OHRENSTEIN & BROWN, LLP

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INSURANCE NEWSLETTER

THE APPLICATION OF U.S. LAWS REQUIRING UNAUTHORIZED INSURERS TO POST PRE-ANSWER SECURITY IN THE CONTEXT OF REINSURANCE DISPUTES: WHAT THE REINSURER SHOULD KNOW

When disputes arise between ceding insurers and their reinsurers, the threat of litigation or arbitration can be a substantial inducement to both sides to reach a commercial settlement. Putting aside the merits of the parties' claims, and financial wherewithal to engage in a legal skirmish, each side faces the same prospects: it must absorb the costs of conducting this legal fight, and sacrifice the time and energy to wage it.

In the United States, however, ceding insurers engaged in disputes with their foreign or out-of-state reinsurers are becoming increasingly cognizant of the fact that the commencement of legal action can provide enormous leverage to the ceding company in many instances. Depending upon the wording of the local version of the Unauthorized Insurers Process Act, which has been adopted in some form in more than 40 states, ceding insurers authorized to do business in a particular state often can require a foreign or out-of-state reinsurer that is not licensed in that state to post a bond, cash or other security sufficient to satisfy any judgment the ceding insurer may obtain in an action or proceeding against the foreign reinsurer before the reinsurer will be permitted to defend itself. Accordingly, before the merits of the case are even considered a reinsurer can be required to post millions of dollars in security or face entry of a default judgment against it.

Cedents have begun to recognize the leverage afforded by this statute. In one reported case a ceding company involved in a dispute with certain Lloyd's underwriters sought to require them to post *$33 million* in security before the parties could arbitrate the dispute. In another case, a default judgment was entered against a reinsurer which failed to post a $10 million bond to secure its dispute[1] with the New York Superintendent of Insurance as liquidator of an insolvent New York insurer.[2] In that case, a New York appellate court held that failure to honor the pre-answer security requirement was properly punishable by entry of a default judgment. The Court's ruling was rendered even though the reinsurer had agreed to post security for a portion of the claim and protested it was financially unable to post the full amount.

THE UNAUTHORIZED INSURERS PROCESS ACT

The requirement that foreign unauthorized insurers post security for judgment before they can defend actions or proceedings commenced by resident insureds is a product of the Unauthorized Insurers Process Act proposed by the National Association of Insurance Commissioners ("NAIC") in 1948.[3] At the time, with the advent of national television and radio advertising, concern had arisen among the various state insurance commissioners that the insurance buying public was purchasing significant amounts of insurance from out-of-state insurers.[4] When claim disputes arose, the policyholders found that they often faced "insuperable" obstacles to recovery on their claims.[5]

In order to protect the insurance buying public, and encourage out-of-state insurers to become licensed to sell insurance in the states where they did business, the NAIC proposed that insurers who engaged in insurance transactions in states where they were not licensed to do business would be subject to the state's jurisdiction if a dispute arose concerning the insurance.[6] As a result, the typical

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policyholder would not have to travel across the country (or to another country) in order to sue his insurer for failing to pay a $1500 claim.

In addition, the NAIC proposed that in any action commenced against the insurer by its insured the insurer be required either to become licensed to write insurance in the state or post security for any judgment which might be rendered against it before it could defend against the action.[7] Thus, in addition to being able to sue his insurer in his home state, the policyholder would no longer have to worry about having to travel to a foreign jurisdiction to try to enforce any judgment he might obtain.

Application to Reinsurers

Although the original intent of the Act appeared to be the protection of average policyholders, and not sophisticated insurance companies, ceding companies have had great success utilizing the various state statutes modeled on the Act's provisions in the context of disputes with their foreign, unauthorized reinsurers. Indeed, while the issue has been litigated on numerous occasions in New York, the courts have consistently held that New York's pre-answer security statute applies in the reinsurance context.[8]

The result has been that an increasing number of courts have required reinsurers to post millions of dollars in security before even being able to defend against the ceding companies' claims.[9] Because the statutes do not identify ability to post security as a consideration in determining the amount of security to be posted, the courts have also refused to permit reinsurers to avoid or limit the security requirement based upon financial hardship. Indeed, in one case the court held that the reinsurer was required to post security notwithstanding the fact that its assets had been frozen.[10] In another, the court dismissed the reinsurer's objection that it was "technically insolvent and cannot provide security beyond present levels,"holding" [t]he financial condition of the insurer is simply not a factor in determining the proper level of security to be posted."[11]

While these rulings arguably threaten reinsurers with entry of judgments against them – and deprivation of property – without due process in violation of the U.S. Constitution, the statutes have thus far withstood all constitutional scrutiny. The courts considering the issue have found that each state's

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substantial interest in encouraging unauthorized insurers to subject themselves to the state's regulatory authority is a sufficient basis for sustaining the provisions. By requiring security as an alternative to becoming licensed to sell insurance in the state, courts have concluded that the various statutes do not unconstitutionally deprive insurers of any property rights.[12]

Reinsurers have responded to the increasing use of these security provisions by raising a flurry of objections, including arguments that: pre-answer security is not available unless personal jurisdiction over the reinsurer was obtained pursuant to the state's unauthorized insurers process act; the security obligation is waived if not raised before an answer is served; invocation of the security provisions should not be permitted because the reinsurance agreement at issue is invalid or the ceding company otherwise has unclean hands; and the Convention on the Recognition and Enforcement of Foreign Arbitral Awards bars the application of pre-answer security provisions to the parties' arbitrable dispute as "judicial intervention" in the nature of an attachment.

Thus far, however, each such objection has failed to find any success.[13] The one exception courts have recognized has been for reinsurers which qualify as agencies of "foreign states" under the U.S.'s Foreign Sovereign Immunities Act – which provides foreign states, and agencies or instrumentalities of foreign states, with immunity from attachment, arrest and execution except where such immunity has been "explicitly" waived. In three reported decisions, courts have found that because the pre-answer security provisions operate in the manner of an attachment, they cannot be applied against such foreign state agencies.[14]

Aside from whether pre-answer security provisions should apply, reinsurers and their cedents have disputed which elements of a disputed reinsurance claim ought to be the subject of the security to be posted. For example, suppose there is a dispute regarding coverage on a particular treaty and there are approximately $1 million in paid losses, $5 million in reported losses, and $25 million in incurred but not reported ("IBNR") losses. Should the ceding insurer's claim be secured in the amount of the allegedly paid losses? Should reported losses also be secured? What about IBNR?

In the decisions which have addressed this issue, the courts have generally found that only paid losses should be secured.[15] The reasoning has been that: (1) reinsurance contracts are contracts of indemnity, and the obligation to pay only arises upon the cedent's payment of underlying claims; and (2) regardless of their actuarial soundness reserves for reported and IBNR claims are nevertheless "estimates" – and judgments are not paid on estimates.[16] Accordingly, these courts have held that pre-answer security should be limited to those aspects of the ceding company's claim which can immediately be reduced to monetary judgment, and not available for claims seeking declaratory or other prospective relief.[17]

This reasoning makes sense from a statutory construction standpoint, but also from a practical standpoint as well. If pre-answer security is required for reported and IBNR losses, the sums could be staggering. Moreover, IBNR calculations are clearly subject to a variety of reputable theories of calculation. Forcing a reinsurer to post security for such amounts would engage the court in a hearing regarding the appropriate reserving, and compel the court thereby to render an opinion upon the value of claims it may ultimately find to have no merit.[18]

What Reinsurers Can Do

Because U.S. ceding insurers increasingly have used this tool, it behooves the foreign or out-of-state reinsurer to be aware of its options. Reinsurers of U.S. cedents should consider the availability of pre-answer security to ceding insurers with whom they are contemplating litigation or arbitration, and prepare future reinsurance agreements with an eye towards protecting against invocation of such provisions in the future. While options in this regard may be limited to a certain extent by general public policy principles which disfavor contract wording intended to avoid statutory obligations imposed for the public benefit, reinsurers may still take steps to avoid invocation of pre-answer security provisions or limit their application. For example, in agreements with New York cedents the reinsurers can provide in the service of suit clause that the state superintendent of insurance is appointed as the reinsurer's agent for service of process in any action arising from the reinsurance agreement. Where such appointment has been made, and the reinsurance was placed by a New York licensed broker

who also produced the underlying risk, New York's pre-answer security provisions do not apply.[19]

Foreign and out-of-state reinsurers can also insist that any disputes be arbitrated outside the U.S. or in the reinsurer's home state, and carefully tailor the typical service of suit clause to make clear that it is not an agreement by the reinsurer to application of any state pre-answer security provisions as between the parties. By limiting the ceding insurer's ability to gain access to the U.S. courts, and undercutting any basis for arguing that the pre-answer security provisions were incorporated in the reinsurance agreement, the reinsurer concomitantly limits the ceding company's ability to obtain a court order requiring the posting of pre-answer security.

More generally, reinsurers can insist that provision be made in the reinsurance agreement that required security for any litigated claims must be limited to paid losses, and may be satisfied by posting of a letter of credit in a pre-agreed form, with agreed safeguards against improper draw-down. While this would not prevent invocation of pre-answer security requirements, such provision would substantially limit and control their application. In an era in which reinsurance is viewed less and less as an "honorable engagement," and more and more as just another business transaction, such considerations are not insubstantial. ❧

End Notes

* **This article was prepared by Christopher Hitchcock, a partner, and Peter J. Biging, a senior associate, specializing in reinsurance arbitration and litigation, at Ohrenstein & Brown, LLP. It was originally published in issues 302 and 303 of the REINSURANCE MARKET REPORT, a publication of Lloyd's of London Press, and is reprinted here (with minor changes) with permission.**

1 *See Travelers Ins. Co. v. Keeling*, Index No. 24376/91, slip op. (N.Y. Sup. Ct. N.Y. Cty. Jan. 5, 1994) (Shainswit, J.). The court found that some security might be required, notwithstanding the existence of over $8 billion in Lloyd's trust funds in the United States specifically designated for the payment of claims. An out of court settlement was reached, however, before a hearing was held regarding the sufficiency of the trust funds in light of Lloyd's financial situation. *See also Hearing Ordered to Determine Whether Lloyd's Required to Post Pre-Answer Bond*, OHRENSTEIN & BROWN INS. NEWSLETTER, Summer 1994 at 9.

2 *See Curiale v. Ardra Ins. Co., Ltd.*, 189 A.D.2d 217, 220-221, 595 N.Y.S.2d 186, 188 (1st Dep't 1993).

3 *See* NAIC Model Unauthorized Insurers Process Act (1948).

4 *See* James Veach, *"Pre-answer Security" May Not Belong in a Reinsurance Arbitration*, 3 Mealey's Litigation Reports, Reinsurance (Issue 21), 16 (March 10, 1993).

5 *See* NAIC Model Unauthorized Insurers Process Act, § 1 (1948).

6 *Id.*, § 2.

7 *Id.*, § 3.

8 *See John Hancock Prop. and Cas. Ins. Co. v. Universale Reins. Co., Ltd.*, 147 F.R.D. 40, 50 (S.D.N.Y. 1993); *Curiale v. Phoenix General Ins. Co. of Greece, S.A.*,No. 83 Civ. 4687 (CSH), 1992 WL 320535, *1 (S.D.N.Y. Oct. 23, 1992); *American Centennial Ins. Co. v. Seguros La Republica, S.A.*, No. 91 Civ. 1235 (MJL), 1992 WL 162770, *1 (S.D.N.Y. June 22, 1992); *Morgan v. American Risk Management*, Inc., No. 89 Civ. 2999 (JSM) (KAR), 1990 WL 106837, *6 (S.D.N.Y. July 20, 1990); *Curiale v. Ardra Ins. Co.*, 189 A.D.2d 217, 220, 595 N.Y.S.2d 186,188 (1st Dep't 1993). A New York federal district court has also found that Kentucky's pre-answer security provisions are applicable as against reinsurers. *See Stephens v. National Distillers and Chemical Corp.*, 91 Civ. 2901 (JSM) (KAR), slip op. at 2 (S.D.N.Y. March 8, 1994). Interestingly, the court rejected the reinsurers' argument that, as reinsurers conducting lawful reinsurance, they were not required to obtain a certificate of authority from the Kentucky insurance commissioner, and thus shouldn't have to post security as an "unauthorized" insurer. *Id.* While a number of states have provisions arguably applicable to reinsurance disputes, it should be

noted that a number expressly exempt reinsurance. *See*, *e.g.*, Pa. Stat. Ann. § 46(e)(3) (1995); Or. Rev. Stat. § 746.360 (1993).

9 *See*, *e.g.*, *International Surplus Lines Ins. Co. v. Certain Underwriters and Underwriting Syndicates at Lloyd's of London*, 868 F. Supp. 923 (S.D. Ohio 1994) (requiring reinsurers to post security in the amount of losses alleged to total $72,707,635.70, to the extent the court was provided evidence establishing they were paid); *John Hancock Prop. and Cas. Ins. Co. v. Universale Reins. Co.* Ltd., 91 Civ. 3644 (CES), 1993 U.S. Dist. LEXIS 2486 (S.D.N.Y. March 4, 1993) (requiring a Swiss reinsurer to post security pursuant to New York Insurance Law § 1213(c) in the amount of $3,647,224); *Republic Ins. Co. v. Atlantica Ins. Co.*, *Ltd.*, No. 91 Civ. 8362 (CSH), 1992 WL 350754 (S.D.N.Y. Nov. 12, 1992) (requiring the defendant reinsurer to post security amounting to $1,353,052.62, constituting paid losses plus interest); *Curiale v. Phoenix General Ins. Co. of Greece*, *S.A.*, No. 83 Civ. 4687 (CSH), 1992 WL 320535 (S.D.N.Y. Oct. 23, 1992) (requiring defendant reinsurer to post security in the amount of $1,633,674.92); *Curiale v. Ardra Ins. Co.*, *Ltd.*, 189 A.D.2d 217, 595 N.Y.S.2d 186 (1st Dep't 1993) (affirming lower court order requiring reinsurer to post security in the amount of $10,351,877.38).

10 *See John Hancock Prop. and Cas. Ins. Co. v. Universale Reins. Co.*, *Ltd.*, No. 91 Civ. 3644 (CES), 1993 WL 267345, *1 (S.D.N.Y. July 12, 1993).

11 *See Stephens v. American Risk Management*, *Inc.*, No. 89 Civ. 2999 (JSM) (KAR), slip op. at 3 (S.D.N.Y. March 11, 1993), *aff'd.*, 69 F.3d 1226, (2d Cir. 1995). In still another case, the court dismissed the reinsurer's objection that under the laws of the country of its domicile the reinsurer could not pledge assets to satisfy the security requirements, holding that the laws of the reinsurer's place of domicile "have no relevance to the obligation of a foreign insurer under [the security provision]." *See* March 23, 1992 Report and Recommendation of Leonard Bernikow, United States Magistrate Judge (adopted by the court in *American Centennial Ins. Co. v. Seguros La Republica*, No. 90 Civ. 2370 (JFK), and *American Centennial Ins. Co. v. Seguros La Republica*, No. 91 Civ. 1235 (MJL), at 11.

12 *See Trihedron Int'l Assur.*, *Ltd. v. Superior Court*, *County of San Diego*, 218 Cal. App. 3d 934, 946-47, 267 Cal. Rptr. 418, 425-26 (Cal. Ct. App., 4th Dist., Div. 1 1990); *American Centennial Ins. Co. v. Seguros La Republica*, S.A., No. 91 Civ. 1235 (MJL), 1992 WL 162770, *2 (S.D.N.Y. June 22, 1992); *Morgan v. American Risk Management*, *Inc.*, No. 89 Civ. 2999 (JSM) (KAR), 1990 WL 106837, *7 (S.D.N.Y. July 20, 1990).

13 *See*, *e.g.*, *International Surplus Lines Ins. Co. v. Certain Underwriters and Underwriting Syndicates at Lloyd's of London*, 868 F. Supp. 923, 925-26 (S.D. Ohio 1994) (purpose of statute was to bring unauthorized insurers within the state's jurisdiction and require them to post security, without reference to the manner in which process was served); *Republic Ins. Co. v. Atlantica Ins. Co.*, *Ltd.*, No. 91 Civ. 8362 (CSH), 1992 WL 350754, *2 (S.D.N.Y. Nov. 12, 1992) (accord); *Curiale v. Phoenix General Ins. Co. of Greece*, *S.A.*, No. 83 Civ. 4687 (CSH), 1992 WL 320535, *1 (S.D.N.Y. Oct. 23, 1992) (waiting until after answer served to demand posting of security does not constitute a waiver because § 1213 does not set time limits upon demand therefor); *Moore v. National Distillers and Chemical Corp.*, 143 F.R.D. 526, 532 (S.D.N.Y. 1992), *aff'd sub nom. Stephens v. National Distillers and Chemical Corp.*, 69 F.3d 1226 (2d Cir. 1995) (noting that "the language of a § 1213(c) (i) does not require a timely demand of pre-answer security; the language only sets a trigger for security (that being before a defendant undertakes to defend the action)," and apparently accepting plaintiff's contention that "because § 1213 is intended to protect the public, it cannot be waived"); *Curiale v. AIG Multi-Line Syndicate*, *Inc.*, Index No. 4835/85, slip op at 4-5 (Aug. 11, 1993) (Gammerman, J.) (the statute mandates posting of security; delay in seeking to compel posting does not waive statutory protection); *Morgan v. American Risk Management*, *Inc.*, No. 89 Civ. 2999 (JSM) (KAR), 1990 WL 106837, *8 (S.D.N.Y. July 20, 1990) (holding that reinsurer's argument that the reinsurance contract at issue was invalid was irrelevant to security issue as "defendants' defenses, no matter how meritorious, have no bearing on the security requirement"); *Curiale v. AIG Multi-Line*, *Syndicate*, *Inc.*, *supra*, at 5-6

(holding that plaintiff's violation of the New York Insurance Law was irrelevant to its ability to invoke the New York Insurance Law security provision); *Travelers Ins. Co. v. Keeling*; Index No. 24376/91, slip op. (N.Y. Sup. Ct. N.Y. Cty. Jan. 5, 1994) (Shainswit, J.) (holding that the Convention on Recognition and Enforcement of Foreign Arbitral Awards did not present a bar to invocation of statutory pre-answer security requirements where the parties had agreed to submit to and comply with the laws of New York in a typical service of suit clause).

14 *International Surplus Lines Ins. Co. v. Certain Underwriters and Underwriting Syndicates at Lloyd's of London*, 868 F. Supp. 923, 928 (S. D. Ohio 1994); *Moore v. National Distillers and Chemical Corp.*, 143 F.R.D. 526, 534 (S.D.N.Y. 1992), aff'd sub nom. *Stephens v. National Distillers and Chemical Corp.*, 69 F.3d 1226 (2d Cir. 1995); Moore v. Aegon Reins. Co. of America, 196 A.D.2d 250, 260-61, 608 N.Y.S.2d 166, 173-74 (1st Dep't 1994).

15 *See International Surplus Lines Ins. Co. v. Certain Underwriters and Underwriting Syndicates at Lloyd's of London*, 868 F. Supp. 923, 928 (S.D. Ohio 1994); *Morgan v. American Risk Management, Inc.*, NO. 89 Civ. 2999 (JSM) (KAR), 1990 WL 106837, *8 (S.D.N.Y. July 20, 1990). But see *Curiale v. AIG Multi-Line Syndicate, Inc.*, Index 4835/85, slip op. at 6 (Sup. Ct. N.Y. Co. Aug. 11, 1993) (Gammerman, J.) (requiring reinsurers to post security for paid, reported and IBNR losses, although the propriety of requiring security for reported and IBNR losses was apparently not contested or considered).

16 *See International Surplus Lines Ins. Co. v. Certain Underwriters and Underwriting Syndicates at Lloyd's of London*, *supra*, 868 F. Supp. at 928; *Morgan v. American Risk Management, Inc.*, *supra*, 1990 WL 106837 at *8.

17 *Id.*

18 The ceding company would respond that the purpose of the pre-answer security provision is to protect it from having to travel to a foreign jurisdiction to enforce a judgment. If the cedent obtains a judgment requiring its reinsurers to pay future paid claims on reported and IBNR losses, but it is unsecured for these, the cedent will have to do exactly what the statute was designed to prevent: travel to a foreign jurisdiction to enforce the judgment obtained in its home state.

19 *See* N.Y. Ins. Law § 1213(e) (McKinney 1985).

NEW YORK COURT OF APPEALS BARS BAD FAITH SUIT AGAINST INSURER

The New York Court of Appeals has stepped in to clear the bad faith litigation waters recently muddied by an intermediate appellate court. In *New York Univ.* v. *Continental Ins. Co.*, __ N.Y.2d __ , __ N.E.2d __ , 1995 WL 761955 (December 27, 1995), New York's highest court reversed a decision that appeared to allow insureds to convert simple coverage claims into claims for bad faith with the potential for recovery of punitive damages and attorneys' fees.

New York University ("NYU") brought an action against its insurer, Continental Insurance Company and Continental's claims servicing agent ("Continental") alleging breach of contract, bad faith, violation of section 349 of New York's General Business Law and seeking punitive damages. NYU based its action upon what it alleged were Continental's bad faith practices in investigating and disclaiming liability for its claim for loss due to employee theft and for ultimately deciding not to renew its policy. Continental moved to dismiss all claims except that alleging breach of contract. The Appellate Division, First Department affirmed the lower court's denial of Continental's motion. *See New York Intermediate Appellate Court Allows Punitive Damages Claim Against Insurer to Stand*, OHRENSTEIN & BROWN INS. NEWSLETTER, Spring 1995 at 2-3 for further discussion of underlying facts.

Initially, the Court disagreed with the Appellate Division's conclusion that NYU had met the stringent standards for recovery of punitive damages as set forth in the Court's decision in *Rocanova v. Equitable Life Assurance Society*, 83 N.Y.2d 603, 612 N.Y.S.2d 339 (1994). *See Punitive Damages Not Available Pursuant to New York Insurance Law Section 2601*, OHRENSTEIN & BROWN INS. NEWSLETTER, Summer 1994 at 1. In *Rocanova*, the Court held that to state a claim for punitive

damages in a breach of contract action, the insured must establish that (1) the insurer's conduct was actionable as an independent tort; (2) the tortious conduct was of an egregious nature; (3) the egregious conduct was directed at the insured; and (4) the conduct was part of a pattern directed at the public generally. Thus, the Court's threshold task was to consider whether a tort independent of the insurance contract could be identified.

NYU argued that its allegations of Continental's violations of section 2601 of the Insurance Law gave rise to an independent tort. The Court disagreed, relying on its holding in *Rocanova* that section 2601 did not give rise to a private cause of action. If the statute itself did not permit a private right of action in favor of the insured, it could not be construed to impose a tort duty of care flowing to the insured separate and apart from the insurance contract and, thus, no independent tort was stated.

As to NYU's other two "tort" claims, the Court determined that neither stated a cause of action, and, in fact, NYU's claim for breach of the implied covenant of good faith and fair dealing was duplicative of its cause of action for breach of contract. Therefore, no independent tort necessary to state a claim for punitive damages was stated; and all three causes of action and NYU's claim for punitive damages were dismissed.

The Court then when on to examine, and ultimately dismiss, NYU's cause of action based upon Continental's alleged violations of section 349 of New York's General Business Law. By allowing NYU to recover for Continental's alleged violations of section 2601 of the Insurance Law under the guise of a claim under section 349 of the General Business Law, the appellate court had in essence circumvented the Court's holding in *Rocanova* that no private right of action was afforded under section 2601. Moreover, by allowing the claim, the appellate court had opened the door for the insured's recovery of attorneys' fees – ordinarily not recoverable in an insured's action on an insurance policy.

Section 349 makes unlawful deceptive acts or practices in conducting a business or furnishing a service. The Court reasoned that to claim the benefit of section 349, the claimant must at the threshold charge conduct that is consumer oriented, that is, conduct that has a broad impact on consumers at large. NYU had not met this threshold. Rather, the case it alleged was essentially a private contract dispute over policy coverage, based upon a policy that was unique to the these parties. Thus, the cause of action, and the potential for recovery of attorneys' fees, was dismissed.

With its reversal of the Appellate Division's decision, the Court of Appeals has reiterated the standards set forth in *Rocanova* and has again reaffirmed New York's pro-insurer inclination. ❧

NEW YORK APPELLATE COURT APPEARS TO SOFTEN DOCTRINE OF PROFESSIONAL MEDICAL JUDGMENT

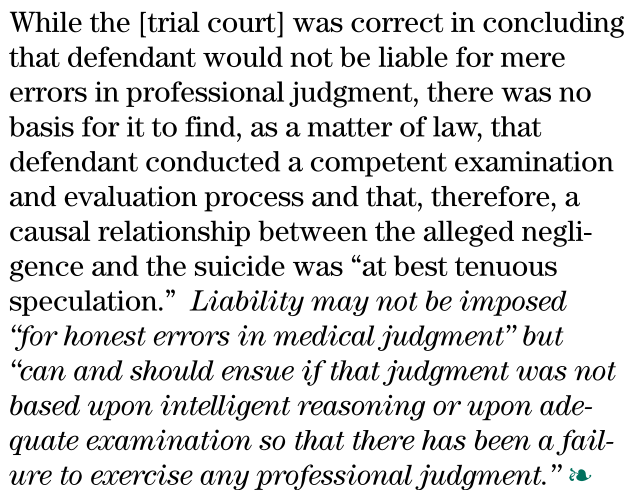
New York's Appellate Division, First Department has held that a psychiatrist, who failed to suggest treatment beyond group therapy for a patient who ultimately committed suicide, may have committed more than a "mere error" in professional judgment. This holding is likely to soften the longstanding New York doctrine of professional medical judgment, which insulates a psychiatrist from liability for "mere error" in professional judgment, as long as the psychiatrist chooses a course of treatment within a range of medically accepted choices after a proper examination and evaluation. The Appellate Division rejected the psychiatrist's argument that he should be freed of liability because the patient had not shown any previous suicidal behavior, and reinstated a claim filed by the patient's estate.

In *O'Sullivan v. Presbyterian Hospital*, __ A.D.2d __ , 634 N.Y.S.2d 101 (1st Dep't 1995), plaintiff's decedent had a stress-induced condition which kept him from working or socializing, was extremely underweight and had withdrawn from most normal daily activities. After his sister convinced him to seek help, he sought psychiatric treatment from Presbyterian Hospital. He was interviewed by a third-year medical student but, despite his abnormally low weight, was not given a physical exam. The hospital recommended group therapy, but the decedent was repeatedly rejected by groups because of his personality. He was offered no interim treatment while he awaited entry into a group. Three days after being rejected by yet another group, he committed suicide.

The defendant psychiatrist moved for summary judgment, noting that the decedent had not shown

any suicidal tendencies and submitted experts' affidavits concluding that his conduct had not departed from accepted standards of psychiatric practice. The patient's estate also submitted an expert's affidavit, stating that the care the decedent received at the hospital was causally related to his suicide, and that the care did deviate from acceptable standards of medical care, including failure to diagnose a major depression, failure to conduct a physical exam, and failure to provide medication and interim treatment.

The trial court granted summary judgment in favor of the psychiatrist based on the doctrine of professional medical judgment. In reversing the trial court the Appellate Division stated:



> While the [trial court] was correct in concluding that defendant would not be liable for mere errors in professional judgment, there was no basis for it to find, as a matter of law, that defendant conducted a competent examination and evaluation process and that, therefore, a causal relationship between the alleged negligence and the suicide was "at best tenuous speculation." *Liability may not be imposed "for honest errors in medical judgment" but "can and should ensue if that judgment was not based upon intelligent reasoning or upon adequate examination so that there has been a failure to exercise any professional judgment."* ❧

"SUDDEN" DEFINED TO DENY POLICY COVERAGE

In *Northville Indus. Corp. v. National Union Fire Ins. Co. of Pittsburgh, PA.*, __ A.D.2d __ , __ N.Y.S.2d __ , 1995 WL 775204 (2d Dep't Dec. 29, 1995), New York's Appellate Division, Second Department revisited "sudden and accidental" discharge clauses commonly found in comprehensive general liability insurance policies. In so doing, the court ruled that discharges at petroleum storage facilities which occurred over a period of years were not "sudden" so as to bring the discharges and their attendant damage within exceptions to the policies' pollution exclusion clauses.

Plaintiff Northville Industries Corp. ("Northville") sought coverage for damages arising from leaks at two different petroleum storage facilities located in New York. Both facilities included extensive networks of underground pipelines through which petroleum products were transported. The defendant insurers had issued several primary and excess comprehensive general liability policies to Northville.

Each of the policies contained similar pollution exclusion clauses which provided that the coverage afforded would not apply to bodily injury or property damage arising out of the dispersal, discharge, or release of toxic chemicals, liquids or gases. Similarly, the policies provided exemptions from this exclusion which stated essentially that coverage would be afforded to any discharge, dispersal, release, or escape that is "sudden and accidental."

In 1986 and 1987, Northville discovered gasoline contamination in the ground water beneath facilities located in Holtsville and East Setauket, respectively. The Holtsville leak was found to result from an improperly installed elbow in an underground piping system and caused the dispersal of approximately 750,000 gallons of gasoline into the soil below the facility. The East Setauket contamination was found to stem from a "pin-hole" leak caused by the internal corrosion of a pipeline which resulted in the dispersal of approximately 1.2 million gallons of gasoline. While it was impossible to determine with certainty the date at which the leaks had begun, both leaks had been ongoing for a period of approximately 25-30 years.

Northville argued that its policies should have afforded coverage for claims by affected property owners, because the leaks in question were "sudden," notwithstanding the fact that such leaks and damages arising therefrom occurred over a period of years. In essence, Northville contended that the "unexpected" nature of the leaks is what made them "sudden." The insurers contended, on the other hand, that the leaks fell squarely within the pollution exclusion and that they were, therefore, not liable on the policies.

The trial court held that the insurers were not liable on the claims arising out of the East Setauket contamination since that leak arose from "a gradual natural process [of corrosion] occurring over a long period of time." However, the court also ruled that the Holtsville claims raised a triable question of fact with respect to the applicability of the pollution exclusion.

Modifying the trial court's decision, the Appellate Division held, relying on the Court of Appeals decision in *Technicon Electric Corp.* v. *American Home Assur. Co.*, 141 A.D.2d 124, 533 N.Y.S.2d 91 (2d Dep't 1988), that the term "sudden" should be construed according to its ordinary meaning and that such meaning required the conclusion that a "sudden" event is one which "occurs over a short period of time." To hold otherwise, the court reasoned, would render the term "sudden" superfluous and would violate the principle of contract construction that every term in an agreement should be deemed to have some meaning.

In so ruling, the court rejected case law from the Appellate Division, Third and Fourth Departments which had previously held that underground leaks occurring over a period of years could nevertheless be "sudden and accidental." The court noted that the Appellate Division, Third Department had clarified its earlier decisions following *Technicon* and refused to vary what it called the "unambiguous" terms of the policies. Importantly, the court rejected the related notion that a discharge or dispersal over a long period of time could nevertheless be "sudden" at its inception.

Moreover, the court ruled, since the underlying complaints alleged contaminations occurring over long periods of time, the broad duty to defend, incident to contracts of insurance, did not apply since no possible construction of the complaints could lead to a conclusion that coverage would be applicable to their claims. ❧

SELECTED LEGISLATIVE AND REGULATORY DEVELOPMENTS

Four States Considering Bills to Revise Procedures Relating to Medical Malpractice Litigation

The legislatures in Illinois, Michigan, New Jersey, and Texas are all considering, or have recently considered, bills which propose procedural changes in medical malpractice actions.

Illinois House Bill No. 966 proposes to enact the "Mental Health Providers Act," which would reduce the implementation of untested or unproven practices in order to encourage doctors to render reliable and efficient services. Under this bill, all mental health care providers must inform their clients of the risks, hazards, and relative benefits of all proposed treatments. Further, all requests for reimbursement for services, including reimbursement from insurers, would have to be accompanied by an "informed consent" form. This form would include: a brief description of the proposed treatment; scientific journal citations demonstrating the effectiveness and safety of the treatment; a brief listing of the known and foreseeable risks, hazards, and relative benefits of both the proposed treatment as well as any alternatives; and must be signed by the practitioner.

This bill also sets forth the requirements that practitioners would be required to meet in legal proceedings in defense of their chosen course of treatment. Among the requirements is a discussion with the patient concerning the strengths and weaknesses of the proposed treatment. Further, the practitioner would be required to obtain the patient's written consent prior to commencing treatment.

In addition, where the provider is testifying as an expert witness concerning the psychological or emotional health of a client, he or she shall provide a report which shall include the following: a description of all evaluations forming the basis for any conclusions; any reservations concerning the reliability of the conclusions or recommendations; disclosure of any disagreement or conflicting information bearing on the practitioner's conclusion; and a statement as to whether the conclusions are based on direct contact between the practitioner and the client.

This bill further provides that any violation of its provisions would be cause for disciplinary action, potentially resulting in the suspension or revocation of the mental health care provider's license; and is currently pending in committee.

Michigan Senate Bill No. 655 would require a plaintiff in an action alleging medical malpractice to prove that in light of the state of the art existing at the time of the alleged misfeasance, the defendant failed to provide the recognized standard of acceptable care in the community in which he or she practices. If the defendant is a specialist, then the applicable standard of care would be narrowed to the standard of care within that specialty in light of the available facilities in the community.

Further, under the bill, which is currently pending in committee, a plaintiff would not be able to recover for the loss of an opportunity to achieve a better result unless that opportunity was greater than fifty percent.

New Jersey Senate Bill No. 2235 proposes amending current law to require a plaintiff in a professional malpractice action to serve a supporting affidavit. The affidavit must be completed by an appropriately licensed professional and state that there is a reasonable probability that the defendant's treatment did not meet the applicable professional standards.

Further, the affiant would be required to be licensed in New Jersey and have demonstrated expertise in the general area or specialty involved in the claim. The bill considers the expertise requirement satisfied by either board certification or devotion of at least 80% of the affiant's practice to the area involved in the litigation. Further, no person with a financial interest in the case would be qualified to submit the affidavit.

The bill, which is currently pending in committee, also provides that if the defendant fails to provide the plaintiff with records or information substantially bearing on the preparation of the affidavit, the plaintiff may submit, in lieu of the affidavit, a statement swearing to the defendant's failure to provide the relevant information. The plaintiff's failure, however, to submit either document shall be deemed a failure to state a cause of action.

Texas House Bill No. 971 proposes to amend provisions of the Texas Code of Civil Procedure to require a plaintiff in malpractice action to file, within 90 days after commencing the suit, a $5,000 bond for each health care provider named as a defendant in the action. In lieu of the bond, a claimant may place $5,000 in an escrow account or file an expert report for each named defendant. If a claimant fails to comply with any of the above requirements, the court may enter an order requiring the filing of a $7,500 bond and further providing that should the bond not be filed, the action will be dismissed for lack of prosecution with respect to the individual health care provider. Should an action be dismissed, however, the claimant may apply for reinstatement by filing the $7,500 bond and any cost incurred by that defendant.

The claimant must also file, within 180 days after the claim was commenced, an expert's report for each health care provider named as a defendant or agree to voluntarily non-suit the defendant. If the claimant fails to file an expert report or to voluntarily non-suit the defendant, the defendant may seek an order awarding as sanctions against the claimant the reasonable attorney's fees and costs incurred by the defendant, the forfeiture of any bond posted to pay the award, and a dismissal of the action with prejudice as against that defendant.

This bill also provides for the qualification standards for expert witnesses. Under the bill, a person may qualify as an expert witness on the issue of whether the physician departed from accepted standards of care only if the person is a physician who is practicing medicine at the time such testimony is given or was practicing medicine at the time the claim arose; has knowledge of accepted standards of care for the diagnosis, care, or treatment of the condition involved in the claim; and is qualified on the basis of training or experience to offer such an expert opinion.

The bill, which was signed into law on May 18, 1995, further provides that in order to determine whether a witness is qualified to give such an opinion, the court shall consider whether the witness is board certified, has substantial relevant training or experience, and is actively engaged in rendering medical services that are relevant to the claim. ❧

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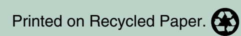

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