay of the underlying action, resolution of facts possibly at issue in the underlying action, negatively impacting on one or both parties, and, to the extent that issues in the declaratory judgment action overlap with those in the underlying action, inefficient use of judicial resources. *See supra* notes 5 and 6 and accompanying text. Duplication of effort will be minimized by the operation of collateral estoppel, but will still occur. *See infra* note 98.

92. *See supra* note 27 and accompanying text.

93. Sterilite Corp. v. Continental Cas. Co., 458 N.E.2d 338, 343-44 (Mass. Ct. App. 1983); *see also* Western World Ins. Co. v. Hartford Mut. Ins. Co., 784 F.2d 558 (4th Cir.

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The real reason for the complaint rule, then, appears to be judicial reluctance to let insurers make factual determinations about their contractual obligations without judicial oversight or approval. The next Section turns to the basic questions of whether such reluctance is warranted.

## III. AN ALTERNATIVE TO THE COMPLAINT RULE: THE INSURER'S FACTUAL ASSESSMENT OF COVERAGE

Uncertainty about coverage in the absence of a legal record of facts, the difficulties occasioned by determining coverage prior to the conclusion of the underlying lawsuit, and judicial reluctance to permit insurers to resolve uncertainties independently of the courts, jointly prompt use of the complaint as a measure of the duty to defend.

This Section argues that insurers should be permitted to decide whether to accept or reject the defense of its insured based on an independent assessment of coverage. Redefining the insurer's duty to defend in this way will eliminate the anomalies created by the complaint rule and reduce significantly the incidence of conflicts of interest in insurance defense. As many of the cases cited throughout this Article indicate, an insurer often has a great deal of factual information[94] independent of the complaint, sufficient to assess coverage and determine the duty to defend. Further, many jurisdictions require an insurer to consider factual information extrinsic to the complaint supporting coverage and the duty to defend in assessing the duty to defend.[95] It is also clear that the question of whether the policy provides coverage is a factual question which exists independently of the litigation between plaintiff and the insured defendant.[96] A limited number of jurisdictions permit judicial consideration of facts which negate the duty to defend.[97]

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1986) (The court was concerned that if the insurer was not bound by allegations and able to rely on extrinsic facts, it "would be given the license to unilaterally resolve issues of interpretation and construction to its benefit without recourse.")

94. And, in many instances, an insurer has the means to obtain more information, through normal investigative procedures permitted by the policy's notice and cooperation provisions. *See infra* Section III.A.

95. *See supra* note 14.

96. Of course, factual issues relating to coverage under the policy and to the insured's liability often overlap. As a conceptual matter, however, the two are distinct: the first involves questions of the contractual obligations between insurer and insured; the other involves the question of the insured's liability to an unrelated third party. It is also possible that the existence of coverage may turn on factual issues which will not be examined in the

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If insurers are permitted to reach independent conclusions about coverage, and thus the duty to defend, the basic rules concerning the duty to defend are simple. Once an insurer determines that the policy provides coverage, it should provide an unconditional defense for its insured. Conversely, if the facts indicate no coverage, the insurer should reject the defense. An insured who disagrees with the insurer's assessment may bring an action to force the insurer to defend. If the facts are unclear, a conditional defense or a declaratory judgment proceeding on the issue of coverage may be warranted.[98] This brief description leaves a number of unanswered questions. Is assessing the defense obligation based on facts rather than complaint allegations workable? Does the insurer have access to sufficient information to permit fact-based determination of the duty to defend? Will the insured's interests be adequately protected if the insurer is given the power to make unilateral coverage determinations? Can a change in the method of determining the duty to defend eliminate or minimize conflicts of interest in insurance defense? This Section addresses, in turn: the insurer's ability to obtain information necessary to make coverage determinations at the outset of the underlying litigation; the insurer's incentives to make accurate, objective assessments of coverage and methods of protecting the insured's interests; and the effect of the proposed rules on the problem of conflicts of interest in insurance defense.

### *A. The Availability of Information*

The question remains whether assessing the defense obligation based on facts rather than allegations is workable. Does the insurer have access to sufficient information to permit an assessment based on facts rather than allegations? In other words, can an insurer make a determination about coverage before the lawsuit gets underway?

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underlying litigation. And even where factual issues related to coverage are litigated, the litigation may not resolve the coverage issue: a general verdict for plaintiff, will not, for example, indicate whether the insured acted negligently (triggering coverage) or intentionally (excluding coverage) or whether environmental pollution occurred gradually (triggering the pollution exclusion) or was "sudden and accidental" (triggering a common exception to the pollution exclusion).

97. *See infra* notes 106-12 and accompanying text.

98. Declaratory judgment procedures can be tailored to protect the insured's interests. For example, some jurisdictions limit the collateral estoppel effects of the declaratory judgment to avoid prejudicing the insured in the underlying action. *See, e.g.*, Gray v. Zurich Ins. Co., 419 P.2d 168 (Cal. 1966).

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First, as many of the cases cited in the course of this Article indicate, the insurer often has sufficient facts to determine coverage,[99] sometimes even before the complaint is filed. Policies require an insured to notify the insurer of any accident or occurrence under the policy, providing, in writing, the identity of the policy and the insured, "reasonably available information" on the time, place, and circumstances of the accident or occurrence, and the names and addresses of any claimants and witnesses.[100] Standard policies also impose on the insured a duty to cooperate with the insurer in the investigation of a claim or suit.[101] Failure to comply with either requirement may invalidate the coverage.[102]

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99. *See, e.g., supra* notes 48-51.

100. The Insurance Services Office Commercial General Liability Policy provides:

> a. You must see to it that we are notified as soon as practicable of an "occurrence" or an offense which may result in a claim. To the extent possible, notice should include:
> (1) How, when and where the "occurrence" or offense took place;
> (2) The names and addresses of any injured persons and witnesses; and
> (3) The nature and location of any injury or damage arising out of the "occurrence" or offense.
>
> b. If a claim is made or "suit" is brought against any insured, you must
> (1) Immediately record the specifics of the claim or "suit" and the date received; and
> (2) Notify us as soon as practicable.

*Supra* note 65.

The Personal Automobile Policy similarly provides:

> We must be notified promptly of how, when and where the accident or loss happened. Notice should also include the names and addresses of any injured persons and of any witnesses.

*Supra* note 66.

101. The Commercial General Liability Policy provides:

> c. You and any other involved insured must...
> (2) Authorize us to obtain records and other information;
> (3) Cooperate with us in the investigation, settlement or defense of the claim or "suit"....

*Supra* note 65.

Limited authority holds that the cooperation clause applies only to the insurer's defense of its insured in the underlying lawsuit and not to coverage issues. Martin v. Travelers Indem. Co., 450 F.2d 542, 553 (5th Cir. 1971) (cooperation clause applies to insurer's right to prepare substantive defenses rather than to its ability to contest coverage); Lafarge Corp. v. Hartford Cas. Ins. Co., 61 F.3d 389, 397-98 (5th Cir. 1995) ("[W]e think it is clear that, once the insurer sues the insured and contests coverage, the insurer cannot rely on the cooperation clause to gain access to information that any other party would be

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Second, many courts impose on insurers a duty to investigate prior to making decisions concerning the duty to defend.[103] Although many jurisdictions still adhere strictly to the complaint rule,[104] exceptions have been created in other jurisdictions. In many jurisdictions, if an insurer's investigation reveals coverage, the insurer must defend; information extrinsic to the complaint triggers the obligation.[105] Most significantly, a trend permitting extrinsic information to negate the duty to defend appears to be emerging.[106] The highest courts of some jurisdictions,[107] isolated

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required to obtain through ordinary discovery methods.") Many courts have not addressed the issue of the applicability of the cooperation clause to coverage issues related to the insurer's duty to defend. Some policy provisions, such as that in the Personal Auto policy, make it clear that the cooperation clause applies to both the insurer's preparation of a defense of its insured and the insurer's investigation of whether the policy applies to a particular claim. The Personal Auto policy provides:

> B. A person seeking any coverage must:
> 1. Cooperate with us in the investigation, settlement or defense of any claim or suit.
> 2. Promptly send us copies of any notices or legal papers received in connection with the accident or loss.
> 3. Submit, as often as we reasonably require: . . .
>    b. to examination under oath and subscribe the same.
> 4. Authorize us to obtain:
>    a. medical reports; and
>    b. other pertinent records.

*Supra* note 66.

102. For cases involving denial of coverage due to failure to notify the insurer properly, *see e.g.*, Rutgers Cas. Ins. Co. v. Vassas, 652 A.2d 162 (N.J. 1995); Mitchell v. State Farm Fire & Cas. Co., 642 So. 2d 462 (Ala. 1994); Granite State Ins. Co. v. Nord Bitumi U.S., Inc., 422 S.E.2d 191 (Ga. 1992), *reh'g denied*, 986 F.2d 421 (11th Cir. 1993); Home Ins. Co. v. Horace Mann Ins. Co., 603 A.2d 860 (Maine 1992); Matter of Arbitration Between Allcity Ins. Co. and Jimenez, 581 N.E.2d 1342 (N.Y. 1991); Continental Ins. Co. v. Stanley, 569 S.W.2d 653 (Ark. 1978).

For cases involving denial of coverage due to failure to cooperate in insurer's investigation, *see, e.g.*, Wildrick v. North River Ins. Co., 75 F.3d 432 (8th Cir. 1996); Utica Mut. Ins. Co. v. Gruzlewski, 217 A.2d 903 (N.Y. App. Div. 1995); Owens v. Allstate Ins. Co., 455 S.E.2d 368 (Ga. 1995); Roussos v. Allstate Ins. Co., 655 A.2d 40 (Md. Ct. App. 1995).

103. *See, e.g.* Colonial Oil Indus., Inc. v. Underwriters, 1995 U. S. Dist. LEXIS 17435 (S.D. Ga. 1995) (investigation of facts for purposes of determining duty to defend can be done through actual field work, such as sending out an insurance investigator or consulting with the insured).

104. *See supra* note 13.

105. *See supra* note 14; *see also infra* notes 106-9.

106. This view enjoyed some prominence in the 1960s and 1970s, *see, e.g.*, Kepner v. Western Fire Ins. Co., 509 P.2d. 222, 223-25 (Ariz. 1973); Texaco, Inc. v. Hartford Acc. &

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appellate courts in other jurisdictions,[108] and federal courts applying state law[109] have ruled that actual facts govern the duty to defend.[110] Some

Indem., 453 F. Supp. 1109, 1112-14 (E.D. Okla. 1978), but not enough to overcome the general reliance on the complaint as the basis of the duty to defend.

107. *Kepner*, 509 P.2d at 223-25 (true facts test of insurer's duty to defend adopted because: 1) pleadings serve notice function; 2) trial often does not resolve coverage issue; and 3) conflicts of interest exist where insurer defends but facts indicate no coverage.); Montrose Chem. Corp. v. Superior Court, 861 P.2d 1153, 1155, 1159-60 (Cal. 1993) (where insurer can show as a matter of law that extrinsic facts negate duty); Cincinnati Ins. Co. v. Vance, 730 S.W.2d 521 (Ky. 1987) (true facts test); F. & M. State Bank v. St. Paul Fire & Marine, 242 N.W.2d 840, 844 n.4 (Minn. 1976) (justifying actual facts rule: "To hold otherwise is to invite undercover deals, lack of candor, and manipulation of the tort pleadings as a device for involving an insurer who could not otherwise be involved."); Haarstad v. Graf, 517 N.W. 2d 582, 584 (Minn. 1994); Garvis v. Employers Mut. Cas. Co., 497 N.W.2d 254, 254 (Minn. 1993); Burns v. Underwriters Adjusting Co., 765 P.2d 712, 713 (Mont. 1988) (complaint alleged only negligence, but insurer properly refused defense based on its investigation showing insured's conduct intentional); Preferred Risk Ins. Co. v. Gill, 507 N.E.2d 1118 (Ohio 1987) ("where insurer does not agree to defend groundless, false, or fraudulent claims, an insurer's duty to defend does not depend solely on the allegations of the underlying tort complaint.").

108. *See, e.g.*, Liberty Mut. Ins. Co. v. Metzler, 586 N.E.2d 897, 901 (Ind. Ct. App. 1992) (where insurer's independent investigation of the facts underlying complaint reveals that claim is patently outside of the policy coverage, insurer may properly refuse to defend); Home Mut. Ins. Co. v. Lapi, 596 N.Y.S.2d 885, 886-87 (N.Y. App. Div. 1993) (no duty to defend where insured admitted conduct intentional); State Farm Fire & Cas. Co. v. Helminiak, 659 N.E.2d 385, 388 (Ohio C.P. 1995) (insurer may produce evidence on summary judgment of "true facts" which contradict allegations to defeat duty to defend).

109. *See, e.g.*, Bankwest v. Fidelity & Deposit Co., 63 F.3d 974, 978 (10th Cir. 1995) ("The insurer must determine whether there is a potential of liability under the policy by examining the allegations of the complaint as well as any additional facts that have been brought to its attention."); Colonial Oil v. Underwriters, 1995 U.S. Dist. LEXIS 17435 (S.D. Ga. 1995) ("If the true facts reveal no coverage, then, notwithstanding the grant of coverage's promise to defend even groundless lawsuits, the insurer nevertheless can safely decline to defend."); Texaco, Inc. v. Hartfort Acc. & Indem., 453 F. Supp. 1109, 1113 (E.D. Okla. 1978) ("We hold that [where alleged facts bring the case within policy coverage but other facts plainly indicate no coverage] there is no absolute duty to defend for these reasons: . . . First . . . the complaint serves a notice function and is framed before discovery proceedings crystallize the facts of the case. . . Second, there are many cases. . .where the allegations of facts in the complaint, even if proved, will not be decisive as to the obligation of the insurer to pay the resulting judgment. . .Third,. . . if on the facts the insurer has reason to believe the policy does not cover the insured, the interests of the insurer and insured may diverge. . . . [T]he insurer should not then control the defense.").

110. Some jurisdictions permit the use of evidence extrinsic to the complaint by the court only. *See, e.g.*, Avondale Indus., Inc. v. Travelers Indem. Co., 774 F. Supp. 1416 (S.D.N.Y. 1991) (reviewing New York and Louisiana law and concluding that although insurer's duty to defend generally determined by complaint, court in underlying action or declaratory coverage action may determine, based on evidence outside the complaint, that insurer has no duty to defend).

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courts have taken a more limited step, holding that the complaint rule gives way when extrinsic information indicates a policy defense (for example, lack of notice) rather than a coverage defense.[111] The gradual chipping away at the rule in favor of facts may suggest that the complaint rule should give way to rules focusing on facts. The evolution of the rule indicates that coverage, as determined by the actual facts, rather than solely by the complaint, should govern the duty to defend. If factual information outside the complaint can trigger a duty to defend, there is no compelling reason why it cannot negate the duty to defend.[112]

### *B. Protecting the Insured's Interests*

Permitting an insurer to decide whether it will accept or reject a tendered defense based on its factual assessment of coverage is reasonable, both because coverage is dispositive of the duty to defend, and because the insurer often has information adequate to assess coverage. Otherwise, the plaintiff's lawyer, a nonparty to the insurance arrangement, controls the duty to defend through the complaint.[113] If nonjudicial decision making concerning the defense is tolerated, it is perhaps more appropriate that the insurer, rather than a nonparty to the contract with a strong incentive to involve the insurer, make this decision.

But will permitting an insurer to make coverage decisions early in a lawsuit impair the insured's rights or create opportunities for insurer overreaching and abuse? It appears that the basic motivation for the judicial adoption of the complaint rule is concern for protecting the insured's interests. As numerous courts and commentators have noted, liability insurance has also become "litigation insurance",[114] at least since

111. Yankee Caithness Joint Venture, v. Planet Ins. Co., 1996 U.S. Dist. LEXIS 5414 (S.D.N.Y. 1996) (evidence extrinsic to complaint that claim arose prior to inception of claims-made policy negates duty to defend; "[o]therwise, the basic purpose for which claims-made policies were designed would be effectively defeated."); Avemco Ins. Co. v. Acer Enter. Inc., 796 F. Supp. 343, 346 (N.D. Ill. 1992) (known loss defense not clear from complaint justifies insurer's refusal to defend); Texaco Inc. v. Hartford Accident & Indem. Co., 453 F. Supp. 1109 (E.D. Okla. 1978) (fact that defendant in underlying action not an insured defeats insurer's duty to defend despite allegations of complaint); Guar. Nat'l Ins. Co. v. de Baca, 907 P.2d 210 (N.M. Ct. App. 1995) (no duty to defend where policy not in effect at time of accident, despite ambiguous complaint allegations).

112. *See, e.g.*, Montrose Chem. Corp. v. Superior Court, 10 Cal. Rptr. 2d 687, 693 (Cal. Ct. App. 1992) ("[N]either logic, common sense, nor fair play supports a rule allowing only the insured to rely on extrinsic facts to determine the potential for coverage.")

113. *See supra* notes 53-54 and accompanying text.

114. *See, e.g.*, Fischer, *supra* note 7; Federman & Ruder, *supra* note 7.

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the California Supreme Court's decision in Gray v. Zurich Insurance Co.[115] Courts have come to view protection of the insured from the expenses of litigation as one of the basic purposes of liability insurance.[116] An expansive reading of the duty to defend, based on the complaint, prevents an insurance company from "guessing wrong", to the insured's detriment, as to the potential for coverage of a lawsuit.[117] Many courts have voiced concerns about letting insurers make unilateral decisions rejecting the defense of lawsuits against their insureds.[118]

Such concerns may be misplaced. A comparison of first and third party coverages[119] is instructive. In first party coverages, the insurer routinely makes unilateral decisions concerning coverage, investigating claims and informing insureds whether or not the policy provides coverage for a particular loss. There is nothing about liability insurance which should preclude similar decision-making by a liability insurer. In both instances, the insurer determines whether coverage exists under the policy; in both instances, the insured has substantial interests at stake. If anything, the liability insured may be in a better position than the first-party insured to monitor the insurer's decision and decision-making process. Because a liability insured will be represented by counsel in the underlying action[120] (unlike a first-party insured, who has no independent reason to obtain legal counsel), concerns relating to the insured's ability to proceed against the

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115. Gray v. Zurich Ins. Co., 419 P.2d 168 (Cal. 1966).

116. *See, e.g.*, Solo Cup Co. v. Federal Ins. Co., 619 F.2d 1178, 1185 (7th Cir. 1980).

117. Idaho v. Bunker Hill Co., 647 F. Supp. 1064, 1068 (D. Idaho 1986).

118. *See, e.g., Sterilite*, 458 N.E.2d at 338.

119. First party coverages protect the insured for losses suffered directly by the insured. Property insurance and health insurance are good examples. Liability insurance is third-party insurance; it protects the third party injured by the insured's conduct. In other words, if the insured's conduct causes an injury to a third party, the liability insurer covers the insured's liability to that third party.

120. Of course, an insured may not be able to afford counsel absent insurer participation. In such cases, there may be a default judgment; another possible alternative is a Damron or Miller-Shugart settlement, in which the plaintiff and the insured settle the action, with the insured assigning to the plaintiff all rights against the insurer (for breach of the duty to defend or settle and for bad faith) in exchange for plaintiff's agreement not to execute the judgment against the insured. Many jurisdictions permit such agreements where an insurer has rejected its insured's tender of the defense of a claim or where the insurer, having accepted the defense, reserves its rights to contest coverage. *See, e.g.*, Hospital Underwriting Group, Inc. v. Summit Health Ltd., 63 F.3d 486 (6th Cir. 1995); Consolidated Am. Ins. Co. v. Mike Soper Marine Serv., 951 F.2d 186 (9th Cir. 1991); Insurance Co. of N. Am. v. Spangler, 881 F. Supp. 539 (D. Wyo. 1995); Glenbrook Homeowners Assoc. v. Scottsdale Ins. Co., 858 F. Supp. 986 (N.D. Cal. 1994); Damron v. Sledge, 460 P.2d 997 (Ariz. 1969); Miller v. Shugart, 316 N.W.2d 729 (Minn. 1982).

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insurer in an appropriate case, or the insured's lack of knowledge or sophistication necessary to challenge the insurer, lose much of their force.

More importantly, an insurer has strong incentives to undertake the defense of an insured where it appears that there is coverage, based on the facts. The insurer's duty to defend is a right as well as a duty:[121] the insurer's ability to participate in and control a lawsuit protects the insurer's interests in containing defense costs and minimizing its liability exposure. If there is coverage, or it appears likely that there is coverage, the insurer will want to defend to protect its interests. Even if coverage is questionable, the insurer might still defend unconditionally, avoiding loss of control over the defense and the added expenses occasioned by the conflict.[122] Alternatively, the insurer could initiate a declaratory judgment action on the issue of coverage[123] or, as a last resort, undertake the defense conditionally.

In order to reduce conflicts, the last alternative, a conditional defense, must be truly a last resort; it may even be reasonable to prohibit conditional defenses. Otherwise, insurers may be able to avoid the costs of their litigation decisions to the detriment of their insureds. Even if jurisdictions do not prohibit conditional defenses, there are still substantial incentives to defend unconditionally. In jurisdictions which follow the Cumis rule and require insurers who may contest coverage to provide independent counsel,[124] insurers have a strong incentive to defend unconditionally. In other jurisdictions, courts can control the balance of incentives by requiring that reservations of rights letters meet certain criteria in order to be effective.[125] If insureds are fully informed of the

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121. *See, e.g., supra* text accompanying note 65.

122. *See supra* notes 44-45 and accompanying text. Choosing to defend unconditionally does not, of course, eliminate the conflict – it still exists. But an unconditional defense precludes an insurer from benefitting in any way from the conflict.

123. In such instances, the conditional defense would trigger the single-client model, with appropriate protection for the insured. Presumably, jurisdictions which permit declaratory judgments on coverage to assess the defense obligation would continue to do so. Jurisdictions which prohibit or limit declaratory judgment actions for various reasons, *see supra* notes 27-30, might continue to do so, forcing an insurer uncertain about coverage to elect to defend or not without the benefit of a judicial determination. Appropriate structuring of permitted damages for erroneous rejection of the defense, *see infra* text accompanying notes 129-30, would eliminate the problems for the insurer in this situation.

124. *See supra* note 45.

125. For example, insurers reserving rights could be required to inform the insured in writing of: 1) the reasons for a reservation of rights; 2) the effects of a reservation of rights, including the possibility of an insurer's successful contest of coverage and the potential for conflicts of interest; and 3) the insured's right to control the defense with independently

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reasons for a conditional defense, the potential disadvantages of such a defense, and their right to reject it, insurers will have an incentive to defend unconditionally even in close cases.

Under the duty to defend as redefined by this Article, an insurer may reject the defense of its insured if its investigation reveals that there is no coverage, without breaching its contract or incurring any penalty. However, serious consequences would result from errors or overreaching. Under the current rules applicable to breaches of the defense obligation, if it turns out that there was in fact coverage under the policy and the insurer incorrectly rejected a defense, the insurer would be required to pay damages for breach of contract. Because defense and indemnification are coextensive, both dependend on coverage,[126] damages would include defense costs and, assuming a judgment against the insured or a settlement, indemnification, as well as attorney's fees necessary to prosecute the action against the insurer.[127] Given the likelihood that the insurer's costs for defense and indemnification would be lower if it controlled the lawsuit,[128] contract damages alone provide a substantial incentive for the insurer to assess its obligations fairly. If, on the other hand, the insurer's rejection was wrongful (if, for example, an insurer rejected a defense where available facts demonstrated coverage, or failed to conduct a reasonable investigation), damages for bad faith would be available in addition to defense and indemnity costs. In short, the insurer would make factual determinations concerning coverage and the duty to defend, at its own risk, internalizing the costs of incorrect decisions. In most instances, this combination of negative incentives would guarantee the insurer's careful, good faith assessment of coverage and its duty to defend.[129]

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chosen counsel or insurer-appointed counsel representing only the insured, in lieu of accepting the conditional defense.

126. *See supra* Section II.B.

127. *See supra* note 26.

128. The insurer's litigation expertise and knowledge about the qualifications of available defense attorneys makes it likely that an insurer-controlled defense will be both cheaper and more effective than a defense obtained by an individual insured.

129. This system works in the first party context, where the insurer routinely makes unilateral decisions about coverage under the policy. In the third party context, abuses are even less likely to occur for two reasons: the incentives discussed in the text accompanying this note; and the insured's representation by counsel in the underlying litigation. The fact that the insured has a lawyer (who also has an incentive to guarantee payment of attorney's fees) means that the insurer's conduct will be subject to legal oversight.

A recent Massachusetts Supreme Judicial Court decision addressed the question of the insurer's incentives in a discussion of whether a defense-defaulting insurer should be permitted to raise a coverage issue to a settled claim. The insured argued that allowing the insurer to deny a defense and later raise a coverage issue gave the insurer no incentive to

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One reason for discouraging, or even prohibiting, conditional defenses is to minimize conflicts of interest and the attendant potential for an insurer to elevate its own interests at the expense of its insured's. The alternative suggested by this Article, allowing an insurer to make unilateral coverage determinations, also carries the risk that an insurer will prefer its own interests. In some sense, allowing unilateral coverage decisions merely injects insurer discretion and the possibility of abuse of discretion at an earlier point in the process. Are there good reasons to believe that an insurer will make coverage determinations, but not decisions about litigation strategy, in good faith? The fact that policing insurers' coverage decisions is far simpler than policing litigation strategies indicates that the Article's approach does in fact make sense; the differing nature of the two types of decisions justifies this Article's approach. Although coverage determinations can be extraordinarily difficult, they ultimately depend on facts and policy language. Policing insurers' decisions on coverage is thus a matter of fact-finding and contract interpretation. In contrast, identifying instances in which an insurer controls litigation to its insured's detriment may involve assessments of choices which depend on numerous variables, including the experience and judgment of counsel.

Structuring the duty to defend in this way requires the insured to obtain and pay for counsel in noncovered lawsuits. This makes sense. A likely result of the insurer's ability to reject the defense based on the facts of coverage is a reduction in the incidence of lawsuits against insureds. It is apparent that the existence of insurance drives much of tort litigation.

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assess the defense obligation correctly. The rationale for the Court's differing view also applies in this context. The Court stated:

> The insurer's only risk, so the [insured's] argument goes, is that, if it loses its claim that it has no defense obligation, the insurer will have to pay defense costs, amounts it would have to pay anyway if it assumed the defense immediately. This argument ignores the benefit of controlling the defense, and the risk of a settlement at an amount that is reasonable but higher than that for which the insurer could have settled the case. This argument also assumes that an insurer will choose to do the wrong thing, a course of conduct that may adversely affect its reputation in a competitive commercial insurance under-writing market. Even more significant is the likely impact in such a case of G.L. C. 93A with its provisions for damages and attorneys' fees where an insurer's acts are unfair or deceptive. The rule we adopt does not provide a safe harbor for an insurer that improperly declines to defend a claim.

Polaroid Corp. v. Travelers Indem. Co., 610 N.E.2d 912, 922 (Mass. 1993).

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Insured individuals are more likely to be sued. If insurers can avoid involvement in noncovered cases, their insureds will also benefit. It is also apparent that rules which promote outright unconditional acceptance or rejection of the defense can minimize harmful conflicts of interest between insurer and insured.

Structuring the duty to defend in this way also requires the insured to bring a lawsuit against the insurer if the insured believes an insurer's denial of coverage was incorrect or wrongful. Although this is a significant burden, some jurisdictions already impose similar burdens without apparent problems.[130] Since the insured has legal representation in the underlying action, any difficulties associated with consulting or retaining a lawyer disappear.

### *C. Conflicts of Interest*

Determination of the defense obligation based on facts, rather than allegations, will eliminate many conditional defenses and thus many unnecessary conflicts of interest in insurance defense. In some instances, the insured will be required to provide his or her own defense; in others, the insurer will be able to provide an unconditional defense. The following table illustrates that assessment of the duty to defend based on facts rather than allegations of complaint will reduce the incidence of conditional defenses.[131] The first two columns set out the various permutations of facts and complaint allegations concerning coverage; the third column indicates the required insurer response under a coverage-based assessment of the duty to defend; and the fourth column indicates the typical insurer response under the complaint rule.

| FACTS | ALLEGATION | RESULTS | |
|---|---|---|---|
| | | **Coverage Rule** | **Complaint Rule** |
| | Coverage | Unconditional Defense | Unconditional Defense |
| **Coverage** | No Coverage | Unconditional Defense | Conditional Defense |

130. *See, e.g.*, Burd v. Sussex Mut. Ins. Co., 267 A.2d 7 (N.J. 1970).

131. In some jurisdictions, an insurer that discovers facts eliminating coverage during the course of the litigation may discontinue its defense. *See, e.g.*, Aetna Cas. & Sur. Co. v. Lee, 229 F.2d 787 (D.C Cir. 1956), *cert. denied*, 76 S. Ct. 1027 (1956). In order to realize the benefits of the redefined duty to defend espoused here, this rule would need to be limited. First, an insurer should not be able to withdraw if the insured would be prejudiced thereby. Second, absent wrongful nondisclosure by the insured, the insurer should generally be held to the assessment of coverage made at the outset of litigation. If it is impossible to make an adequate investigation, the insurer should file a declaratory judgment proceeding on the issue of coverage.

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| FACTS | ALLEGATION | RESULTS | |
|---|---|---|---|
| | Unclear | Unconditional Defense | Conditional Defense |
| No Coverage | Coverage | No Defense | Conditional Defense |
| | No Coverage | No Defense | No Defense |
| | Unclear | No Defense | Conditional Defense |
| Unclear | Coverage | Conditional Defense or Declaratory Judgment | Conditional Defense |
| | No Coverage | Conditional Defense or Declaratory Judgment | Conditional Defense or No Defense |
| | Unclear | Conditional Defense or Declaratory Judgment | Conditional Defense |

If the facts indicate coverage, the insurer must defend. If the facts indicate no coverage, the insurer may safely reject the defense. If the facts do not clearly indicate whether coverage exists, the insurer may defend conditionally, or obtain a declaratory judgment based on the facts. In contrast, under the complaint rule, the insurer's options are more limited: in many instances, a conditional defense is the insurer's best option; in the jurisdictions which preclude or limit the availability of declaratory judgments, a conditional defense is the insurer's only option.

## CONCLUSION

Much of the law surrounding the duty to defend, and the complaint rule in particular, appears to derive from the unexamined assumption that an insurer-provided defense is an unqualified good. That assumption is incorrect. When the complaint rule requires a defense where coverage is at issue, it generates conflicts of interest. In jurisdictions which recognize the conflict inherent in coverage-based reservations of rights and require independent counsel, these unnecessary conflicts increase the costs of insurance and the complexities of litigation. In jurisdictions which do not recognize the conflict inherent in coverage-based reservations of rights, the actual conflicts of interest which arise create thorny ethical problems for counsel and the courts and may ultimately disadvantage the insured. When the complaint rule permits insurers to avoid defense of covered claims, it clearly disadvantages insureds.

The absence of compelling justification for the complaint rule in many of its applications, the creation of conflicts of interest resulting directly from its application, and the trend towards fact-based determinations of the duty to defend, suggest that the complaint rule should be modified to allow insurers to make coverage determinations affecting the duty to defend. It is

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unclear, as an empirical matter, precisely what effects modification of the rule will have. However, it is likely that the number of lawsuits will be reduced, since plaintiffs will no longer be able to involve insurers in the absence of coverage and that the incidence of conditional defenses will be reduced, with a corresponding elimination of numerous conflicts of interest.

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# WHEN WORLDS COLLIDE: THE INTERSECTION OF INSURANCE AND MOTION PICTURES

*by Elizabeth O. Hubbart**

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## INTRODUCTION

*Ars Gratia Artis* is the well-known motto of one of the movie industry's most venerable citizens.[1] In fact, there has rarely if ever been art for art's sake in Hollywood. It has usually been art for profit. And after almost a century of doing business, the movie makers find themselves, more than ever before, thinking about business first and art second.[2] Nowhere is this more apparent than when arrangements must be made for cast insurance.[3]

Insurance and the motion picture business would seem to be polar opposites. At one end sit the actuaries calculating probabilities and at the other extreme are the visionaries to whom insurance is a bothersome detail standing between them and their creative product. Located in the middle are the studios and independent producers who want to oversee an entertainment product that is profitable. Inescapably, insurers impose their real world expectations upon an industry where some members simply don't play by the same rules.[4]

This article will examine the current industry atmosphere vis á vis cast insurance after reviewing the historic dealings between Hollywood and insurance companies. Our springboard will be the unprecedented subrogation action filed in 1994 against the estate of the late actor River Phoenix.[5] This article's position is that insurers have a history of loose

1. Metro Goldwyn Mayer has proclaimed "art for art's sake" since its founding.

2. HAROLD ORENSTEIN & DAVID E. GUINN, ENTERTAINMENT LAW & BUSINESS § 9.2.1.1 (1994). Production insurance is a major element of packaging projects. Typically premiums for insurance packages will run between three to five percent of the total production budget with exact costs based on risk factors such as location, work, hazardous stunts, etc. PHILIP MILLER, MEDIA LAW FOR PRODUCERS 143 (1990).

3. Jacqui Gold Grunfeld, *Docudramas: The Legality of Producing Fact-Based Dramas—What Every Producer's Attorney Should Know*, 14 HASTINGS COMM. & ENT. L.J. 483, 488 (1992). In the delicate business of translating the lives of celebrities onto the screen for docudramas, it is acknowledged that insurance companies often decide what project will be made. *Id.*

4. Sam Friedman, *That's Entertainment; Movie Insurers Play Key Role*, NAT'L. UNDERWRITER (Property & Casualty/Risk & Benefits Management Ed.) May 14, 1990, at 3. ("[M]otion picture coverage is therefore unique . . . 'standard insurance policies are not geared for that type of consequential valuation.'") (quoting John Seery, then management chief of the entertainment unit of Chubb Custom Market in New York City).

5. American Cas. Co. v. Arlyn Phoenix, No. 94-2192-CA (Fla. Cir. Ct., filed June 24, 1994); CNA Int'l Reinsurance Co., Ltd. v. Arlyn Phoenix, No. 94-2163-CA (Fla. Cir. Ct., filed June 24, 1994) [hereinafter collectively referred to as *Phoenix*].

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control when it comes to medical conditions of motion picture stars.[6] Insurers rarely rescind cast insurance contracts for misrepresentation, and if they do, it has been handled behind closed doors.[7] A subrogation action is unprecedented.[8] Consequently, an atmosphere has existed where a star might feel free to misrepresent his medical condition or drug use on a medical certificate. Further, it should be recognized that, since the 1930's, insurance companies increasingly have made it possible to finance and make movies. Instead of making it as difficult as possible for them to properly qualify cast members, the industry has cooperated for reasons of fairness, appropriate risk distribution and economic efficiency.[9] It is ominous that a spokesperson for the Screen Actors Guild has said, "We'd be concerned if insurance companies started making outrageous demands."[10]

This article has been organized into three main parts and a conclusion. The first portion of Part I examines the historic role of insurance in the motion picture industry. Largely anecdotal and leaning heavily on information reported in the popular press and trade publications, it traces the growth of coverage as well as the dynamics of the insurer/insured

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6. Cast insurance is usually reserved for the principal actors in a production who cannot be easily replaced during production. Of course the actor involved, while a "star," might answer to the name of "Lassie" or "Benji." This star quality finds its genesis in the number of scenes the actor has in the film, not in his pedigree. *See also* Brigitte Maxey, *Big Insurance Policies Back Celebrity Pets,* CHI. TRIB., July 7, 1991, at D7.

7. A principal challenge in writing this paper has been the reluctance of those involved to speak on the record. Discretion appears to be a necessary service of motion picture insurers and brokers.

8. Sally Roberts, *Insurer's Sue Star's Estate,* BUS. INS., July 25, 1994, at 1.

9. *See infra* note 11 and accompanying text. CNA should be lauded for its subrogation action against Phoenix's estate, if not for the way the preclaim paper work was handled. Had there been no misrepresentation, the insurance company would have either properly declined to issue the policy, excluded known risks, or charged a higher premium. However, had Phoenix disclosed the information, he might have found himself unemployable as word got around the industry, although some producers might have been willing to pay a premium to secure his services. This paper posits that it is not realistic to expect actors to make truthful disclosures about drug abuse and that the only way to minimize future occurrences is to require stringent medical testing by physicians employed by the insurance company and to rigorously punish intentional misrepresentation with denial of such claims or with subrogation actions. In addition, some higher level of investigation by the insurer should be required before the policy is issued. While this would perpetrate some degree of artistic control by insurance companies, influence over the artistic process has been a reality since the 1930's. Such a practice would be an even-handed way to give fair warning to substance abusers that they must be clean to work in the film industry.

10. Monica Corcoran, *River Phoenix's Real Legacy; Actors Face Tougher Scrutiny from Insurers for Movie Contracts,* MONTREAL GAZETTE, Sept. 25, 1994, at F1.

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relationship in this unique industry. The remainder of Part I segues into the specifics of the Phoenix case, and the aftermath of this rising star's overdose at Hollywood's notorious Viper Room and public death on the sidewalk outside.

Part II focuses specifically on the *Phoenix* case. The insurer based its subrogation action on breaches of various contract provisions and its non-subrogation claims on allegations of fraudulent and intentional misrepresentation by the actor on his medical certificate. The legal elements of such an action will be examined in light of what is currently known about the status of this case.[11]

In Part III, the magnifying glass is focused on the degree of control exercised by underwriters and the consequent effects on the personal liberties of the cast members versus the benefits to the motion picture and insurance industries. This is followed by the conclusion that the controls imposed by insurers, and increasingly by the studios' own risk managers, echo the constraints placed on all Americans by statutes and safety regulations. The article concludes that there is therefore no reason for insurers to impose lesser expectations on cast members.

## I. THE ROLE OF INSURANCE IN THE MOTION PICTURE BUSINESS

Insurance of all kinds is necessary for motion pictures due to the highly risky aspects of the business and the extreme expense of production.

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11. Telephone Interview with David Kohs, Esq. Of Wright & Kohs, P.A., Orlando, Florida (February 29, 1996). The Circuit Court in Alachua County granted Phoenix's Motion to Dismiss. According to Mr. Kohs, the trial court dismissed the action because several key elements necessary to their maintaining an action were missing. First, it appeared that CNA had never actually issued the policy until about a week after Phoenix's death. Due to the well publicized cause of death, Kohs successfully argued that they were on notice of Phoenix's drug use on the night of his death yet issued the policies anyway. Secondly, the medical certificate called for Phoenix's signature at the bottom of the front and back page. His signature was missing from the bottom of the front page where the drug use question appeared. Kohs was successful in arguing that he had not in fact signed a statement that he did not use drugs. Thus, it appears that CNA's claim was fatally sunk by administrative and procedural blundering by its agents and employees. However, this paper takes the position that absent such lapses, an insurer is duty bound to subrogate against cast members who misrepresent their medical status and habits relied upon by the insurer. *See* CNA Int'l Ins. Co., Ltd. v. Phoenix, 678 So. 2d 378, 378 (Fla. Dist. Ct. App. 1996) (CNA and American Casualty Company raised the following two issues on appeal: "(1) whether the defense of impossibility of performance due to death applies when the impossibility is, allegedly, the fault of the person obligated to perform the personal services contract, and (2) whether the trial court erred in ruling that the effective dates of the policies of insurance involved here were in November, 1993, after the widely publicized death in question." The Circuit Court of Appeals affirmed the trial court's decision with regard to the first issue and reversed with regard to the second issue.).

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It is estimated that the average cost of producing and marketing a Hollywood film has reached $50 million.[12] Today, insurers are among the first professionals contacted by filmmakers.[13] Motion picture producers routinely cover their players, as well as their film stock, as part of a package that, before the recent spate of claims, typically cost $1.60 to $2.25 per $100 of production costs.[14]

The production company pays for the coverage and is the beneficiary or assignee of any coverage received. Covered employees are sometimes required to submit to a physical examination and always are required to provide basic information.[15] If the cast insurance cannot be obtained, the production company may give the actor the option of finding and paying for coverage, or being terminated.[16] The importance of cast insurance is demonstrated by the willingness of producers to accede to the demands of insurers.

Increasingly, it has been the cast insurance aspect of the total entertainment package that has drawn the insurer into what were once purely artistic choices.[17] Not surprisingly, cast coverage results in the highest volume of claim dollars paid in insurance package policies.[18]

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12. Gary Dretzka, *Film Insurance Can be a Stunt in Itself; But Chicago Firms See a Chance to Star*, CHI. TRIB., Dec. 18, 1995, at Business-1.

13. *Id.*

14. Nina J. Easton, *The High Cost of Stardom: Lancaster Suit Reveals Role of Insurance in Film Making*, L.A. TIMES, June 17, 1988, at 6-1.

15. Telephone Interview with Carolyn Norton, Vice President, Hogg Robinson, New York office (Feb. 16, 1995). Before the deaths of Candy and Phoenix, actors could more easily use their personal physicians. Many actors prefer this because of the special privacy factors that accompany their celebrity. However, after the recent claims, insurers are more often requiring examination by a physician selected by the them.

16. Stan Soocher, *Negotiating Film Actors' Insurance Provisions*, 1 ENT. L. & FIN., July, 28, 1993, at 3. Many policies go on to require the actor to remain in acceptable health despite a weight gain for a particular role or to fly using only regularly scheduled commercial carriers. *Id.*

17. *See generally* Lee Proimos, *That's Entertainment!*, 89 BEST'S REV. - Property-Casualty Ins. Ed., Aug., 1988, at 54. Prior to 1920, movies were made by individuals and studios so wealthy that they could insure their own risk. Today virtually no major production is self-insured. With the growth of smaller studios, insurance became more important by the 1930s. Cast insurance is traced to the "scarred face" policy that protected the studio in the event of damage to the handsome face of Douglas Fairbanks, Sr. Today cast insurance protects the producer against the costs that would occur if major cast or crew members were unavailable due to death, illness or injury. Such a policy allowed the producers of "Solomon and Sheba" to finish the film with Yul Brenner after 45-year-old star Tyrone Power suffered a fatal heart attack. Typically eight to ten cast and crew members will be covered out of a total of several hundred individuals. Had actor Martin Sheen not been able to resume filming after a heart attack suffered while filming *Apocalypse Now*, the

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Without cast insurance, a domino effect occurs. Cast insurance is usually a prerequisite for independent producers seeking completion bonds which protect against cost overruns.[19] Independent producers find this particularly important in a tight money market.[20] If insurance is not obtainable for certain talent, foreign sales units may not pick-up overseas distribution without the guarantee of certain actors starring. Without the assurance of a good distribution deal, the bank will not loan money to the producer. Drastic effects on the film's profit potential may result.[21] Thus, the good independent producer seeking financing is likely to consult early in the process to be sure his movie, with the planned cast and script, is bondable.[22] If a distributor wants a certain actor, it may pay the producer on delivery of the film to offset increased costs incurred to obtain that actor. If the distributor commits the extra money, the bond company will enhance the bond accordingly and the premium will be higher.[23]

Bond companies have been known to send representatives to sit on a set and observe filming, monitor risks, and make recommendations that affect the cast or storyline. A stunt planned with a helicopter might be changed to an airplane if the representative suggests it. In addition, it is not unheard of for completion bond companies to recommend to the producer that a key player or director be replaced. On rare occasions, a bond

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insurance company would have been exposed to a $26 million claim. *See also* Damian Hoban, *USA: A Look at Hollywood's Unusual Insurance Needs,* Reuter Textline Rev., Mar. 6, 1991, *available in* LEXIS, Insure Library, Allnws File.

18. Proimos, *supra* note 17.

19. Patrice Apodaca, *Securing Budgets Behind the Films; Completion Bond Guarantees That Movies Will be Delivered on Schedule and Within Budget,* L.A. TIMES, Apr. 10, 1990, at D9-A (quoting Ken Coopman, senior vice president of the Bank of America's entertainment group, "I wouldn't finance a film without a completion bond.").

20. *Checklist for Obtaining Bank Loans for Films; Independents' Financing,* 8 ENT. & FIN. L., Feb. 1993, at 1.

21. Easton, *supra* note 14.

22. Telephone Interview with Vincent Waldman, Esq., Mannat, Phelps & Phillips, Los Angeles (February 28, 1996). To cover their risk, both the bond company and the bank financing the project seek assurances concerning the reliability of the domestic and international distributors of the film along with assurances that the film will be delivered. The loan is predicated on the distributor's promise to the producer that the film will be distributed (often based on a requirement that certain actors are used). The producer will pay the bond company a fee up front, with the balance due only if there is a claim later. On rare occasions, a bond company will become so invasive while protecting itself, that a producer will walk away from the film.

23. *Id.*

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company will become so invasive that a producer will walk away from the project.[24]

Typically, the insurance process begins with the producer placing a call to an insurance broker. The broker's job is to review the project and obtain appropriate coverage from an insurance underwriter. The insurer pays the broker a commission, though ultimately it is the production company that pays this commission as part of the premium. Film making is generally broken into four stages: development, preproduction (30 to 60 days before principal photography begins), principal photography, and post production.[25]

Brokers want to be involved as early as possible, especially if the script calls for out-of-the-way locations where illness or unstable politics pose a potential threat. What the broker tells the producer about availability of coverage based on the script, stunts, location and cast probably influences producers' decisions.[26] Thus, another level of "artistic" review is added when the broker preempts the underwriter in ways that can result in a different location, cast or script from that originally planned.[27]

### *A. The Structure of Motion Picture Insurance*

An "Entertainment Package Policy" is the comprehensive insurance vehicle used in the motion picture business. Cast insurance is only one component of the larger package. The CNA "Entertainment Package Policy" issued to Time Warner, Inc. ran from November 15th, 1992 through November 15, 1995. Following a declaration of general policy conditions, it contained coverage for the following: extended preproduction cast insurance; cast insurance; negative film and videotape; props, sets and wardrobe; miscellaneous equipment; third-party property damage liability (covering property of others damaged in the production);

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24. In the words of one entertainment insider who requested anonymity, "it's the sort of thing that should have been done to (director) Michael Cimino during the filming of 'Heaven's Gate,'" a movie that went so far over budget so as to be legendary in Hollywood.

25. River Phoenix died during the final days of principal photography of *Dark Blood* and during preproduction of *Interview with a Vampire.*

26. Telephone Interview with Michael B. McAllister, President, Near North Insurance Brokers Entertainment Division, in Los Angeles, CA (February 27, 1996). "Generally we can buy insurance with the script and casting as planned, but we'll point out that the premium may be higher, the deductible may be higher, and the limit of liability may be lower."

27. *Id.* While brokers are not in a position to exercise creative control over the content, McAllister acknowledges that because there is a great deal of money at risk, the broker's recommendation could well effect something like a stunt.

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extra expense (caused by union strikes, destruction of property, facilities, etc., resulting in delay); commercial vehicle physical damage (vehicles owned by others for which the insured is liable); office contents; and money and securities and blanket employee dishonesty (money and securities used to conduct the insured's business and coverage of dishonest or fraudulent acts of insured's employees).[28] Endorsements limiting liability and setting requirements for coverage were included as to each type of coverage. The endorsement pertaining to pre-production cast insurance stated that a medical examination was required prior to binding.

Under an "Experience Rating Plan" the CNA policy awarded the insured (Time-Warner) a bonus if the premium and loss experience produced an underwriting profit for the insurer.[29] It incorporated, as well, California statutory provisions as to cancellation and non-renewal.[30]

For an additional premium of $259,809, the production entitled *Interview with a Vampire* was "declared hereunder as per attached declarations" for the period of time starting August 15, 1993 and ending March 4, 1994. Endorsements covered each of the areas of coverage outlined above in the master "Entertainment Package Policy." Liability was limited to $50 million with a $35,000 deductible.[31] A "Cast Declaration Endorsement" followed listing the covered cast members and their ages. An asterisk by the name of principal cast member Antonio Banderos excludes his "death or disability directly or indirectly caused and/or contributed to by the neck . . . . " until August 16, 1993.[32]

### *B. Cast Insurance: A Case Study*

If raw film stock is destroyed, it can easily be replaced. If a key actor dies, the ease with which he or she can be replaced depends upon the film's stage of production. In the *Phoenix* case, the losses to the modest film *Dark Blood*, which was close to completion at his death, were far

28. Phoenix, *supra* note 5.

29. *Id.*

30. *Id.* California law allows either party to cancel a policy. The named insured may cancel at any time. The company may cancel on 30 days notice, but only 10 days are required if the premium is not paid or if there were fraud or non-payment. Non-renewal provisions require notice to the named insured at least 60, but not more than 120 days in advance.

31. *Id.*

32. Presumably, Banderos was engaged in some activity or medical procedure hazardous to his neck prior to August 16, 1993. It is easy to imagine a similar asterisk after the name of River Phoenix excluding coverage for any death or disability either directly or indirectly caused and/or contributed to by use of illegal drugs.

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greater than the losses to the big budget *Interview with a Vampire,* which was still in preproduction when Phoenix overdosed.

Coverage for these losses is governed by cast insurance, one of the most critical insurance coverages used in the entertainment field, both before and during production.[33] Costs incurred in preproduction might include any losses incurred before the commencement of "principal photography." While this implies that actual filming has not begun, there are still costs involved in recasting the part. At the other extreme, once principal photography has begun, the costs can include all expenses of the entire production if the film is near completion and cannot be completed. The CNA package policy covers losses due to the death, injury, sickness or kidnapping of the "person or animal" designated for coverage.[34]

Several provisions of the cast insurance agreement are particularly relevant to the *Phoenix* situation. A medical examination by a physician approved by the insurer is required not more than sixty days prior to the first day of coverage. The physician must then submit a medical questionnaire and certificate on company-approved forms signed by the cast member and the physician. The policy expressly states that the examination will be by a company-recommended physician and if one is unavailable, the company gives permission to use any registered physician available other than the examinee's personal physician.[35] The company agrees to review the medical documents and, within two working days, to inform the production company of any reservations, exceptions or restrictions. The insured is obligated to use "due diligence" to ascertain that any persons designated for insurance are in sound physical condition.[36] General policy conditions which are applicable to the endorsement include

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33. Nancy Hooper and Anne Hollyday, *Celebrities at Risk,* RISK MANAGEMENT, May, 1995, at 18 (quoting John Seery, vice president and underwriter for Aon Entertainment, Ltd., New York).

34. Phoenix, *supra* note 5.

35. The misrepresentation by Phoenix is alleged to have occurred on the medical certificate. The endorsement for *Interview With A Vampire* states that all other terms and conditions (of the master policy) remain unchanged, apparently including the prohibition against using an a personal physician. Yet there is a notation on the medical certificate that the physician who completed it in Gainesville, Florida, where Phoenix lived, was his personal physician. Sharon Betterman, senior vice president of CNA Insurance Cos. described it as a "medical" involving "yes" and "no" questions rather than as a "physical." *See Kohs, supra* note 11.

36. The policy does not explain what would constitute "due diligence."

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a section voiding coverage for intentional concealment or misrepresentation by the insured.[37]

### C. How Insurers Exercise Control Over Casting and Creative Decisions

In the process of insuring key cast members, insurance companies have taken on new roles usually associated with the producers themselves. They exercise control over casting both subtly and overtly. Policy provisions make it more difficult to cast those under the age of nine and over seventy-two and those with pre-existing health conditions, especially potentially fatal conditions such as cancer. Had CNA known that one of the principal actors in *Dark Blood* or *Interview with a Vampire* was a drug abuser it might have placed a premium on the policy or excluded losses related to drug use.[38] An economically rational producer could easily look for a more insurable young star. In fact, actor Christian Slater was quickly recast into the Phoenix role.

The insurer exercises control by requiring and evaluating medical certificates of actors and key staff before issuing insurance. It may at any time cancel the policy or refuse to pay a claim. This should provide an incentive to producers to exercise prudence in casting the film and conducting production, especially in light of the insurer's right, at least in the CNA policy, to inspect the property and operations of the insured at any time.

Actors engaging in dangerous activities are usually asked to refrain from the activity or the insurer may exclude them from coverage. CNA's policy specifically excludes actors who fly as a pilot or copilot, actors under age nine or over age seventy-two, and actors under nine who contract chicken pox or tonsillitis.[39] Female actors bear a particularly heavy burden because losses due to pregnancy, childbirth, menstruation, or related conditions are excluded. An actress might not be cast if there is a possibility of causing production delays because of a medical condition such as dysmenorrhea,[40] which results in incapacitating menstrual pain.

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37. The policy defines "insured" to include employees, which Phoenix apparently was. *See infra* note 102 and accompanying text.

38. Dretzka, *supra* note 12. Dretzka reports that Courtney Love, whose history of drug abuse is part of her cachet as a rock star, was uninsurable. Producers of a recent film wanted her so badly that they delayed production of the film and ultimately secured a bond in order to obtain financing.

39. *Phoenix, supra* note 5.

40. MELLONI'S ILLUSTRATED MEDICAL DICTIONARY 139 (2d ed. 1985).

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The content of the movie is often dictated by the insurer with regard to action scenes. Looking again to the CNA policy as a prototype, the reporting of hazardous stunts is required. Whether or not a key stunt will be in the movie may not be decided by the director but by the insurer's risk management department.[41] Industry standards are used to evaluate the danger of any stunt involving an insured cast member.[42] The policy also gives the insurer the right to negotiate special terms and conditions as to such stunts.[43]

The most dramatic instance of intrusion by an insurance company into the movie making process occurred in 1994 after the sudden death of actor John Candy while making *Wagons East* for Carolco Pictures, Inc. Carolco recouped most of the cost of the $22 million production from its insurance company.[44] Within hours of Candy's fatal heart attack, adjusters from the Fireman's Fund and Carolco executives and lawyers for both sides converged on the film location in Durango, Mexico. With about two-thirds of the star's scenes shot, Carolco exercised its rights to abandon the film due to the loss of its essential element, Candy. Fireman's Fund was compelled to pay the cost of the movie to date, $15 million, and to take over production. Fireman's Fund then contracted with Carolco's subsidiary, Live Entertainment, to take over the picture, possibly for as little as one million dollars.[45] The result may be seen as a windfall for Carolco.[46]

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41. For example, an expert was sent to the set of the 1996 release "White Squall," to "help" rather than "dictate" when a stunt involving children was shot. In fact, some insurers coyly deny that they tell producers how to make movies. *See* Kohs, *supra* note 11 (quoting Betterman of CNA and Michael B. McAllister, president of Near North's entertainment division).

42. *For the Record: Disney Worker's Comp May Cover Stunt Crash,* BUS. INS., Jan. 1, 1996, at 19 (reporting on the death of a stunt woman and injury of two other stunt personnel during the Naples, Florida location shooting of "Gone Fishin" starring Joe Pesci and Danny Glover. The stunt personnel were standing off camera when a 21-foot power boat flew off a ramp and landed on a crowd of observers. An anonymous industry insider was quoted as saying that "cast insurance is never taken out on stunt personnel, and it's too early to tell if there's any liability. It sounds like a straight comp case with a death benefit.").

43. Phoenix, *supra* note 5.

44. Robert Marich, *Carolco Covered 'Wagons,' but Other Red Ink Remains,* HOLLYWOOD REP., Aug. 31, 1994, at 1.

45. *See* Norton, *supra* note 15. In fact, the type of cast insurance obtained by Carolco from Fireman's Fund had an endorsement known as "essential element" insurance which gave the insured the option of abandoning production if the essential element can't perform. It operates on the salvage principal, which is how Fireman's Fund bought the movie. They later salvaged it by reselling it to Carolco's subsidiary for a fraction of the insurance settlement. Similarly, the CNA policy for *Interview With A Vampire* required the insurer to

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In fact, when a claim occurs, the first item of business is to limit losses. Because most cast insurance claims respond to temporary illness or injury of a covered player, the shut down period may be only a few days. The insurer acts swiftly often sending a professional adjuster to the set to see how filming can be rearranged to shoot around the actor.[47]

Candy's death was one of a trio of claims arising from the unexpected deaths of movie actors in 1994. Two other huge settlements based on cast insurance followed the accidental death of Brandon Lee on the set of *The Crow* and the drug overdose of Phoenix who was in the middle of filming *Dark Blood* and who had begun preparation for *Interview with a Vampire*.

One insider was quoted as saying, "Since John Candy's death, the type of essential elements coverage that was out there doesn't exist anymore."[48] The source added that prices have sky-rocketed, policies have been restructured and many insurers have left the marketplace. In fact, premium increases of perhaps ten-fold have occurred, dictated by skittish insurers who have been shocked by the successive cast insurance claims.[49]

### *D. Cast Insurance: What Underwriters Consider*

Insurers routinely make casting decisions when they evaluate an actor as being uninsurable for a role. As previously noted, a surcharge is often applied to actors based on age.[50] Older actors or those who have a history of health problems are particularly affected.

Ray Milland was among the actors who have lost plum roles because of their perceived uninsurability. Milland was originally cast in the role that went to Don Ameche in *Trading Places* because the studio's insurance company claimed the actor had unacceptable physical problems. Burt

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relinquish all rights to the underlying works, as well as films, tapes and all copies and related material before payment in the event of an abandonment loss.

46. Jay Greene, *Sudden Death Casts Pall Over Indies*, VARIETY, May 16, 1994, at 1. The loss to the insurer would have been greater still had it shut down production until another buyer could be found.

47. Dretzka, *supra* note 12. (quoting Michael B. McAllister, president of Near North's Entertainment Division).

48. *Id*, quoting Greg Jones, Senior Vice President of Near North Insurance in Beverly Hills.

49. Corcoran, *supra* note 10. *But Cf.* Telephone Interview with John Hamby, Senior Vice President, A. G. Ruben, (Feb. 15, 1994) (estimating that rates for cast insurance are up 25 to 40 percent in the last few years after the "three big claims that rattled the industry"). But as recently as my February, 1996 interview with Michael B. McAllister, McAllister claimed that rates had not risen due to the large number of players in the market, but would rise in 1996 after a shakeout of insurers offering such coverage. *See* McAllister, *supra* note 26.

50. Easton, *supra* note 14.

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Lancaster sued the producers of *The Old Gringo* in which he was to have been cast in the lead role of 19th-century writer and adventurer Ambrose Bierce. Lancaster was replaced by Gregory Peck after the insurers concluded that Lancaster's quadruple bypass rendered him too vulnerable during the high altitude filming schedule. Contending he should have been given an opportunity to resolve the insurance problem, he sued for the $1.5 million salary.[51] Typically, actors are given the opportunity to resolve the problem by paying any extra premiums. Both Katherine Hepburn and Spencer Tracy agreed to forgo their salaries until after completion of *Guess Who's Coming to Dinner* when no insurer would cover Tracy. Ten days after the movie wrapped up and he was paid, he died.[52]

Insurance was a problem when 79-year-old Jessica Tandy, who had been diagnosed with cancer, was cast for *Batteries Not Included*. In fact, some industry insiders believe she had to obtain her own insurance before she could be cast in *Driving Miss Daisy*.[53] The late Jackie Gleason became totally uninsurable when his already poor health declined even further.[54]

Dangerous hobbies can stigmatize actors as well. Perhaps the best example is actor and amateur race car driver Paul Newman. Newman can not get cast insurance unless he refrains from racing for the duration of filming.[55] Also assigned a "no-racing" provision in his contracts is actor Tom Cruise, who was introduced to the sport by Newman.[56]

Despite attempts to prevent them, many hazards can't be anticipated by the insurers and the companies do end up paying. Hazards come in various forms, including health conditions, alcohol and substance abuse and compulsive behaviors. Eighty thousand dollars was paid to the makers of *Kiss Me, I'm Puerto Rican* after the leading lady developed such severe acne that filming could not be completed. Mel Gibson's twisted ankle during filming of *Mutiny on the Bounty* would have cost the insurance companies $2 million if the insurer had not flown its own orthopedic specialist to Tahiti for a second opinion. Gibson was back on his feet in three days instead of a month with a special walking cast and the ultimate

51. *Id.; see also Lancaster Sues Columbia for $1.5 Million*, UPI, May 24, 1988, *available in* LEXIS, Entert Library, UPI File.

52. Easton, *supra* note 14.

53. Interviews with two anonymous industry sources support the proposition that Tandy was not a popular casting choice despite her superb professional reputation, because of the insurance problems engendered by her age and history of cancer.

54. Easton, *supra* note 14.

55. Sherry Amatenstein, *Superstars Need Super Insurance*, COSMOPOLITAN, Aug., 1990, at 192.

56. *Id.*

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claim was for $200,000 rather than $2 million. Societal violence can also result in unexpected claims as during the making of a low-budget film in a tough area of New York City with unknown actors. One of the lead actors was confronted by local residents and had his jaw broken, necessitating recasting and an added insured expense of $30,000.[57]

Insurance problems are not limited to actors. Insurers scrutinize directors just as closely. Three weeks before principal photography was scheduled to commence for the Disney feature, *Honey, I Shrunk the Kids*, the director became too ill to work. The cost of replacing him involved changes to casting, staff, special effects, scheduling, wardrobe and set decoration.[58]

Director Francis Ford Coppola, while filming *Gardens of Stone*, could not work for weeks after his son was accidentally killed. The insurance company had been careful to exclude his well-known pre-existing lower back condition, but had no defenses when unexpected tragedy struck.[59] On the other hand, wary producers did successfully obtain what came to be known as "flake insurance" for the primary animator of a major animated film whom they feared would walk off during the project simply because he was known to be "flakey."[60]

Attempts by producers to insure for every eventuality are understandable because costs of filming have risen steadily. In 1958, Montgomery Clift's disfiguring and near-fatal accident caused an extended shutdown during the making of *Raintree County* which cost $400,000 to cover. Three decades later, during the filming of *Indiana Jones and the Temple of Doom*, Harrison Ford hurt his back, delaying filming for just two weeks at one million dollars per day.[61]

An insurer can also ruin an actor's career. Elliott Gould's career suffered for years when nervous underwriters with long memories refused

57. Margaret Reilly Mason, *On Stage at Risk,* BEST'S REV., Mar. 1984, at 54.

58. *Disney Settles Difficult Film Claim*, BUS. INS., Apr. 30, 1990, at 152.

59. Norton, *supra* note 15; *see also* Peter S. Canellos, *Coppola's Gardens of Sorrow; A Somber Film, Local Setting and the Death of His Son,* WASH. POST, Aug. 2, 1986, at G-1.

60. A key player in motion picture insurance field related this tale but requested anonymity: the source claims that Lloyd's of London issued breach of contract insurance, a type of insurance that is generally thought to be unavailable. No claim was ever made, however, because the animator did not "flake out" and the film was completed.

61. *See generally* Easton, *supra* note 14. When Kristy McNichol became ill on the set of *The Way You Are* in 1984, Lloyd's paid MGM/UA $4 million to enable them to complete the film. When Director Martin Ritt collapsed from exhaustion, causing Columbia to cancel production of *No Small Affair*, the insurers paid out $3 million in losses.

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to insure him. In the early seventies Gould had gone berserk on the set of *A Glimpse of Tiger*, causing $500,000 in damages.[62]

Substance abuse is not unique to the motion picture industry, but certainly it is more prevalent than in most fields.[63] Cocaine use in Hollywood often created production delays in the seventies and eighties. Though that abuse may not be as great as it once was, merely having a reputation for drug abuse has killed the careers of many actors by making them uninsurable, and therefore, unemployable.[64] A few of the more notable substance abusers include John Barrymore (alcohol), Marilyn Monroe (prescription drugs), and John Belushi (various narcotics).[65]

Preexisting health conditions are a major reason that insurers intrude into casting decisions or exclude coverage for a particular problem.[66] Generally, such pre-existing conditions are related to traditional "illness." Substance abuse, however, though self-induced, has the same practical effect on production schedules as, for example, a heart condition. It may not occur to an actor to include some problems in his medical questionnaire, such as lower back spasms. Such misrepresentation is not intentional. Other problems, such as a drug or alcohol addiction, may be in remission when the policy is completed but may reoccur during filming.[67] This is not the case, however, in the *Phoenix* situation. Phoenix flatly denied ever using drugs and the insurance company asserts he was abusing drugs at the time he completed the forms, thereby intentionally misrepresenting his insurability.[68]

Never before River Phoenix's death has an entertainment insurer actually gone to court claiming a fraudulent misrepresentation by an actor causing the insurer to subrogate its claim against the actor's estate. Perhaps

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62. Amatenstein, *supra* note 55. For two years he was insurance poison until he was cast in *The Long Goodbye*.

63. *See generally* Christine Spolar, *River Phoenix's Death Due to Drug Overdose; 'We're a Town of Excess,' Publicist Says*, WASH. POST, Nov. 13, 1993, at A1.

64. Amatenstein, *supra* note 55.

65. *Drug Finding Closes Phoenix Death Probe*, USA TODAY, Nov. 15, 1993, at 2D.

66. *Id.* Burt Reynolds is known to have a touchy stomach which often results in exclusions for that problem. Such preexisting conditions are either revealed by the actors to the insurers or discovered during medical exams required for all principals. Diagnosing drug abuse and determining it to be a "pre-existing" condition is more problematic.

67. Telephone Interview with Dick Watkins, Gaeble, Watkins & Taylor, (Feb. 27, 1995).

68. *Phoenix, supra* note 5. The Cast Insurance Medical Certificate asked, "Have you ever used LSD, Heroin, Cocaine, Alcohol in Excess or any other narcotic, depressant, stimulant or psychedelic whether prescribed or not prescribed by a physician? Two boxes for "yes" or "no" followed and "no" was checked. *Id.*

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it was the very public death of the young actor on a sidewalk in front of a Hollywood nightclub while insured for two major motion pictures that encouraged CNA to take action.[69]

*E. Insurer's Prescriptions*

Despite these and numerous other cases, insurers arguably have not done enough to protect themselves from claims originating from health problems, compulsive behavior, and drug abuse. Although they have traditionally scrutinized actors based on age, they have done little to evaluate lifestyle and habits.[70] In the time since Phoenix's death, however, many stars have been subjected not only to physical examinations, but also to blood and urine tests, electrocardiograms and chest exams. Despite the enormous investment the producers have in their actors' good health, many stars object to these procedures.[71]

However, if they want to work, these actors will have little choice in the prevailing atmosphere. This will pose a dilemma for some stars who

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69. It seems surprising that this is the first case of an insurance company subrogating a claim against a movie star. In fact it is well known in insurance and entertainment circles that similar situations have occurred involving misrepresentation by artists, especially in the concert promotion area, but the insurers have declined to exercise the right to deny coverage or to subrogate, choosing instead to do nothing or quietly negotiate a publicity-free settlement. Consequently, it is almost impossible to document prior instances. Telephone Interview with Glenn Lipnick, Associate, Premier Artists Services (Feb. 20, 1995). It is known that in April, 1986, country superstar Kenny Rogers, promoter of a concert tour featuring himself and Dolly Parton sued two insurance companies for refusing to pay for losses incurred when Parton, claiming illness, had not performed in a number of shows. *Singer Sues Two Insurance Companies*, SAN JOSE MERCURY NEWS, Apr. 21, 1986, at 4A. The outcome of the suit, filed in Los Angeles Superior Court, if it was not settled out of court, is unknown. The insurance adjuster on the case, who declined attribution, would only say that it was an unusual case and one in which no payment was made by the insurer.

70. Corcoran, *supra* note 10. In fact, prior to his role in *Wagon's East* the already obese 40-year-old Candy gained 40 pounds, and he smoked, despite a family history of heart disease. Yet, in spite of these well-known facts, he was not formally examined by a physician before the cast insurance policy was issued. He had, however, been examined within the prior two months for the movie *Canadian Bacon* and because of that fact, the physical examination was waived. *See* Hamby, *supra* note 49.

71. Corcoran, *supra* note 10 (quoting Marty Fink of Complete Films, a unit of Carolco Pictures concerning the attitudes of Demi Moore, Bruce Willis and Sylvester Stallone who recently went through the extensive testing for insurance); *see also* Robert Marich, *Bonders Fee Star-Crossed,* HOLLYWOOD REP, Sept. 22, 1995 (quoting Steve Ransohoff of Film Finances, Inc. on the reluctance of actors to undergo thorough preproduction medical testing becoming a major issue of contention); McAllister, *supra* note 26 (noting that insurance brokers have a large role now in "greasing the skids" because artists are increasingly resentful about insurance physicals and medical questionnaires. "They are more mindful of the requirements and pretty outspoken.").

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will not even see a physician.[72] Others agree to be medically evaluated, but as a condition of their contracts, make it as difficult as possible to accomplish.[73] In fact, although a number of celebrities often insist on only going to their own physicians, many insurance companies now preclude the use of personal physicians.[74] Despite this trend, Phoenix's exam was apparently performed by his personal physician in Gainesville, Florida.[75]

When a star actually dies during production, every effort is made to minimize the loss, depending upon the state of completion at the time of death. For example, Jean Harlow died in 1938 with only a few more scenes to complete in *Saratoga*. Ingenious producers hired a acting double wearing a large, floppy hat to complete the film.[76]

The movie *Brainstorm* would never have been released following star Natalie Wood's untimely drowning if the studio had prevailed over the insurance company. At the insistence of Lloyds of London, the movie was partially rewritten and re-shot. The results proved a sound business decision by Lloyds, if not a good artistic one. MGM added an extra million to its eleven million dollar outlay, and the insurer provided six million dollars to make the changes. MGM recouped most of its investment and Lloyds cut its losses in half.[77]

Other cast insurance claims have originated from accidents which occurred during filming.[78] Risk managers at some studios operate on the philosophy that these risks are somewhat controllable and review scripts

72. Corcoran, *supra* note 10 (quoting insurance broker Carolyn Norton of Hogg Robinson).

73. James P. Forkan, *Insurance Eases Risk from Star in Ads,* ADVERTISING AGE, Dec. 7, 1987, at 40 (recounting how one male television star insists his physical examinations must be conducted on the set on a Sunday afternoon by a female doctor).

74. Norton, *supra* note 15.

75. *Phoenix, supra* note 5. In other areas of show business, particularly in pop music, there has been particular concern about physicians who over-prescribe prescription medication and who are willing to write medical excuses for performers who are incapacitated by emotional or drug problems. Telephone Interview with Glenn Lipnick, Associate, Premier Artists Services (Feb. 20, 1995). *Cf.* LITTLE FEAT, *Rock and Roll Doctor, on* FEATS DON'T FAIL ME NOW (Warner Bros. Records Inc. 1974) (asserting "If you want to feel real nice, pass around the doctor's advice").

76. Amatenstein, *supra* note 55.

77. *Id.*

78. Over a decade before the accidental on-set shooting of Brandon Lee, actor/director Vic Morrow and two child actors were decapitated by helicopter blades during the shooting of *The Twilight Zone: The Movie*. The industry became far more safety conscious where cast members were concerned after this horrifying accident. Michael Bradford, *Safety in Spotlight of Movie Production,* BUS. INS., Nov. 20, 1989, at 78.

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looking for potential problems.[79] Of course, a typical independent production company does not have a full time risk manager on staff, while a major studio suck as Disney does. Another layer of potential artistic control is thus added to the insurance broker and the insurer wherever in-house risk managers are present.

## II. CAST INSURANCE AND INTENTIONAL MISREPRESENTATION: THE CASE OF RIVER PHOENIX

Drug use in the film industry is widely reported in the popular press. From the death of John Belushi to the highly publicized rehabilitation stays in the Betty Ford Clinic by a parade of celebrities, it is apparent that many members of the Hollywood community are substance abusers.[80] Like AIDS, however, it is a condition most actors will not admit to for personal and professional reasons.[81]

Nowhere is this irony more evident than in the subrogation action filed by two units of CNA International Reinsurance Co. Ltd (hereinafter CNA) against Phoenix's estate in a beachhead attempt by an insurance company to rein in the private behavior of cast members.[82] In suits filed in June, 1994 and amended in October, CNA and American Casualty Company alleged that the actor breached service agreements to the insured, and misrepresented medical certificates to the insured and the insurer. The suits refer to the fact that Phoenix died from an overdose of drugs after a night of partying in a Hollywood nightclub but had earlier failed to disclose drug use in his representations to the insurers.[83]

The production companies were paid under the terms of the policies for two movies that Phoenix was involved in at the time of his death. There was no attempt by CNA to rescind the contracts. *Dark Blood,* which was near completion at the time of his death, was totally scrapped. The insurer paid five and a half million dollars on that claim. One hundred and eighty

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79. Kathryn J. McIntyre, *Disney Switches Entertainment Insurers,* BUS. INS., Apr. 30, 1990, at 151.

80. Karen Thomas, *Reaching Out to Stars in the Grip of Drugs,* USA TODAY, June 28, 1994, at 2D.

81. David J. Fox, *Hollywood's Blind Eye: Industry Still Shuns Those With Aids,* S.F. CHRONICLE, Oct., 13, 1991, at 49 (noting that AIDS and HIV do not render an actor uninsurable for cast insurance so long as the actor will be able to complete filming, but do carry a strong social stigma, even in Hollywood. Drug abuse may be less socially unacceptable but because drug mishaps can cause an actor to be unavailable for filming, drug abuse is of greater concern to the insurance industry).

82. Roberts, *supra* note 8.

83. *Phoenix, supra* note 5.

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thousand dollars was paid to the makers of *Interview with a Vampire,* in which Phoenix was set to co-star.

The amended complaint alleges total expenditures of over five million, eight hundred thousand dollars.[84] Industry insiders speculated that the claim was probably paid and subrogated because of the difficulty in proving that the producers were aware of Phoenix's alleged habit.[85] Now that details of the insurer's handling of the policies are known, it seems more likely that the reason was to protect future business. Had the insurer followed proper procedure, it could have established a strong case by showing that Phoenix had a drug habit in 1993 when he represented on his insurance forms that he did not use illicit drugs or alcohol.

The complaints allege that by taking the fatal overdose Phoenix did not provide the services promised and breached his obligation to "generally not do anything which would deprive the parties to the contract of the benefits of the contract."[86] The complaint charges Phoenix with breach for providing false information to the medical examiner by denying drug use. The actor's estate is also charged with erroneously warranting that he was not subject to any disability, when in fact he was disabled by a drug habit.[87]

In addition, a portion of the complaint attempts to recover damages for this misrepresentation on the medical certificate.

### *A. The Subrogation Claim*

In a bottom line industry where mergers and buyouts have become common, it is innovative, but not surprising, to see CNA using the device of subrogation because such recovery can improve its commercial and financial performance.[88]

Subrogation is defined as the substitution of one person in the place of another as to a lawful claim, demand or right.[89] There are two types of subrogation: legal or "equitable subrogation" derives from equity and need not be based upon a contractual relationship, while "conventional subrogation" is based upon the contractual relationship of the parties.[90]

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84. Norton, *supra* note 15, and Hamby, *supra* note 49. *But see* discussion of policy provisions on "due diligence," *supra* note 36 and accompanying text.

85. *Id.*

86. *Phoenix, supra* note 5.

87. *Id.*

88. Felicia F. Credle, *Subrogation Recovery is Key for Financial Success,* PTS PROMT, Feb. 17, 1992 at 9.

89. BLACK'S LAW DICTIONARY 1427 (6th ed. 1990).

90. ROBERT H. JERRY, II, UNDERSTANDING INSURANCE LAW, § 96(B) (1987).

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Where equitable relief is denied, a contractual right might be present, thereby allowing the remedy of subrogation.

This relationship may be more readily understood in the automobile insurance context. Suppose the insured collides with a tortfeasor. The insurer (subrogee) will pay for the insured's (subrogor's) losses and will then seek to stand in the shoes of the insured and assert the insured's rights against the tortfeasor. If the insured wins and is made whole, the loss will be borne by the tortfeasor who caused the loss.[91] Therefore, subrogation can be seen both as a moral tool and a tool by which economic loss is properly apportioned. Were it not for subrogation, innocent policy holders of the insured would doubtless have the cost of losses passed on to them. With subrogation, there is at least an opportunity to place the loss where it belongs.

The flow of subrogation is demonstrated by the *Interview with a Vampire* claim, which is subject to Time Warner's entertainment package policy with CNA. Time Warner, as financier, is the beneficiary of any insurance monies recovered. Under the subrogation clause, the insured, if requested by the insurer, must assign and transfer any rights of action for loss, damage, expense or liability to the insurer and must permit suit to be brought by the insurer in the insured's name.[92] Thus, CNA could pay Time Warner's claim and then, in the insured's name, bring suit while standing in Time Warner's shoes. In this way, it may recover the whole amount it paid on the claim.

A subrogation claim must meet three elements: (1) the insurer seeking subrogation must have paid the claim involuntarily; (2) the party claiming the subrogation must be secondarily liable for the debt; and (3) no injustice will be done by allowing the subrogation.[93] To secure its right of subrogation the insurer must stand in the shoes of the subrogor, which must have suffered damages.[94]

Though an insurer in a case such as this would typically seek to rescind the policy, CNA elected to pay Time Warner and subrogate against Phoenix's estate. CNA probably used the subrogation remedy, rather than rescission, because CNA would have had to show that the insured production company knew of Phoenix's alleged misrepresentation in order

91. *Id.*

92. *Phoenix*, *supra* note 5.

93. JERRY, *supra* note 90.

94. Casualty Indem. Exch. v. Penrod Bros., Inc., 632 So. 2d 1046, 1047 (Fla. Dist. Ct. App. 1993) (citing Allstate Ins. Co. v Metropolitan Dade County, 436 So. 2d 976 (Fla. Dist. Crt. App. 1983), *review denied,* 447 So. 2d 885 (Fla. 1984)).

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to deny the claim and rescind the contract.[95] This would be more difficult to demonstrate than simply showing that Phoenix had taken drugs at some time prior to filling out the form wherein he denied drug usage.[96] The insurer can void the policy or refuse to pay the claim if there has been misrepresentation. If the representation is untrue or misleading, material to the risk, and is relied on by the insurer, that is all that is necessary to void the claim.[97] It appears from CNA's filing that this is what they are claiming. If they paid the claim voluntarily then they cannot claim to have sustained damages and cannot subrogate.[98] If CNA can show they were compelled to pay the insured, subrogation, however, will be available to them.

In the world of insurance, subrogation is seen as a generator of significant cash flow and a method of improving the insurer's bottom line results and cost effectiveness.[99] Properly done, it is distinct from money collection skills. Effective subrogation may require a separate subrogation team and effective phone negotiation skills.[100]

As already noted, in the Phoenix case, the insurers based their subrogation claim on his alleged breach of contract, misrepresentation and fraud. Specifically, the amended complaints, both as to *Dark Blood* and "Interview With a Vampire," assert that: (1) Phoenix breached his contract by failing to provide his services as agreed; (2) that Phoenix had an obligation not to deprive any of the parties of the agreement of the benefits of the agreement; (3) that by taking illegal drugs he breached this duty; and (4) that he was insured as an essential element causing the insurer to pay specified amounts to various insureds. The non-subrogation portion also alleges that Phoenix's representation on the Cast Insurance Medical Certificate induced the insurer to provide coverage, but that his representation as to drug use was a willing misrepresentation and that the insurer would have elected to exclude any losses occurring as a result of

95. Norton, *supra* note 15.

96. However, it might be argued that CNA paid the claim voluntarily for reasons of its own. If this were so, the subrogation action would be jeopardized because the payment must be involuntary: subrogation is not available to volunteers. DeCespdes v. Prudence Mut. Cas. of Chicago, Ill., 193 So. 2d 224 (Fla. Ct. App. 1966), *aff'd* 202 So. 2d 561 (Fla. 1967).

97. *Phoenix*, *supra* note 5.

98. JERRY, *supra* note 90, §§ 96, 102. Lawyers for Phoenix's estate might contend that the claim was paid even though the insurer had a complete defense, because CNA did not wish to alienate Time Warner and dry up sources of future business.

99. Credele, *supra* note 88.

100. *Id.*

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the misuse of drugs or not write the policy at all. The complaint alleges not only misrepresentation but also fraud by the actor.[101]

An actor in Phoenix's position is clearly regarded as an employee who provided personal services to the film company.[102] River Phoenix was considered an employee of his own production company, which provided his services to the producer under a "loanout agreement," the terms and conditions of which form the basis of the insurer's claim. The loanout agreements for both pictures specify that the actor is to be covered by workman's compensation insurance. In the case of *Interview with a Vampire,* Geffen Pictures provided such insurance as the film's producer. Time Warner, Inc. financed the film and therefore became the beneficiary of the cast insurance policy. The terms of the loanout agreement range from an agreement by Phoenix to provide services and submit to a physical examination for cast insurance to the actor's right to review and disprove of a set percentage of still photos used for publicity. Therefore, the traditional bar of insurers subrogating claims against insureds appears not to be at issue.[103] Like many actors, Phoenix did have a production company, Jude Nile Productions, Inc., which entered into an actor loanout agreement with producer Geffen Pictures. In effect, Phoenix's own corporation lent to the producers the actor's "acting and related services."[104] Time Warner Inc., as financier and distributor of the film was the policy beneficiary and the subrogor.

Insurers historically have not subrogated other claims that might be made under a package policy, such as for negative stock, camera and processing problems.[105] But the consecutive deaths of John Candy, Brandon Lee and Phoenix resulted in about $25 million in claims. This was a particularly heavy hit for CNA.[106] Additionally, cast coverage claims

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101. *Phoenix, supra* note 5.

102. Norton, *supra* note 15, and Hamby, *supra* note 49.

103. BARRY R. OSTRAGER & THOMAS R. NEWMAN, HANDBOOK ON INSURANCE COVERAGE DISPUTES, § 5.06(d) (7th ed. 1994) citing 16 COUCH ON INSURANCE § 61:133 (2d ed. 1985). The general rule is that an insured may not bring a subrogation action against its own insured. *Id.*

104. *Phoenix, supra* note 5.

105. Roberts, *supra* note 8, at 30.

106. Norton, *supra* at 15. *See also* Alfred G. Haggerty, *Selling Transamerica Unit Won't Be Easy,* NAT'L. UNDERWRITER, Aug. 3, 1992, at 41 (Financial) (reporting that in trying to find a buyer for its property and casualty unit, Transamerica encountered rough times due partly to losses on cast insurance and completion bonds).

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result in the highest dollar volume of claims paid of all insurance in the typical package.[107]

Consequently, insurers are now being extremely thorough before issuing coverage for cast insurance, to the point of affecting content of the script. One post-Phoenix producer reports that before the insurer would issue cast insurance, he had to debate the merits of action scenes which the insurer wanted justified or removed.[108]

Considering that insurers can be left holding the bag for virtually an entire big budget film if something happens to an essential cast member in the last ten days, this seems a prudent, if not an artistically pure, approach.[109]

Industry experts say that if it can be proved that Phoenix did something deliberately to inhibit his performance under contract, such as using illegal drugs, a breach of contract could be found.[110] As noted, in order to use the subrogation remedy, then, CNA must not have volunteered the payment to the insured. The payment must have been for a risk that was clearly covered in the policy. Full payment should have been made, however, because the insured and insurer should not be in competition for the recovery. Since subrogation is prohibited against an insured or a coinsured, it must be clear that Phoenix was an employee.[111]

### 1. Misrepresentation in the Subrogation Claim

The complaints filed at the time of this writing appear to mix claims of tortious misrepresentation with breach of contract.[112] However, the civil cover sheet indicates that it is strictly a contract action. In any event, the distinction between tort and contract liability between parties to a contract

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107. *Entertainment Brokers International Office Opened in London,* Bus. Wire, Nov. 20, 1990. There seems to have been an element of deferential treatment of movie stars because they are celebrities. There was also the belief that in this very specialized field of insurance coverage, future business would be lost if claims were denied. CNA, a relative newcomer in the field, apparently decided to take a stand. Further, insurance companies have been having problems with reinsurance as to such contingency policies, not only because of the losses associated with Candy, Lee and Phoenix, but also because of claims arising from a string of natural disasters. *See* Norton, *supra* note 15.

108. Jay Greene, *Sudden Death Casts a Pall Over Indies,* VARIETY, May 9, 1994, at 1 (recalling how independent producer John Davis had to pitch his film to risk adjusters much as he pitched it to studio heads, agents and actors).

109. *Id.*

110. Roberts, *supra* note 8.

111. JERRY, *supra* note 90, § 96(h), at 472.

112. The complaints, by two units of CNA, are against separate production companies and distributors. To keep discussion of the complaints as understandable as possible, this article will specify which claim is being discussed.

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is a difficult distinction to make.[113] Yet, the consequences of a misrepresentation are less severe in contract than in tort law.[114]

The elements of the complaint concerning contractual breach of the loanout agreement mostly have to do with Phoenix's pledge to provide services to the producers. These charges are channeled through the loanout agreement, even as to the alleged medical misrepresentations which were made on CNA forms provided by the insurer. The loanout agreement specifies that the actor must submit to a physical examination and complete appropriate documentation associated with his health. This is not to be confused with the direct representations on the CNA medical certificate on which the company is also basing its suit.

Misrepresentation in the contract setting, as would have been made by Phoenix in the loanout agreement, has two distinct prongs: one which goes to the "factum" or "execution" and the other which goes to the "inducement."[115] In this case, the misrepresentation is alleged to have induced the producers to hire Phoenix, who then became unavailable to fulfill the contract, thereby causing the producers and financiers to lose large sums of money. The effect is to make a contract voidable.[116] However, one cannot void a contract if it has already been affirmed, although an action in tort for damages can commence.

Tortious misrepresentation comes in three forms: intentional, negligent and strict liability.[117] The Phoenix complaint deals with intentional misrepresentation, which means that, in order to make out a cause of action, the misrepresentation must be directed at a particular person, must convey a meaning, must be believed, and must be acted on in a certain way.[118] The insurer should be able to easily establish that the misrepresentation was directed at the producer, that it conveyed that Phoenix was not a drug abuser, that it was on a medical certificate and therefore believable, and that it induced the producer to retain the actor in the knowledge that he had no drug abuse problem. In most cases, this is easy to prove.[119] Primary among considerations is the intent to deceive. This should be easy to show where Phoenix allegedly had absolute

113. W. PAGE KEETON, ET AL., PROSSER & KEETON ON THE LAW OF TORTS § 92, at 655 (5th ed. 1984).

114. E. ALLAN FARNSWORTH, FARNSWORTH ON CONTRACTS §4.10, at 402-04 (2d ed. 1990).

115. *Id.* § 4.10, at 402.

116. *Id.* § 4.10, at 403.

117. KEETON ET AL., *supra* note 113, § 107, at 740.

118. *Id.*

119. *Id.* § 107, at 741.

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knowledge that the representation was false. A duty to investigate could be imputed to the producers if it could be shown that they had possession of information which might alert them to a deception.[120]

2. Materiality in the Subrogation Claim

Generally, the plaintiff must show that he relied upon the misrepresentations of the defendant and that this reliance was reasonable.[121] This is even more the case where the person making the representation has reason to know that this information is of particular importance to the user, even though it might not be to most reasonable persons.[122] Therefore, if Phoenix's estate could show that the producers had knowledge or reasonably should have had knowledge of his alleged drug abuse, reasonable reliance could be defeated.[123]

Based upon the wording of the loanout agreement, the state of the actor's health was extremely important and the actor was on notice to that effect.[124] The agreement states that if the physical examination raises any doubts as to the physical ability of the actor to render his services, the producer could terminate the agreement.[125] Likewise, the producer could terminate the agreement if, because of findings of the examination, cast insurance could not be obtained without increased costs or with substantial exclusions. In the case of increased premiums alone, the actor was to be given an opportunity to pay the excess over the normal cost of cast insurance. Thus, the materiality of any alleged misrepresentations to the producers as to Phoenix's health should have been clear to the actor.[126]

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120. In fact, the old days when studio publicity departments zealously guarded the real private lives of stars and projected illusory images is long gone. According to Michael McAllister of Near North, this historic reluctance to pry into the lives of their stars created less likelihood that investigation would occur. Now, however, "the tabloid press has blown the lid off". McAllister, *supra* note 26.

121. KEETON ET AL., *supra* note 113, § 108, at 750.

122. *Id.* § 108, at 754.

123. In fact, this is exactly what happened when the trial court judge learned that the policy was issued after Phoenix's well-publicized death. *See* Kohs, *supra* note 11.

124. *Phoenix*, *supra* note 5.

125. *Id.*

126. Actually, Phoenix did not sign the bottom of the page where the misrepresentations were allegedly made. *See* Kohs, *supra* note 11. Attorney Kohs argued successfully that Phoenix did not sign a statement that he didn't use drugs.

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### B. *CNA's Direct Claim (Non-Subrogation) Against The Phoenix Estate*

Count II of the *Dark Blood* complaint departs from the subrogation offense and seeks direct damages for alleged misrepresentation by the actor to the insurer via the cast insurance medical certificate.[127]

#### 1. Misrepresentation in CNA's Direct Claim

The general rule is that an insurer's obligations are voided under a policy where a material misrepresentation or omission has been made in the application.[128] This goes to the heart of the risk-spreading aspects of insurance. The insurer bases his premium and willingness to assume the risk on this data. The greatest degree of economic efficiency requires that no material misrepresentations be made to the insurer so that the insurer can predicate the premium on the proportionate part of the total predicted cost of meeting specified types of losses, plus a margin for overhead and profit.[129] "[I]t is clear that the abuse of or addiction to drugs are material to the insurer's acceptance of the risk and the failure to disclose this provides grounds for rescission or avoidance of the policy."[130]

Misrepresentation is found where there has been a false affirmative statement, as well as a failure to disclose.[131] The majority of courts has held that if a material misrepresentation was made knowingly[132] or even fraudulently,[133] the insurer may still deny the claim. Therefore, it is irrelevant whether the producers knew of Phoenix's alleged drug use. The simple fact of misrepresentation gave CNA the right to deny the claim if the misrepresentation became known to them before they paid. The further

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127. *Phoenix, supra* note 5.

128. OSTRAGER & NEWMAN, *supra* note 103, § 3.01 (citing Christiana Gen. Ins. Corp. v. Great Am. Ins. Co., 979 F.2d 268, 278 (2d Cir. 1992)); *see also* Metropolitan Life Ins. Co. v. Fugate, 313 F.2d 788, 792 (5th Cir. 1963); Dennis v. William Penn Life Assur. Co. of Am., 714 F. Supp. 1580, 1582 (W.D. Okla. 1989), *overruled by* Hayes v. Jackson Nat'l Life Ins. Co., 105 F.3d 583 (10th Cir. 1997); Viviano v. Travelers Ins. Co., 533 F. Supp. 1, 6 (E.D. La. 1981).

129. *See generally* ROBERT E. KEETON, BASIC TEXT ON INSURANCE LAW, § 1.2, at 2-6 (1971).

130. COUCH ON INSURANCE § 37:187 (2d ed. 1985).

131. OSTRAGER & NEWMAN, *supra* note 103, § 3.01(b).

132. *Id.* at § 3.01(c); *see also* William Penn Life Ins. Co. of N.Y. v. Sands, 912 F.2d 1359, 1364 (11th Cir. 1990).

133. Fernandez v. Bankers Nat'l Life Ins. Co., 906 F.2d 559, 565 (11th Cir. 1990).

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question of why the insurer did pay, despite the fact that it had not yet issued a policy and, when it did issue the policy, actually knew about Phoenix's drug use may have a very simple answer—survival.[134]

In Florida, where the subrogation action was filed, misrepresentations, omissions and concealment of facts will not bar a recovery unless one of the following apply: (1) they are fraudulent or material to either the acceptance of the risk or the hazard assumed by the insurer; or (2) if the true facts had been known pursuant to a policy or other requirement, the insurer in good faith would not have issued the policy in as large an amount, or would not have provided coverage with respect to the hazard resulting from the loss. Further, such a violation does not render the contract void unless the violation increased the hazard by any means within the control of the insured.[135]

Numerous cases illustrate this point. A Florida court affirmed a summary judgment for an insurer where the policy holder had denied, in response to specific question on the applications, that he had a history of substance abuse.[136] Finding the denial material, the court noted that even an unintentional misstatement would preclude recovery where the misstatement materially affects the risk or the insurer's willingness to accept the risk on the agreed terms.[137]

While there is no case law in which an insurer has chosen to subrogate a claim based on a fact pattern similar to the present one, there have been numerous cases dealing with individuals whose insurance companies opted not to pay their claims based on misrepresentation of past or current drug abuse.[138] In each case, the insurance company proved prior behavior which

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134. The combination of CNA's failure to issue the policy and the producer's failure to protest might seem to have placed CNA in a fortuitous position vis-á-vis denying coverage. Yet, CNA failed to take advantage of this fact. As one insurance insider who declined attribution said, "If CNA had played hardball, they'd probably never write another policy in this town (Hollywood) again." According to this source, on hearing of Phoenix's death someone said, 'let's check and see if he was covered,' suggesting that this was when they first discovered they had failed, apparently by mistake, to issue the policy.

135. FLA. STAT. ch. 627.409(1) (1994).

136. de Guerrero v. John Hancock Mut. Life Ins. Co. 522 So. 2d 1032 (Fla. Dist. Ct. App. 1988); *see also* Continental Assur. Co. v. Carroll, 485 So. 2d 406 (Fla. 1986); Shelby Life Ins. Co. v. Paolasini, 489 So. 2d 89 (Fla. Dist Ct. App. 1986); New York Life Ins. Co. v. Nespereira, 366 So. 2d 859 (Fla. Dist. Ct. App. 1979) (holding that an insurer is entitled to rely on the truthfulness of the applicant's statements of medical history and has no duty to make further inquiries).

137. *de Guerrero*, 522 So. 2d at 1032.

138. 1 JOHN & JEAN APPLEMAN § 201 (Supp. 1992) (citing N.Y. INS. LAW § 3105(a) and (b) (McKinney's 1985), and Mutual Ben. Life Ins. Co. v. JMR Elecs. Corp., 848 F.2d

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established the misrepresentation. The insurers in the Phoenix case allege that the actor "died of a drug overdose, *similar usage having occurred prior to the completion of the Cast Insurance Medical Certificate. . .*" (emphasis added).[139] In like cases, insurers have had to show that the insured had been a habitual user of drugs,[140] that insured had been hospitalized for drug addiction twice within two years of applying for life insurance,[141] and that the insured had been convicted of operating a motor vehicle while under the influence of alcohol and of possessing drug paraphernalia.[142]

In addition, a 1978 Georgia court supported an insurer's right to void a life insurance policy where the beneficiary's husband had misrepresented that he had never used or been treated for use of addictive drugs, when in fact it was proved that he had been convicted of heroin possession, did use such drugs, and had received Methadone treatment.[143]

The weight of case law, then, favors the insurer if the insurer is able to prove prior illicit drug use by the actor coupled with the actor's misrepresentation.[144]

2. Materiality in the Non-Subrogation Claim

Materiality is generally found if the untrue or omitted fact could reasonably be considered as affecting the insurer's decision to enter into the contract, assess the risk or calculate the premium.[145] Drug use or addiction have been found to be material to the insurer's acceptance of

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30 (2d Cir. 1988) (holding that a key man policy, similar to the *Phoenix* policy could be rescinded where the insured had misrepresented his history of cigarette smoking)).

139. *Phoenix, supra* note 5.

140. COUCH, *supra* note 130 (citing Equitable Life Assur. Soc. v. Anderson, 727 P. 2d 1066 (Ariz. Ct. App. 1986)).

141. Sharp v. Lincoln Am. Life Ins. Co., 752 S.W.2d 673 (Tex. App. 1988 writ denied).

142. Legel v. American Community Mut. Ins. Co., 506 N.W.2d 530, 530 (Mich. Ct. App. 1993).

143. McGhee v. Independent Life & Accident Co., 246 S.E.2d 349 (Ga. Ct. App. 1978) (finding also that the plaintiff had made numerous other misrepresentations as to the deceased's prior health and her legal relations to him).

144. However, as the trial court's decision illustrates, none of this applied. Attorney Kohs successfully argued that there was no proof that Phoenix had himself filled-in or completed the front side of the medical certificate on which the alleged misrepresentation was made. *See* Kohs, *supra* note 11.

145. OSTRAGER & NEWMAN, *supra* note 103, § 3.01(d).

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risk; failure to disclose provides grounds for rescission or avoidance of the policy.[146]

Whether or not an insured will be relieved of liability for misrepresentation of a habit (including drug use) will be based upon how the insurer has treated similar misrepresentations in the past.[147] In another case, an insurer was entitled to void a life insurance policy where the decedent had falsely denied ever having been medically treated for alcohol or drug abuse.[148] Misrepresentations involving marijuana use have been held to be material barring recovery under a policy.[149] A District of Columbia case, for example, also barred recovery where a decedent had claimed not to use marijuana regularly or currently. The court found that these statements were related to a material matter and barred recovery under the District of Columbia Code.[150] Evidence of alcoholism was admissible in an Alaska case where there was evidence that the insurer would not have issued the policy had the question been answered correctly.[151]

The materiality of such representations was explored in a recent New York case where the insurer was able to show that, had it known the decedent had a history of arrests for drugs, the life insurance policy would not have been issued. [152] "No misrepresentation . . . shall be deemed material unless knowledge by the insurer of the facts misrepresented could have led to a refusal by the insurer to make such contract." Cast insurance is similar to life insurance.[153]

### *C. Moral Hazard and Cast Insurance*

Moral hazard in insurance refers to a characteristic of the insured that increases the probability of loss to the insurer. In other words, it is the tendency of an insured to take more risk or less care when she knows something is insured.

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146. COUCH, *supra* note 130, § 37:187 (citing Jones v. Prudential Ins. Co., 388 A.2d 476 (D.C. 1978); McGhee v. Independent Life & Accident Ins. Co., 246 S.E.2d 349 (Ga. Ct. App. 1978); Peoples Life Ins. Co. v. Jerrell, 318 A.2d 518 (M.D. 1974); Howard v. Aid Ass'n for Lutherans, 272 N.W.2d 910 (Minn. 1978)).

147. APPLEMAN ET AL., *supra* note 138, § 211 (Supp. 1992).

148. Life Ins. Co. of Ga. v. Helmuth, 357 S.E.2d 107 (Ga. App. 1987).

149. *See* COUCH, *supra* note 130, § 32:10.

150. Johnson v. Prudential Ins. Co. of Am., 589 F. Supp. 30 (D.C. 1983), *aff'd,* 744 F.2d 878 (D.C. Cir. 1984).

151. Petersen v. Mutual Life Ins. Co. of N.Y., 803 P.2d 406 (Alaska 1990).

152. Shapiro v. Allstate Life Ins. Co. of N.Y., 609 N.Y.S.2d 323 (N.Y. App. Div. 1994).

153. Hamby, *supra* note 49.

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Once coverage is in place, moral hazard can occur through fraudulent actions by the policyholder or by the policyholder's inaction. As to the non-active form of moral hazard, it encompasses the phenomenon that the existence of insurance may lead insureds to take fewer precautions.[154] In fact, once the risk of loss is transferred to the insurer, it may be economically irrational to secure the insured property.[155] In the case of cast insurance it is not the action of the insured directly which leads to the loss but rather the action or condition of the insured's employee. For example, it is difficult to imagine what precaution the producers could have taken to prevent John Candy's death, since Candy had a fairly recent physical examination attesting to his health.[156] Only those in close daily contact with Candy were likely to have noticed his bingeing behavior. In the Brandon Lee case, Lee would not have been shot with a real bullet in a prop gun if all precautions had been taken. The presence of a risk manager arguably might have prevented the tragedy. In the cases of Harrison Ford's back spasms or Francis Ford Coppola's unexpected incapacity following his son's death, no precautions could have prevented the loss. But drug use by an employee may place a greater onus on the insured. The reason is simply that the film community is a close one and when stars engage in certain conduct, that conduct is telegraphed rapidly through the insular movie colony.

Despite Phoenix's public pronouncements of being "health conscious," he did engage in high profile partying as witnessed by the location of his death, the very public Viper Room. However, the burden of proof on the insurer to prove whom in the production company had knowledge of Phoenix's drug use, when they had it, and whether that knowledge was reliable, would be far more difficult for the insurer to prove than simply showing that the actor had abused drugs when he represented to the production company and the insurer that he had not.

It seems probable that the cast insurance cushion might make the production companies more reluctant to inquire into the private behavior of

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154. Thomas R. Foley, Note, *Insured's Misrepresentation Defense*, 67 S. CAL. L. REV. 659 (1994).

155. Pat O'Malley, *Legal Networks and Domestic Security*, 11 STUD. IN L. POL. & SOC'Y 171, 176 (1991).

156. John Candy had a physical about 6 weeks before *Wagons East* for a movie called *Canadian Bacon*. According to a top executive at an active underwriting firm who declined attribution, a second physical was waived due to tight production schedules. *See also* Hamby, *supra* note 49.

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their stars, especially into drug usage.[157] After all, drug abuse does not usually result in death or disability of stars.[158] It appears to be tolerated to some degree in the entertainment industry.[159] The traditional coercive tools of insurers are cancellation or refusal to pay a claim.[160] Use of these tools to force the production company to take a hard line might well result in labor problems in an industry known for its strong views on individual rights.

Hence, the availability of cast and essential element insurance that will pay the insured when an actor has intentionally misrepresented the use of illegal drugs and subsequently dies, gives the insured little reason to look beyond the actor's denial of substance abuse. So long as the contract is not rescinded, it seems the nature of cast insurance is to fully reimburse the insured production company. Only now, for the first time, is an insurer trying to mitigate its losses by subrogating. Prior to the Phoenix action, the moral hazard to the performer was potentially more direct than to the production company. While the production company did look the other way or simply made no efforts to confirm its suspicions, the actor knew with certainty whether a misrepresentation was being made and made it. No insurer had ever subrogated such a claim. Entertainers, even those who were tortfeasors, were insulated from the insurers' remedies.

As this article notes, there probably have been many secret settlements in which insurers denied claims. One industry insider noted, "there are few suits in this business. Things get settled . . . . everyone has to work together."[161] Such settlements have been hidden to protect the careers of entertainers whose images are all-important. By protecting the entertainer, the production companys' pocketbooks also have been protected and the limited number of insurers in this field can continue to serve the limited number of producers without enmity.

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157. This is especially so in the close knit business community of Hollywood. *See supra* note 7.

158. Yet the death of stars by drugs is not that uncommon. Those that the studios have been unable to keep quiet include John Belushi and Marilyn Monroe. Many stars have died from self-induced barbiturate poisoning such as Nick Adams, Pier Angeli, Dorothy Dandridge, Alan Ladd, Gia Scala, Jean Seberg, Inger Stevens and Margaret Sullavan. *See* KENNETH ANGER, HOLLYWOOD BABYLON II, 303-310 (1984).

159. *Id.* Among the stars documented as having been identified in possession of cocaine have been Linda Blair, Richard Dreyfus, Jodie Foster, Richard Pryor and Louise Lasser. *Id.*

160. O'Malley, *supra* note 155.

161. Waldman, *supra* note 22.

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### *D. Insurance Companies as Legislators of Morality*

If River Phoenix had stated on his application that he was abusing drugs, the production company would probably still have been able to obtain coverage. The insurer might simply have excluded all drug-related risks on the policy or charged a higher premium for the coverage. Insurance companies do not inquire into aspects of personal behavior as substance abuse because they are moralizing or exercising social control. They inquire because they want to be able to assess the risks properly. An actor presenting a risk the insurers do not wish to assume is not losing employment or being asked to make a financial concession because of moral intrusiveness on the part of the insurer. It is simply a bottom line decision. This fact does nothing to obviate the reality that insurers are making decisions which affect the artistic product.

Whereas a subrogation action *is* intended to work justice,[162] investigation of the illegal, dangerous or unhealthful behavior of a potential insured is not an attempt to impose normative values. The underwriter is neither priest nor policeman. The reason is simply that the initial investigation is merely a methodical analysis of the potential risks involved; morality has no place here. But, after the insurance is issued and the loss has been claimed, an insurer will be much more interested in the right and the wrong of the activity in order to obtain equitable relief. When assessing the risk, the insurance company will view drug use much as it does its other criteria for issuing coverage including health history, physical capability for the role, dangerous personal life style or activities. The difference is that hazardous activities can be more easily and demonstrably curtailed than can drug use.[163]

Earlier in our history, the act of using illegal drugs would have been of concern only for moral and legal reasons. Sermons might be preached, editorials written and social or legal sanctions imposed. Disciplinary practices aimed at moving individuals toward the norm. Times have changed. Today, moral judgments are unfashionable and social sanctions have evaporated in our diverse society. Legal machinery only comes into

162. JERRY, *supra* note 90, § 96(c) (quoting Hampton Loan and Exch. Bank v. Lightsey, 152 S.E. 425 (S.C. 1930)).

163. Norton, *supra* note 15. While filming, Tom Selleck had to obtain permission from insurers to take a vacation that included white water rafting. Since Selleck was experienced, the insurance company allowed him to go. *Id.*

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play in the most blatant cases, and moral authority has been decoupled from risk management altogether.[164]

Beginning in the late nineteenth century, as actuarial practices developed, a displacement from morally based societal controls to controls based upon the distribution of costs and benefits to society began to occur.[165] Today's actuarial society takes a statistical look at a behavior and develops strategies to manage it and minimize financial loss. Society and its institutions no longer seek to influence individual behavior. It seeks instead to predict behavior and make economically wise decisions based upon anticipated actions. This has been called a movement from normalization to accommodation.[166]

Insurers are keenly aware that the insured, or in the Phoenix case, the insured's employee, may be immoral.[167] That immorality is predictable if accurate information is supplied and can be accommodated. After all, this is a principal reason for the existence of claims adjusters, who take pride in catching fraudulent claimants.[168]

## III. THE INSURER AS A CONTROLLER OF THE ARTISTIC PROCESS

To those within the film industry, the degree of artistic control exercised by insurers over plot line, action scenes and casting are simply accepted as a part of the business. The motion picture producer is as risk averse as an insured is likely to be given the intense use of large sums of money needed to make movies. To the audience, the idea of an underwriter having final script approval maybe shocking. The result of imposing business restraints on the creative process should not be seen as entirely negative. In fact, it can be socially and economically beneficial.

Society benefits when sanctioned behavior is rewarded and prohibited behavior is discouraged. By electing either to exclude coverage of certain prohibited behavior or to charge a premium for it, even though not done for morally-based reasons, the insurer discourages the type of behavior that society disapproves. Further, the insurer is promoting the health and well-being of the insured employees when dangerous stunts are curtailed or illicit drug use is discouraged.

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164. Jonathan Simon, *Risk Management and Campus Life*, 3 SOC. & LEGAL STUD. 29 (1994).

165. Jonathan Simon, *The Ideological Effects of Actuarial Practices*, 22 L. & SOC'Y REV. 771, 771-773 (1988).

166. *Id.* at 773.

167. Tom Baker, *Constructing the Insurance Relationship: Sales Stories, Claims Stories and Insurance Contract Damages*, 72 TEX. L. REV. 1395, 1411-12 (1994).

168. *Id.* at 1413, n.64.

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Economic benefits are manifold. When an insurer subrogates, the negative impact of cross-subsidization and adverse selection will be minimized.[169] Adverse selection occurs when an insurance buyer knows that he poses a higher risk monetarily than the insurer will charge for coverage and therefore is getting a bargain. Applied to a River Phoenix - type scenario, a production company might feel it could employ higher risk actors who might have substance abuse problems and pay no higher premium as a result. This would be especially true where there has been no prior history of subrogation arising from cast policies. As more insurance is issued to such high risk insureds, more claims will result and the insurers must raise their rates. Low-risk insureds begin to subsidize those with higher risks and the lower risk insureds will be less likely to seek coverage, especially when premiums rise to meet the higher than expected loses.[170] In extreme cases, the cycle continues until only the highest risk insureds seek coverage.[171]

Added to the economic benefits of risk spreading is the simple need to insure fair treatment to innocents. Low-risk insureds who are paying the same premiums as high risk insureds who have either directly or indirectly misrepresented their risk factors should be protected. By subrogating, the insurer is discouraging future misrepresentations and helping to "level" the playing field for all insureds.

In addition, the financial well-being of the insurance company is protected because subrogation attempts to salvage some of the loss and improve the bottom line which benefits not only policyholders, but also shareholders and employees of the firm.

Economic efficiency is also promoted because when a production company is forced to look beyond the representations of an employee who is an essential element of a film, the film is more likely to be completed.[172]

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169. Foley, *supra* note 154, at 666.

170. *Id.* In fact, this is exactly what has happened in the wake of the Phoenix claims and has been exacerbated by the claims from the John Candy and Brandon Lee deaths. There is no evidence that any of the production companies paid commensurate premiums for the risks involved, thus the cost of the losses was spread among many lower risk insureds. Insurers have been forced to raise prices as much as 30 to 40 percent. The result will probably be to cover the minimal number of key employees on a film.

171. *Id.* This phenomenon is known as "unraveling." *See also* KENNETH S. ABRAHAM, INSURANCE LAW AND REGULATION 3-5 (1995).

172. For example, had Carolco insisted on a physical for John Candy prior to shooting *Wagons East*, it is likely that changes in the actor's weight gain and habits would have been observed. The insurer would have excluded him and the production company might have been forced to re-cast Candy's role resulting in a completed film. If the producers of *Dark Blood* had required independent drug testing of their key actor, arguably, the casting

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When a film is completed, the production company has fulfilled the purpose for which it was created. Economic benefits accrue to society when the film is then released and distributed to movie theaters and video stores worldwide and to cable companies. When the film is shelved upon the death of a key player, only the production company and its immediate employees and creditors benefit.

Doubtless, there is a strong argument that imposing drug tests on actors who deny they are using drugs is an invasion of their privacy. Yet for countless other jobs, applicants are screened for drug use. If a clerk in a convenience stores misrepresents his drug use, subsequently overdoses, and can't perform his job, the economic consequences fall dramatically short of what happens when the star of a movie cannot complete the film. Therefore, actors, as responsible members of their profession who are interested in the economic well-being of the industry should be willing to submit to appropriate physical examinations and drug testing.

This recommendation cannot be reconciled with a position that that actors and other movie cast members as artists are somehow held to a lower standard of compliance with society's expectations than the rest of the working populace. Such a dual standard would be counter productive.[173] If anything, the stakes are much higher where actors are involved and therefore they should be held to the highest standards of disclosure.

## CONCLUSION

In support of CNA's subrogation action against the estate of River Phoenix, this article has examined the artistic, moral, legal and economic implications of misrepresentation by an employee of the insured for purposes of obtaining cast insurance. At the same time it has considered the implications of not only control over major casting and script decisions by insurers, but also the resulting role of insurer as moral arbiter or social controller. Doubtless the case would have been more persuasively made if

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decisions might have been different and the film would have been completed. But in both cases essential element insurance was available to the producers allowing them to take higher risks than a fully informed underwriter might normally be willing to assume. The result could be seen as a windfall to both production companies and a waste of economic resources.

173. It has been pointed out in the context of regulating alcohol consumption that policies governing risk behavior must be uniform. "If you are going to limit alcohol at the holiday party for the custodial staff, you had better limit the alcohol at faculty 'wine and cheese' gatherings." Simon, *supra* note 164, at 33 (quoting University of Michigan Task Force, 1991:2).

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the insurer had followed proper procedure by first noting the fact that Phoenix did not sign the front of the medical certificate and then requiring him to do so, and second, by issuing the policy in a timely manner.

This article has concluded that, although cast members may deeply resent the physical examinations and drug testing required by the insurer, there are substantial reasons to enforce this policy due to actors' roles as key employees of movie production companies. There is no reason to hold cast members to a lower standard than employees in other industries, particularly in light of the fact that the motion picture business risks enormous amounts of money, project by project, and depends completely on the availability of its cast.

In fairness to other members of the pool who do not misrepresent or who represent a lower risk, full disclosure of all material information should be required of the cast member. The layer of insulation between the insurer and the employee that is provided by the insured should not be allowed to distort what is fair to other policy holders.

Because the motion picture business poses far greater risks than most industries, it is important that insurance be available to the industry. It is crucial, therefore, that an insurer be given the correct information so that that risks can be properly calculated and appropriate premiums be charged. To do otherwise is to place an unfair burden on the insurer and on all other policyholders of the insured who will pay the cost of losses that could not have been foreseen due to misrepresentation.

Sanctions such as subrogation are necessary if the cast members are to make complete and true representations. Until the River Phoenix case, cast members and other insureds had little reason to worry about repercussions to their pocket books or to their careers. If CNA could prove the fact of misrepresentation, case law supports a finding that such a misrepresentation is material. The consequences to Phoenix's estate should make potential misrepresenters think twice.

Economic efficiency is well served by this subrogation action. Internally, the insurer will improve its bottom line. This should benefit the shareholders and employees and especially other policyholders. For the film industry, more people are employed to complete and distribute a film than to wrap-up a partly finished product which also wastes valuable resources. By discouraging misrepresentations, more films are likely to be completed which is the reason for being of the motion picture industry.

There are undeniabe consequences as to personal liberties, but the personal liberties protected should not encompass the liberty to fraudulently misrepresent oneself on an insurance application. Medical

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examinations have long been an optional requirement before obtaining various types of coverage. If ordinary persons must undergo physical examinations and be expected to truthfully represent themselves on, for example, life insurance applications, why shouldn't the cast members of a motion picture be held to as high a standard? With this suit, insurers may be getting over their awe of entertainers, and producers will now have the ammunition they need to change the way these applications are completed.

It is a myth to believe that the movies are more the result of artistic and creative energy than from a series of calculated business decisions.[174] The industry has been governed by business considerations for a very long time. One of the calculations has been and continues to be the reliability of the cast members to be available, because, once production is underway, key cast members are almost impossible to replace. Technology may have come a long way from the hat worn by Jean Harlow's double to the computerized creation of final scenes in *The Crow*, but technology can only go so far. "The death of a star is the most awful disaster imaginable for a studio."[175]

For the insurer, other insureds, shareholders and employees, however, it is the fraudulent misrepresentation by the covered star that poses the greatest threat: they will lose economically when the insurer is foreclosed from excluding, rejecting or charging a higher premium for the undisclosed risk. Such representations will continue unchecked unless insurers send the message that they will not tolerate behavior from cast members which they would not tolerate from non-celebrities. Their most appropriate messenger is to take the kind of action seen in the *Phoenix* case. But such an action should be based on a coverage situation where the insurer has followed its own procedures properly. Although the flaws in the handling of the policy in the *Phoenix* case render it a poor choice for enforcing a subrogation action, it is nevertheless a benchmark action by an insurer. Having decided to attempt to punish publically and agreesively a cast member's alleged misrepresentation on a medical certificate, it may be that other insurers in similar, if less dramatic cases, will do the same. The Phoenix case is a very valid precedent that everyone in the industry is watching.[176]

It is true that the world of motion pictures is superficially, at least, very different from the world of insurance. This paper has explored some

174. Amatenstein, *supra* note 55 (recounting Director Oliver Stone's Oscar acceptance speech for *Platoon*, in which he thanked the film's insurance company).

175. *Id.* (quoting entertainment insurance broker Robert Boyer of Marsh & McLennan).

176. Norton, *supra* note 15.

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perhaps unanticipated areas of commonality. Both are essentially money-making businesses. Both are concerned with dollars and cents and both may be involved in artistic decisions.[177] So long as the insurance world applies the same expectations and procedures to movie makers that are applied to other businesses, these spheres should orbit harmoniously and profitably.

177. At least one industry insider, Vincent Waldman, maintains that insurance company representatives reviewing scripts, stationed on sets and making recommendations, are experienced and talented in the motion picture business. A self-proclaimed disbeliever in the "auteur theory" of film making, Waldman states that "movies are a collaborative effort." Waldman, *supra* note 22. The film risk management expert for Near North began as a straight insurance employee but now represents the company exclusively on movie and television deals and has acquired considerable expertise. McAllister, *supra* note 26.

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# TOBACCO-RELATED LITIGATION: HOW IT MAY IMPACT THE WORLD'S INSURANCE INDUSTRY

*Mitchell L. Lathrop**

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## INTRODUCTION

The defenses of the impregnable fortress of tobacco in America appear to have been breached. A once invincible industry has taken serious blows in recent months from both federal and state governments, as well as the public at large. Largely unnoticed thus far in the fray is the potential impact tobacco-related litigation may ultimately have on the world's insurance industry. This paper examines that potential, particularly with respect to those insurers which have issued comprehensive general liability or commercial general liability (collectively, "CGL") policies to tobacco manufacturers and peripheral entities[1] serving the tobacco industry, or errors and omissions policies to various categories of professionals which may have worked closely with the tobacco industry over the years. To understand what is happening today, the background of the "tobacco and health" controversy must be examined.

## I. BACKGROUND

In 1964 the Surgeon General's Advisory Committee issued a report on smoking and health which linked smoking to a number of diseases.[2] As concern over smoking and health increased, the federal government passed the Federal Cigarette Labeling Act (the "Labeling Act"),[3] which was later amended by the Public Health Cigarette Smoking Act.[4] The Labeling Act provides, in pertinent part:

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1. Many of these peripheral entities have become defendants in tobacco litigation. *See infra* note 87 and accompanying text.

2. The 387-page 1964 Surgeon General's Report was issued January 11, 1964 by Luther L. Terry, M.D., Surgeon General of the U.S. Public Health Service. The report was based on more than 7,000 articles relating to smoking and disease.

3. 15 U.S.C. §§ 1331-1340 (1965).

4. In 1969 Congress enacted the Public Health Cigarette Smoking Act, which amended the original Labeling Act. The 1969 Act required a statement that cigarette smoking is "dangerous" rather than that it may be "hazardous," banned cigarette advertising in any medium of electronic communication subject to the jurisdiction of the Federal Communications Commission, and modified the pre-emption provision by replacing the original § 5(b) with a provision which states: "No requirement or prohibition based on smoking and health shall be imposed under State law with respect to the advertising or promotion of any cigarettes the packages of which are labeled in conformity with the provisions of this Act." Pub. L. 91-222, 84 Stat. 87 (1969), *as amended,* 15 U.S.C. §§ 1331-1340 (1970).

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> It is the policy of the Congress, and the purpose of this chapter, to establish a comprehensive federal program to deal with cigarette labeling and advertising with respect to any relationship between smoking and health, whereby
>
> (1) The public may be adequately informed that cigarette smoking may be hazardous to health by inclusion of a warning to that effect on each package of cigarettes; and
>
> (2) Commerce and the national economy may be (A) protected to the maximum extent consistent with this declared policy and (B) not impeded by diverse, nonuniform, and confusing cigarette labeling and advertising regulations with respect to any relationship between smoking and health."[5]

The tobacco companies cleverly turned the cigarette warning-label laws to their advantage by arguing that the Labeling Act preempted all common law claims.[6]

Since 1964, a total of twenty-three additional reports have been issued by the U.S. Surgeon General since 1964. These have been prepared by a unit of the Public Health Service known originally as the National Clearinghouse for Smoking and Health, but which is today the Office on Smoking and Health.

Although the tobacco industry is no stranger to litigation, prior to the 1992 holding of the U.S. Supreme Court in *Cipollone v. Liggett Group,*

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5. 15 U.S.C. § 1331 (1997).

6. *See, e.g.,* Cipollone v. Liggett Group, Inc., 789 F.2d 181, 187 (3d Cir. 1986), *cert. denied*, 479 U.S. 1043 (1987) (The district court certified the question of whether the Labeling Act preempted any or all of the state common law claims brought by the Cipollones. The Third Circuit responded "that the Act preempts those state law damage actions relating to smoking and health that challenge either the adequacy of the warning on cigarette packages or the propriety of a party's actions with respect to the advertising and promotion of cigarettes. We further hold that where the success of a state law damage claim necessarily depends on the assertion that a party bore the duty to provide a warning to consumers in addition to the warning Congress has required on cigarette packages, such claims are preempted as conflicting with the Act.") *Id.* at 187.

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*Inc.*[7] the tobacco industry had won virtually every case it tried. Juries were not sympathetic to habitual smokers and the tobacco manufacturers spent huge sums in the defense of smoking and health cases. The defense was extremely well organized and carefully coordinated throughout the country.

The first major losses suffered by the tobacco industry came in *Cipollone v. Ligget Group, Inc.*[8] and *Haines v. Liggett Group, Inc.*,[9] both of which were handled by U.S. District Court Judge H. Lee Sarokin, Jr. in the U.S. District Court for the District of New Jersey. Judge Sarokin was subsequently disqualified in *Haines*[10] and recused himself in *Cipollone* because of remarks he made in a ruling in *Haines*[11] which reversed a Magistrate Judge and permitted discovery of certain Council for Tobacco Research ("CTR")[12] documents based upon the crime/fraud exception to the attorney-client privilege. It has been widely argued that the "special projects" division of CTR was merely a front for research favorable to the tobacco industry. Everything was funneled through attorneys in an attempt to preserve the attorney-client privilege and/or attorney work product immunity from discovery with respect to sensitive documents.

The comments by Judge Sarokin which raised the ire of the Third Circuit were:

> As the following facts disclose, despite some rising pretenders, the tobacco industry may be the king of concealment and disinformation.
> The evidence presented by plaintiff supports a finding that the industry research which might indict smoking as a cause of illness was diverted to secret research projects and that the publicized efforts were primarily directed at finding causes other than smoking for the illnesses being attributed to it.
>
> A jury might reasonably conclude that the industry's announcement of proposed independent research into the

7. 505 U.S. 504 (1992).

8. 593 F. Supp. 1146 (D.N.J. 1984), *modified*, 789 F.2d 181 (3d Cir. 1986), *cert. denied*, 479 U.S. 1043 (1987).

9. 814 F. Supp. 414 (D.N.J. 1993).

10. Haines v. Liggett Group, 975 F.2d 81 (3d Cir. 1992).

11. 140 F.R.D. 681 (D.N.J. 1992), *vacated*, 975 F.2d 81 (3d Cir. 1992).

12. CTR is the successor to the former Tobacco Industry Research Council.

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dangers of smoking and its promise to disclose its findings was nothing but a public relations ploy -- a fraud -- to deflect the growing evidence against the industry, to encourage smokers to continue and non-smokers to begin, and to reassure the public that adverse information would be disclosed.

While the efforts which the CTR chose to advertise were well publicized, plaintiff learned of a secret division of the CTR, the "special projects" division. Under the auspices of the special projects program, defendants' counsel and other tobacco industry attorneys collaborated in assessing, monitoring, and directing the scope of research projects purportedly designed to identify expert witnesses and to develop evidence supporting defendants' positions in existing and anticipated litigation and Congressional hearings. Defendants insist that their "special projects" efforts are entirely distinct from and unrelated to the CTR's advertised "independent" research and thus, "special projects" documents are protected by the attorney-client privilege. However, plaintiff seeks discovery of the "special projects" documents otherwise subject to the attorney-client privilege on the ground that said documents come within the crime/fraud exception to the privilege.

Plaintiff has presented *prima facie* evidence that defendants' "special projects" program was interrelated and intermingled with the CTR's supposedly "independent" research. The facts presented support plaintiff's overall theory of fraud based on the false claims regarding the independence of CTR-sponsored research and on the likelihood that defendants mounted a public relations campaign designed to discredit the links between smoking and disease which defendants knew existed. Furthermore, there is evidence supporting the conclusion that research which might tend to prove smoking a cause of such illnesses was diverted into special projects and

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> intentionally shielded by the attorney-client privilege so as to prevent its disclosure.[13]

*Cipollone* was tried to a jury, which returned a verdict in favor of Mr. Cipollone for $400,000.[14] On appeal, the Third Circuit reversed the trial court on the basis of improper jury instructions and ordered a new trial.[15] When *Cipollone* finally reached the U.S. Supreme Court, the high court rejected the tobacco industry's position and held that the Labeling Act does not preempt common law claims (1) for marketing cigarettes with manufacturing defects; (2) for failing to use a demonstrably safer alternative design for cigarettes; (3) which involve testing or research practices by tobacco manufacturers which are unrelated to advertising; and (4) for breach of express warranties "aris[ing] from the manufacturer's statements in its advertisements."[16] Claims based upon fraudulent misrepresentation and conspiracy to misrepresent or conceal material facts were also not pre-preempted by federal cigarette warning-label laws.[17]

*Cipollone* was a major setback for the tobacco industry. In reaching its decision, the Supreme Court observed that the tobacco litigation involved accusations that tobacco companies were partners in an organized conspiracy "to refute, undermine, and neutralize information coming from the scientific and medical community."[18]

### *A. Governmental Activity*

As the product liability litigation wound along its way, Representative Henry A. Waxman, then Chairman of the House Energy and Commerce Committee, Subcommittee on Health and the Environment, held a series of Congressional hearings on smoking and health. During the hearings, the chief executive officers of American Tobacco Company, Brown & Williamson, Liggett Group Incorporated, Lorillard Tobacco Company, Philip Morris USA, R.J. Reynolds Tobacco Company and U.S. Tobacco Company all testified under oath before Congressman Waxman's

13. *Haines*, 140 F.R.D. at 684. Although the Third Circuit ordered Judge Sarokin's disqualification in the *Haines* case, his ruling that numerous internal CTR documents were discoverable on the basis of the crime/fraud exception to the attorney-client privilege was upheld. *See* Haines v. Liggett Group, Inc., 975 F.2d 81, 97-98 (3d Cir. 1992). Ironically, Judge Sarokin is today a sitting judge on the Third Circuit.

14. Cipollone v. Liggett Group, Inc., 893 F.2d 541, 546 (3d Cir. 1990).

15. *Id.* at 583.

16. 505 U.S. at 524-36.

17. *Id.*, at 524-32.

18. *Id.*, at 528 n.28.

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Subcommittee that they believed their companies' tobacco products which contain nicotine were not addictive.[19] An indefatigable foe of the tobacco industry, Congressman Waxman's committee released a report entitled "The Hill and Knowlton Documents: How The Tobacco Industry Launched Its Disinformation Campaign" (the "Waxman Report").[20] The report was highly critical of the CTR. The Congressional staff report indicated that the alleged independence of CTR from the tobacco manufacturers was a carefully planned deception whereby the impression was given that CTR was in fact engaged in scholarly research about smoking and health, while in fact it waged a "campaign of disinformation". It was alleged that the tobacco industry used CTR as a public relations vehicle to counter negative reports on the dangers of smoking, particularly the report on smoking and tobacco products issued by the U. S. Surgeon General. The Waxman Report resulted in the filing of numerous new "tobacco and health" cases against the manufacturers.

At about the same time, in February 1994, Food and Drug Administration ("FDA") Commissioner Dr. David A. Kessler publicly announced that the FDA was considering regulating tobacco as a "drug" on the basis of evidence which he believed established that the tobacco companies had long been able to reduce the level of nicotine in cigarettes but had declined to do so. The FDA took the position that if tobacco products were intended to pharmacologically affect the "structure or function of the body," they could be regulated or banned as a drug under the FDA's charter and authority. The FDA launched a formal investigation

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19. These are the seven largest American tobacco manufacturers. *See Regulation of Tobacco Products: Hearings Before The Subcommittee on Health and the Environment of the House Committee on Commerce and Energy*, 103d Cong., 2d Sess., pt. 1, at 628 (1994) (testimony of Messrs. Campbell, J. Johnston, Taddeo, Tisch, Horrigan, Sandefur and D. Johnston). The U.S. Department of Justice and the U.S. Attorney for the Southern District of New York have allegedly convened a grand jury to investigate "whether tobacco companies misrepresented to federal regulators the contents and ill effects of cigarettes." *See, e.g.*, Philip J. Hilts, *U.S. Convenes Grand Jury To Look at Tobacco Industry*, N.Y. TIMES, July 26, 1995, at A1. A second grand jury is being convened to investigate "whether company executives lied to Congress about tobacco products" in connection with the testimony of the tobacco company executives before The Subcommittee on Health and the Environment. John Schwartz & Pierre Thomas, *U.S. Widens Tobacco Investigation; Justice Department Pressures Mid-Level Workers in Fraud Probe*, WASH. POST, Sept. 8, 1996, at A1.

20. *Regulation of Tobacco Products: Hearings Before The Subcommittee on Health and the Environment of the House Committee on Commerce and Energy*, 103d Cong., 2d Sess., pt. 2, at 418-522 (1994) (Majority Staff Report: "The Hill and Knowlton Documents: How The Tobacco Industry Launched Its Disinformation Campaign").

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to determine the nature and extent of the knowledge concerning the addictiveness of tobacco held by the tobacco manufacturers, and whether the tobacco companies had deliberately manipulated the level of nicotine in tobacco products to keep users addicted. One month later, Congressman Waxman stated that he was contemplating regulating tobacco as an addictive drug.

Within weeks of the time the tobacco industry executive officers had testified before Congress, copies of internal documents concerning the Brown & Williamson Company were anonymously sent to Congressman Waxman, Commissioner Kessler and several news organizations.[21] The documents allegedly revealed that the tobacco industry had far greater knowledge of the addictiveness of tobacco than was previously known. They also contained allegations that tobacco companies knowingly and deliberately manipulated nicotine levels in tobacco products. These documents are believed to be highly accurate inasmuch as they were purportedly authored by senior tobacco company scientists and executives, and transmitted to top management officials in those companies.

In August, 1995, FDA Commissioner Kessler announced that nicotine is a drug which should be regulated under the Federal Food, Drug and Cosmetic Act.[22] Proposed regulations were submitted to the President of the United States for review and approval.[23] President Clinton publicly supported the proposed regulation of tobacco products[24] on the ground that such regulation would presumably lessen the incidence of smoking by

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21. It has been reported that the Brown & Williamson documents were stolen by a former paralegal at a Kentucky law firm which represents Brown & Williamson. The paralegal in question had been assigned to review the documents in preparation for litigation. After reviewing the documents, he came to believe that his own heart disease had been caused by smoking cigarettes. Brown & Williamson sued the paralegal in Kentucky state court for conversion of its property and in the course of discovery obtained commissions to subpoena two members of Congress and the news media. The subpoenas served on the two Congressmen were summarily quashed. *See* Maddox v. Williams, 855 F. Supp 406, 411 (D.D.C. 1994) *aff'd sub nom.* Brown & Williamson Tobacco Corp. v. Williams, 62 F.3d 408 (D.C. Cir. 1995) ("The subpoenas before the Court were secured by a corporation currently under investigation by a House of Representatives committee . . . [and the] interference with congressional operations is thus as plain and direct as it appears to be intentional." 855 F. Supp at 411.).

22. *See* Philip J. Hilts, *Tobacco Held to Be Drug That Must Be Regulated*, N.Y. TIMES, July 13, 1995, at A18.

23. 60 Fed. Reg. 41,314 - 41,451 (1995) (proposed Aug. 11, 1995).

24. *Id.* at 41,314 (proposed regulations restricting the sale and distribution of cigarettes and smokeless tobacco products to protect children and adolescents, and establishing the FDA's authority to regulate tobacco products).

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youths[25] and on August 23, 1996, approved new federal regulations, "Regulations Restricting the Sale and Distribution of Cigarettes and Smokeless Tobacco Products to Protect Children and Adolescents" by the FDA.[26] These regulations restrict minors' access to nicotine-containing tobacco products and reduce the amount of positive imagery that makes these products attractive to young people.[27] The tobacco and advertising industries immediately challenged the regulations.[28]

*B. The Secret Tobacco Industry Documents*

The documents which have been obtained by the news media, as well as plaintiffs' lawyers and others, reveal the following:[29]

> •In 1946, H.B. Parmele, a research scientist at Lorillard, noted in an internal memorandum that studies of a cancer link were supported by "just enough evidence . . . to justify the possibility of such a presumption." This document continued that the link had not been established with "absolute authority."

25. *See* Michael Wines, *Proposal on Tobacco Gets Some White House Backing*, N.Y. TIMES, July 14, 1995, at A18. The proposal has become a highly political issue, with House Republicans adamantly against any regulation of tobacco by the FDA. Under the proposals, tobacco products would be treated as a drug, subject to the FDA's authority to regulate their sale of these products. Litigation has already been commenced to block FDA regulation of tobacco products. *See, e.g.*, Coyne Beahm Inc. v. United States Food & Drug Admin., No. 2:95CV00591 (M.D.N.C. Aug. 10, 1995); United States Tobacco Co. v. Food & Drug Admin., No. 3-95-0781 (M.D. Tenn. Aug. 10, 1995); American Advertising Fed'n v. Kessler, No. 2:95CV00593 (M.D.N.C. Aug. 10, 1995).

26. 61 Fed. Reg. 44,396 (1996), as corrected, 61 Fed. Reg. 47,550 (1996) (to be codified at 21 C.F.R. pt. 897).

27. The basis for the FDA's conclusion establishing its jurisdiction over these tobacco products is set forth in the FDA NPRM's accompanying proposed jurisdictional analysis. *See* 60 Fed. Reg. 41,453 (1995) (to be codified at 21 C.F.R. pt. 897).

28. *See* Coyne Beahm Inc. v. United States Food & Drug Admin., 966 F. Supp. 1374 (M.D.N.C. 1995); United States Tobacco Co. v. Food & Drug Admin., No. 3-95-0781 (M.D. Tenn., August 10, 1995); American Advertising Fed'n v. Kessler, No. 2:95CV00593 (M.D.N.C., August 10, 1995).

29. Many of the documents were allegedly stolen from the Kentucky law firm of Wyatt, Tarrant & Combs, counsel for Brown & Williamson, by Dr. Merrell Williams, a former scientist/paralegal, and distributed to members of Congress, the FDA and the media. Richard Leiby, *Smoking Gun: Merrel Williams, Ex-Actor, Is the Most Important Leaker of Documents Since Daniel Ellsberg. What He Did Could Bring Down a $45 Billion Industry. What's His Motivation?*, WASH. POST, June 23, 1996, at F1.

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•In 1957, a Liggett marketing firm conducted a "motivation survey" of smokers to assess smoker's attitudes towards potential health fears. The survey concluded that "[w]hat smoker's [sic] are really saying is: 'I wish I had never started to smoke. . .but now that it's got me, I know that I can't stop.'"

•On February 15, 1961, Arthur D. Little, Inc., a Liggett consultant, replicated results from a 1953 health study by Dr. Ernst Wynder which had shown increased skin tumors in mice painted with smoke condensate, and stated that "[t]here are biologically active materials present in cigarette tobacco. These are: (a) cancer causing; (b) cancer promoting; (c) poisonous; (d) stimulating, pleasurable, and flavorful."

•On November 15, 1961, Dr. Helmut Wakeham, research director at Philip Morris, observed that "[c]arcinogens are found in practically every class of compounds in smoke. This fact prohibits complete solution of the problem by eliminating one or two classes of compounds. . . .A medically acceptable low-carcinogen cigarette may be possible. Its development would require: TIME MONEY UNFALTERING DETERMINATION."

•In 1968, Dr. Wakeham referred to a "gentleman's agreement" among the tobacco companies not to perform internal health research.

•In 1971, Dr. William Dunn, a researcher at Philip Morris stated that "(t)he cigarette should be conceived not as a product but as a package. The product is nicotine. The cigarette is but one of many package layers. There is the carton, which contains the pack, which contains the cigarette, which contains the smoke. The smoke is the final package. The smoker must strip off all the package layers to get that which he seeks."

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•In 1971, Dr. Wakeham discussed a gradual emergence from "the dark ages when it was considered harmful to be knowledgeable about the biological effects of smoke . . . ." On May 1, 1972, the Tobacco Institute discussed its strategy as "brilliantly conceived" and one which relied upon "creating doubt about the health charge without actually denying it; advocating the public's right to smoke, without actually urging them to take up the practice; encouraging objective scientific research as the only way to resolve the question of health hazard."

•In October 1972, Dr. T. R. Schori, a Philip Morris researcher, reported to Dr. Dunn concerning the development of a new menthol cigarette. He stated "[i]n this study, we are trying to determine what levels of nicotine delivery are realistically feasible in menthol cigarettes." Dr. Dunn indicated that tests were underway and that a key test was "designed to identify nicotine and menthol parameters which make for optimal acceptability of menthol cigarettes."

•In 1974, Dr. Dunn wrote that "[a] general premise in our model of the cigarette smoker is that the smoking habit is maintained by the reinforcing effect of the pharmacologically active components of smoke."

•In October 1975, Barbara James, Willie Houck and Peggy Martin, three Philip Morris researchers, authored a report on nicotine-to-tar ratios in low-tar cigarettes. They wrote that "[t]his study provides evidence that the optimum nicotine-to-tar (N/T) ratio for a 10 mg tar cigarette is somewhat higher than occurring in smoke from the natural state of tobacco." The report concluded that "[w]e are using the guidelines suggested by this study to attempt to make a 10 mg tar cigarette that will equal a Marlboro in both subjective acceptability and strength."[30]

30. Philip J. Hilts & Glenn Collins, *Documents Disclose Philip Morris Studied Nicotine's Effect On Body*, N. Y. TIMES, June 8, 1995, at A1.

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•In 1977, Dr. Dunn embarked on a study of the "psychology of the smoker in search of information that can increase corporate profits." Comparisons were made between smokers and hungry rats or pigeons trained to "perform grotesque movements." He concluded that a smoker's behavior was the result of "chemical compounds being introduced to the bloodstream." "Without the chemical compound, the cigarette market would collapse, P.M. [Philip Morris] would collapse, and we'd all lose our jobs and our consulting fees." Dr. Dunn observed that there was "understandable legal concern about any industry-endorsed reference to the pharmacological effects of smoke. . . . The risk is great that cigarette smoke contains a dependency-producing drug classifiable with amphetamines and other opiates."

•In 1979, a Philip Morris official wrote that "[t]here is no doubt that nicotine is a powerful pharmacologic agent."
In 1988, Dr. Victor DeNoble, a former research scientist at Philip Morris, who allegedly was familiar with some of the secret internal documents of Philip Morris, stated that "[t]he company began to realize that they could reduce the tar, but increase the nicotine, and still have the cigarette be acceptable to the smoker. After all their work, they realized that nicotine was not just calming or stimulating, but it was having its effect centrally, in the brain, and that people were smoking for brain effects."

•In the July 19, 1995 issue of the Journal of the American Medical Association it is reported that Brown & Williamson and BAT Industries "recognized more than 30 years ago that nicotine is addictive and that tobacco smoke is 'biologically active,' *e.g.*, carcinogenic."[31] As discovery has progressed in many of the pending cases, additional documents have surfaced which will add even more fuel to the fire. Prior testimony of tobacco industry officials has

31. John Slade et al., *Nicotine and Addiction: Brown & Williamson Documents*, 274 JAMA 225 (1995).

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> also been called into question, with potentially harmful consequences for the entire tobacco industry.[32]

A description of the manufacturing process used by at least one tobacco manufacturer was presented during the defamation lawsuit brought by Philip Morris against ABC:[33]

> Philip Morris, by design, adds substantial amounts of what may be characterized as extraneous nicotine to its cigarettes during manufacturing. If anything, the "takes it out, puts it back in" observation that ABC quoted at the outset of its news report was an understatement, not a misstatement, of how nicotine is added during the reconstitution process.
>
> The nicotine that Philip Morris "takes out" from a batch of tobacco materials in its reconstituted tobacco manufacturing process -- and that Philip Morris does not then have to use in manufacturing cigarettes -- is not "put back," "recombined" or added to the same tobacco, or to the tobacco sheet that Philip Morris produces from that batch of tobacco material. Instead, Philip Morris adds a nicotine-containing solution -- manufactured from some other tobacco -- to that original tobacco material or tobacco sheet. This bears repeating: the nicotine applied is derived from another source. The nicotine that is added to tobacco sheet rarely, if ever, originates from -- in other words, was always "extraneous" to -- the tobacco materials from which the tobacco sheet was derived.
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> * * *
>
> One of the processes Philip Morris uses to make reconstituted tobacco -- called the "reconstituted leaf" or

32. A compilation of the Brown & Williamson documents may be found in STANTON GLANTZ ET AL., THE CIGARETTE PAPERS (1996). Dr. Glantz is a heart researcher at the University of California at San Francisco and was a recipient of one of the sets of documents allegedly stolen from Brown & Williamson.

33. *Philip Morris Co. Inc. v. American Broadcasting Co., Inc.*, No. LX-816-3, 1995 WL 301428 (Va. Cir. Ct. Jan. 26, 1995).

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"RL" process -- begins when tobacco waste materials are "pulped" with liquids. Philip Morris then extracts every thing that can be dissolved, including the nicotine, from these tobacco materials. Philip Morris removes potassium nitrate from, adds other chemicals to, and concentrates this tobacco extract to pre-set levels. This concentrated tobacco extract is stored.

Philip Morris takes the tobacco remnants that have not been dissolved and forms them into a tobacco sheet. Philip Morris adds to the tobacco sheet the concentrated tobacco extract it has separately manufactured -- without any regard whatsoever to whether it is being "recombined" with the same tobacco materials from which it originated.

In the initial pulping step of the RL process, Philip Morris adds to a new batch of dry raw tobacco materials, from which no solubles (including nicotine) have been extracted, tobacco extract containing significant amounts of nicotine made from other tobacco. This tobacco extract had never been a constituent part of and had always been physically separate from the dry raw tobacco materials to which it is added. As a result, the mixture of that second batch of dry raw materials and tobacco extract has more nicotine in it than was in the dry raw tobacco materials.

After tobacco sheet is manufactured during the RL process, Philip Morris adds from a storage tank tobacco extract containing significant amounts of nicotine to the tobacco sheet, without regard to whether the tobacco extract and the tobacco sheet had a common origin. Sometimes Philip Morris adds tobacco extract that it has stored for several days to tobacco sheet it is currently manufacturing. That tobacco extract had always been physically separate from, and had no common origin with, the sheet to which it is added. Likewise, Philip Morris sometimes adds tobacco extract made from tobacco processed on one production line to entirely different tobacco sheet made from other tobacco being processed on a wholly separate production line. Again, this tobacco

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extract was always physically separate from and had no common origin with the sheet to which it is added.

When Philip Morris manufactures tobacco extract, it commonly discards the excess tobacco fiber that is left after it has extracted the nicotine and other solubles from it. Later, Philip Morris adds this tobacco extract to different tobacco materials or sheet. Since the tobacco materials that were the source of this tobacco extract have been thrown away, it is beyond dispute that this tobacco extract is not "recombined" or "reapplied" to anything; rather, it is added to tobacco sheet from which it has always been physically separate.

Even if Philip Morris sometimes happens to apply tobacco extract to tobacco sheet of a common origin, the tobacco extract is for some time physically separate from -- outside -- the tobacco materials to which it is then added.

Philip Morris adds tobacco extract containing significant amounts of nicotine without regard to whether the tobacco extract and tobacco sheet had a common origin, because it is necessary to do so to control precisely the amount of tobacco extract -- and thus the amount of nicotine -- it adds to accommodate natural variations in nicotine levels in the incoming raw materials. Philip Morris concentrates the tobacco extracts it adds to achieve predetermined "soluble" levels in its reconstituted tobacco.

Philip Morris could remove all (or virtually all) of the nicotine from the various tobacco extracts it uses in making reconstituted tobacco, but by design does not do so.

In sum, Philip Morris does not in any sense merely "recombine" tobacco extract containing nicotine with the same tobacco materials from which it was extracted. It operates the entire RL process without any attention to

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> whether tobacco extract containing nicotine is "returned" to the tobacco materials from which it was extracted.[34]

The political ramifications of the tobacco controversy are escalating on an almost daily basis. On January 26, 1996, the American College of Chest Physicians sent a letter to House Speaker Newt Gingrich and Minority Leader Richard Gephardt calling for Congressional hearings on tobacco and health and the tobacco industry's attempts to hide meaningful information. The letter carried the support of over 32 medical societies throughout North America.

*C. Pending Tobacco Litigation*

The availability of heretofore secret tobacco industry documents has caused a public furore and fueled the filing of a rash of new smoking and health lawsuits. The new suits, however, differ from the previous ones in that the allegations are much broader and the number and categories of defendants have been greatly expanded. In addition, the attorneys general of several states have filed actions in an effort to recover the costs allegedly paid by the states for smoking-related illnesses.

Current tobacco litigation can be divided into three general categories:

1) Individual cases and class actions brought on behalf of past and present users of tobacco products who have allegedly been harmed from this use. These cases typically include prayers for damages based upon fraud and deceit, violation of consumer protection statutes, breach of express and implied warranties, intentional infliction of emotional distress, negligence, negligent misrepresentation and strict liability.

2) Class actions brought on behalf of persons allegedly harmed through exposure to second-hand tobacco smoke. These cases typically include prayers for damages based upon strict liability for an unreasonably dangerous product, breach of warranty, fraud, misrepresentation, conspiracy to commit fraud, and negligence.

34. *See id.*, Defendants' Memorandum in Support of Summary Judgment.

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3) Civil actions brought by governmental entities to recover the cost of welfare and health care costs associated with illnesses arising from the use of tobacco products. These cases include claims for restitution and unjust enrichment for sums the states have expended on account of the tobacco companies' "wrongful conduct," other equitable relief, indemnity, common law public nuisance and injunctive relief.

As of today, the governments of Alabama,[35] Arizona,[36] California,[37] Connecticut,[38] Florida,[39] Illinois,[40] Iowa,[41] Kansas,[42] Louisiana,[43] Maryland,[44] Massachusetts,[45] Michigan,[46] Minnesota,[47] Mississippi,[48] New

35. Crozier v. American Tobacco Co., No. 961508 (Ala. Cir. Ct. 1996), *removed*, No. CV96A1403N (M.D. Ala. September 9, 1996). This action was filed by the Alabama Attorney General as a private citizen acting on behalf of the state.

36. State *ex rel.* Woods v. American Tobacco Inc., No. CV96-14769 (Ariz. Super. Ct. filed Aug. 20, 1996).

37. People v. Philip Morris, Inc., No. 980864 (Cal. Super. Ct. filed Sept. 4, 1996). The complaint indicates the action is being prosecuted by and on behalf of the Counties of Alameda, Contra Costa, Marin, Sacramento, San Bernardino, San Francisco, San Mateo, Santa Barbara, Santa Clara, Santa Cruz and Shasta, and the Cities of San Francisco and San Jose.

38. Connecticut v. Philip Morris, Inc., No. 9601534405 (Conn. Super. Ct. filed July 18, 1996). On August 5, 1996, the case was removed to the U.S. District Court for the District of Connecticut and on October 9, 1996, the case was remanded back to Connecticut state court for lack of subject matter jurisdiction. In the interim, the tobacco industry had filed its own action in federal court challenging the right of the Connecticut Attorney General to bring an action for medical cost recovery and other relief. *See* Philip Morris, Inc. v. Blumenthal, 949 F. Supp. 93 (D. Conn. 1996). On December 23, 1996, the federal court dismissed the tobacco industry case based upon the Younger v. Harris, 401 U.S. 37 (1971), abstention doctrine and the Anti-Injunction Act, 28 U.S.C. § 2283 (1948). *See id.*

39. State v. American Tobacco Co., No. CL95-1466, 1996 WL 788371 (Fla. Cir. Ct. 1996). On December 13, 1996, the court permitted claims under Florida's Racketeer Influenced and Corrupt Organization Act ("RICO") statute, FLA. STAT. ANN. § 895 (West 1994), to remain in the case.

40. State v. Philip Morris, Inc., No. 96-L13146 (Cook County Cir. Ct. November 12, 1996).

41. State *ex rel.* Miller v. R. J. Reynolds Tobacco Co., No. CL71048 (Iowa Dist. Ct., Polk County November 27, 1996).

42. State *ex rel.* Stovall v. R..J. Reynolds Tobacco Co., No. 96 CV-919 (Kan. Dist. Ct., Shawnee County).

43. Ieyoub v. American Tobacco, No. 96-1209 (14th Jud. Dist. Ct., Calcasieu Parish filed March 13, 1996).

44. Maryland v. Philip Morris, No. 96-122017-CL211487 (Baltimore City Cir. Ct. filed May 1, 1996).

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Jersey,[49] New York,[50] Oklahoma,[51] Texas,[52] Utah, Washington[53] and West Virginia,[54] as well as the California counties of Alameda, Contra Costa, Los Angeles, Marin, Orange,[55] Sacramento, San Bernardino, San Francisco,[56] San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Shasta, and the cities of Los Angeles and San Francisco have filed suits seeking reimbursement of billions of dollars in health care expenses paid by the governmental entities for tobacco-related injuries. The city of Brook Park, Ohio, and Cuyahoga County filed their own lawsuit against the tobacco industry when the Attorney General declined to do so.[57] These lawsuits generally allege fraud, misrepresentation, conspiracy, false advertising and negligence. These suits are particularly unique in that many of them name as defendants, in addition to the tobacco manufacturers, a large number of entities which have done, or are doing, business with the tobacco industry.

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45. *See* Massachusetts v. Philip Morris, 942 F. Supp. 690 (D. Mass. 1996). Philip Morris brought an action against the Massachusetts Attorney General challenging the authority of the state to maintain its first-filed action. *See* Philip Morris v. Harshbarger, Civil Action No. 95-12574-GAO (Mass. Super. Ct. 1995). On November 22, 1996, the federal court denied Massachusetts' motion to dismiss, but indicated it would abstain from consideration of the case until issues arising under Massachusetts law are decided in state court, citing *Railroad Comm'n of Texas v. Pullman Co.*, 312 U.S. 496 (1941).

46. State *ex rel.* Kelley v. Philip Morris, Inc., No. 96-84281-CZ (Mich. Cir. Ct. 1996).

47. Minnesota v. Philip Morris Inc., No. 15-940901-003 (Minn. Dist. Ct., 2d Jud. Dist. filed Aug. 17, 1994).

48. Moore v. American Tobacco Co., No. 94-1429 (Chancery Court of Jackson County, Mississippi filed May 23, 1994).

49. State *ex rel.* Verniero v. R. J. Reynolds Tobacco Co., No. C25496 (N.J. Super. Ct., Middlesex County, Ch. Div. 1996).

50. City of New York & The New York City Health & Hosp. Corp. v. Tobacco Institute, Inc., No. 406225-96 (N.Y.Sup.Ct., County of New York 1996).

51. State v. R.J. Reynolds Tobacco Co., No. CJ 96-1499-L (Okla. Dist. Ct., Cleveland County 1996).

52. Texas v. American Tobacco, No. 5-96CV91 (E.D. Tex., Texarkana Div. filed March 28, 1996).

53. State v. American Tobacco Co., Inc., No. 96-2-15056-8 (Wash. Super. Ct., King County 1996).

54. McGraw v. American Tobacco Co., No. 94-1707 (W. Va. Cir. Ct., Kanawah County filed September 20, 1994).

55. The case of *Ellis v. R.J. Reynolds Tobacco Co.*, No. 766783 (Cal. Super. Ct., Orange County), was brought by Mr. Ellis under California's "private attorney general" statute. *See* CAL. CIV. PROC. CODE § 1021.5 (Deering 1996).

56. County of San Francisco v. Philip Morris, Inc., No. 96-2090-DLJ (N.D. Cal. 1996)

57. Coyne v. American Tobacco Co., No. 315249 (Ct. of Comm. Pleas, Cuyahoga County). It has been rumored that the Ohio Attorney General declined to file an action against the tobacco industry on behalf of the state because of threatened retaliation by Kentucky, whose principal crop is tobacco.

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For example, the West Virginia case names as a defendant, Kimberly-Clark Corporation, a leading supplier of cigarette paper. Hill & Knowlton, Inc., a tobacco industry public-relations firm, is also a frequent defendant. It is alleged that Hill & Knowlton, as well as other advertising firms, encouraged minors to smoke. The Mississippi case names as fictitious defendants public relations firms, trade organizations, law firms, and other entities that promoted, marketed, distributed or purposely placed into the stream of commerce various brands of cigarettes. Through discovery it seems a certainty that the fictitious defendants will be substituted for real defendants in a wide variety of fields. In most American jurisdictions, under the law of civil conspiracy, defendants may be found jointly and severally liable for damages caused by the acts and products of their co-conspirators.[58]

The Minnesota case involving the liability of tobacco manufacturers is currently pending before the Minnesota Supreme Court.[59] Blue Cross and Blue Shield of Minnesota ("BCBSM") sued all the major tobacco manufacturers seeking recovery of sums paid for injuries allegedly caused by its insureds' smoking.[60] The Minnesota Attorney General joined the case as a co-plaintiff on behalf of the state. Trial is scheduled to begin January 19, 1997.

In May, 1995, Judge Kenneth J. Fitzpatrick of the Ramsey County District Court held that BCBSM was the "natural plaintiff best able to pursue the claims,"[61] and denied the tobacco industry's request to dismiss the case. The tobacco companies contended that BCBSM lacked standing to bring a direct action against them. The judge, however, found BCBSM properly represented its subscribers and recovery would inure directly to the insureds. The court also noted that BCBSM was seeking relief independent from any that could be sought by individual smokers. In his decision, the judge held that BCBSM is "a link in the chain of interacting parties" between subscribers and health care providers.

After Judge Fitzpatrick denied the tobacco companies' motion to dismiss, the tobacco companies appealed to the Minnesota Court of

58. *See, e.g.,* Nicolet, Inc. v. Nutt, 525 A.2d 146, 147 (Del. 1987).

59. State *ex rel.* Humphrey v. Philip Morris Inc., No. C1-95-1324, 1995 Minn. LEXIS 784 (Minn. Sept. 20, 1995).

60. The defendants are Philip Morris Incorporated; R.J. Reynolds Tobacco Company; Brown & Williamson Tobacco Corporation; B.A.T. Industries, P.L.C.; Lorillard Tobacco Company; The American Tobacco Company; Liggett Group, Inc.; The Council for Tobacco Research - U.S.A., Inc.; and The Tobacco Institute. *Id.* at *1.

61. Minnesota v. Philip Morris, Inc., 551 N.W.2d 490, 493 (Minn. 1996).

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Appeals. The appellate court denied the industry's petition for review on July 20, 1995. On September 20, 1995 the state high court granted review[62] and similarly denied the industry's petition.[63] Briefing was completed in November, 1995, but in early 1996 R.J. Reynolds Tobacco Company petitioned for further review. The Minnesota Supreme Court denied the petition and also refused to permit The Product Liability Advisory Council, Inc. and The Minnesota Chamber of Commerce to serve and file briefs as *amici curiae*.[64] In July, 1996, the Minnesota high court held that Blue Cross has the necessary interest in the matter to pursue its statutory and common law antitrust and consumer claims[65] as well as its equitable claims, but lacks standing on its tort theory.[66]

In another development in the Minnesota case, on May 28, 1996, the U.S. Supreme Court upheld a ruling requiring the tobacco companies and the Tobacco Institute and CTR, to turn over to Minnesota extensive computerized databases created by attorneys for the tobacco companies over the years. The databases contain computerized records referencing millions of documents for pending or anticipated litigation. Judge Fitzpatrick ruled that Minnesota was entitled to the objective part of the databases identifying information, but not any subjective analysis or comments. A Minnesota appeals court upheld the order and the Minnesota Supreme Court denied a petition for an extraordinary writ. The U.S. Supreme Court thereafter denied without comment or dissent an appeal of Judge Fitzpatrick's ruling requiring them to turn over the databases.[67]

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62. *Humphrey*, 1995 Minn. LEXIS 784.

63. State *ex rel.* Humphrey v Philip Morris, Inc., 551 N.W.2d 490 (Minn. 1996).

64. Minnesota v. Philip Morris, Inc., No. CX-95-2536, 1996 Minn. LEXIS 121 (Minn. Feb. 27, 1996), *cert. denied sub nom.*, R.J. Reynolds Tobacco Co. v. Minnesota, 116. S.Ct. 1852 (1996).

65. These claims are for alleged violation of Minnesota's Unfair Discrimination and Competition (Minn. Stat. §§ 325D.03-.08, .69 (1996)), Unlawful Trade Practices (Minn. Stat. §§ 325D.09-.16 (1996)), Uniform Deceptive Trade Practices (Minn. Stat. §§ 325D.43-.48 (1996)), and False Statement in Advertisement (Minn. Stat. § 325F.67 (1996)) statutes. These statutes are generally very broadly construed to enhance consumer protection. *See* State v. Alpine Air Prod., Inc., 500 N.W.2d 788, 790 (Minn. 1993).

66. *See* Minnesota v. Philip Morris, Inc., 551 N.W.2d at 490.

67. In seeking access to the databases, the government argued it would be a time and money saving way to organize and analyze the estimated nine million pages of documents in the case. Appealing to the high court were Philip Morris Co. Inc., Brooke Group Ltd.'s Liggett Group subsidiary, RJR Nabisco Holdings Corp.'s R.J. Reynolds Tobacco Co., Loews Corp.'s Lorillard Tobacco Co., B.A.T. Industries Plc's Brown & Williamson Tobacco Corp. and the Tobacco Institute and CTR. The companies argued that the trial court order violated the constitutional due process guarantee when it granted opposing lawyers access to databases that should be protected from disclosure as a product of work done by an attorney

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In a later decision, the court limited the manner in which BCBSM would have to proceed in order to recover.[68] The court held that BCBSM must base its theory of recovery on consumer protection and equitable relief claims, and must base its case on evidence obtained from each individual smoker.[69]

The Minnesota action became particularly contentious when on September 17, 1996, Minnesota accused the tobacco industry of destroying unfavorable documents and hiring third parties outside the United States to act as document storage facilities in order to thwart discovery in tobacco litigation. The tobacco industry vigorously denied the charges. The following day, however, the news media reported "tobacco company officials and researchers discussed the need to destroy or hide sensitive documents such as internal reports on the addictive nature of tobacco."[70] One Philip Morris researcher is reported as commenting on a research project he authorized about nicotine's possible addictive effects, if the researcher "is able to demonstrate, as she anticipates, no withdrawal effects of nicotine, we will want to pursue this avenue with some vigor. If, however, the results with nicotine are similar to those gotten with morphine and caffeine, we will want to bury it."[71] The tobacco companies have been ordered to produce all documents by January 15, 1997, after which time depositions will commence. The trial will begin on January 19, 1998.[72]

In the Mississippi action, on May 22, 1996, Mississippi Attorney General Michael Moore filed a motion to compel the testimony of Mr. John Scanlon, a public relations consultant for the tobacco industry.[73] Mr.

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while representing a client. They also argued that the compelled, uncompensated disclosure of the databases, said to cost tens of millions of dollars to create, amounted to an unconstitutional taking of property without just compensation. *See* R.J. Reynolds Tobacco Co. v. Minnesota, 116 S. Ct. 1852 (1996).

68. *Philip Morris*, 551 N.W.2d at 490.

69. *Id.* at 498.

70. Henry Weinstein, *Court Case Details Tobacco Firm's Use of German Lab; Smoking: Philip Morris Had Plans to Conceal Negative Findings, Destroy Data, Papers in Minnesota Suit Suggest*, L.A. TIMES, Sept. 18, 1996, at A1.

71. John Schwartz, *Tobacco Officials Discussed Hiding Data, Memos Indicate*, WASH. POST, Sept. 18, 1996, at A3. (reporting on a memorandum from William Dunn to Thomas Osdene, Director of Research for Philip Morris from 1969 to 1984).

72. *See, e.g.*, Minnesota v. Philip Morris, Inc., No. C1-94-8565 (Minn. Dist. Ct., Ramsey County filed Nov. 27, 1996) (Order with Respect to Parties' Motions to Compel Discovery & Scheduling Matters).

73. On July 2, 1996, the court issued an order compelling Mr. Scanlon's deposition. Moore v. American Tobacco Co., No. 94-1429 (Chancery Ct., Jackson Co., Miss. 1994).

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Scanlon is described as "the industry's foremost practitioner of scorched earth public relations, a man whose *modus operandi* is to defame anyone who reveals inconvenient information about his clients."[74] Mr. Scanlon is alleged to have attempted to destroy the reputation of Dr. Jeffrey Wigand, a former Brown & Williamson official who testified against Brown & Williamson. A grand jury is supposedly investigating Mr. Scanlon's effort to smear Dr. Wigand.[75]

In Florida, there was a similar confrontation. On March 14, 1996, Florida Governor Lawton Chiles defeated efforts in the state legislature to water down the lawsuit filed by the state against the tobacco industry's multi-million dollar lobbying campaign. According to news reports, Chiles and other state officials charged tobacco companies engaged in a range of intimidating tactics in an attempt to sway legislators to their side to stop what is likely to be a costly litigation process. "If you think I was applying pressure, you should see the other side. We had members called off the floor and threatened," Chiles said.[76]

Dexter Douglass, the governor's general counsel, said tobacco industry officials threatened to bring well-financed opponents to the forefront in an effort to influence legislators' votes, although tobacco industry officials denied those charges. "If he means we were standing by the door catching them as they were going in and going out, yes we are. That's what we get paid for doing all the time," said Guy Spearman, a Tobacco Institute lobbyist.[77]

The court in the Florida case[78] ordered mediation, but after several days of attempting to work out an agreement the parties conceded failure. Florida law requires that the discussions during mediation be held confidential, so no further details were given to the public about the positions taken.[79]

The Oklahoma case was unusual because for the first time law firms which traditionally represented the tobacco industry were also named as

74. *Mississippi Files Motion Seeking Deposition of PR Consultant John Scanlon; Questions Role in Wigand Deposition Leak; Cites Smear Campaign Against Whistleblower*, PR NEWSWIRE, May 22, 1996, Financial News.

75. *Id.* A storm of controversy has arisen around Dr. Wigand, with Brown & Williamson accusing Dr. Wigand of making false statements and Dr. Wigand's lawyer denying it.

76. *Tobacco Industry Loses Another Crucial Battle,* CNN Financial News, March 14, 1996, *available in* World Wide Web, fn archive.

77. *Id.*

78. Engle v. R.J. Reynolds Tobacco Co., No. 94-8273 (Fla. Cir. Ct., Dade Co.).

79. FLA. STAT. § 44.201(5) (1996).

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defendants. The Oklahoma complaint alleged that the law firms conspired with the tobacco manufacturers to generate misleading scientific reports and to use the attorney-client privilege to shield harmful documents from discovery.[80]

On the non-governmental side, in February, 1995, a federal judge in Louisiana certified the largest class action in history against tobacco industry defendants in *Castano v. The American Tobacco Co.*[81] The class consisted of (1) all nicotine-dependent persons in the United States . . .who have purchased and smoked cigarettes manufactured by the defendants; (2) the estates, representatives, and administrators of these nicotine-dependent cigarette smokers; and (3) the spouses, children, relatives and "significant others" of these nicotine-dependent cigarette smokers as their heirs or survivors. The class involved all claims from 1943 to the date of filing. According to reasonably reliable sources in the plaintiffs' lawyers' community, some sixty-two law firms have each pledged $100,000 annually per firm to prosecute class action litigation against the tobacco industry.

A war chest of over $6 million a year can pay for a considerable amount of litigation. Louisiana was probably chosen as the initial venue in part because it is one of the few "direct action" jurisdictions, where insurers can be sued in the same case as that involving the claimants against the insured. An interlocutory appeal was filed from the order certifying the class in *Castano*.[82]

On May 23, 1996, the U.S. Court of Appeals for the Fifth Circuit decertified the *Castano* class and remanded the case to the district court.[83] The crux of the Fifth Circuit decision is:

The district court erred in its analysis in two distinct ways. First, it failed to consider how variations in state law affect predominance and

80. Named in the Oklahoma lawsuit were Shook, Hardy & Bacon of Kansas City, and Chadbourne & Parke and Jacob, Medinger & Finnegan, both of New York City. Petition at 8-9, Oklahoma v. R.J. Reynolds Tobacco Co., No. CV 96-1499-6 (Okla. Dist. Ct., Cleveland Co. 1996). All three firms have a long history of representing tobacco interests.

81. 160 F.R.D. 544, 560 (E.D. La. 1995).

82. The district court in *Castano* certified the issue for interlocutory appeal to the U.S. Court of Appeals for the Fifth Circuit, which then heard the appeal. *See* Castano v. American Tobacco Co., 162 F.R.D. 112, 118 (E.D. La. 1995) ("In the order certifying this matter as a limited class action, the Court stated that its decision was taken after much thought and reflection . . . Yet, the system of law is not designed to have one court control the economies and lives of so many in a case of such legal importance. Therefore, . . . the Court grants the defendants' motion to seek review by the Court of Appeals.").

83. Castano v. American Tobacco Co., 84 F.3d 734 (5th Cir. 1996).

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superiority. Second, its predominance inquiry did not include consideration of how a trial on the merits would be conducted.

Of course, there are great differences in state laws which could affect the litigants. It has already been held that variations in individual state laws must be considered before a class is certified.[84] Since the class decertification in *Castano*, similar class actions have been filed in Louisiana,[85] Maryland, Washington, D.C., California, New Mexico, Pennsylvania and Colorado.

These class actions which have been filed in the wake of the decertification of *Castano*, as well as those which will undoubtedly follow, potentially involve millions of class members. The actions brought by the governmental entities seek recovery of hundreds of millions of dollars in health care costs for alleged smoking-related illnesses. Based upon filings to date and those anticipated in the near future, tobacco litigation may well make all previous mass-tort litigation pale by comparison.

In Florida, a class action filed in a state circuit court on behalf of a large group of smokers[86] was allowed to proceed by the Florida Supreme Court.

It is the wide net which is being cast which will also drag many heretofore ignored groups into the litigation. In addition to the tobacco manufacturers, almost anyone who came into contact with tobacco production and distribution may be named a defendant. This group will include lawyers, public relations firms, advertising agencies, paper manufacturers, manufacturers of filter components, and industry accountants (the "peripheral defendants").[87] Anyone who allegedly had knowledge of exactly how the tobacco industry was hiding what it really knew about the nature of tobacco and its relationship to health problems can expect to be sued.

84. Walsh, v. Ford Motor Co., 807 F.2d 1000 (D.C. Cir. 1986) (Edwards & Ginsberg, JJ.), *cert. denied*, 482 U.S. 915 (1987) (a district court must consider how variations in state law affect predominance and superiority).

85. In Louisiana, the tobacco defendants removed Scott v. Philip Morris, Inc. to a federal District Court, but the case was remanded to Louisiana state court. *See* Scott v. Philip Morris, Inc., Civ. A. Nos. 96-1946, 96-2200 - 96-2204, 96-2779, 1996 U.S. Dist. LEXIS 16636 (E.D. La. Oct. 31, 1996).

86. Amended Class Action Complaint for Compensatory and Punitive Damages at 1, Engle v. R.J. Reynolds Tobacco Co., No. 94-8273 (Fla. Cir. Ct., Dade Co. 1994).

87. For convenience of reference, the term "peripheral defendants" will be used to identify all defendants in tobacco and health litigation other than the tobacco manufacturers and distributors of tobacco products.

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Some jurisdictions have product liability "shield" laws covering such products as tobacco and alcoholic beverages. While these give some help, most of them have provisions which will not cover claims for breach of warranties, express misrepresentation and the like.[88] Similarly, the public relations aspects of tobacco litigation cannot be over estimated. It will be extremely difficult to pick jurors who are unfamiliar with the controversy. Even individual lawsuits have received wide publicity. For example, it was widely reported that the widow of the "Marlboro Man," featured in a long-running campaign for Philip Morris's most popular cigarette brand-name, sued the tobacco industry alleging their fraud and deceit contributed to David McLean's death from lung cancer. While working on print and television commercials, McLean's widow alleges he routinely smoked as many as five packs a day.[89]

Even foreigners have started to bring actions against tobacco. In France, two lung cancer victims or their families sued SEITA, the manufacturer of Gauloises and Gitanes, the two most famous brands of French cigarettes. Until 1995, SEITA was owned by the French government.[90]

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88. *See, e.g.,* Tex. Civ. Prac. & Rem. § 82.004 (1996) which provides:

> Inherently Unsafe Products
>
> (a) In a products liability action, a manufacturer or seller shall mot be liable if:
>
> (1) the product is inherently unsafe and the product is known to be unsafe bythe ordinary consumer who consumes the product with the ordinary knowledge common to the community; and
>
> (2) the product is a common consumer product intended for personal consumption, such as sugar, castor oil, alcohol, tobacco, and butter, as identified in Comment I to Section 402A of the Restatement (Second) of Torts.
>
> (b) For purposes of this section, the term "products liability action" does not include an action based on manufacturing defect or breach of an express warranty.

89. *See, e.g.,* McLean v. Philip Morris, Inc., Civ. A. No. 96CV167 (E.D. Tex. 1996), as reported by Counsel Connect, New York.

90. Anne Swardson, *2 Lawsuits Challenge French Cigarette Producer: Accountability Sought from Maker of Gauloises, Gitanes*, WASH. POST, Dec. 27, 1996, at A27.

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*D. Implications for the Insurance Industry*

It has been widely assumed that tobacco manufacturers have no product liability insurance. That, however, may not be correct in all cases. We know that manufacturers of chewing tobacco and snuff have liability insurance, although in many cases the policies contain broad tobacco exclusions. It has been reported, but not confirmed, that some of the manufacturers have high level catastrophe excess liability insurance which covers smoking and health claims. This excess insurance was supposedly purchased during the 1970s and 1980s at a time when tobacco had never lost a case. Based upon the tobacco industry's exceptional record of winning cases, certain insurers allegedly agreed to write high level excess insurance, which is reported to exclude any defense obligation. To date, no known claims against this catastrophe insurance have been tendered.

It has also been alleged that tobacco manufacturers were able to purchase product liability coverage in the 1950's and early 1960's without tobacco exclusions.[91] If that is correct, those insurers which issued such coverage should immediately consider what strategies they wish to employ and attempt to estimate their exposure. Reinsurers should also be advised without delay. Under such policies, a duty to defend could arise as soon as a complaint is tendered.

On January 12, 1996, two cases were filed in Quebec, Canada, which directly involve insurers. The cases are captioned *Imperial Tobacco Limited v. American Home Assurance Co.*[92] and *Imperial Tobacco Limited v. Commercial Union Assurance Company of Canada.*[93] The two cases seek coverage for defense costs and potential damages associated with personal injury suits brought by smokers and others. The coverage cases were filed as an outgrowth of an earlier case filed January 13, 1995, against Imperial Tobacco which seeks damages for the alleged addiction to and sale and manufacture of cigarettes.[94]

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91. Dan Lonkevich, *Tobacco Legislative Deals Could Benefit Insurers*, NAT. UNDERWRITER, Sept. 9, 1996, at 6, 8.

92. No. 500-05-014085-961 (Super. Ct., Province of Quebec, Dist. of Montreal filed Jan. 12, 1996).

93. No. 500-05-01484-964 (Super. Ct., Province of Quebec, Dist. of Montreal filed Jan. 12, 1996).

94. The insurance coverage cases were filed as an outgrowth of an earlier case, David Caputo v. Imperial Tobacco Ltd., No. 95-CU-82186 (Ont. Ct. Just. 1995). The plaintiffs in *Caputo* seek damages of $1 million each, plus aggravated, exemplary and punitive damages, interests and costs.

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In its coverage cases Imperial Tobacco, a subsidiary of Imasco Limited,[95] alleges that American Home issued several excess umbrella liability policies to Imasco and that Commercial Union issued comprehensive general liability policies to Imasco. Imperial Tobacco contends it is covered by the policies issued by American Home and Commercial Union for any defense costs and any amounts awarded in a judgment or settlement which Imperial Tobacco may incur from third-party liabilities such as those alleged by the *Caputo* plaintiffs. Neither American Home nor Commercial Union has assumed the defense or acknowledged a duty to indemnify Imperial Tobacco. Imperial Tobacco claims it has had to pay in excess of $1,000,000 in defense costs in *Caputo*.

The potential for a serious impact on the insurance industry because of tobacco litigation certainly exists. The defense costs alone could rival or exceed those experienced in the asbestos cases. It seems certain that any policyholder drawn into tobacco litigation will demand a defense from its insurers, particularly those peripheral entities which have never manufactured tobacco products.[96] The defense obligation where the potential for coverage exists could be huge, particularly since a majority of jurisdictions hold that a policyholder is entitled to a defense if any one allegation in the complaint potentially asserts a covered claim.[97]

It must be assumed that most insurers which provide a defense at all will do so with a full reservation of rights to deny indemnification and/or withdraw the defense at a later date. In some jurisdictions, that could give rise to a further contention that the policyholder may select its own defense counsel and control the defense. We are all aware of what happens under such circumstances.

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95. Imasco is partly owned by BAT Industries, formerly British American Tobacco. BAT Industries also owns Farmers Insurance Group, Eagle Star Insurance and Allied Dunbar.

96. The author's firm is currently litigating just such a coverage issue involving a manufacturer of chewing tobacco.

97. In the complaints that have been filed, there are a variety of allegations which may trigger an insurer's duty to defend. In the Florida case, count three is for negligence and count six is for "negligent performance of a voluntary undertaking." *See* Amended Class Action Complaint, Engle v. R.J. Reynolds Tobacco Co., No. 94-8273 (Fla. Cir. Ct., Dade Co.). In the Minnesota case, count one is for alleged breach of "the undertaking of special duty." *See* Complaint, Humphrey v. Philip Morris, Co., No. C1-95-1324, 1995 Minn. LEXIS 784 (Minn. Sept. 20, 1995). An allegation of conspiracy may trigger a defense obligation, since some jurisdictions have recognized a tort of "negligent conspiracy." *See, e.g.* Rogers v. R.J. Reynolds Tobacco Co., 761 S.W.2d 788 (Tex.Ct.App. 1988) *reh'g of writ of error overruled,* Oct. 5, 1989; *see also* Adcock v. Brakegate, Ltd., 645 N.E.2d 888 (Ill. 1994).

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## II. PROBABLE COVERAGE ISSUES

It seems unlikely that any policies other than liability policies will be impacted by tobacco litigation. Although most of the claims can be anticipated to arise under Commercial General Liability (CGL) policies, many other types of liability policies may be impacted, such as professional errors and omissions policies, and directors' and officers' liability policies.

### *A. The "Occurrence" Definition*

The 1966 ISO CGL form defined an occurrence as follows:

> "Occurrence" shall mean an accident, including continuous or repeated exposure to conditions which results, during the policy period, in bodily injury or property damage neither expected nor intended from the standpoint of the insured.[98]

The definition of "occurrence" has always excluded coverage for expected or intended harm viewed from the standpoint of the insured. In addition, a majority of jurisdictions hold, either by statute or decisional law, that a loss must be fortuitous for insurance to apply. Certainly, insofar as the tobacco companies are concerned, the secret documents, as well as numerous articles, public warnings, reports and similar communications should be more than ample to establish an "expected or intended" defense.

With respect to peripheral defendants such as suppliers, public relations firms, paper manufacturers, law firms and consulting firms, the defense of "expected or intended" may be problematic. Much will depend upon what can be learned through discovery once coverage litigation is commenced. With respect to peripheral defendants such as lawyers, public relations people and others, there is a very thin line between "misinformation" which may be the result of negligence and fraudulent misrepresentation, which is intentional. The former could certainly give

98. The 1973 ISO definition was changed to read: "An occurrence means an accident, including continuous or repeated exposure to conditions, resulting in bodily injury or property damage neither expected nor intended from the standpoint of the insured.' In 1988 the ISO definition read: "An occurrence means an accident, including continuous or repeated exposure to substantially the same general harmful conditions." "Expected or intended" harm was covered in a specific exclusion. Very few Commercial General Liability (CGL) policies have been issued since 1985, when the "claims made" form was adopted by most of the American insurance industry.

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rise to insurance coverage, and the latter might at a minimum trigger a duty to defend.

Given the intensive litigation efforts being mounted by class plaintiffs' lawyers and governmental attorneys alike, it seems probable that additional documents will be discovered which may give further support to an "expected or intended" defense.[99] The plaintiffs' groups will undoubtedly establish a document depository to centralize all documents in much the way documents discovered in the silicone gel breast implant cases have been handled. Presumably they will also get access to the tobacco attorneys' databases which will be produced in the Minnesota governmental litigation.

Conspiracy claims will also aid in establishing an "expected or intended" defense. As one court put it:

> There is a conscious, decision-making element that takes civil conspiracies out of the range of behavior encompassed within the meaning of an "occurrence." An insured who participates in a conspiracy, even if the agreed upon behavior or course of conduct is to act negligently, cannot expect coverage for "an accident." In its plain, ordinary sense, an accident is "an unforeseen and unplanned event or circumstance." (Webster's New Collegiate Dict. (9th ed. 1984) p. 49.) As a matter of law, a civil conspiracy cannot occur by accident; therefore, the policies afford no coverage for these claims.[100]

A majority of jurisdictions have statutory or decisional law holding that "expected or intended" harm cannot be covered by insurance. For example, section 533 of the California Insurance Code provides "An insurer is not liable for a loss caused by the wilful act of the insured; but he is not exonerated by the negligence of the insured, or of the insured's agents or others."

At the same time, however, allegations of "negligent conspiracy" may prove troublesome. As the Supreme Court of Illinois observed:

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99. The tobacco attorneys' databases of nine million documents are almost certain to yield a substantial amount of new information.

100. Fibreboard Corp. v. Hartford Accident & Indemnity Co., 20 Cal. Rptr. 2d 376, 387 (Cal. Ct. App. 1993).

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> While a civil conspiracy is based upon intentional activity, the element of intent is satisfied when a defendant knowingly and voluntarily participates in a common scheme to commit an unlawful act or a lawful act in an unlawful manner. . . . There is no such thing as accidental, inadvertent or negligent participation in a conspiracy. . . . A defendant who innocently performs an act which happens to fortuitously further the tortious purpose of another is not liable under the theory of civil conspiracy. (Restatement (Second) of Torts § 876, Comment c on Clause (a) (1977).) A defendant who understands the general objectives of the conspiratorial scheme, accepts them, and agrees, either explicitly or implicitly to do its part to further those objectives, however, is liable as a conspirator. . . .Once a defendant knowingly agrees with another to commit an unlawful act or a lawful act in an unlawful manner, that defendant may be held liable for any tortious act committed in furtherance of the conspiracy, whether such tortious act is intentional or negligent in nature.[101]

In *Adcock v. Brakegate, Ltd.*, Owens-Corning and certain of its officers were accused of a civil conspiracy to prevent employees at a Bloomington, Illinois, plant from becoming aware of the true dangers of working around asbestos. The plaintiff obtained an order compelling Owens-Corning to produce certain executives at trial, but Owens-Corning refused. The court entered judgment in favor of the plaintiff and Owens-Corning appealed. Both the intermediate appellate court and the Illinois Supreme Court affirmed, with the Illinois high court holding:

Here, the essential evidence needed to establish both the existence of the conspiracy and Owens-Corning's participation in that conspiracy was within Owens-Corning's knowledge and control. The plaintiff sought to prove, through the testimony of Konzen and Boeschenstein, that Owens-Corning and other asbestos manufacturers engaged in an industrywide conspiracy to conceal and affirmatively misstate the hazards

101. *Adcock*, 645 N.E.2d at 894 (citations omitted). *See also* Halberstam v. Welch, 705 F.2d 472, 481 (D.C. Cir. 1983) ("A conspirator need not participate actively in or benefit from the wrongful action in order to be found liable. He need not even have planned or known about the injurious action . . . , so long as the purpose of the tortious action was to advance the overall object of the conspiracy").

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associated with asbestos exposure. The plaintiff also sought to establish, through the testimony of these witnesses, that the co-conspirators performed tortious acts in furtherance of the conspiracy, thereby proximately causing the decedent's injuries. By refusing to comply with the trial court's order compelling it to produce those witnesses, Owens-Corning made a deliberate and strategic decision to suppress evidence. Owens-Corning's misconduct, which basically amounts to an obstruction of justice, may be regarded by this court as an admission by conduct of each and every element of the plaintiff's cause of action.[102]

A similar 1988 case involved a similar claim with respect to tobacco manufacturers. There a Texas appellate court wrote:

> We decide that a conspiracy of the type in this case has a life of its own where the conspiracy is to engage in attractive, enticing advertisements promoting the smoking of cigarettes.
>
> Appellees dogmatically state that there is no such thing as a conspiracy to commit an unintentional tort or a conspiracy to be negligent. We disagree. . . .Appellees insist:
>
> "The action agreed upon pursuant to a civil conspiracy must be either a criminal act or an intentional tort."
>
> We conclude that a defendant engaged in a civil conspiracy can be charged with legal responsibility if that defendant, with others, proceeds in a tortious manner; which is to say, that the defendant had the intention of committing a tort or merely proceeding in a negligent manner. It is only that defendant, who acts innocently and carefully and in a non-negligent way and who performs an act which happens to fortuitously further the tortious purpose of another, who (being an innocent and careful defendant) is not responsible under the theory of civil conspiracy. The label of conspiracy or civil conspiracy is frequently used in connection with vicarious liability. The law of conspiracy has developed to the extent that this

102. *Adcock*, 645 N.E.2d at 895.

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> term came to be used to extend liability in tort, as well as in crime, to conspirators beyond the active or original wrongdoer to those who had merely planned, assisted or encouraged the original or active wrongdoer.[103]

Even if the tortious acts, *i.e.*, concealment of the dangers of tobacco and related misconduct, were committed by the tobacco manufacturers, it is arguable that those who participated in the conspiracy to hide the real dangers of tobacco, *i.e.*, the peripheral defendants, could also be held liable. Put another way, if the tobacco companies and their suppliers, lawyers, public relations firms and advertisers conspired to conceal the dangers of tobacco usage and its addictive qualities, and only the tobacco companies actually committed any acts in furtherance of the conspiracy which resulted in harm to third parties, the suppliers, lawyers, public relations firms and advertisers could still be held liable.[104] It is highly unlikely that many of the peripheral defendants have either products exclusions or express tobacco exclusions in any of their CGL policies. Given the broad duty to defend, the primary insurers or those found to have a defense obligation could be exposed for huge sums of money.

*B. The Named Insured Clause*

The *Imperial Tobacco* case, cited *supra*, highlights the potential exposure to insurers as a consequence of the "named insured" clause found in almost every CGL policy. While there are various forms of the "named insured" clause in use, the most common reads:

> Persons Insured - Each of the following is an insured under this policy to the extent set forth below:
>
> (a) if the named insured is designated in the declarations as an individual, the person so designated but only with respect to the conduct of a business of which he is the sole proprietor, and the spouse of the named insured with respect to the conduct of such a business;

103. Rogers v. R.J. Reynolds Tobacco Co., 761 S.W.2d 788, 796 (Tex. App. 1988).

104. Such a conspiracy theory is alleged in Feagin v. Brown & Williamson Tobacco Corp., No. 96-08160 (Tex. Dist. Ct., Dallas County filed August 14, 1996).

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> (b) if the named insured is designated in the declarations as a partnership or joint venture, the partnership or joint venture so designated and any partner or member thereof but only with respect to his liability as such;
>
> (c) if the named insured is designated in the declarations as other than an individual, partnership or joint venture, the organization so designated and any executive officer, director or stockholder thereof while acting in the scope of his duties as such;
>
> (d) any person (other than an employee of the named insured) or organization while acting as the real estate manager for the named insured; and
>
> (e) with respect to the operation, for the purpose of locomotion on a public highway, or mobile equipment registered under any motor vehicle law. . . .
>
> This insurance does not apply to bodily injury or property damage arising out of the conduct of any partnership or joint venture of which the insured is a partner or member and which is not designated in this policy as a named insured.[105]

For large commercial accounts, CGL policies often have a "Named Insured Endorsement" which adds affiliates and subsidiaries. A typical endorsement would read, "It is understood and agreed that the named insured is completed[106] to read as follows: (Subsidiaries and affiliates are listed by name.)"

Another, older form of "Named Insured Endorsement" used for large conglomerates states:

105. ISO form GL 00 (2-1-73 ed.).

106. The word "completed" refers to the identity of the named insured as shown on the declarations page.

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> It is understood and agreed that the named insured, as shown on the policy declarations, shall read as follows:
>
>> Jones Corporation and Smith Corporation and any domestic corporation or company in which either or both owns or may own directly or indirectly 50 percent or more of the combined voting power, and any foreign corporation or company in which either or both owns or may own directly or indirectly more than 50 percent of the combined voting power. For the purpose of this insurance, subsidiary companies and corporations owned by subsidiary companies and corporations of the named insured shall be included as insureds if the percentage of ownership is in accordance with the above.[107]

In addition to the "named insured" clause in CGL policies, there is usually a definition of "named insured" in almost every type of policy issued.[108] When organizations employ contractors or sub-contractors, the

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107. Specimen taken from a form used by the Non-Marine Association of Underwriters at Lloyd's, London, between 1966 and 1978.

108. For example, the ISO homeowner's policy (form HO-2, 4-84 ed.) defines "named insured" as:

> In this policy "you" and "your" refer to the "named insured" shown in the Declarations and the spouse if a resident of the same household. . . .
>
> 3. "Insured" means you and residents of your household who are:
>
>    a. your relatives; or
>
>    b. other persons under the age of 21 and in the care of any person named above.
>
> Under Section II, "insured" also means:
>
> c. with respect to animals or watercraft to which this policy applies, any person or organization legally responsible for these animals or watercraft which are owned by you or any person included in 3a or 3b above. A person or organization using or having custody of these

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employed contractor or sub-contractor is frequently required to have the employer included on the contractor or sub-contractor's CGL policy as an "additional named insured" and to provide a certificate of insurance. The "additional named insured" clause used in such situations usually restricts coverage to liability incurred by the employer as a consequence of the activities of the contractor or sub-contractor. Similar clauses are also commonly used in lessor-lessee situations.[109] In some specific areas, legislation may affect the validity of mandatory inclusion of principals as additional named insureds on contractor or sub-contractor's policies.[110]

Of interest with respect to tobacco-related claims is the Vendor's Endorsement, a typical form of which reads:

> It is agreed that the "Named Insured"[111] provision is amended to include any person or organization (herein referred to as "Vendor"), as an insured, but only with respect to the distribution or sale in the regular course of the Vendor's business of the Named Insured's products subject to the following additional provisions:
>
> 1. The insurance with respect to the Vendor does not apply to:

---

animals or watercraft in the course of business or without consent of the owner is not an insured;

d. with respect to any vehicle to which this policy applies:
(1) persons while engaged in your employ or that of any person included in 3a or 3b above; or
(2) other persons using the vehicle on an insured location with your consent.

Another commonly encountered form of "named insured" clause refers to "household member," which is defined as "anyone living in your household who is related to you by blood, marriage, or adoption." *See, e.g.*, Casey v. Metropolitan Property & Liab. Ins. Co., No. 93-2204, 1994 U.S. App. LEXIS 27661 (1st Cir. 1994).

109. *See, e.g.*, General Accident Fire & Life Assurance Corp., Ltd. v. Travelers Ins. Co., 556 N.Y.S.2d 76 (N.Y. App. Div. 1990).

110. *See, e.g.*, Transcontinental Gas Pipe Line Corp. v. Transportation Ins. Co., 953 F.2d 985 (5th Cir. 1992).

111. Sometimes also referred to as the "Persons Insured" provision.

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(a) any express warranty, or any distribution or sale for a purpose unauthorized by the Named Insured;

(b) bodily injury or property damage arising out of

(i) any act of the Vendor which changes the condition of the products;

(ii) any failure to maintain the product in merchantable condition;

(iii) any failure to make such inspections, adjustments, tests or servicing as the Vendor has agreed to make or normally undertakes to make in the usual course of business, in connection with the distribution or sale of the product; or

(iv) products which after distribution or sale by the Named Insured have been labeled or relabeled or used as a container, part or ingredient of any other thing or substance by or for the Vendor;

(c) bodily injury or property damage occurring within the Vendor's premises.

2. This insurance does not apply to any person or organization, as insured, from whom the Named Insured has acquired such products or any ingredient, part or container, entering into, accompanying or containing such products.[112]

112. ISO Vendor's endorsement form as used by The Hartford Insurance Group.

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A named insured clause which adds additional insureds cannot broaden the scope of coverage. As the court stated in *Sonoco Products Co. v. Travelers Indemnity Co.*,[113] the purpose of provisions to add insureds is "to extend the policy coverage to others. . .not to change the nature of the coverage nor to change declarations nor to remove exclusions."[114] Nevertheless, the addition of insureds in the tobacco business or related fields to a CGL policy issued to a non-tobacco-related entity which presumably does not have any tobacco exclusions could prove problematic for insurers

*C. The Tobacco Exclusion*

Most CGL policies sold to tobacco companies since the 1950s contain an exclusion for coverage for liability or potential liability arising out of the use of tobacco products. The tobacco health hazard exclusion excludes coverage for any personal injury or bodily injury liability "sustained by any person and arising out of" the use of any tobacco product. The exclusion found most commonly reads:

> It is agreed that this policy shall not apply to any liability for personal injury sustained by any person and arising out of or contributed to by the consumption or use of any tobacco product manufactured, sold, handled or distributed by the insured.

A more comprehensive exclusion usually found in policies issued to tobacco companies and their distributors reads:

> This policy does not apply to bodily injury or personal injury for the real or alleged emergence, contraction, aggravation or exacerbation of any form of cancer, carcinoma, cancerous or precancerous condition, arteriosclerosis, heart disease or any other disease of the human body as a result of the consumption, use or the

113. 315 F.2d 126, 128 (10th Cir. 1963).

114. *Id.*; *see also* Massachusetts Turnpike Auth. v. Perini Corp., 208 N.E.2d 807, 812 (Mass. 1965) (the naming of additional insureds does not extend the nature of the substantive coverage originally given by the policy but merely gives to other persons the same protection afforded to the principal insured); SCM Chem., Inc. v. Nationwide Mut. Ins. Co., 69 F.3d 537 (6th Cir. 1995), *reported in full*, 1995 U.S. App. LEXIS 35481 (6th Cir. 1995); Wyner v. North American Specialty Ins. Co., 78 F.3d 752 (1st Cir. 1996).

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> exposure to the consumption or use of any tobacco product manufactured, sold, handled, or distributed by, for, or on behalf of the Insured.
>
> Tobacco Products, as used in this endorsement, shall include raw or cured tobacco, cigars, cigar wrappers, pipe tobacco, cigarette filters, snuff, chewing tobacco, "smokeless" tobacco products,[115] cigarettes and cigarette paper, tobacco smoke, gaseous or solid residues or by-products of tobacco use or consumption; and any chemical, mineral or other product sprayed on, applied to or customarily found within or used in conjunction with any tobacco product.

Because tobacco exclusions are typically manuscript provisions, the actual language contained in any given policy may vary from the above language. While the tobacco exclusions generally exclude coverage for injuries which directly arise out of the use of tobacco products, coverage may be available for claims from persons allegedly harmed by second-hand tobacco smoke, as well as states seeking to recover health care costs for smoking-related illnesses. It will depend upon the specific language of each individual exclusion. More importantly, however, the tobacco exclusions do not normally exclude coverage for claims based upon breach of warranty, negligent conspiracy or advertising liability not pre-preempted by the Labeling Act. *Cipollone* made it clear that the Labeling Act does not pre-empt claims based upon the marketing of cigarettes with manufacturing defects, failure to use a demonstrably safer alternative design for cigarettes, or claims that involve manufacturers' testing or research practices apart from advertising or promotion of their products.[116] The Supreme Court also held that claims for breach of express warranties "aris[ing] from the manufacturer's statements in its advertisements" are also not pre-preempted by federal warning-label legislation.[117] These are

115. With respect to "smokeless" tobacco, in 1986 Congress enacted the Comprehensive Smokeless Tobacco Health Education Act, 15 U.S.C. § 4401-4408, which expressly pre-empted State or local imposition of a statement relating to the use of smokeless tobacco products and health but preserved state law damages actions based on those products.

116. 505 U.S. 504, 524-25 (1992).

117. *Id.* at 526.

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precisely the types of claims which are being made against the tobacco companies in the current litigation.

*D. The Pollution Exclusion*

CGL insurance policies issued from 1970 through 1984 almost always contain the ISO 1970-form pollution exclusion, commonly referred to as the "sudden and accidental" pollution exclusion. Since 1984, most CGL policies contain "absolute" pollution exclusions. It is arguable that the exclusion could operate to prevent coverage for claims brought on behalf of persons allegedly harmed by exposure to second-hand tobacco smoke, particularly in light of the number of toxic substances found in tobacco smoke; however, much would depend upon the jurisdiction where a claim is brought.

Some decisions have held that the pollution exclusion, whether "sudden and accidental" or absolute, "follows the product" and applies to bar coverage for the discharge of pollutants arising from the use of a product. While there is little doubt that smoke is a pollutant within the meaning of the exclusions, some courts have limited the application of the exclusions to industrial polluters. While at least one case has expressly held that cigarette smoke is a pollutant,[118] the argument that a pollution exclusion - whether the 1970-form ISO exclusion or an absolute form - would prevent coverage is arguably weak in some situations.[119] In addition, a number of decisions have already held that the pollution exclusion has no application to product liability claims.[120]

In *Northern Insurance Co. v. Aardvark Associates*,[121] the Third Circuit applied Pennsylvania law and held "[t]he clause unambiguously withholds coverage for injury or damage 'arising out of the discharge, dispersal, release or escape' of pollutants, not merely the insured's discharge, dispersal, release or escape of pollutants."[122] A New York court in *Borg-Warner Corp. v. Insurance Co. of North America*,[123] held "[t]he plain

118. Demakos v. Travelers Ins. Co., 613 N.Y.S.2d 709 (N.Y. App. Div. 1994).

119. *But see* Kruger Commodities, Inc. v. U. S. Fidelity & Guar., 923 F. Supp. 1474 (M.D. Ala. 1996).

120. U. S. Gypsum Co. v. Admiral Ins. Co., No. 83 L 53328 (Ill. Cir. Ct. Jan. 14, 1991); Continental Cas. Co. v. Rapid Am. Corp., 609 N.E.2d 506 (N.Y. Ct. 1993); U.S. Fidelity & Guar. Co. v. Wilkin Insulation Co., 578 N.E.2d 926 (Ill. 1991); Karoll v. Atomergic Chemetals Corp., 600 N.Y.S.2d 101 (N.Y. App. Div 1993).

121. 942 F.2d 189, 194 (3d Cir. 1991).

122. *Id.* at 194.

123. 577 N.Y.S.2d 953, 958 (N.Y. App. Div. 1992).

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language of the pollution exclusion precludes coverage for the insured's liability arising out of 'the' (not 'its') discharge of pollutants."

Other jurisdictions, most notably Washington, disagree and require that the insured itself be an active polluter before the exclusions will apply.[124] Louisiana would probably follow the position taken by Washington.[125]

*E. The "Products-Completed Operations Hazard" Coverage*

Standard form CGL policies do not typically provide "products-completed operations hazard" coverage for the insured's products liability exposures. Indeed, policies issued to manufacturers or distributors of products carry products exclusions which eliminate coverage for the insured's products. Products and completed operations coverage must be expressly bargained for. An additional premium is charged and products and completed operations coverage is added to the policy by endorsement.

There are no reported decisions which directly involve tobacco and "products-completed operations hazard" coverage. An analogy can be drawn, however, from cases involving asbestos, where distributors as well as manufacturers were drawn into the litigation. One such case was *Fibreboard Corp. v. Hartford Accident and Indemnity Co.* ("*Fibreboard*").[126] The case involved claims for asbestos-containing building materials ("ACBM"), for which Fibreboard Corporation sought coverage on a theory that the claims were not subject to the "products hazard" limitation in Fibreboard's CGL policies because they did not allege damages "arising out of" Fibreboard's products. Fibreboard had policies from 1978 through 1980 issued by Hartford Accident and Indemnity Company. The policies contained "products hazard" coverage, but in 1980 an asbestos exclusion was added. After Fibreboard had exhausted the "products hazard" coverage under its 1978 and 1979 policies, Fibreboard contended that because many of the underlying claims were based on theories such as concert of action, failure to disclose the hazardous nature of products, civil conspiracy, failure to develop

124. *See, e.g.*, United Pacific Ins. Co. v. Van's Westlake Union, Inc., 664 P.2d 1262, 1266 (Wash. Ct. App. 1983) ("The insured in the case before us was not an active polluter.").

125. *See, e.g.*, Avery v. Commercial Union Ins. Co., 621 So.2d 184 (La. Ct. App. 1993); South Central Bell Tel. Co. v. Ka-Jon Food Stores, 626 So. 2d 1223 (La. Ct. App. 1993), *writ granted*, 633 So.2d 158 (La. 1994), *and vacated, remanded*, 644 So.2d 357 (La. 1994), *reh'g. granted, vacated and remanded to trial court*, 644 So.2d 1268 (La. 1994).

126. 20 Cal. Rptr. 2d 376 (Cal. Ct. App. 1993).

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asbestos-free products and market share liability, they had "nothing to do with any product manufactured, sold, handled or distributed by Fibreboard" and as a consequence were not subject to the limits of liability for "products hazard." Fibreboard argued that there was coverage under the "premises-operations" clause as well as under the personal injury and advertising liability provisions of its policies. The trial court entered summary judgment in favor of Hartford and the appellate court affirmed.[127]

The appellate court framed the issues before it as follow:

> We are asked to decide three issues: (1) whether causes of action based on collective liability, in which a given defendant need not have supplied the harmful product, come within the policies' "products hazard" coverage; (2) whether such causes fall within the general operations coverage; and (3) whether the personal injury coverage applies to certain other claims alleging interference with property rights and related matters.

The three questions were answered "yes," "no" and "no," respectively. Assuming that other jurisdictions follow *Fibreboard*, it would seem that tobacco claims will also fall under "products hazard" coverage or exclusions, at least insofar as the manufacturers and distributors are concerned. Peripheral defendants, of course, would not be affected by "products hazard" provisions.

A result similar to that in *Fibreboard* was reached in *Laminated Wood Products Co. v. Pedersen*,[128] which involved a claim against Fireman's Fund Insurance Company ("Fireman's") for failure to defend and indemnify its insured, Laminated Wood Products Company ("Lamwood"). The case had an unusually complicated set of facts. Lamwood was a manufacturer of prefabricated buildings. A building which it sold was alleged to be defective and Lamwood was sued. Lamwood tendered the defense to Fireman's, which initially accepted but then rejected the defense because the policy it had issued to Lamwood did not provide products liability coverage.[129] When the purchaser obtained a judgment against Lamwood, Lamwood sued both Fireman's and the broker which had

127. *Id.* at 380.
128. 711 P.2d 165 (Or. Ct. App. 1985).
129. *Id.* at 166.

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allegedly failed to obtain product liability coverage.[130] In the course of the litigation, Lamwood dismissed its complaint against Fireman's and proceeded against its former broker. The broker in turn filed a third-party complaint bring Fireman's back into the litigation. Lamwood obtained a judgment against the broker. Execution of the judgment was stayed pending resolution of the broker's claims against Fireman's.

The broker's errors and omissions insurer was substituted as the real party in interest at trial, and argued that even if the broker had obtained completed operations coverage as he was instructed, there would have been no coverage under the Fireman's policy because only the "product hazard" coverage would have covered the claims asserted by the purchaser of the defective building. Lamwood agreed that no coverage for "products hazards" had been requested. The jury entered a verdict against the broker's insurer and an appeal followed.

The appellate court analyzed the Fireman's policy for purposes of the appeal as if it had contained coverage for the completed operations hazard, but not the "products hazard". It observed, "The question is whether Fireman's would have had a duty to defend [the purchaser's] claims against Lamwood under the completed operations coverage."[131] It reversed the trial court, holding " the products hazard covers any claim for damages arising from a product, including representations or warranties made with respect thereto. The completed operations hazard covers injuries arising from the provision of a service separable from the sale of a product, such as installation of a product or construction of a building."[132]

*F. Personal Injury and Advertising Liability Coverage*

Advertising injury may be a particular problem, particularly with policies where there is a personal injury and advertising liability endorsement. For example, the Mississippi complaint alleges claims for

130. As part of the coverage litigation against Fireman's, Fireman's loaned Lamwood the amount of the purchaser's judgment together with costs and attorney fees Lamwood had incurred in product liability litigation. Lamwood agreed to continue to prosecute the errors and omissions action against the broker and appointed Fireman's its agent and attorney-in-fact. The loan was without interest and repayable "only in the event and to the extent of any net recovery Lamwood may obtain from any person . . . arising from the procurement and issuance of the . . . insurance policy." *Id.* at 166.

131. *Id.* at 169.

132. *Id.* at 170. *See also* American Trailer Serv. v. Home Ins. Co., 361 N.W.2d 918 (Minn. Ct. App. 1985); Friestad v. Travelers Indem. Co., 393 A.2d 1212 (Pa. Super. Ct. 1978); Chancler v. American Hardware Mut. Ins. Co., 694 P.2d 1301 (Idaho Ct. App. 1985), *rev'd*, 712 P.2d 542 (Idaho 1985).

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bodily injury, false advertising, and nuisance. Those allegations could fall within the "bodily injury," "personal injury," and "advertising injury" provisions in a CGL policy. The complaints filed by the states of Florida and Minnesota also contain allegations of negligence, bodily injury, and false advertising. In fact most of the currently pending cases against tobacco manufacturers and the peripheral defendants involve claims of false and misleading advertising, as well as conspiracy and a variety of other claims. Those insureds whose CGL policies contain the Broad Form Comprehensive General Liability Endorsement[133] will undoubtedly seek coverage under the advertising liability provisions of those policies. Assuming there is no specific exclusion which would preclude coverage, coverage may well be available. However, in those jurisdictions which hold that claims for breach of warranties and misrepresentations associated with products will be covered only under "products hazard" coverage a different result may obtain. This is such an emerging area of the law and the decisions are so sparse that no definitive answer can yet be given.

Much will depend upon the specific language of a particular policy, since the "personal injury and advertising liability" provisions have been changed significantly since their first introduction in 1966. Covered under the 1973 "personal injury" definition found in the personal injury endorsement were:

> (1) false arrest, detention, imprisonment, or malicious prosecution;
>
> (2) wrongful entry or eviction or other invasion of the right of private occupancy;
>
> (3) a publication or utterance
>
> (a) of a libel or slander or other defamatory or disparaging material, or
>
> (b) in violation of an individual's right of privacy;
> except publications or utterances in the course of or related to advertising, broadcasting, publishing or

133. Coverage for "personal injury and advertising liability" was available as early as 1966. The "Broad Form Comprehensive General Liability Endorsement" was adopted by ISO in 1976, replacing a 1973 ISO personal injury insuring agreement form.

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> telecasting activities conducted by or on behalf of the named insured shall not be deemed personal injury.

The "advertising injury" section of the form provided coverage for:

> injury arising out of an offense committed during the policy period occurring in the course of the named insured's advertising activities, if such injury arises out of libel, slander, defamation, violation of right of privacy, piracy, unfair competition, or infringement of copyright, title or slogan.[134]

The personal injury and advertising liability provisions were changed in the 1985 ISO Occurrence CGL Form to read as follows:

> COVERAGE B. PERSONAL AND ADVERTISING INJURY LIABILITY
>
> 1. Insuring Agreement.
>
> a. We will pay those sums that the insured becomes legally obligated to pay as damages because of "personal injury" or "advertising injury" to which this insurance applies. No other obligation or liability to pay sums or perform acts or services is covered unless explicitly provided for under SUPPLEMENTARY PAYMENTS COVERAGES A AND B. We will have the right and duty to defend any "suit" seeking those damages. But:
>
> (1) The amount we will pay for damages is limited as described in SECTION III LIMITS OF INSURANCE;

134. 1973 ISO personal injury insuring agreement form. ISO's 1976 Broad Form Comprehensive General Liability Endorsement contains similar language.

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(2) We may investigate and settle any claim or "suit" at our discretion; and

(3) Our right and duty to defend end when we have used up the applicable limit of insurance in the payment of judgments or settlements under Coverages A or B or medical expenses under Coverage C.

b. This insurance applies to "personal injury" only if caused by an offense:

(1) Committed in the "coverage territory" during the policy period; and

(2) Arising out of the conduct of your business, excluding advertising, publishing, broadcasting or telecasting done by or for you.

c. This insurance applies to "advertising injury" only if caused by an offense committed:

(1) In the "coverage territory" during the policy period; and

(2) In the course of advertising your goods, products or services.

2. Exclusions.

This insurance does not apply to:

a. "Personal injury" or "advertising injury:"

(1) Arising out of oral or written publication of material, if done by

or at the direction of the insured with knowledge of its falsity;

(2) Arising out of oral or written publication of material whose first publication took place before the beginning of the policy period;

(3) Arising out of the willful violation of a penal statute or ordinance committed by or with the consent of the insured; or

(4) For which the insured has assumed liability in a contract or agreement. This exclusion does not apply to liability for damages that the insured would have in the absence of the contract or agreement.

b. "Advertising injury" arising out of:

(1) breach of contract, other than misappropriation of advertising ideas under an implied contract;

(2) The failure of goods, products or services to conform with advertised quality or performance;

(3) The wrong description of the price of goods, products or services; or

(4) An offense committed by an insured whose business is advertising, broadcasting, publishing or telecasting.

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Since 1986, most insurers have adopted the ISO "Claims Made" CGL Form, which changed the earlier form to read:

> COVERAGE B. PERSONAL AND ADVERTISING INJURY LIABILITY
>
> 1. Insuring Agreement.
>
> a. We will pay those sums that the insured becomes legally obligated to pay as damages because of "personal injury" or "advertising injury" to which this insurance applies. No other obligation or liability to pay sums or perform acts or services is covered unless explicitly provided for under SUPPLEMENTARY PAYMENTS COVERAGES A AND B.
>
> b. We will have the right and duty to defend any "suit" seeking those damages. But:
>
> (1) The amount we will pay for damages is limited as described in SECTION III - LIMITS OF INSURANCE;
>
> (2) We may investigate and settle any claim or "suit" at our discretion: and
>
> (3) Our right and duty to defend end when we have used up the applicable limit of insurance in the payment of judgments or settlements under Coverages A or B or medical expenses under Coverage C.
>
> c. This insurance applies to "personal injury" only if caused by an offense:
>
> (1) Committed in the "coverage territory" during the policy period; and

(2) Arising out of the conduct of your business, excluding advertising, publishing, broadcasting or telecasting done by or for you.

d. This insurance applies to "advertising injury" only if caused by an offense committed:

(1) In the "coverage territory'" during the policy period; and

(2) In the course of advertising your goods, products or services.

2. Exclusions.

This insurance does not apply to:

a. "Personal injury" or "advertising injury:"

(1) Arising out of oral or written publication of material, if done by or at the direction of the insured with knowledge of its falsity;

(2) Arising out of oral or written publication of material whose first publication took place before the beginning of the policy period;

(3) Arising out of the willful violation of a penal statute or ordinance committed by or with the consent of the insured; or

(4) For which the insured has assumed liability in a contract or agreement. This exclusion does not apply to liability for damages that the insured would have in the absence of the contract or agreement.

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b. "Advertising injury" arising out of:

(1) Breach of contract, other than misappropriation of advertising ideas under an implied contract;

(2) The failure of goods, products or services to conform with advertised quality or performance;

(3) The wrong description of the price of goods, products or services; or

(4) An offense committed by an insured whose business is advertising, broadcasting, publishing or telecasting.

It does not appear that coverage can be had under the personal injury provisions of an insurance contract; however, the result may be different under the advertising injury provisions. *Fibreboard Corp. v. Hartford Accident & Indemnity Co.*[135] involved asbestos-containing building materials sold by Fibreboard Corporation which released asbestos fibers into the air. Fibreboard sought coverage under a personal injury provision which covered "wrongful entry or eviction or other invasion of an individual's right of privacy." The *Fibreboard* court held that "[t]o the extent the listed offenses are framed in generic terms, they should be construed broadly to encompass all specific torts which reasonably could fall within the general category."[136] The court also opined that "Coverage thus is triggered by the offense, not the injury or damage which a plaintiff suffers."[137] The *Fibreboard* court went on to explain, "[a]lthough wrongful entry can describe a trespass committed for the specific purpose of dispossessing the owner or occupant of the land... it can also describe a more general, 'simple trespass' involving no intent to dispossess: 'Every wrongful entry upon land in the occupation or possession of the owner constitutes a trespass . . .'"[138] In *Fibreboard* the court found no coverage,

135. 20 Cal. Rptr. 2d 376 (Cal. Ct. App. 1993).

136. *Id.* at 390.

137. *Id.* at 388; *accord* Legarra v. Federated Mutual Ins. Co., 42 Cal. Rptr. 2d 101 (Cal. Ct. App. 1995).

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since there was no direct or indirect entry by Fibreboard on the underlying plaintiffs' land.

In a more recent decision involving a claim for coverage under the personal injury endorsement in an environmental contamination setting, a California appellate court held, "a manufacturer does not commit a trespass through its products."[139] Most jurisdictions can be expected to follow California's position in that regard.[140]

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138. 16 Cal. App. 4th at 511-512, citing *MacLeod v. Fox West Coast T. Corp.*, 74 P.2d 276 (Cal. 1937).

139. *Martin Marietta Corp. v. Ins. Co. of North America*, 47 Cal. Rptr. 2d 670 (Cal. Ct. App. 1995).

140. For a general discussion of "personal injury" in a variety of situations, see Hartford Accident & Indem. v. Krekeler, 491 F.2d 884 (8th Cir. 1974) (trespass on land where insured assaulted third party held sufficient to warrant a defense by insurer); Town of Goshen v. Grange Mut. Ins. Co., 424 A.2d 822 (N.H. 1980) (coverage found for claim public officials conspired to deny a building permit); Town of Epping v. St. Paul Fire & Marine Ins. Co., 444 A.2d 496, 498 (N.H. 1982) (no coverage where municipality purchased policy "with full knowledge and understanding that the coverage purchased did not afford protection against claims for alleged civil rights violations"); Nichols v. Great Am. Ins. Cos., 215 Cal. Rptr. 416 (Cal. Ct. App. 1985) (theft of scrambled cable television signals not covered); Gardner v. Romano, 688 F. Supp. 489 (E.D. Wis. 1988) (coverage found for landlord's racial discrimination against potential tenants, which violated their right to private occupancy); Martin v. Brunzelle, 699 F. Supp. 167 (N.D. Ill. 1988) (no coverage for landlord's racial discrimination against potential tenants); Fragomeno v. Ins. Co. of the West, Inc., 255 Cal. Rptr. 111 (Cal. Ct. App. 1989) ("personal injury" provision in "policy only covers tort, as opposed to contract, liability"); Beltway Mgt. Co. v. Lexington-Landmark Ins. Co., 746 F. Supp. 1145 (D.D.C. 1990) (coverage found for breaches of implied warranty of habitability); Waranch v. Gulf Ins. Co., 266 Cal. Rptr. 827 (Cal. Ct. App. 1990) (no coverage under "other invasion of the right of private occupancy" language for a claim of wrongful repossession of an automobile); Pipefitters Welfare Educ. Fund v. Westchester Fire Ins. Co., No. 90 C 5041 (S.D. Ill. April 25, 1991), *rev'd*, 976 F.2d 1037 (7th Cir. 1992) (coverage found where policy exclusion applied to "bodily injury or property damage," but made no mention of "personal injury"); Decorative Center of Houston v. Employers Cas. Co., 833 S.W.2d 257, 261 (Tex. App. 1992) (no coverage where construction allegedly caused various forms of physical and mental harm to the underlying plaintiffs' persons, property, and lifestyles since "[t]he right of 'private occupancy' can only refer to those rights associated with an individual's act of inhabiting the premises, and not to rights associated with the individual's right to use and enjoy the inhabited premises); Cassinos v. Union Oil Co., 18 Cal. Rptr. 2d 574 (Cal. Ct. App. 1993) (coverage found for trespass where wastewater was injected from defendant's property to plaintiffs, interfering with plaintiff's mineral estate); County of Columbia v. Continental Ins. Co., 634 N.E.2d 946 (N.Y. 1994) (personal injury and advertising liability endorsement does not provide coverage for continuing nuisance or continuing trespass in an environmental contamination case); Scottish Guar. Ins. Co., Ltd. v. Dwyer, 19 F.3d 307 (7th Cir. 1994) (wrongful entry within the personal injury portion of a CGL policy held to be the equivalent of negligent trespass insofar as the duty to defend is concerned); Staefa Control-System, Inc. v. St. Paul

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Turning to the advertising injury provisions, most of the currently pending tobacco-related lawsuits contain claims discussing the nature of the advertising carried on by the tobacco industry for the past 50 years or more. This will undoubtedly give rise to insurance claims under the "personal injury and advertising liability" provisions of CGL policies. Because *Cipollone*[141] preserved the right of plaintiffs to seek recovery for "fraudulent misrepresentation claims that do arise with respect to advertising and promotions (most notably claims based on allegedly false statements of material fact made in advertisements),"[142] claims against insurers under advertising liability coverage provisions may prove problematic. As the Supreme Court observed:

Such claims are not predicated on a duty based on "smoking and health" but rather on a more general obligation -- the duty not to deceive. This understanding of fraud by intentional misstatement is appropriate for several reasons. First, in the 1969 Act, Congress offered no sign that it wished to insulate cigarette manufacturers from longstanding rules governing fraud. To the contrary, both the 1965 and the 1969 Acts explicitly reserved the FTC's authority to identify and punish deceptive advertising practices -- an authority that the FTC had long exercised and continues to exercise. . . .This indicates that Congress intended the phrase relating to "smoking and health" (which was essentially unchanged by the 1969 Act) to be construed narrowly, so as not to proscribe the regulation of deceptive advertising.[143]

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Fire & Marine Ins. Co., 847 F. Supp. 1460 (N.D. Cal. 1994) (loss of use held not covered under personal injury provisions such as trespass and nuisance); Legarra v. Federated Mutual Ins. Co., 42 Cal. Rptr. 2d 101 (Cal. Ct. App. 1995) (personal injury endorsement held "limited to damages *other* than the injury to realty which an occupier of land may suffer when his quiet enjoyment of occupancy is disturbed"); Topeka Tent & Awning Co. v. Glen Falls Ins. Co., 774 P.2d 984, 987 (Kan. Ct. App. 1989) (no coverage where claimant sought construction of phrase "right of private occupancy" to mean occupancy of an employment position).

141. Cipollone v. Liggett Group, 505 U.S. 504 (1992).

142. *Id.* at 528.

143. *Id.* at 529. The Court went on to hold: "Moreover, this reading of 'based on smoking and health' is wholly consistent with the purposes of the 1969 Act. State law prohibitions on false statements of material fact do not create 'diverse, nonuniform, and confusing' standards. Unlike state law obligations concerning the warning necessary to render a product 'reasonably safe,' state law proscriptions on intentional fraud rely only on a single, uniform standard: falsity. Thus, we conclude that the phrase 'based on smoking and health' fairly but narrowly construed does not encompass the more general duty not to make fraudulent statements. Accordingly, petitioner's claim based on allegedly fraudulent statements made in respondents' advertisements are not pre-preempted by § 5(b) of the 1969 Act." *Id.*

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To the extent that claims are based upon breach of express warranties, including express warranties made in advertising materials, the Labeling Act was held not to "pre-empt petitioner's claims that rely solely on respondents' testing or research practices or other actions unrelated to advertising or promotion. In short, a common law remedy for a contractual commitment, *i.e.*, breach of express warranty, voluntarily undertaken should not be regarded as a requirement. . .imposed under 'State law' within the meaning of § 5(b)."[144]

As a general rule, it must be shown that the advertising was a causative event in plaintiff's injuries. That is, there must be a causative connection. The leading discussion of this principle is found in the 1992 decision in *Bank of the West v. Superior Court of Contra Costa County*.[145] The underlying class action arose out of a premium financing scheme adopted by Bank of the West (the "Bank") which was held to violate the federal Truth-in-Lending Act.[146] The underlying case was removed to federal court, which remanded all but the federal claims back to state court.[147] As the case progressed, the only surviving claims under which plaintiffs could recover money damages were claims under California's Unfair Business Practices Act.[148] The class action settled[149] and Bank of the West sought to recover from its insurer under the advertising liability provision of its CGL policy. The *Bank of the West* decision may therefore be somewhat limited in its applicability to tobacco-related advertising due to its focus on unfair competition as opposed to false or misleading advertising or breach of express warranties.

In the insurance coverage litigation, the Bank relied upon the statutory definition of "unfair competition" contained in California's Unfair

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144. *Id.* at 524-26.

145. 833 P.2d 545 (Cal. 1992).

146. 15 U.S.C.S. §§ 1601-1700 (1993). Claims were also brought under California's Unruh Act, CAL. CIV. CODE §§ 1801-1812.20 (West 1994), California's Unfair Business Practices Act, CAL. BUS. & PROF. CODE §§ 17200-17209 (West 1997), and a state statute that prohibits excessive liquidated damages, CAL. CIV. CODE, § 1671 (West 1994).

147. Fallat v. Central Bank, No. C-86-6521 RFP (N.D. Cal. 1986).

148. CAL. BUS. & PROF. CODE §§ 17200-17209 (West 1997).

149. *Bank of the West*, 833 P.2d at 547. Pursuant to a class-wide settlement agreement, the Bank paid the plaintiffs $500,000 and attorneys fees, and agreed to make changes in its premium financing program. The settlement agreement did not characterize the $500,000 payment as attributable to any particular claim and in the parties' joint motion for approval of the settlement counsel for the class plaintiffs opined that $500,000 represented the amount that could be recovered either as the return of unlawful liquidated damages or as the maximum statutory recovery under the Truth-in-Lending Act.

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Business Practices Act.[150] The insurer argued that the language of the policy at issue referred to the common law tort of unfair competition rather than to statutorily prohibited conduct. It also offered to prove that the claims of the class plaintiffs did not occur "in the course of [the Bank's] advertising activities" within the meaning of the policy.

Citing to a number of decisions from other jurisdictions,[151] the California high court unequivocally held that "the term 'unfair competition' as used in policy language defining 'advertising injury' refers to the common law tort of unfair competition rather than to conduct prohibited by unfair business practice statutes. . . .[T]his conclusion substantially limits the scope of coverage." The common law tort of unfair competition requires a showing of competitive injury. Statutory "unfair competition" extends to all unfair and deceptive business practices and hence cannot be equated with the common law definition.

The *Bank of the West* court expressed some general views which will undoubtedly be helpful to insurers if coverage is sought under advertising liability provisions of CGL policies. Again citing to a number of decisions from other jurisdictions,[152] the California Supreme Court made clear that there must be a casual relationship between "advertising activities" and the

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150. Section 17200 provides:

> As used in this chapter, unfair competition shall mean and include unlawful, unfair or fraudulent business practice and unfair, deceptive, untrue or misleading advertising and any act prohibited by Chapter 1 (commencing with Section 17500) of Part 3 of Division 7 of the Business and Professions Code.

Bank of the West v. Superior Court, 833 P.2d 545, 549, n.2 (Cal. 1992).

151. *See, e.g., Bank of the West,* 833 P.2d at 550 (citing Seaboard Sur. Co. v. Ralph Williams' N.W. Chrysler Plymouth, Inc., 504 P.2d 1139, 1140-1143 (Wash. 1973); Ruder & Finn Inc. v. Seaboard Sur. Co., 422 N.E.2d. 518, 522 (N.Y. 1981); Pine Top Ins. Co. v. Public Util. Dist. 1 of Chelan Cty., 676 F. Supp. 212, 215-217 (E.D. Wash. 1987); Globe Indem. Co. v. First Am. State Bank, 720 F. Supp. 853, 855-857 (W.D. Wash. 1989); Westfield Ins. Co. v. TWT, Inc., 723 F. Supp. 492, 496 (N.D. Cal. 1989); Boggs v. Whitaker, Lipp & Helea, Inc., 784 P.2d 1273, 1275-1276 (Wash Ct. App. 1990); Aetna Cas. & Sur. Co. v. Trans World Assur. Co., 745 F. Supp. 1524, 1528-1529 (N.D. Cal. 1990); Tigera Group, Inc. v. Commerce & Indus. Ins., 753 F. Supp. 858, 859-861 (N.D. Cal. 1991); Nationwide Mut. Ins. Co. v. Dynasty Solar, Inc., 753 F. Supp. 853, 855-858 (N.D. Cal. 1990)).

152. *Bank of the West,* 833 P.2d at 558-59 (citing National Union Fire Ins. Co. v. Siliconix Inc., 729 F. Supp. 77, 79-80 (N.D. Cal. 1989); A. Meyers & Sons Corp. v. Zurich American Ins., 545 N.E.2d. 1206, 1209 (N.Y 1989); Lazzara Oil Co. v. Columbia Cas. Co., 683 F. Supp. 777, 780 (M.D. Fla. 1988)).

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injuries suffered by the claimant for there to be coverage under advertising liability clauses:

> Virtually every business that sells a product or service advertises, if only in the sense of making representations to potential customers. If no causal relationship were required between "advertising activities" and "advertising injuries," then "advertising injury" coverage, alone, would encompass most claims related to the insured's business. However, insureds generally expect to obtain such broad coverage, if at all, only by purchasing several forms of insurance, including coverage for "errors and omissions liability," "directors and officers liability," "completed operations and products liability," and/or other coverages available as part of a CGL policy.[153]

The Court also noted that there are varying definitions of what constituted "advertising" within the meaning of a CGL policy, but declined to address the issue beyond that observation. In the case of tobacco-related litigation, the question is certain to arise because of scientific studies and related publications not disseminated to the public at large. The majority view is that "advertising" means widespread promotional activities directed to the public at large.[154] A minority of jurisdictions hold that "advertising" may include limited promotional activities or even personal solicitations.[155]

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153. *Id.* at 560.

154. *Id.* at 560 n.9 (citing International Ins. Co. v. Florists' Mut. Ins. Co., 559 N.E.2d 7, 9-10 (Ill. App. Ct. 1990); Playboy Enterprises, Inc. v. St. Paul Fire & Marine Ins. Co., 769 F.2d 425, 428-429 (7th Cir. 1985); Fox Chemical Co., Inc. v. Great Am. Ins. Co., 264 N.W.2d 385, 386 (Minn. 1978)).

155. *Id.* (citing American States Ins. Co. v. Canyon Creek, 786 F. Supp. 821, 827-828 (N.D. Cal. 1991); John Deere Ins. Co. v. Shamrock Industries, Inc., 696 F. Supp. 434, 440 (D. Minn. 1988), *aff'd on other grounds*, 929 F.2d 413 (8th Cir. 1991)).

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### G. Trigger Of Coverage

Trigger of coverage will most certainly be an issue in any insurance coverage case arising out of an underlying "tobacco and health" suit. The potential for tobacco cases to relate back for decades is definitely present, which could give rise to many of the same issues with respect to trigger of coverage as those which were raised in the asbestos cases.

Trigger of coverage will vary greatly depending upon the type and form of policy at issue. For example, "claims made" policies will only be triggered if a claim is made during the policy period and notice is given to the insurer at the time of the claim or within a reasonable time thereafter. Post-1966 CGL policies typically require that injury occur during the policy period and be caused by an occurrence.

There are a myriad bodily injuries allegedly caused by exposure to tobacco smoke, including cancers of the lungs, lips, larynx, oral cavity, esophagus, bladder and pancreas; cardiovascular disease; coronary spasm; atherogenesis; bronchitis; emphysema; cerebrovascular disease; aortic aneurysms; peripheral vascular disease; and peptic ulcer disease. Smoking during pregnancy is known to retard fetal growth, thereby placing the infant at greater risk both at birth and later in life. This could give rise to a whole new generation of claimants much like the second-generation DES claimants.

Many of the diseases associated with smoking or exposure to second-hand tobacco smoke are not rapid onset diseases. Injury occurs gradually over an extended period of time depending upon the particular disease and the individual patient. While there are a number of competing "trigger of coverage" theories, the so-called "continuous trigger" or "triple trigger" appears to be today's majority view in the case of latent or progressive bodily injury.[156] That trigger theory holds that all policies on the risk from initial exposure to the injury-causing substance through diagnosis must respond to the claim. The other trigger theories which might apply are (1) the exposure theory,[157] which holds that the policy in effect when the

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156. *See, e.g.*, Owens-Illinois, Inc. v. United Ins. Co., 650 A.2d 974 (N.J. 1994); Montrose Chem. Corp. v. Admiral Ins. Co., 897 P.2d 1 (Cal. 1995); Armstrong World Ind., Inc. v. Aetna Cas. & Sur. Co., 26 Cal. Rptr. 2d 35 (Cal. Ct. App. 1993), *review granted, grant vacated and case remanded for further proceedings*, 46 Cal. Rptr. 2d 174 (Cal. 1995), *subsequent decision*, 52 Cal. Rptr. 2d 690 (Cal. Ct. App. 1996).

157. Insurance Co. of N. Am. v. Forty-Eight Insulations, Inc., 633 F.2d 1212, 1217, 1223 (6th Cir. 1980); Porter v. American Optical Corp., 641 F.2d 1128 (5th Cir. 1981); Ducre v. Executive Officers of Halter Marine, Inc., 752 F.2d 976, 994 (5th Cir. 1985);

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claimant is first exposed to the injury-causing substance will provide coverage; (2) the manifestation trigger,[158] which holds that the policy in effect when the claimant's injury is first diagnosed or becomes clinically evident; and (3) the "injury-in-fact" trigger,[159] which holds that the policy in effect when injury first occurs must respond, regardless of whether the illness or disease is manifest at that point in time.

The following chart outlines the "trigger-of-coverage" positions of the 50 states in bodily injury actions, to the extent that they exist and have been adopted by the courts in specific situations:

| **State** | **Bodily Injury Trigger** |
|---|---|
| Alaska | No published decisions. |
| Ala. | Asbestos - exposure - *Commercial Union Ins. Co. v. Sepco*, 765 F.2d 1543 (11th Cir. 1985). |
| Ariz. | No published decisions. |
| Ark. | No published decisions. |
| Cal. | Injurious exposure in cases other than asbestos - *Hancock Labs v. Admiral Ins. Co.*, 777 F. 2d 520 (9th Cir. 1985).<br><br>Trigger for silicosis is any period when victim is exposed to silica particles - *Clemco Industries v. Commercial Union Ins. Co.*, 665 F.Supp. 816 (N.D. Cal. 1987). |

Imperial Cas. & Indem. Co. v. Radiator Specialty Co., No. 93-209-CIV-5-D (E.D.N.C. 1994).

158. Eagle-Picher Indus., Inc. v. Liberty Mut. Ins. Co., 523 F. Supp. 110, 118 (D. Mass. 1981), *modified*, 682 F.2d 12 (1st Cir. 1982); Transamerica Ins. Co. v. Safeco Ins., 472 N.W.2d 5 (Mich. Ct. App. 1991).

159. American Motorists Ins. Co. v. E.R. Squibb & Sons, Inc., 406 N.Y.S.2d 658, 659-60 (N.Y. Spec. Term 1978); American Home Products Corp. v. Liberty Mut. Ins. Co., 565 F. Supp. 1485, 1497 (S.D.N.Y. 1983); Van Wyck Assoc. v. St. Paul Fire & Marine Ins. Co., 454 N.Y.S.2d 266, 269 (N.Y. Spec. Term 1982); State Farm Mut. Automobile Ins. Co. v. Longden, 197 Cal. App. 3d 226, 231 (1987); National Cas. Ins. Co. v. Mt. Vernon, 515 N.Y.S.2d 267, 270 (N.Y. App. Div. 1987); Uniroyal, Inc. v. Home Ins. Co., 707 F. Supp. 1368, 1388 (E.D.N.Y. 1988); Triangle Publications, Inc. v. Liberty Mut. Ins. Co., 703 F. Supp. 367, 371 (E.D. Pa. 1989); Dow Chem. Co. v. Associated Indem. Corp., 724 F. Supp. 474 (E.D. Mich. 1989); Holmes Protection of New York, Inc. v. National Union Fire Ins. Co., 543 N.Y.S.2d 459, 460 (N.Y. App. Div. 1989); Continental Cas. Co. v. Rapid-American Corp., 609 N.E.2d 506 (N.Y. 1993).

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| State | Bodily Injury Trigger |
|---|---|
| | Trigger for toxic waste related bodily injury is either the release of contaminants into the environment or by the ingestion of those contaminants by the claimant - *Beckman Industries v. International Insurance Co.,* No. CV-85-8382, slip op. (C.D. Cal. Jan 28, 1988).<br><br>Asbestos - continuous trigger - *Armstrong World Indus. v. Aetna Cas. & Sur. Co.*, 45 Cal.App.4th 1 (1st Dist. 1996). |
| Colo. | Continuous trigger for bodily injury and property damage - *Broderick Invest. Co. v. Hartford Accident & Indem. Co.*, 742 F.Supp. 571 (D. Colo. 1989), *cert. denied,* 506 U.S. 865 (1992). |
| Conn. | DES case - injury-in-fact - *Aetna Cas. & Sur. Co. v. Abbott Labs.,* 636 F.Supp. 546 (D. Conn. 1986). |
| Del. | Continuous trigger applied to determine when injury occurred for purposes of CGL policy - *New Castle County v. Continental Cas. Co.*, 728 F. Supp. 324 (D. Del. 1989), *aff'd in part and rev'd in part* 933 F.2d 1162 (3d Cir. 1991). |
| D.C. | Triple trigger theory applied for asbestos - *Keene Corp. v. Insurance Co. of North America,* 667 F.2d 1034 (D.C. Cir. 1981), *cert. denied,* 455 U.S. 1007 (1982). |
| Fla. | Discovery trigger was applied to a case involving negligent construction - *Travelers Ins. Co. v. C.J. Gayfers Co.*, 366 So.2d 1199 (Fla. Dist. Ct. App. 1979).<br><br>For tort claims - the infliction of damage is the event that triggers potential coverage under a liability policy - *Trizec Properties Inc. v. Biltmore Constr. Co.*, 767 F.2d 810 (11th Cir. 1985). |
| Ga. | When the injury first manifests itself - *U.S.* |

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| State | Bodily Injury Trigger |
|---|---|
| | *Asbestos v. Hammock,* 231 S.E.2d 792 (Ga. Ct. App. 1976).<br><br>Occurrence referred to the continuous exposure to BNA - *Continental Casualty Co. v. Synalloy Corp.*, 667 F.Supp. 1563 (S.D. Ga. 1986). |
| Haw. | No published decisions. |
| Idaho | Multiple trigger for tort claims where all policies were triggered which were in effect from the time of the initial exposure through manifestation - *Pacific Indem. Co. v. The Bunker Hill Co.,* Civ. Nos. 79-2010, 82-3082 (consolidated), slip op. (D. Idaho July 3, 1984). |
| Ill. | For tort claims damage or injury occurs when the complaining party suffers actual damage, regardless of when the wrongful act that caused the damage took place - *Great Am. Ins. Co. v. Tinley Park Recreation Comm'n,* 259 N.E.2d 867 (Ill. App. Ct. 1970).<br><br>For tort claims - each policy on the risk during the period of exposure would be liable for its pro rata share of coverage based on policy limits - *Insurance Co. of North America v. Forty-Eight Insulations,* 451 F. Supp. 1230 (E.D. Mich. 1978) (applying Illinois law), *aff'd* 633 F.2d 1212 (6th Cir. 1980), *clarified*, 657 F.2d 814 (6th Cir. 1981), *cert. denied*, 454 U.S. 1109 (1981).<br><br>Asbestos - double trigger - *Zurich Ins. v. Raymark Indus. Inc.*, 118 Ill.2d 23, 514 N.E.2d 150 (1987).<br><br>Asbestos - continuous trigger - *United States Gypsum Co. v. Admiral Ins. Co.,* 643 N.E.2d 1226 (Ill. Ct. App. 1994). |
| Ind. | DES - triple trigger - coverage is triggered at any point between ingestion of DES and the |

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| State | Bodily Injury Trigger |
|---|---|
| | manifestation of a DES-related disease - *Eli Lilly & Co. v. Home Ins. Co.*, 482 N.E.2d 467 (Ind. 1985). |
| Iowa | No published decisions. |
| Kan. | Asbestos bodily injury and property damage - Injury-in-fact - *Johnson v. Studyvin*, No. 92-2292 (D. Kan. July 28, 1993).<br><br>Exposure to noise and manifestation of hearing loss triggers policy - *Atchinson, Topeka & Santa Fe Ry. v. Stonewall Ins. Co.*, No. 94-CV-1464 (Kan. Cir. Ct., Shawnee Cty. Sept. 18, 1995). |
| Ky. | No published decisions. |
| La. | For tort claims - exposure - *Porter v. America Optical Corp.*, 641 F.2d. 1128 (5th Cir. 1981).<br><br>Exposure to silica dust - *Ducre v. Executive Officers of Halter Marine Inc.*, 752 F.2d 976 (5th Cir. 1985).<br><br>Exposure to silica dust - *Ducre v. Mine Safety Appliances Co.*, 645 F.Supp. 708 (E.D. La. 1986), *aff'd*, 833 F.2d 588 (5th Cir. 1987). |
| Me. | No published decisions. |
| Md. | For tort claims the general rule is that the time of occurrence of an accident within the meaning of an indemnity policy is not the time the wrongful act was committed but the time when the complaining party was actually damaged - *Hartford Mut. Ins. Co. v. Jacobson,* 536 A.2d 120 (Md. Ct. Spec. App. 1988).<br><br>Asbestos-related bodily injury - exposure theory - *Lloyd E. Mitchell v. Maryland Cas. Co.*, 595 A.2d 469 (Md. 1991).<br><br>Exposure to lead - *Scottsdale Ins. Co. v.* |

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| State | Bodily Injury Trigger |
|---|---|
| | *American Empire Surplus Lines Co.*, 811 F.Supp 210 (D. Md. 1993). |
| Mass. | Manifestation of disease symptoms - *Eagle-Picher Indus. v. Liberty Mut. Ins. Co.*, 682 F.2d 12 (1st Cir. 1982).<br><br>Continuous trigger for cases involving asbestosis and asbestos-related cancers - *Massachusetts Ins. Insolvency Fund v. Eastern Refractories Co.*, No. 89-4811 (Mass. Super. Ct., Suffolk County July 18, 1991). |
| Mich. | Manifestation for bodily injury for injurious gas - *Transamerica Ins. Co. v. Insurance Co. of North America,* 472 N.W.2d 5 (Mich. Ct. App. 1991).<br><br>Continuous trigger from date of implant for breast implants - *Dow Corning Corp. v. Granite State Insurance Co.*, No. 93-325788 (Mich. Cir. Ct., Wayne County Aug. 11, 1995). |
| Minn. | For tort claims the manifestation rule applies even though a claimant's medical disability was partially attributable to a disease that was already present but unmanifested when the policy was purchased - *Cohen v. North Am. Life & Cas. Co.*, 185 N.W. 939 (Minn. 1921).<br><br>Injury-in-fact for negligent elevator installation case - *Singsaas v. Diederich,* 238 N.W.2d 878 (Minn. 1976).<br><br>Exposure to formaldehyde - *Grinnell Mut. Reinsurance Co. v. Wasmuth*, 432 N.W.2d. 495 (Minn. Ct. App. 1988).<br><br>Continuous trigger from date of implant to onset of autoimmune disease, although the court in its order referred to an injury-in-fact trigger - *First State v. 3M,* No. C3-94-12780 (Minn. Dist. Ct., |

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| State | Bodily Injury Trigger |
|---|---|
| | Ramsey Co. July 11, 1996). |
| Miss. | No published decisions. |
| Mo. | Injurious exposure in asbestos case - *Standard Asbestos Mfg. & Insulation Co. v. Royal Indem. Ins. Co.,* CV80-14909, slip op. (Mo. Super. Ct. April 3, 1986).<br><br>Injury-in-fact in a Dioxin case - *Independent Petrochemical Corp., v. Aetna Cas. & Sur. Co.,* 654 F.Supp. 1334 (D.C. Cir. 1986), *aff'd in part, rev'd in part,* 944 F.2d 940 (D.C. Cir. 1991). |
| Mont. | No published decisions. |
| Neb. | No published decisions. |
| Nev. | No published decisions. |
| N.H. | Manifestation - *Mraz v. Canadian Universal Ins. Co.*, 804 F.2d 1325 (4th Cir. 1986). |
| N.J. | Injury-in-fact for drug case - *Hartford Acc. & Indem. Co. v. Aetna Life and Cas. Ins. Co.*, 483 A.2d 402 (N.J. 1984); *Sandoz, Inc. v. Employer's Liability Assurance Co.*, 554 F.Supp. 257 (D.N.J. 1983).<br><br>Injury-in-fact in dioxin/agent orange case - *Diamond Shamrock Chem. Co. v. Aetna Cas. & Sur. Co.*, 609 A.2d 440 (N.J. Super. 1992).<br><br>Continuous trigger applied to bodily injury claims from asbestos and welding fumes - *BOC Group Inc. v. Liberty Mutual Ins. Co.*, No. L-96840-88 (N.J. Super. Ct., Union County).<br><br>Continuous trigger for asbestos - *Owens-Illinois, Inc. v. United Ins. Co.*, 650 A.2d 974 (N.J. 1994). |

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| State | Bodily Injury Trigger |
|---|---|
| N.M. | No published decisions. |
| N.Y. | Manifestation was applied in a DES case - *Van Wyck Assoc. v. St. Paul Fire & Marine Ins. Co.*, 454 N.Y.S.2d 266 (N.Y. Super. Ct. 1982).<br><br>Exposure theory in lead poisoning - *Allstate Ins. Co. v. Colonial Realty Co.*, 468 N.Y.S.2d 800 (N.Y. Super. Ct. 1983).<br><br>Injury-in-fact applied to DDT bodily injury claims - *Olin Corp. v. Ins. Co. of North America*, 603 F.Supp. 445 (S.D.N.Y. 1985).<br><br>For tort claims - injury-in-fact for agent orange claims - *Uniroyal, Inc. v. Home Ins. Co.*, No. CV 84-3999 (Jan. 27, 1989).<br><br>Continuous exposure in asbestos case - *Stonewall Ins. Co. v. Nat. Gypsum Co.*, 1992 U.S. Dist. LEXIS 8898 (S.D.N.Y. June 22, 1992).<br><br>Injury-in-fact - *Stonewall Ins. Co. v. Asbestos Claims Mgt. Corp.*, 173 F.3d 1178 (2nd Cir. 1995); *Continental Cas. Co. v. Rapid-American Corp.*, 593 N.Y.S.2d 966 (1993).<br><br>Injury-in-fact applied in a DES case - *E.R. Squibb & Sons, Inc. v. Accident and Cas. Ins. Co.*, 853 F.Supp. 98 (S.D.N.Y. 1994), *clarified* 860 F. Supp. 124 (S.D.N.Y. 1994). |
| N.C. | Manifestation theory applied - *Peerless Ins. Co. v. Strother* 765 F. Supp. 866 (E.D.N.C. 1990).<br><br>Manifestation - asbestos bodily injury and property damage - *Imperial Casualty & Indem. Co. v. Radiator Specialty Co.*, 862 F.Supp. 1437 (E.D.N.C. 1994). |

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| State | Bodily Injury Trigger |
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| N.D. | No published decisions. |
| Ohio | Exposure - *B.F. Goodrich Co. v. American Motorists Ins. Co.*, No. C84-1224A, slip op. (N.D. Ohio 1987).<br><br>Continuous trigger for asbestos bodily injury claims - *Owens-Corning Fibreglass Corp. v. American Centennial Ins. Co.,* 660 N.E.2d 770 (Ohio C.P. 1995).<br><br>Exposure - The causal event creating injury or damage must occur during the policy period, and not the resultant damage - *Babcock & Wilcox Co. v. Arkwright - Boston Mfg. Mut. Ins. Co.*, 53 F.3d 762 (6th Cir. 1995), *rehrg. denied* (1995). |
| Okla. | Manifestation - For tort claims, the limitation period begins to run when the worker is aware or should be aware of some defect that is casually connected with the job - *Munsingwear, Inc. v. Tullis*, 557 P.2d 899 (Okla. 1976). |
| Or. | Continuous in a DES case - *Safeco Ins. Co. v. Great Am. Ins. Co.*, No. 87-664-JU, slip op. At 4 (D. Ore. July 14, 1992).<br><br>Injury-in-fact - occurrence was not the Archdiocese's negligent supervision of pedophile priest, but exposure of the boy to the negligently supervised priest - *Interstate Fire & Cas. Co. v. Archdiocese of Portland*, 35 F.3d 1325 (9th Cir. 1994). |
| Pa. | Double trigger in a DES case - *Transamerica Ins. Co. v. Bellefonte Ins. Co.*, 490 F.Supp. 935 (E.D. Pa. 1980).<br><br>Continuous - Coverage for asbestos is triggered if any part of the disease process from exposure through manifestation falls within the policy periods - *ACandS, Inc. v. Aetna Cas. & Sur.* |

| State | Bodily Injury Trigger |
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| | *Co.*, 764 F.2d 968 (3d Cir. 1985).<br><br>Continuous trigger for lead - *Gould, Inc. v. Continental Cas. Co.*, 585 A.2d 16 (Pa. Super. Ct. 1991).<br><br>Continuous - in delayed manifestation bodily injury cases - *Air Prods. & Chems. v. Hartford Acc. & Indem. Co.*, 707 F.Supp 762 (E.D. Pa.1989), *aff'd in part, vacated in part* 25 F.3d 177 (3d Cir. 1994).<br><br>Continuous - asbestos - *J.H. France Refractories Co. v. Allstate Ins. Co.*, 626 A.2d 502 (Pa. 1993). |
| R.I. | No published decisions. |
| S.C. | No published decisions. |
| S.D. | No published decisions. |
| Tenn. | No published decisions. |
| Tex. | Continuous trigger - *National Std. Ins. Co. v. Continental Ins. Co.*, No. CA-3-81-1015 D, slip op. (N.D. Tex. Oct. 4, 1983).<br><br>Exposure to asbestos/silicosis - *Clemtex Inc. v. Southeastern Fidelity Ins. Co.*, 807 F.2d 1271 (5th Cir. 1987).<br><br>Continuous trigger for asbestos - *Dayton Indep. School Dist. v. National Gypsum Co.*, 682 F.Supp. 1403 (E.D. 1988), *rev'd on other grounds*, 896 F.2d 865 (5th Cir. 1990).<br><br>Continuous trigger - *Gulf Chem & Metallurgical Corp. v. Associated Metals & Minerals Corp.*, 1 F.3d 365 (5th Cir. 1993). |

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| State | Bodily Injury Trigger |
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| | Continuous trigger beginning with date of implant for breast implants - *Bristol-Myers Squibb Co. v. AIU Insurance Co.*, No. A-145,672 (Tex. Dist. Ct., Jefferson County May 3, 1996). |
| Utah | No published decisions. |
| Vt. | Exposure - exposure to formaldehyde gas triggered duty to defend - *American Protection Ins. Co. v. McMahan*, 562 A.2d 462 (Vt. 1989). |
| Va. | No published decisions. |
| Wash. | No published decisions. |
| W.Va. | No published decisions. |
| Wis. | Exposure - DES - *Kremers-Urban Company v. American Employers Inc. Co.*, 351 N.W.2d 156 (Wis. 1984). |
| Wyo. | No published decisions. |

### *H. Damages and "As Damages"*

The insuring agreements in pre-1986 CGL policies typically provide that the insurance company will pay on behalf of the insured, excess of the underlying and/or retained limit, "all sums which the insured shall be obligated to pay by reason of the liability imposed upon the insured by law or liability assumed by the insured under contract or agreement for damages and expenses, because of personal injury or property damage."

In the early days of environmental insurance coverage litigation, insurers argued that governmental-ordered costs incurred in remediating contaminated property did not constitute legal "damages" as the term is used in CGL policies. Despite initial successes,[160] the "as damages"

160. *See, e.g.*, Patrons Oxford Mu. Ins. Co. v. Marois, 573 A.2d 16 (Me. 1990); A. Johnson & Co. v. Aetna Cas. & Sur. Co., 741 F. Supp. 298 (D. Mass. 1990); Troy Mills, Inc. v. Aetna Cas. & Sur. Co., No. 89-311 (N.H. Super. Ct. Feb. 14, 1990); Lido Co. of New England, Inc. v. Fireman's Fund Ins. Co., 574 A.2d 299 (Me. 1990); Technicon Electronics Corp. v. American Home Assurance Co., 533 N.Y.S.2d 91 (N.Y. App. Div. 1988), *aff'd*, 542 N.E.2d 1048 (N.Y. 1989); County of Broome v. Aetna Cas. & Sur. Co., slip op. at 20-21 (N.Y. Sup. Ct., June 24, 1988); Mraz v. Canadian Universal Ins. Co., 804 F.2d 1325 (4th Cir. 1986); Maryland Cas. Co. v. Armco, Inc., 822 F.2d 1348 (4th Cir.

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defense used in environmental cases has met with little success in recent times.[161] Except in cases involving governmental claims for injunctive

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1987), *cert. denied*, 484 U.S. 1008 (1988); Cincinnati Ins. Co. v. Milliken and Co., 857 F.2d 979 (4th Cir. 1988); Travelers Indem. Co. v. Allied-Signal, Inc., 718 F. Supp. 1252 (D. Md. 1989), *supp. op.*, 1989 U.S. Dist. LEXIS (D. Md. Aug. 4, 1989); Maryland Cup Corp. v. Employers Mut. Liab. Ins. Co. of Wis., 568 A.2d 1129 (Md. Ct. Spec. App. 1990); F. W. Scheper, III v. U.S. Fidelity & Guar. Co., No. 90-CP-07-879 (S.C. C. P., Beaufort Co. Oct. 29, 1991); Sangamo Weston, Inc. v. National Sur. Corp., No. 6:89-642-21 (D.S.C. October 28, 1992); Sangamo Weston, Inc. v. National Sur. Corp., 414 S.E.2d 127 (S.C. 1992); Cedar Chem. Corp. v. American Universal Ins. Co., No. 87-2838-4B, mem. op. at 6 (W.D. Tenn. Sept. 13, 1989); Verlan, Ltd. v. John L. Armitage & Co., 695 F. Supp. 950, 954 (N.D. Ill. 1988); Ulrich Chem., Inc. v. American States Ins. Co., No. 73C01-8901-CP-016 (Ind. Cir. Ct., Shelby County July 26, 1990); Maryland Cas. Co. v. Ormond, No. 87-3038, slip op at 12 (W.D. Ark. Jan. 6, 1989); Grisham v. Commercial Union Ins. Co., No. 88-3063 (W.D. Ark. Feb. 9, 1989); Parker Solvents Co., Inc. v. Royal Ins. Cos., No. 89-2293 (W.D. Ark. July 3, 1990); Continental Ins. Co. v. Northeastern Pharm. & Chem. Co., 842 F.2d 977, 983-984 (8th Cir. 1988); Aetna Cas. & Sur. v. General Dynamics Corp., No. 88-2220C (A) (E.D. Mo., Eastern Div. Jan. 23, 1991; Becker Metals Corp. v. Transportation Ins. Co., No. 91-0802 C (E.D. Mo. Sept. 25, 1992).

161. *See, e.g.*, Coakley v. Maine Bonding and Cas. Co., No. 89-E-87 (N.H. Super. Ct. Aug. 3, 1990); Hazen Paper Co. v. U.S. Fidelity & Guar. Co., 555 N.E.2d 576 (Mass. 1990); Kutsher's Country Club Corp. v. Lincoln Ins. Co., 465 N.Y.S.2d 136, 137-39 (N.Y. Spec. Term 1983); Avondale Indus. v. Travelers Indem. Co., 887 F.2d 1200 (2d Cir. 1989); New Castle County v. Hartford Accident & Indem. Co., 673 F. Supp. 1359, 1366 (D. Del. 1987); New Castle County v. Hartford Accident & Indem. Co., 685 F. Supp. 1321 (D. Del. 1988); Chesapeake Utilities Corp. v. American Home Assurance Co., 704 F. Supp. 551 (D. Del. 1989); New Castle County v. Continental Cas. Co., 725 F. Supp. 800 (D. Del. 1989), *rev'd in part, aff'd in part and remanded*, 933 F.2d 1162 (3d Cir. 1991); Broadwell Realty Services, Inc. v. Fidelity & Cas., 528 A.2d 76 (N.J. Super. Ct. App. Div. 1987); Township of Gloucester v. Maryland Cas. Co., 668 F. Supp. 394 (D.N.J. 1987), *summary judgment gr.*, Township of Gloucester v. Maryland Cas. Co., 702 F. Supp. 1126 (D.N.J. 1988); Jones Truck Lines v. Transport Ins. Co., No. 88-5723, 1989 U.S. Dist. LEXIS 5092 (E.D.Pa. May 10, 1989); Bausch & Lomb v. Utica Mutual Ins. Co., 625 A.2d 1021 (Md. 1993); C.D. Spangler Constr. Co. v. Industrial Crankshaft & Eng'g. Co., 388 S.E.2d 557 (N.C. 1990); Liberty Mutual Ins. Co. v. Triangle Indus., 390 S.E.2d 562 (W. Va. 1990); Hudson Ins. Co. v. Double D Management Co., 768 F. Supp. 1542 (M.D. Fla. 1991); U.S. v. Pepper's Steel & Alloys, 823 F. Supp. 1574 (S.D. Fla. 1993); U.S. Aviex Co. v. Travelers Ins. Co., 336 N.W.2d 838 (Mich. Ct. App. 1983); Fireman's Fund Ins. Co. v. Ex-Cell-O Corp., 662 F. Supp. 71 (E.D. Mich. 1987), *summ. judgment granted, in part*, 702 F. Supp. 1317 (E.D. Mich 1988); U.S. Fidelity & Guar. Co. v. Thomas Solvent Co., 683 F. Supp. 1139, 1168 (W.D. Mich. 1988), *vacated*, 1988 U.S.Dist. LEXIS 3560 (W.D. Mich. Mar. 16, 1988); Polkow v. Citizens Ins. Co., 447 N.W.2d 853 (Mich. Ct. App. 1989), *rev'd*, 438 Mich. 174, 6 N.W.2d 382 (1991); Upjohn Co. v. Aetna Cas. and Sur. Co., No. K88-124 CA4 1990 U.S. Dist. LEXIS 6724 (W.D. Mich. June 4, 1990), *reconsideration denied*, 768 F. Supp. 1186 (W.D. Mich. 1991); Minnesota Mining and Mfg. Co. v. Travelers Indem. Co., 457 N.W.2d 175 (Minn. 1990); U.S. Fidelity & Guar. Co. v. Specialty Coatings Co., 535 N.E.2d 1071 (Ill. App. Ct. 1989); Outboard Marine Corp. v. Liberty Mut. Ins. Co., 607 N.E.2d 1204 (Ill.

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relief, restitution[162] or unjust enrichment,[163] it is unlikely that an "as damages" defense to coverage will be successful.

The number of diseases connected with tobacco is considerable, as noted above. Many of these diseases have periods of latency or delayed onset of symptoms. That suggests that medical monitoring costs may become a component of damages in tobacco-related "smoking and health" cases. A number of courts have permitted the awarding of medical monitoring costs under circumstances less applicable than those involving

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1992); Aetna Cas. & Sur. Co. v. Nuclear Eng'g. Co., No. 87CI03359 (Ky. Cir. Ct., Jefferson Co., Div. 5 January 4, 1995); A.Y. McDonald Indus., Inc. v. Ins. Co. of North America, 475 N.W.2d 607 (Iowa 1991); Independent Petrochemical Corp. v. Aetna Cas. & Sur. Co., 944 F.2d 940, 292 App. D.C. 19 (D.C. Cir. 1991); Intel Corp. v. Hartford Accident and Indem. Co., 692 F. Supp. 1171 (N.D. Cal. 1988), *aff'd in part, rev'd in part*, 952 F.2d 1551 (9th Cir. 1991); Commercial Union Ins. Co. and American Employers' Ins. Co. v. Harold S. Taxel, et al., No. 87-336-S (S.D.Cal. August 22, 1988); Aerojet-General Corp. v. San Mateo County Superior Court, 257 Cal. Rptr. 621 (Cal. Ct. App. 1989); AIU Ins. Co. v. Superior Court (FMC Corp.), 799 P.2d 1253 (Cal. 1990); Aetna Cas. and Sur. Co., Inc. v. Pintlar Corp., 948 F.2d 1507 (9th Cir. 1991), *amended* 1991 U.S. App. LEXIS 30068 (9th Cir. Dec. 30, 1991); Aetna Cas. & Sur. v. Gulf Resources & Chem. Corp., 709 F. Supp. 958 (D. Idaho 1989); Boeing Co. v. Aetna Cas. & Sur. Co., 784 P.2d 507 (Wash. 1990); Compass Ins. Co. v. Cravens, Dargan & Co., 748 P.2d 724, 728-730 (Wyo. 1988); United States Fidelity Guar. Co. v. Colorado Nat'l Bank, No. 86-Z-1033, slip op. at 5 (D. Colo. Nov. 4, 1988); Broderick Invest. Co. v. Hartford Accident & Indem. Co., 742 F. Supp. 571 (D. Colo. 1989), *rev'd*, 954 F.2d 601 (10th Cir. 1992), *cert. deinied*, 506 U.S. 865 (1992); Cessna Aircraft Co. v. Hartford Accident and Indem. Co., No. 91-2346-KHV, 1993 U.S. Dist. LEXIS 3032 (D. Kan. Feb. 17, 1993); Potomac Electric Power Co. v. California Union Ins. Co., 777 F. Supp. 980 (D.D.C. 1991).

162. In *Bank of the West*, 833 P.2d at 545, the California Supreme Court held that claims for restitution under California's Unfair Business Practices Act were not claims for "damages." *Bank of the West* teaches: "[O]ne may not insure against the risk of being ordered to return money or property that has been wrongfully acquired. Such orders do not award "damages" as that term is used in the insurance policies. . . . When the law requires a wrongdoer to disgorge money or property acquired through a violation of the law, to permit the wrongdoer to transfer the cost of disgorgement to an insurer would eliminate the incentive for obeying the law. Otherwise, the wrongdoer would retain the proceeds of his illegal acts, merely shifting his loss to an insurer." *Id.*

163. In its case against the tobacco industry, the State of Mississippi alleges: "In equity and fairness, it is the defendants, not the taxpayers of Mississippi, who should bear the costs of tobacco inflicted diseases. By avoiding their own duties to stand financially responsible for the harm done by their cigarettes, the defendants wrongfully have forced the State of Mississippi to perform such duties and to pay the health care costs of tobacco-related disease. As a result, the defendants have been unjustly enriched to the extent that Mississippi's taxpayers have had to pay these costs." Such claims are probably not covered by insurance.

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tobacco.[164] Others will undoubtedly require some affirmative showing that illness, sickness or disease is likely to occur as a consequence of smoking or exposure to second-hand smoke.[165]

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164. *See, e.g.*, *In re* Moorenovich, 634 F. Supp. 634 (D. Me. 1986) (permitting recovery for fear of cancer without present physical injury.); Anderson v. W.R. Grace & Co., 620 F. Supp. 1219 (D. Mass. 1986) (ruling that evidence of minor injuries such as headaches, nausea and the like, were sufficient to establish present physical injury.); Ferrara v. Galluchio, 152 N.E.2d 249 (N.Y. 1958).

In *Ferrara*, the plaintiff suffered an X-ray burn and then was informed by a dermatologist that the area of the burn might become cancerous. Plaintiff sought to recover for the severe cancerphobia she subsequently developed. The court permitted recovery, finding it to be "entirely plausible, under such circumstances, that plaintiff would undergo exceptional mental suffering over the possibility of developing cancer." *Id.* at 252. Therefore, the court focused upon whether the emotional distress was genuine, as opposed to whether there was a physical injury. *See also* Stead v. F. E. Myers Co. Div. of McNeil Corp., 785 F. Supp. 56 (D. Vt. 1990) (refusing to exclude testimony of experts about an increased risk of cancer from exposure to transformer oil even though the experts could not quantify the increased risk to a reasonable degree of medical certainty, where the purpose of such testimony was limited to the recoverability of medical monitoring costs, not damages for an increased risk of cancer); Herber v. Johns-Manville Corp., 785 F.2d 79 (3rd Cir. 1986) (finding that the fact of exposure to a toxic substance was sufficient to satisfy the present physical injury requirement, thereby allowing recovery for fear of cancer); Villari v. Terminix Int'l, Inc., 677 F. Supp. 330 (E.D. Pa. 1987) (holding that evidence of minor injuries such as headaches, nausea and the like, were sufficient to establish present physical injury); Merry v. Westinghouse Elec. Co., 684 F. Supp. 847, 849 (M.D. Pa. 1988)

In *Merry*, the court quoted Ayers v. Jackson Township, 461 A.2d 184, 190 (N.J. Super. Ct. Law Div. 1983), *aff'd in part and rev'd in part*, 525 A.2d 287 (1987) and stated the following:

> Damages may be recovered for the prospective consequences of a tortious injury. It is not the reasonable probability of whether plaintiffs will suffer cancer in the future that should determine whether medical surveillance is necessary. Rather, it is whether it is necessary, based on medical judgment, that a plaintiff who has been exposed to known carcinogens at various levels should undergo annual medical testing in order to properly diagnose the warning signs of the development of the disease. If it is necessary, then the probability of the need for that medical surveillance is cognizable as part of plaintiffs' claim.

Accordingly, the fact of exposure to a toxic substance was deemed sufficient to satisfy the present physical injury requirement, thereby allowing recovery for fear of cancer. *See also In re* Paoli R. Yard PCB Litig., 916 F.2d 829 (3rd Cir. 1990) (holding that experts may testify about an increased risk of cancer which is unquantifiable but will require medical monitoring for many years even though the experts could not quantify the increased risk to a reasonable degree of medical certainty, when the purpose of such testimony is to permit the plaintiff to recover the cost of medical monitoring); Ball v. Joy Tech., Inc., 958 F.2d 36 (4th Cir. 1991)

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In the *Ball* case, the plaintiffs sought medical monitoring costs designed to facilitate early detection of disease caused by exposure to toxic chemicals. Applying West Virginia and Virginia law, the court held that:

> damages for emotional distress may be recovered in three specific instances: (1) where the emotional disturbance results from an actual physical injury caused by the impact or occurrence of the tort; (2) where there is no initial impact or injury but physical injury thereafter results as the causal effect of the defendant's wrong; and (3) where there is no impact or physical injury but emotional disturbance results from an intentional or wanton wrongful act caused by the defendant.

*Id.* at 38.

In Hagerty v. L&L Marine Servs., Inc., 788 F.2d 315 (5th Cir. 1986), recognizing a plaintiff's right to recover for future reasonable medical expenses and the avoidable consequences rule, which requires a party to submit to treatment that is medically advisable or else be barred from future recovery for a condition that could have been alleviated or avoided, the court found that it was proper to include in a damage award the reasonable cost of periodic medical check-ups to the extent that, "in the past, they were medically advisable and, in the future, will probably remain so." *Id.* at 319. The court permitted recovery for fear of cancer in the absence of present physical injury, noting that an increase in risk cannot be characterized as a physical injury and is not compensable unless there is evidence that it is probable that the disease will occur. Also, in Laxton v. Orkin Exterminating Co., *Inc.*, 639 S.W.2d 431 (Tenn. 1982), the jury awarded fear of cancer plaintiffs approximately $6,000 each. The fact of exposure to a toxic substance was deemed sufficient to satisfy the present physical injury requirement, thereby allowing recovery for fear of cancer. The damage award included recovery for the anxiety parents suffered as a result of their children's exposure to toxic chemicals.

In Molien v. Kaiser Found. Hosp., 616 P.2d 813 (Cal. 1980), the California Supreme Court determined that damages for negligently inflicted emotional distress could be recovered even where there was no physical injury. In that case, the primary justification for the physical injury requirement—to guard against false claims—was criticized by the court as unnecessary. *Id.* at 818. The court reasoned that the requirement encouraged extravagant pleading and distorted testimony, was overinclusive because it allowed recovery even where the physical injury was trivial, and was underinclusive because "it mechanically denies court access to claims that may well be valid and could be proved . . ." *Id.* at 820; *see also* Arnett v. Dow Chem. Corp., No. 729586 (Cal. Super. Ct., San Francisco County, 1983). (requiring plaintiffs to introduce evidence of the possible carcinogenic nature of the chemical to which they had been exposed in order to establish the reasonableness of a present fear of cancer, but not requiring evidence of present physical injury.); Clark v. United States, 8 Cl. Ct. 649 (Cl. Ct. 1985), *later proceeding*, 660 F. Supp. 1164 (W.D. Wash. 1987), *aff'd*, 856 F.2d 1433 (9th Cir. 1988) (holding that any type of emotional distress may be considered reasonable for fear of cancer purposes).

165. *See, e.g.*, Payton v. Abbott Labs, 437 N.E.2d 171, 180-181 (Mass. 1982) (holding that proof of a discernible physical injury is required to recover damages for fear of cancer); Caputo v. Boston Edison Co., 924 F.2d 11, 13 (1st Cir. 1991) (holding that the plaintiff, who had not suffered any physical illness or disease as a result of his radiation exposure could not recover for fear of cancer); Plummer v. Abbott Labs., 568 F. Supp. 920 (D.R.I.

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1983) (denying recovery to DES mothers for their anxiety associated with the present or future medical problems of their daughters); Wisniewski v. Johns-Manville Corp., 759 F.2d 271, 274 (3d Cir. 1985), *appeal after remand,* 812 F.2d 82 (1987) (holding that in order to recover for fear of cancer, proof of a discernible physical injury must be proved); Schweitzer v. Consolidated Rail Corp., 758 F.2d 936 (3d Cir. 1985) (holding that an increased risk of cancer or disease is not physical injury and cannot be compensated unless it can be proved by a preponderance of the evidence that it is probable that the disease will occur); Manzi v. H. K. Porter Co., 587 A.2d 778 (Pa. 1991) (holding that the plaintiff, who had no manifest asbestos-related injuries could not recover for fear that he might contract cancer from his exposure to asbestos); Morrissy v. Eli Lilly & Co., 394 N.E.2d 1369, 1376 (Ill. App. Ct. 1979) (holding that an increased risk of cancer or disease is not physical injury and cannot be compensated unless it can be proved by a preponderance of the evidence that it is probable that the disease will occur); DeStories v. Phoenix, 744 P.2d 705, 707 (Ariz. 1987) (holding that an increase in risk cannot be characterized as a physical injury and is not compensable unless there is evidence that it is probable that the disease will occur); Potter v. Firestone Tire & Rubber Co., 863 P.2d 795 (Cal. 1993)

In *Potter,* by way of a 4-3 decision, the California Supreme Court reversed the judgment of the Court of Appeal insofar as it affirmed the award of punitive damages and the award of damages for plaintiffs' fear of cancer, and reversed the award for future medical monitoring. "[G]enerally, in the absence of a present physical injury or illness, recovery of damages for fear of cancer in a negligence action should be allowed only if the plaintiff pleads and proves that the fear stems from a knowledge, corroborated by reliable medical and scientific opinion, that it is more likely than not that the feared cancer will develop in the future due to the toxic exposure. We also conclude, however, that an exception to this general rule is warranted if the toxic exposure that has resulted in the fear of cancer is caused by conduct amounting to 'oppression, fraud, or malice' as defined in Civil Code section 3294. In such cases, a plaintiff should be allowed to recover without having to show knowledge that it is more likely than not that the feared cancer will occur, so long as the plaintiff's fear is otherwise serious, genuine and reasonable. *Id.* at 800.

In Rodrigues v. State, 472 P.2d 509, 520 (Haw. 1970), the Supreme Court of Hawaii stated :

> It is universally agreed that there are compelling reasons for limiting the recovery of the plaintiff to claims of serious mental distress. The reasons offered to limit recovery are that mental distress of a trivial and transient nature is part and parcel of everyday life in a community, that under certain circumstances social controls may deal more effectively with mental distress, that some kinds of mental distress may have a beneficial therapeutic effect, that the law should not penalize the 'prime mover' in society nor curry to neurotic patterns in the population. We believe these reasons are to be considered by the jury and the court with the particular facts of each case in applying the 'reasonable [person]' standard . . ."

*Id.* at 520 (citations omitted); *see also In re* Hawaii Fed. Asbestos Cases, 734 F. Supp. 1563, 1567 (D. Haw. 1990) (requiring an "objectively verifiable" legal standard and held that plaintiff must show a "functional impairment" due to exposure to asbestos in order to recover for fear of cancer); O'Banion v. Owens-Corning Fiberglass Corp., 968 F.2d 1011

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## III. INDEMNITY

From the standpoint of indemnity, and assuming a finding of liability, the defenses to coverage which are readily apparent are: (1) whether the injuries were expected or intended; (2) whether the loss is covered under the terms of the policy; (3) whether a particular policy applies, *i.e.*, is triggered; and (4) whether a pollution exclusion is applicable, although trying to use a pollution exclusion may be difficult depending upon the type of exclusion and the specific facts of each case, as mentioned above.

The "expected or intended" defense may be difficult to sustain with respect to peripheral defendants that serviced the tobacco industry and were not involved with manufacturing the product and did not prepare or become involved in studies relating to the effects of tobacco on health. Much will depend on the specific facts of each case and the nature and extent of knowledge held by specific peripheral defendants.

The "covered loss" issue may also be problematic. It can be argued that damages sustained as a result of tobacco-related lawsuits brought by governmental entities do not constitute "bodily injury," "property damage," "personal injury" or "advertising injury." Rather, the damages are economic loss which is not covered.[166]

## IV. DUTY TO DEFEND

The likelihood of lengthy and expensive insurance coverage litigation arising from underlying "tobacco and health" cases seems inevitable. If so, primary insurers, or those excess insurers who are found to have a duty to defend, will be particularly hard hit. There is increasing evidence that the

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(10th Cir. 1992) (applying Oklahoma law and holding that a plaintiff must prove an actual disease or evidence of a reasonable medical probability of developing a disease in order to recover for fear of cancer.); Eagle-Picher Industries, Inc. v. Cox, 481 So. 2d 517, 528-529 (Fla. Dist. Ct. App. 1985) (holding that in order to recover for fear of cancer, proof of a discernible physical injury must be proved).

166. *See, e.g.,* Giddings v. Indus. Indem. Co., 169 Cal. Rptr. 278, 281 (Cal. Ct. App. 1981); California Shoppers, Inc. v. Royal Globe Ins. Co., 221 Cal. Rptr. 171 (Cal. Ct. App. 1985); Fragomeno v. Ins. Co. of the West, 255 Cal. Rptr. 111 (Cal. Ct. App. 1989); Aim Ins. Co. v. Culcasi, 280 Cal. Rptr. 766 (Cal. Ct. App. 1991); Loyola Marymount v. Hartford Accident & Indem. Co., 271 Cal. Rptr. 528 (Cal. Ct. App. 1990); Federal Ins. Co. v. Central Diagnostic Lab., 972 F.2d 1338 (9th Cir. 1992); Chatton v. National Union Fire Ins. Co., 13 Cal. Rptr.2d 318 (Cal. Ct. App. 1992); Horsemen's Benevolent & Protective Ass'n v. Ins. Co. of N. Am., 271 Cal. Rptr. 838 (Cal. Ct. App. 1990); American States Ins. Co. v. Canyon Creek, 786 F. Supp. 821 (N.D. Cal. 1991); San Diego Nat'l Bank v. Continental Ins. Co., No. 91-CV-1842 (S.D. Cal. October 21, 1992); Waller v. Truck Ins. Exch., 32 Cal. Rptr.2d 692 (Cal. Ct. App. 1994), *aff'd*, 900 P.2d 619 (Cal. 1995).

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policyholders' bar is gearing up for the fight. For example, the law firm formerly known as Anderson, Kill, Olick & Oshinsky - well known in environmental insurance coverage circles - has already authored at least one article suggesting that insurance coverage may be available for tobacco manufacturers and others, including the categories of peripheral defendants mentioned above. In a recent article, two authors from Anderson, Kill gave the following advice:

> There are two steps that any entity faced with being brought into these cases should take to preserve its insurance. First and foremost, an entity named as a defendant in one of these lawsuits, or with reasonable belief that it may be drawn into these cases, immediately should provide notice to its insurance companies. The importance of notice cannot be emphasized enough. In some jurisdictions, a policyholder's failure to provide timely notice to its insurance company may excuse the insurance company from providing a defense or indemnification.
>
> Second, a policyholder should search for all potentially applicable insurance policies. Many different types of insurance potentially provides protection for the tobacco lawsuits. For example, comprehensive general liability insurance, errors-and-omissions insurance, or directors-and-officers insurance, to name a few, may provide for defense or indemnification of the tobacco lawsuits. The search for potentially applicable insurance policies should not be limited to present policies. The allegations in many of the tobacco lawsuits relate back to the 1950s or earlier. Therefore, all policies in effect from the beginning of the alleged conduct to the present should be examined carefully for coverage. . . .
>
> If drawn into the tobacco litigation, a policyholder should make a demand for a defense from its insurers. One of the most valuable components in a liability insurance policy is the requirement that the insurance company defend or pay the policyholder's defense costs if there is simply the potential for coverage. This part of liability insurance has

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> been called "litigation insurance." A policyholder is entitled to a defense if any one allegation in the complaint potentially asserts a covered claim.[167]

Other policyholders' counsel are sure to follow as the underlying litigation heats up.

One of the most difficult issues facing insurers will be how to handle the duty to defend. While the standard for determining whether a duty to defend exists may vary somewhat between jurisdictions, the majority view is that when the potential for coverage exists, then the insurer has a duty to defend. The duty will fall initially on the primary insurer during whose policy period an occurrence took place. As noted above, however, if one applies a continuous trigger of coverage, many years of coverage and multiple primary insurers could easily be impacted. Once a duty to defend attaches, it requires the insurer to defend the entire case, not just those portions which may be covered by insurance.

Some jurisdictions hold that the duty to defend is determined exclusively by the four corners of the complaint. Others include any extrinsic knowledge obtained by the insurer in determining whether a duty to defend exists. California is the strictest of all the states, requiring that the insurer defend if there is even a remote possibility of coverage based on the complaint and all known facts surrounding the claim.

Even though insurers may have strong defenses to coverage, a defense will nevertheless have to be provided. The costs of defending tobacco litigation are expected to be huge, equaling or surpassing those incurred in connection with asbestos litigation. The population of potential plaintiffs is far greater and the medical issues are more complex.

It has been reported that a number of the major tobacco manufacturers are offering to defend and indemnify their distributors. While this is seemingly a boon for insurers who may have issued policies without tobacco exclusions to distributors, it is a two-edged sword.

Obvious conflicts of interest exist between tobacco manufacturers and distributors. Manufacturers have long had a highly sophisticated research and development program, as well as public relations and legal programs. It is now being alleged that the tobacco manufacturers deliberately misled the public, produced erroneous reports, and hid harmful documents or

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167. Andrew M. Reidy & Robert L. Carter, *Insurance Coverage — The Last Hope For Policyholders Caught Up In The New Wave Of Tobacco Litigation*, MEALEY'S LITIGATION REPORTER (INSURANCE), May 2, 1995.

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destroyed them altogether. If any of such allegations are proven to be true, it would certainly not be in the interests of a distributor to be tarred with the same brush as the manufacturer.

## V. SPECULATION ABOUT THE FUTURE

Whether the tobacco manufacturers can survive under the weight of the litigation facing them, and for how long, remains to be seen. The current situation is reminiscent of the early days of asbestos litigation when asbestos manufacturers gladly defended and, in some cases, indemnified their distributors. But then those asbestos manufacturers were gone, usually by bankruptcy and reorganization, but sometimes by merger and acquisition. Regardless of the means of disappearance, the distributors were left to their own devices and once again turned to their insurers.

The result was insurers being forced to take over litigation which had been in progress for years. The expenses were enormous and very few underlying cases were won. Juries had been hopelessly tainted in many cases because of an onslaught of negative publicity and bad public opinion. When insurers contested coverage, or sought to limit their exposure, the courts generally turned a deaf ear. That scenario is unlikely to develop in tobacco-related litigation.

There remains considerable doubt as to whether insurance coverage will ever be available for tobacco-related claims. At least one commentator has asserted publicly that no tobacco-related claim can ever be covered because the dangers of tobacco have been well-recognized for centuries.[168]

It has been widely reported in the press that the tobacco industry, which up to now has vigorously resisted attempts by the FDA to regulate tobacco as a drug, may in fact change their tune and agree to such regulation in exchange for some type of liability limiting law at the federal level.[169] There seems little likelihood that Congress would - or could - agree to any type of liability limitations in the present political climate. Any such limitations, even if enacted, would be subject to certain challenge by anti-smoking groups. Moreover, it is highly questionable whether any such legislation could be made retroactive so as to eliminate the current tidal wave of litigation being faced by the tobacco industry.

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168. *See, e.g.*, Kimball A. Lane, *Insurance Coverage for Tobacco and Tobacco-Related Litigation and Liability: Distinct Coverage Approaches for Component Part Manufacturers*, Fulcrum Information Services, Inc., New York (1996).

169. *See* Gail Appleson, *Suits or Truce for Tobacco Makers in 1997?*, REUTERS FINANCIAL SERVICE, Dec. 30, 1996.

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Third World sales may eventually return to haunt American tobacco companies, much like the sale to Third World countries of pesticides banned in the United States came back to haunt Dow Chemical Company and others. As long as U.S. courts are willing to entertain lawsuits by foreigners against U.S. companies, the threat cannot be ignored.

Whatever the final outcome may be, it will not be quick, easy or inexpensive. Years of contentious litigation lie ahead for both tobacco manufacturers and the insurance industry. Some of today's players will undoubtedly disappear while new ones will take to the field. When the dust finally settles, the landscape will unquestionably be markedly different from that we see today.

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# EMPHASIZING CONDUCT OVER CONTEXT AND MARKET DEFINITION OVER MARKET POWER: SHORT-TERM STRATEGIC ANTICOMPETITIVE BEHAVIOR ABSOLVED IN *BLUE CROSS V. MARSHFIELD CLINIC*[1]

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1. Blue Cross & Blue Shield United of Wis. v. Marshfield Clinic, 65 F.3d 1406 (7th Cir. 1995), *cert. denied,* 116 S. Ct. 1288 (1996).

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## INTRODUCTION

In recent years the use of economic analysis in antitrust law has frequently operated to validate much corporate conduct which the courts had previously regarded with great suspicion.[2] Such economic analysis is advantageous as it allows the courts to engage in more sophisticated and consistent analysis of the various markets.[3] However, the application of so-called "Chicago School"[4] economic reasoning may legitimize many questionable business practices.[5]

Some scholars suggest that the reason for the overlegitimization phenomenon is twofold. First, the economic efficiency model employed by proponents of the Chicago School seeks to validate market behavior in the presence of any indication of economic efficiency or procompetitive effects. Since procompetitive effects may be postulated in almost any market action, nearly every business practice could be found to be

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2. Barbara Ann White, *Countervailing Power -- Different Rules for Different Markets? Conduct and Context in Antitrust Law and Economics*, 41 DUKE L.J. 1045, 1046 (1992); Herbert Hovenkamp, *Antitrust Policy After Chicago*, 84 MICH. L. REV. 213, 217-18 (1985); Thomas A. Piraino, *Reconciling the Per Se and Rule of Reason Approaches to Antitrust Analysis*, 64 S. CAL. L. REV. 685, 686 (1991).

3. White, *supra* note 2, at 1046, 1047.

4. The Chicago School of antitrust analysis is based fundamentally on price theory - all markets are driven by price. Proponents of the Chicago School assert that meaningful barriers to entry generally do not exist, if the market price is supracompetitive it will attract new entrants. As such, the Chicago School gives little acknowledgment to the issue of strategic anticompetitive behavior since such behavior will be ineffective in the long run. The attraction of higher prices will overcome the restrictions imposed by any anticompetitive strategic behavior. Only those actions which interfere directly with price or market pricing mechanisms are suspect in antitrust in the view of Chicago School proponents. For a general overview of the "Chicago School" model, see Richard A. Posner, *The Chicago School of Antitrust Analysis*, 127 U. PA. L. REV. 925, 925-30 (1979); *see also* Frank H. Easterbrook, *Vertical Arrangements and the Rule of Reason*, 53 ANTITRUST L.J. 135 (1984) observing that:

> The premise underlying the Chicago philosophy is that all markets fundamentally operate atomistically and that atomistic forces will undermine any efforts by businesses to interfere with them. . . . Implicit in the Chicago School philosophy is that, with the exception of restraints that limit output, corporate endeavors are procompetitive by necessity. . . . the restraints that firms engage in must exist to serve those ends and therefore must necessarily be efficient.

White, *supra* note 2, at 1063-64.

5. *Id.* at 1065.

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legitimate.[6] Second, some argue that the economic efficiency model assumes that market conditions are static,[7] apart from the complained about behavior. Such a doctrinal position fails to account for short-term strategic anticompetitive behavior.[8] Some firms may engage in conduct which has no other purpose than to economically harm competitors with no commensurate gain in market efficiency. One form of such behavior cited by Professor Hovenkamp occurs when a dominant firm imposes higher costs in the market which have greater impact on smaller firms, or potential entrants, than on itself.[9] Curiously, as is described *infra*,[10] this is precisely the type of behavior which Blue Cross alleged against the Marshfield Clinic and which was absolved by the Seventh Circuit employing Chicago School price theory.[11]

Operating in rural north central Wisconsin, the Marshfield Clinic allegedly charged supracompetitive prices in one product market, its fee-for-service medical services, which it sold to Blue Cross and other health care insurers.[12] Marshfield then bought medical services in another market, its HMO affiliated physicians, paying an attractive price which was "fixed" by most favored nations contract clauses.[13] Blue Cross contended that it

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6. *Id.*

7. Hovenkamp illustrates the static market fallacy by describing the host of factors which impinge on the health insurance market in Kartell v. Blue Shield of Mass., Inc., 749 F.2d 922 (1st Cir. 1984), *cert. denied*, 471 U.S. 1029 (1985). Viewing the market both before and after the questioned conduct and determining that the market appears to be efficient does not logically presume that one such variable must then be procompetitive. One can not possibly know for certain what other variables might have impacted the market causing it to appear to be efficient. Thus, such a simplistic analysis tends to validate nearly all conduct as pro rather than anticompetitive. *See generally* Hovenkamp, *supra* note 2.

8. "Strategic behavior is conduct designed by the actor to reduce the attractiveness of the offers against which it must compete. Not all strategic behavior is socially harmful. . . . and raises antitrust concerns when it reduces the attractiveness of the offers against which the strategizing firm must compete without producing substantial gains in productive efficiency to the strategizing firm. When socially harmful strategic behavior is successful, the firm engaging in the behavior earns monopoly profits and competitors (or potential competitors) and customers pay the bill." *See* Hovenkamp, *supra* note 2, at 261.

9. *Id.* at 262. Although the increased costs apply equally to all market participants, the increased costs impose a greater burden to those attempting to enter the market or to those who lack sufficient resources to withstand the cost increase.

10. *See infra* notes 104-06 and accompanying text. Although higher prices typically might represent an opportunity for market entry, higher prices which are maintained at a "floor" level by means of most favored nations clauses represent a significant barrier to market entry.

11. *See Marshfield*, 65 F.3d at 1415.

12. *Id.*

13. *Id.* at 1257.

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was both overcharged for specialty medical services which the Marshfield Clinic monopolized in the region and that the Clinic created anticompetitive barriers to market entry in the HMO health care market.[14] The Seventh Circuit's use of Chicago School analysis overlooks the interplay of these two transactions and the strategic opportunity to balance one against the other.

The simplistic view of Chicago School price theory ignores opportunities for strategic anticompetitive behavior.[15] Inefficient or anticompetitive behavior which the Chicago School assumes is irrational, may be strategically effective if it raises costs which create barriers to entry. Judicial approval of otherwise anticompetitive conduct is further exacerbated when courts couch their rulings in terms of the questioned conduct and ignore market context. The combination of reliance on the economic efficiency model which tends to validate any conduct with any hypothesized procompetitive effect, along with diminishing the nuances of market context, ratifies potentially anticompetitive conduct which may then be exported via judicial precedent to those markets where it may cause more damage.[16]

Against this backdrop we now view the evolving health care market and the emergence of health maintenance organizations (hereinafter, HMOs)[17] which by their nature form collaboratives of competitors to provide a complete package of health care services and health care

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14. 883 F. Supp at 1247; 65 F.3d at 1408.

15. Herbert Hovenkamp, *Rhetoric and Skepticism in Antitrust Argument*, 84 MICH. L. REV. 1721, 1723-24 (1986); *see also* Frank H. Easterbrook, *Workable Antitrust Policy*, 84 MICH. L. REV. 1696, 1700-01 (1986).

16. White, *supra* note 2, at 1066-67. Professor White notes that the courts do not completely ignore the ramifications of market context. In order to fashion efficient jurisprudence, however, the courts need to construct rulings which are not so narrow as to have limited precedential value (i.e. not every case is a special case) but which do not overlook important and dispositive contextual issues.

17. The HMO is a method of joining physicians in a firm or network in conjunction with one or more hospitals and then packaging the "product" as a method of financing the prospective payment of health care. HMO physicians are frequently paid a salary, devoting their entire medical practice to the service of HMO members. HMO members are confined to the HMO network for all of their health care needs.

PPOs (Preferred Provider Organizations) are similar to HMOs in that they create a network of service providers and offer the use of the network as a method of prospectively purchasing all necessary health care. PPOs differ from HMOs in that they are more like discount purchasing cooperatives. Members are free to avail themselves of the discount services for which they have prospectively paid or members may also seek medical treatment from non-network providers at less attractive reimbursement rates.

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financing.[18] By design, HMOs must horizontally integrate panels of doctors, vertically integrate physician services, hospital services and insurance programs, and coordinate pricing arrangements among the various components. This structural change in the industry occurs at a time where the health care market is dominated in many sections of the country by relatively few very large players, very often Blue Cross & Blue Shield.[19] Although health care providers nearly always participate in such arrangements on a nonexclusive basis, market forces and practical necessities frequently impose unseen restraints on the market behavior of the various participants. The issue then becomes whether certain market behaviors are motivated by an earnest desire to compete or by the desire to exploit perverse incentives in an anticompetitive way to protect monopolistic or oligolopolistic market power.

This Note considers the context of the health care and HMO markets in an effort to demonstrate that the unique characteristics of the market present unusual opportunities for market distortion.[20] In addition to market forces pushing the industry toward greater integration, some of the unique buying and selling characteristics of the health care industry will be analyzed as also impacting on market behavior. Consumers are not buyers,

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18. "The traditional organization of the health care industry is rapidly changing. Doctors, insurers and hospitals increasingly affiliate, whether by contract or merger, for the most part in order to lower the cost of providing health care. . . Health care is increasingly sold prospectively, through a contract by which a patient commits simultaneously to an insurer, a set of physicians and a set of hospitals for the life of the agreement, typically one year." *See* Jonathan B. Baker, *Vertical Restraints Among Hospitals, Physicians and Health Insurers That Raise Rival's Costs*, 14 AM. J.L. & MED. 147, 148 (1988).

*See also* Blue Cross of Kan. v. Reazin, 899 F.2d 951, 956 n.5, *cert. denied*, 497 U.S. 1005 (1990) (describing the basic nature of HMOs and PPOs); Ball Mem'l Hosp., Inc. v. Mutual Hosp. Ins., Inc., 784 F.2d 1325, 1329 (7th Cir. 1986) (Judge Easterbrook notes the changes in the market for health care services and health care financing and the trend toward integration between and within the markets.)

19. *See* Baker, *supra* note 18, at 149. An interesting irony in the Marshfield Clinic case is that it is Blue Cross & Blue Shield which is on the short end of the stick. In most other cases which have been litigated on this issue, Blue Cross & Blue Shield is the defendant accused of antitrust violations by small, upstart HMOs.

20. "Health care markets diverge in a number of important respects from the assumptions of neoclassical economics that define a perfectly competitive market. The persistence of these sources of market failure helps explain why competition has failed thus far to contain expenditure growth or to efficiently allocate health care resources." *See* Thomas L. Greaney, *National Health Care Reform on Trial: Managed Competition, Integrated Delivery Systems and Antitrust*, 79 CORNELL L. REV. 1507, 1509 (1994).

Although nearly all antitrust defendants may claim that "our markets are different," this Note attempts to explain that, in at least some respects, the health care services and HMO markets are not always amenable to traditional antitrust analysis.

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buyers are sometimes also sellers, and some sellers determine buyers' demand.[21] Perverse incentives exist in what is essentially a triangular rather than two-party transactions and where market participants are engaging in multiple triangular transactions simultaneously.[22] Price theory antitrust analysis does not adequately account for these unusual market conditions.

## I. BACKGROUND

### *A. Antitrust Concerns in the Health Care Industry*

#### 1. Horizontal Restraints in Health Care

Horizontal combinations in the health care industry raise the same concerns as in any other industry. Health care providers may be forming affiliations for the purpose of creating a new managed care plan[23] or, on the other hand, may be collaborating on price for the purpose of price fixing and collusive bidding.[24] In addition, horizontal integration of health care providers threatens to create concentrations of providers which, if unrestrained, might lead to the creation of relatively few large oligolopolistic physician networks.[25]

The principal determinants of whether a collaboration is a legitimate joint venture or illegal horizontal restraint of trade are the degree of control which the participants maintain over price and the amount of integration among the parties in the form of shared resources as well as shared financial risk.[26] Where the physicians or hospitals which form the joint

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21. *See* Greaney, *supra* note 20, at 1509-11. A simple example illustrates part of the problem. When a patient (consumer) goes to the doctor's (seller) office, it is the doctor who decides how much health care service the consumer will receive. The HMO or indemnity insurance company (buyer) pays whatever bill results from the transaction, presumably without ever directly participating in the transaction in question.

22. Marshfield, as an HMO insurer, paid for the services which it sold through its affiliated physicians, the sellers, to the individual health care consumers. At other times, however, Marshfield was the direct seller of services receiving payment from Blue Cross as buyer. Marshfield was then able to manipulate the price at which it sold services in the fee-for-service transactions and then correspondingly inflate the price at which it bought services in the HMO transactions through most favored nations clauses to erect market entry barriers.

23. "Managed care" is the umbrella term for all prospective payment health care plans which purport to provide a full or broad range of health care services within the context of one integrated plan such as an HMO or PPO in exchange for one annual premium.

24. *See generally* Arizona v. Maricopa County Med. Soc'y, 457 U.S. 332 (1982).

25. Greaney, *supra* note 20, at 1526.

26. *Id.* at 1528.

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venture retain control over the price setting mechanism, the courts are quick to find an unreasonable[27] restraint of trade.[28] Greater integration among the participants provides greater opportunity for market efficiencies in terms of scale, scope, and risk, thereby reducing cost and potentially reducing price. Thus, the greater the opportunity there is for the venture itself to create or constitute a new product in the market by virtue of its integrated qualities.[29] Case law and the *Department of Justice - FTC Joint Policy Statements of Enforcement Policy*[30] require significant integration in order to find a legal competitive joint venture. "Loose confederations of doctors that share little more than an administrative apparatus to package bids to buyers are highly suspect."[31]

Horizontal combinations within the health care industry are the natural consequence of market efforts to control spiraling costs and respond to the market demand for more efficient health care delivery systems. However, just as horizontal combinations may promote efficiency and reduce cost, such collaborations raise serious antitrust concerns.

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27. Horizontal joint ventures which don't seek to fix prices are analyzed under the so-called Rule of Reason and are not invalidated as illegal per se. As such, market definition, market entry barriers and procompetitive efficiencies must be considered before finding that a horizontal combination is, on balance, harmful to competition. *See generally Maricopa County*, 457 U.S. at 332; Broadcast Music, Inc. v. Columbia Broad. Sys., 441 U.S. 1, 23 (1979) ("Joint ventures and other [horizontal] cooperative agreements are not usually unlawful . . . where the agreement on price is necessary to market the product at all.").

28. *See* Hahn v. Or. Physicians' Servs., 868 F.2d 1022 (9th Cir. 1988); *Maricopa County*, 457 U.S. at 350-51. *Cf.* Pennsylvania Dental Ass'n v. Med. Serv. Ass'n of Pa., 745 F.2d 248, 258 (3rd Cir. 1984) (Where dentists did not control association board the court could infer no conspiracy to fix prices.)

29. Greaney, *supra* note 20, at 1529; *see also* MANAGED CARE AND ANITIRUST: THE PPO EXPERIENCE 25-38 (M. Elizabeth Gee & Phillip A. Proger eds., 1990) (hereinafter "MANAGED CARE AND ANITIRUST").

30. *See* 4 Trade Reg. Rep. (CCH) ¶ 13,153 at 20,799 (Sept. 5, 1996). The DOJ-FTC policy statement has been issued and revised three times in the past three years. The most recent revision relaxes the requirement of shared financial risk to also include certain types of nonfinancial integration as also likely to produce significant procompetitive efficiencies. Nonfinancial integration which controls cost or increases quality will be considered along with financial risk sharing as indicative of valid competitive influences when analyzing horizontal combinations of physicians (U.S. Dept. of Justice and Federal Trade Commission, Statements of Antitrust Enforcement Policy in Health Care.)

31. Greaney, *supra* note 20, at 1530. Professor Greaney notes that certain "sham-type" PPOs have been challenged by the FTC as nothing more than "thinly disguised cartels." *Id.* at 1531 n.86. If the only purpose of the joint venture is to establish a quoted price announced with one voice, the combination accomplishes little else other than clout (market power) and price fixing.

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### 2. Vertical Restraints in Health Care

Antitrust law recognizes that vertical integration and vertical restraints often create private gains and production efficiencies by reducing a seller's marginal costs.[32] Most commentators advocate a more relaxed treatment of vertical restraints since they invariably produce competitive efficiencies.[33] However, vertical restrictions are not without antitrust problems. Vertical restraints among hospitals, doctors and health insurers may create market power by raising costs for existing or potential competitors without also creating offsetting efficiencies.[34] Vertical arrangements which raise the costs of competitors confer on the controlling organization the power to raise the price of the total health care package above competitive levels or, at the very least, prevent prices from declining. The net result is no different than that which occurs from horizontal price fixing. Both horizontal price fixing and vertical restrictions which raise market entry costs tend to create market power by restricting aggregate industry output and raising industry prices above competitive levels.[35]

Vertical restraints usually take the form of exclusion of certain providers from the HMO or PPO network, exclusive dealing provisions with those providers who are included in the network, and competitive pricing provisions which on their face seem to bargain for the lowest available price provided in the market.[36] Selective and exclusive contracting with physicians attempts to overcome the imperfect market conditions in the health care industry. The integrated organization attempts to obtain and control previously unavailable or incomprehensible consumer

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32. ROBERT BORK, THE ANTITRUST PARADOX, 288-309 (1978); *see also* Baker, *supra* note 18, at 158.

33. *See* Frank H. Easterbrook, *Vertical Arrangements and the Rule of Reason*, 53 ANTITRUST L.J. 135 (1984) ("not all vertical restrictions should be a subject of serious antitrust attention"); Richard A. Posner, *The Next Step in Antitrust Treatment of Restricted Distribution: Per Se Legality*, 48 U. CHI. L. REV. 6 (1981); Baker, *supra* note 18, 158 n.40.

34. Thomas G. Krattenmaker & Steven C. Salop, *Anticompetitive Exclusion: Raising Rivals' Costs to Achieve Power Over Price*, 96 YALE L.J. 209, 215-16 (1986).

35. *Id.*; *see also* Baker, *supra* note 18, at 151 n.17. In the health care market where market demand may be fixed by consumer health needs, restrictions on market entry and consumer options are similar to restrictions on aggregate industry output.

In a typical horizontal price fixing arrangement, the price is fixed, thus also fixing demand along the demand curve. Since demand is now fixed by the established price, no producer will produce more product even though the marginal cost of doing so is lower than the price in the market. Similarly, where market entry barriers are erected the available supply is restricted. The restricted supply thus "fixes" the price on the economic curve no less certainly than an expressed agreement among competitors.

36. MANAGED CARE AND ANTITRUST, *supra* note 29, at 39-42, 57-74; Baker, *supra* note 18, at 150 n.10.

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information, undercut provider-induced demand, and fight the so-called "moral hazard"[37] associated with health care consumption by nonpaying consumers.[38] Most courts see these restrictions as primarily procompetitive and not raising antitrust concerns where market entry is not foreclosed.[39]

However, an underlying concern is that through vertical restraints an integrated organization may tie up so much of the market resources or may so increase the competitors' costs that market entry is effectively foreclosed.[40] To the extent that vertical restraints raise rivals' costs, foreclose market entry, and confer market power, the anticompetitive effect is no different than horizontal restraints among competitors.[41]

3. Imperfect Market Forces

The technical nature of medical information, the complexity of medical diagnoses and the uncertainty associated with medical decisions interferes with efficient interactions in the market.[42] As an example, the supplier (physician) controls the information which the buyer (patient) needs to make an informed decision concerning how much health care to purchase. In this regard, the seller may induce demand for the buyer to purchase more service than she actually needs.[43] Further, the buyer is not constrained economically to any significant degree. The buyer contributes

37. "Moral hazard" is defined as the inclination by health care consumers to overconsume in light of the fact that there is no economic incentive to restrict consumption since "the insurance company will pay the bill."

38. Greaney, *supra* note 20, at 1540; Baker, *supra* note 18, at 152.

39. *See, e.g.*, U.S. Healthcare, Inc. v. Healthsource, Inc., 986 F.2d 589, 594-96 (1st Cir. 1993); Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of R.I., 883 F.2d 1101, 1113 (1st Cir. 1989), *cert. denied*, 494 U.S. 1027 (1990).

40. If all providers are already "signed up" with incumbent health care networks, it will be difficult to establish a rival network. A new entrant would have to "bid" participating physicians away from exclusive deals with incumbents, and this could be very expensive. Individual physicians would take a "you first" attitude, reluctant to sacrifice a beneficial exclusive deal unless a sufficient number of other physicians have already signed up with a new plan to make it viable. For this reason, a new entrant might have to pay a significant premium to gain a critical mass of participating physicians. Thus, by raising the costs to new entrants by exclusive dealing, incumbent oligopolists might successfully maintain their market power. *See* 7 Trade Reg. Rep. (CCH) ¶50,100 at 54,886 (April 27, 1993) (Remarks of Dennis A. Yao before the Los Angeles County Bar Association.)

41. *See* Krattenmaker & Salop, *supra* note 34, at 243. In this context the vertical integrator operates in a fashion to serve as the cartel manager for the retail or distribution outlets which have been organized around the exclusive or restrictive dealing agreements. Physicians or other health care service providers may be inclined to favor the biggest or best "cartel manager."

42. *See* Greaney, *supra* note 20, at 1509.

43. *Id.*

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only a small copayment, or no payment at all when within the confines of the HMO plan, and the health care plan pays for all necessary services as determined by the seller physician.[44] The buyer, therefore, is not constrained to purchase efficiently since the buyer does not pay the price.

A number of other factors contribute to imperfect market conditions in the health care field. Product quality is not easily assessed by the buyers. Consumers frequently must rely on surrogates to monitor quality. These quality control surrogates are now most frequently the purveyor of the integrated HMO product. In addition, the market relies heavily on a highly fragmented provider community which is unlikely to encourage or endorse new entrants to the market due to the transaction costs associated with multiple network membership. A physician who belongs to ten different HMO or PPO networks will necessarily have to transact with ten different utilization and reimbursement systems. Therefore, fewer, larger networks are more desirable to the service providers.[45] The health care industry is undergoing substantial restructuring in response to cost pressures and newly enacted state and federal legislative reforms.[46] Federal regulatory agencies, most notably the Federal Trade Commission, have intensely scrutinized the various combinations emerging in the health care field partly because of suspicion that these market imperfections may be exploited.[47]

### *B. Most Favored Nation Clauses as Price Fixing*

A most favored nations clause (hereinafter, MFN)[48] is a form of vertical restraint between a buyer and seller providing that the price

44. Anthony J. Dennis, *Hospitals, Physicians, and Health Insurers: Guarding Against Implied Agreements in the Health Care Context*, 71 WASH. U. L.Q. 115, 117 n.9 (1993). See *supra* note 37 and accompanying text discussing the phenomena of "moral hazard."

45. *See also* Greaney, *supra* note 20, at 1512.

46. Dennis Yao, *The Analysis of Hospital Mergers and Joint Ventures: What May Change?*, 1995 UTAH L. REV. 381 (1995) (considering whether the health care industry truly represents a special case which is not adequately addressed by traditional antitrust analysis.)

47. Greaney, *supra* note 20, at 1508-16; *see also* Anthony J. Dennis, *Potential Anticompetitive Effects of Most Favored Nation Contract Clauses in Managed Care and Health Insurance Contracts*, 4 ANNALS OF HEALTH L. 71, 72 n.7 (1995).

48. A most favored nation clause is a contractual provision between a purchaser and a seller by which the seller agrees to give the purchaser as favorable a price for the goods and services in question as the seller is giving to any other purchaser. Although MFNs may be used in any commercial relationship and derive their origin from international trade, MFNs are most often utilized in contracts in the health care industry. With only one exception all of the antitrust challenges to MFN provisions have arisen within the health care industry.

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offered by the seller to the buyer will be at least as low as offered to any other buyers for the same commodities.[49] Although MFN clauses may be used by any entity engaged in commerce, MFNs are most often used in contracts in the health care industry between insurers and health care providers.[50] Since health care insurers in a competitive environment seek MFN protection as a method of cost containment, service providers usually agree to MFN contract provisions depending on the size and importance of the particular insurer to their respective medical practices.[51] With only one exception,[52] courts which have considered the anticompetitive effects or antitrust impact of MFNs have done so in the context of the health care industry.[53] Where MFN provisions have been challenged in the health care services environment, however, MFN clauses have been upheld in every case.[54]

Despite what appears to be settled law regarding MFN clauses, the FTC continues to investigate and litigate the MFN issue.[55] The FTC has made it clear that there is continuing concern about the use of MFN

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*See* Anthony J. Dennis, *Most Favored Nation Contract Clauses Under the Antitrust Laws*, 20 U. DAYTON L. REV. 821, 822-27 (1995).

49. Arnold Celnicker, *A Competitive Analysis of Most Favored Nations Clauses in Contracts Between Health Care Providers and Insurers*, 69 N.C. L. REV. 863 (1991); Dennis, *supra* note 47.

50. Dennis, *supra* note 48, at 822, 823.

51. Dennis, *supra* note 48, at 823. If the insurer is a strong competitor with control of a significant amount of the available patient market, providers will feel compelled to concede to the MFN provision. On the other hand, if the insurer is only a small factor in the market, or is a new entrant to the market, the providers will be reluctant to agree to such a provision and reluctant to agree to price discounts which might implicate MFN provisions in contracts which they have with other insurers.

52. In re Ethyl Corp., 101 F.T.C. 425 (1983), *rev'd sub nom.*, E.I. Du Pont de Nemours & Co. v. FTC, 729 F.2d 128 (2d Cir. 1984). Although the case was decided under the Federal Trade Commission Act, 15 U.S.C. §§ 41-51 (1994), the Second Circuit Court of Appeals found that MFNs were a legitimate competitive business practice implemented with the goal of reducing costs and prices, and therefore did not violate the FTCA's prohibition against unfair methods of competition.

53. Celnicker, *supra* note 49, at 864.

54. *See, e.g.*, *Marshfield*, 65 F.3d at 1415 ("Most favored nations clauses are standard devices by which buyers try to bargain for low prices . . ."); *see also Ocean State,* 883 F.2d at 1101 (MFN clauses are not an illegal attempt to obtain or maintain a monopoly); Kitsap Physician Servs. v. Washington Dental Servs., 671 F. Supp. 1267 (W.D. Wash. 1987); Blue Cross & Blue Shield of Mich. v. Michigan Ass'n of Psychotherapy Clinics, 1980-2 Trade Cas. (CCH) ¶ 63,351 (E.D. Mich. 1980).

55. *See, e.g.*, RxCare of Tenn., Inc., Docket No., C-3664, 5 Trade Reg. Rep. (CCH) ¶ 23,957 (June 10, 1996); United States v. Delta Dental Plan of Ariz., 1995-1 Trade Cas. (CCH) ¶ 71,048 (D. Ariz. 1995); United States v. Vision Service Plan, Proposed Consent Decree No. 94-CV02693 (D.D.C. Dec. 15, 1994), 47 Fed. Reg. ¶ 9487 (March 8, 1996).

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clauses in the health care industry because they tend to create an artificial price floor and prevent or deter market entry.[56] As a result, the legal status of MFN clauses may still be a subject of litigation.

*C. Circuit Courts Require Proof of HMO Market Power*

Despite the liberal attitude of the courts toward vertical restrictions, the ongoing reorganization of the health care industry and the continuing scrutiny of vertical restraints by the FTC and the Justice Department has spawned considerable litigation challenging vertical restraints between insurers and doctors or hospitals.[57] Three recent cases[58] involving vertical restraints are illustrative of the judicial attitude regarding vertical price restrictions in the health care field. The overwhelming consensus opinion which can be inferred from these three decisions is summarized by the First Circuit:

> Absent a compelling showing of [market] foreclosure of substantial dimensions, we think there is no need for us to pursue any inquiry into Healthsource's precise motives for the clause, the existence and measure of any claimed benefits from exclusivity, the balance between harms and benefits, or the possible existence and relevance of any less restrictive means of achieving the benefits . . . [I]t does not matter whether substantial foreclosure of new entrants occurs so long as widespread competition prevails in the relevant market, thereby protecting consumers.[59]

The holdings of the courts in these three cases provide insight to the predominant "hands off" judicial approach adopted toward most vertical restraints where monopoly power or market power is not proven.

56. Dennis, *supra* note 47, at 73-76. (quoting remarks and written correspondence from Assistant Attorney General Anne K. Bingaman, head of the Department of Justice's Antitrust Division).

57. *See generally* Dennis, *supra* note 47, 73-77, nn7-12; Baker, *supra* note 18, at 154.

58. *U.S. Healthcare*, 986 F.2d at 589 (finding no antitrust violation in the absence of monopoly power in the "health care financing" market); *Reazin*, 899 F.2d at 951 (relying on a finding of market power to establish antitrust violation); *Ocean State*, 883 F.2d at 1101 (holding that exclusionary practices are not anticompetitive in spite of a finding of legal monopoly power).

59. *U.S. Healthcare*, 986 F.2d at 596-97.

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### 1. *U.S. Healthcare v. Healthsource, Inc.*[60]

Healthsource New Hampshire was a physician founded and controlled HMO in Concord, New Hampshire.[61] In order to combat competition from other HMOs, Healthsource introduced in its 1990 contracts an exclusivity clause which provided for greater compensation to those doctors who agreed to refrain from participating in any other HMO.[62] A doctor who adopted the exclusivity option was free to serve non-HMO patients on a fee-for-service basis and could return to a non-exclusive basis for HMOs simply by giving notice, or in practice, by reverting to the less generous reimbursement schedule.[63] U.S. Healthcare attacked the exclusivity arrangement as a horizontal agreement constituting a group boycott or a concerted refusal to deal constituting a violation of Section 1 of the Sherman Act.[64]

The court found no evidence that the agreement was anything other than a vertical restriction created between the HMO and each individual doctor.[65] Further, the court opined that even if the exclusivity clause was a horizontal arrangement, it would not be illegal unless it was devoid of procompetitive joint venture efficiencies.[66] U.S. Healthcare had simply bargained hard in the market to purchase a valuable resource, exclusive physician services.

### 2. *Ocean State v. Blue Cross & Blue Shield of Rhode Island*[67]

In a case remarkably similar to the *Marshfield Clinic* case, Blue Cross & Blue Shield of Rhode Island, the dominant indemnity health insurer in Rhode Island, attempted to enter the HMO market and displace the smaller, start-up HMO, Ocean State Physicians Health Plan.[68] Blue Cross of Rhode Island's strategy included many of the same tactics that Blue Cross of Wisconsin asserted were anticompetitive when used by the Marshfield

60. *Id.* at 589.

61. *Id.* at 591.

62. *Id.* at 592.

63. *Id.*

64. *U.S. Healthcare*, 986 F.2d at 593 (citing 15 U.S.C. §§ 1-7 (1994)). The plaintiff, U.S. Healthcare, argued that although the exclusivity clause was a vertical restriction in form, in substance it was an implicit horizontal agreement by the doctors to restrain competition. Inference of such a horizontal agreement could be made from the fact that the Healthsource physicians were all stockholders in the HMO.

65. *Id.* at 594.

66. *Id.*

67. *Ocean State*, 883 F.2d at 1101.

68. *Id.* at 1102-04.

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Clinic.[69] Immediately after implementation of the Blue Cross plan, 350 of the 1200 participating physicians resigned from the Ocean State plan in favor of participation with Blue Cross, apparently to avoid a reduction in their Blue Cross reimbursement fees which would result from the imposition of exclusivity and most favored nation pricing clauses.[70]

The parties did not dispute that Blue Cross had monopoly power and that its monopoly power had been acquired legitimately.[71] The sole issue before the court was whether Blue Cross had attempted to willfully maintain its monopoly power by excluding competition through the use of its "Prudent Buyer" MFN clause.[72] The First Circuit held that Blue Cross did not exercise its market power unlawfully when it insisted upon the most favored nation clause in its contract with physicians even though the action undoubtedly harmed Ocean State.[73] The harm resulted from competition, not anticompetitive conduct.

### 3. *Reazin v. Blue Cross & Blue Shield of Kansas*[74]

Blue Cross of Kansas was the largest health care insurer in Kansas, with an estimated market share of 60%.[75] In 1985, Hospital Corporation of America (hereinafter, HCA) simultaneously acquired Wesley Hospital

69. Blue Cross of Rhode Island instituted a differentiated pricing plan which charged higher rates to those employers who offered the competing Ocean State HMO and much lower rates when only the traditional Blue Cross indemnity plan was offered. This practice was justified by claiming that only older, sicker employees would select indemnity insurance and younger, healthier employees would migrate to the HMO plan as part of a so-called "adverse selection" process. Blue Cross also used its substantial market power to require physicians participating in its competing HMO, Healthmate, to agree to most favored nation clauses ("Prudent Buyer" clauses) requiring physicians who participated in both plans to extend to Blue Cross the same deep discount which they had agreed to grant to Ocean State. Id. at 1103-04. *See also* Dennis, *supra* note 48, at 831-32; Celnicker, *supra* note 49, at 873-74.

70. *Ocean State*, 883 F.2d at 1104.

71. *Id.* at 1110. Blue Cross & Blue Shield of Rhode Island controlled a substantial share of the Rhode Island health insurance market, measured at anywhere from 57.1% to 82.7%. Ocean State, on the other hand controlled approximately 10% of the market. Ocean State Physicians Health Plan, Inc. v. Blue Cross & Blue Shield of R.I., 692 F. Supp. 52, 57-58 (D. R.I. 1988).

72. *Ocean State*, 883 F.2d at 1110.

73. *Id.*

74. 899 F.2d 951 (10th Cir. 1990), *cert. denied*, 497 U.S. 1005 (1990).

75. 899 F.2d at 969. The Circuit Court concluded that such a market share, even considering fluctuations over time and other lower estimates, supported the jury finding that Blue Cross possessed monopoly or market power.

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(hereinafter, Wesley), the largest hospital in the Wichita area,[76] and Health Care Plus, a small HMO which accounted for approximately 8-12% of the Wichita health care financing market.[77] Alarmed by this perceived competitive threat from HCA and Wesley, Blue Cross moved to protect its dominant market position. Blue Cross entered into an agreement with the two next largest hospitals in the Wichita market, St. Joseph Hospital and St. Francis Hospital (collectively, "the Saints"),[78] whereby the Saints would agree to discounts in the Blue Cross reimbursement schedule and Blue Cross would terminate its relationship with Wesley, thus shifting a much greater volume of business to the Saints.[79]

The court held that, under Section 2 of the Sherman Act, a competitor who has market power and seeks to preserve that market power through the use of market restraints violates federal antitrust law.[80] The court upheld the jury finding that Blue Cross' actions were an unreasonable restraint of trade despite the fact that the immediate effect of the agreement with the Saints was to lower prices to consumers.[81]

## II. BLUE CROSS & BLUE SHIELD V. MARSHFIELD CLINIC[82]

### *A. Facts and Background*

North central Wisconsin contains one preeminent physician network: the Marshfield Clinic.[83] The Clinic's main office is in Marshfield, its

76. The district court found that Wesley Hospital accounted for approximately 43% of the market for hospital services in the Wichita area. Reazin v. Blue Cross & Blue Shield of Kansas, Inc., 635 F. Supp. 1287, 1297 (D. Kan. 1986) ("*Reazin I*", granting in part and denying in part defendant's motion for summary judgment).

77. Reazin v. Blue Cross & Blue Shield of Kansas, Inc., 663 F. Supp. 1360, 1465 (D. Kan. 1987) ("*Reazin II*", denying defendant's motion for judgment n.o.v. and for a new trial).

78. The Saints together combined to control approximately 52% of the Wichita market for hospital services. *Reazin I*, 635 F. Supp. at 1297.

79. Unfortunately for Blue Cross, there was ample evidence of such a clear agreement. Blue Cross executives and management of the Saints understood that there was an implied quid pro quo. In addition, the president of Blue Cross had issued a letter to all hospitals in Kansas stating it would terminate its relationship with any hospital which affiliated with a competing HMO, as had been done with Wesley Hospital. *Reazin*, 899 F.2d at 958 n.8 & 963-64.

80. *Id.* at 975.

81. *Id.* at 965.

82. 65 F.3d 1406 (7th Cir. 1995), *cert. denied*, 116 S. Ct. 1288 (1996).

83. "Although Marshfield is a town of only 20,000 people in a largely rural region, the Marshfield Clinic is the fifth largest physician-owned clinic in North America, with annual revenues in excess of $200 million." 65 F.3d at 1409.

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twenty-one branch offices extend to fourteen counties, and the Clinic offers an HMO through its subsidiary, Security Health Plan of Wisconsin.[84] The Clinic employs 400 physicians and maintains affiliate relationships with 900 additional physicians through the Security subsidiary.[85] The Security Health Plan requires in its contracts with affiliated physicians that they refer all patients in need of specialized care to the Marshfield Clinic.[86]

Blue Cross & Blue Shield United of Wisconsin (Blue Cross) and its HMO subsidiary, Compcare Health Services (Compcare)[87] brought suit under Sections 1 and 2 of the Sherman Act[88] against Marshfield and its subsidiary Security. After a two week trial, the jury found in favor of the plaintiffs and awarded a judgment which, after remittitur, trebling and the addition of attorney fees, amounted to $20 million.[89] As a competitor, Blue Cross, through its Compcare HMO, alleged that it needed access to a full panel of doctors in order to offer an HMO in competition with Marshfield's Security HMO. Blue Cross alleged that Marshfield had used its control over its own physicians, its affiliated physicians and its Marshfield Clinic facility to exclude Blue Cross, and any other potential entrants, from the HMO market in north central Wisconsin.[90] Blue Cross further alleged that Marshfield had used its market power to fix prices among its affiliated physicians through the use of MFN contract clauses, or their equivalent, and to charge supracompetitive prices to Blue Cross members through Blue Cross' traditional indemnity insurance plans.[91]

The district court denied defendant Marshfield's motion for judgement as a matter of law.[92] The defendants appealed to the Seventh Circuit Court of Appeals.

84. *Id.*

85. *Id.* References to Marshfield include its subsidiary Security Health Plan.

86. *Id.*

87. References to Blue Cross include its subsidiary Compcare Health Services.

88. 15 U.S.C. §§ 1, 2 (1994).

89. 65 F.3d at 1408.

90. *Marshfield*, 883 F. Supp. at 1258. Blue Cross claimed that a complex combination of business practices collectively prevented market entry into the HMO market in North Central Wisconsin. These practices included monopolizing the services of specialty care physicians, requiring affiliated physicians to refer all specialty care cases to the Clinic, controlling the only specialty care facility in the region, and requiring MFN pricing agreements from the affiliated physicians.

91. 883 F. Supp. at 1258.

92. *Id.* at 1252.

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### *B. The District Court Decision*

The district court, ruling on the defendant Marshfield Clinic's motion for judgment as a matter of law pursuant to Rule 50 of the Federal Rules of Civil Procedure, refused to overturn the jury verdict finding of antitrust violations by Marshfield.[93] The court acknowledged the critical importance[94] of establishing the existence of a relevant HMO market and relevant geographic markets[95] but determined that there was legally sufficient evidence for a reasonable jury to conclude that the plaintiffs, Blue Cross, had established for antitrust purposes that the relevant market was HMO services.[96]

The court acknowledged that there could be some limited interchangeability in the health care field between HMOs and PPOs and traditional indemnity plans.[97] But the court, citing Richard Posner,[98] noted that products which are, in fact, poor substitutes may appear to be substitutes in the face of monopoly pricing.[99] Thus, the court concluded that "HMOs may be interchangeable with indemnity insurance when they are priced at monopolistic levels, as is Security HMO, [Marshfield's

93. "When addressing a motion for judgment as a matter of law the court must determine whether the evidence presented, combined with all reasonable inferences that may be drawn from it, is sufficient to support the verdict when viewed in the light most favorable to the party winning the verdict. Any conflicts in the evidence must be resolved in favor of the party prevailing on the verdict." *Id.* at 1252.

94. "Without an HMO market, plaintiff Compcare's [Blue Cross'] claim for exclusion from the market cannot stand." *Id.* at 1253.

95. "A market is defined as a product or group of products and a geographic area in which it is produced or sold such that a hypothetical profit-maximizing firm, not subject to price regulation, that was the only present and future producer or seller of those products in that area likely would impose at least a small but significant nontransitory increase in price." Department of Justice and Federal Trade Commission Horizontal Merger Guidelines, 62 Antitrust & Trade Reg. Rep. (BNA) No. 1559, at S-4 (April 2, 1992). In other words, a separate market exists where a seller could and would institute a price increase without fear of losing buyers to substitute products.

96. 883 F. Supp. at 1253.

97. *Id.* at 1254.

98. RICHARD A. POSNER, ANTITRUST LAW, AN ECONOMIC PERSPECTIVE, 127-28 (1976). The district court, perhaps anticipating an appeal, attempted to invoke the logic and teaching of the Seventh Circuit's noted antitrust expert.

99. 883 F. Supp. at 1254. As an example, if Yugo automobiles are supracompetitively priced, a Cadillac will appear to be a good substitute. However, if Yugos are competitively priced considering their features and quality, a Cadillac will never appear to be a reasonable substitute to the Yugo buyer. (No inference is suggested that HMOs are the Yugos of the health care industry!)

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subsidiary] but are considerably less expensive than indemnity insurance, and correspondingly less substitutable, in competitive markets."[100] Again, the court concluded that the jury had legally sufficient evidence to find that the consumer expects to receive a "unique and distinctive service" from an HMO.[101]

The district court concluded that there was also sufficient evidence to conclude that Marshfield had engaged in other anticompetitive conduct, the willful acquisition or maintenance of monopoly power in violation of Section 2 of the Sherman Act. This conclusion was supported by evidence demonstrating Marshfield's attempts to increase barriers to market entry and exclude potential competitors from the HMO market through the use of MFN clauses, the threat to deny cross-coverage[102] to physicians who participated in other HMOs, and exclusive referral provisions for specialty care.[103]

In addition, although the defendants claimed that higher than average prices charged to Blue Cross members through their indemnity plans were the result of factors such as higher quality and investment in better equipment and facilities, the court again found sufficient evidence for the jury to conclude that the higher prices were instead the result of supracompetitive pricing derived from an exploitation of Marshfield's market power.[104] The court found that the jury could have made reasonable inferences from the evidence to find supracompetitive pricing rather than pricing for enhanced quality as claimed by the defendants.[105] These practices, taken collectively could provide a reasonable inference that Marshfield had used its power over its affiliated physicians to prevent them from offering their services to competing HMOs.[106]

100. 883 F. Supp. at 1254.

101. *Id.*

102. "Cross-coverage" is an agreement "to care for another physician's patients when that physician is on vacation or otherwise unavailable in exchange for a reciprocal agreement by the other physician." 65 F.3d at 1413. The court concluded that cross-coverage was critically important to physicians in rural areas and restrictions on cross-coverage might prove to be a very influential incentive. *See generally* 883 F.Supp. at 1256.

103. *Id.* at 1256-59.

104. *Id.* at 1255. The evidence indicated that Blue Cross had paid charges to Marshfield which were 10% above the usual, customary, and reasonable (UCR) charges prevailing in the community and that the City of Marshfield's charges (which were dominated by the Clinic) were the highest of the 23 cities in the state of Wisconsin. *Id.*

105. *Id.* Antitrust injury may be proved by inference or circumstantial evidence. Zenith Radio Corp. v. Hazeltine Res., Inc., 395 U.S. 100 (1969).

106. 833 F. Supp. at 1255

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The district court also upheld the jury verdict as it related to geographic market definition and a finding that Marshfield had conspired with a neighboring HMO to allocate geographic markets.[107] While important, these particular issues are not, however, the crux of the decision.

### *C. The Seventh Circuit Decision*

Judge Posner articulated the standard of review in the *Marshfield Clinic* case, stating,". . . if there is a reasonable basis for this [the jury's] finding in the evidence, we are bound to accept it regardless of what we think as an original matter."[108] Although Blue Cross had persuaded the jury that HMOs constitute a separate market, the Seventh Circuit declared that " an HMO is not a distinctive organizational form or assemblage of skills."[109] Once the Seventh Circuit had established the market as the health care financing market or the health care services market, the court then resolved to identify the reasonable substitutes available to compete with the Marshfield Clinic HMO in the defined market. The court then concluded that the services offered by HMOs, PPOs, and by various fee-for-service plans are all provided by the same physicians who can easily shift from one type of service to another if relative prices change, and no reasonable jury could have found otherwise.[110]

The circuit court next addressed Blue Cross' claim that monopoly or market power could be inferred from Marshfield's high prices, high rates of return, and power to impose favorable pricing arrangements on its suppliers, the affiliated physicians. The court quickly dismissed this claim, presuming that the high prices and rates of return were the natural result of

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107. *Id.* In light of the appeals court decision, this holding, on remand, would have to be characterized as an agreement to divide or allocate geographic sub-markets.

108. 65 F.3d at 1409.

109. Judge Posner noted that HMOs are but one health care financing choice, in competition with PPOs and traditional indemnity insurance, albeit with certain distinctive product features. Posner noted the HMO distinctions:

> "Many people don't like them because of the restriction on the patient's choice of doctors or because they fear that HMOs skimp on service, since, as we said, the marginal revenue of a medical procedure to an HMO is zero. . . . [T]he HMOs incentive is to keep you healthy if it can but if you get very sick, and are unlikely to recover to a healthy state involving few medical expenses, to let you die as quickly and as cheaply as possible."

65 F.3d at 1409-10.

110. *Id.* at 1411.

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higher quality and efficiency on the part of Marshfield.[111] Further, if the Clinic was charging high prices and achieving high rates of return, competitors would be eager to enter the market and would do so easily.[112] If anything, the Marshfield Clinic is guilty of nothing more than being a natural monopolist in some areas.[113] In the words of the court, "[t]he successful competitor, having been urged to compete, must not be turned upon when he wins."[114]

The Seventh Circuit next considered Blue Cross' allegation that the Marshfield Clinic had itself overcharged and colluded with competitors to overcharge Blue Cross members who were customers of the Clinic or its affiliated physicians on a fee-for-service basis. Again the court quickly dismissed the plaintiff's claims for three reasons. First, the circuit court had already found that Marshfield was not a monopolist, or was at worst a lawful natural monopolist, and was therefore free to charge whatever price it wanted.[115] Second, the court noted the tension of Blue Cross' position with regard to prices charged by Marshfield or its affiliated HMO, Security. High prices, although harmful to Blue Cross as a buyer of health care services, are beneficial to Blue Cross as an incentive for market entry.[116] Finally, the court rejected any notion that Marshfield had colluded with its affiliated physicians to overcharge Blue Cross members through the equivalent of a most-favored-nations clause. The court did acknowledge that MFNs were not without their problems.[117]

With regard to the charge of division of markets, however, the circuit court upheld the finding of the jury and the district court.[118] The Seventh

111. *Id.* at 1411-12.

112. *Id.*

113. A natural monopolist is one who has no competitors simply because the market is too small to support more than one supplier. A natural monopolist who acquires and maintains its monopoly without excluding others is not "monopolizing" and can charge whatever prices it chooses. *Id.* at 1412-13.

114. *Id.* at 1413 (quoting United States v. Aluminum Co. of Am., 148 F.2d 416, 430 (2d Cir. 1945)).

115. *Id.* at 1415.

116. *Id.*

117. "Most favored nations clauses are standard devices by which buyers try to bargain for low prices, by getting the seller to agree to treat them as favorably as any other of their customers. The Clinic did this to minimize the cost of the physicians to it, and that is the sort of conduct which the antitrust laws seek to encourage. . . . Perhaps, as the Department of Justice believes, these clauses are misused to anticompetitive ends in some cases; but there is no evidence of that in this case." 65 F.3d at 1415.

118. Marshfield had been found guilty of anticompetitive behavior by virtue of its "Free Flow" agreement with a neighboring and competing HMO. The "Free Flow" agreement provided for cross-reimbursement to the various physicians affiliated with the

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Circuit Court remanded the case for a new trial to determine damages and injunctive relief relating only to the charge of geographic division of certain submarkets markets.[119]

## III. ANALYSIS

### *A. Overruling the Jury and the District Court*

#### 1. Market Definition

The district court properly recognized the burden which must be overcome to grant the defendant Marshfield Clinic's motion for judgment as a matter of law. A court must determine whether the evidence presented combined with all reasonable inferences that may be drawn from the evidence is sufficient to support the verdict.[120] Given this standard, the district court concluded that there was legally sufficient evidence to find a relevant product market in HMO services.[121] Similarly, Judge Posner recognized that "if there is any reasonable basis for this finding in the evidence, we are bound to accept it regardless of what we might think of it as an original matter."[122] But, although the jury found a separate HMO services market, the circuit court was convinced that "[no] reasonable jury, confronting the record compiled in the district court, could find that HMOs constitute a separate product market."[123]

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two competing HMOs when patients were referred for specialty care so long as neither HMO opened an office in the geographic territory of the other. 883 F. Supp. at 1259, 65 F.3d at 1416.

119. 65 F.3d at 1416.

120. 883 F. Supp. at 1252.

121. *Id.* at 1253. The district court acknowledged the importance of this conclusion, noting that without such a finding the plaintiff's entire case would likely fail.

122. 65 F.3d at 1409.

123. *Id.* at 1411. The parenthetical following this emphatic statement in the opinion was added to satisfy the objection of the Department of Justice which stated: "We are concerned, however, that the court's statement that "HMOs are not a market" (slip op. at 9) might be read out of context to establish a general rule of applicability." The insertion of the parenthetical opens the door just a crack to consider future cases of HMOs as constituting a separate market. *See* Christine Anne Kexel, *Paradigms of Power: A Comment on Blue Cross & Blue Shield United v. Marshfield Clinic*, 71 NOTRE DAME L. REV. 1093, 1106-07 (1996) (citing Department of Justice Amicus Curiae Brief in Support of Rehearing at 4, *Marshfield*, 65 F.3d 1406).

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The Supreme Court has repeatedly held that the definition of markets in antitrust cases should be based on facts.[124] The courts must look for fact-based "practical indicia" of public or industry acceptance of distinct product submarkets which may be subject to antitrust scrutiny.[125] The Supreme Court has also declared that "proper market definition . . . can be determined only after a factual inquiry into the 'commercial realities' faced by consumers."[126]

Judge Posner, however, indicates his frustration with the jury and the district court sojourn into the factual details and dismisses seemingly important market and product distinctions identified by the district court.[127] The circuit court contradicts itself when it, at first, asserts that "[a]n HMO is basically a method of pricing medical services"[128] and then observes that "[m]any people don't like them [HMOs] because of the restriction on the patient's choice of doctors or because they fear that HMOs skimp on service."[129] The circuit court attempts to resolve this apparent contradiction by determining that HMOs are in competition with PPOs and traditional fee-for-service plans. Any perceived differences by consumers are nothing

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124. *See, e.g.*, Eastman Kodak Co. v. Image Technical Servs., Inc., 504 U.S. 451, 482, (1992); United States v. Grinnell Corp., 384 U.S. 563, 572 (1966); United States v. E.I. DuPont de Nemours & Co., 351 U.S. 377, 394 (1956).

125. *See, e.g.*, *Grinnell*, 394 U.S. at 572; United States v. Aluminum Co. of Am., 377 U.S. 271, 283 (1964) (Stewart, J. dissenting); Brown Shoe Co. v. United States, 370 U.S. 294, 325 (1962). "Practical indicia" include: industry or public recognition of the submarket, the product's peculiar characteristics and uses, unique production facilities, distinct customers, distinct prices, etc. 377 U.S. at 283.

126. *Eastman Kodak Co.*, 504 U.S. at 482.

127. "Two forms of collusion are charged, with various furbelows and arabesques that can be ignored. . . . Forget all that [evidence suggestive of exclusionary collusive conduct] . . . This is an ingenious but perverse argument." 65 F.3d 1415.

> Even counsel for the defendant Marshfield Clinic, presumably a supporter of the opinion in the Marshfield Clinic case, acknowledges Posner's apparent frustration or impatience exhibited by the court and reflected in the opinion: Imagine that you have commissioned Marc Chagall to paint a mural, but he could only do so while being towed past the wall at ten miles an hour. The result would be something like the opinion Judge Posner produce in Marshfield: some portions with the expected brilliance, others that could have been improved by a more deliberate touch, and still others that were missed entirely.

Kevin McDonald, *The Marshfield Clinic Case*: *The Sound of a Broken Record*, 5 ANNALS OF HEALTH L. 1, 30 (1996). Kevin McDonald, a partner in Jones, Day, Reavis & Pogue, represented Marshfield at trial and on appeal. He attributes Judge Posner's impatience to arguments by Blue Cross which were at odds with conventional antitrust analysis.

128. 65 F.3d at 1409.

129. *Id.* at 1410.

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more than product differentiation - quality differences between competing products.[130]

2. Ignoring the Context of the Health Care Industry

Judge Posner's simplistic view ignores the unusual complexities of the health care market where triangular transactions prevail rather than traditional two-party buyer/seller transactions. The evolving health care services market is imperfect and subject to significant market distortion and economic inefficiency. Buyer-seller-consumer interactions in the health care market are frequently distorted by imperfect or imperfectly distributed information. The peculiar incentives imposed by insurance plans and the odd, sometimes contradictory relationships of a three-party transaction further contributes to market imperfections.[131]

In recent years health care costs have skyrocketed, partly as a result of these market failures.[132] In response to the perceived market inefficiencies, health care insurers have resorted to vertical and horizontal integration in the form of HMOs, PPOs, and other physician networks attempt to "manage competition" or otherwise compensate for efficient market failure with limited success.[133] Large health care providers like Blue Cross and Marshfield horizontally integrate in order to create the HMO or PPO network.[134] They vertically integrate to price, package and market the network as a complete health care services and financing scheme.[135] In order to coordinate the entire package and market a competitively priced product, the large networks establish reimbursement rates, "prices," between and among the various independent and, sometimes, "captive" service providers. In addition to "fixing" prices among providers HMOs

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130. "HMOs compensate for these perceived drawbacks by charging a lower price than fee-for-service plans." *Id.* at 1410.

131. Greaney, *supra* note 20, at 1507.

132. Anthony J. Dennis, *Hospitals, Physicians, and Health Insurers: Guarding Against Implied Agreements in the Health Care Context*, 71 WASH. U.L.Q. 115, 115 n.1,2. (1993).

133. Celnicker, *supra* note 49, at 868-70.

134. *See generally Ball Mem. Hosp.*, 784 F.2d at 1329 (describing Judge Easterbrook's overview of the health care market). *But cf. Marshfield*, 65 F.3d at 1409 (Judge Posner views HMOs as nothing more than a health care financing and risk shifting scheme in competition with many other forms of health care insurance).

135. In most areas of the country major insurance companies dominate the HMO and PPO markets. The networks are sold primarily as health care financing and cost containment vehicles. *See* Baker, *supra* note 18, at 149; *see also* Dennis, *supra* note 44, at 116-19.

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frequently employ most favored nations clauses [136] as a purported cost containment mechanism.[137]

The Seventh Circuit decision ignores the fact that HMOs and PPOs are attemptimg to rectify market failure by integrating the insurer, who "buys" the physician's services, and the physicians and hospitals, who "sell" the services to the insurer rather than selling to the third-party consumer. The integrated product is then "sold" to the ultimate consumer of the services.[138] But just as market imperfections and inefficiencies may be corrected, they may also be exploited. The Tenth Circuit in *Reazin*[139] recognized this problem when it concluded that, although MFNs are not anticompetitive per se, strategic use of MFNs is an inference not only of market power but also of anticompetitive behavior.[140]

The net result according to Posner, given the substantial burden to be overcome on appeal, is that HMOs do not constitute a separate product market and will not constitute a separate market under anything but the most unusual cases. Still, this conclusion ignores important issues of context and contradicts other facts acknowledged by the circuit court. The court of appeals acknowledged the evidence of exclusionary conduct that had the purpose and effect of preventing Marshfield Clinic physicians from dealing with competing HMOs.[141] The court of appeals did not dispute factual findings of the district court that the Clinic refused to allow its physicians to "cross-cover" with independent physicians, discouraged hospitals that it controlled from joining competing HMOs, and restricted staff privileges of independent physicians at hospitals it controlled.[142] These exclusionary practices contribute to an inference that the sellers perceived HMOs as a fundamentally different product, and the Supreme Court has recognized that exclusionary conduct in a particular market is

136. For a more complete description of most favored nation clauses see note 49 and accompanying text. Anthony J. Dennis, *Most Favored Nation Contract Clauses Under the Antitrust Laws*, 20 DAYTON L. REV. 821, 823-27 (1995).

137. Arnold Celnicker, *A Competitive Analysis of Most Favored Nations Clauses in Contracts Between Health Care Providers and Insurers*, 69 N.C. L. REV. 863 (1991); Anthony J. Dennis, *Potential Anticompetitive Effects of Most Favored Nation Contract Clauses in Managed Care and Health Insurance Contracts*, 4 ANNALS OF HEALTH L. 71 (1995).

138. Baker, *supra* note 18, 152-54; Dennis, *supra* note 44, at 118; Greaney, *supra* note 20, at 1510-11; *see also* Thomas L. Greaney, *Regulating of Efficiency in Health Care Through the Antitrust Laws*, 1995 UTAH L. REV. 465, 482-85 (1995).

139. 899 F.2d 951.

140. *Id.* at 971.

141. 65 F.3d at 1409-10.

142. 883 F. Supp. 1256-58; 65 F.3d at 1413.

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evidence of a separate market.[143] However, Judge Posner has stated that "HMOs are not a market."[144]

*B. Finding an Absence of Market Power*

The Seventh Circuit Court decided, as a matter of law, that a plethora of anticompetitive conduct by Marshfield Clinic was not sufficient to allow the jury to consider claims under either Section 1 or Section 2 of the Sherman Act.[145] The circuit court conceded that; (1) Marshfield physicians prevented competing physicians from obtaining privileges at the key hospital in the area; (2) Marshfield physicians colluded to refuse to "cross cover" physicians not participating in the Marshfield HMO; (3) Marshfield "fixed" prices to the extent that it insisted on most-favored-nation provisions in its physician contracts; and (4) Marshfield colluded with its physicians to prevent cooperation and participation in any other HMO.[146] Rather than consider these practices as an inference of market power, the circuit court relies dogmatically on its definition of the relevant market and ignores this litany of anticompetitive and conspiratorial conduct.[147] It is important to note, however, that the reasoning of the court is somewhat circular. If the market is defined irrespective of these anticompetitive actions, then these actions are not anticompetitive since they do not lead to monopolization of the defined market.[148]

The decision of the Seventh Circuit is consistent with the principles of the Chicago School of antitrust analysis. In the absence of proven market power, in the absence of proof of market foreclosure, and in the absence of clear barriers to market entry, markets should be left to discipline

143. *Eastman Kodak Co.*, 504 U.S. 479-81.

144. 65 F.3d at 1412.

145. "So Security [Marshfield] is not a monopolist . . . HMOs are not a market . . . the Clinic does not have a monopoly of physician services." *Id.* "Since monopoly power was not proved [by virtue of a finding of no HMO market], we need not evaluate the practices by which the Clinic acquired or maintained it." *Id.* at 1413.

146. *Id.* at 1413-15.

147. "[E]ven if these practices are, as we doubt, tortious interferences with Compcare's (Blue Cross') business, they do not constitute monopolizing in violation of Section 2 of the Sherman Act in the absence of acceptable proof, here lacking, of monopoly power." 65 F.3d at 1414.

It is important to note that monopoly power is lacking once the court finds a relevant market which does not include these anticompetitive actions within the context of its relevant market. It is also important to note that the Marshfield opinion is consistent with both the First Circuit in *U.S. Healthcare* and the Tenth Circuit in *Reazin* in holding that the relevant product market is health care financing, not HMO services.

148. *See generally* White, *supra* note 2, at 1064-69 (arguing that conventional antitrust analysis tends to overlegitimize some anticompetitive behavior).

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themselves and competitors allowed to compete.[149] The court concedes, by way of its decision, that in limited instances efficiency improvements will come at the cost of greater market power or that short-term anticompetitive behavior will be tolerated in the interest of allowing competitive markets to evolve without interference.

As indicated earlier, a basic tenet of the Chicago School model is that market forces will self-correct any efforts to interfere with the market.[150] Proponents of this philosophy argue that, in the absence of proven market power, other efforts to raise prices or monopolize markets will not succeed since other firms outside the market will enter with their own production to compete for excess profits.[151] Applying this reasoning to the *Marshfield* case, Judge Posner predictably concludes that since Marshfield does not have exclusive control over the HMO affiliated physician services, a competitor may simply enter and bid the resource away from Marshfield. And if Marshfield's prices for fee-for-service specialty care are too high, a competitor will likewise steal this bit of business with lower prices. This is the simplistic price-driven theory which, according to some commentators almost invariably concludes that any restraining conduct must necessarily be efficient, since no rational market participant would expend resources wastefully.[152] Short-term strategic anticompetitive behavior may be effective if it raises costs which create barriers to entry. The overlegitimization of otherwise anticompetitive conduct is further exacerbated when courts couch their rulings in terms of the questioned conduct and ignore market context. The combination of reliance on the economic efficiency model, which tends to validate any conduct with any hypothesized procompetitive effect along with diminishing the nuances of market context, ratifies potentially anticompetitive conduct which may be exported to those markets, where it may cause more damage.[153]

The market definition and market power holding in *Marshfield* follows the logic of the First Circuit in *U.S. Healthcare*. The First Circuit Court

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149. *See supra* note 4 and accompanying text.

150. *See* White, *supra* note 2, at 1063.

151. *See* Frank H. Easterbrook, *Vertical Arrangements and the Rule of Reason*, 53 ANTITRUST L.J. 135 (1984).

152. Herbert Hovenkamp, *Rhetoric and Skepticism in Antitrust Argument*, 84 MICH. L. REV. 1721, 1723-24 (1986). *See also*, Frank H. Easterbrook, *Workable Antitrust Policy*, 84 MICH. L. REV. 1696, 1700-01 (1986).

153. White, *supra* note 2, at 1066-67. Professor White notes that the courts do not completely ignore the ramifications of market context. However, in order to fashion efficient jurisprudence the courts need to construct rulings which are not so narrow as to have limited precedential value (i.e. not every case is a special case) but which do not overlook important and dispositive contextual issues.

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found no antitrust violations in *U.S. Healthcare*[154] primarily because the court upheld the district court's definition of the relevant market as "health care financing in New Hampshire."[155] Given this market description, it was a simple matter for the court to conclude that Healthsource, with only 25% of the doctors in the area under contract, lacked both monopoly power and the power to foreclose available means of competition.[156] Although rejecting U.S. Healthcare's assertion that HMOs were a separate product market, the court acknowledged that HMOs could possibly be distinguished from other forms of health care services and financing. However, the court noted that differences in product cost and quality alone are insufficient to warrant treatment as a separate product market.[157] As a result, Healthsource was determined to have imposed vertical restrictions with a business justification which created market efficiencies in the health care financing market which Healthsource did not, and was not attempting to, monopolize.[158] The First Circuit chose to ignore the implication of Healthsource's ability to introduce and enforce an exclusivity provision.[159] Similarly, the Seventh Circuit also chose to ignore the theory propounded in *Reazin* that the ability to enforce restrictive agreements implied power over price or market.

### *C. Most Favored Nation Clauses Are Not Anticompetitive*

Although MFN provisions have repeatedly been challenged under the antitrust laws, MFN clauses have been upheld in every court case.[160] In a recent case, however, one circuit court has viewed MFN clauses in a more

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154. 986 F.2d 589.

155. *Id.* at 597.

156. *Id.* at 597-98.

157. *Id.* at 599. The controlling standard for defining the relevant product market is "cross elasticity of demand," the extent to which consumers would switch to other available products as substitutes if confronted with a "significant and nontransitory" price increase. United States Department of Justice and Federal Trade Commission Merger Guidelines, 1992; United States v. E.I. Du Pont de Nemours & Co., 351 U.S. 377 (1956).

158. *U.S. Healthcare,* 986 F.2d at 599.

159. "[A]bsent a compelling showing of [market] foreclosure of substantial dimensions, we think there is no need for us to pursue any inquiry into Healthsource's precise motives for the clause." *Id.* at 596.

160. *See, e.g., Marshfield,* 65 F.3d at 1415 ("Most favored nations clauses are standard devices by which buyers try to bargain for low prices . . ."); *Ocean State,* 883 F.2d at 1101 (MFN clauses are not an illegal attempt to obtain or maintain a monopoly); Kitsap Physician Servs. v. Washington Dental Servs., 671 F. Supp. 1267 (W.D. Wash. 1987); Blue Cross & Blue Shield of Mich. v. Michigan Ass'n of Psychotherapy Clinics, 1980-2 Trade Cas. (CCH) ¶ 63,351 (E.D. Mich. 1980).

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unfavorable light.[161] The Tenth Circuit Court in *Reazin* concluded that MFN clauses create a disincentive for the provider to give a discount to one competitor if the same discount would then have to be extended to others. The MFN had the effect of establishing a "floor"[162] below which prices were not likely to fall and which therefore made entry into the market more difficult.[163] The *Reazin* court noted that its finding might appear contrary to the holding in *Ocean State*.[164] But, the Tenth Circuit distinguished its ruling as only identifying the MFN clause as one indicator or inference of market power and not as a distinct anticompetitive act in violation of the Sherman Act.[165]

In absolving the short-term strategic anticompetitive behavior of Marshfield, the court of appeals particularly failed to consider the MFN issue in proper context when the court ignored the obvious connection

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161. *Reazin*, 899 F.2d at 951.

162. The conflicting goals and incentives of MFN clauses in the managed health care context are best described by the following hypothetical:

> Medical insurers A, B, and C each sign separate HMO provider agreements with the same hospital. Insurer A negotiates HMO reimbursement rates with the hospital, including a contract clause providing that if insurer B or C (or D, an insurer not yet in the market) receives a more favorable rate from the hospital, Insurer A will automatically receive the same discount.
>
> If Insurer A enjoys sufficient market power, Insurer A can threaten to take its business to another provider, or otherwise complicate the hospital's business, unless the hospital agrees to the MFN provision. The hospital, not wanting to lose its biggest customer, will grant the discount to A. The hospital will then resist giving any special discounts to B, C, or any other smaller market participant so a s to avoid activating the MFN clause in the A agreement. The hospital might perceive that the profits from the incremental business provided by B, C, or a new market entrant would be offset by the loss of profit associated with extending a deeper discount to A. Further, the existence of A's MFN clause prevents a new market entrant from bargaining for a low market-entry price. A's MFN clause has established an artificial price "floor." Instead of knocking down trade barriers and lowering price, the MFN clauses actually increase or, at the very least, stabilize prices and erect barriers to market entry.

Susan E. Stenger, *Most-Favored-Nation Clauses and Monopsonistic Power: An Unhealthy Mix?*, 15 AM. J.L. & MED. 111, 112-13 (1989); *see also*, *In re* Ethyl Corp., 101 F.T.C. 425, 427-28 (1983) (Discounting is economically rational only if the seller can obtain more business and make greater profits than the seller would have had it not discounted in the first place.).

163. *Reazin*, 663 F. Supp. at 1418; *See also* Celnicker, *supra* note 137, at 877-79.

164. 899 F.2d at 971.

165. 899 F.2d at 971 n.30.

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between the generous pricing arrangements Marshfield afforded its affiliated doctors, on the one hand, and the high prices which Marshfield charged on a fee-for-service basis through its employee physicians in the Clinic.[166] The circuit court appears to have misunderstood the relationship of the various products in its "health care financing" market when it declared:

> We note a tension between Blue Cross' claim and Compcare's [Blue Cross' HMO]. Blue Cross claims that the Clinic overcharged. The higher its prices, the greater the opening for competitors, such as Compcare. Even if Compcare could not get a foothold in the HMO "market", it could, of course, provide medical services through other means, such as a preferred provider plan; and the higher the prices charged by the Marshfield Clinic, the more attractive such a plan offered by Compcare would be to employers and other purchasers of medical plans.[167]

In essence, Marshfield was actually overcharging Blue Cross in the fee-for-service product market and then sharing the excess profits with its affiliates through the HMO contract reimbursement rate while still retaining control over the affiliates' ability to discount to competing HMOs or PPOs.[168] Judge Posner, in declaring that "[m]ost favored nations clauses are standard devices by which buyers try to bargain for low prices, by getting the seller to agree to treat them as favorably as any of their other customers,"[169] removes the MFN question from the context of the health care services or health care financing market as it existed in north central

166. 65 F.3d at 1414.

167. *Id.*

168. Returning to Susan Stenger's hypothetical, *supra* note 162: The situation is exacerbated if Insurer A owns the hospital, or employs the physicians, and is able to charge Insurers B, C, or new entrant D higher rates for hospital services than it charges to itself through its own integrated health care plan. Insurers B and C effectively subsidize the barrier to entry of which they complain - Insurers B and C are paying for the market entry barriers constructed by A.

If a producer has a monopoly in one product line (in this case, the Clinic and its specialty physicians), it may use its market power in that product to generate the funds necessary to acquire all the available resources for market entry into another product line (HMO physician services). Having cornered the market on the supply of necessary resources by paying a premium price, the producer may now establish power in a second related or unrelated product line. *See generally* Stenger, *supra* note 162, at 111-13.

169. 65 F.3d at 1415.

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Wisconsin.[170] The parties were competing over several product lines which the circuit court insisted had some degree of interchangeability.[171] Marshfield also had a variety of other restrictive practices and contract provisions in place in the HMO market. In this context, it would not be too much of a stretch to infer that one product line could be played off against another.[172] As discussed previously,[173] many commentators express concern that MFNs may operate as de facto exclusive dealing arrangements.[174] Utilization of MFNs by a dominant competitor with market power could foreclose so much of the available supply of resources in the market as to inhibit, or completely prevent, market entry.[175] Clearly, Marshfield was able, at least in the short run, to raise the costs of HMO market entry and underwrite that strategy with the profits from other product lines. This is exactly the strategy employed by Blue Cross & Blue Shield of Kansas in *Reazin*.[176] The only difference is that in *Reazin*, Blue Cross announced its strategy to all hospitals in the market, making it it clear that Blue Cross intended to foreclose a substantial part of the market from any hospital which cooperated with Wesley Hospital and Hospital Corporation of America.[177] The fact that Marshfield did not expressly state the exclusionary intent of its MFN provision should not be dispositive.

170. A further indication that Judge Posner has misunderstood the context of the health care market is his statement: "[T]he services offered by HMOs and by various fee-for-service plans are both provided by the same physicians, who can easily shift from one type of service to another if a change in relative prices makes one type more lucrative than others." *Id.* at 1411.

Physicians generally accept their patients as they find them. The choice of which insurance plan the physician will participate in is more a function of the consumer-subscriber's choice of health care coverage.

171. *Id.* at 1410.

172. *See generally* United States v. Continental Can Co., 378 U.S. 441, 450-54 (discussing under what conditions short-term monopoly profits might be achieved in one product line before complete and effective substitution by a competing product line might occur).

173. *See supra* text accompanying notes 56-69.

174. Greaney, *supra* note 20, at 1540-41; Celnicker, *supra* note 137, at 879-80; Dennis, *supra* note 137, 77-80.

175. Celnicker, *supra* note 137, at 879; Krattenmaker & Salop, *supra* note 34, at 215-16; Baker, *supra* note 18, at 150-51.

176. This is exactly the strategy employed by Blue Cross & Blue Shield of Kansas in *Reazin*, 899 F.2d at 951. The only difference is that, in *Reazin*, Blue Cross announced its strategy to all hospitals in the market, making it clear that it would use excess profits from nonparticipating hospitals such as Wesley.

177. *Id.* at 957-59, 966.

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In a slightly different twist, the parties in *Ocean State*[178] agreed that Blue Cross had monopoly power and that its monopoly power had been acquired legitimately.[179] The only question was whether the imposition of the "Prudent Buyer"/MFN clause itself represented anticompetitive conduct.[180] The First Circuit held that market power was not wielded unlawfully through the use of a most favored nation clause, though the action undoubtedly harmed Ocean State.[181] The court explained:

> [A] policy of insisting on a supplier's lowest price -- assuming that the price is not "predatory" or below the supplier's incremental cost -- tends to further competition on the merits and, as a matter of law, is not exclusionary. It is hard to disagree with the district court's view, "As a naked proposition, it would seem silly to argue that a policy to pay the same amount for the same service is anticompetitive, even on the part of one who has market power. This, it would seem, is what competition should be all about."[182]

The circuit court affirmed the ruling of the district court that the inevitable harm to Ocean State resulting from Blue Cross' use of its bargaining power was a natural consequence of competition, not the result of any antitrust violation.[183] The circuit court also rejected the notion that the "Prudent Buyer" clause, although a legitimate business practice, had been applied in manner to exclude or destroy competition.[184] The court rejected Ocean State's contention that the practices, although constructed as vertical restraints, were actually horizontal by design and effect.[185] The

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178. *Ocean State*, 883 F.2d at 1101.

179. *Id.* at 1110. Blue Cross & Blue Shield of Rhode Island controlled a substantial share of the Rhode Island health insurance market, measured at anywhere from 57% to 82.7%. Ocean State, on the other hand controlled approximately 10% of the market. *See Ocean State,* 692 F. Supp. at 57-58.

180. *Ocean State*, 883 F.2d at 1110.

181. *Id.*

182. *Id.* (quoting 692 F. Supp. at 71).

183. *Id.* at 1113 (supporting the conclusion of the district court at 692 F. Supp. at 71).

184. *Id.* at 1112-13.

185. *Id.* at 1111. If the court could be persuaded that these restrictions were, in fact, intended to be horizontal price restrictions among the competing physicians, Ocean State may have been able to make out a better case of a per se price fixing agreement, thus avoiding the burden of proving that the agreements were, on balance, anticompetitive rather than procompetitive.

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court viewed the Prudent Buyer/MFN clauses as nothing more than a smart business decision and hard bargaining by Blue Cross, and not as an abuse of market power.

In *Reazin*,[186] however, the Tenth Circuit took the position that the MFN clauses which Blue Cross required of all providers were suspect since the MFN clauses themselves contributed to inference of market power by demonstrating the necessary power over price to exclude competitors from the market.[187] Regardless of the widespread dissent regarding MFNs, the law is quite clear. Most favored nation clauses are, on balance, procompetitive and no court has found otherwise.[188] Given that the opinion of the Seventh Circuit was authored by noted antitrust expert Judge Richard Posner, it should carry considerable weight on this issue.[189] The Department of Justice Antitrust Division (DOJ) and the Federal Trade Commission (FTC) immediately filed an *amicus curiae* brief in support of Blue Cross' petition for a rehearing before the Seventh Circuit. "While taking no position on the ultimate question of the sufficiency of the evidence," the agencies urged the Court of Appeals to clarify its position regarding market definition and its analysis of most-favored-nation clauses.[190] The DOJ and FTC did not dispute the court's conclusion that Marshfield had not engaged in illegal price-fixing or collusive conduct. However, the agencies were concerned that the opinion would be misinterpreted to hold that MFNs, by definition, do not violate Section 1 of the Sherman Act.[191] In addition, the agencies supported Blue Cross' contention that the circuit court simply misunderstood the HMO market in Wisconsin. By holding that "HMOs are not a market,"[192] the circuit court "refus[ed] to apply the rule of reason to any of the vertical or horizontal conduct at issue, [and] the panel opinion rejects long held principles of antitrust law," according to Blue Cross and the agencies.[193]

As noted above, the DOJ and FTC have aggressively pursued combinations of physicians, hospitals, and other health care providers, and

186. 899 F.2d 951.

187. *Id.* at 970.

188. *See supra* notes 52-54 and accompanying text.

189. *See generally* Kevin McDonald, *The Marshfield Clinic Case: The Sound of a Broken Record*, 5 ANNALS OF HEALTH L. 1 (1996).

190. 69 Antitrust & Trade Reg. Rep. (BNA) No. 1733, at 407 (Oct. 12, 1995) (characterizing the position of the agencies in their amicus brief).

191. *Id.*

192. *Marshfield*, 65 F.3d at 1412.

193. 69 Antitrust & Trade Reg. Rep. (BNA) No. 1733, at 408 (quoting from Blue Cross' brief in support of petition for rehearing).

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in particular, have treated MFN clauses as suspect.[194] In the Department of Justice and Federal Trade Commission Statements of Antitrust Enforcement Policy in Health Care,[195] the agencies had made it clear that any vertical or horizontal combinations in health care would be suspect if they did not include substantial sharing of financial risk which, in turn, produces competitive efficiencies. It is not surprising that many antitrust experts expected that the agencies might attempt to reconcile the apparent contradictions between their guidelines and the opinion of the Seventh Circuit when the Policy Statements were revised and reissued in 1996.[196]

When the revised guidelines were issued, FTC Chairman Robert Pitofsky explained that the new guidelines "reflect an effort to protect consumers from unjustified price fixing, while at the same time ensuring that the antitrust laws do not unnecessarily impede developments in the dynamic health care marketplace."[197] The new guidelines provide that the agencies will consider the procompetitive effects of physician combinations where agreements on price are reasonably necessary to accomplish efficiencies of cost or quality.[198] However, the agencies retained the provisions relating so-called physician group "safety zones."[199] The agencies did provide the caveat that "merely because a physician network joint venture does not come within a safety zone in no way indicates that it is unlawful under the antitrust laws."[200] In general, the agencies will provide rule of reason analysis to a broader range of physician and multiprovider networks than had been done previously.[201] The agencies also acknowledge that procompetitive efficiencies may include quality and cost control. But all this regulation, although more

194. *See supra* notes 55-56 and accompanying text.

195. 4 Trade Reg. Rep. ¶ 13,153, at 20,799 (Sept. 5, 1996). The Statements were originally issued in 1993, revised in September, 1994, and reissued in September, 1996.

196. Julie Johnson, *Boost for Antitrust Relief: Marshfield Case Pushes Feds to Reconcile Guidelines, Ruling,* 39 AM. MED. NEWS (AMA) 15, at 1 (April 15, 1996).

197. 71 Antitrust and Trade Reg. Rep. (BNA) No. 1777, at 193 (Aug. 29, 1996).

198. *Id.*

199. 4 Trade Reg. Rep. ¶ 13,153 (CCH), at 20,814. The "safety zones" are the percentages of physicians within a geographic market who may participate in a physician group with a presumption that the group does not monopolize the market. The "safety zones" are 20% of physicians participating on an exclusive basis and 30% of physicians participating on a non-exclusive basis.

200. *Id.* ¶ 13,153, at 20,814.

201. *See generally* 71 Antitrust & Trade Reg. Rep. (BNA) 1778, at 223 (Sept. 12, 1996). (Statement 8 of the DOJ and FTC Statements of Antitrust Enforcement Policy in Health Care applies to Physician Networks and Statement 9 provides similar enforcement policy for Multiprovider Networks.)

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relaxed than previous guidelines, seems to fly in the face of the Seventh Circuit's decision. If the Seventh Circuit is correct that "HMOs are not a market,"[202] PPOs "are particularly close substitutes for HMOs,"[203] the "ability to create a preferred-provider plan implies ability to create an HMO",[204] and "physicians . . . can easily shift from one type of service to another,"[205] then no non-exclusive network should raise antitrust concerns. The Seventh Circuit was unwilling to apply rule of reason analysis to any of the host of anticompetitive actions employed by Marshfield, choosing to rely on what the court saw as a viable competitive market to discipline the participants.[206] The DOJ and FTC, instead, behave more like regulators, structuring the market according to what they believe is best for the general public.[207]

## CONCLUSION

The decision of the Seventh Circuit in *Blue Cross & Blue Shield v. Marshfield Clinic*[208] is classical Chicago School theory. The decision is in accord with other recent appellate court decisions scrutinizing integrated health care provider networks, and specifically the incorporation of exclusivity and preferred pricing provisions within such network agreements. Absent proof of market domination or monopolization, restrictive practices are presumed not to be anticompetitive. Market conduct is only evaluated in light of market definition and market context is relatively unimportant. The decision makes clear that short-term anticompetitive actions will be tolerated by the court in favor of providing for a straightforward and simplified market analysis based on market definition. The competitive markets will sort out any inefficient behavior. By applying neoclassical economic efficiency analysis to the unusual facts and markets presented in *Marshfield Clinic*, the Seventh Circuit may have left the door open for the continued use of strategic anticompetitive

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202. *Marshfield*, 65 F.3d at 1412.

203. *Id.* at 1410.

204. *Id.*

205. *Id.* at 1411.

206. *Id.*

207. Professor Clark Havighurst of Duke University Law School, a long time advocate of vigorous application of antitrust laws to the health care industry, stated that the "agencies appear to be anticipating where they think the health care marketplace is or should be headed. . . . They run the risk of substituting their own judgments and preferences for those of purchasers. The agencies have become regulators, displacing the very marketplace they are charged with protecting." Robert Pear, *Doctors May Get Leeway to Rival Large Companies*, N.Y. TIMES, Apr. 8, 1996, at A1.

208. 65 F.3d 1406.

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behavior in the evolving HMO-health care market. The enforcement actions of the Department of Justice and the Federal Trade Commission are inconsistent with the Marshfield decision. The agencies continue to scrutinize and apply rule of reason analysis to a variety of health care joint ventures and networks which the Seventh Circuit, as well as other circuits, would view as normal competitive market forces at work. Obviously, both can not be correct. The inconsistency between the courts and the enforcement agencies must be resolved if health care providers are to have any idea of what will constitute legal conduct.

Robert F. Goff[209]

209. J.D., University of Connecticut, 1997.

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# SOFTWARE TORT: EVALUATING SOFTWARE HARM BY DUTY OF FUNCTION AND FORM

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INTRODUCTION

The old cliché goes something like this: "To make a mistake you need a human. To really screw up, you need a computer."[1] Anyone who has endured a problem caused by a computerized tool, object, alarm system, medical diagnostic system, or billing system knows just how true this is, and how devastating a small computer glitch can be to life and property.[2] Yet, under current law, software manufacturers can significantly limit, if not eliminate any liability for damage which errors in their products create.[3] An unlikely combination of arcane and outdated case law, provisions of the Uniform Commercial Code and U.S. copyright laws effectively shield software manufacturers from the standard of care reasonably expected from all other manufacturers. Often, the only liability the software manufacturer faces is replacement of defective software or payments not to exceed the original licensing fees (sale price).[4] Though

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1. Attributed to Paul Ehrlich, *The Game of Business: The Past is Present*, UPI, Nov. 21, 1988. Also variously attributed to Murphy (of Murphy's Laws); Stephen Knight, *Laws of Technology*, ASAP, Dec. 13, 1989, at 39; W.D. Moore Turnauckas III, *Murphy's Law Revisited*, OIL & GAS J., March 9, 1981, at 39; and Anonymous, P.J. Paluger, *The Physicist as Programmer: Programming on Purpose*, ASAP, June, 1990, at 17.

2. The casual reader of any metropolitan newspaper or national news magazine would be hard-pressed to avoid regularly encountering a computer malfunction article. *See, e.g.*, Tony Collins, *Lives on the Line? The Risks of Safety-Critical Software*, COMPUTER WKLY., July 27, 1995, at 26; *How Trustworthy is Safety-Related Software?*, COMPUTER WKLY., July 27, 1995, at 26 (listing 8 examples of catastrophic or near-catastrophic damages dating to 1987 due to software malfunctions).

3. Fortunately, software manufacturers can still be held liable for bodily injury caused by defects in their software. *See generally* RAYMOND T. NIMMER, COMPUTING AND TECHNOLOGY § 15 (1992); *see also* Vincent M. Brannigan & Ruth E. Dayhoff, *Liability for Personal Injuries Caused by Defective Medical Computer Programs*, 7 AM. J. LAW & MED. 123 (1992).

4. The following is a typical example of the limited warranties accompanying most software sold in the United States today. Generally, to meet the requirements of the Uniform Commercial Code, such limitations of liability are printed on the plastic wrap or envelope(s) encasing the software diskettes.

> **LIMITED WARRANTY.** For 90 days after date of delivery of the Software to you, if you are dissatisfied with the Software for any reason, you may return the complete product, with your receipt, to your dealer for a full refund (not to exceed the suggested retail price) of the amount you paid for this license (the "License Fees"). If your dealer refuses to honor this warranty, then return the complete product to (manufacturer) at the address indicated below within such 90-day period together with the receipt showing the price and date of purchase of this license, postage

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prepaid, for a full refund of the License Fees. Upon the date you return the product, the license granted by this Agreement shall terminate and you must destroy all copies of all or any portions of the Software. You are responsible for the selection of the Software and for the installation of, use of, and verification of results obtained from, the Software. TO THE MAXIMUM EXTENT PERMITTED BY APPLICABLE LAW, (COMPANY NAME) AND ITS SUPPLIERS EXPRESSLY DISCLAIM ALL OTHER WARRANTIES AND CONDITIONS, WHETHER EXPRESS OR IMPLIED, INCLUDING WITHOUT LIMITATION WARRANTIES AND CONDITIONS OF MERCHANTABILITY, FITNESS FOR A PARTICULAR PURPOSE, TITLE, AND NON-INFRINGEMENT. EXCEPT AS EXPRESSLY SET FORTH HEREIN, THE SOFTWARE IS PROVIDES "AS-IS." ALL WARRANTIES AND CONDITIONS SHALL TERMINATE 90 DAYS FROM DATE OF DELIVERY OF THE SOFTWARE TO THE ORIGINAL LICENSEE. Some jurisdictions do not allow limitations on how long an implied warranty or condition lasts, sot he above limitation may not apply to you. THIS LIMITED WARRANTY GIVES YOU SPECIFIC LEGAL RIGHTS, AND YOU MAY HAVE OTHER RIGHTS WHICH VARY FROM JURISDICTION TO JURISDICTION. IMPORTANT NOTE: Nothing in this agreement is intended or shall be construed as excluding or modifying any statutory rights, warranties or conditions which are applicable to this agreement or the Software, and which by virtue of any national or state Fair Trading, Trade Practices or other consumer legislation may not be modified or excluded. If permitted by such legislation, however, (company name)'s liability for any breach of such warranty or condition shall be and is hereby limited to either: (i) the supply of such Software again or; (ii) the correction of any defect in such Software as (company name) at is sole discretion may be necessary to correct the defect.

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damaged parties theoretically have a wide array of remedies via contract actions and tort claims, most of these approaches are easily stymied by clever use of licensing agreements and the reluctance of software purchasers to pursue other remedies through the courts.[5] Though commercial purchasers have certain capabilities and remedies available to them under the UCC which can keep software vendors in check, individual software users remain virtually at the mercy of software manufacturers. This problem is exacerbated by the fact that most damage caused by computer malfunctions affects data stored in the computer or on other storage media.[6] The courts have defined such data as "intangible," and not subject to recovery in the absence of other tangible property damage or physical injury.

Though this situation applies primarily to commercial, "off-the-shelf" software of the type used in offices and homes, it also applies to software specially constructed under contract for a specific buyer and to mass-produced software that the buyer can customize to fit her needs. Because computers and computerized processes have become ubiquitous, however, some commentators have urged a change in the current law to ensure that damages caused by negligent software manufacture can be redressed in the same manner as damages caused by any other negligently manufactured or designed product.[7] For the most part, other commentators have urged that

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PAID FOR YOUR RIGHT TO USE THIS COPY OF THE SOFTWARE WHETHER SUCH LIABILITY ARISES FROM ANY CLAIM BASED UPON CONTRACT, WARRANTY, TORT OR OTHERWISE.

5. In the case of customized software, that is, software developed under contract for a specifically stated purpose, contract remedies are more readily available. *See, e.g.*, St. Alban's City & Dist. Council v. International Computers Ltd., Queen's Bench Division, FSR 686 (1994) (holding software vendor liable for a municipality's lost tax revenues resulting from demonstrably incorrect software).

6. "Although products liability coverage responds to losses that result in physical damage, computers rarely burn up and software programs seldom cause [physical] injury. Instead, they simply stop working or fail to perform to a customer's expectations . . ." Thomas R. Cornwell, *The High Stakes of High Tech: Property and Casualty Insurance for the High Technology Industry*, BEST'S REVIEW—PROPERTY-CASUALTY INSURANCE EDITION, Sept. 1993, at 31.

7. One might think that members of the computer professions would vehemently oppose strict liability standards. This is not the case with some who have seen the computing industry on an intimate basis. *See, e.g.*, Helen Nissenbaum, *Computing and Accountibility*, COMM. OF THE ACM, Jan. 1994, at 72.

> [S]trict liability is a way of assuring that the public is protected against the potential harms of risky artifacts and property . . . [yet] most producers of software explicitly deny accountability for the harmful impacts of their products, even when they malfunction . . . [Applying]

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the courts and legislatures *not* subject software to strict product liability standards claiming that to do so would create a chilling effect and significantly inhibit advances to computing technology.[8]

However, none of these commentators have been able to fit the inherently novel nature of extant software within the confines of product liability laws meant to address products of a more traditional nature.[9] Further, the courts have appeared reluctant to extend strict product liability standards to this area.[10] This reluctance has been exacerbated by the relatively few computer malpractice cases to have been addressed by the courts.[11] Thus, many commercial purchasers and virtually all private

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> strict liability [will send] an emphatic message to producers of software to take extraordinary care to produce safe and reliable systems.

*Id.; see also infra* Section V.C of this Comment for other examples of software professionals advocating for heightened standards for their profession.

8. *See, e.g.*, Robert W. Gomulkiewicz & Mayr L. Williamson, *A Brief Defense of Mass Market Software License Agreements*, 22 RUTGERS COMPUTER & TECH. L.J. 335, 338 (1996) (arguing that courts and legislatures whould validate the use of shrinkwrap licenses as "provid[ing] valuable information to end users, and . . . that permit[ting] software publishers to offer the wide variety of rights that are associated with the features of today's software products."); *see also* Bijoy Bordoloi et al., *A Framework to Limit System Developers' Legal Liabilities*, J. MGMT. INFO. SYS., Spring 1996, at 161-185 (citing numerous commentators on the liability of software developers).

9. Two notable exceptions include Monique C.M. Leahy's excellent article, *Computer Malpractice*, 32 AM. JUR. PROOF OF FACTS 3d (1996), which sets out an intriguing case for holding computer specialists to a standard of computer malpractice, and Daniel J. Hanson, Note, *Easing Plaintiff's Burden of Proving Negligence for Computer Malfunction*, 69 IOWA L. REV. 241 (1983). Hanson's note is a cogent analysis of why existing product liability negligence standards do not provide adequate remedies for malfunctioning software. Effectively predating the boom in personal computing, the note focuses only on negligence standards for software sold by a commercial vendor to a commercial purchaser, but points out that as early as the late 1970s, many legal scholars had noted that traditional tort theories might not work well when computers were involved. *Id.* at n.3. Leahy's article asserts a malpractice standard which argues from the point of view of traditional malpractice, that is, that software professionals' profession has sufficiently matured to come within the boundaries normally assigned to physicians, attorneys and the like. *See* Leahy, *supra*, § 7. Leahy's focus remains on the more traditional route for asserting negligence: analyzing the software programmer's actions. Although this undoubtedly is a fertile area, the objective of this Comment is to suggest that a reasonable alternative is to analyze what the software itself purports to do in determining which legal standards (and which remedies) apply.

10. Cases abound here. As early as 1983, *The Wall Street Journal* estimated a backlog of some 3,500 software-related cases. *Technology, Computers are Transforming Traditions of Law Profession*, WALL ST. J., Aug. 19, 1983, at 21. The number has surely increased. In addition, the number of cases referred to arbitration has increased dramatically.

11. A scan of the LEXIS-NEXIS database finds fewer than two dozen state and federal cases addressing this topic since 1980. The small number of cases uncovered thus far

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software consumers are unable to recover for very real damage caused by malfunctioning software.

A more fertile ground for examination is the possibility of holding software manufacturers and developers to a multi-layered standard of care. This standard would be derived from not only the mechanical functionality of software, but also the "services" it performs during its operation and the inherent tangibility or intangibility of the data with which it interacts for the benefit of its human (or indeed, mechanical) "client."[12] The standard, discussed in detail in Section V of this Comment, recommends evaluating charges of software negligence or malpractice in terms of the actual harm caused to the software itself, the data it contains, and/or the human using it and relying on its output. In practice this would mean that plaintiffs could make a claim against the manufacturer of malfunctioning software on the basis of strict products liability, breach of contract, simple negligence, or malpractice analogous to that applied against physicians, attorneys and

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coupled with the speed of computer technology indicates that the courts have not had an opportunity to address this topic in any comprehensive fashion.

12. The use of the word "client" here is intentional. As will be seen, much software usage involves a (willing) abdication of control from the human user to the machine. This abdication is not due to human laziness, but appears to be a recognition by human operators of software of the software's inherent speed and sophistication. These attitudes are borne out by numerous psychological studies conducted over the past two decades. Psychologists have long recognized that human decision-making is subject to a variety of circumstances, information processing patterns, and biases which can lead an individual to erroneous conclusions, to be too conservative in drawing conclusions, or to be too self-confident in drawing conclusions. Several phenomena are particularly relevant in whether an individual accepts the information provided by a source (in this case, a computer): the individual's positive or negative experience resulting from a previous reliance on the source; a bias against using contrary information (in the above example, to conclude that an otherwise reliable calculator was incorrect); the complexity of the problem to be solved and the individual's feeling of competence to solve the problem independent of another source (that is, to rely on one's own computational skills rather than the calculator). *See generally* Christopher D. Wickens, *Desision Making, in* ENGINEERING PSYCHOLOGY AND HUMAN PERFORMANCE 73-118 (1984); SCOTT PLOUS, THE PSYCHOLOGY OF JUDGMENT AND DECISION MAKING (1993). Other, more dramatic studies underscore the individual's willingness to abrogate her own judgment when confronted with an authoritative figure. The classic example here are Stanley Milgram's experiments at New York University beginning in 1965. Milgram effectively showed that, when encouraged by an authority figure (in Milgram's experiments, a "scientist" in a white lab coat with authoritative demeanor), most participants would administer painful electrical shocks to another participant – despite their own personal misgivings about the act. Given this effect, it is little wonder that many individuals so willingly trust the computer, even in equally dramatic and potentially disastrous situations. For a brief discussion of Milgram's experiments, see *Obedience, in* THE OXFORD COMPANION TO THE MIND 566-68 (Richard L. Gregory, ed. 1987).

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other professionals.[13] This is a particularly critical area because cases which have been heard by the courts have involved only commercial vendors and commercial purchasers of software and related hardware and services.[14] Despite the explosion of personal computing in the past fifteen years, the courts have yet to address the issue of software malpractice vis à vis commercial vendors and private citizens. As this Comment concludes, the current standards promulgated by the courts rely on the UCC, which creates an impassible barrier for non-commercial purchasers. The Comment urges that a new area of software tort be developed. This new tort would recognize the dynamics of the software "product" itself, the nature of software as a tool, and the evolution of accepted practices and standards in the software manufacturing industry.

This Comment will assess the desirability of establishing a non-commercial standard of care for software. First, the comment will briefly examine the history of computer malpractice suits in the United States. Second, it will contrast the current state of computing in the United States with the state of computing when the initial computer malpractice standards were first suggested. Next, it will discuss current insurance arrangements for software disasters. Fourth, this Comment will review the Uniform Commercial Code (UCC) issues lurking in the background of software liability, namely, is software a good or a service and which provisions of the UCC, contract law and/or tort law should apply. Fifth, this Comment proposes a variable duty of care standard for software liability which allows vendors to be held liable for the damage caused by their software in light of the service that software purports to provide. Sixth, this Comment reviews emerging liabilities for the software and computer industries and points to the insurance industry's historical role as standard setter as justification for entertaining liability for software-induced harm. This Comment concludes that insurers have already determined that the software industry is sufficiently robust to withstand software liability suits and that the insurers are already well positioned to provide appropriate risk-spreading.

## I. A BRIEF HISTORY OF COMPUTER TORT

Current software liability law developed from diverse areas of law not specifically suited to this unique product. Case law stretching back nearly two decades consistently rejects the concept of software malpractice,

13. *See generally* RESTATEMENT (SECOND) OF TORTS § 402A (1964).

14. *See, e.g.*, Black, Jackson & Simmons Ins. Brokerage, Inc. v. International Bus. Mach., Corp., 440 N.E.2d 282 (Ill. App. Ct. 1982).

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preferring to require injured parties to seek redress through contract law. Copyright provisions provide software manufacturers some additional protection under certain circumstances by classifying software as a "literary work" not subject to many traditional tort liabilities. The Uniform Commercial Code (UCC) gives software manufacturers wide latitude in limiting liability for damages caused by faulty design or manufacture.

*A. Case Law*

The concept of computer malpractice first appeared in the case of *Chatlos Systems v. National Cash Register Corp.*,[15] in which Chatlos sued National Cash Register (NCR) over software which failed to provide four of six promised functions. Despite repeated attempts, NCR was unable to provide satisfactory software, at a cost of lost revenues to Chatlos. Chatlos sued, claiming NCR had committed a "malpractice" by not providing expertise suitable to recognize that the software would not meet Chatlos' needs and by failing to fix the software once its deficiencies had become apparent.[16] The court rejected the notion of malpractice, noting,

> [The] novel concept of a new tort called 'computer malpractice' is premised upon a theory of elevated responsibility on the part of those who render computer sales and service. Simply because an activity is technically complex and important to the business community does not mean that greater potential liability must attach."[17]

Throughout the 1980's and into the 1990's courts continued to follow this lead. In *Invacare Corp. v. Sperry Corp.*[18] the court concurred with the reasoning in *Chatlos*:

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15. 479 F. Supp. 738 (D.N.J. 1979), *aff'd*, 635 F.2d 1081 (3d Cir. 1980).

16. *Id.* at 740-42.

17. *Id.* at 740 n.1.

18. 612 F. Supp. 448 (N.D. Ohio 1984). Courts, however, have recognized that software and hardware vendors could be held liable for malpractice for providing their customers false or misleading information on which the customers relied to their detriment. In such cases, the courts have noted that the "malpractice" resulted from the customer's foreseeable reliance on the vendor's superior technical knowledge, and the vendor's consequent responsibility to provide a higher standard of care when disseminating advice. *See, e.g.*, Diversified Graphics, Ltd. v. Groves, 868 F.2d 293, 296 (8th Cir. 1989) (holding that Ernst & Whinney should be held to professional standard of care in advising Diversified Graphics' selection of a computer system because of Ernst & Whinney's "superior knowledge and expertise in the area of computer systems"); *see also* Eric A. Savage, *Don't Get Caught Holding the Bag*, COMPUTER WORLD, April 8, 1991, at 89.

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> Chatlos Systems was concerned with creating a new tort on a theory of elevated responsibility [for] computers(sic) sales and service . . . [plaintiff] claims allege a breach of the ordinary standard of care to which those [in the vendor's] industry are held. Such allegations do not involve a new tort of 'computer malpractice.'[19]

In *RKB Enterprises Inc. v. Ernst & Young*, the court recalled *Chatlos*, asserting, "[There] is no cause of action for professional malpractice in the field of computer consulting . . ."[20] Thus, by the end of the decade a consistent position regarding computer malpractice had been established: 1) computer professionals were not subject to malpractice claims; 2) courts viewed assertions of breach of warranty or other contract breaches more favorably than assertions of software negligence; and 3) the Uniform Commercial Code (UCC) was viewed as amply flexible to encompass claims arising out of software transactions gone sour.[21] More recently, the trend has continued in *Fishbein v. Corel,*[22] in which the court held that a software designer cannot be sued in negligence of strict liability even when his software program frequently caused computers to crash and freeze. The disappointed buyer must assert a breach of warranty or breach of contract claim instead.[23]

*B. UCC Provisions*

In part, the Uniform Commercial Code (UCC) safeguards software manufacturers from certain types of suits. Initially under § 2-105, software was not considered a manufactured product.[24] As a result, software producers could not be subject to standards of strict liability like manufacturers of automobiles or power tools. This has changed recently,

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19. *Invacare*, 612 F. Supp. at 454.

20. 182 A.D.2d 971, 971-72 (N.Y. App. Div. 1992).

21. Fishbein v. Corel, PICS Case No. 96-5837, March 21, 1996, construed in Mary Ellen Fox, *Software Glitches Tort Proofed*, PENN. L. WKLY., April 8, 1996, at 2.

22. *Fishbein,* PICS Case No. 96-5837.

23. *Id.*

24. UCC § 2-105 (1995) states: "'Goods' means all things (including specially manufactured good) which are movable at the time of identification to the contract for sale other than the money in which the price is to be paid, investment securities . . . and things in action." But, as some commentators have noted, applying the concept of strict liability to some types of goods is, at best, tenuous. *See generally* Note, *Strict Liability for Defective Ideas in Publications*, 42 VAND. L. REV. 557 (1989) (concluding that strict liability should not be applied to publications that contain defective information).

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and the UCC has been applied to software per se.[25] As a result, software manufacturers can limit their liability simply by stating the limitations in a standard licensing agreement accompanying their products.[26] To be sure,

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25. Advent Sys. Ltd. v. Unisys Corp., 925 F.2d 670, 673-77 (3d Cir. 1991). The Court noted:

> Computer programs are the product of an intellectual process, but once implanted in a medium are widely distributed to computer owners. An analogy can be drawn to a compact disc recording of an orchestral rendition. The music is produced by the artistry of musicians and in itself is not a "good," but when transferred to a laser-readable disc becomes a readily merchantable commodity. Similarly, when a professor delivers a lecture, it is not a good, but, when transcribed as a book, it becomes a good.
>
> That a computer program may be copyrightable as intellectual property does not alter the fact that once in the form of a floppy disc or other medium, the program is tangible, moveable and available in the marketplace.

*Id.* at 675.

Commentators such as Deborah Kemp have noted that many software manufacturers have relied on the UCC's Article 2 warranty provisions because common law does not provide unambiguous guidelines for avoiding liability resulting from defective programs. *See generally* Deborah Kemp, *Mass Marketed Software: The Legality of the Form License Agreement*, 48 LA. L. REV. 87, 119 (1987). Interestingly, there is now a move to declare software an "intangible," and therefore not subject to the provisions of the UCC. *See* National Conference of Comm'rs on Uniform State Laws, *Uniform Commercial Code Revised Article 2. Sales: Chapter 3 — Licenses* (Discussion Draft Sept. 10, 1994) (cited in Douglas E. Phillips, *When Software Fails: Emerging Standards of Vendor Liability Under the Uniform Commercial Code*, 50 BUS. LAW. 151 (1994)). In the recent case of Lotus Dev. Corp. v. Borland Int'l., 49 F.3d 807 (1st Cir. 1995), *reh'g denied*, 116 S. Ct. 1062 (1996), the U.S. Supreme Court let stand a lower court ruling that certain aspects of the software user interface (the menu structure) could not be copyrighted. This has caused a great many attorneys to argue that software should be patentable. An irony of this approach is that patent protection may well create the product liability risks that software vendors have thus far been able to elude.

26. *See generally* UCC §§ 2-316, 2-317 (allowing all parties to a contract to set their own remedies for breach, limit damages that could be awarded, or both); *see also* RRX Industries, Inc. v. Lab-Con, Inc., 772 F.2d 543 (9th Cir. 1985) (software manufacturer liable only to the limits set by agreement between manufacturer and buyer); EJS-ASOC Ticaret ve Danismanlik Ltd. STI v. American Telephone & Telegraph Company, 886 F. Supp. 331 (S.D.N.Y. 1993) (liability limited by contract agreement); Hi Neighbor Enter., Inc. v. Burroughs Corp., 492 F. Supp. 823 (N.D. Fla. 1980) (same). *But see* ProCD, Inc. v. Zeindenberg, 908 F.Supp. 640 (W.D. Wis. 1996) (citing general view of commentators of "shrink-wrap licenses as being of questionable validity, primarily because software users do not have the opportunity to bargain over their terms."); Continental Ill. Nat'l Bank & Trust Co. of Chicago v. Premier Sys., Inc., No. 88-C7703, 1989 U.S. Dist. LEXIS 2664, at *14

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the UCC's "unconscionability" doctrine prevents the software manufacturer from evading liability in cases where personal injury occurs.[27] However, economic or property damage is virtually exempt, except in the case of negligent misrepresentation.[28] There remains some

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(N.D. Ill. Mar. 14, 1989) ("damages 'arising from the use of the software' plainly include damages caused by a basic failure of the software, contra to vendor's interpretation of contract clause limiting liability only to damages caused by the *use of the software*") (emphasis in original). *See also* Eric S. Freibrun, *Court Strikes Down Shrink-wrap License Agreement*, http://www/cl.ais.net/lawmsf/articl22.html (citing ProCD, Inc. v. Zeidenberg and noting that a shrink-wrap license agreement does not provide the buyer with an adequate opportunity to decide whether the license terms were acceptable or not at the time the contract is formed, i.e., at the time the retail transaction is completed.).

27. UCC § 2-302 (1992). Comment 1 to this section notes:

> This section is intended to allow the court to pass directly on the unconscionability of the contract or particular clause therein and to make a conclusion of law as to its unconscionability. The basic test is, whether, in the light of the general commercial background and the commercial needs of the particular trade or case, the clauses involved are so one-sided as to be unconscionable under the circumstances existing at the time of the making of the contract. . . . The principle is one of the prevention of oppression and unfair surprise . . . and not of disturbance of allocation of risks because of superior bargaining power.

28. *See generally* NIMMER, *supra* note 3, § 15, stating that:

> [T]he tort of negligent misrepresentation only covers cases in which information is supplied by a defendant in the business of providing information for the guidance of others. A controversy exists about whether this tort claim can be asserted in cases where the person supplying incorrect information also engages in the sale of goods to a buyer who relies on that information (citing Black, Jackson & Simmons Ins. Brokerage, Inc. v. International Bus. Mach., Inc., 440 N.E.2d 282 (Ill. App. Ct. 1982) (IBM not liable for negligence; it was a seller not engaged primarily in supplying information for the guidance of others); Accusystems, Inc. v. Honeywell Info. Sys., Inc., 580 F. Supp. 474 (S.D.N.Y. 1984) (same); Rio Grande Jewelers Supply Co. v. Data Gen. Corp., 689 P.2d 1269 (N.M. 1984) (negligent misrepresentation claims cannot survive contract disclaimers involving sale of goods).

NIMMER, *supra* note 3, at § 15.15, n.212. Some courts have held that negligent misrepresentation must be predicated on a relationship "greater than that between an ordinary buyer and seller." Daniel v. Dow Jones & Co., N.Y.S.2d 94 (N.Y. Sup. Ct. 1987) (cited by NIMMER, *supra* note 3, § 15.15). In most jurisdictions the "economic loss rule" applies. This limits plaintiff's remedies to those contractually permitted. Consequential damages expressly precluded by the sales contract usually cannot be regained by asserting the vendor's negligence. Richard Raysman & Peter Brown, *How to Limit Liability Issues Before Trial*, N.Y.L.J., June 13, 1995, at 3.

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question as to the applicability of the UCC in cases where a given software package can be construed as constituting a mixed arrangement of goods and services,[29] like expert systems,[30] or software which purports to provide legal or financial advice.[31]

Virtually all the courts addressing claims of computer negligence or malpractice have relied on the UCC to categorize whether the software in question was a "product" or a "service." Most courts determined that software is a product, a tangible representation of the programmer's skill and ideas, especially when it was not incidental to a contract for "services." Once in tangible form, software was not unlike, as one court explained, a composer's music rendered into a compact disk.[32] Once tangible, the full protection afforded by the UCC applies.[33]

*C. Copyright Protection*

Under the copyright law, software is considered a "literary work."[34] The software manufacturer may, therefore, be protected from legal action

29. Traditionally, mixed goods and services contracts have been analyzed to determine which component dominates. Parties rights and liabilities result from this determination.

30 An expert system relies on "rules" developed by "knowledge engineers" who derive the rules by analyzing how human experts work in a particular field of endeavor. Expert systems purport to operate and make "decisions" just as their human counterparts would. The more accurate the rules, the closer the expert system comes to mimicking the human. Expert systems are distant cousins to so-called artificial intelligence systems. While expert systems cannot extend beyond the rules embedded within them, artificial intelligence (AI) systems apply their rules to a variety of new situations from which they can "learn," and self-adapt their operating rules.

31. *See generally* Lawrence B. Solom, *Legal Personhood for Artificial Intelligences*, 70 N.C.L. REV. 1231 (1992) (discussing whether artificial intelligence software should be treated as a person in litigation).

32. Lucker Mfg. v. The Home Ins. Co., 23 F.3d 808, 819 (3d Cir. 1994).

33. Some commentators have argued that to limit the seller's U.C.C. protection, e.g., by applying a strict liability theory, would be tantamount to "allowing the buyer to have his cake and eat it too" providing an injured consumer "a theory of redress not envisioned by our legislature when it enacted the U.C.C., since this strict liability remedy would be completely unrestrained by disclaimer, liability limitation and notice provisions. Further, manufacturers could no longer look to the Uniform Commercial Code provisions to provide a predictable definition of potential liability for direct economic loss." David B. Gaebler, *Negligence, Economic Loss and the U.C.C.*, 61 IND. L.J. 593, 625 (1986); *see also* Metropolitan Life Ins. Co. v. Noble Lowndes Int'l., 643 N.E.2d 504 (N.Y. 1995) (holding that a limitation of liability provision in a contract to supply software to the plaintiff imposed liability only if the software company willfully harmed the plaintiff).

34. 17 U.S.C. § 102(a)(1) (1994) (providing protection for literary works) and 17 U.S.C. § 101 (1994) (defining literary works as "works expressed in words, numbers, or other verbal or numerical symbols or indicia, regardless of the nature of the material objects . . . in which they are embodied").

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for damages caused by incorrect information contained in her software, much as publishers are not held liable for even fatally incorrect information contained in the books they produce.[35] This is especially so if the publisher does not control the content of the work, but merely provides for its dissemination. There remains a significant question whether a software manufacturer remains sufficiently in control of the contents of software she designs, codes and produces for distribution to be held liable for any damages the software may cause. Cases involving publishers who developed their publications wholly in-house (rather than relying on an outside author) have held the publisher responsible for personal injuries caused by such publications.[36]

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35. The classic case here is Winter v. GP Putnam's Sons, 938 F.2d 1033 (9th Cir. 1991), in which a publisher was deemed not liable for incorrect information contained in its book THE ENCYCLOPEDIA OF MUSHROOMS. A family of mushroom hunters, relying on the information in the book, collected and consumed poisonous toadstools, resulting in serious physical injury. The court held that the free flow of ideas was too important to restrict by making a publisher liable for information brought to it by an author. Consequently, a publisher has no duty to verify the accuracy of the information in books it publishes. The software industry noted Senior Circuit Judge Sneed's dicta that malfunctioning software may be considered a "sufficiently tangible" product. WORLD INS. REPORT, *Software Liability — Mushrooming?*, August 2, 1991.

36. Contrast, however, with several other cases Nimmer cites: Brockelsby v. United States, 767 F.2d 1288 (9th Cir. 1985); Saloomey v. Jeppeson & Co., 707 F.2d 671 (2d Cir. 1983); and Aetna Cas. & Sur. Co. v. Jeppeson & Co., 642 F.2d 339 (9th Cir. 1981). NIMMER, *supra* note 3, § 15.14, n.206. In these cases, a publisher was held strictly liable for faulty airplane flight charts. Because the publisher had developed the information contained on the map as well as published it, it was held responsible for factual errors in the publication. Interestingly, Nimmer argues that applying strict liability principles to such cases is "excessive." *Id.* at § 15.14. *But see contra*, Jonathan B. Mintz, *Strict Liability for Commercial Intellect*, 41 CATH. U. L. REV. 617 (1992). Mintz argues that

> Courts make an unprincipled distinction by recognizing compensable damage resulting from, for example, an unreasonable risk of paper cuts from a cookbook, rather than the hazardous and eminently foreseeable, consumption of one of the ingredients specifically called for in a recipe therein. Moreover, such artificial distinctions unnecessarily limit and often completely shield suppliers of defective goods from the normative influences of the American system of strict liability.

*Id.* at 618.

Mintz asserts that the courts' decisions in this area smack of an unrealistic reliance on free speech concerns and an erroneous anticipation of a chilling effect resulting from applying product liability principles to "intellectual" products. *Id.* at 619. He concludes that applying such standards is "both analytically appropriate and constitutionally sound." *Id.* at 630.

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## II. UPDATING THE HISTORY OF SOFTWARE MALPRACTICE

### *A. State of Computing - Then*

Computers and computerized process have become so pervasive today that one finds it difficult to remember that only a scant 15 years ago, computing was the purview of specially trained (or at least highly knowledgeable) engineers[37] or the electronic hobbyist holed up in a basement workroom building the latest Heathkit "computer."[38]

In 1980, computers were specialized and expensive tools, managed by special cadres of professionals trained in the mysterious languages, symbols and syntax required to make computers work. Software programs primarily addressed problems that required a great deal of straightforward "number crunching:" inventory management, billing, tax records, and so on. Virtually all data processing occurred in "batch" operations, in which the software would process new sets of data at pre-determined times. Interaction between an end-user[39] and the computer was through the intermediary of the data processing professionals who spent all day, every day, wrestling to make the computer work, through laboriously keypunched computer cards, or through teletype terminals connected to a mainframe computer via acoustic couplers. Typically, computer software permitted only small variations and flexibilities in output without having to be rewritten; this was, of course a vast improvement over earlier computers which had to be manually re-wired to make the simplest changes in the computing output.

A key characteristic of this period in computing was the competing software standards advanced by the major hardware manufacturers, IBM,

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37. *See, e.g.*, *Chatlos Systems*, 479 F. Supp. at 738.

38. Indeed, computing was primarily known as "data processing." Computers were generally huge, finicky machines requiring specially built rooms and air conditioning systems to reduce damage from dust and maintain constant temperatures. Software development required personnel specially trained to program in COBOL, FORTRAN or their variants. Software coding was costly, and prone to "bugs," mistakes in the program that often caused a program to "crash" (stop running) or produce incorrect output. Computerphiles with electronics skill could produce rudimentary computers at home by purchasing kits of electronic components and circuits manufactured by the Heath Corporation. Thus, until the advent of the Apple computer in the late 1970's, computing and its associated software remained essentially a professional or hobbyist's endeavor. The average citizen experienced computing primarily via computerized bills and invoices.

39. An "end-user" is defined as the person who receives the computer output and uses it to perform her job, for example, an inventory manager or a department store accounts receivable clerk. As will be seen, the growth of computing has vastly increased the number of end-users.

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Sperry, Univac, Burroughs, NCR and Digital Electronics Corporation (DEC). Each manufacturer's hardware used a proprietary operating system.[40] As a result, software developed for one manufacturer's computer could not operate on that of another manufacturer, even though both machines might be using COBOL[41] or FORTRAN.[42] Because no standard dominated the marketplace, data processing professionals often had to know intimately the rather obscure rules and formulations of a variety of programming languages and dialects. The sheer multiplicity of dialects created an almost insurmountable barrier for the non-professional.

As a result, computers and their related software were viewed by the courts as specialized tools, used by specialized people, for specialized purposes. Computer professionals knew, or should have known, that software could be prone to bugs, glitches, and potentially devastating errors. They also knew that software could be highly complex and took reasonable steps to mitigate any damages faulty software might cause. In short, software users knowingly accepted the risks inherent in using the software. Absent clear misrepresentation, fraud, or breach of contract by the software vendor, the software purchaser had little recourse for damages resulting from software errors.[43]

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40. An operating system is the basic "brains" of a particular computer, the "super software" that enables the computer to understand and act upon the instructions supplied by the end user.

41. The COmmon Business Oriented Language, COBOL was one of the earliest widely-used computer languages, and was specifically geared to the data processing needs of business, e.g., billing, inventory and sales. So popular was the language that even some 30 years later, many major corporations still rely on at least some COBOL code for their day-to-day operations.

42. The FORmula TRANslator language, FORTRAN, was developed for use in scientific research and engineering.

43. *See, e.g.*, *Chatlos Systems*, 479 F. Supp. at 740. The court noted that limitations on damages for personal injuries were not favored, but that no such prejudice applied to property losses. It was also important, the court said, that the claim was for commercial loss and that the adversaries were substantial business concerns. The court found no great disparity in the parties' bargaining power or sophistication, and no "surprise" element. The court pointed out that apparently the buyer, which was itself a manufacturer of complex electronic equipment, had some appreciation of the problems that might be encountered with a computer system.

A major exception, of course, was for software that proximately caused personal injury. To eliminate this liability, some vendors of general application and application building software (software used to build other software) explicitly denied warranty for their software if it was used for life-support or medical equipment. (*See, e.g.,* Oracle licensing agreement, on file with the author.)

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*B. The Current State of Computing*

In contrast, today the average person encounters at least one computer every day. Personal computers dominate business offices and have gained a huge foothold in homes and schools. Increasingly, people carry computers with them in their wrist watches, their briefcases, and jacket pockets. Computers now manage home appliances, utility and safety systems.[44] They monitor hospital patients[45] and send and receive electronic mail,[46] among many other uses. Virtual reality headsets enable an individual to "walk through" houses not yet built.[47] Electronic whiteboards allow meeting attendees thousands of miles apart to edit the same

44. *See, e.g.*, Victor D. Chase, *Putting a "Human on a Chip" to Improve Space Conditioning*, APPLIANCE MANUFACTURER, Jan. 1995, at 14 (describing the use of fuzzy logic to enable home heating and cooling systems to self-regulate based on the presence or absence of one or more individuals); *5th Annual Discover Awards for Technological Innovation*, DISCOVER, Oct. 1994, at 72 (describing Whirlpool corporation's fuzzy logic-based refrigerator which utilizes fuzzy logic to defrost itself only when necessary); Phil Patton, *What to Buy in the '90s*, MONEY, Aug. 1992, at 142, describing:

> Appliances with sense. Due next year, this "fuzzy logic" Sharp microwave oven . . . will be the first of its kind in the U.S. Such sophisticated appliances are already available in Japan. Fuzzy-logic technology is the same as that found in smart cameras that have built-in light meters and automatic focus. In the microwave, 11 sensors calculate the shape, type and size of food and then determine the optimal cooking time and temperature. After the microwave, Sharp plans to introduce a fuzzy-logic vacuum cleaner that can regulate its power and cleaning brushes.

This article also describes "[t]he smart house. Using a central computerized panel . . . or a Touch-Tone phone, this technology, adopted by 25 firms including Pioneer and AT&T, lets you fine-tune heating and air conditioning as well as control appliances and lamps. A car phone can switch on the Jacuzzi or program the thermostat to be energy-efficient." *Id.* In addition, it speaks of "[f]ail-safe cooking. Computerized microchips in breadmakers and toasters . . . assure even browning." *Id.*

45. *See, e.g.*, *3Com Network Makes British Columbia Children's and Women's Hospitals Ready for the Future; Hospital Group Uses Network to Lower Costs and Increase Reach of Health Care Services*, BUS. WIRE, Feb. 17, 1997; *Toshiba Receives FDA Clearance for Breakthrough Diagnostic Imaging Technology*, BUS. WIRE, Dec. 4, 1996.

46. *See, e.g.*, Peter Scisco, *Magic Cap Puts a Friendly Face on Your E-mail*, PC WORLD, March, 1997, at 86; Paul M. Eng, *Keeping the Junk Out of E-mailboxes*, BUS. WK., February 24, 1997, at 104.

47. *See, e.g.*, Marcia Mogelonsky, *Reconfiguring the American Dream*, AMERICAN DEMOGRAPHICS, January, 1997, at 26; Danny Bradbury, *Out of This World: Virtual Reality Technology*, COMPUTER WKLY., July 18, 1996, at 43.

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document simultaneously.[48] Virtually all forms of human activity, including sex, now have computer-based analogs.[49]

The style of computing has changed significantly during the past 15 years. Graphical user interfaces (GUIs) predominate, allowing users to operate a computer by pushing on-screen buttons, or selecting from a list of choices. At no time does the typical user have to do anything remotely akin to programming. Indeed, the major selling points of hardware and software manufacturers in recent years has been that virtually anyone can operate a computer.[50]

Increasingly this opportunity results from increased "intelligence" in software packages to anticipate what the end-user might wish to do. Such intelligence can be represented in several ways: via software "wizards" (pre-packaged mini-programs which ask the end user specific questions about the contours of the task she wishes to perform, then automatically completes the task and presents the results to the user);[51] via "agents" (anthropomorphic representations with "whom" the end user interacts and "converses" to accomplish a given task);[52] via "expert" systems (software which captures the rules and heuristics human experts utilize to perform a given task, which then allows a novice to perform similarly to the expert);[53] or via artificial intelligence software (which, though initially programmed, can "learn" from its "experiences" and re-organize its internal logic).[54] In all cases, the objective is to liberate the end-user from

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48. *See, e.g., Touch-sensitive Screen Featured on Smart 72-inch Smart Board*, COMPUTING CANADA, Feb. 3, 1997, at 51.

49. Recent issues of PC WORLD and PC MAG. list more than two dozen ads for "adult" software. PC WORLD, March, 1997, at 301; PC MAG., March 25, 1997, at 438, 443-45.

50. Any magazine containing computer hardware or software advertising provides ample evidence that software manufacturers gear their pitches to emphasize no special skills are required to operate their products. *See, e.g.*, Microsoft's multi-page ads appearing in TIME and NEWSWEEK during the period November 1, 1996 through February 1, 1997.

51. *See, e.g., New E-Mail Rules Wizard and Sample Groupware Applications Provide Sophisticated Collaborative Solutions to Widest Range of Users*, PR NEWSWIRE, Jan. 28, 1997; *AirLink Introduces New CDPD Cell Wizard*, TELECOMWORLDWIRE, Jan. 6, 1997.

52. *See, e.g.*, Gralla Preston, *Agents*, WINDOWS SOURCES, March, 1997, at 165; Robert L. Scheier, *Autonomous Agents Promise Productivity Gains*, COMPUTERWORLD, Feb. 17, 1997, at 17; *Johns Hopkins University Press Employs PLS Search and Intelligent Agent Technology to Publish Journals Online*, BUS. WIRE, Feb. 10, 1997.

53. *See generally*, PAUL HARMON & DAVID KING, EXPERT SYSTEMS (1985).

54. One early example of artificial intelligence was the ELIZA program, written in the first widely used AI language (LISP). ELIZA was designed to provide the effect of a Rogerian psychoanalytic session. It did so by parsing the sentences the end user typed at her terminal, turning them into questions and querying the end user. Thus, the end-user's statement, "I hate my mother," became ELIZA's, "Why do you hate your mother?"

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her own limitations of skill or knowledge. Indeed, as one key designer at Apple Computer noted, the purpose of well-designed software is to "enable the novice to perform like an expert, and the expert to go beyond his own expertise."[55] To accomplish this end, the user must rely more and more heavily on the expertise and accuracy of the software itself, since the end-user often cannot independently assess the correctness of the outcome.[56] This, coupled with the tendency of some 80% of the users of a typical software application to learn only 10% of the functionality of the package, indicates that users tend to leave ever more of the "thinking" to the software.[57] Thus, when software fails, its impact can be dramatic:

> When software controls missile defenses, radiation equipment and other life-and-death machines or processes, the consequences of failure are self-evident. For the more common software systems primarily affecting business health and well-being, software failure is a major economic issue and potentially a matter of corporate survival. When business systems fail, the costs to the user often far exceed its investment in the software or even its total system management, including hardware conversion and training. Software automates manual functions and performs other functions

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response. Theoretically, the conversation continued until the end user tired of it or had a psychologically profound insight. (Software on file with the author.)

55. BRUCE TOGNAZZINI, TOG ON DESIGN 12 (1992).

56. Many software manufacturers incorporate "self-correcting" features with their software so that the software appears to be preventing the user from doing something erroneous. For example, Microsoft's word processing software underlines words which appear to be misspelled. Graphical user interfaces generally "gray out" commands which cannot be used at a given time, e.g., one can not "paste" without having first "copied" or "cut" some object in the interface.

57. Susan A. Wiedenbeck, *Learning Styles for New Software Applications*, paper presented at the 39th Annual Conference of the American Society of Information Science (ASIS), San Diego, CA, March 27, 1989. Wiedenbeck studied a number of users of a word processing package. Based on their use of the package, she grouped them into three categories. Approximately 10-20% of the users were classified as "novices," that is, first time users who new a little about the program. Most of these would progress into "discretionary" users. Discretionary users formed the largest group (approximately 60-70%). Discretionary users learned about 10-20% of the total functionality of the software package. As they encountered new requirements, say, placing a table in a memo, they would either (1) learn the new steps to accomplish the task or (2) combine steps they already knew to approximate the desired result. Beginning typists unfamiliar with Tab or Indent functions use a similar strategy when they press the space bar several times to create the appearance of an indented paragraph. The last group, the "power" users (approximately 10-20%)are analogous to the data processing professionals. Power users typically learn all there is to know about the software and regularly use most of the features it provides.

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> that are impractical or impossible to perform on a manual basis. *Much of its appeal is achieved by promising to transform the way a user does business. It invites, and requires, dependency. When key software fails, this dependency often results in major losses* (emphasis added).[58]

Users, especially less experienced ones, generally appear willing to release control over their tasks to the computer. When mistakes occur, users tend to blame themselves or their own lack of skills rather than the software.[59] Often, users are simply unaware of computer-generated errors, assuming the computer must, by definition, be correct.[60] Or, the computer's ability to work at high speed on problems of mind-boggling complexity may encourage acquiescence on the part of the end-user whose own capabilities are significantly slower and more prone to distraction.[61]

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58. Douglas E. Phillips, *When Software Fails: Emerging Standards of Vendor Liability Under the Uniform Commercial Code*, 50 BUS. LAW. 151, 154 (1994).

59. In a telling experiment, users were asked to manually calculate the sum of a list of numbers, then to calculate it using calculators that had been doctored to provide incorrect answers. A significant number of participants changed their correct manually derived answers to match the incorrect answer produced by the calculator. The researchers reasoned that the users assumed that the calculator had to be correct, and that any discrepancy was based on errors of their own making.

60. Even in instances where the end-users suspect faulty software, the problem can be elusive and intermittent. *See, e.g.*, Jason Allardyce, *Countdown to Disaster*, THE SCOTSMAN, March 22, 1996, at 4 (describing concerns about the automatic piloting system of the RAF's Chinook Mark II aircraft:

> In March 1994, a memo - sparked by concern about the Mark II's automatic piloting system - instructed RAF pilots to avoid prolonged cruising at below 300 ft.
>
> That same month, trials involving the new aircraft at a base in Boscombe Down in Wiltshire were suspended, between 7 March and 20 April, after problems developed with FADEC, the digital engine control system.
>
> Tests resumed *after no software faults could be found*, but further problems occurred, five of which were FADEC malfunctions." (emphasis added)

61. *See, e.g.*, Jeremy Laurance, *Cancer Patients Given Wrong Dose*, TIMES (London), Feb. 7, 1992 (describing concerns over 1000 cancer patients who had received smaller doses of radiation than they required because of a correction factor unnecessarily programmed into an isocentric (revolving) x-ray machine.)

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Increasingly, embedded software is being used in such a wide array of products that the end user may be oblivious to the fact that, say, his washing machine contains more computing power than was required to launch Sputnik[62] and that it is making its own washday decisions.[63]

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> The problem arose when a correction factor, which adjusts the dose according to the distance of the radiation source from the skin, was unnecessarily programmed into the system's computer. The medical physicist responsible did not realize the correction factor was built in, so a double correction was made. . . .
>
> In 1988, 207 patients at Exeter Hospital received excess doses after an x-ray system was wrongly calibrated.

This report prompted a response by one reader who noted:

> The concerns expressed (Error Threat to Cancer Victims, February 7) echo feelings throughout the engineering world, that more needs to be done to make software safer. The International Electrotechnical Commission is drafting standards for both the identification of safety critical systems and the design of software for those systems deemed by analysis to be critical.
>
> This follows the production of two similar standards for the defense (sic) sector last year. The cost of such work is expensive. Safety is possible, but it has a price.
>
> The costs can be minimized (sic) be collective effort in procurement. While the article states that the erroneous software was running for up to 10 years, in which case it is very old software and would not have been subjected to the rigors a program developed over the next few years will, the hope must be that safety will be assured in the future...
>
> Two reasons will remain problems. One is a mistake in the specification of the software, which is certain to lead to useless, potentially dangerous, though correct software. The other is the negligence of users, which can be reduced through disciplined training.

62. Sputnik was the first man-made satellite placed in orbit around the earth. Launched by the then Soviet Union, it immediately panicked the Unites States populace, which feared the U.S. was losing the "space race" because of a "brain drain," i.e., a lack of sufficient training of U.S. engineers and scientists. As a result, the U.S. government embarked on massive engineering and space-related projects to demonstrate U.S. superiority over Soviet technology.

63. Washing machines are merely one example where embedded software and new software techniques such as "fuzzy" logic are being employed. In such applications, the appliance "decides" how dirty the clothes are and adjusts the user-selected wash cycles accordingly, either shortening or lengthening the cycles, using more or less water, or water at higher or lower temperatures. Similar applications have been used for dish washers. There

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Such acquiescence does not appear limited to the casual or home software user. In the oft-cited example of the *Therac-25* radiation equipment, a radiologist administered triple doses of radiation to his patients because of faulty software.[64] As the general population increases its reliance on the computer, its skills at discerning computer errors may erode further.[65] The software engineering community exacerbates this condition because of its hubris and belief in its own infallibility.[66]

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are hopes that fuzzy logic software can be used for medical diagnostics, i.e., a thermometer which can determine whether you, personally, are running a fever based on your personal temperature "profile" rather than by using the 98.6° standard. See Smithsonian magazine and Fuzzy Logic book. *See* DANIEL MCNEILL & PAUL FRIEBERGER, FUZZY LOGIC 161-62 (1993).

64. Laurence, *supra* note 61.

65. For example, several studies have shown that math students who have learned to use the calculator exclusively are less able to discern errors in computation than those who have learned both manual and calculator-based techniques. *Contra* studies that indicate that students learn to read and write more quickly using computers than with manual methods, as in IBM's experimental program Writing to Read. However, these results may be more a function of students' increased motivation to use "fun" computers instead of "boring" hand scribing than an intrinsic added value to computers over manual methods.

66. Paul Andrews, *Chipping Away at Trust in Technology — Pentium Flaw Sharpens Computer-Fallibility Debate*, SEATTLE TIMES, Dec. 22, 1994, at A1 (describing a massive overdose of radiation received by a cancer patient from a software-controlled machine):

> Despite putting a striped radiation burn on the woman's hip, the machine remained in operation upon assurances from its manufacturer, a medical subsidiary of Atomic Energy of Canada Ltd., that the damage "could not have been produced by any malfunction of the Therac-25."
>
> So confident was the company in its software that it had removed mechanical safety devices from an earlier design.
>
> Subsequent accidents caused at least three deaths and numerous disabling injuries before the Food and Drug Administration stepped in with tough new safety requirements. Investigation linked the overdoses to a software bug.

*See also* Barbara Wade Rose, *Fatal Dose: Radiation Treatment Deaths*, SATURDAY NIGHT, June 1994, at 24; *Static Testing: Bridging the Quality Chasm*, SOFTWARE FUTURE, May 1995 (noting that software developers seldom attempt to learn from experience or the experiences of others. The article opines that "software probably escapes attention because of the intangible nature of the stuff. When a computer system goes wrong, even today people have a tendency to blame the very visible (and normally faultless) box of electronics, not the software it's (sic) running (which is often very faulty indeed)." ).

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In addition, the current move to standardize user interfaces[67] will require less effort on the part of the end user to learn or understand each new software package. Microsoft, for example, touts the concept of "information at your fingertips"[68] with the world merely a button press away. As UIs become more "transparent" to the end user, the end user will spend the majority (if not all) of her time contemplating the tasks she wishes to accomplish, rather than thinking about how to operate the software.

Software manufacturers have added to this trend by ever-increasing the functionality bundled with their software packages. Whereas 15 years ago, most consumers were thrilled that *VisiCalc*™ could allow simple spreadsheet input and output, today's buyer of Microsoft's *Excel*™ spreadsheet program not only includes spreadsheet functions, but also financial calculations, statistical functions, and graphing features, to name just a few.[69]

In short, modern software programs encourage users to abrogate their own autonomy to them. Is it then reasonable to conclude that in doing so, the software user is, in reality abrogating her autonomy to the software manufacturer?

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67. User interfaces, or UI's, are what the end user actually sees on the computer screen. The UI forms the mechanism through which the end user converses with the computer and operates the software. The basic objective in UI design today is to make UI's so intuitive that the typical user can walk up and become immediately productive, even without prior training. To accomplish this, UI designs borrow from each other so that the end user need remember only a small set of rules to operate any number of different software packages. Some UI designs use a concept known as DWIM'ing (for "Do What I Mean"), so that an end user who inadvertently enters a command to invoke a specific function for application X, but who is actually using application Y, will be understood and the appropriate function in application Y invoked. In the legal research world, for example, it is possible for someone trained exclusively on LEXIS-NEXIS™ to operate significant portions of WESTLAW™ (and vice-versa) because of each system's DWIM'ing capabilities. Similar capabilities exist for user shuttling between Lotus Corp.'s *1-2-3* and Microsoft's *Excel* spreadsheet programs and *WordPerfect* and *Word* word processing software.

68. *See, e.g., Windows 95 Plus the Internet Will Broaden Access Options Tomorrow*, COMPUTERWORLD, Feb. 13, 1995, at 115.

69. For example, Excel 7.0 provides 205 functions for financial analysis, math and trigonometry functions, statistical analysis, text analysis, logical operations, data and time functions, and the like. These functions are in addition to Excel's ability to add notes to spreadsheets, create a wide variety of graphs, become embedded in word processing documents, add embedded sound recordings, and automatically update a spreadsheet in whatever other documents it might have been embedded by the user.

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## III. SPREADING THE RISK: INSURING AGAINST SOFTWARE DISASTERS

### *A. Let the Vendor Beware: Inadequate Insurance Coverage for Software Disasters*

The uncertainty surrounding just how to deal with malfunctioning software creates considerable risk for uninsured, incorrectly insured and under-insured software vendors. Computer software vendors view themselves as service providers,[70] enjoying the safety of UCC liability disclaimers and contract law and thus avoiding the snares of most product liability claims[71] and all professional liability claims. Certainly, they do not consider their software as subject to actions sounding in tort law. From an insurance standpoint, this typically results in a failure by most software vendors to purchase either products liability insurance[72] or general liability or malpractice policies. This may prove a fatal oversight in which vendors inoculate themselves from liability claims with entirely the wrong policy.

Even among software vendors which do carry liability insurance, most assume that their policy will cover all product-related legal actions. The typical product liability insurance policy covers all legal costs (subject to the limits and deductibles of the policy).[73] It does not cover damage to a user's data or the costs of a product recall.[74]

Commercial General Liability (CGL) policies provide for unforeseen liabilities[75] and the insurance industry has standardized their coverage over the years.[76] The CGL policy was developed by the insurance industry in response to the increasing number of areas in which their insureds sought coverage. Traditionally, each new liability had required a separate policy. As Malecki, et al., note, this was due to the relative inexperience of insurers in insuring against a wide variety of liabilities and a desire to "1) confine [their] writings to particular types of liability policies and 2)

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70. Walker, *The Expanding Applicability of Strict Liability Principles: How is A Product Defined?*, 22 TORT & INS. L.J. 1, 2 (1986).

71. The exceptions would be, of course, software malfunctions which cause bodily injury or death.

72. Walker, *supra* note 70, at 2.

73. Judy Semas, *Companies Want to Recall Defective Product Liability Laws*, S. F. BUS. TIMES, at Section A-7.

74. *Id.* Separate electronic errors and omissions insurance covers damage to a user's data. Product recall insurance is "virtually unobtainable" for complex products. Therefore, large vendors self-insure. *Id.*

75. David M. Halbreich & David E. Weiss, *Insuring Against Technical Disasters*, THE RECORDER, at 44.

76. *Id.*

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exclude from these policies any loss exposures that the insurer regarded as undesirable, uninsurable, or insurable only for an additional premium".[77] Even with the inherent risk aversion of the industry, a wide variety of liability coverages became available. The earliest liability insurance was employer's liability (1886),[78] which was soon followed by such coverage as for contractor's public liabilities (1886), manufacturers' public liabilities (1892) and landlord and tenant's liabilities (1894).[79] Increased experience and expertise in the various liability areas persuaded the industry that it was desirable to incorporate several loss exposures under a single policy rather than require customers to travel from insurer to insurer to cover all their liability-related needs.[80] Over time, however, liability coverage became

> a veritable patchwork of complexity and heterogeneity, not always rational, of cover, rating base and underwriting rules. Particularly for larger risks, a combination of policies or endorsements is required to secure coverage, and the often arbitrary dividing lines among covers confuse agent and insured, encourage the insured to select from the total hazard and leave a twilight zone of hazards unprotected because they are not specified in any combination of policies. There is also probably less incentive to prevention when part of the total hazard only is covered, and several insurers split the subhazards.[81]

However, the standard CGL policy is not a panacea for all and sundry liability claims.[82] Typically CGL policies will cover "ordinary lawsuits," e.g., slip and falls and any specific liability added for specific harms.[83] CGL's typically exclude several key areas where software vendors are

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77. DONALD S. MALECKI ET AL., COMMERCIAL LIABILITY, RISK MANAGEMENT AND INSURANCE 238 (Vol. 1 1986).

78. *Id.* at 237.

79. *Id* at 238.

80. *Id.*

81. *Id.*, quoting C.A. KULP, CASUALTY INSURANCE 241 (2d ed. 1928).

82. CGL's do provide certain benefits which vendors of mass market software would likely find appealing. Most CGL policies accept a broad duty to defend against claims, even if they are without merit. Because mass market software by the nature of its clientele is more prone to class action law suits than more customized software vendors. Under a CGL policy, the carrier has agreed to defend against these very expensive suits for an established price. *Id.*

83. Paul Cottrell & Barry D. Weiss, *Third-Party Liability Insurance: Protection in Case of Computer Error*, COMPUTERWORLD, Apr. 2, 1984.

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likely to be most vulnerable for software attacked under product liability claims, such as for damage caused by a virus,[84] for strictly economic losses,[85] or for injuries caused as the result of professional activities.[86] Damage only to the product manufactured by the insured does not receive coverage (insurers consider this a warranty issue), but damage to third party property does.[87] So-called "impaired property"[88] is likewise not covered, unless repairing the impairment could not be accomplished without creating more or other damage to the property.[89] Property damage that the insured "expected or intended" is not covered.[90]

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84. *See* Cornwell, *supra* note 6, at 31.

85. Still, these are likely the only losses one will encounter when using software. As one commentator notes, "Although products liability coverage responds to losses that result in physical damage, computers rarely burn up and software programs seldom cause [physical] injury. Instead, they simply stop working or fail to perform to a customer's expectations." *Id.*

86. *Id.*

87. *Id.*

88. Halbreich and Weiss note that CGL policies define "impaired property" as

> tangible property other than the insured's product "that cannot be used or is less useful because" it incorporates a product manufactured by the insured "that is known" or thought to be defective, deficient, inadequate or dangerous . . . if such property can be restored to use by the repair, replacement, adjustment, or removal of" the insured's product. The impaired-property exclusion precludes damage to impaired property or tangible property that has not been "physically injured," if such damage arises out of a defect in the insured's product.
>
> [Thus] . . . although an IBM PC PC may be less useful because it contains a flawed Pentium chip, Intel would not be covered for claims brought by IBM, or purchasers of IBM computers, because the computers could be restored simply by replacing the flawed chip. Damages claimed for the costs of recalling the insured's product or for recalling impaired property also are not covered. Thus, if IBM had recalled PCs containing flawed Pentium chips and then had sought to hold Intel liable for its recall expense, Intel's liability would not be covered under a standard CGL policy.

Halbreich & Weiss, *supra* note 75.

89. *See* Elco Indus., Inc. v. Liberty Mut. Ins. Co., 361 N.E.2d 589, 591 (Ill. 1977) (coverage found where repairing defective pins in an engine caused other damage to the engine); and Travelers Ins. Co. v. Penda Corp., 974 F.2d 823, 829 (7th Cir. 1992) (styrene sheets incorporated into books yellowed, rendering them unusable and the books could not be returned to usable form simply by replacing the sheets).

90. Arguably, this could include damage caused by software defects of which the vendor became aware after shipping. *See supra* Section III for recent attempts by vendors to limit their liability in these situations.

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The liability coverage most software vendors think they obtain under CGL policies is more likely obtained through E&O ("errors and omissions") policies. The insurance industry has long foreseen the need to indemnify clients against computer-age damages via specialized policies. As early as 1984, the computer industry trade press noted the availability of comprehensive data processing insurance, E&O insurance and computer malpractice insurance from such firms as Shand, Morahan & Co., St. Paul Fire & Marine Insurance Co., and The Chubb Group and its National Union Fire Insurance Co. of Pittsburgh subsidiary.[91] These policies, also known as professional liability coverage are of the type that cover professionals such as architects, physicians and attorneys.[92] These do not, however, cover the commodity which is most likely to be damaged because of malfunctioning software: data. Replacement costs for data may be insured via business interruption ("extra expense") insurance policies.[93]

A more recent insurance development is computer performance liability insurance, a very expensive insurance coverage, but one in which vendors have expressed great interest.[94] At least one Lloyd's of London Syndicate provides professional indemnity insurance for London-area software companies,[95] which provides coverage for negligence, mistakes or ommisions, including loss of documents and data.[96]

### *B. When the Buyer Insures Against Catastrophe: An Incomplete Solution*

The buyer can take steps to insure herself against software malfunctions which damage or destroy data, though her opportunities to protect herself fall far short of those available to the software vendor. For an additional premium, most Electronic Data Processing (EDP) policies

91. Paul Cottrell & Barry D. Weiss, *Insuring Against the Perils of PC*, COMPUTERWORLD, Aug. 21, 1984, at 301.

92. *Id.*

93. *Id.*

94. Bruce A. Bierhan, *Faulty Software Problem or Puffery? Responsible Law Suits Keep Vendors Honest*, COMPUTERWORLD, March 28, 1994, at 87.

95. Adrian Ladbury, *Ruling May Expand Software Firms' Liability*, BUSINESS INS., Oct. 17, 1994, at 75 (describing the *St. Alban's* case, *supra* note 5, and its effect on software firm's insurance needs).

96. The United Kingdom insurer offering professional indemnity insurance notes that a British court awarded a claim of £25,000 when a contractor neglected to provide copies of programs and the programs provided failed to meet required standards within an acceptable time frame. Http://www.icl.co.uk:80/services/higher/news2.html.

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can include coverage for re-creation of lost business records[97] as additions to more traditional general business insurance policies. Such general policies typically indemnify the software buyer for lost income occasioned by any number of catastrophic interruptions to business;[98] however, most will exclude damage caused by programming errors.[99] As with professional liability insurance available to software vendors, the buyer must be aware that standard business property and liability policies do not provide coverage for the types of software-related damage they are likely to encounter. Unfortunately, not all business insurers offer such coverage[100] and those which do provide minimal indemnities under their standard policies.[101] Generally, software buyers are instead urged to do business with vendors who can provide a certificate of insurance confirming they carry an E&O policy.[102]

## IV. IS SOFTWARE A GOOD OR A SERVICE?

A number of diverging issues must be reconciled before the issue of software vendor liability can be addressed. First, is software a product? Is liability for damages addressed by the UCC, contract and/or products liability law? Or, is software an "intangible" more akin to a service, with liabilities sounding in tort law? Second, if software is a product, does its "sale" by licensed use rather than as a transfer of property affect the ability

97. Unless otherwise stated in the policy, coverage for magnetic media is for the cost of the media itself, not the value of the data it contains. The insured is covered for the some portion of the cost of researching and duplicating the lost data. Terry Brock & Chaim Yudkowsky, *Does Your Insurance Policy Have Coverage Glitches?*, ATLANTA BUS. CHRONICLE, January 13, 1997, http://www.amcity.com:80/atlanta/stories/011397 /smallb6.html.

98. The various types of insurance are treated as separate provisions in the policy, rather than as a standard "package." The buyer can then choose which combination of coverage she desires. BARRY D. SMITH & ERIC WIENING, HOW INSURANCE WORKS 136-39 (1994); *see also How to Prevent Bad Things From Happening to Good Equipment*, http://www.smalloffice.com/maven/archive/bmspot3.html.

99. Brock and Yudkowsky, *supra* note 97. Damage causes by viruses, however, can be insured against. Terry Brock and Chaim Yudkowski, *Is Your Computer Insured?*, AMERICAN CITY BUS. J. at http://www.amcity.com:80/consultants/columns /cyber35.html.

100. The insurance industry is still debating whether or not to leap into this area. Though most companies will cover the loss of purchased software, they will not necessarily cover lost data as a matter of course. *See, e.g.*, *Consumer Information: Protecting Your In-Home Business*, http://www.iiaa.iix.com/homeins.html.

101. *Id.* Insurer RLI, for example, will cover up $1000 in recovery charges to research, replace and restore lost data. With the exception of the smallest of companies or end-users, this amount will almost certainly fall short of the actual costs incurred.

102. Brock & Yudkowsky, *supra* note 97.

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of "purchaser" to recover for damages? The answers here have a profound effect on the insurance coverage required to anticipate liability claims.

### *A. Software as a Good*

As a general rule, the courts have applied Article 2 of the UCC to cases involving claims by a software purchaser of malfunctioning software against its vendor.[103] In numerous cases, the courts have held not only that software is a product,[104] but that the limitations of vendor liability expressly contained in standard software licensing agreements[105] are valid and enforceable.[106]

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103. Though the whole of Article 2 applies, key advantages for software vendors rest in the provisions of § 2-508, which allows the vendor to cure an improper tender or delivery merely by replacing the defective item, and § 2-316, which permits the exclusion or modification of warranties.

104. *See, e.g.*, ProCD v. Zeidenberg, 908 F. Supp. 640, 651 (W.D. Wis. 1996) ("Commentators agree that the UCC should apply to computer software transactions. . . . [T]here are sound reasons for treating a software transaction as a sale of goods under the UCC rather than as a license: purchasers of mass market software do not make periodic payments but instead pay a single purchase price, the software company does not retain title for the purpose of a security interest and no set expiration date exists for the 'licensed' right.")

105. A recent wrinkle in limitation of liability clauses asks the buyer to waive even the simplest form of quality control by the vendor:

> (Company name)'s maximum liability and obligation to Licensee and Licensee's sole exclusive remedy for any cause whatsoever, regardless of the form of action, whether in contract or tort including negligence, relating to this Agreement shall be limited to the repair or replacement of any defective diskette, replacement with identical or like Product, or refund of purchase price, all of which at (company name)'s option.
>
> IN NO EVENT WILL (COMPANY NAME) BE LIABLE TO LICENSEE FOR ANY DAMAGES, INCLUDING ANY LOST PROFITS, LOST SAVINGS, LOST OR DESTROYED DATA, OR OTHER SPECIAL, INCIDENTAL OR CONSEQUENTIAL DAMAGES WHATSOEVER ARISING OUT OF THE USE OR OF THE INABILITY TO USE SUCH PROGRAM OR FOR ANY OTHER CLAIMS BY LICENSEE OR BY ANY OTHER PARTY *EVEN IF (COMPANY NAME) OR AN AUTHORIZED (COMPANY NAME) DEALER OR DISTRIBUTOR HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES* IN ANY OF THE FOREGOING CASES. (capitalization in the original; emphasis added) (contract on file with the author).

106. *See, e.g.*, RRX Industries, Inc. v. LAB-CON, 772 F.2d 543, 546 (9th Cir. 1985) (contract which obligated software vendor to correct malfunctions in a telephonic system but which limited the contractor's liability to the contract price is valid because the

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Article 2 can be applied to software only by analogy,[107] since software purchasers generally do not purchase the software per se, but merely a

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dominant feature of the contract was a sale, not a service agreement). *But contra see* Salvage Ass'n v. Cap Fin. Serv., Ltd., 1995 FSR 654 (QB 1995), a British case where, despite the parties having equal bargaining leverage, the court considered a £25,000 cap on liability as too low and a factor in refusing to allow the defendant to limit its liability. *See also* St. Albans v. International Computers Ltd., 1992 FSR 345 (QB 1992), another British case, in which the municipality of St. Albans fought the defendant's attempt to limit its liability to £100,000 for malfunctioning tax collection software which effectively reduced the city's collectible revenue by £1,300,000. Limitation of liability was not upheld because 1) the court considered the parties to be of unequal bargaining power, 2) the defendant carried ample liability insurance, 3) the defendant could not justify the limit it imposed and 4) the court preferred the costs be borne by the corporate defendant rather than the tax payers of St. Albans. Note that the difference in attitudes between RRX on the one hand and Salvage Association and St. Albans on the other may be due in large part to changing expectations since RRX was heard in 1985. Commenting on the *St. Albans* case, one analyst argues,

> Such [limitation] clauses are common in the computer industry. Their origins lie in the early days of the industry, when hardware was unreliable and it was unfair to expect suppliers or software house to bear all the risks of innovation. Limits on liability originated in the United States, where damages could be high enough to bankrupt small software suppliers.
>
> But times have changed: most software is now reliable; indeed, most customers prefer reliability to leading-edge technology. That is why the courts are now questioning the justice of tough limitations on liability.

Laurence Jacobs, *When the Cap Doesn't Fit*, THE INDEPENDENT, Nov. 7, 1994, at 23. It appears that the British are further along in dealing with this issue than the United States. *See, e.g.*, Andrew Johnson, *My Outsourcing Contracts*, ASAP, Sept. 7, 1994, at 146.

107. Kemp, *supra* note 25, at n.72, citing Daniel E. Murray, *Under the Spreading Analogy of Article 2 of the Uniform Commercial Code*, 39 FORDHAM L. REV. 447 (1971) and Edward Allen Farsnworth, *Implied Warranties of Quality in Non-sales Cases*, 57 COLUM. L. REV. 653 (1957); *see also* Raymond T. Nimmer, *The Revision of Article 2 of the Uniform Commercial Code: Intangible Contracts: Thoughts of Hubs, Spokes, and Reinvigorating Article 2*, WM. & MARY L. REV 1337 (1994). Professor Nimmer serves as the Reporter on Technology Issues for the drafting committee revising Article 2 for the first time since the 1950's. He argues that computer software and data ought to be considered intangibles under the UCC. Despite the fact that many software and intangibles contracts are governed by Article 2, that Article applies an inappropriate model (the traditional sale of goods model) to such contracts without consideration of the unique aspects of software and electronic data transmission. The Draft Article describes a "hub and spokes" model for addressing Article 2 goods which allows for both the use of a central core of legal principles (the hub) and specially tailored rules (the spokes) to reflect the rich variety of contractual relations existing today. Under this concept, Article 2 would no longer address sales of goods, but rather the transfer of personal property. *Id.* at 1341. Thus, a discussion of

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license to use it.[108] Article 2 has nonetheless provided a welcome haven for software manufacturers,[109] generally limiting their liability to the replacement of defective software or any property damage done as a result of the operation. Consequential damages can be easily avoided via the licensing agreement; purely economic losses even more so.[110]

### B. *Software as Other Than a Good*

As some commentators have observed, however, treating software licensing as if it were a sale of chattel creates a legal fiction which – contrary to the general intent of the UCC -- places the purchaser at a severe disadvantage vis a vis the vendor.[111] This is especially so when purchasing

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software under the revised Article 2 might address "information, data, technology, intellectual property, or software as the subject matter of a license contract" rather than as a sale of goods. *Id.* at 1342.

108. Under extant interpretations of these licensing agreements, purchasers may make only authorized copies of the software, e.g., "backup" (archival) copies and may not transfer possession of the software to another party. Nimmer, *supra* note 107, at 1346.

109. If anything, the courts have readily leaned toward contract remedies than tort remedies when it comes to defective "goods." *See, e.g.*, Krider Pharm. & Gifts, Inc. v. Medi-Care Data Sys., 791 F. Supp. 221, 226 (E.D. Wis. 1992) ("the legislative protections granted by the Uniform Commercial Code are not to be buttressed by tort principles and recovery" (citing Spring Motors Distribs. v. Ford Motor Co., 489 A.2d 660 (N.J. 1985)); Canon U.S.A, Inc. v. Nippon Liner Sys., 1991 U.S. Dist. LEXIS at *6 (N.D. Ill. 1991) ("[The Moorman doctrine] and its progeny bar suits in negligence where the parties have contractual remedies and the injury is solely economical."). Article 2B is currently undergoing revision, with specific emphasis on software licensing issues; as of this writing, a great deal of controversy surrounds proposed revisions to software licensing, with software vendors resisting substantive changes which would likely increase their liability for defective software. For a complete history of the various drafts to software-related portions of the UCC Article 2B and comments to proposed drafts, see http://www.webcom.com /software/issues/guide/hbici.html.

110. The "economic loss rule" limits a plaintiff's recovery to contractual remedies when the parties had a buyer-seller relationship and the claim was for such purely economic losses as lost profit, damages to good will, and out-of-pocket expenses. Richard Raysman & Peter Brown, *How to Limit Liability Issues Before Trial*, N.Y.L.J., June 13, 1995, at 3. Given the heavy reliance on UCC Article 2 to establish classic buyer-seller relationships even when the buyer has limited or no access to the sales/licensing agreement or the ability (with mass market) software to negotiate the details of the agreement, the net effect is to leave the buyer at the mercy of the vendor.

111. Kemp, *supra* note 25, at 127. "These license agreements are wholly favorable to the software producer and largely unreasonable from the software user's standpoint. Various rationales are utilized by the producer to justify the provision, such as prevention of software (continue)." *Id.*; *see generally* Thomas M. S. Hemnes, *Restraints on Alienation, Equitable Servitudes and the Feudal Nature of Computer Software Licensing*, 71 DENV. U. L. REV. 577 (1994) (questioning the need or utility of any software licensing in today's

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mass market software. Contrary to licensing agreements executed between commercial entities,[112] the purchaser at the local retail store or mail order catalog does not have the key benefit which the UCC requires as a fundamental element of any sale: the opportunity to bargain.[113] Indeed, until recently, mass market software purchasers did not even have a chance to review the conditions of the license prior to purchase; vendors printed licenses on envelopes containing the software diskettes.

More recently, vendors have engineered installation programs so that the license agreement appears in a dialog box when the installation is invoked. The user must press a button that she accepts the provisions of the license before the installation continues.[114] An even more recent development is the announcement on exterior software packaging advising the prospective purchaser that she must accept the enclosed license to operate the software or return the software.[115] This, however, presumes

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computer environment marked by expanding protection from patent law, copyright law, the UCC, and others).

112. An irony in applying the UCC to software sales is that the UCC provides the most significant protection to those best able to fend for themselves in software transaction: commercial purchasers. Not only can commercial purchasers negotiate more favorable sales conditions, they are more likely than the average consumer to be able to anticipate the likely pitfalls of the purchase. Consider that an increasing amount of software advertising attempt to entice new users with promises of no fuss no worry software. Some commentators have noted however, that even supposedly sophisticated commercial buyers simply accept vendors' boilerplate agreements. Bierhan, *supra* note 94, at 87.

113. In *ProCD*, 908 F. Supp. at 643, the court noted that "[t]he widespread use of shrink-wrap licenses has generated intense interest in academic and intellectual property fields, but surprisingly little litigation. . . . Most commentators view shrink-wrap licenses as being of questionable validity, primarily because software users do not have an opportunity to bargain over their terms."

114. Interestingly, the dialog box displays the license a small number of lines at a time. The user must scroll the display repeatedly to read the entire license agreement. Further, the display arrangement does not permit the user to print out the license agreement for review. It is possible to obtain a printed copy of the agreement by following this sequence: 1. Display a section of the agreement. 2. Press the "print screen" key on the computer keyboard. 3. Activate a utility program which will allow the displays of screen prints. 4. Display the screen print in this utility. 5. Print a hard copy of the screen print. 6. Return to the licensing display. The author recently installed software from a major manufacturer which required 11 passes through the above sequence to obtain a complete copy of the license agreement.

115. For example, the back of the sales box for Microsoft's Internet Web Site designer, Front Page™ version 1.1 contains the following message: "You must accept the enclosed License Agreement before you can use this product. If you do not accept the terms of the License Agreement, you should promptly return the product for a refund." These developments are likely in response to a proposed provision to the UCC, § 2-2203. The draft section would

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that the purchaser is able to understand the risks involved in operating any piece of software as well as the opportunities for recovery waived by accepting the license. Ironically, those who would be most apt to understand these conditions and act accordingly are also those purchasers who are in the best position to negotiate the conditions of the license.[116] The general public remains effectively at the mercy of whatever conditions the software vendor imposes, short of not using the software at all.

### *C. Software as an Intangible*

An increasing number of commentators have argued that software should not be considered a product at all. They argue that it is an "intangible," not foreseeable as a chattel against which UCC sales of goods provisions or traditional tort law were intended or should apply.[117] The

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> [M]ake standard form licenses enforceable if:
> (a). . . prior to or within a reasonable time after beginning to use the intangible pursuant to an agreement, the party
> (1) signs or otherwise by its behavior manifests assent to a standard form license; and
> (2) had an opportunity to review the terms of the license before manifesting assent, whether or not it actually reviewed the terms.

*ProCD*, 908 F. Supp. at 645. The *ProCD* court continued, noting, "the draft provision appears to introduce a § 2-206 type of inspection, rejection and revocation into shrink-wrap contracts and thereby place significant responsibility on buyers to actively reject those terms by returning goods if they find the terms unacceptable." *Id.*

116. *See, e.g.*, Analysts Int'l Corp. v. Recycled Paper Prod., Inc., 1987 U.S. Dist. LEXIS 5611 (June 19, 1987) (memorandum opinion) (regarding a malfunctioning invoicing and shipping software, the court referenced its adoption of the "commercial expectation" test:

> [I]f one would not expect the resulting damage to be caused by the product's failure to perform its intended function a plaintiff may sue in tort . . . Destruction of . . . data and the attendant consequences of erroneous invoices, lost or misshipped orders, "bizarre" product substitutions, lost good will and morale, as well as lost profits, are just the type of damage one would expect when a software system of [this] complexity malfunctions. In other words, the contracting parties had reason to foresee the consequences of the breach; contract damages are the proper remedy for a breached contract.

*Id.* at 17-18.

117. Andrew T. Bayman, Note, *Strict Liability for Defective Ideas in Publications*, 42 VAND. L. REV. 557, 576 (1989). Bayman argues that computer output is analogous to the expression of ideas by humans. Thus, the likelihood exists for the courts to attach the same type of liability to computer programs as has been attached to defective publications, such

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majority of cases, however, follow the reasoning in *Advent Systems Ltd. v. Unisys Corp.*:[118]

> Computer programs are the product of an intellectual process, but once imparted in a medium are widely distributed to computer owners. . . . That a computer program may be copyrightable . . . does not alter the fact that once in the form of a floppy disk or other medium, the program is tangible, moveable and available in the marketplace.[119]

As Raymond Nimmer, the preminent Computer Law scholar notes, however, there are a variety of directions and exceptions to this philosophy. For example, sometimes custom or specially-designed software can be considered a "service" rather than a "good."[120] In *USM Corp v. Arthur Little Systems, Inc.*,[121] software was found to be a good, subject to Article 2, while in the previous year another court in *MicroManagers, Inc. v. Gregory*[122] held that software constituted services. Many more examples of divergent holdings are readily available.[123] Nimmer has observed:

> These issues in software transactions reflect a broader dispute about what law applies to design contracts of all types, but the basis on which cases are decided is especially obscure in the context of software because the intangibles have characteristics of pure intangibles and goods. The lines drawn are unpredictable because the licensee's goal is both to obtain rights to use software and to receive a product that performs a useful function....[124]

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as aircraft approach charts. *See, e.g.*, Fluor Corp. v. Jeppesen & Co., 170 Cal. App. 3d 468 (1985) (chart manufacturer strictly liable for defects in charts it created as well as published). It is important to note here that the *Fluor* court distinguished between liability for publishing and liability for creating. The courts have solidly embraced a philosophy that publishers are not liable for damages resulting from works they did not create.

118. 925 F.2d 670 (3d Cir. 1991).

119. *Id.* at 675.

120. Nimmer, *supra* note 107, at 1347.

121. 546 N.E.2d 888 (Mass. App. Ct. 1989), cited by Nimmer, *supra* note 106, at 1348.

122. 434 N.W.2d 97 (Wis. Ct. App. 1988), cited by Nimmer, *supra* note 107, at 1348.

123. *See generally* Nimmer, *supra* note 107, Section II.

124. *Id.*

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> Today, these questions are asked in an environment in which information, software and other intangibles increasingly are regarded as valuable commodities in commercial practice. Yet modern law mandates that if the intangibles dominate the contract, the commercial relationship is governed under common law, rather than under commercial codification.[125]

Ironically, the data stored by the user in the software, e.g., a spreadsheet or memorandum, is definitely considered an intangible.[126] Thus, in cases where malfunctioning software destroys a valuable database of information, but does not damage itself, create personal injuries or damage the hardware on which it operates traditional product liability claims are fruitless because of the economic loss rule. The user, though sustaining potentially dramatic financial loss, is barred from recovery for the loss of vital information.

Where justice or civil rights are affected, the ability to recover remains similarly muddled. In Hartford, Connecticut, a software program designed to scan voter registration and driver license lists to call citizens for jury duty mistakenly included a seven character space for an eight letter name (Hartford). The software, once having filled in the first seven characters of the abbreviation, placed the eighth letter in the next available space: Living or Deceased. The "D" of "Hartford" caused many people within the Hartford city limits to be listed as "deceased" and therefore not eligible for jury duty. This resulted in a preponderance of jurors selected from Hartford's suburbs, whose populations do not closely reflect the ethnic and economic levels of the central city. Individuals convicted during this period argued that they had not had an opportunity to be judged by a jury of their peers.[127]

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125. *Id.* at 1350.

126. *See, e.g.*, Lucker Mfg. v. The Home Ins. Co., 23 F.3d 808, 819 (3d Cir. 1994) (the real value of data stored is in the ideas they contain, and the loss of data is a loss of an idea, which is not tangible property); State Farm Fire & Casualty Ins. Co. v. White, 777 F. Supp. 952, 954-55 (N.D. Ga. 1991) (through architectural plans in blueprint form are tangible property, the destruction of them limits liability to the cost of the medium [the paper and ink] which contains the ideas underlying the blueprint).

127. Matthew Kauffman, *Computer "Killed" Hartford Jurors Before They Could Serve; Omission of City Residents Attributed to Computer Error*, THE HARTFORD COURANT, Sept. 29, 1992, at A1; Lynne Tuohy, *Probe of Jury Selection Ordered*, THE HARTFORD COURANT, Sept. 24, 1993, at A1. Similar catastrophes can be imagined: inaccurate voter registration lists which prevent a citizen from voting, electronic records which prevent establishing credit or receiving benefits, electronic records which release prisoners prematurely, etc.

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The legal community has long recognized the round peg nature of software and the square hole we attempt to force it to occupy under the UCC. Professor Nimmer is the Reporter on Technology Issues for the drafting committee revising Article 2 for the first time since the 1950's. He argues that computer software and data ought to be considered intangibles under the UCC.[128] Despite the fact that many software and intangibles contracts are governed by Article 2, that Article applies an inappropriate model (the traditional sale of goods model) to such contracts without consideration of the unique aspects of software and electronic data transmission. In place of the goods/services dichotomy mandated under the existing Article 2, the Draft Article describes a "hub and spokes" model. The model allows for both the use of a central core of legal principles (the hub) and specially tailored rules (the spokes) to reflect the rich variety of contractual relations existing today.[129] Under this concept, Article 2 would no longer address sales of goods, but rather the transfer of personal property.[130] Thus, a discussion of software under the revised Article 2 might address "information, data, technology, intellectual property, or software as the subject matter of a license contract" rather than as a sale of goods.[131] The purchaser and vendor's rights and duties would be allocated accordingly.

*D. Why This Matters*

Formally recognizing that software is not the kind of "good" envisioned by the UCC requires us to take a closer look at what software really is. To date, the law views software primarily in terms of its form and delivery. Yet, other goods reasonably classified by these conditions do not exhibit the inherent flexibility and independence of human control that software increasingly possesses. Perhaps a more fruitful approach is to consider not the form, but the function that software attains.

Software's basic and fundamental nature is as a representation of human thought. Unlike other such representations, such as books or recordings, it remains to some degree unfixed and varying through its interaction with a user. More than merely representing the ideas it contains, it can apply them, as in grammar checkers and checkbook balancers. Some software can learn from its own experience or can profile

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128. Nimmer, *supra* note 107, at 1337.

129. *See generally* Nimmer, *supra* note 107, at Section III.

130. *Id.* at 1341.

131. *Id.* at 1342.

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its user's habits and preferences. Clearly, these fundamental characteristics take software far afield from the goods envisioned under the UCC.

It is perhaps more accurate to consider software as an alter ego for the vendor (or at least the vendor's design team). The intelligence encompassed by the software is their intelligence, with the software merely being the conduit for its application against the specific problem the user seeks to solve. Sometimes the intelligence is rudimentary, involving simple, rote actions which require no great sophistication. In most other cases, however, the intelligence is much more complex, more subtle and, because it can be applied so much more rapidly, much more trusted.

Assuming this to be the case, software malfunctions ought be examined in terms of what the correctly performing software ought to have done (in effect, what its -- or its manufacturer's -- duty to the user was). Based on that duty, the relevant law can be applied in a much more direct and predictable way than current interpretations permit. This approach still allows commercial vendor and commercial purchaser all the benefits of a UCC transaction, while also leveling the play field between commercial vendor and private purchaser.

## V. STANDARDS OF CARE

### *A. Definition, Application and Professions Affected*

The Second Restatement of Torts distinguishes between two standards of care: those of the reasonable person[132] and the higher standards of care applied against the actions of those engaging in professional activities.[133] The basic reasonable person standard results from "(1) the recognition of the risk involved in his conduct . . . ;(2) the realization of the unreasonable character of the risk . . . ;(3) the amount of care, skill, preparation, or warning which he must exercise, make, or give . . ."[134] However, those who "undertake to render services in the practice of a profession or trade [are] required to exercise the skill and knowledge normally possessed by members of that profession or trade in good standing in similar communities"[135] unless the individual represents greater or lessor skill or

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132. RESTATEMENT (SECOND) OF TORTS § 283 (1965).

133. *Id.* at § 299A.

134. *Id.* at § 285 Comments. The standard may be established by: (1) legislative enactment or administrative regulation; (2) court interpretation of a legislative enactment or administrative regulation; (3) by judicial decision; or (4) interpretation of the facts of the case by a trail judge or jury. *Id.*

135. *Id.* at § 299A.

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knowledge than a member of that profession.[136] Conceivably, failure to disclose knowledge of a flaw in a software product (analogous to a "lesser" skill) would make the manufacturer liable at least for the general standard of care.[137]

By contrast, professionals can be held to a variety of higher standards. Physicians, for example are held to standards for their field of medicine as practiced by competent practitioners in their local area[138] or by national standards.[139] Attorneys are held to the canons of ethics promulgated by the American Bar Association as interpreted and applied by individual state bar associations.[140] Architects,[141] accountants[142] and other professional groups are held to standards established by their own professional associations and state licensing boards.[143] The rationale for higher standards in general is that professionals receive extensive training, have an established code of ethics and conduct, police the behavior of their members, and provide services on which their clients deserve a high level of care for safety, accuracy and expertise.

Commercial professionals, though not traditionally considered as part of this group, are nonetheless distinct from the general populace. The courts have noted that sellers of products carry a higher duty of care to their customers, especially in instances where the product is to be used for

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136. *Id.*

137. Jerald E. Rosenblum, *Liability for Executives of High-Tech Companies: A Tale of Two Torts*, COMPUTER LAW., Apr., 1995. Rosenblum argues that liability can be limited by using conspicuous warning notices.

138. RESTATEMENT (SECOND) OF TORTS § 285, Comment g.

139. *Id.*

140. *Id.* at Comment b.

141. *Id.*

142. *Id.*

143. Interestingly, more and more white collar occupations have attempted to "license" their members through so-called professional designations, e.g., the Society of Logistics Engineers (Certified Professional Logistician), the Human Factors and Ergonomics Society (Professional Ergonomist), and the insurance industry itself in a variety of forms (Certified Professional Underwriter, Chartered Life Accountant, etc.) Except for senior members "grandfathered" in at the start of the certification process, those seeking a professional designation must pass a battery of tests ostensibly designed to evaluate the candidate's knowledge of fundamental and advanced concepts and techniques.

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a "professional" purpose.[144] Similarly, a higher duty of care is owed to business visitors.[145]

*B. Analyzing Conditions for Higher Standard of Care*

Over time, the shorthand enumerated by the New York Court of Appeals has come to define when higher standards are appropriate. In *In re Estate of Freeman (Lincoln Rochester Trust Co. v. Freeman)*[146] the court rejected a malpractice claim against a software vendor by asserting that the rationale for applying such standards was well established, and by definition and custom could not include them:

> A profession is not a business. It is distinguishable by the requirements of extensive formal training and learning, admission to practice by a qualifying licensure, a code of ethics imposing standards qualitatively and extensively beyond those that prevail or are tolerated in the marketplace, a system for discipline of its members for violation of the code of ethics, a duty to subordinate financial reward to social responsibility, and, notably, an obligation on its members, even in non-professional matters, to conduct themselves as members of a learned, disciplined, and honorable occupation.[147]

Continuing this line of thought, the District Court for New Jersey commented:

> Professionals may be sued for malpractice because the higher standards of care imposed on them by their profession and state licensing requirements engenders trust in them by clients that is not the norm of the marketplace. When no such higher code of ethics binds a person, such trust is unwarranted. Hence, no duties

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144. Fullard v. Urban Redevelopment Auth. of Pittsburgh, 293 A.2d 118 (Pa. 1972). Plaintiff was an employee injured by flying steel from a defective chisel which the Redevelopment Authority had provided to his employer. The court held that the Redevelopment Authority must meet the higher duty of care required of suppliers of tools for business purposes. *Id.* at 120.

145. Crotty v. Reading Indus., Inc., 345 A.2d 259 (Pa. 1975) (landowner found liable for injuries sustained by independent contractor when landowner's employee started a machine in which the contractor was working).

146. 311 N.E.2d 480 (N.Y. 1974).

147. Hospital Computer Sys., Inc. v. The Staten Island Hosp., 788 F. Supp. 1351, 1361 (D. N.J. 1992), citing *In re* Estate of Freeman (Lincoln Rochester Trust Co. v Freeman), 311 N.E.2d 480 (N.Y. 1974).

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> independent of those created by contract or under ordinary tort principles are imposed on them.[148]

The court's assertion suggests that the malpractice universe ought be fixed and unchanging, with all the players already known. Yet, the court ignores numerous extensions and exceptions to its rule. For example, many states license beauticians, real estate agents, and automobile drivers but do not allow malpractice claims against them. Thus, mere licensing cannot be a sufficient test of liability for malpractice. In an ever more complex world, many disciplines can assert a claim as a "learned profession," yet botanists, teachers, and economists do not fall under the malpractice umbrella.

There must be more to becoming subject to malpractice than the mere incantation of an ancient rule. Consider the following characteristics which unite the members of the malpractice professions:

a. their clients relinquish virtually all control for decision making to them when engaging their services; the client relies heavily on their representations and expertise;
b. they retain control over their work product;
c. they work under professional standards established and maintained by their professional group/industry;
d. privity of relationship with the customer;
e. the direct effect of their work output on the client;
f. society has a stake in deterring their negligent acts because of the potential for damage; and
h. their work products are primarily intangible.[149]

Imposing a malpractice standard against computer professionals is, admittedly, a bit of a stretch insofar as the standards articulated by the New York court. For example, there are no established educational or licensing requirements, despite the obviously wide -- and increasing -- difference in knowledge between computer professionals and the rest of the populace.[150]

### *C. Emerging Standards in the Software Industry*

Though the trend against software malpractice seems unwavering since *Chatlos*, there has been some support from the courts for claims of simple

148. *Hospital Computer Sys., Inc.*, 788 F. Supp. at 1361.

149. Bily v. Arthur Young & Co., 834 P.2d 745 (Cal. 1992).

150. Leahy, *supra* note 9, at 16, citing VERGARI & SHUE, STATE COMPUTER LAW § 2.04.

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negligence against software vendors, especially where software service is involved.[151] In *Invacare Corp. v. Sperry Corp.*[152] the court distinguished the ordinary care the buyer has a right to expect from the vendor from the "theory of elevated responsibility on the part of those who render computer sales and service. . . . [if] machinists, electricians, carpenters, blacksmiths, and plumbers are held to the ordinary standard of care in their professions . . . why [ought] personnel in the computer industry be held to any lower standard[?]."[153]

However, most commentators discount the likelihood even a simple negligence claim would succeed. Some argue that two hurdles stand in the way of a successful negligence claim: the economic loss rule, which effectively limits economic loss to contractual (meaning software license) remedies, and a consistent refusal by the courts to hold software manufacturers to the higher duty of care of the "learned professions."[154]

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151. Raysman & Brown, *supra* note 28, at 3. (noting that asserting a negligence claim against the manufacture of the software itself is much less likely to produce the desired result.

152. 612 F. Supp. 448 (N.D. Ohio 1984). Other courts have accepted this reasoning. *See, e.g.*, Metpath Inc. v. IDS Corp., No. 89-0435312S, 1991 WL 39617 (Conn. Super. Ct. March 12, 1991), citing *Invacare*, 612 F. Supp at 453 ("Those in the computer industry should be held to an ordinary standard of care.")

153. *Invacare*, 612 F. Supp. at 453-454.

154. *See, e.g.*, *Chatlos*, 479 F. Supp. at 741 n.1

> [the] novel concept of a new tort called 'computer malpractice' is premised upon a theory of elevated responsibility on the part of those who render computer sales and service. Simply because an activity is technically complex and important to the business community does not mean that greater potential liability must attach."

*Id.* For a contrary point of view, see Bruce A. Bierhan, *Faulty Software Problem or Puffery? Responsible Law Suits Keep Vendors Honest*, COMPUTERWORLD, March 28, 1994, at 87 (arguing that the catastrophic property or financial damage modern computer systems and software can cause demand accountability equal to professionals and product manufacturers). "Software vendors have argued that particular software programs, such as a disaster recovery program in a nuclear power plant, are so complex that you couldn't hold the system designers liable. To the nuclear power plant's neighbors, that argument is specious and unsatisfying." *Id.* Bierhan further argues that heightening software vendors' accountability will ultimately produce better designed software. *Id. But see* Ronald J. Palenski, *Faulty Software Problem or Puffery? Competition, Not Litigation Ensures Quality Systems*, COMPUTERWORLD, Mar. 28, 1994, at 86 (arguing that competition and the rising computer skills of software customers has served to eliminate "inattentive" and "unresponsive" vendors and increase the general quality and reliability of software).

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Even from a purely service standpoint, courts have been loathe to extend malpractice beyond the traditional professions. Attempts to include software consultants within that framework have been rejected.[155]

But the absence of all the formalities of the traditional "learned profession" perhaps should not automatically relegate software professionals to the category of "ordinary worker." The key distinctions raised by most commentators is that, unlike the other professions,

> [t]he distinguishing factors between computer specialists and traditional professions include: 1) extensive formal education and training are not mandatory in the computer industry; 2) the computer industry lacks accepted professional standards, ethics and disciplinary measures; and 3) no state regulates or licenses computer specialists.[156]

Yet, these assertions are not wholly correct and imply the profession has done nothing in this area. Several of the major computing organizations have, indeed, promulgated codes of ethics,[157] though all either lack the power to sanction,[158] or the power to enforce any sanctions imposed.[159] The Association for Computing Machinery (ACM), perhaps the largest of the computing groups with over 50,000 members, has also undertaken with colleges and universities to formalize curricula for training in computer science[160] The Institute for Certification of Computer Professionals maintains a formal certification process. The International

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155. Richard A. Glaser & Leslee M. Lewis, *Redefining the Professional: The Policies and Unregulated Development of Consultant Malpractice Liability*, 72 U. DET. MERCY L. REV. 563, 577 (1995), citing Hospital Computer Sys., Inc. v. Staten Island Hosp., 788 F. Supp. 1351 (D.N.J. 1992) in which the court declined to impose malpractice liability for a computer software consultant because it did not consider consulting to be a profession nor did it find that adequate policy reasons for so defining it. The courts, however, have not wholly rejected negligence claims against software consultants.

156. Glaser & Lewis, *supra* note 155.

157. *See, e.g.*, E. Oz, *Professional Standards for Information Systems Professionals: A Case for a Unified Code of Ethics*, 16 MIS Q. 4 (Dec. 1992), 423-433; E. OZ, ETHICS FOR THE INFORMATION AGE (1994) (describing more than one dozen examples of codes of ethics promulgated by various computer science and computer engineering organizations).

158. *See, e.g.*, *IEEE Ethics Action: Image or Substance?*, ELECTRONIC ENGINEERING TIMES, Oct. 10, 1994, at 44; Ronald E. Anderson et al., *Using the New ACM Code of Ethics in Decision Making*, COMM. OF THE ACM, Feb., 1993, at 98 ("Recent codes of ethics emphasize socialization or education rather than enforced compliance.").

159. ACM SPECIAL INTEREST GROUP ON COMPUTER-HUMAN INTERACTION (SIGCHI), CURRICULA FOR HUMAN-COMPUTER INTERACTION (1992).

160. Leahy, *supra* note 9, at 31.

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Standards Organization (ISO) standards for software development have reached an increasing level of acceptance in the United States; an increasing number of software firms have voluntarily sought the undergo the rigors of ISO certification and its required triennial follow-up certifications.[161] Increasingly, members of the profession have urged the adoption of formal professional standards -- even in the expectation of software malpractice claims -- to make the point that programmers and software vendors are not merely average members of the commercial community.[162] The computer industry trade press has regularly characterized events as "computer malpractice," a distinction not legally binding, but which nonetheless suggests a belief in its possibility. Although the profession as a whole has far to go before it reaches parity with the requirements placed on the other professions, even the casual observer would be hard pressed to classify software professionals in the same legal category as the mythical "reasonable person."[163]

If one looks, however, at the implied requirements of a professional, a different picture emerges. Consider that the underlying rationale for permitting malpractice claims is that the professional need demonstrate a higher standard of care for her clients because to do otherwise would be

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161. *See, e.g., DP Crime: Where There's a Will, There's a Way*, COMPUTERWORLD, Dec. 26, 1983, at 53; Paul Cottrell & Barry D. Weiss, *Third-Party Liability Insurance: Protection in Case of Computer Error*, COMPUTERWORLD, Apr. 2, 1984, at 82.

162. *See, e.g.*, Helen Nissenbaum, *supra* note 7, at 1 (urging the industry to "clarify and vigorously promote" software-related standards of care which include simpler software design, "meaningful quality assurance, independent auditing, excellent document which could evolve into a standard of care"). *See also* Karen Hooten, *To Engineer is Trouble*, COMPUTER LANGUAGE, Nov., 1990, at 107 (suggesting that legal responsibility "creates an overwhelming desire to set up quality-control standards" for protection); Richard K. Aeh, *Is IS Ripe for Malpractice Suits?*, J. SYS. MANAGEMENT, Sept., 1990, at 23 (noting that in October 1989 the attendees at the Computer Professionals for Social Responsibility debated whether to license programmers as a way of preventing ill-programmed software); W. Robert Collins *et al.*, *How Good is Good Enough? An Ethical Analysis of Software Construction and Use*, COMM. OF THE ACM, Jan., 1994, at 81; Karen Hooten, *An Engineer by Any Other Name*, COMPUTER LANGUAGE, Jan., 1990, at 143 ("If we want to be considered professionals, we must accept responsibility for the quality of our work by establishing proven standards of practice . . . [W]hen you're preparing software for a client who trusts your judgment and skill, you should use engineering techniques and established methods, not the latest design trend.").

163. The subject is one of ongoing debate within the engineering and legal communities, with software professionals more vehemently arguing for the same professional status as other engineering professionals and legal observers arguing for more complete regulation of such professionals, especially when operating in their frequent role of consultant. *See generally* Glaser & Lewis, *supra* note 155; Hooten, *supra* note 162, at 143.

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necessarily dangerous to the client and society. Few activities have the potential for mass catastrophe as does malfunctioning software.

*D. Establishing the Standard of Care*

A number of commentators have suggested standards by which software vendors should be assessed. These range from the purely functional approach of the International Standards Organization (ISO) to purely philosophical suggestions.

ISO standards are intended to be thorough and effective mechanisms for insuring that products developed in accordance with the standards meet or exceed minimum requirements for safety, engineering, quality control and the like. Each ISO standard is typically comprised of multiple discrete steps which must be successfully completed before the product can be ISO certified. The standards are unstinting in their expectations. A single portion of the overall ISO standards for software development lists more than 150 steps.[164] Vendors, especially those who wish to market their goods in Europe where ISO compliance is encouraged, take achieving ISO certification for their products very seriously, indeed.

At the other extreme, Collins et al. suggest evaluating software vendors using a schema derived from Rawl's Theory of Justice.[165] This approach utilizes three key tenets:

> Least advanced. Don't increase harm to the least advanced. Software should not increase the degree of harm to those already the most vulnerable to that kind of harm because of their lack of knowledge about software. Here degree means probability x magnitude and the harm can be financial or personal.
>
> Risking harm. Don't risk increasing harm in already risky environments.
>
> Publicity test. Use publicity [to] test for difficult cost-benefit trade-offs. Trade-offs between financial benefit to one party and personal (i.e., non-financial) harm to another party should be made on the basis of a cost-benefit ratio that, if made public would not outrage most members of the public. That is, make only those decisions you can defend with honor before an informed public.[166]

164. *ISO Software Certification Checklist* (copy on file with the author).
165. J. RAWLS, A THEORY OF JUSTICE (1971).
166. Collins, *supra* note 162, at 81.

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On a more practical legal level, Lawrence Levy and Suzanne Bell urge software vendors to implement the following approach:

1. Use qualified software programmers.
2. Document each step in the process, to show who wrote the program and the care taken in each step.
3. Test the software adequately and thoroughly before its release.
4. It may be prudent to have a different group of employees test the software than the group that developed it.
5. Take actions to avoid errors in the information incorporated into the program. The vendor should keep records of how such technical information is incorporated, and who provided it. To the extent possible, the vendor should confirm the accuracy of this information through several sources.
6. If the software is being developed for a particular industry and there are applicable professional codes of conduct for that industry, it may be prudent to follow these codes.[167]

Another commentator has argued that officers and directors of software companies should institute a design review committees to protect themselves from tort actions.[168] The review committee would be answerable directly to the board of directors and would be empowered to evaluate all software designs against the following factors: 1) the gravity of the danger posed by the design; 2) the likelihood that such a danger would cause damage; 3) the feasibility of an alternate design at the time of manufacture; and 4) the financial cost of the new design.[169] Additional considerations should address the adverse consequences to the product and the user that would result from an alternate design. For example, an alternate design may avert an unlikely injury but create a greater risk of injury in other, more common situations.[170]

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167. Lawrence B. Levy & Suzanne Y. Bell, *Software Product Liability: Understanding and Minimizing the Risks*, 5 HIGH TECH. L. J. 24 (1989). With reference to the fourth item in the list, some courts have recognized the value of adequate quality assurance systems in determining products liability issues. *See, e.g.*, U.S. v. Laerdal Mfg. Corp., 853 F. Supp. 1219 (D. Ore. 1994), *aff'd.*, 73 F.3d 852 (9th Cir. 1995).

168. Although this is ostensibly intended to protect the officers and directors from liability, its net effect would be to decrease the liability potential for the software itself.

169. Rosenblum, *supra* note 137, at 9.

170. *Id.*

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### *E. Insurance and Professional Status*

Typical professional liability policies specifically exclude coverage for acts outside the scope of the insured's "professional services." In determining whether an act falls within such scope, the courts will look at the act itself, rather than the performer's status. If, however, the act creates a contract liability, profession liability policies have been found not to apply; only tortious acts are considered covered.[171]

### *F. Proposing a Multi-layered Standard for Software Negligence*

Merely to disallow software malpractice claims while failing to recognize the Catch-22 of the UCC provisions leaves a strong sense of injustice. The Catch-22 works this way: if software malfunctions and it's the manufacturer's doing, but it only causes economic damage, the buyer can't recover, despite the fact that most businesses travel on information these days. If the malfunction causes injury (not likely) or damage to itself (more likely) or damage to other tangible property (not likely) the buyer can recover, but not for damage to intangible property (what is likely to be most damaged -- the data). Thus the buyer's potential recovery is small compared to the buyer's potential loss unless the buyer has been wise enough to negotiate a license or sale agreement which indemnifies for such losses or has purchased her own insurance. If the software merely fails, the buyer can get it replaced. If the buyer truly wants to recover for damages, she must hope for some physical damage to other tangible property or a personal injury to create the opportunity to recover for damage to her intangibles and the resulting consequential damages. Yet, under tort law, the buyer has a duty to mitigate the damages that she experiences.[172]

Much of the problem in addressing this area is that the nature of computer software constantly evolves, metamorphosing into increasingly

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171. *See generally* 43 AM. JUR. 2D § 726. Thus, in Northern Ins. Co. v. Superior Court for San Francisco, 154 Cal. Rptr. 198 (Cal. Ct. App. 1979), an unwanted abortion was found to be covered as a professional service rather than an administrative, i.e., contract, error, while in McGee v. United States Fidelity & Guar. Co., 53 F.2d 953 (1st Cir. 1931), a physician who guaranteed a patient that a skin-graft operation would restore the patient's hand 100%, but failed to do so had created a contract which was not covered under the physician's professional liability policy. *Id.* at 956; *but see* Touchette Corp. v. Merchants Mut. Ins. Co., 429 N.Y.S.2d 952 (N.Y. App. Div. 1980) (permitting recovery under an E&O policy for contract liability if such liability resulted from negligence).

172. RESTATEMENT (SECOND) OF TORTS § 918 (1979).

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complex and subtle forms.[173] Rather than approaching software from the standpoint of what it is, a more fruitful approach is to view it in terms of what it does, and apply the appropriate legal frameworks. Let us define computer programs for what they are: representations of human thought which are capable of independent or nearly independent action. And, let us define the commodity likely damaged as a result of a malfunction -- data -- as tangible property, with real value independent of its form, capable of sustaining real loss for which its owners should have access to suitable remedies.

On this basis software can be classified into three categories:

a. software operating as a "product"
b. software which provides a service not ordinarily subject to malpractice claims
c. software which provides a professional service

1. Software Operating as a Product

Software of this type is of the "unintelligent" type. Its primary function is to speed well-defined rote processes and requires the user to set it and monitor its operation. Failure of this type of software is more akin to conditions anticipated by contract warranties under the UCC. Examples of such software would include spreadsheet software performing standard spreadsheet functions, word processing software, software which reads bar-coded instructions, and the like. Otherwise "intelligent" software which fails to operate in a purely mechanical sense, i.e., simply does not function or cannot be installed, functions too slowly, conflicts with other software, etc. also falls into this category.

2. Software Providing a Service Not Ordinarily Subject to Malpractice Claims

This category includes software which incorporates properties and functions extending beyond the rote and mechanical processes of software in the first category. This software does more than merely accelerate standard human processes. It may "trap" the user's errors, e.g., the automatic spell checking feature in Microsoft Word™ or "suggest" the most appropriate way to represent data graphically, as in most spreadsheet

173. One book on programming from the early 1980's was entitled, "Nailing Jelly to Tree." The allusion remains apt. JERRY WILLIS & WILLIAM DANLEY, JR., NAILING JELLY TO A TREE (1981).

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programs. The user relies on such software as a tool not to automate the user's tasks, but rather to extend and enhance the user's capabilities.

Most mass-market software and a great deal of commercial software would fall into this category. Here, vendor liability would be more akin to that currently anticipated under Article 2 of the UCC. Software which includes "bugs" of which the vendor has knowledge and which materially affect the functioning of the software are rightly placed here because the vendor has notice of a material flaw and has failed to take action to prevent the sale of a clearly defective product. Similarly, software which accidentally introduces a virus to your computer system would violate general industry standards (and common sense) for software testing and quality assurance. This does not require that a piece of software be error-free,[174] merely that the vendor has taken reasonable precautions to prevent the error or fix it once known.[175]

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174. Indeed, error-free software appears virtually impossible to attain, but this does not mean that software companies are necessarily using all the quality control tools at their disposal as effectively as they might. *See, e.g.*, Effy Oz, *When Professional Standards are Lax: The CONFIRM Failure and its Lessons*, COMMUNICATIONS OF THE ACM, October, 1994, at 29 ("Software development failures are not rare occurrences. According to one survey, an astonishing 75% of all system development undertaken is either never completed or the resulting systems are not used.") See also *Product Liability, A Multibillion-Dollar Dilemma: The Impending Software Quality Crisis*, AMA Management Briefing No. 1984, noting:

> The industry's 60 leading software vendors ship software with less than 75% of the application being tested for software bugs or flaws. In the overall development community, a typical application ships with as much as 65% of its code untested. Only the top four application developers are committed to quality-centered development and have invested in sufficient processes and tools to find up to 95% of their software defects before they reach users.
>
> One problem companies face is that most engineering managers have no idea what percentage of a project's code is actually tested.

*Id.*

175. The issue of viruses is an interesting one, though beyond the primary scope of this commentary. Though used as a general term to encompass computer programs which are engineered deliberately to damage or destroy data or cause equipment to malfunction, such programs are actually of two distinct types: "viruses" (programs that can attach or be attached to other programs, and which can modify their host, replicate themselves and otherwise "infect" a computer or computer system; "worms" (programs that do not replicate but travel through computer systems seeking out specific target software to harm); and "time-bombs" (which are embedded in software, rendering it inoperable at some pre-determined time). Legitimate vendors are unlikely to knowingly include the first two

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### 3. Software Providing a Professional Service

Medical, legal, and other software which diagnoses, advises or otherwise applies expertise and understanding for the benefit of the non-professional user occupies this category. Such software purports to act in the place of a reasonably proficient member of the profession it automates. Therefore, the user's reliance on the output of the software ought to be considered as if it were reliance on its human analog.[176] Granted, expert systems are not likely to reach a level of sophistication such that a user will not verify their accuracy with a human physician or attorney. However, the possibility of other types of mischief may occur because of an emergency situation where time is essential or in situations where events move so quickly that the individual is not likely to spend time reflecting on alternate course of action. In such situations, the user places her reliance on the accuracy of the software,[177] prompting some commentators to suggest that programmers purchase malpractice insurance for the profession for which they are programming.[178]

A more tenuous, but nonetheless real, opportunity for malpractice rests with malfunctioning or otherwise incorrect professional software which leads the human practitioner to an incorrect professional conclusion and

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varieties in their products. "Time-bombs" are often included in software loaned to a potential purchaser for a trial period or in software which requires renewal of license fees for continuing use.) For a discussion of "virus liability," see Mary L. Beyer, *Managing the Risk of Virus Liability*, COMPUTER LAW., Dec. 1993, at 22. Insurers have long recognized the need for protecting software users from virus attacks. *See, e.g.*, *Allstate Insurance Becomes First Company to Offer Computer Virus Insurance*, 1989 COMPUTER L. REP. 1019 (1989).

176. Recall the mushroom book and the flight charts, *supra* notes 34 & 36. To date, there has been a single administrative ruling which held a software developer to the standard of the field of the software purchaser (a tax preparer). Rev. Rul. 85-189, 185-2 C.B. 341.

177. As Prof. Mintz notes,

> A consumer physically injured by words or ideas [intangibles] sold as a product is as much injured, and as much deserving of recompense, as someone injured by a tangible aspect of a product. Likewise, an actor who sells words or ideas as a product should not be able to insulate himself or herself from strict liability when those words or ideas causc an otherwise compensable injury simply because of the communicative nature of that product.

Mintz, *supra* note 36, at 649.

178. Alexander Zaharoff, *Expert Systems: Strategies for Minimizing Liability*, 6 COMPUTER LAW. 31, 31 (1989); L. Nancy Birnbaum, *Strict Products Liability and Computer Software*, 8 COMPUTER L. J. 135, 155-57 (1988).

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thereby causes direct harm to the client. Various commentators have argued that such a liability may be approached against medical diagnostic software,[179] failure of an accounting firm to use standards-certified accounting software,[180] too much reliance by an attorney on computerized research[181] and information repositories.[182]

4. Exceptions

Note that under this schema, the failure of a single piece of software might implicate the remedies for more than one category. For example, assume a payroll application mistakenly prevents paychecks from being electronically transferred to employee's bank accounts, but generates general ledger reports indicating that the transfers have taken place. The vendor would be liable for breach of contract for a malfunctioning product as well as a negligence claim by the employees not in privity to the

179. Bradd N. Feldbaum, *Computers and Medical Diagnosis*, N.J.L.J., Feb. 7, 1994, at 10. "Defective software, too much reliance by doctors on computer diagnoses, inadequate computer-systems maintenance, incorrect data input, electrical surges, and security of accessible medical or patient information all present new problems." *Id.*

180. *Id.* (citing Diversified Graphics, Ltd. v. Groves, 868 F.2d 293 (8th Cir. 1989) ("[b]ecause of accounting firm Ernst & Whinney's 'superior knowledge and expertise in the area of computer systems . . . [it] was properly held to a professional standard of care" in providing computer consulting services to Diversified Graphics.); *see* Amiel Kornal, *User v. Vendor: Are the Scales Tipping? Computer Lawyers Say Rulings Starting to Favor Users*, COMPUTERWORLD, June 4, 1990, at 89. Interestingly, the computer magazines picked up on this case, describing it as the court having "edged very close to permitting a claim for computer malpractice." Savage, *supra* note 18, at 89.

181. David M. Boyhan, *Law Office Technology*, N.Y.L.J., Mar. 23, 1993, at 4.

182. *See generally* Joseph R. Tiano, Jr., Comment, *The Liability of Computerized Information Providers: A Look Back and a Proposed Analysis For the Future*, 56 U. PITT. L. REV. 655 (1995). Tiano argues for permitting recovery of economic losses caused by incorrect or incomplete information, primarily because the nature of the harms incurred and the "product" involved can reach only to purely economic harm. "Blameless victims who miss business opportunities, forego payments, default on business obligations, or make other decisions resulting in loss are denied recovery simply because they did not suffer personal injury or property damage. Intuitively, this is not a just result." *Id.* at 690. Tiano urges a 3-part standard for determining how to compensate victims of such harm by balancing the 1) purpose to which the erroneous information was put, the degree to which the user could rightly have relied on it, the nature of the user involved (familiar or unfamiliar with the information and therefore more or less likely to accept it without question) and whether the information was purchased or not (assuming purchase indicates lesser recklessness in relying on the data); 2) the amount of control the provider could exert in determining the accuracy of the information: whether it was static or variant, whether the provider had the means to monitor and verify the information and the relative value of the information to the provider with greater value suggesting greater control; and 3) the foreseeability of harm from the information. *Id.* at 682-83.

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software purchase but who suffered a loss due to the vendor's negligence. Similarly, software which drafts one's will but fails to note the conditions under which your state recognizes such documents would subject its vendor to a malpractice claim. If by its design the mere act of loading it damages other software by introducing a virus to your hard disk drive, a simple negligence claim could result.[183]

What this framework does provide is the opportunity to deal with software malfunctions on a case by case basis and in terms of the effect of the malfunction on the user.

## VI. WHY SHOULD INSURANCE COMPANIES AND SOFTWARE VENDORS BOTHER WITH INSURANCE?

If the current state of the law virtually allows software vendors to pre-empt all claims against them,[184] why then should software vendors and insurance companies bother to insure against a non-existent threat?

Four converging trends suggest a possible rationale: 1) an emerging legal concept of electronically stored data as tangible property; 2) equity concerns regarding the severe and growing imbalance between the buyer's potential for catastrophic injury to critical and expensive data; 3) increasing willingness by the software community to recognize its liability for damage caused by software defects; and 4) the willingness of the insurance industry to validate that the software industry is robust enough to support damage claims.

### *A. Data as Tangible Property*

A major impediment to software buyers' ability to raise damage claims rests on the twin concepts of data as an intangible commodity and the majority economic loss rule which requires damage to physical property before economic losses can be considered.[185] The net effect of this combination has historically prevented data owners from recovering the costs related to reconstructing critical information, such as blueprints and business records unless they carry their own insurance for replacement. When recovery has been permitted, the courts have limited it to any tangible property through which the data was expressed, but not the data itself. In one curious case, the plaintiff sued for the recovery of the value of

183. Breyer, *supra* note 175, at 23.

184. The exceptions are claims for bodily injury (which are prohibited under the unconscionability doctrine) and for misdesigned or operating software developed under a negotiated contract between vendor and buyer (typically covered by warranty provisions and indemnified via errors and omissions insurance policies). *See supra* Section III.

185. *See* discussion, *supra* Section III.

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a set of architectural drawings; the court allowed recovery of the cost of the ink and blue print paper on which the drawings had been rendered, but not for the value of the ideas they contained.[186]

With the advent of computer "hackers,"[187] and several widely-publicized cases of break-ins to proprietary data bases, the Congress[188] and several states[189] created legislation to permit data owners redress for damage caused by such unauthorized access. By doing so, they implicitly recognized that electronic data has value and is property in the legal senses of those words. These create significant cracks in the "economic loss rule" wall barring damage to electronic information alone, though it is too soon to say whether or to what extent the courts might apply these concepts to instances of data loss or damage in the absence of criminal acts.

From an insurance standpoint, redefining data as tangible property would create entirely new exposures under existing CGL policies. Under the 1986 standard form CGL policy, "property damage" includes physical injury to tangible property, including loss of use.[190]

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186. *See supra* note 126.

187. "Hackers" is a generic term, originally designating a closed society of individuals who spent the bulk of their time and energy programming software, experimenting with computing technology and conversing with other hackers. More recently the term has taken a more sinister term, designating individuals who attempt to show their computing prowess by breaching the security of private, commercial, and governmental computer systems and data bases. Although many hackers remain benign, simply enjoying the sport of breaking into restricted areas to see if it can be done, others have deliberately vandalized, altered or destroyed data for revenge, economic advantage or to demonstrate their skills.

188. *See* Economic Espionage Act of 1996, Pub. L. No. 104-294, 110 Stat. 3488 (providing for criminal penalties for the unauthorized intentional or negligent destruction or modification of another's data).

189. As of this writing, 14 states provide for criminal penalties for the unauthorized intentional or negligent destruction or modification of another's data base. ALA. CODE § 138A-8-102 (1996); ARK. CODE ANN. § 5-41-101 (1995); CAL. PENAL CODE § 502 (West 1996); DEL. CODE ANN. CRIMES & CRIM. PROC. II § 435 (1996); FLA. STAT. § 815.02 (1996); GA. CODE ANN. § 16-9-91 (1996); HAW. REV. STAT. ANN. § 708-890 (Michie 1996); KAN. STAT. ANN. § 21-3755 (1996); MISS. CODE ANN. § 97-45-01 (1996); MO. ANN. STAT. § 569.093 (1996); N.J. STAT. ANN. § 2A:38A-3 (1996); 21 OKLA. STAT. ANN. CRIMES & PUNISHMENTS 1952 (1996); TENN. CODE ANN. § 39-14-602 (1996); W. VA. CODE § 61-3C-2 (1996); and WIS. STAT. ANN. § 943.70 (1997). Montana provides similar penalties for public records. MONT. CODE ANN., § 44-6-311 (1995). New York defines data as personal property for the purposes of artisan's liens. N.Y. LIEN LAW § 180 (1996).

190. MALECKI, *supra* note 77, at 219.

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### *B. Buyer's Potential for Catastrophic Injury to Critical and Expensive Data*

Despite IBM chairman Thomas J. Watson, Jr.'s 1948 prediction that the world market for computers was "five, maybe six" machines, one would be hard-pressed not to encounter dozens of computers in the course of a single day. As computing power has soared and computing costs have nose-dived, computer use has expanded in some form into virtually every occupation and activity of any size. At the same time, however, not every computer user has adequate resources to install the sophisticated back-up and recovery systems or hire the technical support that can forestall or limit the effects of many computer catastrophes. Commercial software purchasers can, of course, more readily access such resources; they can also negotiate major software purchases so as to require the vendor to indemnify them against losses resulting from malfunctions and design flaws.

The vast majority of users, however, do not have such recourse, nor is such support offered by the typical software vendor. The potential for uncompensated losses is therefore high, unless the user assumes the cost of protective insurance, which may not be available, be uneconomically priced, or fall far short of the harm caused. Thus, the party least able to spread the risk of a software catastrophe or pay out of pocket for recovery must, at worst carry the cost for damage alone, or at best, pay both for the software and for insurance against its possible malfunction, with only a small hope of appropriate indemnification.[191]

### *C. Recognition Within the Software Community of Its Liability for Harm Caused*

Software professionals and academics recognize the need for the software profession to address its responsibility for poorly designed or developed software.[192] At Stanford University, a prominent training ground for computer scientists feeding California's Silicon Valley, students attend a class on software liability. Though the course prominently addresses how to limit liability via warranty, it also specifically accepts the probability of software vendor liability for negligent design or manufacture. Any such negligence, it urges, should be allocated according to the type of software produced. Simple negligence standard should apply to the vast majority of software; malpractice standards should apply against life-critical software

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191. *See* discussion of available insurance coverage to software users, *supra* Section III.

192. *See also* discussion, *supra* section V.

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only, e.g., medical software.[193] Though this comment urges a somewhat stronger, multi-pronged approach for assessing negligence, it is becoming increasingly clear that the software community recognizes both a professional responsibility to produce reasonably harmless products and the likelihood that the courts sooner or later will begin to expect it to meet the same levels of responsibility already expected of other industries.

### *D. Insurance Industry Validation*

The willingness of insurance companies to indemnify against software risks is important in several regards.

First, it illustrates the insurance companies' reasoned assessment that the software industry is mature enough to be able to absorb the necessary premiums for some type of coverage[194] and anticipates its potential for

193. Ravi Belani et al., *Liability Law and Software Development*, COMPUTER SCIENCE 201, Part 3, Conclusions: Policy Recommendations at http://www.cse.stanford.edu/class/cs201/projects/liability-law/conclusion.html. The authors make the following recommendations: 1) the law should distinguish between safety critical and "normal" software applications; 2) for normal applications, a simple negligence standard, drafted by the computer professional organizations should be imposed; strict liability would chill innovation and subject software vendors to unreasonable amounts of potential litigation; 3) the negligence standard should include software engineers as professionals; 4) strict liability should be applied only to safety-critical software.

194. Prof. Kent Syverud argues that insurance companies actively seek to broaden the liability universe to increase their own profitability. This is an admittedly controversial concept, but bears some consideration as banks and other financial institution enter traditional insurance markets. *See* Kent Syverud, *On The Demand For Liability Insurance*, 72 TEX. L. REV. 1629 (1994). The fundamental economics of the insurance industry support this contention. Typically, the "combined ratio" (the total business costs of an insurance company, e.g., general and administrative, marketing, salaries, payouts to third parties and the like) exceeds 100% of the premiums taken in. Profitability results when the total of premiums and the interest and other income obtained while premiums are still held by the insurance company exceeds the total costs of operation. Syverud argues that this encourages the insurance industry to increase the liability universe whenever possible. For a more traditional and opposing view, see KENNETH S. ABRAHAM, DISTRIBUTING RISK 24 (1986) (noting that because most people are risk averse they are willing to pay premiums greater than those normally to be expected for the potential losses covered under a given policy).

Since insurance companies' assure profitability by income from the cash flows through their operations, the larger the cash flow, the larger the potential income over and above the combined ratio. Appropriately balancing the increased risk of additional payout (a higher combined ratio), with the potential income generated from the increase in cash flow, then, becomes a critical concern. An insurance company's decision to take on such additional risk indicates it has determined that the new market is sufficiently reliable to provide income sufficient to offset potential claims on the company's resources. EVERETT RANDALL, INTRODUCTION TO UNDERWRITING 191-93 (1994).

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liability claims.[195]

Second, it reflects that the industry is broad enough to permit economically-priced premiums. This encourages software vendors to incorporate insurance within their business operations. Too high a price would, of course, encourage vendors to self-indemnify and take their chances with whatever legal actions might come their way.

Third, it illustrates that the risks of payouts to injured third parties are within tolerable limits, can be estimated with some degree of accuracy, and do not pose unnecessary risk to the indemnifying company. By providing a "safety net" to the industry, insurance unfetters the courts by giving them wider latitude in assigning liability to software vendors, and removing to some extent any hesitation they might have of accidentally killing off a burgeoning part of the economy via appropriate damage claims.[196]

Fourth, the increasing variety of insurance policies available to the software industry demonstrates that insurance companies feel increasingly comfortable in their ability to differentiate accurately among the types of software liability possible and, of importance to insureds, to price such policies competitively.[197]

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195. Insureds may decide to purchase insurance for a variety of reasons, even though there may not be a current and viable threat to its operations. For example, a vendor might purchase insurance as a defensive tactic, because it perceives that the current legal climate might change to its disadvantage. Alternately, it may bundle liability insurance together with its other business-related insurance coverage at some minimal cost, "just to be on the safe side."

196. In this instance I am not referring to specific knowledge during trial of whether a specific software vendor is insured. That information is generally embargoed in civil trials. Rather, this refers to a general knowledge of the court that the defendant vendor is part of a generally-insured industry. Some courts have noted that at least in strict liability cases, "the availability and cost of liability insurance is significant . . . because in those cases the defendant's superior ability to spread the victim's loss, through insurance or price adjustments, is a major justification for imposing liability." Bily v. Arthur Young & Co., 834 P.2d 745, 783 (Cal. 1992) (Kennard, J., dissenting). Though the *Bily* dissent noted that insurance is a significantly less important consideration when liability is based on fault, it nonetheless serves to create the same opportunity for spreading the victim's loss. In *Bily* the dissent seems to imply that there is a desirable element of punishment attributable to fault-based claims that is not inherent in strict liability claims, and as a result the defendant's insurance status becomes less relevant and, perhaps less desirable to know.

197. For example, in the early 1980's, one insurance company offered computer liability insurance at a premium rate of $10,000 to $15,000 per $1,000,000 of coverage. Other insurers readily acknowledged that software liability insurance was priced 50% higher than standard liability policies, in large part because of the uncertainty they faced in accurately assessing the risks involved. By contrast, at least one insurance company offers

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Though often overlooked, the imprimatur provided simply by the availability of insurance often presages an increased willingness by the courts to assign liability to the insured, a variation of the "deep pockets" concept in traditional tort law. In the case of various types of liability insurance, the insurance industry often recognized a need to insure before the courts reached a similar conclusion.[198]

Though each of these is important in its own right, the last is the most critical. Accurate assessment of where and how software can injure its user permits insurance companies to: 1) develop competitive and accurate premium structures for the various coverages they provide to vendors and users alike; 2) provide economic incentives to software vendors which follow proven development procedures and professional standards, thus limiting the potential for liability claims; 3) provide some peace of mind via its duty to defend against lawsuits;[199] and 4) create market efficiencies not currently available in a no-liability software world.

1. Competitive and Accurate Premium Structures

At the heart of insurance lie two inseparable principles: risk spreading and accurate premium pricing. Premiums reflect the insurer's assessment of the risk it is asked to indemnify against; they should be at levels commensurate with the risks assumed.[200] Moreover, they should encourage the insured to seek opportunities to reduce the risk of loss, e.g., through lower rates.[201] As risks will vary from, say insuring a home rather than

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software E&O policies at a rate of $11,000 of premium for $1,000,000 in coverage for a software vendor with sales of $4.5 million a year, roughly the same rate as 15 years ago.

198. See discussion of Commercial General Liability policies, *supra* Section I.

199. If CGL policies are taken as a guide, the insurer's duty to defend is typically much broader than its duty to indemnify. *See, e.g.*, Horace Mann Ins. Co. v. Barbara B., 846 P.2d 792 (Cal. 1993). Insurers have been forced to defend under a CGL even when specifically excluding programming errors from coverage. In DecisionOne Corp. v. ITT Hartford Ins. Group, 942 F. Supp. 1038 (E.D. Pa. 1996), the insurer was unable to convince the court that all the claims arising were "programming errors" and therefore excluded under specific provisions of the CGL. The court noted that "an insurer owes a duty to defend its insured in a suit brought by a third party so long as it appears on the face of that party's pleading that the allegations 'may potentially come within the coverage of the policy.'" *Id.* at 1040. Thus, "[i]f even a single claim in a multi-claim lawsuit could be covered, the insurer is obligated to defend the entire action until the lawsuit is confined to claims not encompassed by the policy provisions." *Id.* at 1041. The court's reluctance to rule for the ITT Hartford may, therefore, create some urgency among insurers to develop better mechanisms for defining and insuring programming liability – if for no other reason than to avoid the trap sprung in *DecisionOne*.

200. SMITH & WIENING, *supra* note 98, at 166.

201. *Id.*

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insuring an automobile, so too will the appropriate premiums required. Each insurance company has developed a number of different rating frameworks which it uses to determine the premiums required for the risks it assumes.[202] For example, a CGL policy premium may be based primarily on the gross sales of an insured manufacturing company,[203] while the age, sex and previous driving record of the insured (among other criteria) become critical information for an automobile policy.[204] In each case, the specific criteria used have been found to be accurate indicators of the risks assumed and the potential for liability. Policies will not be written in cases which violate thse norms.

Because of the special nature of software and the wide variety of harms it may cause, any software insurance program must be able to identify the criteria on which it will rely to determine premium rates and risks assumed. Section C provides such a framework by assessing the type of harm caused, rather than by attempting to gather all software harm under a single category. Moreover, using such a schema enables remedies appropriate to the scope of the injury sustained. This is emminently more realistic an approach in the late -1990's than those the courts have invoked via the U.C.C. and *Chatlos* and its progeny.

2. Economic Incentives

The insurance industry has a long history of encouraging its insureds to minimize their exposure to third party claims. The famous Underwriters Laboratories, best known for their ubiquitous UL symbol on manufactured products, was created as a joint venture of several insurance companies as a means of testing the quality of the products which their insureds produced. Because higher quality products posed less risk exposure, the insurers could pass along a portion of their savings to the insureds via reduced premiums. The consuming public enjoyed higher quality products, less risk of injury and prices moderated at least in part by the lower premiums the manufacturer were required to pay. More recently, insurance companies have instituted "loss control" programs in which insurance specialists work closely with insureds to identify and eliminate avoidable exposures for business claims, property claims and the like.[205]

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202. *Id.* at 173-84.

203. *Id.* at 179.

204. *Id.* at 174.

205. *See, e.g.*, Martin C. Loesch, *Recent Developments in Self-Insurance and Risk Management*, 32 TORT & INS. L.J. 583 (1997).

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Similar opportunities exist with the software industry. The kinds of liabilities outlined previously mimic those already considered through existing property, casualty, business and professional liability insurance programs, even though the scope of those existing programs is considerable smaller than similar exposures the software industry poses. Because insurance companies can attach tangible economic incentives (via lower premiums) to adoption of what are currenly voluntary industry standards, they have the advantage of moral suasion that other software professional groups do not possess.[206]

3. Duty to Defend and Creating Market Efficiencies

Given enough time, consumers will ferret out and ignore marginal vendors,[207] according to efficient market theories. Unfortunately, frivolous law suits can accomplish the same effect, especially with smaller software vendors just starting or those with a well-defined but small market niche. Appropriate insurance coverage can assist with the former (through economic disincentives via higher premium rates or refusal to issue insurance), and help prevent the latter by accepting a duty to defend the insured against all law suits, regardless of merit and by spreading the risks associated with such defense.

Although a single successful lawsuit could send shockwaves through the software industry, the long time lag between filing a suit and its resolution prevents the kind of effect on market efficiencies that an influential insurance program might have. Though the software company directly involved in the suit might immediately change its operations in response to a suit, the effect may not spill over to its brethren in the rest of the industry, who may prefer to wait until a definitive resolution is at hand. Insurance company involvement, however, can prompt proactive and preventive measures via changes to loss control programs throughout the industry as a way of reducing future exposures. In this manner, the insurance company provides a central repository of "lessons learned" from

206. Consider the adoption by numerous manufacturers of the ISO standards for manufacturing. Obtaining ISO certification is a long, painstaking and expensive process. Beyond the immediate improvements in manufacturing processes it creates, the primary motivation for most U.S. companies to undergo the ordeal is that ISO certification opens up numerous markets in the European Economic Community (EEC), where such certification is a prerequisite to doing business. Similar effects could be expected from insurance-inspired adoption of software development standards.

207. This, of course, has numerous exceptions. Many users seem willing to accept minimally-acceptable software because of its price, brand-loyalty or because they know of nowhere else to turn. For example, users flocked to purchase Microsoft's *Windows '95* product despite numerous bugs, and a delivery date nearly a year later than promised.

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a wide variety of policyholders which can be used to benefit all policyholders.

CONCLUSION

Existing contract and tort law create a veritable maze through which few victims of software malfunction emerge with compensation for their losses. Commercial purchasers find little solace for software-induced damages because of court interpretations of software as a product governed by licensing agreements severely restricting recovery. Much software damage creates neither the physical injury or tangible property loss which permits recovery of consequential damages, yet it is precisely such damages most software malfunctions create. Consumers are in a worse position, since they cannot typically negotiate the software license that severely limit recovery, as can savvy commercial purchasers. Indeed, their loss of consequential damages can be relatively more devastating than those suffered by commercial victims, if for no other reason that the private consumer cannot spread the risk of software malfunctions among her clientele as efficiently (if at all) as can the software vendor.

More over, extant contract or tort law cannot adequately address the special nature of software: simultaneously holding the characteristics of a product, an intangible service, and capable of the entire range of unintelligent action through expert analysis. To attempt, as the courts currently do, to categorize all software on the basis of product or service essentially in terms of its form of delivery and the contract which underlies it does not fully address the variety of harm software malfunctions can create, often as product and service simultaneously.

This comment argues that a more equitable approach for dealing with this very unique commodity is to assess the form of harm a software malfunction creates and to apply the standards and rules for recovery of damages appropriate for that form of harm. In many cases, this will allow a determination of negligence or malpractice in the design or development of the software. This requires the courts to abandon the ever more tenuous logic exhibited in software cases since *Chatlos* and *Putnam* and to acknowledge the duty of care which software professionals now actively seek. In the Information Age, to do otherwise unjustly ignores what is obviously real harm to very real "intangible" assets. By expanding the concept of software tort, the courts can ensure that innocent victims of devastating software malfunctions will be made whole. The insurance

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industry has already begun to acknowledge the validity of such claims; it's time for the courts to catch up.

Donald R. Ballman[208]

208. University of Connecticut School of Law, J.D./MBA expected May, 1998. I dedicate this article to my family, who have been enthusiastically supportive of their late-blooming lawyer and to Joseph Steffan, University of Connecticut School of Law, '94, whose example and courage were the single greatest factors in convincing me to attempt law school. My greatest, most profound and most public thanks, however, are due to Jennifer Cona, University of Connecticut School of Law, '96, Jack Genser, University of Connecticut School of Law '94, Scott Gray and Scott, Arlo and Linda Storbo whose good humor, generosity of spirit and unstinting affection have sustained me throughout the rollercoaster ride which is law school. They have become my family in the process.

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