OHRENSTEIN & BROWN,
INSURANCE NEWSLETTER
SPRING 1995

NEW YORK COURT OF APPEALS HOLDS "ASSAULT AND BATTERY" EXCLUSION FORECLOSES COVERAGE FOR CLAIMS BASED ON NEGLIGENT HIRING

The New York Court of Appeals has ruled that an insurer may disclaim coverage for bodily injury, pursuant to a standard "assault and battery" exclusion, in suits based on negligent hiring. Our readers may remember that we have highlighted the split between New York's state and federal courts in two earlier issues, stating that if the "based on" language of the exclusion were to have any effect, insurers should be able to properly disclaim coverage for all suits arising out of an assault or battery. *Duty to Defend Assault and Battery Claim*, Ohrenstein & Brown Ins. Newsletter, February 1994, at 11. Subsequently, the United States Court of Appeals for the Second Circuit reversed a decision which had followed several other New York Federal Court rulings, and held that the "assault and battery" exclusion did not excuse insurers from defending claims based on negligent hiring. *See Second Circuit Resolves State/Federal Split Over Application of "Assault and Battery" Exclusion*, Ohrenstein & Brown Ins. Newsletter, Fall 1994, at 1.

Resolving this longstanding conflict and adopting the position advanced by the federal courts until the Second Circuit holding, the Court of Appeals held, in *U.S. Underwriters Ins. Co. v. Val-Blue Corp.*, __ N.E.2d __, 1995 WL 50550 (Feb. 9, 1995), that the standard exclusion for assault and battery extends to claims for negligent hiring or supervision where such claims are "based on" acts which constitute assault or battery.

The recurring, yet familiar, fact pattern commonly involves nightclubs or bars sued by patrons who claim to have been injured by the excessive use of force at the hands of bouncers, or other security personnel. In *U.S. Underwriters*, however, the plaintiff in the underlying case (the "claimant") was an off-duty police officer who had just apprehended a suspect outside of the insured's nightclub. With his gun still drawn, the officer entered the nightclub intending to use the phone.

Inside the nightclub, a security guard, also a retired police officer, confronted the claimant and demanded that he drop his weapon. When the claimant failed to comply, the security guard shot the claimant twice. The claimant claimed that he identified himself as a police officer prior to the shooting. The security guard claimed that the claimant only identified himself after the shooting.

The claimant brought suit against the security guard and Val-Blue Corp., the owner/operator of the club, claiming that the security guard "negligently, carelessly and recklessly" shot the claimant. Val-Blue sought defense and indemnification from U.S. Underwriters under its comprehensive general liability policy. The policy contained the standard "assault and battery" exclusion, which stated, "It is agreed that no coverage shall apply under this policy for any claim, demand or suit based on Assault and Battery and Assault and Battery shall not be deemed an accident, whether or not committed by or at the direction of the insured."

U.S. Underwriters sought a declaratory judgement that it was not obligated to defend or indemnify Val-Blue because the suit, though couched in terms of negligence, was "based on" assault and battery, notwithstanding the numerous claims of negligence alleged in the complaint, and "surrounding the injury." The Court agreed and held that U.S. Underwriters was not obligated to defend or indemnify its insured." ❧

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NEW YORK INTERMEDIATE APPELLATE COURT ALLOWS PUNITIVE DAMAGES CLAIM AGAINST INSURER TO STAND

Just when it appeared that the New York Court of Appeals had clarified the standards for bad faith litigation, and had reaffirmed New York's pro-insurer inclination, a decision by a New York intermediate appellate court, *New York University v. Continental Insurance Company*. ___ A.D.2d ___, 618 N.Y.S.2d 634 (1st Dep't 1994), has unsettled matters.

Early in 1994 in *Rocanova v. Equitable Life Assurance Society of the United States*, 83 N.Y.2d 603, 612 N.Y.S.2d 339 (1994), the Court of Appeals held that section 2601 of the New York Insurance Law, which delineates unfair settlement practices, does not afford a private right of action to an insured. In *New York University*, however, the Appellate Division, First Department essentially circumvented the Court's holding in *Rocanova*, by allowing the insured to recover for an insurer's violations of section 2601, but under the guise of a claim under section 349 of the New York General Business Law.

Further, relying on the decision of the United States Court of Appeals for the Second Circuit in *Riordan v. Nationwide Mutual Fire Insurance Company*, 977 F.2d 47 (2d Cir. 1992), the Appellate Division held that if the insured prevailed on its claim under section 349, it could recover attorneys' fees. In a typical coverage dispute, where the insured sues to recover under an insurance policy, New York courts have held that the insured's attorneys' fees are not recoverable. Ironically, in *Riordan*, the Second Circuit had deferred to the New York Court of Appeals to determine whether section 2601 of the Insurance Law provided a private right of action and whether the recovery of punitive damages was pre-empted by the statute. These questions were withdrawn as moot when the insurer subsequently settled with the insured.

Finally, the Appellate Division held that the allegations in the complaint before it, along with evidence submitted by the insured, met the stringent standards for recovery of punitive damages set forth in *Rocanova*. In *Rocanova*, the Court of Appeals held that to recover punitive damages the insured must show (1) that the insured "was personally the victim of a cognizable tort arising out of [the insured's] contractual relationship with [the insurer];" and

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(2) that the "wrong" to the insured not only "rose to the level of 'such wanton dishonesty as to imply a criminal indifference to civil obligations'. . . , but was also a part of a pattern of similar, publicly directed misconduct." In so holding, the court liberally construed the insured's complaint to discern a fraudulent inducement claim sufficient to satisfy the first element. The insured in *Rocanova* was unable to meet this standard despite alleging 124 disputes between the insurer and other policy-holders because he had failed to establish that he had been personally aggrieved by tortious conduct arising out of his relationship with his insurer.

Briefly, the facts alleged in *New York University*, and accepted by the court as true upon the insurer's motion to dismiss, are as follows. In 1988, the insured, New York University ("NYU") purchased a commercial crime liability insurance policy from Continental Insurance Company ("Continental"). The policy provided, in part, coverage for employee dishonesty. In May, 1990, NYU discovered that one of its employees, who purchased stationery and clothing for its bookstore, had engaged in a scheme with at least one of the bookstore's merchandise suppliers to bill NYU for goods not sent or received.

Soon thereafter, without full knowledge of the extent of the theft, NYU apprised its insurance agent of the potential claim. The agent provided Continental with a "First Notice of Loss." NYU then filed a proof of loss and a supplemental proof of loss documenting a loss of more than $1.5 million as a result of the employee's dishonesty.

Continental immediately began investigating the claim, on which it ultimately disclaimed liability, stating that NYU's documentation did not support its allegations of employee dishonesty. Thereafter, Continental informed NYU that its policy would not be renewed for underwriting reasons. NYU commenced an action against Continental (and Continental Guaranty & Credit Corporation, Continental's claims servicing agent) for breach of contract, bad faith, violation of section 349 of the General Business Law and for punitive damages.

Continental moved to dismiss all of NYU's claims (except for breach of contract), arguing that NYU had failed to present any evidentiary facts which showed that Continental had engaged in recurring deceptive practices harmful to the general public. In opposition, NYU submitted evidence obtained from the Consumer Services Bureau of the New York Insurance Department of nearly 1,400 complaints filed against Continental since 1985, along with evidence of Continental's admitted violations of the New York Insurance Law resulting in penalties and fines. Additionally, on appeal, NYU attempted to satisfy the intervening standard set forth in *Rocanova* by arguing that it had further pled facts that would constitute egregious tortious conduct by Continental against NYU itself. Specifically, NYU argued that Continental, by not revealing its alleged history of refusing to indemnify policyholders at the time NYU had purchased its policy, had fraudulently induced it to purchase the policy. NYU also argued that Continental acted recklessly in investigating, and ultimately denying coverage for NYU's claim.

Based upon the allegations in the complaint and the evidence submitted in opposition to Continental's motion, which the lower court apparently found evidenced conduct by the insurer aimed at consumers other than the insured, the lower court found that NYU had adequately stated a section 349 claim and a claim for bad faith premised on Continental's unfair settlement practices. In addition, the court sustained NYU's cause of action for punitive damages. The Appellate Division unanimously affirmed.

As it now stands, an insured, while not able to recover directly under section 2601 of the Insurance Law, may allege violations of this section to satisfy section 349 of the General Business Law, thereby allowing it to recover attorneys' fees. It may now be up to the Court of Appeals to determine the interplay between section 2601 and section 349 in light of its decision in *Rocanova*. Unless reversed or substantially modified by the Court of Appeals, *New York University* would appear to open the door to allowing insureds in New York to convert their coverage claims into claims for bad faith, punitive damages and recovery of attorneys' fees. ❧

NEW YORK CONFLICT OVER LLOYD'S FORUM SELECTION CLAUSE

Creating an apparent conflict of authority between two different departments of New York's intermediate appellate court, a recent decision of the Appellate Division, Fourth Department held that a service of suit clause long used in Lloyd's of London policies does not preclude an insurer's pre-emptive

declaratory judgment action, despite the commencement of a later action on the same policy by the insured in a different jurisdiction. *Price v. Brown Group, Inc.*, 206 A.D.2d 195, 619 N.Y.S.2d 414 (4th Dep't 1994). A 1985 decision of the Appellate Division, First Department had held under similar circumstances that the Lloyd's service of suit clause essentially operated as a forum selection clause, vesting the insured with the authority to choose the forum in which an action on the policy was heard and precluding a pre-emptive declaratory judgment action by the insurer. *See Rokeby-Johnson v. Kentucky Agricultural Energy Corp.*, 108 A.D.2d 336, 489 N.Y.S.2d 69 (1st Dep't 1985).

In *Price*, the Lloyd's Underwriters ("Underwriters") were presented with a claim for costs incurred by the insured arising out of the ordered closing of the insured's landfill in New York. Following an investigation, the Underwriters denied coverage and commenced a declaratory judgment action in New York seeking a determination that they were not obligated to provide coverage for the costs. Shortly following the commencement of the New York action, the insured brought an action in Circuit Court in Missouri against the Underwriters seeking coverage. Following the commencement of the Missouri action, the insured moved in the New York proceeding for dismissal on *forum non conveniens* grounds, arguing that the service of suit clause permitted it to select the forum regardless of whether the Underwriters had filed suit first. The trial court granted the insured's motion, finding that the service of suit clause operated as a forum selection clause which permitted the insured, not the Underwriters, to choose the forum in which disputes concerning the policy were to be resolved.

On appeal, the trial court's decision was reversed. The Appellate Division's analysis began with an historical review of contractual choice of forum clauses. Recognizing that the common law generally disfavored private choice of forum agreements because of their ability to divest a court of jurisdiction, the court noted that the initial reluctance of courts to apply choice of forum clauses significantly waned by the time the United States Supreme Court had held (in *The Bremen v. Zapata Off-Shore Co.*, 407 U.S. 1 (1972)) that the right of parties to limit jurisdiction was protected under the constitutional right to contract. Given the *Bremen* decision, as well as other supporting New York decisions on the subject, the *Price* court concluded that "[i]t is now well-settled that forum selection clauses are *prima facie* valid."

The court then turned to the fundamental question of whether the Lloyd's service of suit provision was indeed a forum selection clause. The text of the provision provided in pertinent part that:

> It is agreed that in the event of the failure of Underwriters hereon to pay any amount claimed to be due hereunder, Underwriters hereon, at the request of the insured (or reinsured) will submit to the jurisdiction of any Court of competent jurisdiction within the United States and will comply with all requirements necessary to give such Court jurisdiction and all matters arising hereunder shall be determined in accordance with the law and practice of such Court.

Such clauses, the court observed, were added to Lloyd's policies in response to claims by domestic competitors' that Lloyd's was not amenable to service of process in the United States. The court further observed, however, that "[i]t would be more appropriate to describe the service of suit clause as a 'submit to jurisdiction of a court within the United States' clause'" rather than a "forum selection" clause. That conclusion, the court explained, is particularly appropriate under circumstances where, "[t]here is nothing in the wording of the provision that would lead one to the conclusion that it entailed more than [the Underwriters'] voluntary submission to the jurisdiction of the courts of the United States."

In reaching the result that the Lloyd's service of suit clause was not a forum selection provision, the court rejected analysis of the Appellate Division, First Department in *Rokeby-Johnson*, which had held that the service of suit clause operated as a forum selection provision despite the commencement of a prior action by the Underwriters. In addressing *Rokeby-Johnson*, the *Price* court noted that there was a "split of authority," and that other jurisdictions have refused to follow the rule established in *Rokeby-Johnson*. *See International Ins. Co. v. McDermott, Inc.*, 956 F.2d 93 (5th Cir. 1992); *St. Paul Surplus Lines Ins. Co. v. Mentor Corp.*, 503 N.W.2d 511 (Minn. Ct. App. 1993). In *International Ins.*, the Minnesota Court of Appeals held that where the insurer brings a declaratory judgment action against its insured in federal court,

the insured should not be permitted to "block an otherwise valid federal action simply by a later filing in state court." Similarly, in *St. Paul Surplus Lines*, the court there found that a service of suit clause similar to that at issue in *Price* did not require that the insurer's first-filed and served Minnesota action be dismissed in favor of the insured's "earlier-filed, but later-served California action."

The court concluded that a result similar to that reached in *International Ins.* and *St. Paul Surplus Lines* was warranted here, especially in light of the language of the service of suit clause at issue, which provided that "at the request of the insured, [the Underwriters] will submit to the jurisdiction of any court of competent jurisdiction within the United States." The court remarked that this language did "not indicate the defendant [insured] has been given the right to select the forum where plaintiff [Underwriters] has filed suit first." The Court further remarked that the concern expressed in *Rokeby-Johnson* that "such a conclusion would result in 'races to the courthouse'" between insurers and insureds did not warrant a different result.

Given the apparent conflict of authority in New York between the *Price* and *Rokeby-Johnson* decisions it is likely that this issue will be resolved by the New York Court of Appeals. Until then, however, it appears that the greater weight of authority rests with the decision in *Price*. ❧

FEDERAL JUDGE ENJOINS ENFORCEMENT OF NEW YORK EXCESS INSURANCE LAW

A federal district judge in New York has recently enjoined New York State from enforcing a provision of its insurance law, the Excess Insurance Law, in a manner that treats risk retention groups ("RRGs") differently from admitted insurers. The court held that New York's Excess Insurance Law, by indirectly regulating and unfairly discriminating against RRGs, directly contravenes both the letter and the spirit of the federal Liability Risk Retention Act of 1986 (the "Act"), 15 U.S.C. § 3901 *et. seq.*, and the Commerce Clause of the U.S. Constitution. Therefore, the court determined, the New York law is preempted by the conflicting federal provisions. The court also denied the State's motion to dismiss the plaintiffs' antitrust claims, finding that they had adequately alleged facts which might entitle them to relief.

In *Preferred Physicians Mutual Risk Retention Group v. Cuomo*, 865 F. Supp. 1057 (S.D.N.Y. 1994), plaintiffs, two Missouri-domiciled risk retention groups, were authorized pursuant to the Act, to engage in the medical malpractice liability insurance business in New York. Plaintiffs initiated this lawsuit, seeking to enjoin New York State from enforcing its Excess Insurance Law, alleging that it denied them their rights under both the Act and the Commerce Clause.

The Excess Insurance Law, originally enacted in 1986, established an alternative means of providing excess insurance coverage to physicians affiliated with hospitals. The Excess Insurance Law provides that New York State, through the Superintendent of Insurance and the Commissioner of Health, shall purchase this excess coverage, or reimburse a hospital which purchases the excess coverage, for hospital-affiliated physicians and dentists. This coverage is contingent upon the physician or dentist having obtained primary malpractice coverage from a New York licensed insurer in an amount of at least $1 million per claim and $3 million in the aggregate.

The Act provides that RRGs may be licensed in a single state, but can do business in all other states without obtaining separate licenses. The purpose behind this legislation was to increase competition in the liability insurance markets by eliminating state law barriers to the formation and operation of RRGs. The Act achieves this goal by providing that RRGs are exempt from any state law, rule or regulation to the extent that it would, directly or indirectly, regulate or proscribe an RRGs' operation. Through a limited number of exceptions, however, Congress has permitted the states to impose certain expressly authorized regulations on RRGs. For example, an RRG must comply with a state's unfair claim settlement practices law, pay premium taxes and other assessments, and provide notice to its insureds that it is an unlicensed carrier. The Act also prohibits states from unfairly discriminating against RRGs and its members.

The plaintiffs' claimed that by regulating their conduct and unfairly discriminating against them, the Excess Insurance Law runs afoul of both of these provisions. The court agreed with that assessment, finding that the Excess Insurance Law indirectly regulates RRGs by providing an advantage to their competitors. The court specifically found that since the Excess Insurance Law operates only where a

physician has obtained primary coverage through a New York-licensed insurer, physicians have an incentive to purchase their coverage from those admitted insurers. Thus, since New York does not consider RRGs domiciled outside of the State to be admitted carriers, physicians obtaining insurance from such RRGs are not eligible for this "free" excess coverage. This disparity, the court found, offers an enormous competitive advantage to licensed insurers at the expense of the RRGs. Consequently, the only means an RRG has at ameliorating the situation is to become licensed by New York, subverting the purpose of the Act.

The court then found that this mechanism's unequal treatment of RRG's is also a form of unfair discrimination, further violating the Act. Noting that the Excess Insurance Law (1) does not fall within any of the Act's exceptions to its general prohibition against state regulation of RRGs, (2) cannot be construed as a permissible financial responsibility law, and (3) subjects RRGs to disparate treatment, the court found that the Excess Insurance Law unfairly discriminated against RRG's and was preempted by the Act. For all of the above reasons, the court further held that the Excess Insurance Law imposed an unreasonable burden on interstate commerce, in violation of the Commerce Clause.

The court accordingly issued a preliminary injunction against New York State, finding that the plaintiffs have no adequate remedy at law. The injunction prohibits New York from enforcing the Excess Insurance Law in a manner that treats RRGs differently from a licensed carrier. One possible means of complying with this injunction, the court suggested, would be for New York to offer excess coverage to all eligible physicians and dentists, abrogating the condition that they need to have purchased their primary coverage from a New York-licensed carrier. ❧

NEW YORK INTERMEDIATE APPELLATE COURT ENJOINS FORMER OFFICER OF REINSURANCE INTERMEDIARY FROM REVEALING CONFIDENTIAL INFORMATION

In *U.S. Reinsurance Corp. v. Humphreys*, 205 A.D.2d 187, 618 N.Y.S.2d 270, (1st Dep't 1994), the Appellate Division, First Department granted a preliminary injunction which enjoined a former officer and director of U.S. Reinsurance Corp. ("U.S. Re") from using or disclosing proprietary information related to certain reinsurance products that U.S. Re had developed and marketed.

While the defendant was still employed by U.S. Re, the company had developed and marketed a "finite risk catastrophe reinsurance" cover known as the "U.S. Re Continuity Scheme". This reinsurance cover was offered at a reduced premium, but the specific details and mechanics of the product were kept confidential and remained so during the proceedings.

Based on the limited information revealed by U.S. Re the product called for the reinsurer to set aside a portion of the premium in a separate fund. The fund would then be treated by the ceding company for accounting purposes as an asset rather than an insurance liability. The fund would be used for payment of losses and replenished by an additional premium in the event that the balance became negative. But, if there were no claims submitted during the contract period, the balance would be refunded to the reinsured with interest. This reinsurance cover also provided an allowance for yearly cancellation by the ceding company.

At some point after U.S. Re developed and marketed this cover, the Financial Accounting Standards Board ("FASB") changed the rules regarding finite risk covers. FASB mandated that with respect to finite risk covers, certain payments made by the ceding company were to be treated for accounting purposes as liabilities rather than assets. As a result, U.S. Re developed and marketed a substitute product called the "U.S. Re Successor Product."

The defendant, having resigned from U.S Re, informed U.S Re that he did not feel obligated to comply with any confidentiality requirements relating to the company's reinsurance products or, for that matter, any information that he had obtained through his directorship. Subsequent thereto, the defendant attended an insurance trade associated conference and while flaunting his knowledge of the industry, boasted about how he planned to take a million dollars in brokerage fees away from U.S. Re.

Faced with the risk of public disclosure, U.S. Re thereafter commenced this action under an affi-

davit of emergency, seeking a preliminary injunction to prevent the defendant from revealing confidential information about its reinsurance products. In support of its motion seeking to enjoin the defendant's use or disclosure of proprietary information, U.S. Re alleged that the defendant anticipatorily breached a Director Confidentiality Agreement ("agreement") entered into between the parties on January 10, 1992. The agreement specifically prohibited the defendant from disclosing "information concerning the affairs, business clients, customers or other business relationships of the Company . . . or . . . [using] any such information for his own purposes or for the benefit of" others. Plaintiff also alleged that the defendant breached a common law fiduciary duty of loyalty as a former officer and director, and that he was threatening the misappropriation of trade secrets.

To support its contention that the defendant was cognizant of its efforts to safeguard the confidentiality of its reinsurance products, U.S. Re stressed how the defendant had himself promoted the company's policy of requiring that employees sign confidentiality agreements. U.S. Re stated further that the defendant had constructed various agreements to be executed between ceding company clients and assuming reinsurers in order to preserve the confidentiality of its reinsurance products.

The defendant contended that the entire reinsurance scheme was nothing more than a wonderful marketing plan to make clients believe that U.S. Re had some unique products by requiring confidential agreements. In a move to vacate a temporary restraining order issued when U.S. Re commenced the action, the defendant argued that U.S. Re's reinsurance products were not unique, confidential or proprietary, and that such was evident by the apparent absence of proof of confidential matter in plaintiff's papers.

The lower court denied U.S. Re's motion for injunctive relief and vacated the temporary restraining order on the grounds that U.S. Re failed to disclose alleged confidential information and trade secrets, which information necessarily formed the basis for obtaining a preliminary injunction.

In a motion to renew and reargue its motion for a preliminary injunction, U.S. Re again sought to convince the court that its reinsurance scheme was confidential and required the court's intervention to prevent public disclosure. In support thereof, U.S. Re submitted previous correspondence with its clients concerning the reinsurance, as well as affidavits from insurance executives vouching for the uniqueness of its reinsurance products. U.S. Re was also prepared to present its proprietary information for *in camera* review.

The lower court denied U.S. Re's motion to renew and reargue on the grounds that it had failed to offer new facts which were unknown or unavailable to it on its original motion and that the court did not overlook or misapprehend relevant facts, or misapply controlling principles of law. In short, the court found that U.S Re had failed to meet the requirements for grant of such a motion. Thereafter, U.S. Re appealed from the lower court's initial order denying its motion for a preliminary injunction.

The Appellate Division, First Department, in reversing the trial court's order denying renewal of U.S. Re's motion for a preliminary injunction, held that injunctive relief be granted, with costs. Noting that preliminary injunctive relief should be granted where one demonstrates a probability or likelihood of success on the merits, a danger of irreparable injury without such relief, and a balancing of the equities in one's favor, the court stated that U.S. Re had presented sufficient proof that its reinsurance products constituted a trade secret and should remain confidential. In so doing, the court examined the amount of effort expended in developing the products, the extent to which information about the product was known outside of the U.S. Re, and the possible value of the information to U.S. Re's competitors.

The court noted that (1) U.S. Re had taken considerable steps to develop its reinsurance products; (2) U.S. Re took appropriate measures to preserve the confidentiality of its reinsurance products; (3) U.S. Re provided evidence demonstrating that its products were known and recognized industry wide; and (4) a statement previously made by the defendant in which he stated that he would take substantial business away from plaintiff had shown that the reinsurance products were valuable to competitors. For these reasons, the court enjoined the defendant from the using or disclosing of any proprietary information having to do with U.S. Re's products. ❧

FOURTH CIRCUIT FINDS COVERAGE UNDER PHYSICIANS' PROFESSIONAL LIABILITY POLICY FOR CLAIMS OF FRAUD MADE AGAINST FERTILITY SPECIALIST

In *St. Paul Fire & Marine Insurance Co. v. Jacobson*, No. 93-1986, 1995 WL 82887 (4th Cir. Feb. 17, 1995), the U.S. Court of Appeals for the Fourth Circuit held that coverage would be provided under a physicians' professional liability policy against claims of intentional and fraudulent professional practices in connection with the artificial insemination of various patients.

The insured, Dr. Cecil B. Jacobson, who operated a fertility clinic, was convicted of mail fraud, wire fraud, travel fraud and perjury, in part, due to his misconduct in effectuating a fraudulent sperm donor scheme. Dr. Jacobson had artificially inseminated his patients using his own sperm, rather than the promised sperm of a patient's husband or an anonymous donor.

Following the criminal conviction, numerous civil suits were commenced against Dr. Jacobson by the parents of children he had allegedly fathered. These suits alleged various counts of fraud, battery, negligence, tort of outrage, negligent infliction of emotional distress, medical malpractice, and child support, all arising out of the rendering of professional services. Dr. Jacobson requested that his insurer, St. Paul Fire and Marine Insurance Company ("St. Paul"), defend him against the civil suits pursuant to the terms of a physicians' professional liability policy.

St. Paul refused to extend coverage and, instead, commenced an action seeking rescission of the policy or a declaration that it had no duty to defend or indemnify Dr. Jacobson against any claims made in the civil actions. Both parties moved for summary judgment. In support of its motion, St. Paul argued that rescission of the policy was warranted because Dr. Jacobson's insurance application contained materially false representations in that he failed to disclose past and ongoing fraudulent insemination activities. St. Paul also claimed that the intentional and fraudulent use by Dr. Jacobson of his own sperm for artificial insemination was not a professional service and was, therefore, not covered under the policy. The trial court ruled for Dr. Jacobson.

The Fourth Circuit agreed that the policy provided coverage to Dr. Jacobson and affirmed. The court stated that although Virginia state law would permit an insurer viable grounds to rescind an insurance policy for misrepresentation of a material fact, an insured is only required to disclose the specific information requested in the application and is not under any affirmative duty to volunteer information.

The St. Paul application specifically requested that Dr. Jacobson provide information of any pending claims or activities (including requests for medical records) that might give rise to future claims. In response, Dr. Jacobson provided information about two lawsuits brought against him, one settled and the other pending. St. Paul argued, however, that Dr. Jacobson was required to disclose information about his intentional and fraudulent insemination activities because he knew that these activities might lead to future claims against him. To support its argument, St. Paul stated that the term "activities" should be interpreted to mean an insured's activities in rendering professional services which could result in a claim against him as opposed to activities taken by third persons, a patient, or law enforcement personnel.

The court disagreed and found "activities" to be synonymous with the policy language regarding "pending claims" and included the various stages of a lawsuit pursued by a third person prior to the actual filing of a claim. The court also noted that St. Paul's interpretation of the policy would require physicians to list virtually all activities undertaken in providing medical services since arguably all of a physician's activities in rendering such services are a potential source of claims against the physician. Thus, the court found that Dr. Jacobson's response to the question posed in the application was sufficient and that St. Paul was not entitled to rescind the policy.

The court next examined St. Paul's argument that Dr. Jacobson's fraudulent insemination was not the providing or withholding of professional services as required for coverage under the policy. St. Paul argued that the production of sperm and the acts of fraud and deception did not constitute

the rendering of professional services. Dr. Jacobson argued that while the actual production of his sperm did not require any medical competence, the act complained of was the fraudulent use of his sperm to inseminate his patients, an act which required medical knowledge and special skill in its application.

The court concluded that because the act complained of necessarily included Dr. Jacobson's medical act of artificially inseminating a patient, it constituted a professional service under the terms of the policy. As such, the Court found that St. Paul was not relieved of its obligation to defend and indemnify Dr. Jacobson against claims brought in the civil lawsuits. ❧

NEW YORK PUBLIC POLICY DOES NOT PRECLUDE INSURER FROM INDEMNIFYING INSURER FOR OUT OF STATE PUNITIVE DAMAGES AWARD

The New York Court of Appeals has held that an insurer is not precluded from indemnifying an insured for an out-of-state punitive damages award. In *Zurich Ins. Co. v. Shearson Lehman Hutton, Inc.*, 84 N.Y.2d 309, 618, N.Y.S. 2d 609 (1994), the Court held that New York's well-established public policy against insurance coverage for punitive damages would not be offended by ordering an insurer to indemnify an insured for punitive damages if the relevant statute of the judgment state provided that a jury could award such damages to deter or punish, or "...as compensation for the wounded feelings of the plaintiff."

The dispute arose after judgments in slander actions had been entered against Shearson in Texas and Georgia. Zurich commenced a declaratory judgment action in New York state court seeking a determination that it had no obligation to provide coverage for the punitive damage awards, and, in fact, was precluded from doing so by New York public policy.

Although the Court noted that it was applying New York public policy, it also noted that where the judgment state, by statute, allowed insurance coverage for punitive damages, New York's public policy would not be offended by enforcing such a statute.❧

SELECTED LEGISLATIVE AND REGULATORY DEVELOPMENTS

Texas Department of Insurance Proposed Rules 28 TAC 21.1002, 1004, and 1005 expand definition of unfair trade practices.

The Texas Department of Insurance has proposed new rules to further prohibit certain trade practices. A revised section 1002 of the Texas Insurance Regulations would prohibit the use of underwriting guidelines by private passenger automobile and residential property insurers which are not related to the risk of loss for insuring a hazard or the expense in issuing or servicing the policy. Further, underwriting guidelines based, in whole or in part, on race, color, religion, natural origin or familial status would also be defined as unfair trade practices, and thus, prohibited. This provision contains certain guidelines to enable insurers to comply with the regulation. These guidelines provide in general, that where there is objectively verifiable data concerning the risk and the trustworthiness of the insured, it will not be deemed an unfair trade practice to decline to write the policy.

A revised section 1004 would promulgate an anti-discrimination rule applicable to all entities or persons licensed by the Texas Department of Insurance, including those carriers subject to Section 1002, discussed above. This provision would prohibit discrimination on the basis of race, color, religion, or natural origin; and to the extent not justified by sound actuarial principles, on the basis of geographic location, disability, sex, or age, in deciding whether to sell or cancel an insurance policy.

In addition, the next section, 1005, would prohibit the use of an underwriting guideline by private passenger automobile insurers that are based on whether an insured purchases certain types or amounts of coverage in excess of the statutory minimum liability coverage.

These regulations became effective February 9, 1995.

California Department of Insurance Proposed Regulation §2361.l *et seq.* proposes to further implement Proposition 103

Proposed Regulation 2361.1 *et seq.* of the California Administrative Code would govern

the development, application and record-keeping requirements of Schedule Rating Plans. These provisions would empower the Commissioner of Insurance to disapprove any rating plan as discriminatory unless its application is adequately supported by objective data or information applied in a reasonable and objective manner. This rule would require insurers to reflect their rating standards in the base rates and to clearly identify risk characteristics and debit and credit calculations. Further, this regulation would require an insurer to maintain eligibility criteria for every schedule rating plan, which must be indicated in its rate filing. Insurers would also be required under this provision to maintain documentation concerning the rating plans.

This proposal was the subject of a public hearing on December 20, 1994; as of this date the regulation is not effective.

Missouri Senate Bill 73 proposes to require certain disclosures by motor vehicle insurers.

The Missouri Senate is currently considering Senate Bill 73 which would require all insurers writing non-commercial motor vehicle insurance to specify to the insured the nature of each premium reduction generally available and the nature of each premium reduction or surcharge actually applied on a specific policy. Such disclosure would be required both at the time of application and at subsequent renewals.

This bill is currently pending in the Senate Committee on Insurance and Housing.

Mississippi Senate Bill 2154 Would Require Insurers to Explain Reasons for Cancellation

The Mississippi Senate is currently considering Senate Bill 2154 which would impose a requirement on every insurer seeking to cancel or non-renew a policy. A carrier would be required to furnish a written explanation of the reason for the cancellation or non-renewal of the policy with the non-renewal/cancellation notice. Absent such an explanation, the cancellation or non renewal notice would be invalid.

This bill is currently pending in the Senate Committee on Insurance.

Washington Senate Bill 5437 Proposes to Impose Mandatory Disclosures by Insurers of Material Transactions.

The Washington Senate is currently considering Senate Bill 5437 which would impose new disclosure requirements on all Washington-domiciled insurers, certified health plans, health service contractors and health maintenance organizations. The bill would require companies to file a report with the Insurance Department disclosing material acquisitions and dispositions of assets and material non-renewals, cancellations or revisions of reinsurance agreements.

A material acquisition or disposition of assets would be defined as one that is nonrecurring, not in the ordinary course of business and involves more than 5% of the insurers' total reported assets. A material non-renewal, cancellation or revision would be one that affects: more than 50% of a property/casualty insurer's total ceded written premium or total ceded indemnity and loss adjustment reserves; more than 50% of a non-property/casualty insurer's total reserve credit for ceded business; more than 10% of an insurer's total cession, if replaced by another authorized reinsurer; or previously established collateral requirements when they have been reduced or waived where unauthorized reinsurers represent over 10% of a total cession.

Filings are not required where a property/casualty insurer's total ceded written premium represents less than 10% of its total written premium for direct and assumed business; or a non-property/casualty insurer's total reserve credit taken for ceded business represents less than 10% of the statutory reserve requirement. Similar standards would also be imposed upon certified health plans, health service contractors, and health maintenance organizations.

This bill has been passed out from the Senate and is currently pending in the Washington House of Representatives. ❧

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