LIABILITY EXPOSURES

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Table of Contents

CHAPTER ONE

THE PERILS AND CHARACTER OF LIABILITY

Profiling Liability

The peril of liability is high profile in any industry or organization for severe risks today. Because of this, operating an organization without liability insurance puts owners, employees and the consumer at risk. Learning about liability insurance is a great way to prolong the life of an organization.

The Law and Liability

There is a reason why law and liability have to be discussed together. The reason is found in the definition of liability. The definition for liability is the state of being legally obliged and responsible. Liability means that an individual is legally liable for what happens.

Tort Law

A "tort" is a private or civil wrong but not a crime or a breach of contract. A tort violates a private right whereas a crime violates a public right. "Tort law" governs legal liability for this type of wrong. A tort is remedied by an action for damages. The "tortfeaser," an individual who commits the tort, is the defendant in a legal action brought by the plaintiff. The defendant must compensate the plaintiff for the court set amount if he or she is found to be guilty.

Negligence

Tort law requires that negligence or fault be established for an accident victim to receive a damage or injury award. Negligence is covered by tort law because negligence is an unintentional act along with assault and battery, slander, libel and conspiracy. In order for negligence to be legally determined, four conditions must exist:

- A legal duty to act or not act is owed.
- A breach of this legal duty occurs.
- Damage or injury results.
- There is proximate cause between the duty and the damage or injury.

Breaching Legal Duty

Legal duties involve the duty to protect one another's rights and property and behaving as a reasonable and prudent individual. Omitting this behavior, is committing

a breach of legal duty. When we chose to not protect the other people, we set ourselves up for committing a breaching of duty.

Damage or Injury

Damage or injury must occur in order for negligence to exist. Should a breach of legal duty occur and no injury or damage result, then negligence does not exist.

Proximate Cause

Negligence occurs when a breach of a legal duty results in injury or damage. The doctrine of proximate cause states that a causal link must exist between an event and a loss. The breach of duty must initiate an unbroken chain of events which lead to damage or injury for negligence to exist. Under tort law, the wrongdoer is not held legally liable for harm done to a plaintiff unless the plaintiff is able to prove to the court that the defendant's actions were the proximate cause of the plaintiff's harm.

Reasons for Negligence

There may be reasons for negligence which reduce or eliminate liability in the eyes of the law. These reasons are:

- **Intervening Cause** -- An intervening cause, an event which intervenes in or interrupts the chain of events initiated by the breach of duty, creates a new chain of events making the negligent party free from liability.
- **Contributory Negligence** – Contributory negligence denies recovery if the party to whom injury or damage is done is shown to have contributed in some way to the damage or injury.
- **Comparative Negligence** -- Comparative negligence rules are applied when the damage award is reduced based on the amount of damage for which the injured party is responsible.
- **Assumption of Risk** – A court may deny awarding for damages when an injured party has knowingly exposed himself or herself to a risk.
- **Last Clear Chance** – To be released from liability, must demonstrated that the injured party had the last clear chance to avoid the damage or injury.

Types of Damages

Damages, in law has two different meanings. It refers both to the harm suffered by a plaintiff in a civil action, and to any monies paid or awarded to him to compensate for harm. Damages are assessed against the defendant who is found by the jury or judge to have been responsible for the plaintiff's injuries.

Compensatory Damages

Compensatory damages, monetary payments to compensate a plaintiff for his or her loss, include payment for medical expenses, for repair or replacement of damaged property, for lost wages in the present or future, the loss of a property's use value, and for intangible damage.

Punitive Damages

Punitive damages are awarded to a plaintiff in order to punish the defendant for the wrong committed. Besides being used to punish, punitive damages are used to deter like action by others, serve as an example to others and to teach the defendant a lesson. In the past, punitive damages were awarded only in cases where the defendant was shown to be "grossly negligent" or to have practiced "wanton and willful misconduct." However, more recent cases have more aggressively awarded such damages.

Types of Liability

Liability is the state of being liable. A liability is an obligation to pay an amount in money, goods, or services to another party.

Product Liability

Products Liability" can be divided into three distinct areas:

- **Design Defects** includes when foreseeable risks of harm are specifically posed by the product but could have been reduced or avoided by using a reasonable alternative design, and failure to use the alternative design places the product in a position of not being safe.
- ***Manufacturing Defects include incidents when the product departs from its intended design, even when all care was exercised in every possible way.***
- **Inadequate Instructions or Warnings Defects** include times when the foreseeable risks of harm posed by the product could have been reduced or avoided by reasonable instructions or warnings included in the package, and leaving them out causes the product to be unsafe.

Design Defects and Manufacturing Defects have been established for a long time as a basic part of tort law. This has not changed through the years nor has it expanded in its definition. Inadequate Instructions has been expanding rapidly, particularly in cases where the consumer alleges that there was a duty on behalf of the manufacturer and the seller to warn of any potential dangers.

Professional Liability

Because of the growing frequency of professional negligence suits and the sympathies of courts, professional people are now held more accountable for their mistakes than ever before. Any professional can be held liable for his or her actions in assisting or representing some individual person.

Workers' Compensation Liability

Employers' Liability involves employment-related claims brought by employees for work-related injuries or illness. The Employers' Liability insurance coverage is usually one portion of a standard Workers' Compensation policy. Simply defined, workers' compensation recompenses, gives something to a worker, one who performs labor for another, for services rendered or for injuries. This simple definition is taken in part from Webster's Ninth New Collegiate Dictionary and in studying this subject closely, we find this definition extremely accurate. Workers' compensation is not "insurance", rather, it is social insurance, much the same as unemployment compensation and social security. It is however, the oldest form of social insurance.

Umbrella Liability

A liability contract for umbrella liability is for incidents of liability that are not covered by standard liability insurance policies. It is subject to a self-insured retention (deductible), covering exposures otherwise uninsured.

CHAPTER TWO

INTRODUCTION TO LIABILITY INSURANCE

Reasons for Liability Insurance

Liability insurance was created to protect the interests of the insured against loss due to liabilities toward a third-party. Unlike property insurance, which indemnifies the insured, liability insurance pays damages to a third-party. For example, liability insurance will pay for damages for a car damaged by the insured. The damages are paid for the benefit of the third-party, and the insured is then no longer liable. Several legal concepts are involved in the use and application of liability insurance, including the determination of when liability is present and to whom liability applies.

Punitive Damages and Liability Insurance

Punitive damages, until recently, were not much of an issue, even though liability policies typically state that the insurer will pay "all sums the insured shall become legally obligated to pay as damages because of bodily injury or property damage." Liability insurance has historically covered compensatory damages. The policies do not make a distinction between compensatory and punitive damages. As punitive damages have become more common, some believe that punitive damages should not generally be considered to be the responsibility of the insurer, since the reason behind them is to punish the defendant.

Some insurers tried to write exclusions in their policies which would remove the responsibility of paying punitive damages from the insurer. When such action was contemplated, insurance regulators believed that this exclusion should result in a rate reduction. Those who happened to commit a tort in a jurisdiction which commonly awarded punitive damages would suffer more harm than those who did not if such an exclusion were permitted. Therefore, liability insurance generally covers both compensatory and punitive damages, unless a jurisdiction specifically prohibits it.

Liability Without Establishing Negligence or Fault

Negligence or fault must exist to establish liability except in some cases, liability exists without fault or negligence.

Considering Absolute Liability

Absolute liability arises out of conduct which is indisputably hazardous. Damage or injury occurring from this indisputably hazardous conduct establishes liability. This type of conduct also includes keeping wild or dangerous animals and doing activities which involve a variety of dangerous materials.

Considering Strict Liability

Strict liability holds that damage occurring from certain items or activities automatically establishes liability. However, the injured party must prove that a defect in a product caused damage or injury for it to be considered strict liability.

Considering Imputed Liability

When an individual is considered to be responsible for another person's negligence, it is referred to as "imputed liability." Imputed liability may exist in employer-employee relationships where the employer is considered liable for an employee's negligence.

The Basis for Liability Insurance

Negligence is the basis for the legally obligated liability covered by most liability insurance policies. The term "negligence" is not part of liability policy terms and provisions. However, it is covered because it is not excluded. Strict liability and intentional wrong are excluded in liability policies. It would not make sense to have the insured be the claimant, or the party owed, under liability insurance because then the insured would be suing himself or herself.

Liability insurance covers the suits or claims made by others against the insured differing from property coverage which pays for direct damage to the insured's property. Liability insurance pays for the activities of the insured, or the insured's business, which cause damage or loss. The insured has liability for the damage or loss caused by or as a result of property owned by the insured.

Public wrongs are covered by crime statutes and federal regulations Tort law deals with private wrongs. When an insured is found to be legally liable for damages done to another, the insured is legally obligated to pay damages to that party. If liability insurance covers the liability, the amount awarded the injured party may be settled in court, or in an "out of court" settlement.

The practice of awarding damages based on ability to pay rather than proportionate responsibility for the damages is called the principle of "joint and several liability."

General Liability Insurance

General liability insurance coverage applies to claims against the insured from customers, tenants, members of the public, and more. People today, tend to expect monetary remuneration to compensate for discomfort as well as for tragedy. The need for liability protection has existed for centuries but in today's marketplace, the need is even greater.

General liability insurance is essential for most companies to protect the assets of a business when it is sued for something it did or didn't do but caused an injury or property damage. General liability insurance can be purchased separately or as part of a business-owner's

policy (BOP) that bundles property and liability insurance into one policy. The amount of coverage a business needs depends on two factors:

- **Perceived risk:** Consider the amount of risk associated with their business.
- **Location of business:** Carry liability insurance with higher coverage limits if businesses are in states that award high damage amounts

Examining the General Liability Policy

Under the arrangement of a liability policy, the insurer is obligated to pay the legal costs of a business. General liability insurance policies state a maximum amount that the insurer will pay during the policy period. Companies purchase umbrella liability insurance to picks up where a general liability coverage ends.

After a policyholder reports any accidents that could lead to a liability claim, he or she must document the situation, forward all summons and legal notices, and cooperate fully in investigations. All businesses can take precautionary steps to lower the chance of a liability insurance claim:

- maintain up-to-date company records;
- properly trained employees;
- set high standards for quality control.

Looking at General Liability Rates and Underwriting

A rate is the amount of premium per unit of insurance which is typically $1,000. Rates differ because of the type of business or occupation, the risks of the business, and the type of product or service provided. The insurer needs enough premium to cover policyholder claims and pay for the overhead expenses of the business. The insurer will charge more for risks which are more frequent and severe. Rates are regulated by state regulation to keep rates affordable. Generally, states require that rates not be excessive, inadequate, unfairly discriminatory, or non-confiscatory.

Underwriting Looks at Rates

Underwriters determine rates for a risk:

- Review records to determine insurance amounts when evaluating loss;
- Examine application forms, inspection reports, and statistical data;
- Applying rates to risks maintain conservative risk exposure with profitability;
- Evaluate property inspection reports to determine risk or declining risk.

An underwriter bases decisions to accept a risk on the type of risk, the likely frequency and severity of the risk based primarily on historical data, and the quality of management of the risk with a premium or declines the risk.

Risk Selection

In selecting risk, the underwriter ascertains the type of risk the processes of risk management, and reviews the risk profile.

Risk Profile

The underwriter uses several tools to make a risk profile. ***The primary tool is the application***. Applications are developed to provide all the basic information an underwriter needs. The answer to questions on an application may result in an applicant being required to submit additional documentation, either at time of application, or later after an underwriter receives the application in the home office.

Depending on the risk, the application may require personal information about the insured, such as when the insured's creditworthiness is a factor in the risk assessment process. Information about the management personnel of a business, such as whether or not any have been involved in a bankruptcy, may also be required. Once an application is received in underwriting, the underwriter or an underwriting assistant will schedule inspections, request reports on the applicant and the risk, and review the application for completeness, accuracy.

The underwriting process cannot go on for an unreasonable length of time. Insurers are required to meet certain standards for the turn around on the issuance of policies or denial of a risk. More complicated risks are allowed more time. Underwriters, therefore, will include in requests for more information a certain amount of time in which the information must be received, or the file will be closed and any premium returned.

Company Records

Company records are also used in assessing the risk. An insurer wants to spread its risk. A risk may not be excessive, yet if it is of a certain monetary value, an underwriter may review it very carefully. A large risk may impact the stability of the overall risk profile of the business on an insurer's books. So, company records are reviewed to see if an applied-for risk will cause the insurer to have exposure to a particular type of risk that may be too excessive for that insurer. This type of concern would only be for extremely large risks. To help spread the risk, an underwriter may look to reinsurance, or to a syndicate to insure a portion of the risk.

Inspection Reports

Inspection reports, made by an on-site examination of a risk, are also used by underwriters to analyze a risk. Buildings are inspected for construction, safety devices, general upkeep of the facilities, any hazardous conditions and contents, the size and value, access and condition of the grounds. The underwriter is provided with the inspection report and uses it to create a more complete profile of the risk.

Industry Reports

Besides company records, national repositories of insurance statistics, such as the National Association of Insurance Commissioners and the Insurance Services Offices (ISO) also provide loss statistics.

Consumer Reports

Consumer reports, often used in underwriting, are regulated by the Fair Credit Reporting Act of 1971. A consumer report provides information about the applicant such as their credit history, bankruptcy information, lawsuits, liens, arrests, etc. The purpose of the Act is to require that consumer reporting agencies to adopt reasonable procedures for meeting the needs of commerce for consumer credit.

Generally, certain information may not be included on a consumer report such as items pertaining to bankruptcy over ten years old, suits and judgments, paid tax liens, accounts placed on collection, crimes, or any other adverse information that is over seven years old.

Rates

Once a risk is thoroughly profiled, underwriters assign rates to the risk. Underwriters use three different methods for determining rates: the judgment, manual and merit methods. Judgment rating involves reviewing the individual risk but not reports, statistics, and analyses. Manual rating involves taking pre-set rates from a manual that is prescribed by a state insurance department, developed by a service organization, or developed by the insurance company.

Merit rating includes schedule rating, experience rating, and retrospective rating. Under experience rating, the underwriter applies the insured's loss experience when determining the rate. Retrospective rating involves adjusting rates based on loss experience during the policy period.

Binding Coverage

Once an application is completed, an agent may have the responsibility of binding coverage which is in the form of an oral or written statement telling the applicant that the insurance coverage is in effect.

CHAPTER THREE

COMMERCIAL GENERAL LIABILITY

History of Commercial Liability

Commercial liability coverage used to be provided on a type of risk basis. Coverage forms existed for premises and operations exposure and products and completed operations. Premises and operations exposure included a coverage for owners, landlords and tenants and another coverage for manufacturers and contractors. Coverage also was available separately for contractual liability. Owners and contractors protective liability insurance was also available to cover risks related to hiring a contractor or subcontractor. Multiple coverages could be attached to a premises and operations coverage form or a products and completed operations form, but each coverage had to be scheduled and rated separately.

Changes in 1980

In the 1980's, changes in the general liability field resulted in the Insurance Services Office (ISO). This introduced two new Commercial General Liability Coverage Forms. These forms replaced the Comprehensive General Liability forms which had been in use previously. The term "Comprehensive" was traded for the word "Commercial" to indicate coverage that was more complete. The new commercial forms cover all of the major liability coverages, unless an endorsement excludes a coverage.

Claims and Occurrence Based Liability Policies

The two commercial general liability form types cover liability on an "occurrence" basis, and on a "claims made" basis. In terms of the provisions of the policy, whether a form is occurrence based or claims made based makes little difference.

General Liability Triggers

Whether a liability policy is an occurrence policy or claims made, the policy includes an inception date and a policy period. Both policies also have a specified coverage territory in which covered injury or damage must occur. But the "trigger" of the coverage differs. The "trigger" is the event or set of circumstances which exists for a coverage to apply. Under occurrence coverage, the injury or damage must occur during the policy period. If an injury or damage occurs during policy coverage, but a claim is made after the policy period, the claim would be covered under an "occurrence" policy. The occurrence has to take place during the policy period in order to trigger coverage, but the claim need not be.

The trigger in claims made coverage is more complicated. Claims which are first made against an insured during the policy period are covered, even if the injury or damage occurs later. However, injury or damage which occurred before the "Retroactive Date," is not covered nor is injury or damage occurring after the policy date.

Retroactive Dates and Extended Reporting Periods

A claims-made policy may include a "Retroactive Date" which typically is prior to the policy inception date and marks the coverage beginning date. A claims-made policy may allow coverage to extend beyond the policy period through inclusion of an "Extended Reporting Period" (ERP) If an ERP is included in the policy, the insured has additional time to submit claims. Extended Reporting Period coverage helps to ensure no gaps in coverage occur at the end of the policy period. An ERP does not extend the coverage period of a claims-made policy. The ERP would cause the coverage of the claims made policy to be triggered if the claim for injury and damage occurring during the policy period were made during the ERP.

The ERP includes two coverages, a mini-tail which provides a 60 day period after the policy period for the reporting of claims, and a midi-tail which provides 5 years after the policy period for reporting claims which arise out of an occurrence reported not later than 60 days after the end of the policy period.

A retroactive date can serve as an incentive to an insured who is considering changing coverage from an occurrence based policy to a claims-made coverage. Claims-made coverage is more restrictive than is occurrence coverage regarding the trigger event. If a retroactive date is not available, a gap in coverage could occur between the occurrence and claims based policies. By establishing a retroactive date that reaches to the termination of the prior policy, the insured is covered without a gap between the two policies. Some policies include a retroactive date even if the coverage does not actually apply any earlier than it would have had there been no retroactive date.

Commercial Package Policies

Commercial Package Policies cover commercial risks including Commercial Property Coverage, Commercial General Liability Coverage, and possibly Commercial Inland Marine, Commercial Crime, Commercial Glass, Professional Liability Insurance, Boiler and Machinery. Commercial Package Policies have many different components including the Common Policy Declarations, Common Policy Conditions and the Commercial Property and Commercial General Liability Coverage Forms. Below are the different components and the mechanics of each one.

Common Policy Declarations

The Common Policy Declarations has a simple insuring agreement which says something like this: "In return for the payment of the premium, and subject to all the terms of this policy,

the company indicated above agrees to provide the insurance stated in the policy." The verbage, "terms of this policy" refers the reader to the policy where all the particulars are stated under which the insurance is provided.

The Declarations includes the policy number, insurance company name, the named insured and named insured's mailing address, policy period, location of premises, the business description, and the types of coverage provided along with the premium amount. Lastly there is a signature and date by the authorized representative of the insurance company.

Commercial General Liability

The commercial general liability coverage policy includes the common policy declarations, the common policy conditions, and a liability coverage part. The liability coverage part includes the commercial general liability declarations page, a general liability coverage form, the broad form nuclear energy liability exclusion endorsement, and other endorsements attached to the policy.

Coverage A Bodily Injury and Property Damage Liability Insuring Agreement

Under Coverage A, the insurer will pay the sums the insured becomes legally obligated to pay as damages because of bodily injury or property damage to which the coverage applies. The insurer also has the right and duty to defend any suit seeking damages covered under this insurance. The insurer may investigate any occurrence, and may settle any claim or suit which may result. The amount the insurer will pay will not exceed the Limits of Insurance. The insurer's right and duty to defend ends when the insurer has 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***.

Bodily injury and property damage is covered only if they are caused by an occurrence that takes place in the coverage territory, and occurs during the policy period. Damages because of bodily injury include damages claimed by any person or organization for care, loss of services or death resulting at any time from the bodily injury.

Comprehensive General Liability Forms

Comprehensive General Liability forms were introduced at a later time period. The comprehensive form included the most important general liability coverage provisions, besides those pertaining to contractual liability. Endorsements to the comprehensive general liability form were available to cover special risks, or to extend coverage. Each major coverage type was a separate sub-line of insurance with a different classification table, rates, and exposure bases. The General Liability Coverage Form commonly used is the "occurrence" form. This form includes the following sections:

- Section 1 - Coverages

- Section 2 - Who is an Insured
- Section 3 - Limits of Insurance
- Section 4 - Commercial General Liability Conditions
- Section 5 - Definitions

Section 1 -- Coverages

Coverages A and B Supplementary Payments

The Commercial General Liability Coverage includes extensions of coverage related to Coverages A and B. If a claim or suit is defended, the insurer will pay the following:

- All costs taxed against the insured in the suit;
- All expenses incurred by the insurer;
- All reasonable expenses incurred by the insured;
- Interest on the amount of a judgment accruing after entry but before the insurer has paid;
- Prejudgment interest awarded against the insured;
- The cost of bonds used to release attachments, within the applicable limit of insurance;
- Up to $250 for the cost of bail bonds because of accidents or traffic law violations.

Coverage C Medical Payments

Coverage C covers medical expenses for bodily injury under certain conditions. The exclusions under Coverage A for bodily injury also applies to Coverage C. The insurer pays for medical expenses for bodily injury caused by an accident on premises owned or rented by the insured, or on ways next to premises owned or rented by the insured, or because of the insured's operations, as long as:

- The accident takes place in the coverage territory and during the policy period;
- The expenses are incurred and reported to us within one year of the date of the accident;
- The injured person submits to examination, at the insurer's expenses, by physicians of the insurer's choice as often as the insurer will reasonably require.

The insurer will pay for reasonable expenses for first aid at the time of an accident, necessary medical, surgical, x-ray and dental services. This also will include prosthetic devices, and necessary ambulance, hospital, professional nursing and funeral services. Coverage C excludes payment for bodily injury to any insured, to a person hired to do work for an insured or a tenant of an insured, to a person injured on that part of premises owned or rented.

Section 2 –

Depending upon the circumstances, many different people or organizations may be entitled to insurance protection under Section 2. Other insureds are the Named Insured, Employees, Other Persons and Organizations. If the Named Insured happens to be an individual versus a partnership or joint venture, both the named and his or her spouse are insured. On the other hand if the Named Insured is a partnership or joint venture, all the partners along with their spouses are insured for liability claims coming from the conduct of the business.

Section 3 -- Limits of Insurance

The Limits of Insurance section explains the limits of coverage for items covered under Coverages A, B and C. The limits apply separately to each consecutive annual period, and to any remaining period of less than 12 months, starting with the beginning of the policy period. If the policy is extended after issuance for an additional period of less than 12 months, the additional period is considered to be part of the last preceding period for purposes of determining the Limits of Insurance. The Limits of Insurance are applied regardless of the number of insureds, claims made or suits brought, or persons or organizations making claims or bringing suits.

Subject to these conditions, the "Personal and Advertising Injury Limit" is the most the insurer will pay under Coverage B for the sum of all damages. The "Products-Completed Operations Aggregate Limit" is the most the insurer will pay under Coverage A for damages because of bodily injury, and property damage. Subject to the conditions of the "General Aggregate Limit" and the "Products-Completed Operations Aggregate Limit," the "Each Occurrence Limit" is the most the insurer will pay for the sum of Damages under Coverage A and Medical Expenses under Coverage C.

Subject to conditions of the "Each Occurrence Limit," the "Fire Damage Limit" is the most the insurer will pay under Coverage A for damages because of property damage to premises rented to the insured. Also subject to these conditions, the "Medical Expense Limit" is the most the insurer will pay under Coverage C for all medical expenses due to bodily injury.

Section 4 - Commercial General Liability Conditions

Section 4 coverage form contains the CGL policy conditions that supplement the common conditions. Bankruptcy or insolvency of the insured does not relives the insured of any one of the obligations that he or she has under the terms of the policy.

Under the Duties in the Event of Occurrence, Claim, or Suit part of Section 4, the insurance company may be relieved of its duty to defend and pay claims if the insured does not comply with the requirement stated here. Whenever the insured becomes aware of an occurrence or an offense that may be the result of a claim, a notice must be given to the

insurer as soon as possible either orally or written. When a claim or suit is brought against any insured, the named insured must immediately record the details of the claim or suit and the date received along with notifying the insurer in writing as soon as possible. The insured is also supposed to forward immediately to the insurer copies of any demands, notices, summonses, or other legal documents in regards to the claim.

The named insured has to authorize the insurer to obtain any legal records or other documents and cooperate with the insurer in the investigation, the settlement, or the defense of the claim and assist the insurer in whatever action there may be against a third party that is liable to the insured.

Legal Action Against the Insurer refers to the provision that no person or organization has the right to bring the insurer into a suit seeking damages from an insured. The second part of this part is that no person or organization can bring suit to enforce the CGL coverage part unless that part has fully complied with the policy conditions.

Limited Pollution Liability Coverage Form

The Limited Pollution Liability Coverage Form provides a more limited form of coverage than the Pollution Liability Coverage Form on a claims-made basis. It covers bodily injury and property damage caused by a pollution incident, while it does not cover mandated or voluntary clean up costs. Clean up required by government authority is excluded.

Types of Commercial Liability Insurance Coverage

Commercial liability exposures arise out of: Products, Business Operations, Business Premises, Completed Operations and Contractual Agreements. Basic examples of general liability exposures include a customer slip-and-fall on the owner's premises, or an injury that results from a defective product.

Owners and Contractors Protective Coverage

Owners and Contractors Protective Coverage protects the principal owner or contractor from liability which results from those they hire. This form is used when an owner or contractor uses a contractor or subcontractor on a job for which the owner or contractor is responsible. This policy covers such liability from a specific job, so is a limited form. This coverage may be a requirement of the contractor or owner as a condition of hire, so the hired contractor or subcontractor may have to provide the coverage. Or, the contractor or owner may provide the coverage on the hired contractor or subcontractor and therefore, pay the premium.

Contractors and owners may be held liable for certain actions related to hiring of a contractor. For example, if it is found that the contractor or owner negligently hired a contractor or subcontractor, the owner or contractor may be found legally liable for actions

of that contractor or subcontractor. Contractors and owners must exercise due care to select an able and competent contractor.

Also, a contractor or subcontractor will not be covered, as an employee would, under worker's compensation, so the contractor or owner may be legally liable for injury sustained by a contractor or subcontractor whom he or she hires. If a hired contractor or subcontractor obligates the owner or contractor, the owner or contractor may be held liable for action or non-action arising out of that obligation. For all these reasons, owners or contractors purchase Owners and Contractors Coverage.

Contractors Liability Coverage

Contractors Liability Coverage policies provide coverage for a contractor's liability for personal injury, advertising injury or property damage arising from the contractor's business operations. Personal injury coverage may include bodily injury, libel, slander, false arrest, defamation of character, malicious prosecution, racial or religious discrimination and invasion of privacy. Other policies provide the more narrow bodily injury protection. As a business owner, contractor's liability also includes advertising injury coverage, to protect against the liability from libel, slander, defamation of character, violation of copyright, title or slogan, resulting from advertising activities.

Contractors Liability can also include coverages for elevator liability coverage, for damage to elevators used by the contractor or any property under the contractor's control which is damaged by an elevator collision. It can also cover medical payments coverage for persons other than the contractor or the contractor's employees, and other coverages available to businesses like hired and non-owned auto liability, broad form property damage liability, host liquor liability, and worldwide policy territory extension.

Pollution Liability Coverage

The pollution exclusion in the Commercial General Liability Form results in the practical elimination of coverage for pollution which comes from the insured's premises or operations, or from the handling, treatment or disposal of waste materials by the insured. Liability for emissions is covered when it results from the use by others away from the insured's premises and work sites of the insured's completed work or products. This broad exclusion creates a gap for those who have a risk of liability related to pollution.

Those needing pollution liability coverage may be able to obtain it in one of four ways: through a Pollution Liability Extension Endorsement, a Limited Pollution Liability Extension Endorsement, a Pollution Liability Coverage Form, or through a Limited Pollution Liability Coverage Form. These forms are not necessarily widely available. Not all insurers are willing to cover the liability resulting from pollution.

The risk of pollution could involve regulators, politically motivated interest groups, goodwill, class action suits, and more. Because the risk is surrounded by such factors, insurers are careful about the risks they will insure and those they will not, and premiums reflect the risk insured.

Railroad Protective Liability Coverage

A form of liability coverage for railroads protects railroads from liability arising out of the acts of those who conduct operations on or adjacent to railroad property. The coverage provides insurance which covers third party claims against the railroad, as well as direct property damage to the railroads own property.

This coverage is often a requirement when construction work is done on roads or bridges which are on or adjacent to railroad property. The railroad will require that this coverage be purchased to protect them while the construction work is done.

Employment Related Liability Coverage

Suits against employers have increased dramatically in recent years. Claims of discrimination, harassment, failure to promote, wrongful termination and more are occurring with more and more frequency. Claims may come from current or former employees and even job applicants.

Liability policies are available to cover claims and suits which arise out of employment practices. An employer who maintains a workplace environment using such tools as a formal harassment policy, a current and complied with employee manual, anti-discrimination training for managers and supervisors and so on can qualify for comprehensive employment related liability coverage.

Employment related liability insurance is normally available on a claims-made basis. The insurer will pay for covered claims arising from the insured's employment practices. High limit coverage is available in amounts as high as $5,000,000 or more. Employment related liability policies will generally include broad Discrimination Coverage provisions.

Coverage B Personal & Advertising Injury Liability Insuring Agreement

Coverage B provides liability insurance for personal injury and advertising injury. The insurer will pay sums that the insured becomes legally obligated to pay as damages due to personal injury or advertising injury which is covered under Coverage B. The insurer assumes the right and duty to defend any suit which seeks such damages. The insurer may investigate any occurrence or offense and may settle any claim or suit that result.

The amount the insurer will pay for damages will not exceed the limits of insurance. The insurer's right and duty to defend ends when these limits have been reached in payment of judgments or settlements under Coverage A, B or medical expenses under Coverage C.

If other obligation or liability to pay or perform acts or services is covered, such obligation or liability must be explicitly provided for under "Supplementary Payments - Coverages A and B."

Coverage B applies to personal injury caused by an offense arising out of the insured's business, excluding advertising, publishing, broadcasting or telecasting done by or for the insured and by advertising injury caused by an offense committed in the course of advertising the insured's goods, products or services if the offense was committed in the coverage territory during the policy period.

The exclusions under Coverage B are not as extensive as those under Coverage A, in part because the coverage relating to advertising and personal injury is less broadly defined than the covered events in Coverage A.

Excluded from Coverage B is personal injury or advertising injury:

- which arises out of oral or written publication of material, if done by or at the direction of the insured with knowledge such material is false;
- which arises out of oral or written publication of material whose first publication took place before the beginning of the policy period;
- which arises out of the willful violation of a penal statute or ordinance committed by or with the consent of the insured; or
- 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.

Also excluded is advertising injury which arises from

- the wrong description of the price of goods, products or services;
- a breach of contract, other than misappropriation of advertising ideas under a contract;
- the failure of goods, products or services to conform with advertised quality;
- an offense committed by an insured whose business is in some type of advertising;

Claims Made Coverage Endorsements

A Claims-Made Coverage Endorsement excludes specific accidents, products, work or locations may be excluded at policy inception because the related risk exposure is determined to be great enough that the insurer will not cover it, or will cover it at a premium amount which is considered too costly by the insured. This claims made endorsement is sometimes referred to as a "laser beam" endorsement because it can exclude such specific items. If the endorsement applies to a claims-made policy which is being renewed,

and previously did not include the endorsement, the insurer will provide an ERP for the excluded exposure.

At renewal, a specific accident, product, work or location may be excluded because a related occurrence has resulted in the risk exposure to have increased enough so that the insurer either will not continue to insure it, or will raise the premium higher than the insured desires to pay. The claims-made insurer may use the endorsement to remove an accident which occurred while the prior coverage was in force to make clear that no claims related to that accident is covered by the new insurance.

Voluntary Clean-Up Costs Endorsement.

The Pollution Liability Coverage Form generally covers mandated clean up costs. An endorsement is available to add coverage for voluntary clean up costs. Coverage applies if the clean up costs are reasonable and necessary to reduce or prevent a pollution incident that has a substantial danger of causing injury or damage. The insured must request and receive prior written consent from the insurer for the voluntary clean up in order for the coverage to apply.

The Broad Nuclear Energy Liability Exclusion Endorsement

The Broad Form Nuclear Energy Liability Exclusion Endorsement excludes coverage from hazardous properties of nuclear material related to the operations of any nuclear facility for:

- bodily injury;
- property damage;
- medical payments.

Anyone who owns, operates, supplies or services a nuclear facility, or who handles, transports, or disposes of nuclear waste material may apply for coverage through Nuclear Energy Liability Insurance Association, the Mutual Atomic Energy Liability Underwriters.

This endorsement excludes coverage for an insured who is also an insured under a policy issued by one of the nuclear risk insurers. A person who is required under the Atomic Energy Act of 1954 to maintain financial protection is excluded.

Exclusions

Coverage A includes several exclusions. Coverage A is broad in nature, and so these exclusions are necessary to narrow the risk exposure, and to limit exposure to liability which is not covered by other forms of insurance, by specific inclusion, or by government regulation, or represents an uninsurable risk.

Exclusion Related to Insureds In Businesses Associated With Alcohol

Also excluded for insureds which are in the business of manufacturing, distributing, selling, serving or furnishing alcoholic beverages are bodily injury or property damage for which any insured may be held liable because of causing or contributing to the intoxication of any person, furnishing of alcoholic beverages to a person under the legal age or under the influence of alcohol, or because of any statute, ordinance or regulation relating to the sale, gift, destruction or use of alcoholic beverages.

Expected or Intended Injury

Excluded from coverage is bodily injury or property damage expected or intended by the insured.

Obligations Arising Out of Acting As An Employer

Any obligation of the insured under a workers' compensation, disability benefits, or unemployment compensation law or any similar law is excluded. Bodily injury to an employee of the insured which arises out of and in the course of employment by the insured, or the spouse, child, parent, brother or sister of that employee as a consequence of this bodily injury is also excluded. This exclusion applies whether the insured may be liable as an employer or in any other capacity and to any obligation to share damages with or repay someone else who must pay damages because of the injury. This exclusion does not apply to liability assumed by the insured under an insured contract.

Exclusion Related to Intended or Expected Damages

Bodily injury or property damage expected or intended by the insured is excluded from Coverage A. This exclusion does not apply to bodily injury which results from the use of reasonable force to protect persons or property or which the insured is obligated to pay damages by reason of the assumption of liability in a contract or agreement is excluded. The exceptions are:

- assumed in a contract or agreement which is an insured contract if the bodily injury or property damage occurs subsequent to the execution of the contract or agreement, or
- that the insured would have in the absence of the contract or agreement.

Exclusions Related to Pollutants

"Pollutants" is a solid, liquid, gaseous or thermal irritant or contaminant, including smoke, vapor, soot, fumes, acids, alkalis, chemicals and waste. Waste includes materials to be recycled, reconditioned or reclaimed. Bodily injury or property damage is excluded which arises out of the actual, alleged, or threatened discharge, dispersal, seepage, migration, release or escape or pollutants:

- at a premises, site or location on which an insured or contractors or subcontractors working on the insured's behalf are performing operations;
- at a premises, site or location which is used by the insured or others for the handling, storage, disposal, processing or treatment of waste;
- at some time was transported, handled, stored, treated, disposed of, or processed as waste by or for the insured.
- at a premises, site or location which was at some time owned or occupied by, or rented or loaned to, the insured;

Any loss, cost or expense is excluded which arises out of a:

- Request, demand or order that any insured or others test for, monitor, clean up, remove, contain, treat, detoxify or neutralize pollutants;
- Claim or suit by or on behalf of a governmental authority for damages because of testing for, monitoring, cleaning up of pollutant.

Exclusion Related to War

Bodily injury or property damage due to war, whether or not declared, or any act or condition incident to war is excluded. As in other coverage, war includes civil war, insurrection, rebellion or revolution. This exclusion applies only to liability assumed under a contract or agreement.

Exclusion Arising Out of Obligations as an Employer

Any obligation of the insured under a workers' compensation, disability benefits, or unemployment compensation law or any similar law is excluded.

Bodily injury to an employee of the insured is excluded that arises out of, or in the course of employment by the insured, or a relative of the employee. This exclusion applies whether the insured may be liable as an employer or in another capacity and to any obligation to share damages with or repay someone else who must pay damages because of the injury.

Exclusion Related to Aircraft, Auto or Watercraft

Bodily injury or property damage which arises out of the ownership, maintenance, use or entrusting to others of any aircraft, auto, or watercraft owned or operated by or rented or loaned to an insured is excluded. Use under this exclusion includes operation and loading and unloading. This exclusion does not apply to:

- bodily injury or property damage arising out of the operation of air compressors, pumps and generators, and devices used to raise or lower workers.
- a watercraft the insured does not own which is less than 26 feet long and is not being used to carry persons or property for a charge;
- parking an auto on or next to premises owned or rented by the insured;

- liability assumed under a insured contract for the ownership, maintenance or use of aircraft or watercraft;
- a watercraft while ashore on premises owned or rented by the insured;

Exclusion Related to Property

Property damage is excluded to:

- Property owned, rented or occupied by the insured;
- Premises sold, given away or abandoned by the insured, if the property damage arises out of any part of those premises;
- Property loaned to the insured, unless the liability is assumed under a sidetrack agreement
- Personal property in the care, custody or control of the insured;
- The part of real property on which the insured or any contractors or subcontractors working directly or indirectly on the insured's behalf;
- The part of any property that must be restored, repaired or replaced because "your work" was incorrectly performed by the insured.

Commercial Liability Insurance Clauses

Commercial Liability Insurance has certain clauses that are necessary to the clarity o the insurance policy. So are mandatory and others are optional with the insured can chose. Below are a variety of clauses for a policy.

Bankruptcy Clause

Bankruptcy or insolvency of the insured or of the insured's estate does not relieve the insurer of its obligations under this coverage.

Duties in the Event of an Occurrence Clause

The insured must notify the insurer as soon as practicable of an occurrence of an offense that may result in a claim. The notice should include how, when and where the occurrence or offense took place, the names and addresses of any injured persons and witnesses, and the nature and location of any injury or damage arising out of the occurrence or offense.

If a claim is made or a suit is brought against any insured, the insured must immediately record the specifics of the claim or suit and the date the suit or claim is received and notify the insurer as soon as practicable. The insured is responsible to see that the insurer receives written notice of the claim or suit as soon as practicable.

The insured and any involved insureds must send copies of any demands, notices, summonses or legal papers received in connection with the claim or suit immediately. The insurer must be authorized by the insured to obtain records and other information. The

insured must also cooperate with the insurer in the investigation, settlement or defense of the claim or suit and assist the insurer in the enforcement of any right against any person or organization which may be liable to the insured because of injury or damage to which the insurance applies.

Legal Action Against the Insurer Clause

No person or organization has a right to join to the insurer as a party or otherwise bring the insurer into a suit asking for damages from an insured or to sue the insurer on this coverage unless all its terms have been fully complied with.

A person or organization may sue the insurer to recover an agreed upon settlement or on a final judgment against an insured obtained after an actual trial, but the insurer will not be liable for damages that are not payable under the terms of this coverage or that are in excess of the applicable limits of insurance. An "agreed upon settlement" means a settlement and release of liability signed by the insurer, the insured and the claimant or the claimant's legal representative.

Other Insurance Clause

The Other Insurance Clause of this coverage provides the circumstances under which coverage is considered primary or excess. If other valid and collectible insurance is available to the insured for a loss covered under Coverages A or B, the insurance is applied as **excess insurance.** It is considered as excess insurance if the other applicable insurance is Fire, Extended Coverage, Builder's Risk, Installation Risk or similar coverage. When this coverage is in excess, the insurer does not have any duty under Coverage A or B to defend a claim or suit that another insurer has a duty to defend. If no other insurer defends a claim or suit, the insurance company will do so, but will be entitled to the insured's rights against all other insurers.

When this coverage is applied as excess, the insurer will pay only its share of the amount of the loss that may exceed the sum of the total amount. The remaining loss will be shared among the insurer and other insurance which is not described under the excess insurance provisions and was not bought specifically to apply in excess of the Limits of Insurance as shown in the Declarations.

The remaining loss will be contributed to in equal shares, if all the other insurance permits this method. Under the equal shares method, each insurer contributes in equal amounts until it has paid its applicable limit of insurance, or none of the loss remains, whichever comes first. If any of the other insurance does not permit contribution by equal shares, the insurer will contribute based on the limits of the insurance. Under this method, each insurer's share is based on the ratio of its applicable limits to the total applicable limits of insurance of all insurers.

Premium Audit Clause

Premium is paid for this coverage on an estimated basis. At the end of the audit period, the earned premium is calculated based on the actual risk covered. Advance premium shown in the Declarations is a premium deposit only. At the close of each audit period the named insured is notified of the earned premium. Audit premiums are due upon notice. If the calculation of the audit premium shows that excess premium was paid, unearned premium is returned to the insured. The first named insured must keep records of the information the insurer needs for premium computation, and send the insurer copies of these records when insurer may request.

Subrogation Clause

If the insured has rights to recover all or part of any payment made by the insurer under this coverage, those rights are transferred to the insurer. The insured must do nothing after loss to impair these transferred rights. At the insurer's request, the insured will bring suit or transfer those rights to the insurer and help the insurer enforce those rights.

Representations Clause

By accepting the clause, the insured agrees that the statements in the Declarations are accurate and complete, those statements are based upon representations made to the insurer by the insured, and the insurer has issued the policy in reliance upon these representations.

Definitions

Bodily injury means bodily injury, sickness or disease sustained by a person, including death which results from any of these at any time.

Advertising injury is an injury which arises out of one or more of the following offenses:

- Oral or written publication of material that slanders or libels a person or organization or disparages a person's or organization's goods, products or services;
- Oral or written publication of material that violates a person's right of privacy;
- Misappropriation of advertising ideas or style of doing business;
- Infringement of copyright, title or slogan.

Personal injury means injury, other than "bodily injury" arising out of one or more of the following offenses:

- False arrest, detention or imprisonment
- Malicious prosecution
- The wrongful eviction from or wrongful entry;

- Oral or written publication of material that slanders or libels a person or organization;
- Oral or written publication of material that violates a person's right of privacy

"Your product" is defined to mean any goods or products, other than real property, manufactured, sold, handled, distributed or disposed of by the insured, others trading under the insured's name, or a person or organization whose business or asset the insured have acquired.

"Your work" is defined to mean work or operations performed by the insured or on behalf of the insured and materials, parts or equipment furnished in connection with such work or operations.

"Impaired Property" means tangible property, other than "your product" or "your work" that cannot be used or is less useful because it is thought to be defective, deficient, inadequate or dangerous.

"Products-completed operations hazard" includes all bodily injury and property damage occurring away from premises owned or rented by the insured and arising out of your product or your work.

"Completion of "your work'" is considered to be at the earliest of the following:

- when all of the work called for in a contract is completed;
- when all of the work to be done at a particular site has been completed;
- when that part of the work done at a job site has been put to its intended use.

"Loading or unloading" is the handling of property after it is moved from the place where it is accepted for movement into or onto an aircraft, watercraft or "auto."

Suit means a civil proceeding in which damage because of "bodily injury," "property damage", "personal injury" or "advertising injury" to which this insurance applies are alleged.

CHAPTER FOUR

GENERAL LIABILITY RATES AND UNDERWRITING

General liability rates are set based on a number of factors. A rate is the amount of premium per unit of insurance and a unit of insurance is typically $1,000. Rates differ and are set based on several objectives from the insurers' point of view. The insurer needs enough premium to cover claims and overhead expenses of the business.

Rates are regulated by state regulation who establish maximum rates for each coverages. Generally, states require that rates not be excessive, not be inadequate, and not be unfairly discriminatory.

Underwriting Determines Rates

Underwriters perform the following functions to determine whether a risk should be assumed by an insurer, and if so, at what rate:

- Applying rates to risks with the objective of maintaining conservative risk exposure;
- Communicating with agents, adjusters, inspectors, for information;
- Declining risks that are unacceptable to the insurer.
- Examining application forms, insurance reports, inspection reports;
- Reviewing company records to determine current in-force insurance amounts on a risk;
- Evaluating property inspection reports to determine the degree of risk.

Items that determine risk for an underwriter are:

- the type of risk;
- the likelihood of risk;
- the frequency of risk;
- the severity of a particular risk based on historical data;
- the quality of the management of risk.

The underwriter makes critical decisions for the insurer, and must use good judgment. Setting the premium has a direct impact on the profitability of the insurer. If it is too low the company will lose money. If the premium is too high, then the company becomes uncompetitive.

Tools to Profile Risk

The Application

The application will probably require personal information about the insured including the insured's creditworthiness or information about the management personnel of a business. Once an application is received in underwriting, the underwriter schedules inspections, request reports on the applicant and the risk, then reviews the application for completeness and accuracy. The underwriting process has to meet certain standards for the turn around on the issuance of policies or denial of a risk.

Inspection Reports

Inspection reports are made by an on-site examination of a risk to analyze a risk. The underwriter is provided with the inspection report and uses it to create a more complete profile of the risk based on construction, safety devices, general upkeep of the facilities, hazardous conditions, etc.

Company Records

Company records show whether a risk is excessive or not. One large risk may change the dynamics of the overall risk profile of the business on an insurer's books***. An underwriter may look to reinsurance to insure a portion of the risk in order to spread the risk***. Company records are reviewed to ascertain whether the applicant has had in the past any other insurance with the company.

Industry Reports

Besides company records, national repositories of insurance statistics, such as the National Association of Insurance Commissioners (NAIC) and the Insurance Services Offices (ISO) also provide loss statistics. The NAIC publishes studies based on the reports it receives from the insurance departments nationwide.

Insurance Maps

Insurance maps provide information about the level of risk exposure such as certain zip codes have higher automobile related losses and certain areas are statistically evaluated as high-crime areas, versus those ranked as low-crime. Some Gulf Coast and East Coast zip codes have high exposure to weather-related damage. An underwriter can use an insurance map to make important determinations about the risk on any one application.

Rates

Underwriters assign rates to the risk after they have thoroughly profiled the risk. Generally, an insurer must develop rates using reasonable measures often times developed by a service organization, such as ISO.

Underwriters use three different methods for determining rates: the judgment, manual and merit methods. Judgment rating involves reviewing the individual risk. Reports, statistics, and analyses are not used. The underwriter uses his or her own judgment to determine the rate of the risk. Manual rating involves taking pre-set rates from a manual. The manual may be prescribed by a state insurance department, developed by a service organization, or developed by the insurance company. Merit rating begins with standard or manual rates, and then applies the characteristics of the specific risk to modify the risk's rating.

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Merit rating includes experience rating, schedule rating and retrospective rating. Under experience rating, the underwriter applies the insured's loss experience when determining the rate. Typically, a period of three year is used. This is why an insured under an auto policy is asked in the application whether he or she has had any traffic violations during the last three years. Risks submitted by applicants or insureds who have not had losses, or have losses below a specified frequency and/or amount, are given a lower rate than those submitted by applicants or insureds with a poorer loss record. Retrospective rating involves adjusting rates based on loss experience during the policy period. Schedule rating uses a prescribed schedule of debits or credits to modify a risk based on its particular merits.

Application Process and Underwriters

A "field underwriter" is an agent who is responsible to use standards established by the company to determine whether an application can be taken on a particular risk. Companies normally have a standard regarding the amount of coverage which may be applied for. Some risks may only be written if certain elements are present, such as working seat belts in a covered auto. The agent is typically responsible for communicating this to an applicant, rather than the underwriting department.

The agent may also have to use judgment in submitting an application. If the agent doubts information the applicant is providing, the agent's duty to the company requires that the agent communicate that an inspection report should be done, or other method of certifying information be undertaken. Even though an agent may not be required to personally view a business operation, the agent may have reason to decide to take a look at the property before submitting an application.

If an applicant has other insurance on a risk, the agent should undertake to review the other insurance thoroughly in order to make a suitable recommendation for coverage under the new policy. The agent is responsible to suggest the appropriate amount and type of coverage for a risk before an application is submitted to underwriting.

Besides the gathering of information for an application, the agent is responsible to accurately record the application information. Errors in addresses, phone numbers, coverage types or amounts can cause delays, inconvenience or even improper coverage

to be issued. The agent must also submit the application in a timely fashion, as the insurer's company standards dictate.

Documentation Needed For The Application

Additional documentation may need to be submitted with the application. The agent is responsible to communicate the documentation needed and to follow-up with the applicant in obtaining the documentation. The agent must also review the documentation to make sure it meets the requirements of the company. The agent generally keeps a file of the application and documentation, and a system to remind the agent to follow-up with the underwriting department or applicant during the underwriting process.

Binding Coverage

An agent may have the responsibility of binding coverage once an application is completed. Binding coverage may be in the form of an oral or written statement telling the applicant that the insurance coverage is in effect. The binding coverage continues until underwriting is complete and the coverage is in force or denied.

Changes in Coverage

Depending on the circumstances, changes in coverage may require partial underwriting or a full underwriting process. It is important that the agent carefully complete applications, supply needed documentation, and follow-up with underwriting and the insured when changes of coverage are made.

Risk Management

Underwriting may at times include suggestions of more risk management which would result in a reduction of premium if performed. Part of the underwriting process is ascertaining the current risk management in place and determining any requirements of risk management in order to underwrite a risk. In order to underwrite a risk, an underwriter may include some underwriting requirements for use on the insured property.

Risk management is generally a function of loss control. For some types of insurance, the applicant and policyholders must be provided with loss control information so that they have an informed opportunity to implement risk management or loss control measures, thereby reducing the risk of loss and resultant premium. The loss control function of an insurer may fall under the Underwriting department of an insurer, or may be part of a separate department. Either way, the functions work closely together.

PROFESSIONAL LIABILITY MODULE

CHAPTER FIVE

INTRODUCING PROFESSIONAL LIABILITY

Professional Liability

A professional act or service is one that arises out of a vocation, calling, occupation or employment involving specialized knowledge, and intellect, rather than physical or manual labor. The investigation of claims arising out of Professional Liability policies, commonly known as malpractice claims, obviously requires some specialized knowledge of the professional field that is involved. The professional person is held to the same degree of care and skill as is usually exerted by other reputable people in the same profession. In many instances, an investigator who is concerned with a professional liability claim involving some other profession can substitute basic principles of investigation without too much orientation.

Professional Liability and the Law

The history of law is a study of social development which has been unfolding and changing throughout time. American social development and law have a long history. The evolution of law can take place through the use of shortcuts called *legal fictions*, pleadings or papers filed in court.

Professional liability was rarely thought of as a part of law, but as part of the law of contract. The law of contract held a special place in 19th century American law. A contract was identified as the single most important hallmark of modern law and was defined as a meeting of the minds. This phrase cannot be taken too literally though, because the law still emphasized the document itself, providing there was one. The document and its plain words held as the ultimate evidence as to whether or not negligence played a part in the dispute.

The Purpose of Professional Liability Insurance

Professional liability insurance is sometimes referred to as errors & omissions, or *E&O* insurance. In the case of medical professionals, it is often referred to as malpractice insurance. Insurance helps minimize the impact of potential risks involved with everyday living and unexpected losses making it possible for individuals and businesses to plan confidently for the future.

The Aspect of Lawsuits

Should a firm be sued by a client, who, in turn, files a cross-complaint against anyone and everyone who was even remotely involved in the disputed work; any company could very

likely be served with a lawsuit as well. Even if it turns out that the company had not done anything wrong, that same company could still be faced with thousands of dollars in defense costs. Not only do defense attorneys expect to be paid, regardless of the outcome, they usually also require that a substantial retainer and deposit against costs be paid - prior to formally representing a client.

The Aspect of Accidents

Many real collisions happen on a daily basis. Just as most intentional assaults involve assailants and victims who already know each other well, most unintended injuries occur in the context of commercial acquaintance. It is thought that unintentional accidents are often a subject of advance understanding, the unspoken awareness of the possibility of an incident, between the victim and the assailant.

The Aspect of Negligence

With the growing frequency of professional negligence suits, professional people must be more accountable for their mistakes than before. Negligence can be defined as the failure to provide the degree of knowledge, care or the skill of the average professional peer, in good standing, under similar circumstances would provide.

Negligence lends itself to the law of tort. Human nature being what it is, the two sides often have different views on this same incident.

Eligibility for Professional Liability

More and more the law is surrounding the professional and the legal issues he or she is facing. Understanding basic legal issues can help avoid basic legal problems and be an aid in making the best decision when choosing a professional liability policy. The necessity of professional liability coverage is the utmost of importance to the future of the potential customer's financial security. Depending on how one has decided to set his or her business up determines the degree of liability for any and all debts that may be incurred. The absolute necessity for professional liability is at the forefront of the businessperson's priorities or at least, should be.

A Risk of Loss

The insurance company must look for common characteristics to figure the probability of loss with a reasonably acceptable degree of certainty because it cannot accept every risk of loss. In order to be insurable, a risk of loss must meet five general principles

- ***The risk of loss must not be excessively catastrophic***.
- The risk of loss must be accidental as insurance is meant to cover loss.
- The risk of loss must be definite.
- The risk of loss must be calculable.

- The risk of loss must be important.

Investigative Procedures of Professional Liability Claims

It is essential that the investigator gathers and corroborates information in a manner that can be presented in court if necessary. Factual details would include:

- The exact date, time, and place of the incident and other factual details;
- The complete medical or other records including the professional bill;
- Statements from associates, assistants, nurses, attendants, in the incident;
- Determine whether a medical practitioner made a promise of definite cure;
- Determine whether the professional was under the influence of intoxicants or narcotics at the time of the alleged malpractice.
- Find out if there was equipment failure;
- Obtain the opinion of legal practitioners in the same profession to determine whether the services or treatment performed are in accordance with ordinary good practice;
- Determine if the insured held out a promise of results and, if so, get full details.
- Determine whether the injured ever made a previous medical malpractice claim, and, if so, obtain complete details.

Some information that the investigator needs to obtain from the injured person or persons could be as follows:

- Check to see if all recommendations were complied with.
- Check on the hospital's own regulations and if they were followed.
- Determine when the injured made the first complaint after the alleged malpractice and why such complaint was directed at the specific doctor, surgeon, or nurse involved.
- Determine what subsequent treatment was received and get medical reports
- Determine the advisability of obtaining a physical examination by a specialist.
- Determine if the hospital and/or the doctors and nurses were accredited.
- Determine if the hospital had previous experience with similar incidents.
- Find out who referred the doctor, surgeon, hospital, to the injured.
- Find out whether the injured followed the doctor's, surgeon's, or nurse's instructions.
- Find out whether the injured received a settlement or was awarded compensation.
- Find out when the hospital was last inspected and get a copy of the report.
- Was consent obtain for surgery to be performed and where and when;

Additional information to any investigation, the investigator will need to obtain, are the hospital records whether or not the hospital is a party defendant to an action for malpractice or other liability. These records are of vital importance to any investigation where the plaintiff received care that could be involved in the liability, medical treatment, or the factual situation of a case. Still more records which need to be brought under the scrutiny of investigation are manuals and handbooks regarding nursing procedures and regulations, operating procedures, and one should check to see if there are any standing orders of attending doctors.

It is important for the investigator to never lose sight of the fact that bad results do not necessarily explain malpractice. Once a claim representative has determined that the case is one for settlement consideration, he should never forget to obtain the insured's written consent if such settlement is affected, if this is called for by the policy.

Courts routinely require expert testimony to establish the standard of care in malpractice claims against physicians, lawyers, dentists, accountants, and architects, reasoning that there are few lay people who understand professional standards of care concerning the issue of negligence, without the benefit of expert testimony. For this same reason, courts are recently beginning to require expert testimony where an insurance agent's negligence is required to be shown.

There are times when the expert testimony is not needed like when the agent improperly advised the insured that she did not need workers' compensation insurance for a part-time employee. The court awarded the plaintiff a verdict despite the fact that expert testimony was not presented because the agent's own testimony admitted his negligence.

Professional liability policies are designed to protect the practitioner from liability for acts or omissions performed as a result of his or her practice. The following paragraphs tell of a few instances where the courts may closely scrutinize one's actions.

- *Expert Testimony* – The only situation in which an absence of expert testimony is excused is when the lack of skill or care of the dentist is so apparent that the average layman could understand and recognize it, and where express warranties of results were made.
- *Honest Error in Judgment* – It has been held that in order to fully state the standard of care applicable to a professional, the jury must be instructed that one is not responsible for an honest error in choosing accepted methods of care.
- *Locality Rule* – Most jurisdictions have now abandoned the locality rule as a standard in judging the negligence of a nurse. It has been recognized in medical malpractice generally, that the locality rule has become obsolete, but hospitals, as will be pointed out, should not be judged on the same basis

as others connected with the medical sciences.

- *Some courts have created wrongful Pregnancy – Another category of wrongful birth cases* which is called wrongful pregnancy or wrongful conception.
- *Standard of Care* – Initially, the standard for evaluating the conduct of a professional in a malpractice suit was that degree of skill and care of a reasonably skilled professional in the same or similar locality.
- *Wrongful Birth* – These are actions brought by the parents of usually healthy, normal children who were unwanted and usually resulted from the failure of contraceptive devices, or as a result of unsuccessful sterilization operations, and even ineffective abortions.
- *Wrongful Life* – These claims usually involve the birth of a defective or disabled child and are ordinarily brought by the parents or guardian on behalf of the child.

Doctrines

- *Benefits of Parenthood* – argues that the benefits of having a healthy, normal child defy precise measurement. Deciding in favor of the parents – according to the courts – would be incompatible with contemporary views concerning one of life's most precious gifts – - the birth of a normal and healthy child.
- *Charitable Immunity* – Early in this century, hospitals were exempted from vicarious liability as they were considered to be charitable institutions;
- *Continuing Negligence* – Medical treatment that was subsequently received after an accident and then aggravated the initial injury. It has been held that a separate action may be brought against the doctor who was guilty of medical malpractice despite the fact that a previous verdict was rendered or a settlement made of the underlying case.
- *Contributory and Comparative Negligence* – Defenses of contributory and, more often, comparative negligence are usually available in cases involving dental malpractice. Dentists can also be held liable for the negligence of their employees.
- *Discovery* – which appears to be the majority rule, gives the broadest interpretation of when the limitation period begins. This rule overrides the statute of limitations where foreign substances were left in the body of a patient after an operation.
- *Good Samaritan* – Before the good Samaritan laws were enacted, a doctor was under no duty to help an injured person in the event that he was fortuitously present when an emergency situation arose.
- *Informed Consent* – Up holds the philosophy that every human being of adult years and sound mind has a right to determine what shall be done with one's own body;
- *Last Act* – holds that the date of the last act of the treatment, which can be

after the regular course of treatment and post-treatment check-up have been completed, is the date from which the statute should toll.

- ***Ostensible Agency – This doctrine requires that the hospital has given the impression that a doctor employed by the hospital gave the medical treatment;***
- *Respondeat Superior* – The doctrine on which the liability of a hospital may rest;
- *Res Ipsa Loquitur* – Requirements commonly associated with the application of this doctrine in negligence cases include an injury or condition related;

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CHAPTER SIX

TYPES OF PROFESSIONAL LIABILITY COVERAGES

Professional liability insurance protects a professional from legal liability when individuals are involved in these professions:

- Accountants,
- All Medical Fields,
- Architects and Engineers,
- Attorneys,
- Dentistry,
- Insurance Agents,
- Stockbrokers, Nurses,
- Veterinarians.

All these positions of trust and require a high standard of conduct because of the dependence of others on their performance. If any of these professionals fail in these endeavors, another individual, or possibly many individuals, are harmed. The law has traditionally treated professionals differently from the average holder of an occupation. The average working person is usually just fired for being careless or grossly inefficient, not brought to a court of law.

In order to practice, these professionals have to be licensed through the state where they practice. In order to keep these licenses, they must meet standards established by the state.

Professional Liability Coverage

Professional liability coverage is not included in a general liability coverage policy. Professionals encounter special risks not a part of other businesses. Architects and engineers are excluded from Commercial General Liability coverage for rendering or failing to render professional services under an agreement. Advertisers are not covered for advertising injury under the general policy. Professional liability coverage, like other liability coverage, does not cover criminal acts. Nor does it cover acts which are fraudulent or dishonest.

Professional liability insurance is normally written on a claims-made basis. A professional may be found legally liable for an occurrence long after it happened. Even if the professional kept liability coverage during his or her entire working life, he or she could still be exposed to many unprotected claims under an occurrence based policy. To meet the needs of

professionals more efficiently, professional liability insurance began to be written on a claims made basis. In this way, as long as the professional holds liability insurance, he or she is protected from many liability claims.

Claims Made Coverage

Professional Liability insurance is normally offered on a claims-made basis. ***Claims made insurance covers claims that are first made during the policy period***. A retroactive date may apply, so that occurrences which happen prior to the policy period, but not before the retroactive date are covered. An ERP may also apply, providing an additional window of time for claims to be filed.

The premiums charged for a claims-made policy are lower initially than those of the occurrence policy. The incremental increases in premiums are made in the first five years, and then the premiums are generally equal to those of a comparable occurrence policy. The reason for this premium treatment is that the insurer expects fewer claims in the first five years of the policy than for the following years, and expects fewer claims in the first year than in the second year, in the second year than in the third, and so on, until the end of the fifth year, when the policy is considered to cover "mature" risks.

Fiduciary Liability Insurance

Liability insurance for pension plan fiduciaries or employee benefit plan fiduciaries provides coverage for their activities administering these plans and managing funds on behalf of plan participants. ERISA, the Employee Retirement Income Security Act permits legal action to be brought by a participant, beneficiary against a plan fiduciary for a breach of duty. The Secretary of Labor is also able to bring suit against a fiduciary. The fiduciary may be found to be personally liable. Under ERISA, a fiduciary is defined to be a person who performs any one of the following:

- Exercises any discretionary authority or control over the management of the plan generally or with respect to the management or disposition of plan assets;
- Renders investment advice with respect to plan assets for a fee or other compensation; or
- Exercises any discretionary authority or responsibility in the plan's administration.

A fiduciary is required to act with care, skill, prudence, and diligence in the best interests of participants and beneficiaries. He or she must act in accordance with the prudent man standard of care, "with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a capacity and familiar with such matters would use."

A fiduciary has good reason to purchase liability insurance. Claims made basis coverage also makes a good deal of sense for a fiduciary since the results of his or her actions may not

be known for several years after an occurrence. Errors and omissions insurance will not cover them for any dishonest or intentional act. However, professional liability is covered.

Directors and Officers (D&O) Liability Insurance

Errors and omissions for director and officers of corporations covers their liability for claims made by stockholders and other parties. Directors are liable to the company and to shareholders for negligence, fraud or for acts which are committed outside their scope of authority. A director can be held personally liable for certain activities, which is the reason errors and omissions insurance is acquired by them. The officers of the corporation are selected by the board of directors. Officers too can be held personally liable for certain of their actions, decisions, lack of action, errors or omissions.

Directors, trustees and officers of nonprofit organizations are also subject to personal liability exposures. Beneficiaries may bring suits or claims for being denied benefits or receiving fewer benefits than they believed they were entitled to receive. Donors may bring suits or claims alleging the misuse or waste of contributions. Board members of the organization may bring suit against another board member for misinterpretation of the charter.

Comprehensive liability coverage for directors and officers of profit and non-profit organizations can protect these parties from the risks stemming from their professional duties. The coverage pays for claims and suits arising from wrongful acts of the director or officer insured.

Lawyers' Professional Liability

Lawyers also need liability coverage. A lawyer can be held liable for the failure of a case he took on if he or she is found not to have exercised reasonable care and judgment. Besides liability for trial cases, lawyers manage estates, write trusts, handle trust administration, and draw up any number of legal documents. Lawyers have like fiduciary responsibilities of the benefits plan administrator. Under each of these duties, the lawyer is susceptible to claims or suits against him or her. Liability insurance can help protect a lawyer against the risk of these claims or suits.

Lawyers' Liability forms are available on a claims-made basis as well as an occurrence basis. Policies will generally cover liability arising from the lawyer's actions while conducting professional services. Included generally in the definition of professional services are Lawyer, Notary, Arbitrator, Mediator, Title Agent Administrator, Conservator, Executor, Guardian, and Trustee Coverage.

Policies generally include payment for costs related to defending the claim incurred by the insured, including reimbursement for trial appearances. A typical coverage limit for such expenses is $500 per day, up to $5000 per claim. If an insured is involved in a disciplinary

proceeding, a lawyers' professional liability policy will generally cover related expenses up to a specified limit, for example $7500 if outside counsel is used to defend the insured.

Computer Consultant Liability Insurance

More and more professionals are in the business of computer consulting. Responding to this burgeoning business, the insurance industry has designed Computer Consultant Liability Insurance. This insurance provides coverage for professional liability, general liability, and property .

Professional liability insurance protects the insured against claims of negligent acts, errors or omissions in the performance or professional services. Professional liability for the computer consultant also includes Intellectual Property Infringement coverage. This coverage protects against claims of patent/copyright infringement. Also included in this insurance is personal injury and advertising injury.

General liability insurance is also part of such protection. It provides coverage for bodily injury and property damage claims that arise out of an occurrence at the insured's premises, or at a customer's location. A special type of property coverage, Electronic Equipment and Media Protection, is included in Computer Consultant Liability Insurance. All of the insured's business computer hardware, electronic equipment, and hardware of others in the care of the insured is insured against physical damage. Data processing media, including converted data owned by the insured and similar property owned by others in the care of the insured, is protected.

Insurance Agents and Brokers Errors and Omissions Insurance

Insurance agents and brokers have a need for errors and omissions insurance stemming from their professional and fiduciary responsibilities in suggesting appropriate coverage, communicating coverage provisions accurately, and submitting premium as the insurer and state laws require.

Errors and Omissions Insurance

One type of professional liability coverage available is errors and omissions insurance. This insurance is used by professionals who do not have a risk of liability for bodily damage, like accountants, insurance agents and brokers, attorneys, securities registered representatives and so on. Other professions which are able to purchase errors and omissions insurance include advertisers, broadcasters, publishers, architects, directors and officers of corporations, engineers, and pension plan fiduciaries.

Most errors and omissions insurance excludes coverage for bodily injury or property damage. Typically, monetary remuneration is required for damages from these professionals. However, if a profession does include the risk of bodily injury or property

damage to third parties, such as the profession of architecture or engineering, policies for these professionals include such coverage.

E&O Insuring Agreement

The insuring agreement of an error and omissions policy varies based on the type of professional covered. Generally it will include an agreement to pay amounts which the insured is legally obligated to pay due to any act, error or omission in professional services rendered. As claims made based policies, the claim will have to occur during the policy period in order to be covered. The insured's employees or representatives are also covered in respect to the carrying out of the insured's business. The insurer will also assume the right and duty to defend the insured in any claim or suit against the insured which meets the coverage terms.

Exclusions

Excluded from coverage are dishonest or fraudulent acts. Also normally excluded are libelous or slanderous acts. Some claims made based coverage will include an exclusion for claims made during the policy period for acts, errors or omissions if the insured knew of the act, error or omission at the time the policy took effect.

Policy Period

The policy period of a claims made based policy is the coverage period. However, if an insured notifies the insurer of an act, error or omission which may lead to a claim during the policy period, and the subsequent claim occurs after the policy period, the subsequent claim or claims which arise out of the act are normally covered.

Premiums

The insurance industry helps our economy grow by providing funds for community investment. The premiums collected by insurance companies are used to pay out claims and support business expenses, but legally required cash reserves are invested in Federal, State and Municipal Bonds, commercial construction, housing developments, and stock market investments. These investments stimulate economic growth.

Good safety and security measures may eliminate the need for some types of insurance or lead to lower insurance rates. It is a good idea to ask an insurance agent what to do in order to get a better rate. Sometimes something as simple as installing deadbolt locks or buying two more fire extinguishers could qualify a company for a lower premium. Other ideas that can aid in cutting losses and lowering premiums are:

- install a fire alarm system;
- install fireproofing materials to minimize fire damage;
- isolate and safely store flammable chemicals;

- provide adequate smoke detectors;
- install a sprinkler system.

It should also go without saying that professional liability extends beyond just fire safety. While placing bars on doors or windows are a necessity in some areas, in other communities this may create a negative impression even so much as to deter business prospects. In order to prevent injuries to customers, employees or members of the public, a business owner can:

- give additional training to drivers he or she hires;
- give employees protective clothing and goggles if necessary;
- set up a system for safer operation of machinery;
- conduct fire drills;

A good approach to managing risk is to ask all employees to identify any safety risks, regardless of how small in their work area and in the work environment in general and to propose cost-effective ways to eliminate or minimize the risks. Insurance premiums can vary widely, depending upon the exact nature of the insured risk.

Co-Pays

The everyday consumer naturally associates insurance with deductibles and co-payables. In referring to professional liability and general liability the aspect of co-pays can be thrown out of the window. Co-payments are also known to go hand in hand with what is called *out-of-pocket* expense limit. Co-pays are to be applied toward each visit to one's healthcare provider.

Deductibles

Expenses incurred by an insured, which may be applied to any applicable deductible referenced in one's policy, will be applied equally toward the satisfaction of the deductible or the deductible can be defined by saying that it is an item or expense subtracted from adjusted gross income to reduce the amount of income subject to tax. Perhaps the reason for the differences is due to the fact that one is termed an *annual* deductible while the other is not.

Another type of deductible is the amount of a loss that an insurance policyholder has to pay out-of-pocket before reimbursement begins in accordance with the coinsurance rate. Deductibles are used primarily for real and personal insurance, including motor vehicle collision coverage.

CHAPTER SEVEN

OUTLINING A PROFESSIONAL LIABILITY POLICY

Covered Participants

Professional liability insurance covers a person or an organization for claims made by third parties such as clients, patients, or customers, alleging negligence in the rendering of, or the failure to render, professional services. The way in which coverage is provided for the employees is to cover them in the case of sexual misconduct, breach or neglect of duty, honest error, misstatement, or omission that occurred during a typical day.

Coverage is also extended to the company owner by means of providing protection in the case of a breach of duty, whether honestly or not an error, neglect, misstatement, or omission committed in the rendering of one's professional services. The business owner is also covered for defense costs, charges, and expenses incurred in conjunction with a claim or suit filed against his or her company. Employees can be included in this description because the employer has trained them in respect to the specific field.

Coverage Provided

A well-designed insurance program can protect a business from a variety of perils in numerous events. The following incidents are some to be considered:

- A customer slips on the floor and shatters a bone;
- A fire destroys all the furniture, fixtures, and equipment in one's business;
- A painter has a severe allergic reaction to a chemical made by a company;
- An employee is hospitalized back injury received when lifting a heavy package;
- Burglars steal thousands of dollars of company equipment;
- The building where one's company is located is severely damaged by a windstorm.

Insurance policies are available to cover each of these events and in most cases it can be reasonable and cost effective. However, if a business that would try to buy insurance to cover all insurable risks may not have enough money left over to do anything else. Deciding on insurance coverage usually involves some difficult choices so some general rules to start with could be:

- Chose aggressive policies to reduce the likelihood of insurance claims.
- Chose high deductibles;

- Liability coverage to protect a company from common claims;
- Liability coverage for serious risks;

One of the most important issues to consider, when deciding upon professional liability insurance coverage is that of defense because anyone can allege virtually anything. However, as a rule, most companies will require minimum limits of $1,000,000 in General Liability and $1,000,000 in Professional Liability coverage. Limits of liability are available from as little as $100,000, to as much as $25 million. Deductibles can range from $1,000 to $50,000.

The Civil Rights Act was adopted in 1964 and it established the Equal Employment Opportunities Commission, which later issued important regulations and guidelines on sexual harassment. The Civil Rights Act prohibits discrimination in employment based on race, color, religion, or national origin. Discrimination on the basis of sex was not included. It was attached to the bill at the last moment, when opponents of the measure introduced an amendment prohibiting discrimination on the basis of sex. It was thought that by adding sexual equality the whole idea would become so obviously preposterous that it would scuttle the entire bill when it came to a final vote.

Here are some factors to consider when evaluating behavior in the workplace to determine whether it is likely to be considered by the courts to be sufficiently outrageous to support a claim of intentional infliction of emotional distress.

- Coercion;
- Duration;
- Frequency;
- Physical contact;
- Retaliation.

Many of the initial costs of proving the innocence of the accused are reimbursable. Once a claim, or lawsuit, has been brought against an individual or company the proceedings will begin to fall into place. Listed below are some of the costs that are incurred when involved in such an action.

- Deposition Fees/Expenses;
- Defendant Expense Benefit;
- Retirement/Leave Discount.

Exclusions

Most applicable liability policies contain an exclusion for intentional acts either directly or by definition of accident or occurrence. A few courts require evidence of actual intent to

injure and some courts also insist that there is at least a duty to defend where negligence is alleged. Still, others refuse to recognize such allegations of negligence.

This applies to any claim or claim expenses based upon or arising out of any dishonest, fraudulent, criminal, intentional or malicious act, error or omission, or those of a knowingly wrongful nature or the willful violation of any statute, regulation, ordinance, or administrative complaint, notice or instruction of any governmental body or agency, committed by an individual. This exclusion will not apply to an Insured who did not commit, participate in, or have knowledge of any of the acts described.

Limitations

Under legal rules that were firmly in place until the early 1970s, plaintiffs had to be very careful about their time element. Injury claims could be thrown out without any real rhyme or reason should the timing not be deemed reasonable. Judges of the earlier legal era did enforce the statutes of limitation, but did so in a manner that was particular and inflexible. The reasoning for having limits was confusing because the logic was uncomplicated as far as some were concerned.

If an injury was incurred due to negligence, one needs a reasonable amount of time to decide if pursuing a claim is the course of action to choose. Should it be so, decisions such as the right person to sue, how much money to sue for, and just exactly who all are the parties that are liable need to be addressed. From the other side of the coin – so to speak, if too much time is taken to make such decisions it becomes unfair to the one who is potentially facing a lawsuit.

Policies

The way in which claims are handled varies from insurance carrier to insurance carrier. Some policies include a clause stating one's consent to settle, while others give the insurer the sole right to determine when to settle. Some carriers also include a clause requiring the policyholder to consent to a common defense with any other defendant insured by the same company. While this has certain advantages, it also has certain risks, and the acceptance of any such clause should be given very careful consideration.

Most professional liability policies are written on a claims-made basis, though sometimes coverage is available on an occurrence basis. Knowing which one has - or needs - can be absolutely critical in preventing dangerous gaps in coverage.

Professional liability policy coverage is sometimes provided only for work produced during the policy period and, only those claims that are first made against the business owner and are reported during the policy period will be covered under the policy when a policy is written in this manner.

Various Policy Examples

- *All-risks Policy* – Coverage by an insurance contract that promises to cover all losses except those losses specifically excluded in the policy. To be covered for damage or loss under a basic contract, the damage or loss must be caused by a peril that is named or listed in the contract.
- *Block Policy* – A form of inland marine insurance designed to cover loss to the property of a merchant, wholesaler, or manufacturer including: property of others in the insured's care, custody, or control, property on consignment and property sold but not delivered.
- *Claims-Made Policies* – An insurance policy covering only those claims which both occur and are reported during that policy period. In certain instances, a claims-made policy may cover claims arising prior to the policy's inception date.
- *Commercial Multiple Peril Policy* – A package of insurance that includes a wide range of essential coverages establishment.
- *Commercial Package Policy (CPP)* – A commercial policy that can be designed to meet the specific insurance needs of business firms. Property and liability coverage forms are combined to form a single policy.
- *Economic Policy* – Special type of participating whole life insurance in which the dividends are used to buy term insurance or paid-up additions equal to the differences between the face amount of the policy and some guaranteed amount.
- *Farm Owners-Ranch Owners Policy* – A package policy for a farm or a ranch, providing property and liability coverages against personal and business losses.
- *Limited Policy* – An insurance contract which covers only certain specified diseases or accidents.
- *Master Policy* – A policy that is issued to an employer or trustee, establishing a group insurance plan for designated members of an eligible group.
- *Multi-Peril Policy* – A package policy that provides protection against a number of separate perils. Multi-peril policies are not necessarily multiple line policies, since the combined perils may be all within one insurance line.
- *Non-Occupational Policy #1* – Contract which insures a person against off-the-job accident or sickness. It does not cover disability resulting from injury or sickness covered by Workers' Compensation. Group accident and sickness policies are frequently non-occupational.
- *Non-Occupational Policy #2* – One that provides off-the-job coverage only; it does not cover loss resulting from accidents or sickness arising out of or in the course of employment or covered under any workers' compensation law.
- *Occurrence Policy* – A liability insurance policy that covers claims arising out of occurrences that take place during the policy period, regardless of when the claim was filed.

- *Policy* – The legal document issued by an insurance company to a policyholder, which outlines the conditions and terms of the insurance; also called the policy contract or the contract.
- *Rated Policy* – An insurance policy issued at a higher-than-standard premium rate to cover a higher-than-standard risk.

CHAPTER EIGHT

FORMS OF PROFESSIONAL LIABILITY

Specific Types of Coverage

Liability policies may be claims made or occurrence. Since old liability policies are likely to be the occurrence type, they would cover injuries that developed while they were still in effect.

Purchase power insurance also serves as a basis for credit in our economy. Insurance provides this protection and allows people to make major purchases. Bailee insurance is typically purchased by businesses such as dry cleaners, jewelers, repairers, furriers, etc., and is coverage designed to protect for loss or damage to property of customers regardless of a Bailee's legal liability. Bailee insurance is inland marine coverage on property entrusted to the insured for storage, repair, or servicing. Blanket insurance provides coverage under a single limit for two or more items, i.e. a building and/or its' contents; two or more locations, or a combination of items and/or locations.

Broadcasters' liability insurance covers exposures such as the use of incorrect news stories, libel and slander, invasion of privacy, and copyright infringement. The legal liabilities of a broadcaster are vast and varied which is why it is a wonderful thing that unauthorized use of plot, characters, and music are included in coverage as well as defense costs in contesting suits or claims. While employees are acting within the scope of their duties, coverage is implemented.

A comprehensive personal liability insurance policy does provide coverage for protection against loss arising out of legal liability to pay money for damage or injury to others for which the insured is responsible. It does not include automobile or business operation liabilities.
A lapsed policy is defined in two ways. One of which is a policy that has been terminated for non-payment of premiums. The second being a policy that has been terminated for non-payment occurring before the policy has a cash or other surrender value.

Physicians, Surgeons, and Dentists

The insuring agreement under C*overage M* includes all sums which the insured shall be legally obligated to pay as damages because of injury to which this insurance applies and was caused by a medical incident that has arisen out of the insured's profession as a physician, surgeon or dentist. The coverage provides protection arising out of the furnishing of professional medical or dental services by the insured, an employee of the insured, or any person acting under the personal direction, control or supervision of the insured.

The insuring agreement under *Coverage N* reads the same except that coverage N provides for the insured's liability for damages arising out of injury caused by any person for whose acts or omissions the professional partnership, association or corporate insured is legally responsible.

A Hold Harmless Agreement

Hold Harmless Agreement is defined as the assumption of all expenses incident to the defense of any claim and to fully compensate an indemnitee for all loss or expense, undiminished by the costs of defending a claim or litigation.

A professional may need to take part in a hold harmless agreement if he or she is asked to indemnify one or several contractors, subcontractors, or suppliers if damages resulting from a liability claim or suit are considerable. One may ask the exact definition of indemnify. A good definition states that indemnity is a contract by which one engages to save another from a legal consequence of the conduct of one of the parties, or of some other person. The indemnitor assumes responsibility for protecting the indemnitee against liability.

It is interesting to point out that the wording of hold harmless clauses is limited only by the imagination of creative lawyers. Hold harmless clauses can normally be grouped into five basic types:

- Indemnitor agrees to hold the indemnitee harmless from liability arising out of the indemnity's own negligence.
- Indemnitor agrees to hold indemnitee harmless from all liability arising out of the negligence of both parties except for the sole negligence of the indemnitee.
- Indemnitor agrees to hold indemnitee harmless from all liability arising out of either party, without regard to fault.
- Indemnitor agrees to hold the indemnitee harmless from all liability arising out of the negligence of anyone in the performance of the work.
- Indemnitor agrees to hold the indemnitee harmless from all injury, loss or damage, regardless of fault or cause.

Insurance Agents and Brokers

An insurance broker principally represents the insured in an insurance transaction with no distinction between agents and brokers with reference to legal responsibility for wrongdoing. The broker may be the representative for the insurer and the insured and both may be held liable for the same wrongdoing. Brokers have been held liable for failing to procure insurance for an insured under various circumstances. Failure to make sure that a policy covered the insured adequately has also been a controversial issue but failure to notify the insured concerning cancellation may not be held against the broker if the insured should have known of the cancellation.

Types of Agents

A general agent or a managing general agent usually stands in the shoes of the insurance company by contract and generally assumes all of the duties that an insurer owes to an insured, including the disposition of claims. They usually represent small insurance companies, and their numbers are gradually diminishing.

Duties and Responsibilities of An Agent

The duties and responsibilities of an insurance agent are different from other professionals because the insurance agent has duties to the insurance companies that write the policy, as well as to clients who buy the insurance. Often these duties conflict over matters of coverage, when claims are presented. Since the agent receives a fee for placing a risk and is not immediately affected by loss ratio on that risk, it becomes more difficult for him to abide strictly to company authorization and the code of ethics.

Generally speaking, the insurance agent is not ultimately responsible for determining how much coverage should be purchased unless he or she is consulted about it and if there is no clear-cut understanding to the contrary. The decision concerning the amount of insurance to be purchased rests with the insured. The general rule of reasonable care which an insurance agent owes a client does not include the obligation to procure a policy affording the client complete liability protection. The two exceptions to the general rule are:

- When the agent holds himself out as an insurance specialist and specifically receives additional compensation as such, and
- When there is a long-standing relationship between the two depending on reliance by the insured upon the agent. The agent's knowledge of insured's income is not enough.

Standard of Care Required of Agents

The standard of care required of insurance agents is the usual one applied to professional liability; to exercise the degree of skill and knowledge of the reasonably prudent insurance agent under similar circumstances. Locality plays a very minor part in determining the professional liability of an insurance agent. Again, as with other professional liabilities, an agent does not undertake to render perfect service, and mere errors of judgment, where negligence or fraud are not involved, should not warrant recovery against him for malpractice.

The authority of an insurance agent to act on behalf of the insurance company that he or she represents is determined by the agency contract, the underwriting rules of the company, and past relationship with it. An agent is usually granted specific written authority and, in addition, has implied authority to act in a proper manner to accomplish the usual purposes of an insurance agent where it does not contradict his or her written authority, with some exceptions to be noted hereafter.

As with many other professional liability policies, there is no standard policy form, although the policies of those companies that write this coverage have many common provisions. Exclusions usually include libel and slander, fraud, criminal or malicious acts. Most such policies are liability forms, but in some of the older forms these were written as indemnity contracts, thought often not interpreted as such by our courts.

The Laws of Insurance

Insurance laws usually limit the time within which a binder is effective and agency authorizations often limit an agent's authority to issue binders. Any limitations must be reported to the client, if applicable. It is important that there is agreement on all of the essential terms of the policy to be issued and that confirmation be sent to the client and the insurer, with all essential information including the exact time of the day on which the binder was issued.

Actions Brought Against the Agent by the Company

Actions brought by an insurance company against an agent are, for the most part, indemnity suits brought to recover payments made by the insurer because of the malpractice of the agent, since knowledge of the agent is usually imputed to the insurer. While for business reasons, indemnity actions are not of the greatest concern to the average agent, such suits are not at all unusual for the following reasons:

- Failure to follow instructions;
- Failure to disclose adverse information;
- Binding unauthorized risks;
- Fraud involving intentional concealment of material facts.

Actions Brought Against the Agent by the Insured

The areas of greatest danger and exposure to malpractice actions for insurance agents involves suits brought about by the clients or prospective clients against them for a number of reasons:

- Failure to:
    - advise client promptly concerning inability to obtain renewal, rejection, or cancellation;
    - apply for coverage promptly with a solvent and authorized carrier;
    - explain the boundaries and exclusions of coverage – misrepresentations of coverage;
    - advise insured about differences in overage because of renewal changes, or mistakes of which the agent was, or should have been aware of;

- obtain adequate coverage;
- procure or renew insurance that the agent had contracted to obtain;
- process application in time.

While standards in medicine, law, and architecture are more or less standard throughout the country, the professional knowledge of agents varies greatly, depending on the sophistication required. It appears obvious that a large agency dealing with many large insureds is required to have agents with much greater knowledge than agencies in a small community dealing with personal and small commercial lines. Accordingly, others should measure the standard of care required by agents in the same location.

Actions Brought Against the Agent by Third Parties

While it is still uncommon, a few cases have held that an agent may be liable for malpractice against innocent third parties. An agent should take every precaution to insure oneself against the chance of a malpractice suit being brought. Below are some guidelines.

- Adhere to NAIA Code of Ethics;
- Be familiar with client's needs;
- Carry out all obligations as called for in applications, renewals, binders, etc.;
- Carefully accept premiums after cancellation;
- Check for any indication of misrepresentation;
- Confirm that the insured understands the policy coverage when it is issued;
- Document significant events with letter, memos, or notations;
- Let the client make the final decision after discussing options;
- Make no gratuitous promises of coverage if there is any doubt ;
- Make sure that proper policies and renewals are issued in a timely manner;
- Make sure that proper limits are procured on policies and renewals;
- Obtain appraisals to confirm values if necessary;
- Prepare authorized endorsements and send copies to the insured and the company;
- Understand the limits of the authorization;

Insurance Claims Adjusters

Independent insurance adjusters are considered to be within the meaning of persons engaged in the business of insurance and subject to liability for violations of the ***Unfair Claim Settlement Practices Act.*** But it has been held that the claim adjuster is acting for and on behalf of the insurance company and is not held personally responsible for any

malfeasance. Plaintiff's lawyers seem to see a strategic advantage to the inclusion of claim representatives who handle settlement negotiations for the insurer and at times have made them party defendants. As a result, the exposure of claim representatives is increasing and in addition, the enactment of Unfair Claim Settlement Practices Acts has permitted personal actions against insurers and claim representatives in some states which has increased that exposure.

Three hazards that cause errors and omissions problems for claim adjusters are:

- Improper documentation;
- Procrastination;
- Unclear communications.

For those who are meticulous with their time, it could be said that all three are symptoms of procrastination. Some of the many hazards that could cause errors and omissions problems are listed below:

- Failure to properly reserve insurer's rights where there is a conflict of interest;
- Failure to use defense attorney's services properly;
- Failure to keep insured and company supervisors properly and promptly advised;
- Lack of courtesy and diplomacy;
- Improper or incomplete investigation.
- Improper evaluation and failure to continue reevaluation of settlement values.;
- Incorrect interpretation of coverage leading to improper disclaimers of coverage.

Medical Disciplines of Professional Liability

Professional liability or malpractice is simply a term of common usage and refers to certain types of misconduct or improper performance of a professional in the servicing of his or her duties. The accused individual is only liable to compensate the accuser when and where there is an actual act of malpractice that was due to incompetence, human error, or some other form of error and can be proven.

There are any number of ways that a professional can find himself or herself faced with a problem in obtaining professional liability or malpractice insurance coverage. These situations can range anywhere from malpractice claims/lawsuits; disciplinary actions; license restriction, suspension or revocation; felony conviction; substance abuse; sexual misconduct, and even to non-accepted medical practices & procedures.

The marketplace for professional liability insurance is going through tremendous changes these days. Due in large part to pricing pressure brought on by intense competition over the past few years. Some carriers are finding themselves faced with mounting losses. Well-

known, and respected, insurers have seen their financial ratings reduced as a result of medical malpractice claims. Some major national carriers have sharply curtailed their writing, since they feel that they simply cannot make a profit.

Claims' handling varies from carrier to carrier. Some policies include a clause stating an individual's right to consent to settle, while others give the insurer the sole right to determine when to settle. Some carriers also include a clause requiring the policyholder to consent to a common defense with any other defendant insured by the same company. While this has certain advantages, it also has certain risks, and the acceptance of any such clause should be given very careful consideration. Obviously, the subject of medical professional liability insurance coverage is tremendously complex.

The fact is that in order to remain in practice, or return to practice once one's license has been restored, it is critical that a professional be able to obtain professional liability insurance coverage. Most hospitals, group practices, HMO's & PPO's, county, state or federal government contracts require this type of insurance. Few, if any, of the many association-sponsored insurance programs, or state mutual malpractice insurance companies are equipped to deal with the impaired risk or hard-to-place professional.

It would be a lie to say that this type of coverage is inexpensive. In some cases, policies are written at very high premiums, while in other cases, the pricing has been really quite reasonable. Other situations have found one insurer's pricing is dramatically higher or lower than another's, which is why it is most assuredly in one's best interest to look around at many insurance agents and brokers.

Physicians and Surgeons

A person visits a doctor's office due to a prolonged illness but despite all the physician's efforts, the symptoms do not diminish and are getting worse. Has the doctor failed in his or her duties or is it a case of whatever is wrong is simply out of his or her field of expertise? A physician is held to a standard of performance representative of accepted professional skills, but not all physicians are held to the same level of performance. This is a common understanding among physicians and should be among the general public once the reality of a doctor's education and training is considered.

The general rule applied by the courts to determine if an incident of malpractice has been committed is to ask if the doctor has performed in a manner consistent with his or her education level and training. The community clause or locality rule states that initially, the standard for evaluating the conduct of a professional in a malpractice suit was that degree of skill and care of a reasonably skilled professional in the same or similar locality. It is important to remember that the general public does not understand what the physician does nor do they think as a physician would.

The relationship the doctor and patient share is the same as with any relationship, be it in business or not, communication is a key element in a happy outcome. If one has questions of the other, the questions should be asked. If this open line of communication is not established early in the relationship, there could be room for an error or omission. This could and would be bad for all parties involved.

When standard methods do not provide success it does not necessarily mean that the doctor has been negligent. Doctors must consider how the human body works within itself and how it may respond to prescribed treatment. The patient's behavioral habits, personality, diet, heredity, and level of activity are of vital importance. Once all the information has been factored in, the doctor is able to reach a conclusion as to the cause of an illness.

When a doctor is negligent he or she should be brought to justice without any guilt on the part of the plaintiff. When the accused doctor becomes a publicized defendant in a lawsuit he or she is too often already deemed guilty even before the trial has begun. There are doctors who almost never are sued. While it is hard to characterize said doctors due to our individuality as a human species, it is not hard to determine what separates negligence and an honest error or omission.

The outcome of a medical malpractice suit has an effect on all parties involved. Lawsuits are brought for many reasons ranging from being just, to frivolous, and out of seeking vengeance. Fearing future lawsuits may even affect a doctor's choice of treatment, causing him or her to second-guess oneself. It is clear to see that a physician whose suit has become public knowledge has already suffered some harm to their professional reputation despite the reasoning for the suit.

The physician has the potential of having malpractice insurance cancelled and to reinstate such a necessity may not only be difficult, but costly. The usual medical professional liability policy is written on either an occurrence or a claims-made basis, though the trend is increasingly towards occurrence forms. Limits are customarily $1 million per occurrence and $3 million aggregate, though other options are available. The process to become insured again may mean an increase in each of these.

Nurses

Nurses have been classified as professional persons employed to exercise their calling on their own responsibility, and that nurses are grouped with physicians and surgeons. A nurse's primary function is to follow the doctor's orders and to record and keep the doctor advised of observations. In determining what statute of limitations is applicable to the negligence of a nurse in the care of a patient, the court held that it was ordinary negligence and not malpractice.

The duty of nurses differs from that of physicians in that nurses are subject to the orders and instructions of physicians and their duty to follow such orders is limited only to the use of independent judgment commonly attributed to others in the same profession. A nurse is in an anomalous position requiring a great deal of judgment and technical skill. It is a demanding role that makes it a target for malpractice suits.

Hospitals

In hospital professional liability policies, the insured has the option of purchasing either the claims-made policy forms or the usual occurrence forms. The general liability coverage comes into play when injury arises out of such general activities as housekeeping, the making and serving of meals, and other hospital responsibilities not connected directly with medical care and treatment of patients. Liability arising out of food served to patients is covered, but food served to relatives or other visitors, is not.

Access to hospital facilities is essential to the practice of a doctor. Licensing and review procedures provide some measure of quality control of the physicians who are connected with a hospital, but the burden is on the hospital to make its' own investigation concerning the competency of any doctor who is accepted on its' staff. Today's hospitals are larger and more complex than ever before and operate as highly integrated systems utilizing a team approach to medical care. A patient commencing a malpractice action will probably sue the hospital in addition to the treating doctor. The changing nature of hospitals has precipitated a reevaluation of the traditional legal analysis regarding hospital's liability for the negligence of their physicians.

A hospital has a duty to all invitees to use reasonable care in the maintenance of buildings, grounds, and furnishings, which are usually referred to as administrative duties, as distinguished from medical duties. Nurses who are employed, or being trained by a hospital, are employees of the hospital, and their negligence is accordingly also attributable vicariously to the hospital for which they work.

The fact that a nurse's negligence occurs while acting under orders from the personal doctor of the patient does not insulate the hospital from liability, assuming the nurse is an employee of the hospital. There are, however, some circumstances in which the nurse may be considered as the temporary employee of the doctor or surgeon. This is usually when the nurse is acting in the capacity of an assistant at an operation, or at the birth of a child. In such instances, the hospital has, until recently, ordinarily been absolved of responsibility for the nurse's negligence if there was no question of general incompetence. If, however, the hospital does not supervise the nurse's work and, as with a private nurse, does not pay her salary, it is not vicariously responsible for the professional acts of that nurse.

Hospital Liability

The liability of a hospital may rest on its' corporate or administrative acts and responsibility, or ***on the doctrine of agency or master and servant which is the respondeat superior.*** Responsibility for its' administrative or corporate acts usually falls within three categories:

- Defective equipment;
- Selection or retention of incompetent personnel; and
- Unsatisfactory maintenance of buildings, grounds, furnishings, medical, and other equipment, and defective food and drink.

Hospitals may be government owned, privately run for profit, or privately run on a nonprofit or charitable basis. Hospitals run for profit are responsible for the wrongdoing of their employees, generally to the same degree that ordinary corporations, partnerships, or other business entities would be held accountable.

Corporate Liability

One theory used to impose liability on a hospital is that of corporate liability, which is predicated on the notion that a hospital owes a direct duty to its' patients to render good and adequate medical care. Most hospitals are corporations and their duties encompass responsibility for their administrative staffs and their medical staffs. Generally speaking, such duties include:

- The exercise of reasonable care in providing proper medical equipment, supplies, medication, and food, beds and other sheltering equipment.
- The providing of safe physical premises for patients and invitees.

It may still be important to distinguish administrative from professional duties and acts, the prevalence of hospital insurance which provides both general liability and professional liability coverage makes this distinction of less importance than previously.

The hospital is responsible for the proper preservation, freedom from infection, infusion procedure, typing, and labeling of the blood. A blood transfusion is another area in which there is a great deal of controversy as to whether the hospital is providing a product or a service with the question of strict liability. This situation becomes all the more complicated where hepatitis is alleged to have been contracted as a result of a blood transfusion. The number of private hospitals operated for profit has proliferated.

Proper drafting of pleading may be critical to a plaintiff's suit against a hospital for medical malpractice. Where, for instance, the plaintiff's complaint failed to plead a theory of respondeat superior, a verdict in favor of the physicians allowed accelerated judgment for the defendant in view of the fact that the plaintiff pleaded no theory of liability against the hospital that had not been predicated against the individual doctors.

Chiropractors

Chiropractic is increasingly accepted as a legitimate while once considered outside of the mainstream by the medical establishment is still an alternative form of medical treatment. These developments, along with the general public's greater acceptance of not only chiropractic, but of all forms of alternative healing, have brought chiropractic doctors increased respect, visibility, and financial success.

Many insurance companies are recognizing the value and expertise of chiropractors. More and more managed-care plans now have at least some provision for chiropractic treatment. In addition, insurance companies are looking for chiropractic examination in the claims process, particularly in the evaluation of workers compensation and personal injury claims.

Chiropractors' professional liability insurance is referred to as malpractice insurance and written by several national insurers, as well as a number of smaller state-specific mutual carriers. Some insurers have even developed a special niche in the coverage of impaired risk cases. Some carriers write coverage on a claims-made basis; some write coverage on an occurrence basis; and some offer a choice. Whichever is currently insuring one's business, or should one be researching policy coverages for the first time, the chosen policy will have an impact on how one's business is insured for and in the future.

Druggists

Druggists liability insurance, as written today, for the most part is not written as a professional liability policy. It can be written as a liability policy; either separately or as an attachment to some of the general and products liability policies. It is important that the general liability and products liability coverages be written in the same company so that coverage problems in borderline cases will be kept at a minimum. Except as covered under premises and operations liability which stems from incidental operations arising out of the ownership, maintenance, or use of the insured premises, if there is no pertinent professional liability exclusion in the policy or if such exclusion has not been endorsed out.

CHAPTER NINE

CONSIDERING ADDITIONAL DISCIPLINES

The professions subject to the need of professional liability are as vast as the scope of one's imagination. Engineers, architects, and clerics can become involved in a lawsuit either directly or indirectly as the result of another's lack of insight or as the result of an honest error or omission. In this chapter the discussion will revolve around various occupations, or professions as it were, and how each is subject to claims of malpractice selective in and of itself. Ways and means of avoidance of said situation will also be discussed as well.

Lawyers

Lawyers, as with anyone who sets himself or herself out as a professional, must adhere to certain rules of conduct. All professions have a code of ethics to follow. Two examples are doctors who have their Hippocratic Oath and lawyers who have rules of professional conduct.

Contained within the next few lines are just a few of the Model Rules of Professional Conduct that have been set down by the American Bar Association. The following rules are those that most commonly relate to lawyer-client dealings and some of the problems found in such a relationship.

Model Rules of Professional Conduct

- Rule 1.1 Competence
- Rule 1.2 Scope of Representation
- Rule 1.3 Diligence
- Rule 1.4 Communication
- Rule 1.5 Fees
- Rule 1.6 Confidentiality of Information
- Rule 1.7 Conflict of Interest: General Rule
- Rule 1.8 Conflict of Interest: Prohibited Transactions
- Rule 1.9 Conflict of Interest: Former Client
- Rule 1.15 Safekeeping Property
- Rule 1.16 Declining or Terminating Representation

There are five types of claims that can be made against a lawyer. These include:

- malpractice;
- breach of contract;
- conflict of interest;
- ineffective assistance of counsel;
- financial misconduct.

Whatever circumstances lead to a claim of legal malpractice, the reality is that such claims have risen significantly over the past 10 to 15 years, in terms of both sheer numbers, and financial magnitude. Even when the client is completely satisfied with the quality of the representation, lawyers and law firms can find themselves named as defendants in shareholder lawsuits - even class actions - or those actions brought by government agencies, alleging some breach of duty to the public. There are people that think it an oxymoron to say there is an ethical lawyer.

Whether one is a solo-practitioner or a small to mid-size firm, it is critical that protection of one's being, practice, and assets is sought, with a properly underwritten policy of professional liability insurance. The best way is to be certain that one has the broadest possible coverage; tailored specifically for the nature of one's practice, and at the most competitive premium, is to seek out an experienced, independent insurance broker.

Limits of liability are available from as little as $100,000, to as much as $25 million. ***Claims expenses are sometimes included within the limits of liability; though a number of carriers will offer claims expense apart from limits, or cap the offset at 50% of the liability limit.*** Generally, small to mid-size firms most often take a deductible of between $2,000-$10,000, and carriers vary in terms of whether claims costs are charged against the deductible. Programs are generally slot underwritten, which means that the underwriters' flexibility is limited, since each policy must be viewed as part of the program as a whole.

If the focus of one's practice tends to be in areas of high-liability potential, such as IPO's, financial institutions, securities, etc., there are underwriters and companies who are more comfortable with this type of risk-profile. If the goal is to concentrate one's practice in areas known to be lower in liability, there are other underwriters and other insurers that prefer this type of risk. Even if an attorney has just recently passed the Bar exam and is in the process of opening a practice – there are companies that offer discounts. Perhaps an expansion or merger has recently occurred or maybe a dissolution of one's partnership is in the recent past.

No matter what the nature of a practice, today's lawyer or law firm is increasingly becoming the target of allegations of malpractice. Sometimes, this is the result of honest mistakes; at times, it is a result of unreasonable or unrealistic client expectations; sometimes it is simply due to a misunderstanding; and in some cases, the claim is false, frivolous, or outright fraudulent.

Accountants and Auditors

Today's accounting professionals and firms must adapt to the changes as they occur. Some are merging; others are expanding, often by adding various consultancies - technology, computers, software consultants; management consultants; even legal services in some cases. The frequency and severity of malpractice claims against accounting professionals has risen dramatically over the past 10 to 15 years.

Even a sole-practitioner, or a small to mid-size firm that might handle only compilation, review or non-audit services - or even just tax issues for businesses or individuals is faced with a significant risk of a malpractice claim. According to one major malpractice insurer, tax engagements alone accounted for over 50% of all claims during the years 1993-96. The fact is that even if one has done nothing wrong, he or she can still face a claim for malpractice.

Most professions, including those of doctor, lawyer, teacher, and others require no specific definitions since their activities are generally well known. Accountants are different in that their activities range over a wide area, including bookkeeping, auditing and certifying for a large group of business enterprises. Many individuals and other legal entities with which his client is doing business or intends to do business rely upon an accountant's statements. The accountant's errors or omissions could affect many third parties. Some of the principal areas of responsibility might concern:

- Failure to file proper tax returns on time;
- Improperly prepared tax returns;
- Incorrect financial status reports;
- Misappropriation of funds by employees.

There are three major areas of responsibility of an accountant that can be grouped as follows:

- Liability to his or her client or someone who 'stands in the shoes' of the client;
- Liability to third parties who have not retained the services of the accountant;
- Statutory liability, particularly under federal securities acts.

Liability to Client

The standard of care expected of an accountant requires that he or she exercise that degree of skill and competence reasonably expected of a person in his or her profession and, at times, within the community, state or nation wherein he or she practices. The accounting profession itself has established standards by which a member can be measured according to guidelines published by the American Institute of Certified Accountants. In addition, some states have also enacted guidelines for accountants, and

while the violation of such acts may not constitute negligence per se, they would in any event be an indication thereof.

There is so little agreement concerning correct accounting and auditing procedures so that establishing specific boundaries as to which is right is very difficult. Once again, as in other professions, an accountant or auditor is not legally responsible for honest errors in judgment made on a non-negligent reasonable basis. At the other extreme are cases involving fraud by the accountant that, whether perpetrated directly on clients or indirectly on third parties, has from an early date been held to be actionable malpractice. For the most part, malpractice actions against accountants are based on negligent misrepresentation.

Section 552 of the Restatement (Second) of Torts adopts a limited approach to liability. It rejects the requirement of a privity of contract and requires instead knowing reliance as a yardstick. Liability is not extended to all parties whom the accountant might reasonably foresee as using the information he or she disseminates. A growing number of states have ruled that accountants may be held liable for professional negligence affecting third parties who are reliance on the accountant's representations was reasonably foreseeable.

A corporation offering, or firms or individuals selling stock through a secondary offering is subject to the provisions of the Federal Securities Act of 1933. Section XI of this Act imposes liability on the parties to the registration for material misstatements made in the registration documents and for omissions of material facts. Parties who may be liable under this section of the Act include:

- Auditors whose reports give erroneous and misleading information;
- Directors of the corporation that issues the stock;
- Others who sign the registration statement;
- The issuer of the securities;
- Underwriters of the stock issue.

Accountants

Coverage is provided for the named insured, partners, officers, directors, stockholders, and employees while acting in the scope of their duties. The exclusions vary, but fraudulent, criminal or dishonest acts committed by or at the direction of a named insured are not covered and no coverage is provided for any insured who commits a dishonest act. Most policies do, however, cover a partner who has no knowledge of the dishonest or criminal act of the wrongdoer. Other exclusions that are usually excluded include bodily injury and damage to tangible property.

Today's accounting professional or firm is faced with tremendous competitive pressures, in an ever-changing business environment. With this dramatic change comes an increasing number of legal and medical questions and potential pitfalls.

Along with the garment industry there co-existed a thriving accounting industry. Many small-to-mid-sized accounting firms did little else besides the garment industry. Now, due to a convergence of political, economic and technological forces, many of these accountants are finding themselves scrambling to adapt. While it is true that some programs offer good, reliable coverage, they are generally slot underwritten; meaning there is very limited flexibility for customizing the coverage terms to match the practice profile of each individual firm or professional.

Architects and Engineers

Any distinction between an architect and an engineer is irrelevant to the question of tort liability. Both are required to be certified by a state before being permitted to practice their professions. The standard of care for both professions is similar to that of other professions except for the greater duties assumed by contract. Many of the duties assumed by architects and engineers are based upon the oral or written contract between them, their clients, contractors, and subcontractors. The first and prime duty of the attorney representing the architect or engineer in the event of suit for professional malpractice is to carefully review all contracts and agreements.

In the later part of 1957, courts confirmed the demise of privity of contract as a defense for an architect or builder as to a structure erected on real property. It also decided, as a matter of law, that neither the architect nor the builder was liable to third parties for defects in buildings or other structures on real property. Once the owner, where the defect or danger was known, obvious, and could have been discovered by reasonable inspection, accepted them. By the early 1970's nearly every jurisdiction had discarded the privity of contract defense for architects and engineers. In recent years, the law concerning the liability of architects and engineers for their professional liability has paralleled the development in the law of products liability.

More than in any other profession, architects and engineers may be held liable for their professional liability to third parties as well as to their first party clients. The following areas of possible liability for architects and engineers include aspects of both first and third party liability. Liability for defects attributed to plans and specifications. This usually involves dangerous conditions that could cause injury or death resulting from:

- Cracking, buckling, or collapsing roof, floors, or walls;
- Deviations from plans or specifications without previous agreement;
- Fixtures that may be inadequate or badly installed;
- Foundation of a building being inadequate;
- Improper specification of materials;
- Improper supervision of construction;

- Liability arising out of improper certification of partial or total completion;
- Waterproofing, heating, or air conditioning inadequacies.

Statute of Limitations

Discounting any statutory enactment on the subject, the statutory period would be affected by whether the action was brought in contract or tort. Some cases hold that the statute begins to run from the time of completion of the construction. As a result of pressure brought by architects and engineers through their professional organizations, many states have adopted special periods of time limitation within which an action may be brought against architects and engineers for malpractice.

While most of them have been declared constitutional, the time period of usually four to seven years was felt to be inadequate by the organizations representing the architects and engineers, since many malpractice actions are brought many years after the completion of the buildings involved.

Churches and Clerics

The U.S. Constitution holds that Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof, in the first amendment. Although the freedom to believe is absolute, the freedom to act is not.

There is a belief that the dramatic rise in malpractice cases involving churches and clerics is due to modern religion's declining social influence plus the availability of malpractice insurance and the decline of the charitable immunity doctrine. The proliferation of litigation in this country is especially true where cults are involved. Intentional tort actions arising out of personal activities and clerical malfeasance have been instituted against ministers, pastors, and priests. Allegations sometimes even involved sexual misconduct.

Directors and Officers

The great difficulty in handling errors and omissions claims involving corporate directors is the common misconception that a board of directors actually manages a corporation. Nothing is further from the reality of the situation. Most directors know very little about the day by day operation of the corporation with which they are involved as directors, and yet some courts have held directors to a high standard of knowledge and responsibility for such daily operations. The courts have generally held directors to be obligated to act in good faith, and with diligence and loyalty. The degree of skill and care is the usual one required of the prudent person under similar circumstances in the conduct of their personal business affairs. They are regarded as fiduciaries of their corporations and stockholders.

Some directors perform special duties requiring specific skill or knowledge. Some of the grounds upon which actions have been brought against corporate directors and officers involved the following:

- Failure to comply with state and federal laws and regulations;
- Inefficient administration;
- Misstatements of financial reports and misuse of funds;
- Payment of unwarranted dividends.

The by-laws of most corporations states that an officer or director will be indemnified for expenses and even some damages for which a director has been held personally responsible. Many states have also enacted statutes agreeing with this position where fraud or illegal gain was not involved. The statutes involved are not uniformed to say the least. Some authorize corporations to make indemnification, some require indemnification, and others require court approval on an individual basis. A few even permit indemnification for expenses involved in criminal defense, where the defendant has been successful. Where civil defense is successful, it is obviously just a matter of reimbursing a director or officer for legal expenses involved in defending himself or herself.

Once the problem of the legality of indemnification has been hurdled, it becomes obvious that the hazards of personal liability by directors and officers are insurable. It has been argued that since the law imposes certain duties and obligations on directors, it should not permit them to evade those obligations by the purchase of insurance. This is a very untenable position to take. All liability insurance could be subject to the same liability, products or any other coverage of this nature.

Some states have specifically enacted statutes permitting corporations to purchase insurance for the protection of officers and directors from financial disaster resulting from actions brought against them in their capacities as such.

The Insurance Policy

There is no standard form for this insurance, but there is a great deal of uniformity in the policy provisions***. The two general forms in common use in this country are the so-called Mini policy for financial institutions of modest size, and the blanket or Maxi policy for large corporations and conglomerates.*** These policies provide protection for any wrongful act of a director or officer. Wrongful act is ordinarily defined as an actual or alleged error, misstatement, act of omission or breach of duty by the insured while acting in an individual or collective capacity, solely by reason of being a director or officer.

The wrongful act, in some policies, must occur during the policy period and claim or suit concerning that act must also be made or brought within the policy period. Notice of the

wrongful act committed during the policy period is required to be given when committed, or if the insured is unaware that his act was wrongful, then notice must be given when a claim is made or suit is brought. Some policies provide coverage for wrongful acts committed before the effective date of the policy period if claim is first made or suit first instituted during the policy period. Assuming the insured had no previous knowledge of the impending claim or suit and could not reasonably have foreseen it, and also assuming that there was no other applicable insurance.

On the issue of failure to give proper notice of claim to the insurer, the court decided that if the notice provided to an insurer is considered to be defective by the insurer, good faith requires the insurer to notify the insured of its' objections within a reasonable time, and if the insurer fails to do so or proceeds to act as though notice was satisfactory, it has waived any right to assert notice as a defense at a later time. In any event, notification as to the loss or claim does not constitute notification as to another.

The exclusions in most Officers' and Directors' malpractice policies exclude claims or suits that were insured by another policy or policies. This is sometimes put in the form of an *Other Insurance* condition, which is found in most liability policies. Some policies exclude claims or suits brought on the grounds of libel or slander, and a few exclude claims or suits based on failure to obtain or maintain insurance. The limits of the policy usually include expenses and damages in a lump sum. If the limits are exceeded, the problem quickly becomes sticky, but the intent is probably to apportion such expenses.

Educators

More than other professions, teaching is an art even more than it is a science. Volumes have been written on how to teach and more volumes have informed prospective teachers not to pay too much attention to the former. In past years, by and large the teaching colleges and institutions for the training of grammar and high school teachers have been rigidly narrow and unimaginative. It is indeed odd that certification is required to teach at the primary and high school levels, but not in colleges or universities, where some of our best teachers have never taken any teaching courses.

It is rightfully expected that teachers and educational institutions be expected to educate. This is theoretically just, and in days long gone, the teacher was a respected professional who did not have to worry unduly about discipline or the cooperation of parents.

While there has been no general acceptance of educational malpractice as a cause of action, it does not take a soothsayer to see that this attitude will soon change. Negligence and misrepresentation are the two most likely areas for a possible cause of action. In the area of negligence, sports and athletic activities present the greatest danger. As to misrepresentation, the most likely candidates for becoming defendants are the for profit

commercial institutions that imply in their advertising much more than they do or can produce.

Actions for sexual molestation of school children allegedly by their teachers, while justified in many instances, in some cases have turned into witch-hunts where the lives of innocent teachers and other have been ruined because of unreliable testimony of children. It is a difficult problem, especially where parents are sure that their child is telling the truth, without the realization that the very discussion of the problem could cause an impressionable child, or a vindictive one, to respond unreliably to questions concerning sexual molestation. Among other types of suits or actions for injuries resulting from athletic or sports activities are proliferating at an astonishing rate.

The assumption of risk defense, where effective, completely bars a plaintiff's cause of action based on negligence. This doctrine has been severely limited in the jurisdictions that have adopted the doctrine of comparative negligence.

Veterinarians

Lawsuits against veterinarians have increased dramatically in recent years as the numbers of pets have increased. While malpractice claims against veterinarians may be brought for breach of contract, bailment and breach of warranty, most by far, are brought on the basis of negligence.

Recent cases require the veterinarian to have used the standard of care of practitioners on a national rather than a regional basis. The general standard of proof and care do not differ much from the other malpractice suits. Humans can also bring claims for injuries allegedly received from improper handling, care or medical treatment of pets, although coverage for worker related injuries are not usually covered.

PRODUCT LIABILITY MODULE

CHAPTER TEN

INTRODUCING PRODUCT LIABILITY INSURANCE

In 1266 there were enacted specific criminal statutes mandating criminal penalties upon all types of sellers of "corrupt" food and drink products. In the late 1700's, Lloyds of London underwriters would only write insurance for vessels traveling to the Orient if ship owners took important safety precautions such as installing lifeboats. The Medical Practice Act in California in 1876 was passed demonstrating the need for product liability. Over the course of the next three decades, additional professions and vocations were brought under the scrutiny of various state authorities.

Production Liability Claims and State Law

Product liability claims are regulated and resolved under state law. Over the past 30 years, proponents of product liability reform have argued that the current system of resolving product liability claims is expensive for both sides of the law resulting in large costs to manufacturers and sellers of insurance rates that are 10 to 50 times higher than those in other countries.

The Product Liability Reform Act of 1997 was approved by the Senate Committee on Commerce, Science and Transportation to cap punitive damages for both small and large businesses. Then the defendants that are held responsible for non-economic damages can protect sellers from the negligence of a manufacturer.

Product liability insurance provides protection against financial loss arising out of the legal liability incurred by a manufacturer, merchant, or distributor because of injury or damage resulting from the use of a covered product. It also encompasses the liability incurred by a contractor as a result of improperly performed work following job completion. Product liability can be further defined into absolute liability and contingent liability.

Growth of Product Liability Insurance

For a consumer to file a complaint in a product liability case, they must list the particular product and include the manufacturer's consumer service department and president of the company in the original complaint.. With the number of federal agencies in place to protect consumer interests, the topic of product liability and the need for increased insurance coverage rises.

The Consumer Product Safety Commission (CPSC) was set up under the Consumer Product Safety Act of 1972 as a vigilant watchdog of product safety issues. The CPSC can enforce

mandatory standards on consumer products, with civil and criminal penalties including time in jail.

Additionally, it may require product recall, repair, replacement, or refund. Its National Electronic Injury Surveillance System monitors and records hospital emergency rooms across the nation for incidents of product related injuries. Consumers file reports directly with the CPSC, and can petition the CPSC to issue, amend, or revoke a consumer product safety rule. The CPSC must then grant or deny the written request within 120 days. If the petition is to be denied, the CPSC has to publish its rationale in the Federal Register.

Moreover, consumers have the right to appeal the decision in court and can sue the CPSC if it fails to act on a petition with the requisite 120 days.

Types of Product Liability Insurance

Insuring for liability claims can be divided into four basic types; protective liability insurance, joint and several liabilities, strict liability, and vicarious liability.

Protective Product Liability

Protective liability insurance protects against claims that may arise out of the insured's contingent liabilities for the conduct of others, e.g., insurance, which protects member companies from the financial burden of any loss for which a claimant has filed.

Strict Liability Insurance

Strict Liability insurance covers manufacturers and merchandisers who may be subject for defective products sold by them, regardless of fault or negligence. A successful claimant must prove only that the product was defective and therefore unreasonably dangerous when relinquished by the defendant.

Issues of strict liability are product-oriented. The elimination of fault has been a significant advantage to consumers since the fault standard was difficult to prove among several manufacturers and distributors. Many cases of design defects may be termed as strict liability due to the difficulty of proving negligence. In the case of medical devices that are implanted in the body, the question of strict liability for design defect may be the same as that of prescription drugs in many states. Those products such as pacemakers, breast implants, heart valves, and intrauterine devices, if medically needed, could possibly fall under other product liability areas than that of strict liability.

Features Of Product Liability Coverage

Since the risk that the behavior of an individual or manufacturer could result in injury to another person or damage to someone's property is valid, it is understandable that one is responsible for the results of one's behavior.

Liability risk has no maximum predictable limit. Large liability suits and judgments won for claimants could take all the valuable assets of an individual or manufacturer along with their insurance policies. The minimum product liability insurance recommendation may be adjusted based upon what is available to the individual/manufacturer, the lifestyle, and public profile.

Product Liability Premiums

Product liability premiums are based on the extent of the product range, previous liability history, and the size of the business product line. Any setting of premium would require an inventory of products and product lines as well as the types of products by the insurer in order to determine the premium rates appropriate for the amount of risk. Previous history of product liability would also be important to consider.

Litigating product liability claims is increasing manufacturers and retailers to pay higher insurance premiums to produce and market their products. Higher premiums directly affect manufacturer profits and investments where the savings in a reduction in premiums could be utilized to promote products and services.

Types of Product Liability Insurance

The difference between product liability insurance and other types of liability insurance is that product liability insurance is based on a defect-based liability principle instead of fault-based liability principle. Product liability coverage is defined as that insurance which covers the policyholder's liability for occurrences resulting from actual or alleged defects arising from the handling, use or existence of any condition in goods or products manufactured, sold, or distributed by the manufacturer after the products have been delivered to the buyer. Additionally, it covers accidents resulting from the misdelivery of products.

Product Liability Insurance

Product liability insurance covers the legal liability resulting from injuries to persons or damage to their property. Product liability insurance then, protects individuals and manufacturers up to a specified amount under the terms and statutes of state and federal law.

Contingent Liability

Liability for damages arising out of the acts or omissions of others, who are not employees or agents of the entity held liable. Liability is difficult to quantify, or which may or may not come to pass, such as an outstanding lawsuit. Contingent liability is the possibility of an obligation to pay certain sums dependent on future events. Contingent liability is also defined obligations by a company that must be met, but the probability of payment is minimal.

Absolute Liability

Liability arising from extremely dangerous situations or operations, under which the party responsible for those operations is liable, without exception or excuse, for virtually all resulting harm. Absolute liability may be imposed simply because an accident happens, regardless of whether one can actually be determined at fault. Absolute liability is a type of liability that arises from extremely dangerous operations. An example would be in the use of explosives: A contractor would almost certainly be liable for damages caused by vibrations of the earth following an explosive detonation. With absolute liability it is usually not necessary for a claimant to establish that the operation is dangerous.

Strict Liability

Strict liability constitutes the primary basis for liability of manufacturers of products. Three basic arguments are given to support the premise that manufacturers should be held strictly liable for defects in their products. First is the notion that sellers of defective products, rather than purchasers, should bear the cost of compensating victims for the injuries sustained from defective products. Proponent

Secondly, it is thought that sellers should be made to internalize the cost of any injuries their products inflict, forcing them to incorporate the cost of liability into the product itself and thereby increasing the market cost of the product. The third argument encompasses the idea that the complexity of today's products precludes the average consumer from pinpointing the act of negligence responsible for subsequent injuries incurred from defective products.

Clinical Trials Liability

Product liability insurance may also be required for clinical trials. During the testing of certain medical devices and procedures, liability resulting directly from study results may be at issue. Clients who must defend the integrity of a product, whether pharmaceutical, industrial, or medical, require insurance to defend against challenges to design and manufacturing. Product liability must also cover issues of regulatory compliance, preventative practices, and indemnity agreements.

Non-Economic Damages Liability

Currently, the trend is for the elimination of joint liability for non-economic damages, such as pain and suffering or emotional distress. In a product liability action involving more than one defendant, each defendant's liability for non-economic damages would be limited to the defendant's percentage of responsibility for the harm.

Liability for Rented or Leased Products

Recommendations by the Senate Commerce Committee have allowed that businesses that rent or lease products should be subject to the same rights and responsibilities as product manufacturers with respect to product liability actions. The product liability insurance sellers would be liable for these products though not the harms caused by others using the products in an unsafe manner.

Time Limitations on Liability

The requirement regarding two-year statute of limitations for filing product liability complaints begins when the claimant discovers or should have reasonably discovered the harm and its cause. A 20-year statute of repose for workplace durable goods (products used in the workplace with an economic life or greater than 3 years) should not be brought for harm caused by a product more than 20 years after delivery of the product. Manufacturers could be held liable under a product liability policy only if the guarantee of its product's safety was listed to be 20 years or greater in duration.

Liability Reduction

A product liability insurance policy would not be held responsible for the entire insured amount of liability in the event that there was evidence of misuse or alteration of a product. A defendant's liability would be reduced in proportion to the amount of harm attributable to misuse or alteration of the product.

Punitive Damages and Bifurcation

The current federal standard for punitive damages limits the damages to three times the amount of economic damages or $250,000, whichever is greater. It is possible for the punitive damages phase of a product liability proceeding to occur separately from the proceedings on economic/compensatory damages. Evidence involving punitive damages would be inadmissible in the initial procedure regarding the final determination of liability.

Excessive Liability

Once negligence has been determined, there must be actual damage or a loss as a result of the negligence. In most cases this is measured by the actual monetary loss suffered by the injured party. When one suffers a bodily injury as a result of negligence of another, the injured party may sue for compensatory payments and for specific damages such as medical expenses and loss of income. These damages are straight forward, but the injured party may also ask for general damages to compensate for the intangible losses resulting from pain and suffering, disfigurement, mental anguish and loss of consortium. The monetary value of these losses is more subjective. Punitive damages, the third form of damages that may be assessed against the negligent parties, are a form of punishment. An

injury to a party from gross negligence or willful intent is likely to result in sustainable claims for all three types: specific, general, and punitive damages.

Most often, the burden of negligence is on the injured party, but if one breaks the law and causes an injury, it may be referred to as "negligence per se". The injured party then might not have to prove negligence. The fact that the law was broken would be sufficient to establish negligence.

Comprehensive Personal Product Liability Insurance

Comprehensive personal liability coverage can be acquired by purchasing a separate comprehensive liability policy or by purchasing a rider on an individual homeowner policy. A property casualty insurance agent will tailor the policy for the personal circumstances. Under this type of policy, the insurance company would register to pay, up to the limits of liability set in the policy, all payments that become the insured's legal obligation because of bodily injury or property damage falling within the scope of the coverage provided by the policy.

Under a personal comprehensive liability policy are the insured, relatives who are residents of the household, and any other person under age 21 who is in the care of the resident of the household. The policy would pay all medical expenses, including funeral expenses, incurred by persons who are injured while on the premises with the permission of any insured, or injured away from the premises if injury results from activity of an insured or member or the insured's family.

CHAPTER ELEVEN

MANUFACTURING AND PRODUCTS/SERVICES

Product Defects

A defect does not include merely the lack of quality of a product, but infers the lack of safety in the product that may cause injury to body, life, or property. A defect in design can be judged in three separate views with regard to the lack of safety that the product normally should provide.

- The nature of the product;
- The ordinarily foreseeable use of the product;
- The time when the manufacturer delivered the product.

Product Nature

Representation of the product with accompanying instructions, warnings, etc. is combined with effectiveness and usefulness of the product along with its cost and effect. Moreover, the probability of occurrence of accident and its extent with the ordinary use period and durable period of the product are all to be considered when writing up a policy for product liability insurance.

Foreseeable Product Use

This includes the circumstances concerning use of the product including such factors as reasonable use of the product, and the possibility of preventing damage from occurring by the primary product user. In practice, the courts have determined generally that under the theory of negligence, a manufacturer must warn only of foreseeable dangers and the liability will not be attributed to those injuries resulting from product use and any harmful effects of which no trained or educated foresight could have predetermined.

Additionally, the foreseeable use of a product implies use in the manner the manufacturer intended. However, the misuse of a product does not ultimately bar liability recovery if the misuse could have been foreseeable. Moreover, the duty to warn though foreseeable, must be balanced against the cost of preventing the greater increase of risk. In fact, strict liability has frequently been excused in duty to warn when the manufacturer could not have reasonably anticipated the dangers inherent in a product, or been aware through reasonable skill and foresight of a usage.

For example, in the case of asbestos, the manufacturer of products containing asbestos had no duty to warn of the risk of using such products due to asbestos content since the risk was unknown at the time the products were marketed.

Manufacturer Delivery Time

This third lack of safety view includes the circumstances when the manufacturer delivered the product. The situation at the time the product was delivered to the buyer and the technological capabilities, including the state-of-the-art safety regulations and alternative design possibilities in place at the time of the product delivery.

Design Defects

Faulty fabrication, assemble, or quality control are manufacturing defects which may or may not be obvious. A manufacturing defect is the result of a production flaw on what would normally be a safe product. The key issue in a design defect case is whether the manufacturer utilized a design that posed an unreasonable danger to the plaintiff in light of the availability of another safer design.

A defect caused by an erroneous primary design and/or the accompanying design of a component part of a product is known as a design defect. A design defect may be present even in a perfectly manufactured product with the best materials and no accompanying breakdown in either the product's manufacture or use. A design defect is not self-evident. A design defect arises when a product is marketed in its original condition, but nevertheless causes injury to a user during the use for which it was intended.

The Restatement (Second) of Torts 402A states that "a product is defectively designed if it is unreasonably dangerous for its intended use." The courts are left to decide what is reasonable and if the product was used for that which it was intended. Restatement (Second) of Torts 402A further defines that the "unreasonably dangerous" condition depends on the "reasonable expectations" of the user.

As defined legally, a sale is the passing of title from the seller to the purchaser for a price. A common guideline merely holds that it is foreseeable that one could have sustained injury as a result of a defect, in order to recover damages. Any design defect brought into a product liability action by the purchaser must fall into one of three categories: 1) structural defects; 2) lack of safety features; and 3) misuse of product.

Structural Defects

A structural defect exists when the defendant's materials choice results in a structural weakness causing the product to be inherently dangerous. A chair that collapses when anyone of greater than average weight sits on it may be structurally defective. The

manufacturer, however, is not required to build a chair that is invincible, only that it is reasonably safe for the average user.

Safety Features

In the event that a product is found to lack safety features, the question of cost is raised. If the cost to provide added safety to the purchaser is minimal and not incorporated, then the product may be considered defective. If a similar product has a substantially reduced element of hazard and has provided the added safety feature, then the manufacturer would, by comparison, be viewed as negligent. If a defendant claims that their product is as safe as the competition, and the entire industry is negligent with respect to safety, then the courts will most likely find for the plaintiff.

Foreseeable Misuse

The most common foreseeable misuse actions center on the production of "crashworthy" or defective vehicles. If a similar product has a substantially reduced element of hazard and has provided the added safety feature, then the manufacturer would, by comparison, be viewed as negligent. If a defendant claims that their product is as safe as the competition and the entire industry is negligent with respect to a specific product, then the product liability claim by an injured purchaser will most likely be upheld in most jurisdictions.

Design Alternatives

Considering the test of design alternative, a manufacturer is held under strict liability for damage or injury caused by a product if it were possible to design a safer product and an average consumer would agree that the manufacturer should have utilized that design. In order for this claim to work, a suit must show that the magnitude of the product's danger outweighed the costs of avoiding the danger. In court, the newer design would have to meet multiple criteria compared with the original design and proof of improved design could only be cited by expert testimony.

Manufacturing Defects

A defect in production caused by an assembly line error is called a manufacturing defect. Such defects caused by poor quality control may go undetected through faulty inspection practices and testing performed by the manufacturer and seller.

Warning Defects

Warning defects generally involve a written communication regarding a product's use. If a product has no accompanying warning to aid the consumer as to the correct use of the product, it may render the product unsafe. This lack of written warning has been called a warning defect since it causes a product's utility to be unreasonably dangerous. Warning defects are frequently combined with manufacturer design defects since they share similar characteristics. For instance, a warning defect, as a

design defect can apply to an entire line of products rather than a spurious one or two sample.

Misrepresentation

The seller of a product may be liable for the misrepresentation of a product's characteristics and capabilities even if no defect exists. Since the representation itself affects one's basis of purchase, the standard of implied expectation is inaccurate. The product defect is the misrepresentation itself.

Risk-Utility Analysis

Risk-Utility is best understood as essentially the same as risk benefit. The liability is phrased in terms of whether the cost of making a safer product is greater or less than the risk or danger from the product in its present condition. With regard to a test for defectiveness, risk/utility analysis is used as a comparison yardstick of the cost of making a particular product safer, against the risk of injury present if safety measures are not implemented.

If it is determined that the cost of safety is less than the risk of injury, the benefit of changing the product to make it safer outweighs the accompanying cost and the unchanged product is proclaimed defective. If the risk is thought to be minimal compared to the cost of re-designing the product, then the unchanged product is not deemed defective. Understanding Risk-Utility can greatly benefit a company in understanding the exposure faced within the manufacture of a product or service. Seven factors commonly considered by the judiciary in their risk/utility analysis include:

- The usefulness and desirability of the product;
- The likelihood and probable seriousness of injury from the product;
- The availability of a substitute product that would meet the same need;
- The manufacturer's ability to eliminate the danger without impairing usefulness;
- The user's ability to avoid danger;
- The user's anticipated awareness of the danger;
- The feasibility of spreading the risk of loss by pricing or insurance.

Wear and Tear

Another related area not usually considered pertinent by the courts as falling into strict liability is the area of wear and tear of a product. If an accident occurs due to the failure of a product after its useful lifetime, then the onus fails on the user in these cases. Only when the reasonable life expectancy has been ascertained, the length of time and conditions under which the product was used, maintenance considerations, and possible time warranties or warnings considered that a product liability action could be possible.

Unavoidably Unsafe Products

Those products that are incapable of being made safe for their intended and ordinary use are frequently deemed unavoidably unsafe products. The current trend in judicial decisions is that if the benefits of such products outweigh the risks of such products, then the manufacturers will not be held strictly liable for hazards experienced by purchasers. For example, experimental drugs are the epitome of unavoidably unsafe products. Due to lack of supporting research data these products are inherently filled with the potential for harm or good.

Those manufacturers that sell these products cannot assure their complete safety due to lack of medical research and study experience. Therefore, the manufacturers cannot be held strictly liable for any potential harm resulting from their use if they market the drugs clearly and provide sufficient warnings. If the manufacturer is found negligent in failing to perform adequate testing prior to selling the drugs, a claimant can recover for negligence.

Unreasonably Dangerous Products

Unreasonable dangerous" has been defined as that "to an extent that which would be contemplated by a typical (ventilators) equipment technician who knew about the characteristics of the product, as those characteristics are commonly understood by similar personnel." More precisely, the comparative standard was not what the plaintiff knew, but those individuals of the worker's craft, education level, training, and experience. Three factors to be considered in determining unreasonably dangerous products include:

- social utility and desirability;
- presence or absence of adequate warnings;
- obvious or latent nature of the defect.

It must be added that even the best warnings and highest level of usefulness does not absolve a manufacturer from liability where the risk of danger could have been reduced without significant impact on the product's effectiveness and manufacturing cost.

Some advocates of proving unreasonable danger maintain that alternative designs may be safer than those marketed and attempt to influence the manufacturing process by implying that the product liability risk would be lower by changing business practices.

The Restatement (Second) of Torts proposes a test of sorts in order to determine whether a product is unreasonably dangerous. A risk-benefit test that holds that a product may be found defectively designed if either of two alternative conditions is met:

- If the product failed to perform as safely as one would expect;
- The product causes injury and the defendant fails to establish, relevant factors that the benefits of the design outweigh the inherent risk.

It has been found that an unreasonably dangerous product's utility when used in the manner intended may outweigh the accompanying risk known. In fact, the associated liability of a product may affect an otherwise beneficial product's availability, cost, and insurability. The manufacturer would be forced to defer research or marketing to the general detriment of the consumer.

Warnings Liability

Inadequate instructions or warnings describing a potential for danger must be specific enough for the general consumer to understand and heed in order to avoid the danger or possible injury described. The liability that is derived from poor illustrative information of the potential for danger can be just as damaging to a manufacturer during product liability litigation as a defective product itself.

Defective Warnings

The absence of a warning regarding the potential hazards of a product may also present the background for a defective product claim. In determining the quality of the product warning, courts examine the likely number and severity of accidents that may have been avoided by a more complete or understandable warning. The court then assesses these components against the difficulty of issuing pertinent warnings or instructions.

Duty to Warn

The duty to warn of any dangerous properties of a product applies to any individual whom the manufacturer or distributor might reasonably expect might use or consume the product or be endangered by its use including customers, users, consumers, and handlers of the product. In some cases, this would apply to any that might conceivably come in contact with the product at any stage in production or after delivery.

Any product liability action based on duty to properly warn may be brought in negligence or strict liability, but the difference appears to be that in strict liability, there is no requirement of proof of fault that conversely would be an integral part of any negligence case. However, while a manufacturer has a duty to warn of dangerous

properties of a product, there is not such duty to warn of product conditions that are open and obvious to even the most careless users.

However, it is commonly thought that when a product is well designed or manufactured and the potential for injury occurs from a dangerous property of the product that is open and obvious, there is no duty to warn about the danger in the product use. This knowledge is thought to be common to all users of a product or to a specific industry, profession, or group of which one injured may belong.

Negligence

Negligence encircles unintentionally caused harms that create a degree of unreasonable risk to another. Unlike strict liability, the analysis of the issues in a negligence claim are similar to being conduct-oriented. In negligence, the reasonableness of a manufacturer's product package with a suitable warning comes into play. In a strict liability case, the dangerous situation of a product that is sold without a warning is the distinction from negligence. In negligence, a manufacturer must test sufficiently in order to determine any potential latent design defects and if any are discovered then the manufacturer has the obligation to properly warn the consumer or end user of any dangers discovered.

Adequacy of Warning

It is well accepted throughout the business and manufacturing communities that the duty to warn of latent, inherent, production, or design dangers is a necessary component of doing business. The large number of product liability actions are not based on the need for a warning, but rather that the provided warning was specific enough to apprise the consumer or user of a dangerous product in a particular set of circumstances.

A sufficient warning has been found to describe:

- Being in simple language such as to catch the attention of a reasonable person in the course of the product's ordinary and expected use.
- Contain international symbols for those who cannot read or understand beyond a rudimentary level or cannot read or understand English.
- Having within the warning's content such comprehensible text such that the user is cognizant of the nature and extent of any danger to a reasonable and average person.
- The warning must be conspicuous.
- The risk of harm must be communicated beyond the normal hazardous operations inherent in the normal use of the product.
- Warnings must be comprehensive and detail all possible known dangers.

Liability of Vendors or Other Suppliers

A seller of a product is equally responsible in strict liability with the manufacturer for injury incurred by a defective and dangerous product, used correctly or consumed as the product manufacturer. This is especially important if the product was reconstructed or changed by the vendor without the express knowledge of the manufacturer. Vendor liability may be examined on warranty, negligence, or strict liability.

Suppliers And Users of Component Parts

A supplier may not be the vendor who sold the product to the plaintiff. With the complicated interrelated commerce in existence today, the supplier may be any one of a number of steps between the manufacturer and distributor. A manufacturer who uses component parts made by others may be liable if reasonable care is not taken in the manufacture or inspection of the component part. With products the center of such intricate relationships, the liability of suppliers is equally complicated involving holding corporations and their subsidiaries.

The trend through the Uniform Products Liability Act (1979) and more recently the Product Liability Reform Act (1997) has been to limit the liability a vendor may be responsible for through the distribution of a product that has been determined to contain a manufacturer's design defect. Protection against liability for vendors has also been strongly supported by states in favor of limiting liability for vendors in the products manufactured by others.

Retailers

A manufacturer is liable if a retailer fails to perform an obligatory inspection. If however, the retailer is made aware of a defect by inspection or some other means and fails to warn the purchaser, the courts have declared the chain of causation to be broken and have cleared the manufacturer of any liability. Commonly, retailers are not required to inspect products unless a hazard is suspected. A manufacturer is liable if a retailer fails to perform an obligatory inspection. If the retailer is made aware of a defect by inspection or some other means and fails to warn the purchaser, the courts have declared the chain of causation to be broken and have cleared the manufacturer of any liability.

Lessors, Real Estate Agents, and Sellers of Services

Lessors of products may also be liable in negligence for failing to discover defects. Rental companies that rent farm equipment, for example, may be found liable for leasing defective tractors. Real estate agents, as well as, service suppliers such as providers of blood transfusions, may also be found negligent.

Products/Services

Vehicles

Design defects in vehicles frequently come under the heading, "lemon law" liability. All lemons, whether due to poor design or poor quality control on the assembly line can increase a manufacturer's risk of liability from injury. If the defect was due to an assembly line error, one vehicle or many may be defective depending on how long the design or assembly defect went unnoticed and undetected. If the defect was in the design, all the vehicles of that make and model would be defective.

"Crashworthiness" is the singular term used for design defect in the event the product is a vehicle. It is a slang term applied to the ability to protect vehicle occupants from injuries or aggravation of injuries due to a "second impact" immediately following an accident.

Injury or impact are terms used to describe injuries that have been caused or increased by a failure in the design of a vehicle, after an initial accident has occurred. Some injuries may not have occurred except for some design defect which contributed to the severity of the subsequent injuries. Such defects increase the uncrashworthiness of a vehicle and may contribute to product liability actions against the manufacturer, distributor, or seller.

Even in the states where the use of seat belts is mandatory, juries have decided both ways as to the admissibility of evidence in "crashworthiness" decisions. It is thought that a manufacturer that provides safety devices should not be punished for an occupant not using the provided safety devices. This use of safety devices has also been used as a defense on contributory negligence, proximate cause, and other defenses.

Finally, it has become the common thread of product liability cases involving vehicles that the automobile manufacturer upholds a duty to design a vehicle that will not irritate the injuries of an occupant in the event of an accident.

Lemon Laws

Lemons are of two types with the first type being the automobile with known defects, as a constant source of problems for their owners. This type generates a continuing flow of necessary repairs, some minor and some more serious of which some can be fixed and others never adequately resolved.

The second type of lemon has defects that are relatively undetectable such as an exhaust leak but are rarely found to be the cause of accidents, but thought to be a result of driver error. Unfortunately, police and insurance investigators are not equipped to detect and evaluate such vehicle failures since the damage to the wrecked vehicle makes thorough testing impossible. I

Many states define a lemon as an automobile that requires three or four repair attempts for the same problem, or that has been out of service for thirty days with the first year or 12,000 miles of the warranty period. The defect or condition must significantly impair the value, use, or safety of the vehicle; that is, minor cosmetic flaws such as broken radio knobs, do not qualify. In a few states, one repair for a safety related problem qualifies for relief under the lemon law.

All automobiles deemed lemons, whatever the cause, come from a common source, poor design and assembly by automobile manufacturers or manufacturers of component parts. Whether insufficient design or minimal quality control on the assembly line, either defect can produce a lemon. If the defect is due to an assembly line error, one automobile or hundreds may be defective depending on the number of automobiles manufactured before the defect was observed and corrected. The complexity of modern automobiles yields some explanation for the number of defects and assembly errors encountered across the nation, but cost cutting to meet foreign competition throughout the industry can be brought into the discussion as well.

Lemon laws serve to point out the intrinsic necessity of vehicle safety within a vehicle's basic design as well as the manufacturer and assembly of component parts. Several states have enacted legislation giving the consumer the right to sue when a new or used car they purchased turns out to be defective or a "lemon".

If the car does not meet the terms of the written warranty, and the purchaser is still having problems with the vehicle after a reasonable number of repair tries by the manufacturer or dealer during the earlier of the first 18,000 miles or two years, the purchaser may receive a full refund or a replacement vehicle of comparable value. Loss of the vehicle (out of service) for a cumulative total of thirty days within a two-year or 18,000 mile period also qualifies under the law. A used vehicle is also included under this law if:

- It was purchased, leased, or transferred after the earlier of a) 18,000 miles of operation or b) two years from the date of original delivery;
- It had a purchase price or lease value of at least $1,500; and
- It had been driven less than 100,000 miles at the time of purchase;
- It is primarily used for personal purposes.

The Used Car Lemon Law requires the dealer to provide the consumer with a written warranty stating the dealer must repair, free of charge, any defects in certain specified covered parts. If the one continues to have problems after repair attempts have failed, one is entitled to a full refund. The warranty period on a covered used car is based on the mileage at the time of purchase or lease.

Defective vehicles are a substantial area of concern for product liability insurers as thousands of complaints are sent to the National Highway Traffic Safety Administration every year. The number of lemons brought back through manufacturer arbitration and the courts yielded 15,000 cars in 1988 and the number was deemed inaccurate due to the number of faulty cars that are merely traded in. The Center for Auto Safety estimates that automobile manufacturers turn out at least 50,000 lemons each year. The total cost to manufacturers, consumers, courts, state and federal processes, and the taxpayer easily reaches into the billions of dollars.

Appliances

The number of small appliances that contribute to consumer dissatisfaction is probably affected by the willingness of the consumer to report minor product defects and the cost of bringing legal action against a manufacturer who will not stand behind a faulty product. In the case of an item that originally costs less than $50, it is unlikely that the consumer would file a product liability action unless physical harm resulted from a poorly designed appliance.

Generally, poor performance claims are either handled by the manufacturer under warranty or guarantee, or given up as a bad investment by the purchaser. It is only when the cost of the product is substantial and demands restitution or when an injury results from a defective product that a consumer will seek relief through litigation for the purchase cost of the product and medical fees.

CHAPTER TWELVE

PRODUCT LIABILITY LAWS

The federal tort reform movement began in the 1970s, sparked by an explosion of liability litigation that precipitated an insurance crisis for businesses. Throughout the ensuing years the number of civil cases filed in federal courts increased eleven-fold. At the same time, state courts narrowed traditional legal defenses and jury awards skyrocketed.

Studies have shown that 87% of manufacturers will become defendants in a product liability suit at least once. As a result of the high costs of facing liability lawsuits:

- 47% of U.S. manufacturers have withdrawn products from the market;
- 39% have deliberately not introduced new products;
- 25% have discontinued product research;
- 8% have actually closed plants and eliminated crucial American jobs.

Many states have adopted some form of tort reform legislation in an effort to stem the growing tide of litigation and its damaging consequences. Measures taken include limits on lawsuits, residual market mechanisms or alternative dispute resolution systems.

Liability Reform Bills

Dozens of product liability reform bills have been introduced in the U.S. Congress since the mid-1970s. Most have included provisions to standardize product liability laws nationwide, restrict punitive damages and clarify manufacturers' liabilities. Although none has become law yet, revisions and compromises reached during each successive Congress have gained the support of more cosponsors and brought reform closer to reality.

The Restatement (Third) of Torts: Product Liability

The American Law Institute adopted the final version in November of 1997 of its restatement of law that fundamentally changes how many courts approach product liability cases since much of today's product liability law originated from a single section of the Institute's 1964 restatement of torts. The Restatement (Third) of Torts: Product Liability offers new methods to approach historically problematic issues in products liability law including liability for prescription drugs and medical devices.

The restatement has replaced the original product liability section with a code of 21 sections or rules addressing a variety of topics from the post-sale duty-to-warn to corporate successor liability. The new restatement distinguishes prescription drugs and medical devices from all other products. The restatement retains the traditional structure of liability for drugs and devices, that is claimant's must base claims on alleged defects in design, manufacturing, or warnings. It also provides additional comprehensive and detailed liability standards that currently exist in most states.

The Restatement (Third) of Torts states: "Product Liability is not law and therefore not binding until states choose to adopt its provisions, it is however a significant compromise from a variety of consumer, manufacturing, and academic interests." While the final outcome of the restatement may take many years to determine its effectiveness to drug and device manufacturers as well as the public, it is sure to provide immediate changes in defense methods in drug and device product liability litigation.

Design Defects

In the case of design defect claims for drugs and medical devices, The Restatement (Third) of Torts: Product Liability veers significantly from current law in that it is considerably more precise and defines the manufacturer's defense of a product defect in more accurate terms. The Restatement (Third) of Torts does away with comment k and instead assumes safe and adequate drug or device design unless the claimant can establish that the drug or device is so unsafe that no physician should prescribe it for any category of patients.

Drugs and devices under the third restatement are defectively designed only when "the foreseeable risks of harm posed by the drug or medical device are sufficiently great in relation to its foreseeable therapeutic benefits that reasonable health care providers, knowing of such foreseeable risks and therapeutic benefits, would not prescribe the drug or medical device for any class of patients".

The greater burden is upon the claimant to prove that a large portion of the medical community would stop prescribing a drug or device if they found it to be unsafe. The manufacturer then, would only have to show the greater number of informed health care providers prescribe the drug or device with confidence to negate the claimant's case under the Restatement (Third) of Torts. This line of reasoning creates a very difficult standard and makes the prosecution of product liability for design defects less likely except under highly unusual circumstances.

Liability For Warnings

The Restatement (Third) of Torts: Product Liability provides for the manufacturer to warn physicians and other health care providers, who are in a position to diminish the risks of harm from a drug or device, of the foreseeable risks of the drug or device. Three

exceptions where the health-care provider's ability to counsel a drug or device recipient may be compromised are:

- Mass inoculations;
- Where FDA requires direct patient warnings;
- Where the manufacturers have advertised the drug or device in mass media.

In these instances, the manufacturer's duty to warn goes directly to the patient. The inherent problem with the mass media marketing of prescription drugs and devices directly to the patient is that the manufacturer's illustrations and warnings will be interpreted at the patient level and not the physician's or other health care provider for contraindications.

Manufacturing Defects

Any significant deviation from design specifications in a drug or device that causes the patient injury can be imposed as a manufacturer defect under restatement liability. Unlike the design and warnings claims, the rule of liability for manufacturing defects is the same for drugs and devices as for all products. Liability for manufacturing defects falls under "strict" liability in that liability is imposed without regard to manufacturer conduct. Liability for design or warnings claims is determined under negligence standards. Litigation involving manufacturing liability for drugs and devices has historically been less of an issue than that of design defects.

Statute of Limitations

In order to determine the statute of limitations in a product liability action, the manufacturer must appraise how long the purchaser has owned or been affected by the injurious product as well as the date when the product left the manufacturer. The Uniform Commercial Code's statute of limitations, which usually applies to breach of warranty cases, gives the claimant four years from the time of the sale of the product for legal action. Dissimilar to statute of limitations, which initiates at the time of injury, a statute of repose begins to run at the date of sale. Since the majority of injuries from defective products or negligence occur within five years of purchase, statutes of repose have very little effect on most claims.

Nutrition Labeling and Education Act of 1990

Under the auspices of the Food and Drug Administration of the Department of Health and Human Services and the Food Safety and Inspection Service of the U. S. Department of Agriculture, the food label has been amended to offer a wide variety of nutritional information. Currently food labels include:

- Claims regarding the relationship between a nutrient and food and a disease or health-related condition;

- Distinctive, easy-to-read formats for the information of consumers;
- Information on total percentage of juice in juice drinks.
- Nutrient reference values, expressed as % Daily Values of an overall daily diet;
- Nutrition information on nearly every food in the grocery store;
- Standardized serving sizes;
- Uniform definitions for terms that describe a food's nutrient content.

The above changes in food labels to increase consumer information and avoid product liability actions are included in the final rules published in the Federal Register in 1992 and 1993. The FDA's rules implement the provisions of the Nutrition Labeling and Education Act of 1990 (NLEA) which require nutrition labeling for most foods except meat and poultry and authorizes the use of nutrient content claims and approved FDA health claims. Meat and poultry products are regulated by United State Department of Agriculture, which closely follow the FDA rules of the NLEA.

Under the Nutrition Labeling and Education Act of 1990, nutrition labeling is required for most foods. Moreover, voluntary nutrition information is available under the FDA's voluntary point-of-purchase nutrition information program for many raw foods such as the twenty most frequently eaten raw fruits, vegetables, fish and 45 most popular cuts of meat under the USDA program. This voluntary FDA program for raw produce and fish carries a significant incentive for retailers to participate. The program will remain voluntary only if at least 60% of retailers participate, otherwise the information required will become mandatory.

Nutrition Information Panel

Under the label's "Nutrition Facts" panel, manufacturers are required to provide information on certain nutrients. If a claim is made about any of the optional components, or if a food is fortified or enriched with any nutritionally significant components, the nutritional information for these components becomes mandatory.

Nutrition Panel Format

All nutrients must be declared as percentages of the Daily Values which are label reference values. The amount, in grams or milligrams, of macronutrients (such as fat, cholesterol, sodium, carbohydrates, and protein) are listed to the immediate right of these nutrients and a column headed % Daily Value" appears on the far right side. Declaring nutrients as a percentage of the Daily Values is intended to clarify comparisons that arise with quantitative values.

For instance, a food with 140 milligrams (mg) of sodium could be mistaken for a high-sodium food because 140 is a relatively large number. However, that amount represents less than 6% of the Daily Value for sodium, which is 2,400 mg. Moreover, a food with 5 g of saturated fat may be construed as being low in that nutrient when in

reality that food would provide one-fourth the total Daily Value because 20 g is the Daily Value for saturated fat.

Daily Values--DRVs

The new label reference value, Daily Value, comprises two sets of dietary standards: Daily Reference Values (DRVs) and Reference Daily Intakes (RDIs). Only the Daily Value term appears on the label, though, to make label reading less confusing.

DRVs have been established for macronutrients that are sources of energy: fat, saturated fat, total carbohydrate (including fiber), and protein; and for cholesterol, sodium and potassium, which do not contribute calories. DRVs for the energy-producing nutrients are based on the number of calories consumed per day. A daily intake of 2,000 calories has been established as the reference.

Nutrition Labeling--Exemptions

Under NLEA, some foods receive exemptions from nutrition labeling. Under 1993 amendments to the NLEA, food produced by small businesses with fewer than 100 full-time equivalent employees may claim an exemption for food products that have U.S. sales of fewer than 100,000 units annually. Companies claiming this exemption must notify the FDA that they meet the exemption criteria before marketing their products. U.S. companies, other than importers, with fewer than 10 full-time equivalent employees and selling fewer than 10,000 units of a food in a year are also exempt and do not need to notify the FDA. Also exempt are retailers with annual gross sales in the United States of less than $500,000 or with annual gross sales of food to consumers in the United States of less than $50,000.

Although certain foods may be exempt, they may carry nutrition information as long as it complies with regulations. However, these foods will lose their exemption if their labels carry a nutrient content or health claim or any other nutrition information.

Nutrition information concerning game meats such as deer, bison, rabbit, quail, wild turkey, and ostrich is not required on individual packages. Rather, it can be provided on counter cards, signs, or other point-of-purchase materials. Because few nutrient data exist for these foods, the FDA permits this exemption to enable game meat producers to give priority to gathering appropriate data and updating pertinent nutritional information as it becomes available.

Health Claims

Under FDA regulations, nutritional claims for ten connections between a nutrient or a food and the risk of a disease or health-related condition are now allowed. They may be issued in various ways: through third-party references such as the National Cancer Institute, statements, symbols, and summaries or descriptions. The claim must meet

requirements for authorized health claims. They may not state the degree of risk reduction and can only use "may" or "might" in referring to the nutrient or food-disease relationship. Additionally, the involvement of other factors in the risk for that disease must be acknowledged and the claims must be stated such that consumers can understand the relationship between the nutrient and the disease within a daily diet. An example of a possible claim might be: "While many factors affect the risk of heart disease, diets low in saturated fat and cholesterol may reduce the risk of this disease."

The allowed nutrient-disease relationship claims and rules for their use are illustrated below.

Calcium and osteoporosis: To carry this claim, a food must contain 20% or more of the Daily Value for calcium (200mg) per serving, have a calcium content that equals or exceeds the food's content of phosphorus, and contain a form of calcium that can be readily absorbed and used in the body. The claim must also mention the target group and list the need of adequate calcium intakes.

Fat and cancer: To meet the requirements for this claim, a food must meet the nutrient claim requirements for "low-fat" or, if fish and game meats, for "extra-lean".

Saturated fat and cholesterol and coronary heart disease: This claim may be used if the food meets the definitions for the nutrient content claim "low saturated fat", "low-cholesterol," and "low-fat" or if fish and game meats, for "extra-lean." The link between lower intakes of saturated fat and cholesterol and reduced risk of coronary heart disease may be mentioned.

Fiber-containing grain products, fruits and vegetables and cancer: To make this claim, a food must be or must contain a grain product, fruit or vegetable and meet the nutrient content claim requirements for "low-fat", and without fortification be a "good source" of dietary fiber.

Fruits, vegetables and grain products that contain fiber and risk of coronary heart disease: To carry this claim, a food must be or must contain fruits, vegetables and grain products. It must also meet nutrient requirements for "low saturated fat", "low cholesterol," and "low-fat" and contain, without fortification, at least 0.6 g soluble fiber per serving.

Sodium and high blood pressure: to make this claim, a food must meet the nutrient content claim requirements for "low-sodium."

Fruits and vegetables and cancer: this claim may be made for fruits and vegetables that meet the nutrient content claim for "low-fat" and without fortification contain dietary fiber or vitamins A or C.

Folic acid and neural tube defects: This claim is allowed on dietary supplements that contain sufficient folate and on natural foods that contain folate, as long as they do not provide more than 100% of the Daily Value for vitamin A as retinol or performed vitamin A or vitamin D.

Dietary sugar alcohols and dental caries (cavities): This claim pertains to food products, such as candy or gum, containing the sugar alcohols xylitol, sorbitol, mannitol, maltitol, isomalt, lactitol, hydrogenated starch hydrolysates, hydrogenated glucose syrups, or a combination of any of these. If the food also contains a fermentable carbohydrate, such as sugar, the food cannot lower the pH of plaque in the mouth below 5.7.

Soluble fiber from certain foods, such as whole oats and psyllium seed husk, and heart disease: This claim must state that the fiber also needs to be part of a diet low in saturated fat and cholesterol, and the food must provide sufficient soluble fiber. The amount of soluble fiber in a serving of the food must be listed on the Nutrition Facts panel.

National Tracking System

A tracking system of consumer product reports is maintained in FDA national headquarters. Reports from across the nation regarding baby food, prescription drug reactions, illness, injury, or life-threatening circumstances are sent to FDA headquarters. Over 22 cents per consumer dollar spent goes toward FDA regulated products. With the FDA inspecting more than 90,000 food, drug, and other manufacturers and facilities per year, this amounts to more than $700 billion. During the course of product reviews, the FDA routinely collects product samples from manufacturers, producers, supermarkets, drugstores, importers, and others to check quality, safety, and labeling.

In some cases, product reports do not reflect a risk of illness or injury. The information from the consumer report is forwarded to the FDA district where the manufacturer is located and is used as data upon which to base a more in-depth inspection at the next regularly scheduled check period. Top priority is given to products such as swollen cans of various food products, an unexpected drug reaction, a medical device defect or product mislabeling that may have caused serious illness, injury, or death. In the event of consumer injury or death from a product, all background information on a manufacturer from the FDA's files will be called upon as evidence in product liability litigation.

Ingredient Labeling

Ingredient declaration is required on all foods that have more than one ingredient. Since many people are allergic to certain additives, the ingredient list must include:

- FDA-certified color additives;

- Sources of protein hydrolysates, which are used in many foods as flavors and flavor enhancers
- declaration of caseinate as a milk derivative in the ingredient list of foods that claim to be non-dairy, such as coffee whiteners.

As required by NLEA, beverages that claim to contain juice must declare the total percentage of juice on the information panel. Additionally, the FDA's regulation establishes criteria for naming juice beverages.

Rules and Regulations for Product Liability

Product Liability Fairness Act of 1995

When the Product Liability Fairness Act of 1995 was introduced to provide a uniform standard of product liability law, applicable in State and Federal courts, the bill was designed as an attempt to address problems in the American product liability tort system. The bill was intended to reduce the transaction costs of product liability actions, clarify the rights and responsibilities of all parties of product liability disputes, encourage innovation in product development, and increase United States manufacturer competitiveness.

The Product Liability Fairness Act was to preempt State product liability laws only in the cases to establish a uniform Federal rule. State law would continue to define when a product is found to be defective and how much a claimant could recover in compensation. No new Federal court jurisdictions would be created and the Fairness Act would not apply to commercial litigation.

Alternate dispute resolution (ADR) is offered as a voluntary, State-approved process for either party to a product liability action. In the event a defendant refuses to participate in an alternate dispute resolution, and judgment is maintained for the claimant, the defendant would be liable for the claimant's reasonable attorney's fees. No penalty would be assessed against a claimant who refused ADR, but the judiciary may consider mitigating circumstances before assessing any penalties against the defendant.

The Product Seller would be responsible if the seller's own lack of care in handling a product resulted in harm to the claimant. This point was included to allow the injured party to recover from either the manufacturer or the product seller.

The Product Liability Fairness Act as described would make businesses that rent or lease products subject to the same rights and responsibilities as product sellers with regard to product liability actions. These businesses however, would not be liable for harms caused by others, simply because they own the product in litigation.

Additionally, a claimant would be unable to recover damages for harm caused by a product if the claimant was under the influence of alcohol or any drug and such condition was more than 50% responsible for the harm.

In essence, the Product Liability Fairness Act served as an important forerunner to the Product Liability Reform Act of 1997 which further developed the details of jurisdiction, manufacturing and design defects, warning, and a punitive damage cap.

Food and Drug Administration (FDA) Modernization Act of 1997

The FDA Modernization Act of 1997 ended a year's long dispute between the FDA and industry over off-label use promotion. Manufacturers and companies must be careful that their advertising is in line with FDA-approved uses for their devices and supplements. Those companies using specific language outside the boundaries of FDA allowed approvals may received written warning and be required to withdraw the advertising. Additionally, the Act advises which information uses are not described in the approved labeling.

These include: a copy to the FDA of the off-label uses a manufacturer plans to market 60 days prior to dissemination; any unabridged reference publications containing information about clinical investigations. The reprint or text must also be accompanied by a statement disclosing any approved treatments for applicable use and the names of any authors who have received compensation or have significant financial interest in the manufacturer.

The FDA may take corrective action after the dissemination occurs if based on new data that the product may not be effective for the unapproved use or may present a "significant risk to public health". The FDA may order corrective action if:

- Following dissemination, a manufacturer must submit biannual reports to FDA listing the articles and reference texts distributed and the categories of providers that received the materials along with updates of any new safety or effectiveness data concerning the new use.
- The manufacturer has not complied with the requirements for dissemination
- The manufacturer certifies that it will submit a supplement within six months and fails to do so and/or certifies that it will conduct studies necessary for a supplement but does not pursue the studies with focused diligence.

Product Liability Reform Act of 1997

When the Product Liability Reform Act of 1997 was approved by the Senate Committee on Commerce, Science, and Transportation, Senator John Ashcroft, one of the sponsors of the bill, emphasized, "The product liability system is characterized by unfairness,

delays, and outlandish damage awards. The threat of crippling lawsuits stifles important innovation, economic growth and even the availability of lifesaving medical treatments. Ultimately, consumers pay the bill for the legal system, in the form of higher prices, lost jobs, and lost progress."

In an amendment to Product Liability Reform Act of 1997, punitive damages would only be capped for small businesses and if reform of joint and several liability was exercised. The amendment would also decrease the scope of the defense based on a claimant's use of alcohol or drugs***. The Product Liability Reform Act of 1997 prohibits most product liability actions from litigation after 18 years from delivery;*** the amendment would apply the 18-year restriction only to workplace goods.

While some advocates criticize the amendment for having too many out of committee concessions, they are still optimistic that product liability reform is moving in a positive direction.

EU Labeling Directive

Beginning January 1, 1999, device manufacturers may have to produce different labels and in some cases, different devices altogether to United States and European Union (EU) markets to meet new EU requirements for units of measurement on devices and their labels. Starting in 1999, English units of measurement, such as inches, were banned from devices sold in the EU. Only international system of units (SI) measurements, metric units like centimeters, are now allowed. That requirement is included in a 1979 directive from which devices currently have a waiver. Device makers are fighting to have the waiver renewed again. It is unlikely that device firms will get the exemption renewed before the deadline. Without the exemption, device makers will not be able to use the same packages or devices (if the measurement is on the device itself) in the United States as the EU, because the directive will not allow US measurements to appear anywhere on a product or labeling. Among the measurements that were not allowed after December 31, 1998 are:

- Blood pressure – millimeter of mercury
- Activity (of a radionuclide) – curie
- Absorbed dose – rad
- Equivalent dose – em
- Exposure (X and y rays) – Roentgen
- Dynamic viscosity – strokes
- Length – inch, foot, yard, mile
- Volume – fluid ounce, grill, pint, quart, gallon
- Mass – ounce (avoirdupois), troy ounce, pound

Informed Consent

The doctrine of duty-of-care extends to the Declaration of Helsinki, under which certain fundamental rights are accorded, including rights that apply when clinical investigations are performed on human subjects. These rights are embodied in the concept of informed consent.

Care of the patient must never be prejudiced in the name of research. This poses an ethical challenge for clinical investigators who must necessarily take some amount of risk when undergoing clinical trials with human subjects. The doctrine of informed consent is established upon fundamental individual rights. The right of privacy together with the common-law right of bodily integrity and self-determination form the basis for the recognized right of an individual to not be subjected to any medical procedure without authorization. The process of informed consent is designed to protect that right, requiring a patient to give permission before submitting to any medical procedures, drugs, or therapies.

Since many patients lack the medical knowledge required to judge accurately the usefulness of a particular procedure or drug, they must rely on the expertise, information, and experience of physicians, health care providers, and product manufacturers. Generally, in medical practice, the patient is given the benefits of a drug or procedure in a particular case rather than the benefits overall in clinical trials. The importance of manufacturers and researchers disclosing information of an unsolvable roadblock is tantamount rather than inflict harm on a patient or include one who does not meet set baseline qualifications. The following four principles apply to all healthcare and research protocols regardless of the type of procedure or device being tested:

- Respect for autonomy
- Help the patient
- Do no harm to the patient and achieve a net benefit over harm
- Distributive and economic justice with equal distribution of the benefits

Treatment using medical devices and prescription drugs must advance through researched and informed consensus on the clinical usefulness and benefits of a given product. Some testing of the product can only be achieved through human trials. The variety of factors that enter into this testing in order to reach a scientific objective must include the highest of ethical considerations. Product liability in the case of a manufacturer's failure to maintain a high ethical standard is sure to be found for the claimant seeking redress. Insurance companies should insist on the careful maintenance of this standard whenever insuring products in the medical field.

CHAPTER THIRTEEN

LEGAL ISSUES FOR PRODUCT LIABILITY

Duty to Warn

In order for a product to be advertised to the best of the public's awareness, three basic duties must be met. Appropriate instructions or directions for the products safe and proper use or assembly must be provided. These instructions must properly focus on correct use to avoid injury while warnings illustrate avoidance of unsafe handling or use. Instructions must give proper warning against an inherent danger when the product is being used properly and as intended.

The duty to warn is most often an important fact in a product liability case; however, some spurious uses of a product may precipitate a judicial decision as to the intended use of a product.

In addition to using reasonable care, in the design and manufacture of a potentially dangerous product, a manufacturer may have the increased duty to warn a consumer of any latent potential dangers in a product's use. Products that fall into this category include, prescription and "over-the-counter" drugs, vehicles, housewares, appliances, motorized tools and gardening equipment, sports equipment, construction and agricultural equipment and many others.

Compliance with a governmental agency mandate to label products is acceptable on the subject of product warning, but cannot be viewed as the only defense of liability. Whether a manufacturer knew or should have known that a product hazard is sufficiently dangerous to warrant a warning is generally determined in court. It is fair to say that a manufacturer cannot be held responsible for warning of risks that were unknown at the time of the sale of the product.

Drug Warnings

The duty to warn of any dangerous properties in a product runs to all that the manufacturer or supplier should reasonably expect might use the product or be endangered by its use. The exception applies to prescription drugs where most jurisdictions hold that the duty to warn is owed to the physician, rather than the patient.

If a drug has dangerous side effects, the manufacturer must take steps to warn doctors or users of the drug concerning the hazards of the newly discovered side effects. Moreover, as the expert in the field, the manufacturer must keep abreast of the latest research developments and to further inform the medical profession of any and adverse findings or developments. For example, if the side effects of two different drugs, taken at times in combination, causes problems, then the manufacturer must warn the consumer of the hazardous combination and warn against this application.

Each of these methods singly or in combination serve to issue product warning which in the case of product liability concern the liability of the manufacturer. It is important to note that some drug-related injuries from side effects may be due to the specific and unique sensitivities of a very few people to one drug or combination of drugs.

While it is true that some chemicals produce deleterious effects at very minute doses, others cause no harm whatsoever at doses of several grams. Toxicity categories are devised on a wide spectrum of doses required to induce injury or death. Chemical idiosyncrasy is defined as "a genetically determined abnormal reactivity to a chemical substance". The scientific community has yet to determine who may or may not react adversely to a certain drug or chemical. Only testing of sensitive people after the fact can gain additional information since the reactivity is specific to an individual's unique physiology and biological metabolism. Therefore, it is nearly impossible to warn against these peculiar adverse reactions.

Clinical Investigations

Essential to the prescription drug and medical device development process is the methods of clinical investigation. A well thought out clinical investigation procedure is invaluable in the validation of a product's statement of usage and performance verification. In some cases, established protocols may only serve to confirm advertised performance, but conversely such protocols should reinforce manufacturer's product benefits and insure patient safety through repeated product trials.

Post-Accident Warnings

Whenever there has been an accident involving a product, it is the obligation of the product's manufacturer to warn prior customers of any defects or hazards that have been discovered. This duty includes the manufacturer's records on its own research and on technical and scientific advancements regarding the product in order to warn the consumer or user of the newly discovered dangers.

When strict liability actions have been brought following an injury by a product previously thought safe and now determined to have risks, a post-injury warning to buyers can be justified as pertinent. However, warnings made following the injury may or not be considered significant by courts to establish warning for the injury incurred.

Recalls

The term "recall" as most commonly applied comes from automobile manufacturers in the form of notices sent to customers that indicate certain defects in the vehicles that were sold to them that are in need of correction. This requirement is necessary in order that the vehicle may continue to be driven without hazard to life and limb.

There are different types of recall. Recall may refer to a government directive or a voluntary recall issued by the manufacturer. A recall is different from a withdrawal where a product is withdrawn from the market with no intention of any correction on the recalled product as was the case with the Tylenol and other drug products that were the object of tampering. There have also been recalls or withdrawals due to fire hazard of dolls and other toys because of unsafe packaging, parts, or other various reasons. Generally however, recall is used primarily by automotive manufacturers.

Duty to Recall

A manufacturer is liable for negligent failure or recall if the manufacturer has knowledge of, or should have been aware of a defect warranting recall. One can note that it is within federal jurisdiction to order a recall or seek court-ordered recall and some laws require manufacturers to recall products whenever they find safety-related defects. Some courts disallow a duty to recall in the absence of a statutory requirement. Other legal arenas hold that an after sale duty to the customer lies, where appropriate, in negligence.

The age of the manufactured product has a definite effect on the duty to recall, as well as, the anticipated life of the product and the period of time since the original delivery from the manufacturer.

Coverage from Loss Resulting from Recall

The intent of a manufacturer's liability policy is to provide third party liability coverage for injury or damage resulting from the policyholder's fault. The intent is not to pay for the cost of repairs or replacement of the defective product itself, or the monetary loss therein. Such a loss is covered by a product guarantee policy, which is usually provided by corporations specializing in this type of coverage.

The 1986 Commercial General Liability policy which provides for a product's liability addition, contains the specific exclusion "N" which states that there is no coverage for damages claimed for any loss, cost or expense incurred by the policyholder or others for the loss of use, withdrawal, recall, inspection, replacement, adjustment, removal or disposal of the product. This inclusion leaves no doubt as to the insurance providers' lack of requirement to fund recall losses.

Recall announces to a product purchaser that a product may be defective. The recall notice is not required to fully describe the defect in all detail, or the potential for danger, but it is important to bring a possible threat to the common public knowledge.

Recall Letter

Several theories have been brought regarding the content of a recall letter. In order for a manufacturer, wholesaler, or retailer of a product to relate the nature of the defect, certain requirements must be met. First, it must be determined whether mailing must be proved, or whether receipt is required. Some courts have held that proof of mailing is not sufficient to insure proper warning has been issued. It has also been maintained that a recall letter should be as specific as possible in order to inform the product purchaser of the true nature of the danger.

Doctrine of Duty-of-Care

The voluntary issuance of a recall notice by a manufacturer or its distributors is viewed by the general public and judiciary as generally doing business in good faith. Any individual or corporation which notifies consumers of a product's potential defect is seen as having the interests of the common good in mind.

Generally, state courts have allowed recall letters to be introduced as pertinent proof that post-accident repairs are being made. When recall letters are issued as mandated by government requirement, the courts look differently upon those manufacturers who issue recall letters voluntarily.

Manufacturers of medical devices owe a duty-of-care that must be considered in carrying out or omitting to carry out a particular activity. Breach of this duty may be grounds for negligence. The manufacturer usually must show these elements by a significant amount of evidence (usually 49% to 51%). Damages awarded by the court would be substantial in the event that the manufacturer is proven to have acted in an unethical manner in the promotion or sanction of the product or technique used that resulted in harm to the patient.

In particular cases, the courts would review the state of knowledge possessed by the manufacturer, as well as, a product's clinical usefulness and potential for recognized complications. This information would be judged in determining reasonable duty-of-care that the manufacturer owed to the patient regarding products undergoing clinical investigation and those already on the market.

Recall as a Defense

Generally, recall has not been particularly effective as a defense to a product liability claim. However, each case is unique and has various factors, which play into the

judicial decision making regarding the product liability claim and accompanying recall. These factors include:

- Degree of negligence of the manufacturer
- The number of products recalled
- The age of the product at the time of the recall
- The necessity of the product
- If the defect was common to all recalled items or only a few

Additionally, the number of previous product recalls conducted by a particular manufacturer is of significance in a product liability action. The continued use of a recalled product after a consumer has been notified, may be construed as product misuse by the consumer. Where government recall has been ordered, the manufacturer must comply. However, recall programs may be voluntary as well.

Punitive Damages in Recall Cases

In Gillham v. Admiral Corporation, the manufacturer of a defective telephone receiver, which spontaneously combusted on more than one occasion, not only failed to warn consumers, but also glossed over the product safety. The court awarded for the plaintiff without considering the existence of the duty to recall based on the blatant withholding of safety information by the defendant. The alleged malicious act or omission is the sale of a defective product and a dishonest motive is inferred from the failure to recall or notify the consumer of the known danger.

Claims

The outcome of a product liability case is won or lost in the early days following the accident, injury, or negligence when the preliminary investigation must be initiated. With the recent sky rocketing of product liability claims and suits and the accompanying increase in the monetary amounts of case settlements, there has been a dramatic increase on insurance company loss ratios. Insurance premiums have also increased greatly and the clamor by policyholders, manufacturers, and insurance companies has been for legislative intervention and regulation.

Immediate Investigation

The first priority is to make sure all the evidence is secured. Whether the product is a wrecked automobile, or defective medical device, the product must be obtained.

Next, a complete history of the product should be taken to determine the date of the original sale, identity of the manufacturer, distributor, purchasers, lessees and users. The instruction booklet, assembly booklet, warranties, and all written material that accompanied the new product at the time of the original sale and distribution should be gathered. A determination as to whether the product was modified or otherwise

changed or misused after it left the manufacturer and distributors must be made along with the identity of the users who made the modifications.

Basic background data such as product description, manufacturer, distributor, sources of component parts and all written material pertaining to the product such as advertising, instructions, technical data, parts manuals, repair manuals, catalogs, blueprints, and diagrams should be collected. Two or more duplicate products should be purchased for later testing and trial if necessary.

Defendants

It should be noted that the potential defendants in a product liability action include the manufacturer, assembler, component supplier, testing laboratories, advertising agencies, distributors, retailers and repairers. In some cases, the predecessor corporate manufacturer may be liable, but only if expressly stated in the contract of sale. Additionally, bailers and lessors can be held strictly liable.

Alternate Dispute Resolution

Arbitration

Arbitration is strictly defined as the settlement of a dispute by an impartial person chosen specifically to settle such dispute between two or more parties. Arbitration is different from mediation in that mediation is seen as assistance necessary to help agreement between opposing parties.

The terms, mediator and arbitrator, however, are frequently used interchangeably. Both listen to two sides of a complaint and try to solve it using whatever experience and training they bring to the discussion. The proceedings may take the form of an informal discussion or may be very similar to courtroom procedure with opening statements, rebuttals, and closing arguments from both sides of the issue. The significant difference between mediation and arbitration is that neither side must agree to the solution found in mediation, while under a binding arbitration, both groups have to agree in advance to follow the final solution arrived at between the parties.

Once the arbitration process has been initiated, some programs require the claimant to mediate the case with the manufacturer prior to arbitration. A settlement is frequently worked out between both parties at this point, however, if it is not, then the next step is arbitration.

In fact, in a binding arbitration there is no right to a subsequent trial, appeal, or other remedies available to the loser in a court decision. Whether the arbitration will be binding or not will depend on the contract terminology of the product liability insurance policy and the laws of the individual state as well as whether the manufacturer and defendant agreed to make the results binding.

Preparation for arbitration is very similar to that enforced under the lemon law, the Magnuson-Moss Act, or small claims court. Both require thorough documentation of defects and repairs. Commonly, the claimant will possess a service bulletin on a defect of a widespread problem in a particular model. Additionally, the National Highway Traffic Safety Administration (NHTSA) has received numerous complaints on a certain make and model through its Technical Reference Division. Additionally, General Motors, Volkswagen, Audi, and Ford maintain indexes and copies of all service bulletins and the NHTSA's Auto Safety Hotline will provide any claimant with information on vehicle safety problems and any vehicles that have been recalled.

To initiate the arbitration process, the claimant must state what is being sought. The arbitrator is bound by the terms of the agreement and it determines what he or she is authorized to award the claimant. In particular, a claimant may be awarded a sum of $12,000 for vehicle buyback, but be denied several more thousand dollars in additional expenses for legal fees, down payment, and out-of-pocket repair expenses.

Generally, a claimant is allowed to arbitrate any vehicle lemon complaint for up to the purchase price of the vehicle plus the repair bills. This does not necessarily have to be in currency, but may be in important unsatisfied repairs by the manufacturer. Compensation is usually not given for expenses such as alternate transportation, lodging, lost wages, or other incidental and subsequent damages, but each program awards claimants differently. If a claimant is dissatisfied with the final settlement, he or she may file in small claims court.

Additionally, it should be noted that a buyback is not automatically done or done at the original purchase price of the vehicle. If the vehicle has major and/or numerous repeated failures, or if the manufacturer and its dealers have not repaired a major problem, a buyback will probably be awarded via arbitration. These buybacks are frequently made at market value of the defective vehicle and are not true replacement awards. Minor repairs will not receive buyback awards, regardless of the level of aggravation involved in the case, but will receive monetary reimbursements.

Another point to consider when arbitrating for a buyback is that of the issue of deducting for use. The manufacturer may submit low repurchase prices. The focus many claimants maintain is on the original purchase price of the defective vehicle. A manufacturer may suggest deducting 25-30 cents per mile of use because that is along the lines of what the Internal Revenue Service (IRS) allows as a tax deduction for a personal vehicle used in business. However, this figure includes gas, oil, and maintenance that the claimant has already paid, so it can be expected that the average depreciation per mile of similar vehicles (or roughly 1/3 of the IRS value) would be better received by the claimant.

The arbitration process is touted as a fair and low-cost option to litigation (the claimant and the insurer split the cost of the arbitration process), but the trend is toward increasingly more complicated arbitration proceedings that resemble actual litigation. One advantage of arbitration is that of speed, unlike court cases which can take years to reach a verdict through the legal system. Mediation, though non-binding, is increasing in popularity as the complexity of arbitration continues to grow.

Various automobile manufacturers and dealers maintain arbitration programs. The law requires the claimant to participate in in-house arbitration proceedings before being permitted to sue in court, providing the proceedings comply with the state's lemon law and federal regulations. Although this may work out the claims submitted, the proceedings are not binding on the purchaser who may subsequently submit the dispute to the American Arbitration Association under the State Lemon Law Arbitration Program.

UMBRELLA LIABILITY MODULE

CHAPTER FOURTEEN

INTRODUCTION TO UMBRELLA LIABILITY

Umbrella Liability

The umbrella liability policy was originally developed for business purposes and at one time, was exclusively underwritten by Lloyds of London. The personal umbrella liability policy expands the liability coverages home and auto owners normally have within their homeowner's and auto policies to defray costs in the event that an individual is subject to liability claims of catastrophic proportions. Umbrella liability covers both general liability and automobile liability.

In order to qualify for an umbrella liability policy, the purchase of certain underlying liability protection within a homeowner, corporate, or auto policy is required. The objective of each insurance company is to have the umbrella policy written as excess coverage, over the limits of the required basic contracts from one to ten million dollars. The umbrella policy expands the basic coverage and fulfills its first function of "excess coverage" and would pay in addition to standard basic coverage. The umbrella liability is designed to establish broader coverage than that provided under the basic contracts. The property casualty precepts should provide protection against certain liability exposures not covered under other underlying policies.

Specifically, umbrella liability expands individual protection in the areas of slander, defamation of character, invasion of privacy and damages caused by use of non-owned property in the care, control, and custody of the policyholder. Claims of plagiarism or violation of copyright laws are covered under personal liability or umbrella liability policies. Such protection would most likely not be covered under a simple homeowner's or auto policy.

In the event that a homeowner or member of the family has a small business manufacturing and selling a product out of the home, product liability insurance in the form of an umbrella policy would cover an injury from the use of the product.

All umbrella policies are not created equal and contain property exclusion clauses pertaining to business activity conduct on residential premises. If a fire should occur, personal effects would be covered, but not the products held for sale to others. Umbrella liability policies are written for personal and business use. They are used to provide additional liability coverage if the insured must pay damages resulting from a suit. They are also used to pay reasonable expenses resulting from defending the suit.

Umbrella liability policies provide coverage over and above general liability insurance. Policies similar to umbrella policies can be written on an excess basis, providing the same coverage and exclusions of the underlying policy. Umbrella policies can be written with excess coverage which provides broader coverage than does the underlying policy. An umbrella policy provides broad, blanket excess liability coverage which applies to certain areas that are not covered by underlying policies.

An excess policy, which is very similar to an umbrella policy, and so is commonly referred to as an umbrella policy, is one which provides the same insurance as the primary insurance, but for an excess limit of insurance. For example, a business may carry primary insurance with an aggregate loss limit of $1,000,000 and carry excess coverage for an additional limit of $10,000,000 or more for the same coverages. Excess coverage may have some coverage which is more restrictive than the underlying policy.

Umbrella policies are broader than the underlying primary insurance because the insuring agreement, definitions and exclusions are broader on many umbrella policies than on the primary commercial general liability, automobile liability, and other business coverages.

Umbrella Liability Insurance Coverage

Many umbrella policies include an insuring agreement which covers "personal injury" rather than bodily injury. Personal injury could include such things as mental anguish, mental injury, defamation of character, discrimination, false arrest, humiliation and so on. This creates a broader coverage than under common primary insurance which covers bodily injury. Umbrella policies often contain provisions for coverage not found in the underlying insurance. For example, umbrella policies often provide worldwide product liability coverage, which can be used by companies selling to international markets.

They may offer coverage which includes liability resulting from non-owned aircraft and non-owned watercraft. Employee liability may be covered through the inclusion of employees in the definition of named insured. Blanket contractual coverage, which provides blanket liability coverage for both oral and written contracts may be included. Umbrella policies may also provide coverage for libel and slander suits, coverage not normally provided in standard liability policies.

Whether coverage is for a business insured or is personal insurance, the insurer normally requires that the insured possess other insurance before umbrella coverage will be issued. A business will normally be required to carry commercial general liability insurance, commercial automobile liability insurance and statutory employer's liability coverage. Personal umbrella providers will normally require homeowners and automobile coverage. Commonly, the personal insurance provider will require that the insured be covered for $100,000 per person and $300,000 per occurrence in order to qualify for an umbrella policy.

Since most personal liability damages are within this range, the additional umbrella coverage is relatively inexpensive, even though it normally covers an additional $1,000,000 in liability.

Self-Insured Retention

Umbrella policies which provide coverages that the primary insurance does not include require self-insured retention. Self-insured retention is in practicality a deductible for the excess insurance. It is typically at least $10,000, but may be as high as $25,000. Some coverages may require a self-insured retention of $50,000 to over $100,000.

Insurers which provide umbrella coverage are, in effect, insuring events with a very low frequency. The rates charged for the coverages reflect this. The primary insurance will cover most items, absorbing most of the claims. So, if an umbrella policy covers items not covered in whole or in part by the primary insurance, the umbrella provider creates the "cushion" normally provided by the primary insurer through the requirement of self-insured retention. The effect of this retention will be to reduce the frequency of claims for those items not covered by the primary insurance. The size of the self-insured retention reflects the extent of the risk the umbrella coverage provides.

Personal Umbrella Insurance

Personal umbrella liability insurance is designed to protect individuals and their family against a catastrophic lawsuit or judgment. It provides expanded coverage and increases the amount of primary liability protection beyond the basic coverage provided under standard homeowners/renters and auto insurance policies. However, in this litigious world we live, people may want to have an extra layer of liability protection. That's what a personal umbrella liability policy provides.

Personal umbrella insurance provides additional limits of coverage if a person is sued for damages suffered by someone as the result of an accident involving the insured's car, property, or while participating in recreational activities such as boating or golfing. People are especially exposed to the risk of an incident resulting in a lawsuit if they:

- Have a swimming pool.
- Have a young driver in the family.
- Engage in sporting activities like snow skiing, golf or baseball.
- Operate personal watercraft or other high-risk recreational vehicles.

Coverage for the Unexpected

We live in a time when million-dollar verdicts are no longer rare, and when more and more families have valuable assets to protect - vacation homes, investments, rental property. Unexpected dangers could be as close as the backyard. And any situation that could result

in serious injury, long-term physical impairment, psychological damage or death could put financial well-being at risk. Examples include:

- Accidents on the policy holder's rental property;
- Backyard accidents in swimming pool, hot tub/spa, etc;
- Recreational pursuits like skiing, golf, boating or horseback riding;
- Serious auto accidents.

Most insurance carriers will allow individuals to purchase higher limits (or amounts) of liability protection but the most they can typically purchase is $500,000 for homeowners' policies or $250,000 per person, $500,000 per accident for auto insurance. This may not be enough protection in today's lawsuit frenzied environment where million dollar judgments are fast becoming the rule rather than the exception, even for seemingly minor situations.

The more earning power and assets increase, the more people have at risk, and therefore, the more they need to protect. If they don't have high enough coverage limits, assets might be sold or income might be garnished (a portion of future earnings would be contributed) until their debt is paid.

People should not make the mistake of assuming that auto and homeowners' insurance coverage provides all the liability protection needed. Protection of an individual and their family is needed with *a* Personal Umbrella Policy**.** Personal umbrella policy provides an extra layer of protection above underlying auto and homeowner's insurance coverage, and because the policy is stand-alone, insureds never have to change their current auto and/or homeowner's insurance carrier. A program is available in most states for:

- Competitive premiums available for all coverage limits and types of risks;
- Liability limits up to $5 million are available;
- Preferred, Standard, and the new Standard II underwriting tiers;
- Quick and simple application process.

Liability Suits

Anyone can be sued, regardless of income level, for just about any reason. The average size of liability suits has increased dramatically, and everything owned could be at risk: car, home, savings, even future income could be at stake if a person is involved in a lawsuit.
Here are just a few examples of situations that can lead to devastating lawsuits:

- On the drive home one evening a person does not see a stop sign and collides with a bus. Thankfully they are not seriously hurt, but several of the occupants are injured. The driver could find himself or herself involved in an extremely large lawsuit.

- A neighborhood child taunts a family's friendly dog. Suddenly, the dog nips at the child. Although the child is not seriously injured physically, the dog's owner could be sued for a substantial sum.
- A homeowner is responsible for a fire that sweeps through his condominium complex and damages other units, resulting is several lawsuits.
- On vacation a person rents a boat and a water skier crosses the path. The boater accidentally hits the skier, severely injuring his legs. That skier may decide to take the boater to court.

If any of these were to happen, there's a good chance that liability insurance limits would not be adequate. There are also some types of losses that the normal auto and home policies are not intended to cover; but a personal umbrella liability policy will cover. People can also incur defense costs from a suit, even if they are not legally liable. A Personal Umbrella Liability Policy is designed provide liability coverage once the liability limits on basic policies are exhausted.

It kicks in when the insured reaches the limit on the underlying liability coverage in a homeowners, renters, condo or auto policy. An umbrella policy may also cover for things that may not be covered in the underlying policy, such as libel and slander. For about $150 to $200 per year they can buy a $1 million personal umbrella liability policy. Because the personal umbrella policy goes into affect after the underlying coverage is exhausted, there are certain limits that usually must be met in order to purchase this coverage.

Additional Liability Coverage

For a person and their family over and above the present amounts insured on recreational vehicles and snowmobiles. The umbrella policy provides customers with $1 to 10 million dollar worldwide coverage. The policy allows protection from major claims and lawsuits and provides coverage that may be excluded by other liability policies. Coverages also include protection for: False arrest, libel, slander, owners of rental units

High Risk of a Personal Liability Lawsuit

Our society is an increasingly litigious society – an existing umbrella policy may not be providing enough protection. Individuals need to ask if they are a possible risk in a liability lawsuit:

- Are there dependants that expose them to liability?
- Are there often guests on their property?
- Does a current umbrella policy fail to protect all assets?
- Does income make one individual an attractive target for a lawsuit?
- Does a particular address make an individual more vulnerable to lawsuits?

- Do donations to a not-for-profit organization create an exposure to liability?

If Assets Exceed Current Umbrella Coverage

Most insurers are unwilling to provide large limit umbrella policies because a few large losses could adversely affect their annual earnings. For that reason, only a small amount of umbrella coverage is available to reduce this risk. A successful insurance company with unparalleled financial strength is able to take a long-term view of this risk and provide large umbrella limits that other insurers are unable to match.

The Best Financial Security Available

The financial security of the insurer should be a key consideration. It may take several years to arrive at a settlement involving a large loss. Insureds need to be sure their insurer will be there to protect them - not just to collect their premium. Often, insurers with low prices do not have high financial ratings. The insured should seek out a company with a strong financial strength rating.

There are many factors to consider when calculation a premium: the state in which the insured lives, the number of liability exposures (cars, drivers) etc. Usually the best rates occur when the customer insures both auto and home with the same insurance company and the personal umbrella liability policy. This is a requirement for many insurers offering umbrella coverage.

Insuring Agreements of The Policy

Subject to the terms, conditions limitations and exclusions of the policy, the insurer shall indemnify the insured for damages caused by the occurrence for which coverage is provided by the underlying personal umbrella insurance. Liability shall assign to the insurer only after the underlying personal umbrella insurance and any applicable primary insurance have paid the full amount of their respective limits as shown in the declarations.

The insured shall promptly notify the insurer an keep the insurer informed of any and all claims to which the insurance or the underlying personal umbrella insurance may apply. The insurer may make investigation of claims or to investigate or defend any claim against the insured. If the insurer does not elect to defend, the insurer shall have no obligation to underwrite the insured for the expenses of the defense.

Looking at Conditions in a Policy

The policy provides coverage solely for damages which occur during the policy period caused by an occurrence. Where any insured has notice prior to commencement of the policy period that an occurrence may have resulted in damages for which an insured may be liable, the policy does not apply to damages. The policy does not provide any coverage for damages arising out of an occurrence for which the insurer or any of its affiliates already provides coverage under another excess personal umbrella insurance

commencing prior to the commencement date of this policy, or would provide such coverage but for the exhaustion of the earlier policy's limit of liability.

Either the insurer or the insured may not cancel the policy more than sixty days after commencement of the policy unless the underlying personal umbrella insurance is cancelled or expires. If the policy is cancelled prior to the expiration date, the insurer's aggregate limit of liability shall be reduced to equal the aggregate limit of liability shown in the declarations multiplied by a fraction, the numerator of which is the number of days the policy was in force and the denominator of which is 365, and the insurer's premium shall be reduced to equal the premium shown in the declarations multiplied by the fraction, the numerator of which is the number of days the policy was in force and the denominator of which is the number of days that was originally to constitute the policy period prior to cancellation.

The terms of the policy cannot be waived or changed, except by written endorsement issued to form a part of the policy because it symbolizes all agreements existing between the insured and the insurer, or any of its agents, relating to this insurance. The insurance is in excess of the underlying personal umbrella insurance, any applicable primary insurance, and any other insurance available to the insured.

The premium under the policy shall automatically increase in an amount equal to any increase in premium of the underlying personal umbrella insurance. The named insured agrees to give prompt notice of any change in the premium or other policy terms, conditions, limits or exclusions of the underlying personal umbrella insurance and to furnish such additional information as the insurer may require. If the insured fails to notify the insurer of any such changes in the policy, the insurer may cancel this policy.

No action shall lie against the insurer unless, as a condition precedent thereto, the insured shall have fully complied with all terms and conditions of this policy, nor until the amount of the insured's damages have been fully and finally determined either by judgment against the insured, after actual trial, or by written agreement of the claimant and the insurer.

- The policy does not apply to claims from governmental direction or request.
- The policy does not apply to damages caused by, contributed to or arising out of the discharge, dispersal, release or escape of pollutants into or upon the land, the atmosphere or any course or body of water;
- The policy does not apply to liability arising out of the rendering of or failure to render professional services by any insured.

All expenses incurred by the insurer in the defense of any suit against an insured is a part of the policy's aggregate limit of liability. Any dispute arising under the policy between the insurer and the insured must be settled by binding arbitration in accordance with the commercial rules of the American Arbitration Association.

EMPLOYER LIABILITY MODULE

CHAPTER FIFTEEN

INTRODUCTION TO WORKERS' COMPENSATION

History

The historical origins of modern workers' compensation legislation may be found first in Germany and then in England. Philosophers and politicians, especially Socialists, were a great influence in the development of European compensation legislation that later influenced the development of similar compensation legislation in United States.

The German influence began in 1838 with the enactment of an employers' liability act that was applicable to railroads. In 1873, Germany extended coverage to workers in factories, mines, and quarries. In 1884, Germany enacted a compulsory system of accident insurance that is regarded as the first true workers' compensation act, and it covered all employees engaged in manufacturing, mining, and transportation. Similar workers' compensation laws were enacted in Austria in 1887, Norway in 1894, Finland in 1895, and Great Britain in 1897.

The Workman's Compensation Act of 1897 provided the prototype, and was the forerunner of the majority of compensation acts passed in the early 1900's in the United States. The Act contained important limitations:

- only hazardous employments were covered
- there were no insurance provisions
- the employer bore the complete burden of compensation benefit costs

The statute also gave rise to the key phrase, "arising out of and in the course of employment", which is generally found today in compensation statutes in the United States. The British legislation differed from the German. Germany attempted to provide broader coverage in the area of social insurance and to provide a more complete compensation system. The British act gave the workman only moderate recovery, with the cost being borne by the employer as an expense of doing business.

Employee's Common-Law

The common-law imposed a number of duties on employers for the protection of their employees, and an action existed for the breach of these duties, however, as a practical matter the common–law failed to provide adequate remedies for such inquiries and deaths. The common–law duties imposed upon the master were as follows:

- To provide a safe place to work

- To provide safe appliances, tools and equipment
- To give warnings of dangers of which the employee might reasonably be expected to remain in ignorance
- To provide a sufficient number of fit, trained, or suitable fellow servants to perform assigned tasks
- To enforce rules relating to employee conduct which would make the work safe

The common – law defenses, restricted employee remedies based upon a breach of the foregoing duties:

- The fellow–servant doctrine
- Contributory negligence
- Assumption of risk

Fellow- Servant Doctrine

Unless there was an express contract, the rule at common law was that a master was not liable to a servant for injuries due to the negligence of a fellow servant. The doctrine provided that the negligence of the co-employee was not to be imputed to the master; the injured employee could still sue a co-employee. The fellow-servant rule was not founded in abstract or natural justice, and the rule was an exception to the rule of agency and the general rule that a master was responsible for injuries caused to third persons by the negligence of servants who were acting within the scope of their employment. It was said that the negligence of a fellow servant was one of the risks incident to employment, and, as an implied term of the employment contract, the servant assumed the risk.

Contributory Negligence

An employee or servant was required to exercise reasonable care for his own safety, and his failure to use the precautions that ordinary prudence required, barred any recovery under the contributory negligence defense. Exceptions existed on the basis of the last clear chance doctrine and in situations in which the master's conduct was willful or careless. As a result of the doctrine's harshness, statutes sometimes abrogated the defense and statutorily imposed requirements for worker safety, placing certain servants in a special, protected category. In some jurisdictions comparative negligence statutes aided employees.

Assumption of Risk

The assumption of risk defense was grounded in the notion that the servant or employee had voluntarily agreed to assume the dangers normally and ordinarily incident to the work. Risks were covered which the mature worker was presumed to know, regardless of whether one had actual knowledge. The employee further assumes extraordinary and abnormal risks of which he has knowledge and

appreciation. Assumption of risk is customarily based upon contract theory, as opposed to contributory negligence, which is based upon tort theory. Contributory negligence involved the notion of fault and a breach of duty to one's self, whereas assumption of risk could exist in the absence of fault because of its contractual nature. Employees or servants did not assume those risks growing out of the negligence of the master, or vice principal.

Employers' Liability Acts

Employers' liability acts came into being in response to rising industrial injury and death rates in the 19th Century, and in response to dissatisfaction with the common–law remedies available to employees. In 1855 the state of Georgia enacted a statute making railroads liable to employees and others for negligence in situations previously barred by the fellow–servant defense. By 1908, almost every American jurisdiction had passed similar legislation. In 1908 Congress placed interstate railroad employees under it employers' liability act system and later extended this same coverage to seamen.

State Compensation Acts

There was a gradual recognition at the turn-of-the-century that the common-law remedies of employees injured or killed on the job, were filled with inequities. The states were slow to adopt workers' compensation laws, and initial attempts to do so face legal and political opposition. Early compensation legislation was very limited and legislators exercised great caution in replacing the common-law recovery system. Here are a few examples of the various attempts of the states to enact compensation legislation. This was an important phase in the history of workers' compensation legislation in United States.

Maryland - In 1902, Maryland passed the first workers' compensation act in United States. In 1910, Maryland enacted a voluntary workers' compensation statute, but apathy on behalf of employers and employees rendered the legislation ineffective.

Montana - In 1909, Montana enacted a compulsory workers' compensation statute, which was designed for employees in the coal industry. in 1911, because it was held that employers were denied equal protection of the laws, in that there was the potential for double liability because employers had to contribute to the state compensation fund and additionally were opened to suit if an employee or beneficiaries so elected.

Massachusetts - In 1908, Massachusetts passed a voluntary workers' compensation statute. The voluntary nature of the act was designed to avoid some of the constitutional problems concerning compensation acts. So both employers and employees had no incentive to commit themselves to the scheme.

New York - in 1909, in New York a commission on Employers Liability was created. It was to inquire into the liabilities of employers to employees for industrial accidents, and compare and study the various components. In 1910, both compulsory involuntary acts were passed. In 1913, New York amended its Constitution to permit the enactment of a compulsory workers' compensation statute and in 1914 the New York Legislature passed a compulsory workers' compensation law that applied only to hazardous employments

Florida - In 1935, the state of Florida enacted its first workers' compensation act, which is elective in theory. From 1935 forward, practically every session of the Florida Legislature amended the compensation act. The Florida Legislature in 1978, because of its concern over excessive awards at a backlog of claims, initiated a study of the problems.

General Principles of Workers' Compensation

The basic theory of compensating an injured employee is that regardless of personal negligence or the negligence of the employer, the injury has to have arisen out of and in the course of his employment. The first workmen's compensation laws in the United States were passed in 1911. Despite the fact that the spread of workmen's compensation laws was temporarily halted by some courts, which declared them unconstitutional, subsequent decisions by the Supreme Court upholding the constitutionality of serious types of workman's compensation laws soon spurred their enactment throughout the country.

Although most of the acts follow the same general pattern and agree in basic principles, the uniformity ends there. Details as to what is compensable, amounts covered, time limits, procedural setup, and so on, differ an almost all the 50 states.

There are certain general principles that apply to all of the workers compensation acts. Workers compensation laws, since their inception, have been consistently liberalized in both benefits and coverage afforded. The only employments generally excepted from the acts are agricultural, some domestic employees, and casual laborers. Compensation acts today require practically unlimited medical expenses in almost all states.

Identifying Types of Compensation Acts

Elective Acts

For the most part, the states that have adopted collective acts have done so in name only. There are few so-called collective acts that do not provide for a penalty of some sort should an employer elect to remain outside the provisions of the act. Should he do so, the employer would still be subject to suit at common law. In most of the elective

acts, a further penalty is provided for the employer by removing his three common law defenses to such an action.

Compulsory Acts

In those states operating under compulsory workers compensation acts, neither the employee nor the employer has any choice in the matter. As long as none of the exceptions are applicable, both must comply with the provisions of the act of the particular state.

Compulsory or Elective Acts

Some workers compensation acts combined features of both the elective and compulsory acts. In these cases, certain specifically described employments fall within the compulsory provisions, though others not so described are elective.

Obtaining Coverage

Provisions for obtaining workers compensation coverage under the various acts fall into four general categories.

- ***Monopolistic state managed insurance***: In the states operating under this system, an employer has no option and, with rare exceptions, cannot either be a self-insurer or obtain insurance from private insurance company.
- ***Competitive state funds:*** In some states an employer can make a choice between state-managed insurance and have a private carrier. In some instances, he may become a self-insurer.
- ***Private insurance only*:** The employer must obtain insurance for private carrier; under certain circumstances, he may become a self-insurer.
- ***Partial monopolistic state managed insurance*:** Under some statutes, employers, upon certain express conditions, may be permitted to carry their own risks or insurer in private companies.

Administration

The workers compensation acts of the various states are not uniformly administered. In some states the courts are the initial administrative body. In others, the commission or board is the body of initial administration. States that have no administrative setup other than the regular courts of law are by far in the minority. There are exceptions. A few states have made their administrative body so weak that they are almost completely ineffectual.

Most states require an injured employee to notify his employer concerning an accident within a certain specified time. Some states require notice to the investor commission or workers compensation board by the insurance carrier. Most boards or commissions

require the actual claims for compensation to be filed with them. All states have some time limitation for the filing of such claims.

Despite the fact that most states definitely require the employee to notify his employer of an accident within a specified time, many of the acts allow additional time known as an "excusable time" within which notice may be made. And in many instances, the courts, in interpreting the various statutes, have excused late claims as well as late notice. This is especially true in those jurisdictions in which time limitations are not altogether clear and specific. Errors of fact may in some instances justify late notice or claims. The employer's knowledge of an accident has been held to excuse late notice or even no notice at all. The courts have excused late notice in some instances if it was not prejudicial to the employer or the insurer.

Basic Benefits

The basic benefits provided by the workers compensation laws include:

- Cost of prosthetic devices
- Custodial care where necessary
- Death benefits for dependents
- Lump sum payments in the event of certain partial disabilities
- Medical and hospital expenses
- Payment for lost wages
- Payment for loss of bodily members or loss of sight
- Rehabilitation costs

While the law was never intended to compensate an injured employee for complete loss of wages, it is fast approaching that level in some states and certain instances. There are several significant benefits available to workers and their families who qualify for workers compensation.

Medical Benefits

Many states have what is known as the "fee schedule" for some types of medical services. These statutes usually have a list of approved physicians who are required to keep their charges within the fee schedule.

Such items as doctor's fees, surgeon's fees, hospital expenses, and nurses' fees are universally considered proper medical expenses. In some states, however, the courts have enlarged the meaning of this term to include such items as practical nurse's care in the home, convalescent home expenses, and even room and lodging where greater expense would have been incurred, possibly necessitating confinement to a hospital, had these items not been provided for.

In cases of prolonged disability, insurance companies have even considered such items as expenses incurred for morale boosting visits to the injured, and have paid for such items under the medical expense provision.

Indemnity Benefits

The benefits paid to the injured employee are a direct result of his loss of weekly earnings and are known as indemnity or compensation benefits. These benefits are a portion of the employee's wages; they are paid to him while he is unable to perform greater duties of his employment. Most states also specify the duration in number of weeks for which benefits are to be paid. In some states, under certain circumstances, benefits may be continued for life.

Payments may be made on the basis of temporary total, permanent total, or permanent partial disability. Most states have what are known as scheduled injuries that provide for the payment of a stipulated amount for certain permanent partial disabilities.

Federal Legislation

Workers' Compensation laws are designed to ensure that employees who are injured or disabled on the job are provided with fixed monetary awards, eliminating the need for litigation. These laws also provide benefits for dependents of those workers who are killed because of work-related accidents or illnesses. Some laws also protect employers and fellow workers by limiting the amount an injured employee can recover from an employer and by eliminating the liability of co-workers in most accidents. State Workers Compensation statutes establish this framework for most employment. Federal statutes are limited to federal employees or those workers employed in some significant aspect of interstate commerce.

The Federal Employment Compensation Act provides workers' compensation for non-military federal employees. Many of its provisions are typical of most worker compensation laws. The act covers medical expenses due to the disability and may require the employee to undergo job retraining. A disabled employee receives two thirds of his normal monthly salary during his disability and may receive more for permanent physical injuries, or if he has dependents.

CHAPTER SIXTEEN

PRINCIPLES OF EMPLOYERS' LIABILITY

Workers' compensation benefits provide coverage for medical expenses as well as reimbursement for lost wages when employees are injured on the job. Workers' compensation coverage includes two types of protection:

- workers' compensation and employer's liability

The workers' compensation portion of the policy pays for claims made by employees, and the employer's liability portion pays the cost of defending lawsuits filed against the company by an employee or an employee's family.

Workers' Compensation

- ***Workers' compensation insurance is required by law in all 50 states***;
- Workers' compensation insurance can protect one's business from lawsuits
- Without the right coverage, an injured worker might sue his employer's business to recover medical costs, disability costs and damages
- If one understands how the system works, he can take advantage of simple ways to reduce workers' compensation costs

Each state enacts its own workers' compensation statutes, so the employer needs to check with his state insurance commissioner's office or his insurance agent to find out about rules that govern his business.

Depending upon where he lives, he can buy coverage through a state-run fund or a private insurer. Some states offer a choice of either. If one's state does not offer a state-run insurance fund and he cannot qualify for private insurance, he will be insured by an assigned-risk pool. Workers' compensation premiums depend upon

- the nature of one's business
- the jobs one's employees perform
- the number of hours they work

Each job type is assigned a classification code. Riskier work is classified as such and assigned a higher premium. Thus, one might pay 48 cents in premiums for every $100 in payroll that goes to a clerk in a retail store. By contrast, a truck driver's premiums might

set him back $9 per $100 of payroll. There are ways to control one's costs. The employer should:

- Review his classifications to make sure he is using the proper codes
- Review his case with his state workers' compensation rating bureau. If he is not satisfied with the result, he can request an onsite inspection and rating.
- Consider a deductible. More than half of states allow small companies to cut premiums by paying a deductible on workers' compensation claims.
- Check his payroll. Most states don't require employers to include overtime in the payroll numbers used to compute premiums. If the employer's state is one of them, he does not need to figure in overtime.

If the employer is in an assigned-risk pool due to a poor safety record or unusually high risk, he will pay high premiums for relatively poor service. He needs to find out why he is in the pool. If the problem is his firm's safety record, he should take steps to improve safety and reduce the chance of accidents in his workplace. Enhancing workplace safety will improve his workers' quality of life as well as his costs. An employer should consider some of the following ideas:

- Conduct regular inspections of the facility to identify and correct hazards such as poor lighting, unsafe warehouse conditions and ergonomically incorrect workstations
- Communicate to employees the importance of safety in the workplace
- Award and recognize safe operations
- Keep detailed records of all accidents and set quantifiable goals for improvement
- Create return-to-work programs for injured employees and stay in close contact with employees who are out
- Use ergonomic products. The right chairs, keyboards, mats and tables can sharply reduce claims
- Provide protective equipment. Goggles, helmets, gloves and other safety gear make sense in many situations

The Employers Liability Act

The Employers' Liability Act extended protection to workers concerning accidents caused by the negligence of managers, superintendents and foremen. Railway companies were also made liable when their employees were injured through the negligence of signalmen, drivers and point's men. However, the act did not protect employees against accidents caused by fellow workers.

The liability of an employer to pay compensation shall be exclusive and in place of all other liability of such employer to the employee, his legal representative, husband or wife, parents, dependents, next-of-kin, and anyone otherwise entitled to recover

damages at common law or otherwise from such employer on account of such injury or death, except that if an employer fails to secure payment of compensation as required by this chapter, an injured employee, or his legal representative in case death results from the injury, may elect to claim compensation or to maintain an action at law for damages on account of a injury or death.

Launching a Reasonable Investigation

In order to conduct a reasonable investigation, the employer must take into account the severity of the potential risk of harm the employee may pose in the employment position. Depending upon the nature of the work, employers should make an appropriate investigation into the background of the employee by going beyond the job application form and interview by making an independent background check on the employee by calling former employers and references. In addition, in some situations it may be appropriate to look at the employee's driving record, criminal record, qualifications and character, especially when the job involves security duties or the use of weapons.

Where risks to others posed by the employment are slight, an employer may only be liable if the employer had actual prior knowledge of an employee's propensity for violence. No single standard or formula has emerged to determine the employment situations where a heightened duty to investigate exists. Most authorities suggest that the important factor is that the victim was made vulnerable because an unfit employee was in a position that facilitated the commission of the injurious conduct.

When evaluating a case for viability as a negligent hiring claim, certain aspects of an employer's hiring decision should be scrutinized. While there are many specific steps that employers could use to cut down on their possible liability for negligent hiring, did the employer utilize them?

Following are questions that the jury will consider:

- Did the employer check the employment application carefully for any discrepancies or red flags?
- Did the employer obtain the employee's consent to contact previous employers and references?
- Did the employer contact listed references and the previous employers to find out whether the employee is an honest, trustworthy and reliable applicant?
- Did the employer inquire about any gaps in the employee's work history?
- Did the employer inquire about the employee's reasons for leaving previous jobs?

- If the employee was fired from previous employment, did the employer check the validity of the employee's answer?
- Did the employer determine whether the responsibilities of the position indicate a need to investigate any possible criminal conduct or driving infractions?
- Did the employer investigate appropriate areas of the employee's background as deemed necessary by the responsibilities of the position?
- If the employee sought to change positions, did the employer reevaluate the employee's suitability for the new job's responsibilities?
- Did the employer make a reasonable decision in hiring the employee in light of the responsibilities of the job and the totality of the information learned about the employee?

Basics of Workers' Compensation

Workers' Compensation is a no-fault system of social legislation, first instituted in the United States shortly after the turn of the century, in response to serious societal problems caused by a dramatic rise in the number of people injured in industrial settings. Prior to the enactment of workers' compensation laws, the only means for an injured worker to recover any benefits to pay for his/her medical expenses and loss of employment income, was to bring a law suit in court accusing the employer or some other party of negligence and seeking damages.

The courts were bogged down with a multitude of such law suits, and even if the employee was able to establish negligence on the part of the employer or another party, which was often not the case, the road to recovery was drawn out and expensive, and an employee might well lose his/her home, health and family waiting for relief. Supporting a large number of indigent, injured workers' was a drain upon society.

State legislatures across the United States began to adopt workers compensation laws designed to withdraw lawsuits against employers from the Court system, and to provide some measure of swift relief to the injured worker, regardless of fault. Thus, it is often said that workers' compensation laws were a very early instance of no- fault legislation. Each state enacts its own law, and there is no Federal control over individual states' workers' compensation laws. In general, each states' workers' compensation law provides disability benefits and medical care for individuals injured in the course of job connected activities. Workers' Compensation varies from state to state, but there are many features that are fairly common to a typical workers' compensation statute.

Workers' compensation laws cover those in "industrial employment," a term that encompasses office workers and those working in factories and stores. Certain kinds of employment are generally excluded from workers comp laws, such as agricultural and

domestic workers and those who work for religious organizations. Also, some states exempt businesses with only three, four, or five employees from having to cover their workers. But while these groups are exempted, an employer can still voluntarily bring his workers into the system.

Basic Features

If a person is hurt while working, workers' compensation pays the medical bills and reimbursement for lost wages. But being able to collect on a claim also depends on how impaired the worker was at the time of the accident. If an employee were drunk when he falls and hurts himself, he would have a hard time being compensated. Self-inflicted injuries are not compensated, either.

Other factors that would prevent one from collecting workers' compensation have been hotly debated in recent years. In the early 1990s, the system underwent an overhaul that was hailed as a badly needed reform by some and decried by others as a shredding of the safety net for America's workers. Included among the changes — and regulations are different in each state — are the strengthening of procedures to evaluate impairment, the introduction of managed care systems, reductions in cash benefits (meaning income replacement payments), and provisions designed to reduce fraud.

More employers are finding alternate work assignments for their employees after they are injured and can no longer perform their original tasks, which means workers are receiving full disability benefits for shorter periods of time. And disability-case management is also encouraging people to go back to work sooner than they would have in the past. There are also more stringent rules about the kinds of injuries and conditions that will be compensated.

The typical Workers' Compensation statute has the following features:

The Compensable Injury Requirement - An employee is automatically entitled to certain benefits whenever the employee suffers from an accidental personal injury (or in some states occupational disease) arising out of and in the course or scope of employment. There are differences among the states as to the exact language employed to qualify the injured worker for benefits, with some states having peculiar meanings to some of the same wording. The word "accident" is interpreted differently between the states. Not all states even have that word in their statutes. The meanings of the phrases "arising out of" and "in the course" or "scope" of employment are also different between the states, thereby giving new meaning to the cautionary instruction that the injured worker should always seek experienced counsel in these cases.

"Arising out of " - The injury was caused by a risk to which the worker was subjected by his or her employment. "*In the course of*" - This is a term of art involving consideration of the time, place and circumstances of the accident in relation to the employment. Thousands of state court decisions can be found discussing such issues as going to and from work, walking into the plant from the parking lot, coffee breaks, lunch breaks, trips between employment locations, company sponsored picnics or sporting events, etc.

Fault Is Irrelevant - Fault on the part of the employer and/or the employee is largely immaterial, although a body of cases has arisen over such issues as horseplay, intoxication, and willful disobedience to the instructions of the employer.

Employee vs. Independent Contractor - Coverage is limited to those having the status of an employee, as opposed to an independent contractor. Again, a large body of cases has arisen over the distinction between an employee and an independent contractor, and this distinction is in many cases, hazy, at best.

Temporary Total Disability Benefits - Lost income benefits to the employee during the period the employee is out of work under active medical care (called temporary total disability) of anywhere from one-half to two-thirds of the employee's average weekly wage.

Permanent impairment or permanent disability benefits - Most states provide some form of compensation to the injured employee for certain categories of permanent injury. These are not to be mistaken for general damages for pain and suffering such as are awarded in civil damage claims within the court system.

Death benefits - Most states provide some form of compensation for survivors of workers who are killed as a result of job related accidents. Most often the compensation is an effort to replace the lost stream of income to the decedent's surviving dependents.

Hospital, medical and vocational rehabilitation expenses - Generally, all reasonable and necessary medical care required by the injured worker is covered, including prescriptions, medical appliances, etc. Needless to say, the medical condition requiring treatment must be causally related to the injury. Some states regulate the amounts the medical care providers may charge for treatment, and make charges in excess of the permitted amounts unenforceable by the medical care provider. States differ on the right of the injured worker to choose the person(s) who will provide his/her medical care, with some states leaving this choice entirely up to the claimant and other states heavily regulating it by requiring that physicians be chosen from panels or selected by the employer.

"Statutory Immunity" of the Employer - Third Party Suits - The employee, in exchange for the certainty of receipt of benefits regardless of fault, under most states' laws is

deemed to have given up his or her common law right to sue the employer for negligence and damages for any injury covered by the statute. This is called the "statutory immunity" of employers. It was one of the historic trade-offs legislatures made to justify requiring employers to pay workers' compensation regardless of whether they were at fault. Most states retain the right of the employee to sue an outsider (a person or company other than the employer) for negligence or any other tort theory of liability, such as product liability or medical malpractice. These are called third party suits.

Covered Injury - In most states an injury must be an event-taking place within a relatively short time frame, producing physical harm to the injured worker. Some states require a form of trauma. Some states with laws containing the term "accidental injury" will disallow claims for lifting or strain injuries not produced by a traumatic event such as slipping, tripping and falling, unless the amount of lifting required of the employee can be shown to be unusual for the particular employment. Other states are not as strict, and will allow almost any claim for an injury, which is causally related to work activity. An injured worker should never assume his/her injury is clear-cut or covered and should always seek experienced counsel as soon as possible after the injury.

Occupational Disease - The common element in most occupational disease statutes is a disease or condition, which is characteristic of the trade or occupation of the worker, and is shown by medical evidence to be causally related to the trade. In other words, diseases, which might be contracted in other occupations or in everyday life apart from employment, are usually not compensable.

Temporary Total Disability - This is payable when the injured worker is unable to work during a period when he/she is under active medical care and has not yet reached what is called "maximum medical improvement". Disputes often arise both on the issue of whether the injured worker is, in fact, disabled from work and on the issue of whether maximum medical recovery has been reached. In most states, compensation is paid at two-thirds of the employee's average weekly wage, not to exceed statutory weekly maximums above which no worker is entitled to be paid. It is not unusual for an employee's temporary total disability weekly benefit to be capped by these statutory maximums.

Temporary Partial Disability - An employee may be eligible for temporary partial disability when he or she is able to do some work but is still recuperating from the effects of the injury, and is, thus, temporarily limited in the amount or type of work which can be performed compared to the pre-injury work.

Permanent Partial Disability - These benefits are awarded for certain types of permanent conditions that do not cause the employee to be totally unable to work. As previously indicated, there is a wide variety of different ways the various states treat

permanent injuries, and it is necessary to consult counsel in one's state to understand that states' rate structure for permanent injuries.

Permanent Total Disability – For this benefit, it must generally be shown that the employee is unable to return to work in any capacity, and that this is a permanent problem. On the other hand, there are rulings in many states to the effect that a worker, who can perform only occasional, sporadic or undependable work, may still be deemed to be permanently totally disabled. Frequently a states' workers' compensation law permits the hearing officer to take into account a workers' age, education, training and experience in making the determination of whether the worker is capable of substantial gainful employment.

Disfigurement/Mutilation - A state's workers' compensation law may permit the employee to be compensated for disfigurement or scarring, frequently in the absence of any actual impairment, and sometimes in addition to actual impairment. The workers' compensation system in most jurisdictions is a highly complex statutory scheme with great variation, depending upon the particular jurisdiction in which a worker is injured.

Insurance

Many states have a procedure for authorizing larger, more secure employers to self-insure, a process that typically requires the business to maintain a hefty cash reserve earmarked for workers' compensation claims. Usually, this is not practical for small businesses. Often one can save money on premiums by coordinating workers' compensation coverage with property damage and public liability insurance. Insurance rates are based on the industry and occupation involved, as well as the size of the payroll. One's safety record can also influence the rate.

Controlling Costs

Premiums are based on two factors:

- industry classification;
- payroll.

If the employer's premium is above a certain amount - $5,000 in many states – his actual experience with workers' compensation claims will affect his premiums. His rate can go up or down, depending on how his claims compare with other businesses in his industry. The number of claims filed by his employees affects his premium more than the dollar value of the claims. It is assumed, if there have been a lot of accidents, that the workplace is unsafe, and that the insurance company eventually will have to pay out some large claims. There are some steps the employer can take to try to keep his workers' compensation costs down.

Eligibility

If one's work injury is severe, he may receive benefits for the rest of his life. But that is less likely today because medical advances are helping to get people back to work quicker, and of course managed care is guarding the purse strings with respect to medical benefits. One gets benefits under workers compensation only if he is injured on the job or develops an occupational disease.

The employer usually does not have to dig very deeply into the fine points of workers' compensation law. The state fund or private insurance company that covers one's workplace will have its own lawyers resolve legal questions about whether a worker is entitled to compensation for a particular disability and, if so, how much the worker is entitled to receive. When a worker seeks to receive benefits that are questionable, these lawyers will challenge the employee on behalf of the employer.

To be covered by workers' compensation, an employee's injury need not be caused by a sudden accident such as a fall. Any injury that occurs in connection with work is covered. Many workers receive compensation for repetitive motion injuries such as Carpal Tunnel Syndrome, which primarily afflicts the wrists, hands and forearms.

If a worker's injury was intentionally self-inflicted or was caused by substance abuse or by some other non-work cause such as a hobby, the injury will not be covered. But in a disputed case, the worker is still likely to get the benefits by showing that his or her behavior was not the only thing that caused the injury.

Workers may also be compensated for some illnesses and diseases. An illness is likely to be covered by workers' compensation when the nature of the job increases the workers' chances of suffering from that disease. Illnesses that are the gradual result of work conditions—for example, emotional illness, heart conditions, lung disease and stress-related digestive problems—increasingly are being covered by workers' compensation. Dependents of workers killed on the job can usually collect workers' compensation benefits.

Basic Mechanics

Workers compensation insurance covers medical care, dismemberment, disability, and death (with each state defining a benefit level that employers must meet). Essentially, the medical benefits are the same as those one would get with health insurance. But, unlike with health insurance, one can also be compensated for lost wages as long as he is considered partially or permanently disabled.

It is tricky to make generalizations about compensation for pain and suffering because it depends on the state. Payment for pain and suffering is sometimes a part of a lump-sum settlement. It is not a benefit per se, but it may be included. Compensation for

pain is recognized in some jurisdictions as part of the total body award or the settlement a worker receives if he or she is permanently and totally disabled.

There is a controversy over whether physical pain can be measured, and many jurisdictions do not compensate for mental anguish. But if the workers compensation jurisdiction takes a holistic approach in assessing eligibility for benefits — including an analysis of the worker's ability to perform the tasks of daily living — then pain and mental anguish payments may be included.

Today, workers' compensation laws are in place throughout the United States and Canada. The system has expanded beyond that originally contemplated, to include work-caused illness as well as injury. For many, the benefits received are terribly low; creating not so much a safety net but a few slender threads that may cushion the fall but not prevent permanent financial injury.

Although employees primarily receive the benefits of workers' compensation, it is the employer who pays the costs. Civil and sometimes even criminal penalties can be brought against an employer who fails to provide for employee coverage, whether through a private insurance company, adequate self-insurance, or a non-profit state compensation insurance fund. The advantages to the employer are:

- his liability for on-the-job injuries is limited to the remedies available under the workers' compensation system
- he can not be sued for everything he owns
- the types of benefits he has to pay to employees are limited to those available under the laws
- his disability planning is made easier because the costs are predictable

The disadvantages to him are:

- his premiums may be high, depending upon his accident record
- filing requirements increase his administrative burdens
- spurious claims may needlessly take up his time

Here are some common elements shared by the state workers' compensation laws:

- Benefits are provided for accidental job-related injury;
- Benefits include wage-loss, medical, and death benefits;
- Employees retain the right to sue negligent third parties;
- Fault is generally not an issue — neither the employee's own negligence in causing the accident nor the employer's complete lack of fault are factors in deciding whether the worker gets benefits.

- Law defines covered "employees" — "employees" generally does not include independent contractors.
- Most employers are required to participate — except in Texas and New Jersey, which have voluntary systems.

Workers' compensation benefits are payable only for work-related injuries. Benefits are not available for self-inflicted injuries or for those caused by intoxication or substance abuse. The payable benefits include:

- income replacement for partial or total disability of a temporary or permanent nature
- medical and rehabilitation costs
- survivor benefits in the case of a fatal illness or injury

Coverage is provided for certain occupational diseases that are set out in the state laws. There are two important actions to take when a job-related accident happens. The employer must file an accident report with the appropriate workers' compensation agency in a particular state. He or she should, at least initially, treat every injury as legitimate, even if the circumstances surrounding the injury make him suspicious.

File an accident report. Each state has its own laws that determine the time period within which reports must be filed. One's state agency will decide whether payments should be awarded to his employee. An appeal to a court of law is usually allowed only where the facts are in dispute. Payment of compensation benefits to the employee is usually made after a waiting period, most commonly three to seven days, and is retroactive.

Treat accidents as legitimate. Although workers' compensation laws protect the employer from lawsuits for workplace injuries, they do not completely insulate him from being sued. His employees, for example, could sue him for failing to provide them with the workers' compensation benefits to which they are entitled. Treating every accident as legitimate will help reduce the chances of being sued. To treat every accident as legitimate, the employer should do the following:

- Respond to the injured employee — this includes providing assistance, getting the facts from the employee about the accident, and telling the employee that there is a system available that will take care of the injuries.
- Give first aid or get medical attention — this includes accompanying the employee to the medical provider.
- Document the accident — this includes writing down what happened, which should be done within 24 hours of the accident, designating who should be the contact person who stays in touch with the family, and explaining to the employee which benefits are available.

- Ensure prompt medical treatment — this includes following up with the medical care provider (although one should first get permission from the employee to contact the provider).
- Follow up with the employee to file an accident report.

Most states have special administrative systems to handle disputed cases. These states have established administrative hearing boards apart from their court systems to handle workers compensation cases that cannot be resolved by the parties themselves. Because courts of law do not generally handle workers' compensation cases, there are no juries and the rules of evidence are more lenient than would otherwise be true. This allows cases to be decided more simply than would be required in a full-blown trial.

In order to qualify for benefits under the workers' compensation statute, the injury or illness must be work related. If an employee is injured while driving to his job as an assembly-line worker, he will not be compensated. However if a traveling salesman is injured in an accident, his injury will probably be covered, since traveling to and from appointments could be considered one of the requirements of the job.

In addition to compensating for injuries sustained in industrial accidents, workers' compensation will also pay benefits for sufferers of some occupational diseases. An occupational disease is one that arises out of and in the course of employment and is peculiar to that occupation. There is also a growing controversial trend in some states to award benefits for illness caused by stress or for heart attacks, if the malady can be shown to have been partially caused by the work environment.

Workers' compensation is a pure no-fault system, so it does not matter whether the worker, a fellow employee, or the employer caused the injury. The worker who drops a heavy box on his own foot will receive the same rights under workers' compensation as the co-worker who hurts his back trying to lift the box off his injured co-worker.

One does not need to hire a lawyer if he wishes to pursue his rights under workers' compensation. He can represent himself, and many states allow non-lawyers such as union representatives to assist in workers' cases. However, despite the fact that workers compensation systems are designed to remove fault from the process and seek to simplify the resolution of disputes, attorneys remain integral to the successful operation of the system.

Few insurance companies pay benefits gladly, even when they cannot dispute that certain benefits are due. If there is any way to eliminate or reduce benefits, the company will dispute all or part of the worker's claim. The company may contest the extent of the injury that is work related. Or they may claim that the worker is fit and does not need to continue receiving medical care. When disputes arise, workers often hire lawyers to fight for their rights.

Filing Claims

The employer needs to file the claim. The employee should report an injury to his employer as soon as it happens, and they should take it from there. The employee should keep his own records. One's employer will file a claim with its insurance carrier, which in turn files with the state. Or, if the company is self-insured, it will file the claim directly with the state. If the employee is concerned about the status of his workers' compensation claim, he or she should check with his employer first and then seek out the state's workers' compensation agency.

In some cases, one may have to resort to litigation if he or she has been wrongly denied workers' compensation benefits. But there are usually other ways to handle the dispute. ***Some states have an ombudsman who explains workers' rights, and the services of the*** ombudsman may be enough to resolve the claim. For example, if an employer has told an employee that he or she has to go to a doctor chosen by the employer, when in fact state law entitles him to use a doctor of his choosing, an ombudsman will inform him of that right. Other states use mediators to resolve disputes.

CHAPTER SEVENTEEN

WORKERS' COMPENSATION POLICY

Before 1954, the Workmen's Compensation policies applied to the workmen's compensation acts of the states in which the insurance was purchased, assuming that is where the insured was located. Where there was any indication that the insured might be subject to the workmen's compensation acts of other states, endorsements were added to the policy in order to provide the necessary additional coverage.

The present Workers' Compensation policy gives automatic coverage for all operations and locations of the insured within the scope of any state compensation law named in the Declarations. The specific workers' compensation law becomes a part of the policy.

Although all casualty policies must conform with the laws of the jurisdictions where they apply, none is so tied in, hand and foot, with any particular statute as the workers' compensation policy. The provisions of this policy are the provisions of the Workers' Compensation Act of the state in which it is applicable. It differs again from liability policies in that it is actually a combination of two separate and distinct policies.

Coverage A-Workers' Compensation

Employees whose salaries are included in the payroll upon which the policy premium is based are covered by this compensation. All employees entitled to receive benefits under the particular Workers' Compensation Act or Acts are covered. The obligation of the insurance company is a direct one, from the carrier to the employee, instead of the employer.

The obligations of the company may be enforced by such person, or for his benefit by any agency authorized by law, whether against the company alone or jointly with the insured. Bankruptcy or insolvency of the insured or of the insured's estate, or any default of the insured, shall not relieve the company of any of its obligations under Coverage A.

The policy goes on to state that notice or knowledge of the injury on the part of the insured shall be notice or knowledge on the part of the company, and that the company will be bound by the findings, awards and judgments rendered against the insured, within the provisions of the Workers' Compensation Law.

If payment is made in excess of the regular benefits because of the serious and willful misconduct of the insured, or because of employment in violation of the law with the

knowledge of the insured or any executive officer, then the company is entitled to reimbursement for such excess from the insured.

The policy contains a Definitions section in which Workers' Compensation Law is defined as including an Occupational Disease Law of the state designated in the Declarations, but does not include any provisions for non-occupational disability benefits. Under the same section, the policy distinguishes between bodily injury by accident and bodily injury by disease, and gives the standard definition for assault and battery.

Section IV of the policy states that it applies to any accident occurring during the policy period and to any disease caused or aggravated by exposure provided that the last day of the last exposure in the employment of the insured to the conditions causing the disease occurs during the policy period.

The policy conditions require the insured to give notice of injury *as soon as practicable* and notice of suit immediately, but as with all of the provisions of this policy, if there is any contradiction between the statute and the policy, the statute always prevails. The interpretation of "*as soon as practicable"* by the courts has made a shambles of any effective defense for failure to properly report a workers' compensation claim.

With rare exceptions, the injured employee is hardly ever held to any strict reporting responsibility to his employer. The policy follows the format of the casualty policies and some of its conditions are similar to other policies.

Coverage B - Employers' Liability

Coverage B provides employers liability protection for the insured in addition to the workers' compensation coverage provided under Coverage A.) The Employers Liability section of the combined policy properly falls with the Public Liability group. It covers the employer for his legal liability.

With the continued growth of the Workmen's Compensation Acts, and the development of Workmen's Compensation insurance, Employers' Liability policies became less important until today they play a relatively minor part in the casualty insurance field. However, as long as Workers' Compensation Acts continue to restrict some types of employment and certain numbers of employees from coverage, there will be a continuing need for Employers' Liability insurance.

Basic Features

The Employers' Liability policy was primarily designed for the protection of the insured, and not for the benefit of his employee, as with Workers' Compensation insurance. Coverage is restricted to the liability imposed by law upon the insured employer. The

insurance carrier can avail itself of all the common law defenses open to the employer, unless those defenses were modified by statute.

According to The Insuring Agreements in the Employers Liability section of the policy it provides that it will cover the liability for disease to which the last exposure, which caused or aggravated the disease in the employment of the insured occurred during the policy period. The Employers Liability provisions specifically state that "the limit of liability stated in the declarations for coverage B is the total limit of the company's liability for all damages."

Employers Liability does not apply to liability under any workers' compensation law. Its sole purpose is to protect the insured from his possible liability to employees apart from, and distinct from, any Workers' Compensation Act. In addition to the two exclusions mentioned in Coverage A, and which also apply to Coverage B, the Employers Liability section of the policy excludes:

- Liability assumed by the insured under any contract or agreement, but this exclusion does not apply to a warranty that work performed by or on behalf of the insured will be done in a workmanlike manner.
- Punitive or exemplary damages on account of bodily injury to or death of any employee employed in violation of law or so employed with the knowledge of the insured
- Bodily injury by disease, unless prior to thirty-six months after the end of the policy period, written claim is made or suit is brought against the insured for damages because of such injury or death resulting there from.
- Any obligation for which the insured or any carrier as his insurer may be held liable under the workman's compensation or occupation disease law of a state designated in the declarations or similar law.

Calculation of Cost

The workers' compensation board in one's state determines the cost of workers' compensation insurance. Although base rates vary slightly from state to state, the basic process each state uses to calculate base rates is similar.

Each type of occupation is assigned a **risk classification**. Risk is determined by two factors: the frequency of on-the-job injury and the severity of injury. Severity is measured by both medical payments and indemnity benefits (payments made directly to the injured employee to compensate for losses suffered as a result of an accident).

Obviously the occupational hazards of a roofer are much different and quite a bit higher than those of an office clerk. Therefore, workers' compensation rates are much higher for roofing companies than for administrative companies. To arrive at a base

rate for workers' compensation insurance, each classification is translated into a dollar amount, which is then multiplied by 1% per $100 of the total payroll for that employee.

Workers' compensation insurance carriers can reduce or increase base rates based on a number of factors. The most important factor is the employer's safety history. Another important factor is whether or not the employer offers health insurance to their employees. Employers' costs, including workers' compensation insurance premiums and benefits administration by self-insured employers, fell from $57 billion in 1995 to $55.2 billion in 1996, a 3.3% decline. Employers' costs peaked at $60.8 billion in 1993.

Occupational Disease

The Workers' Compensation policy gives complete coverage for occupational disease. There is great variance on this subject in different jurisdictions. In some states, practically all occupational diseases are covered in either the Workers' Compensation Act or in a separate Occupational Disease Act. In other states, certain specified diseases only are covered. The policy follows the laws of the state or states in which it is applicable.

The Employers Liability section of the policy covers liability for bodily injury by accident or disease so it is quite clear that coverage is provided for occupational disease. There is a limitation. Claims must be brought against the employer within thirty-six months after the policy period and the last day of the last exposure to a disease during the employment of the insured and must have occurred during the policy period.

It is sometimes technically difficult to distinguish injury from disease. Usually we think of injury as being related to accident and applying more specifically to a disability resulting from some specific outward force. We think of disease as a bodily disability that is the result of gradual exposure or deterioration.

Under the various statutes, diseases contracted by reason of employment are generally considered as injuries. They are not ordinarily construed as being contracted by accident. Those states, which still use the word accident, provide no coverage for occupational disease unless separate occupational disease statutes have been enacted. Some provision has been made in all jurisdictions for disability resulting from occupational disease.

An occupational disease is one definitely associated with some employment hazard, which is not likely to be incurred by a member of the general public. It may range from industrial skin conditions that are not usually too serious, to diseases, which affect the vital organs and are deadly in nature.

Benefits provided for occupational diseases do not necessarily correspond with those provided for injuries that fall within the regular provisions of the workers' compensation laws.

The statutes dealing with occupational diseases generally require a time limitation within which notice of the incidents or claim must be given. This usually commences when the disease or injury first manifested itself.

Special Endorsements

Most of the Workers' Compensation Acts exempt certain classes of employees such as domestics, and others specifically listed, from coverage. The employer may obtain Workers' Compensation coverage for such employees by endorsement, for an additional premium.

By issuing such an endorsement, the carrier agrees to pay the benefits stipulated in the Workers' Compensation Act, as though the employee was actually covered under it. The employer and his insurer retain such defenses as would be available under the Act and, in most instances, the employee retains his right to pursue an action under common law if he does not choose to accept the Compensation benefits.

CHAPTER EIGHTEEN

PRINCIPLES OF EMPLOYER LIABILITY COVERAGE

There have always been difficulties in fixing and defining the boundaries of coverage. Problems in this area have largely been the result of a failure to properly identify and inquire into the issue of the scope of the risk. One can best understand scope of the risk questions by reference to three broad categories of risks.

- Definite employment risks, such as the loss of a limb by a machinery operator
- Personal risks, such as an injury produced by an epileptic seizure while at work
- Neutral risks, such as acts of God, or random acts of violence unrelated to one's employment

Principle of Risk

One of the major controversies in workers' compensation coverage is with regard to whether a sufficient relation exists between one's employment and one's injury. Time, place, and circumstances may be relevant, but the real question here is whether the perils of such a journey should be within the scope of the risk created by one's employment, given the policies and purposes of workers' compensation. There is also a necessity for a factual connection between one's activities at the time of injury and the injury of which one complains. The principal elements directed at coverage in workers' compensation cases are:

- Scope of the risk;
- Sufficient relation to employment;
- Factual cause.

The coverage formula used in the majority of workers' compensation acts requires a "personal injury or death by accident arising out of and in the course of employment." The coverage formula requirements of "personal injury by accident" have caused problems in cases involving diseases, mental illnesses, and injuries to artificial limbs. We will look at this later also.

Basic Risk Doctrines

First, we are going to discuss the five basic risk doctrines employed by the courts to determine the scope of the risk.

Proximate Cause

Judges have had difficulty separating themselves from tort law with its *proximate cause* and fault concepts. Therefore, some early cases adopted the fault-related proximate cause test for the "arising out of" concept, which required that one's employment be the proximate cause of one's injury. This approach is much too narrow, and it is incompatible and in conflict with the objectives of any statutory no-fault compensation system.

Actual Risk

The actual risk doctrine is a liberal approach toward the scope of the risk issue. The sole question to be answered is whether the risk realized was a risk of one's employment, regardless of whether the risk is commonly shared by the public. Heat prostration would be compensable if the nature of the employment exposed the employee to the risk. The fact that the risk is common to all who are exposed to the sun's rays on a hot day would be immaterial.

Increased Risk

The increased risk doctrine is a modern approach that provides broader coverage than the peculiar risk test. This approach includes within the scope of the risk those risks to which an employee has been exposed for a longer period of time than the public, even though all commonly shares the risk. If one's employment results in a greater exposure to a risk there would be coverage even though the risk is not one that is different from that shared by others. For example, the farm worker who is constantly exposed to extreme heat on the job and who suffers from heatstroke should be entitled to compensation under the increased risk theory.

Peculiar Risk

The peculiar risk doctrine was a concept that excluded coverage for injuries caused by risks that were within the course of one's employment, but which were commonly shared by others, even though the employee was exposed for a longer period of time by virtue of the nature of the employee's employment.

Positional Risk

The positional risk doctrine is the most liberal of the scope of the risk theories, and it has been adopted in a few jurisdictions. The only inquiry under a positional risk theory is whether one's employment was responsible for one's being at the time and place where an injury occurred. The most neutral of risks can be included under this doctrine

Types of Risk

Acts of God

While acts of God such as windstorms, tornadoes, exposure, lightning, floods, earthquakes, etc., would at first appear to be outside the employment risk, it is generally agreed that if one's employment has enhanced or "increased" the risk of injury from these sources, the injury would be compensable. In addition to an *increased risk* approach to recovery, it may be possible to recover on the basis of *actual risk* or *positional risk* theories. The *proximate cause* or *peculiar risk* approaches would disallow compensation.

Imported Dangers

It is common for employees to be exposed to a risk of harm that they or their fellow employees have imported to the worksite. A danger imported by one's co-employee, while it may appear to be a neutral risk, could give rise to recovery on the basis of increased, actual or positional risk theories. An employee might be able to recover for the realization of a personal risk that the employee has imported, if it could be established that the employment had increased such a risk.

Assault

Assaults are considered to be within the scope of the risk and to arise out of one's employment when the nature of the employment increases the likelihood of such an occurrence, or if the assault has grown out of a controversy that is work related. Usually assaults are not within the scope of the risk if they have been prompted by malice or personal motives. Assaults in some cases, such as those by stranger, lunatics, children, etc, may be viewed as neutral risks outside coverage. The aggressor defense has been discredited today because it creates a fault-based defense in a no-fault system.

Pre-Existing Injury or Disease

It is not uncommon for employees to bring pre-existing medical problems to the workplace. The difficulty posed in this area stems from the fact that pre-existing medical problems constitute personal risks, which would fall apart from coverage. The obvious problem facing employees is that of factual cause and medical proof. One must establish through expert medical testimony the fact of aggravation and a causal connection between one's employment and the claimed injury.

Heart Cases

One of the most problematic areas in the law of workers' compensation is that of heart cases. The approach on of whether or not a personal injury "by accident" has occurred requires that "unusual" strain or exertion precipitate the heart attack. This is an impractical and unsatisfactory test for coverage in heart cases; distinctions between

usual and *unusual* strains are practically impossible to make, and serve to confuse the issue.

It is better to approach this issue from a scope of risk perspective. If one's employment has contributed to the heart attack because of exertion or other work-related circumstances, the attack may be found to have arisen out of one's employment. Otherwise, heart attacks occurring on the job would involve personal risks.

Unexplained Accidents

Coverage questions arise in cases of unexplained deaths, unexplained falls, and idiopathic falls. A strict application of the neutral risk or personal risk theories could result in a denial of coverage, even if a fall or death occurred in the course of employment. An application of the positional risk doctrine can result in recovery even if the cause of a fall or death is unknown, because of the employment relation that existed at the time. The positional risk doctrine could also permit recovery in idiopathic fall situations in which the fall was the result of a purely personal condition, if, for example, the fall occurred at work.

Principle of Personal Injury

The terms injury or personal injury in the workers' compensations acts means only injury by accident arising "out of and in the course of the employment" and shall not, except as provided in regulations, include a disease in any form except where it results naturally and unavoidably from the accident. Injury and personal injury shall include the aggravation of a preexisting condition by accident arising out of and in the course of employment, but only for so long as the aggravation of the preexisting condition continues to be the cause of the disability The preexisting condition shall no longer meet this criteria when the aggravation ceases to be the cause of the disability.

Injury and personal injury shall also include emotional or mental injury requiring professional treatment and care arising out of and in the course of employment and resulting from an employee being a victim of a violent act or from direct exposure to a violent act which violent act is a crime.

Injury and personal injury does not include injury caused by the willful act of a third person directed against an employee for reasons personal to such employee, nor shall injury and personal injury include heart disease or heart attack - the failure or occlusion of any of the coronary blood vessels, stroke, or thrombosis unless it is shown by a preponderance of competent and credible evidence, which shall include medical evidence, that any of such conditions were attributable to the performance of the usual work of employment.

Alcoholism and disabilities attributable thereto shall not be deemed to be 'injury' 'personal injury' by accident arising out of and in the course of employment. Drug addiction or disabilities resulting there from shall not be deemed to be 'injury' or 'personal injury' by accident arising out of and in the course of employment except when such addiction or disability resulted from the use of drugs or medicines prescribed for the treatment of the initial injury by an authorized physician.

Principle of Eligibility

The principal prerequisite for recovery under Workers' Compensation Acts is that the injured be an employee. Usually employment is so obvious that it presents no unusual difficulties. There are, however, many instances in which the relationship is questionable.

The original report of accident and the preliminary investigation will indicate that there is no question concerning employment. The problem of obtaining confirmation from the employer is then a relatively simple one. The questionable case, however, contains many pitfalls for the unwary claim representative. In the serious cases at least, an extensive investigation should be completed if there is any reason to suspect anything other than a direct employer-employee relationship.

Employees and Employers

There is no simple definition of "employee" that will fit all of the circumstances. The common law defined a master as one who employed another to perform services and who controls or has a right of control over the other's conduct in performing such services. The master had to have not only the power to control, choose, and direct the servant with regard to the object to be accomplished but also had to possess the power to control the details of the work.

The principal consideration is control. To determine control, the claim representative must look into the character and conditions of the employment in all its aspects. The common law definitions are still of importance in establishing who is an employer and employee, but the definitions provided in workers' compensation legislation are controlling. A liberal construction should be given to the definitions of employer and employee because of the objectives of workers' compensation and the need to make coverage as expansive as possible.

Problems arise with the employer-employee relationship when an independent contractor is involved. Generally, an employer of an independent contractor is not liable for the negligence of the contractor. However, an exception to the general rule of non-liability may exist where an employer fails to employ a competent and careful contractor that leaves the employer liable for injuries caused by the contractor's failure to exercise due care.

CHAPTER NINETEEN

UNDERSTANDING EMPLOYER LIABILITY

The Employers Liability Act

The Employers' Liability Act extended protection to workers concerning accidents caused by the negligence of managers, superintendents and foremen. Railway companies were also made liable when their employees were injured through the negligence of signalmen, drivers and point's men. However, the act did not protect employees against accidents caused by fellow workers.

Negligent Hiring

A woman is assaulted in her own apartment. In fact, the woman had willingly let the perpetrator into her home, because he was her apartment complex's maintenance man and he had come to fix her dishwasher. In order for the apartment complex, the maintenance man's employer, to be liable for this tortuous act of its employee under the traditional doctrine of respondeat superior, the maintenance man must have been acting within the scope of employment and in furtherance of the employer's business.

This woman would be forced to prove that the assault was committed within the scope of the maintenance man's usual duties and that the apartment complex, through action or inaction, ratified the conduct of the maintenance man. Unfortunately, this woman, like many other victims of similar crimes, will not be able to prove that the employee's injurious conduct was in the scope of employment or in furtherance of his master's interest. However, she may have another option.

Considering Negligent Hiring as an Alternative

The doctrine of negligent hiring is a broad doctrine that extends liability to employers for the injurious conduct of its employees even when the injurious acts are committed outside the scope of employment. Specifically, liability may be imposed when an employer places a person "with known propensities, or propensities that should have been discovered by a reasonable investigation, in an employment position in which, because of the circumstances of the employment, it should have been foreseeable that the hired individual posed of a threat of injury to others."

Liability will not be imposed upon an employer who simply fails to investigate or adequately investigate the employee unless the investigation would have disclosed

information that would have put the employer on notice that the prospective employee posed a risk of harm to others.

Since negligent hiring alleges the employer hired a dangerous or incompetent employee, the person's character, reputation and criminal record may become important issues. The victim may introduce evidence of an employee's prior misconduct to illustrate the employer's failure of reasonable care. With negligent hiring causes of action, victims may be able to seek punitive damages against an employer who was reckless or grossly negligent in the hiring of an employee. However, in negligent hiring cases, some juries are quite willing to award punitive damages against employers.

The Employers' Knowledge of Employee's Unfitness

The victim possesses the burden of proof in regard to the unfitness of the employee and risk of harm that the employee posed to persons who might come into contact with the employee due to the job. Thus, the victim must prove that the employer had actual or constructive knowledge that the employee is unfit; the employer knew or should have known of the employee's dangerous propensities. Actual knowledge exists when the employer personally witnessed such violent propensities in the employee.

On the other hand, constructive knowledge may be found when a reasonable investigation would have put the employer on notice of the employee's criminal or tortuous tendencies. Similarly, summary judgment in favor of a hospital was reversed because the court found that there was sufficient evidence, by way of an affidavit, which demonstrated that the hospital could have discovered through reasonable diligence that a nurse, who repeatedly made sexual advances toward patients, had a criminal record. A number of other factors are considered regarding the background an employer knew or should have known.

Proximate Cause

Not only must an employer have a duty to investigate the employee, the breach of that duty must be the proximate cause of the victim's injury. The victim must establish that his or her injuries were actually and proximately caused by propensities of the employee that the employer knew or should have known posed a risk of harm to others.

The proximate cause combines a necessary showing of cause-in-fact as well as a showing of foresees ability. Sometimes the employment relationship is not instrumental to the employee committing the crime.

In the end, the responsibility for criminal acts is with the perpetrator. Yet, when an employer puts that dangerous person in a position to harm others, the employer should be liable. The liability not only means monetary compensation to the victim, but also

serves as a deterrent example to other employers when making hiring decisions. In the long run, successful recovery against employers under the doctrine of negligent hiring will greatly benefit individual victims as well as society at large.

Employer Liability

If an employer decides to hire or lease employees or use independent contractors, it is important to be aware of the federal and state laws that may affect those relationships. Whether or not a business is subject to specific employment laws depends on how many employees that business has and for how long. There's a large array of federal and state laws and, in some states, it only takes one employee to make an employer subject to certain employment laws. The legal liability as an employer involves four things:

- Understanding the definition of an employee;
- Knowing status of one's liability under federal employment laws;
- Knowing status of one's liability under state employment laws;
- Structuring contracts for non-employees to minimize liability.

Many business owners think that the way to get around all of the employment laws is not to have employees and to employ leased workers, temporary workers, or independent contractors.

Most employers are required by the law to insure against liability for injury or disease to their employees arising out of their employment. The employer is responsible for their health and safety while they are at work. If one is injured as a result of an accident at work, or becomes ill as a result of his work, and if he believes his employer is responsible, he may seek compensation from him. In order for the employer to pay the compensation they must take out an insurance policy. This is employers' liability insurance.

Liability Insurance

Employers' liability insurance will provide compensation for injuries or illnesses caused on or off site. Any injuries or illnesses relating to motor accidents, which occur as a result of one's employment, may be covered separately by his employer's motor insurance.

Public liability insurance is different. It covers employers for claims made against them by members of the public or other businesses, but not for claims made by employees. While public liability insurance is generally voluntary, employers' liability insurance is compulsory. An employer can be fined if they do not hold a current employers' liability insurance policy, which complies with the law. All employers must have employers' liability insurance except the following:

- Most public organizations including government departments and agencies;
- Local authorities;
- Police authorities and nationalized industries;
- Health service bodies;
- Some other organizations which are financed through public funds, such as passenger transport executives and magistrates' courts committees.

If one works for one of these public sector organizations, he can still claim compensation if he is injured at work or becomes ill as a result of his work and his employer is to blame. Any compensation will be paid directly from public funds.

Family businesses are also exempt. One's employer will not need employers' liability insurance to cover him if he is closely related, that is if the employer is his husband, wife, father, mother, grandfather, grandmother, stepfather, stepmother, son, daughter, grandson, granddaughter, stepson, stepdaughter, brother, sister, half-brother or half-sister.

Most employers are required by the law to insure against liability for injury or disease to their employees arising out of their employment. This type of coverage is typically found in Part One of a standard policy. When purchasing a workers' compensation policy, however, an employer may also obtain Employers Liability ("EL") coverage, which is written under Part Two of the standard policy. EL insurance provides coverage for claims which arise from injuries suffered by employees in the course of their employment that are not otherwise covered by Part One under the policy. In most cases, a workers' compensation carrier is not subject to a significant risk of loss arising from EL coverage.

Generally, once an employer's obligation to an employee to provide workers' compensation benefits is established, an employee (or his estate) cannot sue an employer based upon common law claims for damages sustained as a result of an injury or death that arose out of and in the course of employment. This exclusive remedy also applies to situations in which an employee's injury or death results from the negligence of a co-employee.

Some state law does provide for three principal exceptions to this exclusive remedy doctrine:

- If an employer fails to provide coverage as required by the WCL, an employee is allowed to either sue for damages that were sustained as a result of the injury or seek benefits provided under the WCL.
- If an employee's injury arises as a result of an intentional act, which *is perpetrated by the employer, or perpetrated by an employee at the*

direction or instigation of the employer, then the employee has a common law right for damages against the employer. In order to prevail, an employee needs to prove that the employer's acts were deliberate and intentional, not merely reckless. Given this standard, EL coverage under Part 2 likely would be excluded for these claims. The standard NCCI policy form, upon which most companies' policies are based, specifically excludes EL coverage for bodily injury intentionally caused or aggravated by the employee. In view of this exclusion, the loss exposure for these intentional-act based claims should be limited.

- A third exception has developed out of common law and appears to provide a significant risk exposure in connection with EL coverage, or the **Dole exception**. Originally, this exception allowed a third party, that was sued by an employee for injuries sustained in the course of the employee's employment, to implead the employer for contribution or indemnification if the third party was found liable for the employee's injuries.

An employee suffers a grave injury in the course of his employment due to actions or negligence of a third party. Although the employer was negligent in connection with the incident (for example, not providing proper safety devices or a vehicle was negligently maintained), the employee recognizes that his only remedy against the employer is workers' compensation benefits. Under Dole, as limited by the amended Section 11 of the WCL, the third party will likely implead the employer for contribution or indemnification in the event the court or jury finds the third party liable for damages.

In spite of the recent limitation of the Dole exception to situations in which an employee suffers a "grave" injury, the implications of this risk are still significant with respect to an insurer's EL loss exposure. The first factor in this regard concerns the potential unlimited liability an insurer faces under EL claims. The New York Department of Insurance takes the position that a workers' compensation insurer is prohibited from imposing any limit for EL coverage in New York.

Despite the intention to limit the broad Dole exception, the status of EL loss exposure in New York is still significant for insurers. To be sure, liability is now restricted to cases involving grave injuries. Yet, these circumstances still can expose an insurer to considerable losses, especially since the New York Department of Insurance will not allow an insurer to place limits on its EL coverage. This risk, coupled with the historical loss data reflecting that EL losses account for a sizable portion of all workers' comp losses, provides ample cause for all parties involved in workers' comp programs, including insurers, agents/brokers, and employers, to carefully weigh potential loss exposure under EL coverage in New York.

Absolute Liability

It is wise for an employer to carry Absolute Liability if his employees are working in extremely dangerous situations. An example would be in the use of explosives: A contractor would almost certainly be liable for damages caused by vibrations of the earth following an explosive detonation. With absolute liability it is usually not necessary for a claimant to establish that the operation is dangerous.

Employment Practices Liability

This protects the corporation, directors & officers and employees for claims resulting from wrongful termination, discrimination, sexual harassment, wrongful discipline and failure to employ or promote. Whether one is right or wrong in the eyes of the jury, the typical defense costs alone average $100,000 - $200,000 per case!

Employment law cases have fast become one of the largest components of the civil dockets of federal courts, rising 125% over the past 20 years. Current trends are showing the majority of employment practices cases are now going into state courts, and therefore, federal court cases are only the tip of the iceberg. In 1994, the average award for a sexual harassment suit was $225,800 and the defense costs on these cases are averaging $100,000-$125,000 each.

Employment Practices Liability means different things to different people, but is commonly defined as a liability resulting from actual or alleged wrongful termination, sexual harassment or discrimination against an employee. Employment Practices Liability Insurance (EPLI) is any insurance policy that covers the liability for claims arising from any of these types of employment –related risks.

EPLI covers defense costs, judgments and settlements for the corporate entity, employees, former employees as well as directors and officers. Depending on the type of business, coverage is provided up to a limit of $50 million. Deductibles range from $10,000 to $25,000. On the average, companies are spending $100,000 annually for EPLI coverage. Workers' compensation, bodily injury and property damage are not covered by EPLI. Here are some tips to limit EPLI exposures in one's business:

- Instill tough "no tolerance" policies toward workplace harassment, discrimination and drug or alcohol abuse;
- Develop an employee standards handbook that defines the skills and performance expected for each position.

Being unjustly accused of discrimination or sexual harassment can seem like a "no win" situation. Making a mistake, terminating or laying off an employee can result in damaging headlines and potential lawsuits, which are costly and demoralizing. EPLI

coverage protects business assets against defense expenses and damages resulting from wrongful employment practices. Insurance is available in all 50 states.

This coverage protects employers against the risks and liabilities that arise out of their employment practices in relation to tests on employee. EPLI covers for negligent actions arising out of other parts of program administration such as a supervisor's handling of a reasonable suspicion test.

EPLI policies today remain a mixed bag, and it is unclear whether such policies will become the rule or remain the exception. It is clear, however, that the number of employment-related lawsuits continues to increase, and that insurance companies are increasing their marketing efforts of these policies. Given these facts, and the fact that employment claims are typically excluded from general liability policies, many employers will consider whether purchasing an EPLI policy makes business sense. Because of the flexible and complex nature of EPLI, employers considering purchasing such a policy, or renewing an existing policy, must be aware of and understand the myriad of issues involved.

One of the most important issues, which must be considered, is whether the employer or the insurer will have control over selection of counsel. Failure to address this issue prior to obtaining a policy may result in a situation in which the employer's long- term attorneys, those most familiar with its operations and policies, and who perhaps even represented the employer with respect to a claim at the stage of an EEOC charge, cannot represent the employer once litigation is filed.

Employers should be aware that EPLI carriers tend to be flexible prior to acceptance of a policy and may permit employers to modify provisions in proposed policies to address these concerns. This flexibility, however, can have the effect of creating uncertainty regarding the scope of coverage; and it is, therefore, important that employers understand what type of lawsuits are covered by the wide variety of EPLI policies, as well as the policy deductibles and policy limits.

If the employer is not insured, his liability hereunder shall be primary and direct. If he is insured, his liability shall be secondary and indirect, and his insurer shall be primarily and directly liable hereunder to the injured employee, his dependents or other persons entitled to rights hereunder. On the request of the division or the commission and at every hearing, the employer shall produce and furnish it with a copy of his policy of insurance.

General Liability

General Liability policies were not specifically designed to cover today's discrimination, breach of contract, and wrongful discharge claims. Numerous courts have held that

such employer conduct does not constitute an occurrence, but is deemed an "intentional act" that falls outside the coverage provided by the standard GL policy.

Most GL policies exclude wrongful discharge and discrimination claims brought by past, present, or prospective employees. In addition, many GL carriers exclude bodily injury claims by employees and consider employment-related emotional injuries to bodily injury. Likewise, umbrella policies frequently contain exclusions relating to termination or failure to promote an employee or failure to hire a prospective employee.

Employer Responsibility

The employer has a particular duty towards his employee. He is by law obliged to provide a safe place of work, a safe system of work and employees are supposed to be correctly trained. In the real world however, particularly in view of the large degree of unemployment, work places are often unsatisfactory but this of itself may not be sufficient for one to succeed in a claim against ones employer. Certain judges may take the view that an employer is only supposed to do what is reasonable in the circumstances in providing employment.

The verified loss of earnings will be recovered when ascertained at the conclusion of the case. The employee should not sign an admission of liability or other document that holds him responsible for the accident. This is often very difficult where an employee is pressured to sign a statement and does not wish to jeopardize his job.

Although the employee may have a cause of action against the employer for negligence which resulted in personal injury, this does not mean that the employer can necessarily dismiss the employee simply because a claim is being brought. If the employer tries to dismiss the employee on these grounds then the employee will have a separate action in the court for wrongful dismissal. If there is a genuine accident at work, the employer realizes that the employee is entitled to be compensated and that's why insurance was arranged in the first place.

An employer may however be entitled to dismiss an employee for different reasons and the employee's rights in these circumstances will depend on, among other things, whether proper warnings were given and whether the employee has worked with the company for a sufficiently lengthy period of time (normally twelve months) to acquire statutory rights.

CHAPTER TWENTY

WORKERS' COMPENSATION & EMPLOYER LIABILITY

Before 1954, when a uniform standard Workmen's Compensation-Employers' Liability policy was promulgated, the policies previously issued applied to the workmen's compensation acts of the states in which the insurance was purchased, assuming that is where the insured was located. Where there was any indication that the insured might be subject to the workmen's compensation acts of other states, endorsements were added to the policy in order to provide the necessary additional coverage. Since the policies differed from state to state, there was much confusion.

The present Workers' Compensation policy gives automatic coverage for all operations and locations of the insured within the scope of any state compensation law named in the Declarations. The specific workers' compensation law becomes a part of the policy.

Although all casualty policies must conform with the laws of the jurisdictions where they apply, none is so tied in, hand and foot, with any particular statute as the workers' compensation policy. The provisions of this policy are the provisions of the Workers' Compensation Act of the state in which it is applicable. It differs again from liability policies in that it is actually a combination of two separate and distinct policies.

Coverage A-Workers' Compensation

Coverage A concerns the obligation of the insurance company under the workers' compensation provisions of the Act. It requires the carrier to pay promptly all compensation and other benefits required of the insured by the Workers' Compensation Law.

Employees whose salaries are included in the payroll upon which the policy premium is based are covered by this compensation. All employees entitled to receive benefits under the particular Workers' Compensation Act or Acts are covered. The obligation of the insurance company is a direct one, from the carrier to the employee, instead of the employer.

The obligations of the company may be enforced by such person, or for his benefit by any agency authorized by law, whether against the company alone or jointly with the insured. Bankruptcy or insolvency of the insured or of the insured's estate, or any default of the insured, shall not relieve the company of any of its obligations under Coverage A.

The policy goes on to state that notice or knowledge of the injury on the part of the insured shall be notice or knowledge on the part of the company, and that the company will be

bound by the findings, awards and judgments rendered against the insured, within the provisions of the Workers' Compensation Law. If payment is made in excess of the regular benefits because of the serious and willful misconduct of the insured, or because of employment in violation of the law with the knowledge of the insured or any executive officer, then the company is entitled to reimbursement for such excess from the insured.

The policy contains a Definitions section in which Workers' Compensation Law is defined as including an Occupational Disease Law of the state designated in the Declarations, but does not include any provisions for non-occupational disability benefits. Under the same section, the policy distinguishes between bodily injury by accident and bodily injury by disease, and gives the standard definition for assault and battery.

Section IV of the policy states that it applies to any accident occurring during the policy period and to any disease caused or aggravated by exposure provided that the last day of the last exposure in the employment of the insured to the conditions causing the disease occurs during the policy period. The policy conditions require the insured to give notice of injury *as soon as practicable* and notice of suit immediately, but as with all of the provisions of this policy, if there is any contradiction between the statute and the policy, the statute always prevails. The policy follows the format of the casualty policies and some of its conditions are similar to other policies.

Coverage B - Employers' Liability

Coverage B provides employers liability protection for the insured in addition to the workers' compensation coverage provided under Coverage A. The Employers Liability section of the combined policy properly falls with the Public Liability group. It covers the employer for his legal liability.

Before the Workmen's Compensation Acts became widespread in this country, the casualty insurance industry was already issuing Employers Liability policies for the protection of employers against claims and suits by their employees. With the continued growth of the Workmen's Compensation Acts, and the development of Workmen's Compensation insurance, Employers' Liability policies became less important until today they play a relatively minor part in the casualty insurance field. However, as long as Workers' Compensation Acts continue to restrict some types of employment and certain numbers of employees from coverage, there will be a continuing need for Employers' Liability insurance.

Basic Features

The Employers' Liability policy was primarily designed for the protection of the insured, and not for the benefit of his employee, as with Workers' Compensation insurance. Coverage is restricted to the liability imposed by law upon the insured employer. The insurance carrier

can avail itself of all the common law defenses open to the employer, unless those defenses were modified by statute.

The Insuring Agreements in the Employers Liability section of the policy state that the insurer will pay damages which the employer is legally obligated to pay because of 'bodily injury by accident or disease by any employee of the insured arising out of and in the course of his employment by the insured either in operations in a state designated in the declarations or in operations necessary or incidental thereof.

As in the Workers' Compensations' section, the policy provides that it will cover the liability for disease to which the last exposure, which caused or aggravated the disease in the employment of the insured occurred during the policy period. The Employers Liability provisions specifically state that "the limit of liability stated in the declarations for coverage B is the total limit of the company's liability for all damages."

Employers Liability does not apply to liability under any workers' compensation law. Its sole purpose is to protect the insured from his possible liability to employees apart from, and distinct from, any Workers' Compensation Act. In addition to the two exclusions mentioned in Coverage A, and which also apply to Coverage B, the Employers Liability section of the policy excludes:

- Any obligation for which the insured or any carrier as his insurer may be held liable under the workman's compensation or occupation disease law;
- Bodily injury by disease, unless prior to thirty-six months after the end of the policy period;
- Liability assumed by the insured under any contract or agreement;
- Punitive or exemplary damages on account of bodily injury to or death of any employee employed in violation of law.

Fraud and Workers' Compensation

The employer may not discriminate against a worker who has filed previous workers' compensation claims. However, when he or she has several suspect behaviors present or he observes an emerging pattern, he or she should investigate. Claimant fraud is the most talked about kind of fraud. It is also the type that employers are in the best position to help uncover. Claimant fraud happens when employees knowingly lie to collect benefits. They may claim an injury was work-related when it wasn't, exaggerate an injury, or secretly continue working while collecting benefits.

Types of Fraud

There are five types of fraud commonly found in the workers' compensation system:

- Attorney fraud;
- Employer premium fraud;

- Health care provider fraud;
- Injured worker benefit fraud;
- Insurance carrier fraud.

Insurance carriers identify a potential workers' compensation fraud case in the following cases:

- duplicate medical billings;
- employer classification codes not consistent with the duties associated with the employer's type of business
- frequent change of doctors;
- health care providers attempting to bill an injured worker for medical services when the injury occurred;
- incorrect information on attorney bills or duplicate billing;
- past history of workers' compensation claims;
- multiple businesses located at the same address.

According to insurance carriers, on average, attorney fraud cases took the longest time to investigate (one to two years) while injured worker benefit fraud cases took the least amount of time to investigate (three to six months).

Although fraud referrals are down in many places, the number of workers' compensation fraud arrests and convictions has steadily increased since 1992. Even with additional staff to handle fraud, the lack of agency policies and procedures associated with prosecuting workers' compensation fraud initially caused problems within the agency including a backlog of cases that have yet to be investigated.

Considering Fraud Losses

The American Insurance Association estimated fraud losses at 10% of the cost of claims paid, or about $3 billion. The National Insurance Crime Bureau doubled the AIA's estimate to $6 billion, even though it was involved in only 99 fraud prosecutions in 1994 and 134 in 1995 nationwide. The Coalition Against Insurance Fraud adopted the AIA's estimate.

The presumption in the press and in the state houses was that fraud was rampant and that most workers' compensation fraud was claimant fraud. Since that time, more than half of the states have passed legislation on workers' compensation fraud, with most of the laws directed primarily at claimants.

Thirty-three states currently have active workers' compensation insurance fraud units, many of them geared to fighting claimant fraud. In its extensive investigation of workers' compensation fraud, one survey concluded that the perception that workers are cashing in

by faking or exaggerating injuries has created a climate of mistrust in which every person who is injured and files a claim can become the subject of suspicion by insurance adjusters, doctors and industry lawyers.

According to surveys some insurance companies saw fraud as a way to explain why premiums were soaring, and politicians and the media jumped on the bandwagon. While some insurance companies claim one out of three workers lie about their injuries, the actual number of fraud cases sent to prosecutors is less than 1 out of 100, or less than 1%.

Defining Employer Fraud

Premium collection is fundamental to the operation of workers' compensation, but amidst the often sensational stories of cheating employees it is easy to lose sight of the other major element of fraud in the industry: premium evasion by employers. Investigations have found many companies who have no workers' compensation insurance whatsoever and many others who under-insure by false declaration of wage levels or by providing misleading information concerning their industry classification. Premium levels are generally calculated as a percentage of total wages and are also influenced by the type of industry an employer is competing in.

Surveys have revealed that the level of non-compliance with correct premium payment in the building industry is between 30-60 percent. Workers have been fined for fraud, but little has been done against employers who are committing unprecedented corporate crime until recently

Types of Employer Fraud

Premium fraud includes a number of schemes used by employers to reduce the workers' compensation insurance premiums by underreporting payroll, misclassifying employees' occupations and misrepresenting their claims experience. According to the National Council on Compensation, the most common frauds include:

- *Declaring independent contractors*;
- *Misclassifying workers;*
- *Misrepresenting claims experience*;
- *Underreporting payroll*.

Employers may underestimate employment projections at the beginning of the premium year and consequently receive an interest-free loan from the insurance company for the amount that would have been required to insure new employees. In addition to premium fraud, employers often fail to purchase workers' compensation insurance, despite state laws mandating that they do so. Other reports include:

- discouraging workers from filing workers' compensation claims;

- firing workers who file claims.
- instructing injured workers to seek treatment under group health insurance rather than workers' compensation;

Experts at the Division of Insurance Fraud in Florida report that there has been a common presumption that those committing the most costly type of workers' compensation fraud have been claimants whose actions, such a double-dipping or claims for false injuries, drove up the cost of workers' compensation insurance. Claims fraud pales in comparison with the occult type of fraud known as "premium fraud," where loss estimates range around $400 million. Premium fraud scams are costly to companies causing workers compensation insurance rates to escalate and legitimate companies to lose business because they are less able to compete with companies shirking the system.

Another case involved underreporting of payroll at a large fruit harvesting company, with fraud charges totaling $3.5 million. Yet another employer in central Florida was charged with defrauding insurers of $2 million while operating one of the state's largest temporary employment agencies. The employer disguised the high-risk nature of the work done by many of the employees, concealed its claims history, prevented insurance companies from conducting audits and lied on applications for workers' compensation insurance. In January of 1998, two Florida insurance executives and their attorney were charged with multiple criminal counts in connection with the $100 million collapse of two insurance companies caused by kickbacks to reduce workers' compensation premiums.