Mouse II: Public Policy Issues in Arkansas Insurance Law

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This set of annotations was developed in the context of an insurance survey course taught at the University of Arkansas School of Law in the spring of 2008. The course enrollment was capped at 32 students; 16 volunteered to participate in “the Mouse Project,”¹ so named to reflect the title and intent of a first set of annotations published in 2000: The Mouse in the Annotated Bibliography: an Insurance Law Primer (“Mouse I”).² Each student selected a recent legal periodical³ discussing an issue in insurance law, summarized it, and researched Arkansas case and/or statutory law parallels.

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1. The inspiration was in this quote: “There is something radically amiss in a world [of] hundred-page articles ... where authors ... detail what every imaginable reader already knows before coming forth with the usual mouse, where readers must sift through mountains of verbiage to find the kernels of truth they so diabolically conceal. David P. Currie, 1 Green Bag 2d 1, 2 (1997).


3. To facilitate further reading of the annotated articles, the students were coached to select an article of highly readable length, averaging 20 or fewer pages of printed law review pages.
The student annotations were completed in the spring of 2008. Editing for this compilation was delayed by a separate writing project, Nonprofit Risk; Nonprofit Insurance, published last year in Arkansas Law Notes.

Well-developed responses from the annotators led to a lengthy original draft of Mouse II; to heighten the focus on Arkansas law parallels, the students’ efforts have been shortened significantly. Many edits have removed repetitious sentence-level attribution to the annotated author; direct attribution should be assumed where points of discussion from the annotated articles appear in text.

This compilation has much in common with Mouse I. However, as to content, where Mouse I focused on basic doctrinal points, like the difference between first party and third party insurance, between coverage and exclusions, and the conflicts of interest that inhere in an insurance defense relationship, Mouse II focuses on more subtle points drawn from insurance practice, with a dominant public policy focus. These Mouse II annotations, and related Arkansas law updates, are of timely relevance to an insurance practice and include, inter alia, tort reform, charitable immunity, subrogation, insurability of punitive damages; very specific issues related to health insurance (including the insurability of clinical trials, anorexia, and infertility as well as underwriting problems associated with genetic testing); specific property insurance issues (including title insurance and causation analysis); and issues related to employment law. The variety of topics is divided into three major categories: 1) Insurance Litigation—Procedural Matters; 2) Misrepresentation and Underwriting to Anticipate Risks; and 3) Special Topics (covering Medical, Property, and Workplace Insurance).

I. Insurance Litigation—Procedural Matters

This section focuses on tort reform, charitable immunity as it applies to hospitals, the make-whole doctrine in the subrogation arena, and the insurability of punitive damages in a bad faith failure to settle action.


While tort-reform efforts at the federal level have failed, many states, including Arkansas, have enacted reforms with goals to decrease medical malpractice insurance rates and to ensure that local doctors can continue to afford to serve their communities.


5. Several of the annotations in this section featured thorough original research and detailed connections to Arkansas law, scholarly additions that deserve broader coverage. Given the constraints of this collection, some excellent materials have been deleted. Please feel free to contact the Mouse II editor or its annotators directly, for a more detailed discussion on a topic of interest.

Arkansas joined the tort-reform movement in 1979 with the passage of the Medical Malpractice Act ("MMA"). More recently, the Civil Justice Reform Act of 2003 ("CJRA") was enacted with the goal of reducing "excessive tort litigation." The legislature's intent in passing the CJRA was "first and foremost to improve the 'availability and affordability of medical liability insurance'... as well as to improve 'accessibility and affordability of medical care...'."  

The impact of the CJRA has not yet been fully realized, as the Arkansas Supreme Court ruled key provisions unconstitutional in Johnson v. Rockwell Automation, Incorporated, an April 2009 decision. Jan M. Ambrose and Anne Carroll, in Medical Malpractice Reform and Insurer Claims Defense: Unintended Effects, explore the effect of tort reform on the claims defense expenses of medical malpractice insurers. Ambrose and Carroll provide an overview of the policy goals associated with tort reform, review the general types of reforms that have been implemented, and test the relationship between claims defense expenses and the implementation of reform efforts.

An insurer will document claims defense expenses in the "loss-adjustment expenses" in its financial report. "Claims defense expenses represent all expenses that an insurer incurs as a result of adjusting a claim, litigated or not, including costs associated with claims investigation, medical examinations, expert witnesses, fees and salaries for claims adjusters and others working for the defense of a claim, and defense-attorney fees." Ambrose and Carroll estimate that defense expenses account for approximately thirty percent of malpractice premiums. Therefore, claims defense expenses are a significant variable in evaluating the overall success of tort-reform legislation.

The authors limit their evaluation to 1998-2002 and note a significant increase in underwriting losses despite a 40% increase in premiums during the same period. Ambrose and Carroll consider both tort law reform and government sponsorship of insurance mechanisms, hypothesizing the effect each might have on claims defense expenses. They then create a mathematical model and apply the model to state data between 1998 and 2002. The authors conclude that malpractice reform
has a significant impact on the claims defense spending of malpractice insurers. However, the impact may be inconsistent with policy justifications for tort reform.20

Ambrose and Carroll’s model evaluates one variable in a complex legal environment. Some insurance law scholars question whether a malpractice litigation crisis exists and dispute the premise that litigation costs are driving increases in premiums.21 Others accept this premise, but dispute that the reforms have a significant impact on insurers’ behavior.22 Still other scholars note states that have passed significant tort-reform measures have experienced increased profitability and decreased premium rates for medical malpractice liability coverage.23 A focus on the claims defense expense variable helps shape the emotional tort reform debate with an analytical framework grounded in quantifiable data.


The Arkansas Supreme Court first recognized charitable immunity in 1856.24 In her 1999 article, Tort Immunity for Non-Profits,25 Christa S. Clark observed that, as recently as 1999, Arkansas still adhered to “the distinct minority position of full charitable immunity for hospitals and their staffs.”26 Clark wrote the article to highlight a conflicting analysis between the seminal 1995 “charitable immunity factor” case of Masterson v. Stambuck27 in which the Arkansas Supreme Court held that a utility company failed to satisfy the factors, and the 1999 charitable hospital case of George v. Jefferson Hospital Association28

20. Id. at 863.
26. Id. at 144.
in which the Court held that a charitable hospital satisfied them. Clark summarized the progression of charitable immunity case law from its English origins, to its 1856 importation to Arkansas, up to 1999 when the article under review was published. Clark focused her analysis on how the 1999 George case created an effective “hospital exception” to a strict application of the eight-part charitable immunity test, created in Masterson.

The excellent history from the Clark article maintains continuing vitality, even after the Arkansas Supreme Court’s 2007 decision in Sowders v. St. Joseph’s Mercy Health Center and, in response to calls to action among the Arkansas justices who heard the Sowders case, the Arkansas General Assembly’s amendment to the relevant direct action statute. The 1999 Masterson factors still provide some protection to charitable hospitals, but the post-Sowders amendment to Section 23-79-210 demonstrates that complete immunity from tort victims no longer exists in Arkansas, even for charitable hospitals, except perhaps where the Federal Volunteer Immunity Act or the Arkansas Volunteer Immunity Act may be construed to preserve it.


Johnny C. Parker, in Unraveling the Enigma, considers subrogation and the made whole doctrine. Subrogation allows insurers to “step into the shoes” of the insured to assert the insured’s rights against third parties, subject to the third party’s rights against the insured. Subrogation allows the carrier to recover money paid on the grounds that the insured injured party may not collect from both the insurer and the tortfeasor.

30. Masterson v. Stambuck, 321 Ark. at 401, 902 S.W.2d at 809.
33. Sampson, supra note 32, at 101 (“after the General Assembly amended its statute in 2007 in response to Sowders, the Arkansas law of charitable immunity remains only tenuously intact”). But see id. at 84 n.4, and 94 n.41-51 (discussing the potential arguments that may be made for volunteer immunity pursuant to the Federal Volunteer Protection Act of 1997 or the Arkansas Volunteer Immunity Act).
35. Id. at 724.
36. *Id.* at 726. Legal subrogation is also known as equitable or judicial subrogation. 

37. *Id.* Contractual subrogation is also referred to as conventional subrogation. 

38. *Id.* at 727. Statutory subrogation can be vested in a person, entity, or person. 

39. *Id.* at 736. The standard commercial liability policy contains this subrogation language:

**Transfer of Rights of Recovery Against Others To Us**

> If the insured has rights to recover all or part of any payment we have made under this Coverage Part, those rights are transferred to us. The insured must do nothing after loss to impair them. At our request, the insured will bring “suit” or transfer those rights to us and help us enforce them.


41. *Id.* at 737.

42. *Id.*

43. *Id.*

44. *Id.*

45. *See, e.g., id.* at 75 (where an overt balancing of the equities is employed, courts consider the facts and circumstances of the situation, conduct of the parties, contractual language, and general public policy to determine if and to what extent the doctrine applies).
Although the Arkansas Supreme Court has allowed a single exception to the made-whole rule, in the case of state administration of Medicaid, the court has not exempted settlement agreements or the payment of workers' compensation benefits.


James Daniel, in Can Two Wrongs Make a “Right,” explores the problem of punitive damages from a liability carrier’s perspective. An award of punitive damages in an underlying personal injury claim is likely to lead to an insured’s bad-faith action against her carrier when the carrier has failed to accept a reasonable settlement offer. Such a lawsuit will raise the question of the insurability of punitive damages. In this context, “two analytically distinct wrongs might possibly create a right.”

Daniel reminds the reader of the complicated and delicate nature of the insurer’s duties to defend and to settle claims. Some states prohibit, as a matter of public policy, indemnification of punitive damages. Reasoning that insurance for a potential punitive damages award would defeat the primary purpose of punitive damages, some courts do not allow indemnification on the grounds that the guilty party should bear the economic consequences of her own bad behav-

46. See Franklin v. Healthsource of Arkansas, 238 Ark. 163, 942 S.W.2d 837 (1997), abrogating Higginbotham v. Arkansas Blue Cross & Blue Shield, 312 Ark. 199, 849 S.W.2d 464 (1993). Franklin and Higginbotham variously analyze the earlier case of Shelter Mutual Insurance Co. v. Bough, 310 Ark. 21, 834 S.W.2d 637 (1992). Franklin applied, and Higginbotham dismissed as dicta, the following language from Bough:

the general rule is that an insurer is not entitled to subrogation unless the insured has been made whole for his loss, [however], the insurer should not be precluded from employing its right of subrogation when the insured has been fully compensated and is in a position where the insured will recover twice for some of his or her damages.

Franklin, 328 Ark. at 167; 942 S.W.2d at 839.


51. Id. at 26.

52. Id.

53. Id.

54. Id. at 26-27.

ior.\textsuperscript{56} The absence of a contractual duty to indemnify, or the presence of an explicit policy exclusion for punitive damages will provide a contractual justification for a holding that no punitive damages are available.\textsuperscript{57}

Characterizing a bad-faith cause of action as a tort may lead to a different result. Under a tort analysis, punitive damages are recoverable as a consequence of the insurer’s independently tortious failure to accept a reasonable settlement offer.\textsuperscript{58} “Bad faith” is an actionable tort that may be brought against an insurance carrier in Arkansas, even in the first party context.\textsuperscript{59} When pleadings and proof meet the heightened standards,\textsuperscript{60} indemnification for punitive damages is possible.\textsuperscript{61} An Arkansas insured is entitled to indemnification for punitive damages, in part, because “nothing . . . prevent[s] the insurer from excluding the payment of punitive damages.”\textsuperscript{62}

The potential for a punitive damages award is latent in Arkansas’s “failure to settle” law which already holds the insurer liable for any excess judgment when the insured proves the insurer engaged in fraud, bad faith, or negligence in failing to settle the claim.\textsuperscript{63} The Eighth Circuit illustrated this potential in its analysis of a bad faith failure to settle action and its allowance or insurance coverage for a punitive damages award.\textsuperscript{64} In the Eighth Circuit case, the jury returned a punitive damages award against the policyholder who was held personally liable for one million dollars in punitive damages.\textsuperscript{65} The policyholder subsequently filed a bad faith action against the carrier for failure to settle the personal injury claims, and the jury awarded both compensatory and punitive damages.\textsuperscript{66} Upholding the verdict, the Eighth Circuit held that, despite a punitive damages exclusion in the policy, the insured was “en-
titled to be made whole.” 67 Additionally, the court awarded “consequential damages flowing from [the insurer’s] bad faith.” 68 This juxtaposition of contrasting tort and contract language creates a complex rationale in support of the court’s decision, obscuring the fine tort-contract doctrinal distinctions that other courts have used to support their analyses.

II. Misrepresentation and Underwriting to Anticipate Risks

Three students selected misrepresentation as a focal point for their annotations. Because of synergy among their contributions, the annotations in this section have experienced heavier editing than others. Of particular note in this section is the annotation by Catherine Odom which contains much original Arkansas case law research, developing Arkansas’s misrepresentation standards. 69 Additionally, Saundra Thompson selected the timely topic of credit scores used to underwrite risks, a topic which has seen current, and ongoing, legislative and administrative work at both the state and federal level. 70

All annotations in this section focus on the inherent risks a policyholder brings to the insurance contract. This section begins with a discussion of three angles on the misrepresentation concept and ends with a discussion of underwriting through credit ratings.

A. Misrepresentation

This section begins with an overview of the inherent financial incentives that create the ongoing problem of misrepresentation in applications for life insurance. It continues with a brief outline of the types of concerns that are considered in statutory provisions that have addressed misrepresentation. Finally, the section provides a fairly exhaustive treatment of Arkansas case law addressing misrepresentation.


David McDowell, in Organized Fraud, 71 considers the life insurance carrier’s justification for an “aggressive fraud prevention and litigation plan.” 72 Life insurers set the in-
sured’s premiums and death benefits based on health information the insured provides. For the insurer, life expectancy is the key underwriting detail. Life insurance policy issuance, premium payments, and benefits are, thus, based on the health and medical information the insured provides. When applying for a policy, the insured has an incentive to provide the most positive health and medical information possible. This incentive can lead to a fraudulent application.

McDowell observes “the disparity between the relatively low annual premiums used to procure relatively high death benefits [is] what makes life insurance fraud so attractive.” Where a carrier discovers fraud and rescinds a policy, state law typically requires that the premium payment be returned to the perpetrator. Because the relevant statutory law likely focuses on the contractual remedy of rescission in cases of misrepresentation, criminal punishment for such fraud is unlikely, and any cost experienced by the former policy holder is limited to the return the premiums could have obtained in another investment. This, McDowell concludes, translates into one thing: big bucks and no whammies.


Thomas F. Segalla & Carrie P. Parks, in Dangers in Those Lies, outline the application process (including the role of the insurance agent, and whether the insurance application is attached to the policy). They proceed to a detailed discussion of misrepresentation, and finally to a discussion of remedies, both for the insurer and the insured.

For purposes of this annotation, the Segalla and Parks outline of traditional grounds for a misrepresentation challenge to a life insurance claim is instructive. A representation becomes grounds for rescission if: 1) the representation is material to the risk assumed, 2) the representation is false, 3) the insured knew that the representation was false or reckless, 4) the insured intended for the insurer to rely on the representation, and 5) the insurer relied on the representation. Arkansas statutory law tracks these bases for rescission.

73. Id. at 23. (“If insureds typically died within five years of a policy’s issuance, life insurance companies, under current underwriting and actuarial standards, would quickly go out of business.”).

74. Id. (e.g., “stealing someone’s identity” or “clean sheeting” the health history questionnaire).

75. McDowell, supra note 71, at 23.

76. See, e.g., Ark. Code Ann. § 23-79-108 (Repl. 2004) (“After an insurer rejects or declines to issue a life or accident and health insurance policy, the insurer shall return the premium to the applicant within a reasonable period of time.”).

77. Ark. Code Ann. § 23-79-107 (a) (Repl. 2004) (“Misrepresentations, omissions, concealment of facts, and incorrect statements shall not prevent a recovery under the policy or contract unless ...”).

78. McDowell, supra note 71, at 23 (“Hence we have the low-risk high-reward proposition”).


80. Id. at 118-122.

81. Id. at 122-26.

82. Id. at 126-28.

83. Id. See also Ark. Code Ann. § 23-79-107(a)-(c) (Repl. 2004).


John Dwight Ingram, in Misrepresentations,85 covers many of the same points that are discussed in the Segall & Parks analysis from the preceding Mouse II summary, but also includes analysis of intent,86 effects of an incontestability clause,87 and contestability as between first party and third party claims.88 Ingram also provides an overview of many misrepresentation sub-issues89 that are summarized in this annotation with reference to Arkansas law.

Ingram discusses tests courts have used to determine materiality, focusing variously on whether 1) a fact would be deemed material by all similar insurers, 2) a reasonable and prudent insurer would regard it as material, and 3) the particular insurer regards it as material.90 In Arkansas, the minimal definition—that the representation would have affected the insurer’s decision to accept the application—will constitute a material misrepresentation, as will the more stringent standard that the representation be material to the risk.91 Materiality in Arkansas is determined from the particular insurer’s point of view.92 Thus, an “incorrect statement may justify rescission regardless of whether it was made with fraudulent intent.”93

An insured’s statement or omission may be material even if it is not significant to the “disposition of the claim,” as long as it was reasonably related to the insurer’s investigation.94 Arkansas law examines the materiality of the statement at the time the statement is made, not in light of facts that are later revealed.95

The majority of courts hold that where an applicant has disclosed some information that raises questions about his insurability and thus has placed the insurer on notice, the insurer has the burden to investigate further.96 The Arkansas Supreme Court has held that when an insured has disclosed previous medical treatment and listed the physician who performed the procedure, the insurance company is placed on notice of the condition.97

86. Id. at 105-06.
87. Id. at 112-14.
88. Id. at 114-18.
89. Id. at 104-11.
90. Id. at 110.
92. Id.
95. Id.
96. Ingram, supra note 85, at 107.
The carrier then bears the burden to seek out additional information from the physician listed on the application; therefore, rescission based on a material misrepresentation is not available, even when the insured failed to state additional relevant facts.

While Arkansas once was a part of a minority that required proof of causation between the misrepresentation and loss, in 1988, the Arkansas Supreme Court joined the majority and relaxed this proof requirement.

In Arkansas, an incontestability clause goes into effect after two years, with an exception for fraud in the procurement claims. The insurer, however, may omit the “except for fraud in the procurement” provision if it chooses and have an absolute incontestability clause. Ingram notes that most insurers would not likely choose the absolute incontestability clause, although some might in order to create market incentives.

The Arkansas Supreme Court has long held that an agent’s knowledge acquired while working within the scope of his employment is imputed to the principal. The Arkansas Court of Appeals has similarly ruled that any knowledge an insurance agent receives is imputed to the insurance company if the company gave the agent authority to obtain information during the application process, stopping the carrier from use of the misrepresentation defense. Finally, the Arkansas Supreme Court has ruled that an insurer may not rescind a policy based on a misrepresentation when third-party claims are at issue.


Ian O’Neil, in *Use of Credit Scores by Insurance Companies*, discusses how consumer credit scores help carriers underwrite their risks, as the carriers believe consumer credit information statistically predicts probability of an insurance claim. When used
to underwrite an insurance risk, carriers see higher credit score as predictors of safer driving or more responsible homeownership.\textsuperscript{110}

The Fair Credit Reporting Act (FCRA) of 1970 (revised in 1996)\textsuperscript{111} allows insurance companies to use consumer credit scores when they issue new policies,\textsuperscript{112} review rates for existing policies,\textsuperscript{113} and take adverse actions, such as canceling a policy or increasing rates.

The Fair and Accurate Credit Transactions Act (2003) (FACTA), which amended the FCRA,\textsuperscript{114} allows insurance companies to use consumer credit reports to prescreen consumers for firm offers of insurance or credit and sets standards for resolving consumer disputes as well as carrier duties to provide data to credit bureaus.\textsuperscript{115}

Consumer credit scores have historically played a role in underwriting on both the federal and state level; however, growing concerns have surfaced.\textsuperscript{116} The explosive growth in the use of credit scores by insurers “has been fueled by the introduction of more sophisticated analytic tools and additional research indicating a strong correlation between credit history and insurance risk.”\textsuperscript{117}

First, critics assert that the links between credit performance and insurance claims are spurious at best and fraudulent at worst: “credit scores merely measure ‘claims consciousness,’ which assumes that people with good credit scores are more likely to settle an accident out of their own pocket rather than file a claim with the insurance company.”\textsuperscript{118}

Second, critics assert that credit scores disproportionately target certain ethnic groups\textsuperscript{119} under a theory of disparate impact,\textsuperscript{120} which holds that a practice is presumptively illegal when it disproportionately excludes members of legally protected groups.\textsuperscript{121}

\begin{itemize}
  \item \textsuperscript{110} Id. at 155-156.
  \item \textsuperscript{112} 15 U.S.C. § 1681(a).
  \item \textsuperscript{115} 15 U.S.C. § 1681(t) (2004). The FCRA specifically preempts state law in the following areas: uses of credit report of prescreen consumers for firm offers of insurance or credit, time and manner of resolving consumer disputes with regard of accuracy, and duties of companies providing the data to the bureaus. Id.
  \item \textsuperscript{116} O’Neil, supra note 108, at 159.
  \item \textsuperscript{117} Id.
  \item \textsuperscript{118} Id. at 170 (quoting Sara Lapham, The Truth Behind Credit Scoring, http://www.insurancescored.com/industryvsconsumer.htm).
  \item \textsuperscript{119} Id.
  \item \textsuperscript{120} Robert Detlefsen, Disparate Impact Theory Provides No Support For Banning Credit Scoring In Insurance, 20 Legal Backgrounder No. 17 (Wash. Legal Found. 2005), available at http://www.namic.org/pdf//050408WLFCreditScoringDispImpact.pdf
  \item \textsuperscript{121} Id.
\end{itemize}
While O'Neil recognizes that credit scoring, for purposes of pricing and underwriting insurance products, is “important,” unresolved tensions exist as between the federal government and state authorities, and in consumer protection policies. Federal acts such as the FACTA and FCRA explicitly permit insurance companies to use credit scores for the purpose of assessing risk and pricing insurance policies, while not necessarily preempting state laws designed to protect consumers. State laws governing the use of credit scores vary from state to state.

O'Neil notes a number of studies that establish that a majority of consumers benefit from the use of credit scores and observes “while banning the use of credit scoring might lower the cost of insurance for some, it would most certainly increase the cost of many.” Prohibiting the use of credit scores would not change the overall number of claims an insurer receives; it would only change the manner in which the insurer could allocate that cost among customers. The effect of prohibiting credit scoring would be to handicap an insurer’s ability to allocate risk, forcing it to make more sweeping and less fair assumptions.

In Arkansas, insurance companies must file scoring models or other scoring processes with the State Insurance Department if the insurance company chooses to underwrite or rate risks. Any proprietary consumer report scoring system or model filed with the Insurance Commissioner must remain confidential unless otherwise directed by a court order.

In its 2005 session, the Arkansas General Assembly House considered Bill 1315 which would have prohibited insurance companies from using a consumer’s credit rating when determining automobile insurance premiums. Supporters of the bill argued that people with excellent credit, but who were no longer using credit cards after paying off all their debts, were being penalized through higher premiums. Opponents cited sta-

122. O'Neil, supra note 108, at 175.
123. Id.
125. O'Neil, supra note 108, at 175.
126. Id.
127. Id. at 176.
128. Id.
129. Id.
130. Id.
Statistics showing those with poor or no credit file more insurance claims.\textsuperscript{135} The House approved the bill 72-20.\textsuperscript{136}

In 2007, Arkansas joined twelve other states in a brief filed with the United States Supreme Court in support of consumers, in a lawsuit challenging the industry’s use of credit scores to fix auto insurance rates.\textsuperscript{137} In these class actions, based on alleged violations of FCRA\textsuperscript{138} for failure to transmit adverse action notices reflecting negative credit reports, the Court found no violation.\textsuperscript{139} The Federal Trade Commission has since promulgated extensive regulations regarding adverse action notices involving credit card companies.\textsuperscript{140}

### III. Special Topics

The material in Mouse II’s first and second sections potentially affects any number of topical insurance situations. In this third, and final section, Mouse II moves to a very specific focus on discrete topics affecting medical insurance, property insurance, and employment insurance.

#### A. Medical Insurance

This medical insurance section includes annotations on 1) clinical trial coverage, 2) genetic discrimination in underwriting practices, 3) infertility coverage, and 4) the physical and mental health distinctions that affect coverage for anorexia.


Christine Mangoian, in Hidden Side Effects,\textsuperscript{141} discusses clinical trial coverage through Medicare and TRICARE, issues raised by the Employment Retirement Income Security Act of 1974 (ERISA), and three coverage scenarios.

For Medicare coverage, clinical trials must: 1) evaluate an included Medicare ben-

\textsuperscript{135} Id.


\textsuperscript{139} Safeco, 551 U.S. at ___. 127 S. Ct. at 2214-16.


\textsuperscript{141} Christine Mangoian, Hidden Side Effects of Cancer on the Family: The Struggle for Mandated Insurance Coverage of Clinical Trials, 5 Whittier J. Child & Fam. Advoc. 577 (2002). Reynolds summarizes the note and provides original research into relevant Arkansas case law.
enefit category item or service; 2) have “therapeutic intent;” and 3) treat, for therapeutic intervention, clinical trial patients who have been diagnosed with a Medicare-covered disease.\textsuperscript{142} TRICARE has similar coverage.\textsuperscript{143} ERISA guidelines may limit recovery for clinical trials under an “experimental treatment” analysis.\textsuperscript{144}

Three state models for clinical trial coverage have emerged.\textsuperscript{145} Broad coverage, as illustrated in 2001 California legislation,\textsuperscript{146} requires state healthcare service plans, disability insurers and Medi-Cal to cover routine patient care associated with cancer clinical trials.\textsuperscript{147} By contrast, Rhode Island illustrates limited coverage where mandated insurance only applies to approved trials and only during certain phases.\textsuperscript{148} Rhode Island requires private insurers and managed care plans to cover routine patient-care costs only for those trials that evaluate cancer and related illnesses.\textsuperscript{149}

Finally, Georgia illustrates “voluntary coverage”; in Georgia, patients who have cancer and are recommended by a physician to participate in a clinical trial are entitled to clinical trial coverage.\textsuperscript{150} The Georgia coverage applies to all phases of clinical trials, where the various stakeholders agree to provide coverage for routine clinical trial care costs.\textsuperscript{151}

Given the array of available insurance, and given that availability is dependent on particular location, Mangoian suggests a uniform federal mandate similar to the federal Medicare model.\textsuperscript{152}

Arkansas court decisions favor coverage for clinical trials. In a recent decision, the Arkansas Court of Appeals allowed an insured to recover costs for high dose chemotherapy.\textsuperscript{153} The court resolved policy language conflict, between exclusion from experimental or investigational treatment on the one hand, and a specific policy provision regarding cov-

\textsuperscript{142} Mangoian, supra note 141, at 594.
\textsuperscript{143} Id.
\textsuperscript{144} Id. at 592-93. See also Administrative Committee of the Wal-Mart Stores, Inc. Associates’ Health and Welfare Plan v. Shank, 500 F.3d 834 (8th Cir. 2007) (illustrating the effects of the court of public opinion).
\textsuperscript{145} Mangoian, supra note 141, at 596. These state systems do not help the uninsured, who are also likely above Medicare’s stringent income guidelines. Id.
\textsuperscript{146} Id.
\textsuperscript{147} Id.
\textsuperscript{148} Id. at 597-98.
\textsuperscript{149} Id.
\textsuperscript{150} Id. at 598.
\textsuperscript{151} Id.
\textsuperscript{152} Id.
MOUSE II: PUBLIC POLICY ISSUES IN ARKANSAS INSURANCE LAW

coverage on the other.\textsuperscript{154} The Eighth Circuit has also held in favor of the insured.\textsuperscript{155} However, the 2008 Arkansas Comprehensive Health Insurance Pool Act (CHIPA) limits coverage to that which is “medically necessary” and explicitly defines “medically necessary” to exclude procedures undertaken pursuant to investigational, experimental, or research purposes.\textsuperscript{156}


Robyn Nicoll, in Long-Term Care Insurance and Genetic Discrimination,\textsuperscript{157} discusses “pre-symptomatic” or “predictive” testing performed on healthy individuals with a family history of disease. Like newborn screening, testing occurs before the individual presents any signs or symptoms.\textsuperscript{158}

Gene\textsuperscript{tic} testing raises several legal and ethical issues\textsuperscript{159} arising from business practices to use genetic information for predictive underwriting.\textsuperscript{160} Several states have enacted laws to prohibit the use of genetic information in health insurance decisions.\textsuperscript{161}

Arkansas law protects consumers from pre-symptomatic genetic testing. Prior to issuance of a policy, insurers may not require, either directly or indirectly, a genetic test.\textsuperscript{162} However, an insurer may decline an application or enrollment request and may charge a higher rate for such a policy where the applicant has “manifested” any condition, disease or disorder.\textsuperscript{163}

An individual who is damaged by an insurer’s violation of the genetic anti-discrimination law may recover equitable relief, including a retroactive order that directs the insurer to provide insurance coverage to the individual under the same terms and conditions which would apply had the violation not occurred.\textsuperscript{164} The Genetic Nondiscrimination in Insurance Act does not apply to those seeking life, disability or long-term care insurance.\textsuperscript{165}

\begin{itemize}
  \item \textsuperscript{154} Id.
  \item \textsuperscript{155} Henderson v. Bodine Aluminum, Inc., 70 F.3d 958 (8th Cir. 1995) (ERISA plan challenged under Americans with Disabilities Act; preliminary injunction in favor of insured granted).
  \item \textsuperscript{156} ARK. CODE ANN. § 23-79-503 (2008).
  \item \textsuperscript{157} Robyn B. Nicoll, Long-Term Care Insurance and Genetic Discrimination—Get It While You’re Young and Ignorant: An Examination of Current Discriminatory Problems in Long-Term Care Insurance through the Use of Genetic Information, 13 ALB. L. J. SCI. & TECH. 751 (2003).
  \item \textsuperscript{158} Id. at 757.
  \item \textsuperscript{159} Id. at 754.
  \item \textsuperscript{160} Id. at 753.
  \item \textsuperscript{161} Id.
  \item \textsuperscript{162} ARK. CODE ANN. § 23-66-320 (c)(1)(2) (West 2008).
  \item \textsuperscript{163} § 23-66-320 (d).
  \item \textsuperscript{164} § 23-66-320 (e)(2).
  \item \textsuperscript{165} § 23-66-320 (b)(5)(B).
\end{itemize}
Disclosure of personal data gleaned from genetic research studies is protected from: 1) subpoena or discovery in civil suits;\(^{166}\) 2) disclosure to health insurers (without the informed, written consent of the individual);\(^{167}\) 3) publication of individual data (any anonymous publication must be limited to research and educational purposes).\(^{168}\) Only when informed consent is obtained may an individual be identified in the course of such research or educational experience.\(^{169}\) The statute does not define “informed consent.”

In 2007, the United States House of Representatives supported the Genetic Nondiscrimination Act of 2007 (“GINA”), which prohibits group health plans from requesting, requiring, or purchasing genetic information for underwriting purposes.\(^{170}\) On April 24, 2008, one day before the annual celebration of National DNA Day, the Senate passed the Genetic Information Nondiscrimination Act of 2007-2008 by a vote of ninety-five to zero,\(^{171}\) after Congress had debated the issue for thirteen years.\(^{172}\)

Jessica L. Hawkins, in *Coverage of Infertility Treatments*,\(^{173}\) provides a broad overview of medical and legal issues related to infertility: causes and treatments, the Americans with Disabilities Act (ADA) and the Pregnancy Discrimination Act, current state law, and support and opposition to mandated coverage.

Infertility affects approximately one in ten couples;\(^{174}\) it is “a disease of the reproductive system that impairs the body’s ability to perform the basic function of reproduction.”\(^{175}\) Conventional treatments work for 85-90% of couples.\(^{176}\) For the 10-15% who are not helped by conventional treatment, assisted reproductive technologies (ART) that handle both sperm and eggs, are available.\(^{177}\) ART includes

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167. § 20-35-103 (b).
168. § 20-35-103 (c)(1).
169. § 20-35-103 (2).
172. *Id.*
174. *Id.* at 205.
175. *Id.*
176. *Id.* at 207 (including surgery on reproductive organs to restore them to working order or hormonal treatment).
177. *Id.*
both artificial insemination and in vitro fertilization (IVF). Conversional treatments can be expensive, but ART is much more so, costing upwards of $10,000 per cycle. Conversional treatments are commonly, and repeatedly, attempted before a positive result is seen; a small number of unsuccessful couples then use ART which accounts for a small percentage of total healthcare costs.

ADA disability includes health conditions, like HIV. By analogy, infertility is a disability under the ADA. However, a health insurance plan does not violate the ADA if both infertile and fertile persons are offered the same coverage.

Fifteen states have enacted a mandate to offer coverage or a mandate to provide coverage. In Arkansas, group health insurance companies are required to cover IVF costs when the woman’s husband donates the sperm. Typical limitations include extended periods of infertility before insured IVF and truncated availability of insured IVF treatment. Where a state infertility coverage mandate is in conflict with the Employee Retirement Income Security Act (ERISA), ERISA will control and the state law will have no effect.


In Anorexia Killed Her, Beth A. Brunalli examines private insurance treatment of anorexia nervosa, insurance policy exclusions, and federal and state legislative responses.

Symptoms and treatment affect how anorexia is classified in the insurance industry, and insurance policy definitions tend to classify it as a mental illness. Under current legal limits, the insurance industry may impose greater restrictions on mental health

178. Hawkins, supra note 173, at 207.
179. Id.
180. Id. at 208 (analogizing Bragdon v. Abbott, 524 U.S. 624 (1998) (holding HIV-positive woman’s infection “substantially limited her ability to reproduce and bear children”).
181. Id. (discussing Saks v. Franklin Covey Company, 117 F. Supp. 2d 318 (S.D. N.Y. 2000) aff’d in part, remanded in part, 316 F.3d 337 (2d Cir. 2003)).
182. Id.
185. Hawkins, supra note 173, at 215 (e.g., limiting IVF treatment to one attempt).
186. Id. at 219 (noting The Family Building Act, proposed in February 2005, addressed ERISA exemptions and proposed innovations).
188. Id. at 591-622.
189. Id. at 583.
Employment healthcare benefits exist through “insured” plans or “self insured plans,” each with its own set of definitions. Additionally, analysis of private insurance often implicates the Employment Retirement Income Security Act (ERISA).

These features result in restrictive coverage related to construction of specific contract-specific terms like “mental health” and “other physical impairment.” These contractual definitions govern. Mental health treatment stipulations, financial stipulations and cost-sharing arrangements limit coverage.

Under financial stipulations and cost-sharing agreements, anorexia patients finance an average of $80,000 for a single incident with $130,000 of expenses (61% of treatment expense), compared to out-of-pocket expense of $1,800/$60,000 split (3%) for treatment of a physical injury. This coverage disparity has led to an increase in mental health litigation where the courts split on the central physical-mental distinction with doctrinal differences focusing on (1) origin, (2) symptoms, or (3) treatment.

Brunalli observes that the Mental Health Parity Act of 1996 (MPHA) contains inherent limitations on coverage for anorexia. First, the MHPA’s broad mental illness definition neither includes nor excludes anorexia nervosa, allowing the carriers to fill in the gap with limiting policy definitions. Second, the MPHA allows for employers to opt out of coverage. Third, the MPHA does not affect the “terms and conditions of an insurer’s plan”, thus, a plan may continue to utilize treatment stipulations that exclude the full range of medically necessary treatment. Finally, the MPHA allows two major exemptions: (1) a small employer exemption which automatically excludes nearly 30% of U.S. workers; and (2) an increased cost exemption that applies when MPHA compliance would increase costs by 1% or more.

190. Id. at 594.
191. Id. at 592.
192. Id. at 593.
193. Id. at 592-95.
194. Both are subject to ERISA; only health insurance plans, and not “employment benefit plans” must comply with state and federal insurance regulations. Id.
195. Id. at 595-98.
196. A treatment stipulation would limit the number of days for hospitalization, e.g., 10-15 days for some form of inpatient treatment; 10-15 sessions for outpatient treatment and one nutritional visit annually.” Id.
197. Id. at 595.
198. Id. at 596.
199. Id. at 599 n.15.
200. Id. at 599.
203. Id. at 604.
204. Id. at 606.
206. Id. § 1185a(c)(2) (2000).
Brunalli also examines two public health programs: Medicaid and the State Children’s Health Insurance (SCHIP) Program. Emphasizing the shortcomings of both programs, Brunali observes that SCHIP programs vary by state. Medicaid requires Medicaid-qualified providers as well as early and periodic screening, diagnosis, and treatment.

Supporters of mental health parity recognize the sharp limits on insurance protection for anorexia. While Arkansas is a mandated-benefit state, state exemptions exclude a large number of individuals. Forty-one percent of private sector employees are insured by ERISA-exempt self-insurance health benefit plans. Arkansas’s small-employer exemption for firms with 50 or fewer employees excludes an additional 18%. A cost increase exemption excludes an unquantified number of additional Arkansans from coverage.

Courts have not been flooded with litigation on the issue. The Arkansas Court of Appeals has addressed the mental/physical distinction and has affirmed a trial court’s decision in favor of an insured, holding that “hospitalization and treatment [for bipolar disorder] were for a physical illness rather than a mental condition.” It affirmed, citing evidence the cause for the condition was physical. The Arkansas Supreme Court has subsequently held that whether the term “mental illness” is ambiguous is a question for the jury.

B. Property Insurance

This section includes two useful annotations, the first on potential attorney liability for failure to recommend title insurance, and the second on the analysis of causation in property insurance.

207. See Brunalli, supra note 187, at 622-27.
208. Id. at 625.
209. Id. at 624.
210. Confidential phone interview with Arkansas defense attorney in Arkansas (April 4, 2008) (discussing Arkansas’s mental health programs, legislation, and medical services).
213. Id.
214. Id.
215. Confidential phone interview, supra note 210. “…there is need for litigation in this area; however, the proper defendant is likely discouraged by cost, resources and the exposure from litigation...” Id.
216. Arkansas Blue Cross and Blue Shield, Inc. v. Doe, 22 Ark. App. 89, 733 S.W.2d 429 (1987) (discussing the mental/physical distinction in regards to bipolar disorder).
217. Id. at 90, 733 S.W.2d at 430.
218. Id. at 93-94, 733 S.W.2d at 432-33.

In Is Title Insurance the Answer?, John C. Murray recognizes that, while courts have been reluctant to impose a duty to recommend title insurance, an explanation of the risks involved and a recommendation for purchasing title insurance may protect attorneys from potential malpractice actions.221

In general, “a title search is not a guaranty of the accuracy of the recorded land records,” and courts will only hold attorneys liable for negligence in performing a search.222 To illustrate, a Connecticut court recognized that an attorney’s failure to explain or suggest title insurance is “not per se improper,” even if the insurance might have been beneficial.223

However, in the Washington state decision of Bohn v. Cody, the court recognized that an attorney could be negligent for failure to recommend that a non-client obtain a title report.224 In Bohn, the defendant attorney, who represented a borrower, failed to recommend to the borrower’s mother that she obtain a title report before loaning her daughter money. The Bohn court applied a multifactor balancing test, including the foreseeability of harm to the non-client and the degree of certainty that the non-client suffered injury; this factor analysis implies possible liability for failure to recommend a title report. Liability for failure to recommend the purchase of title insurance is a next logical step.225

Murray also considers the analogy of a negligent title search through a Connecticut case in which the plaintiff sued his attorney for negligence and breach of contract, based on the attorney’s failure to perform a title search and obtain a credit report of the purchasers.226

Murray further considers the theory of failure to disclose a defect in the title. He illustrates this theory with a New York case in which the court held an attorney’s negligent failure to mention a flaw in the record to his client-seller could establish malpractice.227 The attorney failed to communicate to the client that he had found an invalid executor’s deed creating a defect in the record.228 After discovering the defect, the buyer successfully brought an action against the seller to recover his deposit and expenses; the seller recovered those damages from his attorney.229 Murray

221. Id. at 222.
222. Id. at 225.
223. Id. at 5.
225. Id. at 75-77.
226. Murray, supra note 220, at 226-27 (discussing Bohn, 832 P.2d at 75-77).
227. Id. at 229-31 (discussing Namoury v. Tibbetts, No. 3:04CV599 (WWE), 2005 WL 3466007 (D.Conn. Dec. 19, 2005) (finding no malpractice based on evidence of good faith in the attorney’s dealings with his clients)).
228. Murray, supra note 220, at 239-41 (discussing Trimboli v. Kinkel, 123 N.E. 205 (N.Y. 1919)).
229. Trimboli, 123 N.E. at 205-06.
230. Id. at 206-07.
MOUSE II: PUBLIC POLICY ISSUES IN ARKANSAS INSURANCE LAW

projects that, had the defendant attorney recommended his client obtain title insurance, he might have avoided the malpractice judgment.\(^{231}\)

In a related situation, a court held an attorney liable for failing to ensure a proper recording, even though the recorder’s office committed the error.\(^{232}\) Murray projects that title insurance might have protected the attorney from mis-indexed documents.

While Murray advocates that attorneys take up the practice of explaining and recommending the purchase of title insurance, title insurance will not provide a complete shield as illustrated by one case where the buyers purchased title insurance but failed to file a claim against the carrier until after the limitations period had run.\(^{233}\) The court dismissed the buyers’ claim against the carrier, but held the attorney liable for failure to discover the restrictions in his title search.\(^{234}\)

In Arkansas, “title examination . . . constitutes the practice of law in its strictest sense” and “requires . . . the securing of professional advice and assistance.”\(^{235}\) Arkansas law demonstrates that the practice of law includes drafting, preparing instruments involving real estate transactions, and completing title searches for others.\(^{236}\)

In Arkansas, a duty exists to search the record thoroughly for title defects, to “make a reasonable search of the relevant records to detect clouds or defects in title.”\(^{237}\) The issuance of a title insurance policy is “predicated upon an examination of the public records” and in purchasing title insurance, the insured “expects to obtain a professional title search and opinion as to the condition of his title.”\(^{238}\) Thus, the contractual agreement between the agent and client imposes upon the agent a duty to accurately discover any title defects and penalizes the agent for his negligence in such searches.\(^{239}\)

Arkansas case law is primed to support one of the liability theories suggested in Murray’s national survey. First, title work is unquestionably the practice of law, and thus attorneys who engage in this type of work owe their clients a duty to provide “competence and integrity” and “freedom of full disclosure, with complete confidence in . . . one’s counselor in the definition and assertion of the rights in question.”\(^{240}\) Second, the duty established by the contractual agreement between title insurance agents and clients can lead to a breach of contract action for negligent title searches.\(^{241}\) Because non-lawyer agents have been held accountable for their negligence in

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232. Id. at 230.
234. Id. at 606.
236. Id. at 500, 326 S.W.2d at 904 (holding non-lawyer who engaged in abstracting was engaged in the unauthorized practice of law); see also Ark. Bar Ass’n v. Block, 230 Ark. 430, 323 S.W.2d 912 (1959) (enjoining a real estate company from engaging in the illegal practice of law by performing certain title work).
239. Id.
241. See Welch, 341 Ark 515, 17 S.W.3d 467.
such activities, it follows that those attorneys who engage in similar work may be vulnerable to a legal malpractice lawsuit.

Against this background, Murray suggests that attorneys protect themselves by recommending the purchase of title insurance to those clients whom the attorneys advise in real estate matters.


As Phillips and Coplen note in Concurrent Causation versus Efficient Proximate Cause,242 where multiple causes are present in the cause of an insured’s claim and “at least one cause would be included [under the policy] and at least one excluded . . . a ‘concurrent cause’ problem arises . . . ”243 A minority view allows for coverage whenever two or more causes contribute to a risk and one of them is covered under the policy.244 The order of events or the degree of contribution of the cause is irrelevant provided the cause “is not remote or tenuous in nature.”245 By contrast, the majority of courts apply an “efficient proximate causation” standard, which requires coverage only where the cause that sets the damage-causing series of events into motion is also the predominant cause of the injury.246

The courts have adopted a general policy to provide coverage through broad interpretation of policy language and narrow interpretation of exclusionary language.247 Phillips and Coplen explain that, where a concurrent causation approach is used, coverage under a policy is required any time one of the causes “contributes in a meaningful way . . . ” to the property damage where that cause is not excluded from the policy.248 Remote causes of damage are not considered; therefore, the but-for analysis ends upon the determination that a cause was “remote.”

Arkansas has followed the majority view, allowing for recovery when the damage is substantially caused by a risk covered in the insurance policy,249 an approach that dates back to 1958.250

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243. Id. at 33.
244. Id.
245. Id. at 34.
246. Id. at 39.
248. See Phillips & Coplen, supra note 242, at 33.
250. See Wash. Fire & Marine Ins. Co. v. Ryburn, 228 Ark. 930, 311 S.W.2d 302 (1958) (engaging in proximate cause analysis and broad construction of coverage provisions, to reject insurer’s argument that separate water damage insurance had not been purchased).
Efficient proximate cause requires that a cause be “the ‘leading’ or ‘predominant’ cause” of the loss in order for the insurer to be liable under the policy for the loss.251 Where an excluded cause is the predominant cause, the insurer may deny the claim. “Whether a cause of loss is the efficient proximate cause of the loss is a question of fact.”252 Remote causes may not be considered as the cause of the risk; the efficient proximate cause theory focuses on the event that “set in motion the chain of events leading to [a] loss . . . .”253

The danger to an insurer is that under either the majority or the minority view, a court may require the insurer to provide coverage for a loss that the insurer had specifically intended to exclude. The danger of court-imposed coverage is more likely to manifest in those situations where one of the causes is excluded from coverage, and one of the causes is covered by the policy. Expansion of coverage through litigation is the countervailing carrier concern that drives the carrier’s litigation posture when multiple causes have created the harm.254

To narrow coverage and set more definite guidelines within the insurance industry, insurance companies include policy language that is designed to avoid application of the multiple causation theories. The usual language is “[s]uch loss is excluded regardless of any other cause or event contributing concur-

ently or in any sequence to the loss.”255 While recognizing the carrier has an understandable motivation to limit its financial obligation to specific risks, some jurisdictions have found that the limitation is against public policy.256 However, most jurisdictions allow such limitations, including Arkansas.257

C. Workplace Insurance

This last section focuses on two loosely related annotations, both arising in the employment setting. One focuses on corporate owned life insurance and the other focuses on the intersection of workers’ compensation insurance with federal bankruptcy law.


Susan Martin, in Another Scheme, examines the practice of corporate owned life insurance (COLI).258 Prevalent among large banks that have held COLI policies valued somewhere in the billions,259 it has also been used by Wal-Mart which, at one point, had 350,000 employees covered by COLI’s.260

251. See Phillips & Coplen, supra note 242, at 33.
252. Id. at 40.
253. Id. at 42.
254. Multiple causation coverage restrictions are absolutely not clear to consumers of insurance.
256. Id.
257. Considerations that could prohibit an insured’s attempt to preclude application of the efficient proximate cause doctrine through contract language include public policy, reasonable expectations and statutory prohibition. Id.
COLI’s originated with “key man” or “key person” insurance, to cover employees critical to the operation of the business and who are not easily replaced. Corporations have an insurable interest in such employees, and the practice does not generate debate.261

By contrast, the use of COLI policies with respect to “rank and file” employees is a controversial practice because such employees are fungible and their departure does not cause irreparable harm to the corporation. While it is costly to hire and train new employees, a COLI makes an insured employee worth more to a corporation dead than alive. To this end, COLI’s are commonly known by the terms “dead janitor policies” and “dead peasant policies.”262 In some corporations, income from COLI payouts constitutes up to 12 percent of total net income.263

Historically, corporations received a large, tax-free payout through COLI transactions; in addition, many responsible corporations used COLI payouts to fund pension plans.264 However, COLI’s have also been used as tax avoidance vehicles because corporations were able to deduct the interest costs incurred in financing these policies.265 Tax benefits would extend to the use of policies as loan mechanisms, in which the corporation would take a “loan” against the cash value of the policy. Because it would be a loan, no taxable event occurs, even though the loan would not actually have to be repaid until the policy would pay out upon the insured’s death—a tax-free event.266 Even with redemption of part of the cash value of the policy, no taxable event would occur, because redemptions would be subtracted from the corporation’s basis in the cash value, not the increased value (gains), which are taxable.267

The Tax Reform Act of 1986 added limitations to these deductions.268 Because the death benefit payment was tax-free to the beneficiary, the Reform Act was designed to limit corporate ability to avoid taxes on both the front and the back end of the life insurance transaction. The Pension Protection Act of 2006 set further limits on the tax-free status of the death benefit for a COLI.269 Under this Act, a corporation that uses COLI’s is taxed on the death benefit unless the decedent was an employee within the previous twelve months, was a director or highly compensated employee at the time of the policy issue, or proceeds of the policy have been directed to the family.270

In those instances where the corporation does not disclose the fact that it holds COLI’s on its employees, such non-disclosure has led

262. Martin, supra note 258, at 654.
263. Id. at 672.
264. Id. at 659.
265. Martin, supra note 258, at 653.
266. Id. at 665.
267. Id. at 666.
268. Id.
270. Martin, supra note 258, at 653.
to litigation. In Texas, a widow obtained COLI benefits because, under Texas state law, Wal-Mart did not have an insurable interest in her husband.\textsuperscript{271} Had the Texas case been brought under Arkansas law, however, a contrary result would have been likely. Arkansas statutory law recognizes an insurable interest and expressly allows corporations to purchase life insurance policies on key employees.\textsuperscript{272}


Matthew J. Bates, in Not an Employee Benefit Program,\textsuperscript{273} analyzes a 2006 United States Supreme Court decision that resolved a split in the circuits as to whether workers’ compensation insurance was part of an employee benefit plan and holding that it was not.\textsuperscript{274} The Court held that unpaid workers’ compensation premiums owed to a private creditor are not part of the employee’s benefit plan and as such are not afforded priority status,\textsuperscript{275} adopting the analysis the Eighth Circuit had taken in the circuit split.\textsuperscript{276} The Court reasoned that workers’ compensation insurance shields employers from tort liability,\textsuperscript{277} making workers compensation insurance more like liability insurance than an employee benefit.\textsuperscript{278}

Bates, after detailing the history of the relevant bankruptcy code provision, concludes that the Court read language into the statute: “In holding that an ‘employee benefit plan’ may not simultaneously benefit the employer, [the Court] maintained that the term implicitly excluded programs that benefit both employees and employers alike.”\textsuperscript{279}

After the Supreme Court’s decision in Howard, one bankruptcy court in the Eighth Circuit has demonstrated the continuing vitality of the Bankruptcy Code’s priority provision for employee benefit plans.\textsuperscript{280}

For further reading:

The students who drafted these annotations and conducted the Arkansas law updates that accompany them participated in a

\begin{flushleft}
271. \textit{Id.} \\
272. \textit{Ark. Code Ann.} § 4-26-204(4) (2007) (empowering a corporation to “procure for its benefit insurance on the life of any employee or officer whose death might cause financial loss to the corporation, and to this end, the corporation is deemed to have an insurable interest in its employees and officers”). \\
275. \textit{Id.} \\
276. \textit{In re HLM Corp.}, 62 F.3d 224 (8th Cir. 1995). \\
277. \textit{Id.} at 50. \\
278. Bates, \textit{supra} note 273. \\
279. \textit{Id.} at 760. \\
\end{flushleft}
full semester insurance survey course. That course was well-informed by a casebook and a single-volume treatise; both are excellent sources for additional reading and reference in the insurance arena. Both are written from a practice perspective, with generous citation to secondary authorities and primary leading case law.

The casebook’s recent second edition includes a new Automobile Liability Insurance section that highlights very basic and recurring issues in auto insurance litigation, in a compact number of pages. The automobile liability materials include lead case treatment of the omnibus clause, the family member exclusion, the “arising out of the use of an automobile” limitation, and the intersection between automobile and homeowners policies.

Other insurance articles by this annotation editor, as noted earlier in this text, include: *The Mouse in the Annotated Bibliography: an Insurance Law Primer* and *Non-profit Insurance*. Finally, several of the contributors to this collection have served as editors and/or student authors for the University of Arkansas School of Law’s publications; each of those publications are represented by contributors to this compilation: Arkansas Law Review, The Journal of Food Law and Policy, and The Journal of Islamic Law and Culture.

287. Emily Reynolds (Editor-in-Chief, Journal of Food Law and Policy, 2008-09); see supra notes 6-23 and accompanying text (Civil Justice Reform Act); and see Note, Merit or Mandatory Preference?: The Effect of Huber v. Wal-Mart Stores, Inc. on the Application of the ADA’s Reassignment Provision, 61 Ark. L. Rev. 389 (2008).
288. Farah Lolagne (Lead Student Editor, Journal of Islamic Law and Culture, 2008-09); see supra notes 157-172 and accompanying text (genetic testing).