ARE YOU OVERCHARGED FOR WORKERS COMPENSATION?

by Mark Seidel, Esq.

Introduction

If your workers compensation insurer uses an “experience modifier” to adjust your premium payments, you may be entitled to challenge those adjustments. If you prevail, you can secure not only lower premium payments, but also a substantial refund for past premium payments.

Your “Experience Modifier”

Your insurer uses an “experience modifier” to adjust your premium payments to account for your past workers compensation losses, which are defined as: the number of claims filed against you; the funds paid out for claims filed against you; and the funds reserved to pay pending claims filed against you. To the extent you have succeeded in keeping such losses down, the insurer will lower your experience modifier (and, therefore, your premium payments) as a reward; to the extent you have failed to prevent such losses, the insurer will raise your experience modifier (and, therefore, your premium payments) as a penalty.

Your insurer will argue that the experience modifier creates a financial incentive for you to create and maintain a safe work environment, by discounting your premium payments if you keep claims losses down. However, the experience modifier also creates a financial incentive for your insurer to mismanage your policy. If your insurer fails to investigate your claims properly, over-settles claims against you, or over-reserves funds for pending claims against you, your insurer can raise your experience modifier (and premium payments), and secure for itself an unwarranted bonus.

Your Insurer Has A Duty To Deal Fairly With You When Calculating Your Experience Modifier

Courts recognize that experience modifiers can tempt your insurer to mismanage your policy for its own benefit. Courts impose on it a duty to deal fairly and in “good faith” with your policy. Your insurer violates this duty if it wrongly inflates your experience modifier. To the extent your past and future premium payments reflect insurer mismanagement rather than your actual loss experience, you may be entitled to a substantial recovery.

Conclusion

How can you determine whether your experience modifier and premium payments have been wrongfully inflated because of insurer mismanagement of your policy? Your state rating bureau can provide you with an experience modifier “worksheet” for your company, which compares your premium history with your claims history; a glance at this worksheet can reveal patterns of insurer mismanagement, such as excessive claims settlements or excessive claims reserves. Your own business records also can provide anecdotal evidence of insurer mismanagement, such as sluggish claim investigation and questionable settlement practices. If you conclude that your experience modifier could be inflated because of insurer mismanagement, you should consult with your counsel, to determine whether you should negotiate a settlement with your insurer or look to the courts for relief.
BEWARE THE ABSOLUTE POLLUTION EXCLUSION CLAUSE

by Robert D. Chesler

When the insurance industry added the absolute pollution exclusion clause ("APEC") to general liability policies in about 1986, most policyholders understood that they had no further coverage for traditional environmental hazards such as Superfund sites. What policyholders did not know was that courts across the country would apply the APEC very broadly to eliminate coverage in many product liability and completed operations contexts. We have set forth below a summary of key cases outside of New Jersey that applied the APEC to deny coverage in situations that most policyholders would not have thought of as environmental at all:

1. Bodily injury to a homeowner caused by paint and glue fumes from renovations to her home: no coverage.

2. Lead contaminated work clothing left at a work site; children are injured by lead ingestion after playing at work site: no coverage.

3. Employee suffers carbon monoxide poisoning when a direct-fired steam generator manufactured and sold to employer malfunctions: no coverage.

4. Roof repairs to school building; several months after repairs are completed school employees and students report respiratory problems; injuries alleged from vapors emitted by the negligent application of foam and coatings to roof: no coverage.

5. Operator of cold storage warehouse has ammonia leaks from pressure release valve on refrigeration system; people in surrounding area treated in local hospitals: no coverage.

6. Company provides engineering and environmental consulting services; owns blueline printing machine in leased office space which emits ammonia vapors vented to roof; tenant directly above office space alleged injuries from ammonia released into his office: no coverage.

7. Respiratory injuries suffered by office workers when contractor negligently applies concrete sealant; fumes traveled to office through fresh air intake in HVAC system that was not sealed off: no coverage.

8. Tenants suffer carbon monoxide poisoning when blockage of free air passage in chimney flue caused buildup and dispersal of carbon monoxide throughout building: no coverage for landlord.

9. Employee sustains injury after he faints from breathing in the fumes of cement curing agent at a worksite: no coverage.

It is probable that none of these policyholders thought that they had environmental exposures. Courts in many jurisdictions have simply gone overboard when construing the term "pollutant." So far, New Jersey courts have not gone this route. In cases involving solid waste and lead paint, the Appellate Division held that the APEC did not apply in such non-traditional environmental settings as a release of sewage waste and ingestion of lead paint. However, no one can predict how a New Jersey court will rule in the next case, or indeed whether New Jersey law or the law of a less favorable jurisdiction will apply to a particular case.

Policyholders need to review their operations to determine if exposures exist where the APEC could bar coverage. If so, the policyholder should either clarify the coverage with the broker, or see if there is an endorsement available to bridge the gap.

LITIGATION GROWS OVER DISABILITY INSURANCE CLAIMS

by Thomas E. Redburn

Thousands of employees and professionals in New Jersey are insured under privately-purchased insurance policies against loss of income as a result of total or partial medical disability. Many employers choose to provide disability coverage as part of their standard package of group employee benefits. Others allow their employees to purchase individual policies. Higher-income employees and professionals will often purchase individual policies on their own, to secure more or better coverage than that provided by their employers. More and more persons are filing claims under these policies, and litigation over disability claims is growing nationwide.

In general, disability policies provide a monthly insurance benefit to an employee who becomes "totally disabled," as defined in the policy. The precise terms of coverage vary from policy to policy. Some policies provide coverage for a person’s inability to work in his or her "own occupation," which the policies tend to define narrowly. The more typical policies insure only against the employee’s inability to perform the material duties of “any occupation,” meaning that the carrier can refuse to pay benefits even if the insured cannot return to his former job, so long as he is capable of working at a different job. How similar the new job has to be the employee’s former occupation (i.e., does a stockbroker have to accept work as a toll collector?) is a fiercely-contested issue in the courts.

Litigation over private disability insurance claims has exploded in recent years. During the 1980s, the insurance industry was highly successful in marketing these policies to employers and professionals, charging low premiums for fairly broad coverage. In the 1990s, the claims started to pour in at a pace the insurers never anticipated. At the same time, insureds started to push the limits of coverage, submitting claims for controversial conditions such as chronic fatigue syndrome, chemical sensitivity, drug and alcohol...
abuse, and hard-to-verify psychiatric claims (such as “anxiety” disorder). Faced with dire financial consequences for which they did not adequately prepare, the insurers began denying claims on a massive scale. The result, not surprisingly, has been a flood of lawsuits.

Disability cases present a panoply of complex legal issues: Is the insured “totally disabled” within the meaning of the policy? Is his condition the result of a covered “sickness” or “injury”? Did the insurance carrier deny benefits in bad faith? Did the insured fraudulently misrepresent his or her medical history on the policy application? Even if there was a misrepresentation, has the policy become “incontestable” for fraud? Is the policy subject to the Employee Retirement Income Security Act of 1974 (“ERISA”), a federal statute that regulates many pension and employee benefit programs?

If ERISA applies, it will pre-empt state law claims – like common law bad faith – and will only permit the insured to assert claims under federal law. Moreover, courts have developed a set of special legal doctrines that apply to benefits claims governed by ERISA. For example, under some circumstances, a reviewing court must give deference to an insurance carrier’s denial of benefits under an ERISA plan, and can reverse the denial only if it was “arbitrary and capricious.” In these cases, it is not enough for the plaintiff to show the insurer got it wrong – the plaintiff must also show that the carrier acted arbitrarily.

Despite the litigiousness of recent years, however, most disability claims can be amicably resolved with the insurance carrier without the need for litigation. If the medical issues in a given case are complex, or the carrier appears uncooperative, counsel for the insured should be involved in the claim as early as possible. Often, a letter from the insured’s attorney clearly and concisely explaining the basis for coverage, coupled with submissions from the insured’s treating physicians, is enough to keep the carrier from denying the claim. Even if the carrier initially denies the claim, it is not always best to immediately charge into court. If the policy is part of an ERISA plan, the carrier must provide at least one layer of internal appellate review, which the insured should utilize before bringing a lawsuit. More frequently than one might expect, denials are based upon an incomplete understanding of the facts, and carriers will reverse their own claims denials on appeal.

AN OUTLINE OF LIABILITY INSURANCE ISSUES
by Robert D. Chelser, Esq.

The insurance market has become more dynamic, with new products and the ability to customize policies.

I. General Liability Policies - From Comprehensive to Commercial

A. There are Four Different Coverages:

Property Damage - covers tangible property including loss of use. Current key issue does property damage occur when a defective component is inserted into a larger system?

Bodily Injury - does not include emotional distress in New Jersey

Personal Injury - collection of torts including defamation, wrongful arrest, invasion of privacy - includes many internet torts

Advertising Injury - may include intellectual property (especially trademark infringement) and business torts - beware of new IP exclusions

II. Employment Insurance

A. No coverage under post-1985 general liability policies.

B. A general rule - coverage exists for groundwater pollution occurring prior to 1985.

C. Burden is on insured to produce pre-1985 policies.

D. Beware of the absolute pollution exclusion clause - does it apply in non-traditional areas such as fumes from paints and sealants?

E. New Environmental Policies: Cost Cap and Legal Liability - Active Market - Less expensive, more innovative and more available than usually suspected. Insurers will manuscript policy for client’s individual situation. These policies help facilitate real estate transactions.

IV. IP and E-Commerce

A. Potential coverage under personal injury and advertising injury coverages of CGL - defamation, invasion of privacy, IP infringement.

B. Host of new, untested policies, including narrow policies (e.g., hacker insurance) and broad policies combining in one place many different types of E-Commerce exposure.
C. Is your data covered? What is “tangible” or “physical” property in context of information?

V. Claims Handling
   A. Review every claim to see if it is potentially covered for coverage. The duty to defend is very broad.
   B. Insurers make mistakes. Moreover, sometimes they just say “no.” Do not accept an insurer’s “claim denied” as final.
   C. Do not be afraid to sue.
   D. Developing bad faith law.

VI. What is your broker’s duty?
   A. Your broker must understand your business and your risks.
   B. Your broker must advise you of coverage limitations, changes in your policy and new products.

Conclusion - Traditional off-the-shelf liability policies no longer provide coverage for key emerging employment, intellectual property and environmental risks. Every company must compare its risk profile and its insurance portfolio to determine whether it has adequate protection.

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The Lowenstein Sandler Insurance Practice Group Credo

Insurance should provide security and peace of mind. In exchange for a premium payment, the policyholder externalizes risk. However, the relationship of trust between policyholder and insurer that once existed has vanished. The cavalry has turned and run, the umbrella lies in tatters and the good hands are a fist. All too frequently, the insurer’s response to a valid request for coverage is ‘claim denied.’ We, in the Lowenstein Sandler Insurance Practice Group, still believe that insurance policies provide coverage. We will advise our clients of their rights, guide our clients down the tortuous paths of claims-handling, and partner with our clients to pursue coverage through litigation when necessary. We stand prepared to be your insurance advocate.