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### Recent Case Developments

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## RECENT CASE DEVELOPMENTS

*Jeffrey W. Stempel\**

### LIFE INSURANCE BENEFICIARY MAY NOT BE CHANGED THROUGH WILL WHEN POLICY SETS FORTH SPECIFIC CONTRARY PROCEDURE FOR CHANGING BENEFICIARIES

*McCarthy v. Aetna Life Ins. Co.*, 704 N.E.2d 557 (N.Y.  
1998).

As a one-time employee of J.C. Penney in New York, Stephen Kapcar received a group life insurance policy issued by Aetna Life Insurance Company. In 1972, he married Christine McCarthy and she was designated as his beneficiary under the policy. Sadly, Kapcar developed multiple sclerosis, which led to severe tremors, blindness, and eventually quadriplegia. Kapcar and McCarthy were separated in 1977 and divorced in 1978. The property settlement in their divorce did not mention the Aetna policy, but did provide that they relinquished and released any claims upon one another's property.

After his separation from McCarthy, Kapcar lived with his father until his death in 1984. Kapcar's holographic will, written in 1977 and probated in Pennsylvania, stated: "I will all my personal belongings, stock certificates, bank accounts, insurance benefits, and any other earthly belongings to my father . . . . This will voids my previous will bequeathing my belongings to Christine B. Kapcar." *McCarthy*, 704 N.E.2d at 559.

However, Kapcar did not change the beneficiary designation on his Aetna life insurance policy. After Kapcar's death, a struggle ensued between Kapcar's father and former wife over the \$16,000 life insurance policy proceeds. McCarthy sued Aetna in an attempt to collect. Aetna brought

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Emil Kapcar into the action as another interested claimant, deposited the funds with the court, and then was dismissed from the case.

The trial court ruled for the former wife, who was the designated beneficiary. The intermediate appellate court ruled in favor of the father, who was designated in the will. The New York Court of Appeals, the state's highest court, resolved the issue in favor of the former wife, essentially electing to follow contract law more than the seeming equity concerns presented by this sad case.

The New York Court of Appeals applied conventional contract and insurance rules. In particular, the court noted that under Pennsylvania law (decedent Kapcar's home state), New York law (the place of contracting), and Delaware law (the applicable law designated in the policy), the agreed rule was that the method for designating or changing beneficiaries set forth in the insurance policy itself must be followed in order to effectively change a beneficiary. Because decedent Kapcar had not followed the Aetna procedure for changing beneficiaries, his obvious desire to leave the money to his father rather than his former wife would not be enforced, despite being part of his last will and testament.

Because the controlling law would be the same under any of the three states interested in the case, the court did not engage in any choice of law analysis because "the result would be the same" in all three jurisdictions. *See id.* at 560. The court approved the basic rationale of the rule that policy procedures control beneficiary designation because the rule "serves the paramount goals of ensuring that life insurance proceeds are disbursed consistently with an insured's stated intent and of preventing the courts and parties from engaging in rank speculation regarding the wishes of the deceased." *Id.* The court also noted that the rule is necessary to protect insurers from possible lurking liability if they pay the policy benefits to a beneficiary designated on the face of the policy but then later are confronted with heirs or others making a claim to the policy on the basis of another document. *See id.*

However, the court also stated that "[s]trict compliance with the rule is not always required." *Id.* Rather, it is sufficient if there is substantial compliance or attempted compliance that reflects the intent to change the beneficiary. However, mere intent is not enough. There must be some affirmative act that seeks to accomplish the intended beneficiary change, even if the action falls short of strict adherence to the policy procedure. Some of the case law cited by the New York court suggests that the compliance, even if not strict, must be substantial in that the record must show that the insured "made every reasonable effort" to follow the policy

procedure for changing a beneficiary. (Internal quotation marks omitted.) *See id.*

Applied to Kapcar's case, these general rules made ineffective his attempt to change a life insurance beneficiary through his will. The will and the life insurance policy are two separate documents. The will cannot change the life insurance policy any more than a rider on the life insurance policy can alter a last will of the decedent. Consequently, the Aetna policy continued to have the same beneficiary as it had in 1972 – Christine McCarthy, Kapcar's former wife.

Although Kapcar was obviously not in good health, the court found no evidence that he was incapable of effecting the beneficiary change during the 1977-84 period, suggesting that physical or mental inability to arrange the change might be grounds in rare cases for seeking a beneficiary change on the basis of something other than normal policy procedure. Consequently, despite what laypersons would probably regard as Kapcar's clear intent to give the money to his father who had faithfully cared for him during his declining years (rather than to a former spouse), the court unanimously found the issue to be clearly controlled by definitive contract principles.

RECEIPT OF WORKERS' COMPENSATION  
BENEFITS BY AUTO ACCIDENT VICTIM MAY BE  
DEDUCTED ONLY ONCE FROM UNDERINSURED  
MOTORIST BENEFITS AVAILABLE TO VICTIM

*Roberts v. Northland Ins. Co.*, 705 N.E.2d 762 (Ill. 1998).

Kirk Roberts was seriously injured driving a truck while working. Because he was acting in the course of his employment, he was eligible for workers' compensation, and he received more than \$196,000 in benefits. He also received social security disability benefits of \$300 per month. The driver of the other vehicle had only \$50,000 in liability coverage, all of which was paid to Roberts. Despite these amounts, Roberts was not fully compensated and made a claim under two separate insurance policies – his own and that of his employer.

One policy issued by the Chicago Motor Club Insurance Company provided underinsured motorist ("UIM") coverage of \$300,000, while the Northland Insurance Company policy had \$500,000 of underinsured motorist coverage. The Chicago Motor policy was primary (meaning that its policy limits would need to be exhausted first) while the Northland policy was excess (meaning that it would begin to pay its UIM benefits after the last

dollar of Chicago Motor's UIM coverage was spent). The Chicago Motor policy had language stating that UIM benefits "will be reduced by . . . the present value of all amounts payable under any workmen's compensation, disability benefits or similar law." *Roberts*, 705 N.E.2d at 763. The Northland policy had similar language.

Both Chicago Motor and Northland argued that they should be able to reduce their respective UIM benefits otherwise available to Roberts by the amount of the workers' compensation benefits paid to Roberts. In other words, Chicago Motor argued that it need only pay \$100,000 (not its \$300,000 UIM limits) and Northland argued that it need only pay \$300,000 (not its \$500,000 UIM limits). This prompted a lawsuit by Roberts, who sought a declaration that the UIM benefits would not be reduced by the workers' compensation benefits.

The trial court ruled largely for Roberts, holding that the workers' compensation benefits should be set off only once against combined applicable policy limits and that Roberts' social security disability benefits could not be set off against the insurance to reduce available benefits. The appellate court reversed as to the workers' compensation benefits and ruled that these funds should be separately set off against each of the two UIM policies.

The Illinois Supreme Court reversed the appellate court and ordered one deduction of the workers' compensation benefits. Even though there were two policies that provided for reduction of coverage by the amount of workers' compensation benefits paid, state substantive law and public policy were held to limit the reduction to one setoff of the workers' compensation benefits.

The court reasoned that allowing the workers' compensation funds to be set off twice against auto insurance coverage would defeat the purpose of UIM coverage, since underinsured motorist coverage exists to place the insured in the same position he would have occupied if injured by a motorist who carried liability insurance equal to that of the policyholder and sufficient to compensate the victim for the amount of damage.

In other words, Roberts successfully argued that if he had been hit by a tortfeasor with adequate insurance, in view of his serious injuries, Roberts would have available to him at least \$800,000 in coverage, an amount limited by the amounts of Roberts' own coverage, but still apparently not enough to fully compensate Roberts for his injury. Consequently, the court ruled that fairness and the state's interest in having accident victims fully compensated through the insurance markets militated against permitting more than one reduction of UIM benefits because of the workers' compensation payments. "Although the insured receives his workers' compensation award only once,

the insurers nevertheless attempt to subtract that award twice from the insured's coverage. Allowing such a double setoff would frustrate the [legislature's] intention [in the state's UIM regulation]." *Id.* at 765.

Defendants repeatedly assert that because the instant plaintiff held two separate insurance policies, two setoffs should be allowed. Public policy allows one setoff, however, because the setoff prevents the plaintiff from receiving an unfair windfall through his workers' compensation benefits, while still guaranteeing plaintiff the level of coverage he would have received had he been injured by an adequately insured tortfeasor. A double setoff, on the contrary, deprives the victim of the level of coverage he would have received if the tortfeasor had been adequately insured, and therefore violates public policy.

*Id.* at 765-66.

The Illinois high court emphasized the general applicability of its decision for similar cases in the future, stating "[w]e hold that when an accident victim is covered by more than one insurance policy providing underinsured-motorist coverage, public policy permits only one setoff to that coverage for the amount of workers' compensation benefits received by the insured." *Id.* at 766.

Having limited the workers' compensation setoff to one amount, the Illinois Supreme Court also needed to determine the manner in which the \$196,000 setoff would be allocated. The court permitted primary insurer Chicago Motorist to reduce its \$300,000 UIM liability by this figure, effectively requiring Chicago Motorist to pay \$100,000 to Roberts while Northland was required to pay \$800,000.

The court reasoned that the Chicago Motorist policy was primary, and that as a primary policy Chicago Motorist was at greater risk than the excess insurer because it is closer to the risk and more likely to pay out its policy proceeds than is an excess insurer. "Because it bears this greater burden, the primary carrier should also be the first to receive the benefit of the setoff in order to reduce the coverage upon which the insured has first claim." *Id.* The court made this holding generally applicable.

The court was unanimous in holding that workers' compensation benefits could be set off only once to reduce available UIM coverage, and that social security benefits could not be used to reduce applicable insurance. Three justices dissented, however, on the issue of allocation. The dissenters

argued that the workers' compensation setoff benefit should be prorated among the applicable insurers because both insurers bore similar risks, and because both the Chicago Motorist and the Northland policies contained clear language entitling both of them to reduce benefits because of workers' compensation funds received by the claimant.

The issue of apportionment in a case like this is indeed more difficult than the issue of whether to reduce the victim's available insurance by twice deducting his workers' compensation benefits. The majority opinion is analytically sound in distinguishing between primary and excess insurer obligations. Ordinarily, primary insurers should both be obligated to respond at the initial levels of a claim and reap the benefit of any setoff because of collateral sources of compensation, since the primary insurer had the first obligation to pay.

However, as applied to the facts of the *Roberts* case, the practical effect of this unapportioned setoff is to give a windfall to the primary insurer by effectively cutting its policy limits by two-thirds. In effect, the workers' compensation setoff almost makes for illusory UIM coverage by the Chicago Motor Club policy. After *Roberts*, that policy provides not \$300,000 of benefits, but only \$300,000 minus workers' compensation funds. Where the workers' compensation funds are significant, the primary policy not only pays far less than one might expect, but the excess insurer's attachment point is lowered from its stated \$300,000 to an actual attachment point of \$100,000, greatly increasing the excess insurer's obligations and risk of being tapped by a claim. In effect, the Northland policy was required to attach at \$100,000 rather than \$300,000.

In the wake of *Roberts*, excess insurers should give serious consideration to revising their policy language to provide for reduction in benefits to the extent that underlying primary coverage is reduced by workers' compensation setoff. In the alternative, excess and primary insurers could agree to prorate any setoff by equal shares, policy limits, or premium ratios. Although cases like *Roberts* seem comparatively rare (most serious injuries covered by workers' compensation do not involve applicable auto insurance coverage as well), the potential detriment of the decision to excess insurers is clear.

EMPLOYEE INJURED WHILE DRIVING CO-  
WORKER'S CAR IS NOT BARRED FROM  
RECOVERING UNINSURED MOTORIST BENEFITS  
BECAUSE OF RECEIPT OF WORKERS'  
COMPENSATION BENEFITS

*Gardner v. Erie Ins. Co.*, 722 A.2d 1041 (Pa. 1999).

Lorren Gardner was injured by a hit-and-run driver while operating an automobile owned by Steven Ward, a co-worker. Gardner received \$15,000 from his own auto insurer as well as receiving workers' compensation benefits since he was driving the Ward automobile in the course of his employment at the time of the accident. However, because Gardner was seriously injured, the benefits he received were insufficient. The hit-and-run driver was not located, which made his liability insurance, if any existed, unavailable to pay Gardner's claims. Gardner thus sought to recover uninsured motorist ("UM") benefits under the Ward policy.

Ward's insurer, Erie Insurance Company, argued that Gardner's receipt of workers' compensation benefits precluded his receipt of uninsured motorist benefits as well. The trial court agreed, but the superior court (Pennsylvania's intermediate appellate court) reversed. The supreme court affirmed and held for Gardner, finding that the exclusivity of the workers' compensation remedy did not extend so far as to prevent injured workers from recovering otherwise available automobile insurance benefits.

Erie's argument was premised upon a part of Pennsylvania's workers' compensation law found in virtually all state workers' compensation laws – the ban on negligence actions against a co-employee for work-related injury. In particular, Pennsylvania's law stated:

if disability or death is compensable under this act, a person shall not be liable to anyone at common law or otherwise on account of such disability or death for any act or omission occurring while such person was in the same employ as the person disabled or killed, except for intentional wrong.

77 PA. CONS. STAT. §72 (1992).

Both the supreme court and the superior court reasoned that a claim for uninsured motorist benefits was not a claim against the co-employee who owned the policy providing such benefits. Rather, Gardner's negligence claim was against the third party tortfeasor, a hit-and-run driver and



nonemployee. Because this third party had no accessible insurance, Gardner turned to the UM provisions of the policy covering the automobile in which Gardner was riding at the time of the accident, which only incidentally happened to be the automobile of a co-worker. As the supreme court observed, the "plain language [of the statute] is directed to providing relief from liability to the co-employee," not to a third party or the co-employee's insurer (which provides coverage in the event the third party is uninsured). See *Gardner*, 722 A.2d at 1046.

This characterization of UM coverage as a substitute for third-party liability coverage is consistent with much of insurance law. However, there is also case law rejecting Pennsylvania's approach and holding that a claim against a contract held by a co-employee is the essential equivalent of a claim against the co-employee, a view taken by the trial court in *Gardner*. On balance, however, the Pennsylvania Supreme Court's view appears preferable. The *Gardner* ruling does not permit an injured employee to avoid the exclusive remedy provisions of the workers' compensation statute and reinstate the pre-existing system of common law torts against co-workers or employers (including common law defenses of the employer). Rather, Gardner was permitted to seek compensation for the damage done by a non-employee in a manner that does not undermine the workers' compensation scheme of the state.

The *Gardner* opinion also dealt with some nuances of relatively recent state statutory revision that the trial court had read as strengthening the bar to suits against a co-employee, including the co-employee's UM coverage. The supreme court rejected this view and distinguished a 1995 precedent in ruling for Gardner. According to the court, the recent statutory revisions did not have the effect of reducing any available UM benefits through set off of workers' compensation benefits. However, the workers' compensation carrier is "given the right of subrogation for any benefits paid to the employee under workers' compensation." *Id.* at 1045.

#### ERISA DOES NOT PRECLUDE CLAIMS AGAINST HEALTH INSURER

*Pappas v. Asbel*, 724 A.2d 889 (Pa. 1998).

At 11:00 one morning, Basile Pappas went to the emergency room ("ER") of Haverford Community Hospital complaining of paralysis and numbness in his arms and legs. The ER physician diagnosed Pappas as suffering from an epidural abscess pressing against his spinal column and

posing a serious threat of injury. A neurologist and neurosurgeon were consulted and confirmed that Pappas faced a neurological emergency. The ER doctor arranged to transfer Pappas to Jefferson University Hospital ("Jefferson") for further specialized treatment. As the ambulance arrived, Pappas's insurer, U.S. Healthcare of Pennsylvania ("U.S. Healthcare"), denied authorization for treatment at Jefferson.

Continuing efforts to authorize treatment ensued, with U.S. Healthcare continuing to deny treatment at Jefferson, but approving treatment at Hahnemann University, Temple University, or Medical College of Pennsylvania. The ER physician ultimately arranged treatment for Pappas at Hahnemann, but the HMO-required shuffle of hospitals resulted in approximately a three-hour delay in treating Pappas, who today is a permanent quadriplegic as a result of the compression of his spine caused by the abscess.

Pappas filed suit against his primary care physician and Haverford Community Hospital, alleging negligence in the delay of transferring him to a hospital that could address his neurological emergency. Haverford filed a third-party complaint that brought U.S. Healthcare into the case as a defendant. Haverford's allegation was that the delay was the fault of U.S. Healthcare, which had refused to authorize the original, timely transfer of Pappas to Jefferson. U.S. Healthcare filed a motion for summary judgment seeking to be removed from the case on the ground that any claim against it under state law was precluded and preempted by the Employee Retirement Income Security Act of 1974 ("ERISA").

In particular, ERISA contains broad preemption language that states that ERISA supersedes "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. §1144(a)(1988). HMOs like U.S. Healthcare that provide health insurance coverage under an employer's group plan are almost always classified as part of an "employee benefits plan" within the meaning of ERISA. *See* 29 U.S.C. §1002(1)(1988). State law includes not only statutes but also court decisions and state regulations. *See* 29 U.S.C. §1144(c)(1)(1988).

The trial court granted the motion and released U.S. Healthcare from the case. The intermediate appellate court (the "Superior Court" in Pennsylvania) reversed, holding that the broad preemption language of ERISA could not be read with full literal breadth where HMOs are concerned because HMOs were not a major part of the health care scene at the time of ERISA's enactment. The Pennsylvania Supreme Court rejected the reasoning of the Superior Court but affirmed on other grounds, keeping U.S. Healthcare in the *Pappas* case as a third-party defendant. In particular, the supreme court found HMOs sufficiently within the contemplation of

Congress at the time of ERISA's enactment. The Pennsylvania high court noted that a year prior to ERISA's enactment, Congress passed the Health Maintenance Organization Act of 1973. According to the court, "[t]he HMOs described in that act are too similar to a contemporary HMO for us to conclude that Congress, when crafting ERISA, was ignorant of the cost containment procedures utilized by HMOs." *Pappas*, 724 A.2d at 893 n.6.

The supreme court permitted the claim of negligence against U.S. Healthcare based on its reading of the most recent United States Supreme Court decisions regarding the scope of ERISA preemption. According to the Pennsylvania court, federal precedent of the 1980s and early 1990s did read ERISA's preemption language with near-literal breadth and these cases were heavily relied upon by U.S. Healthcare. However, according to the Pennsylvania court, the United States Supreme Court "noticeably changed tack" in 1995 when it handed down *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 115 S. Ct. 1671, 131 L. Ed. 2d 695 (1995), a decision rejecting an ERISA preemption challenge to a New York statute requiring hospitals to collect surcharges from patients covered by commercial insurance but not by the Blues. *See Pappas*, 724 A.2d. at 892.

As seen by the Pennsylvania court, the U.S. Supreme Court has in *Travelers* and subsequent precedents moved away from a text-based assessment of ERISA preemption and toward a purpose-based analysis. In particular, the U.S. Supreme Court has, since 1995, permitted state claims involving an ERISA plan so long as this does not have the effect of subjecting employee benefit plans to a multiplicity of regulation, and where the state law is not directed specifically at ERISA plans. Thus, where a law of general applicability (such as negligence) is applied to an HMO or other ERISA plan entity, there is no preemption problem unless the state law invoked is in actual conflict with ERISA's substantive provisions or purpose.

Applying this precedential yardstick, the Pennsylvania court concluded that negligence claims against an HMO do not "relate to" an ERISA plan within the meaning of the ERISA statute. These laws govern the provision of safe medical care, not the structure of employee benefits plans or relations between the plan administrator and the health insurer. The court observed: "We acknowledge that by allowing negligence claims, there will be a financial impact on HMOs. Yet, that is not enough to countermand the conclusion that these claims are not preempted. . . . [A]n incidental increase in the costs imposed on an ERISA plan will not mandate a finding of preemption." *Id.* at 894 (citing *DeBuono v. NYSA-ILA Med. and Clinical Servs. Fund*, 520 U.S. 806 (1997)).

Although U.S. Healthcare had substantial Supreme Court precedent supporting its argument, the Pennsylvania court found that *Travelers*

and its progeny have thrown the expansive holdings of those earlier cases into question. We thus believe that it would be improper to adopt U.S. Healthcare's position that we must reflexively interpret the preemption provision in the broadest possible manner. Instead, we believe that the proper course of action is to follow the reasoning contained in the *Travelers* line of cases, even though we recognize that the [United States Supreme] Court's earlier cases have not been expressly overruled.

*Id.* at 893 (footnote omitted).

To date, the U.S. Supreme Court has not ruled on the specific question of whether an HMO may be sued for negligence resulting in a patient's injury. The *Pappas* court acknowledged that a number of United States Court of Appeals decisions have found HMOs immune from such state law claims. *See id.* n.5.

Yet, the bulk of these cases were handed down prior to *Travelers*. The only one of these cases which was decided subsequent to *Travelers* – *Cannon* [*Cannon v. Group Health Servs. of Oklahoma, Inc.*, 77 F.3d 1270 (10th Cir. 1996)] – fails even to mention *Travelers*. Since we find the recent trend of the Supreme Court to be so compelling, it would be inappropriate for us to utilize the reasoning of these courts of appeal cases as they fail to discuss the *Travelers* line of decisions.

*Id.*

Undoubtedly, further chapters remain to be written regarding the relationship between state tort law claims stemming from medical treatment and the scope of ERISA preemption, with the story's conclusion in doubt until the Supreme Court acts. In the meantime, *Pappas* will likely provide considerable ammunition to plaintiff patients' lawyers (and their initial target defendants who may want to point the finger at HMOs) and may well be influential in the ongoing debate.

OVERRULING OLD PRECEDENT, FLORIDA  
ADOPTS MAJORITY VIEW THAT "ACCIDENT"  
ENCOMPASSES NOT ONLY ACCIDENTAL  
EVENTS, BUT ALSO UNEXPECTED OR  
UNINTENDED DAMAGES FROM VOLITIONAL  
ACTS

*State Farm Fire and Casualty Co. v. CTC Development Corp.*, 720 So. 2d 1072 (Fla. 1998).

Even the most venerable of precedents is subject to change – especially when it is out of sync with modern decisions of other courts and leading academic commentary. In *Hardware Mutual Casualty Co. v. Gerrits*, 65 So. 2d 69 (Fla. 1953), the Florida Supreme Court had held that an intentional act by an insured resulting in unintended injury, damage, or liability could not be an "accident" under a liability policy. Some forty-five years and nearly 700 volumes of Southern Reporter later, the court overruled ("recede[d] from," in the parlance of the court, see *State Farm*, 720 So. 2d at 1072.) *Gerrits*, holding that an insured's conduct may constitute an "accident" under a liability policy even when the actions were volitional so long as the resulting injury was not expected or intended from the standpoint of the insured.

Gregory Uzdevenes was a professional architect and the sole owner of CTC Development, a construction company, both of which were insured under a State Farm "Contractor's Policy." While building a home, CTC sited the house too close to lot lines in violation of the neighborhood's restrictive covenants. CTC was well aware that the house was within fifteen feet of the lot line and intentionally located the house at that distance but believed it had been granted a variance by the homeowners' association.

After the home was sixty percent done, CTC was informed of "a possible problem with the variance." *Id.* at 1073. At that point, according to CTC, it would cost \$275,000 to tear down the home and rebuild it at further setback. CTC declined to remediate the home's location, was sued by the structure's neighbors, and settled for \$22,500 after being refused a defense by its insurer. State Farm denied coverage, contending the lawsuit did not arise out of an occurrence as required under the Contractor's Policy which, like most general liability policies, defines an occurrence as an "accident." CTC sued State Farm for the settlement amount and \$29,400 in counsel fees and costs. Based on the old *Gerrits* case definition of an accident, the trial court ruled for State Farm. However, the First District Court of Appeals reversed, correctly anticipating that Florida's legal landscape had changed during the intervening half-century.

The Supreme Court affirmed the First District opinion and rejected the *Gerrits* analysis. In particular, the *CTC* court criticized *Gerrits* for using tort law reasoning to define an accident rather than the contract law reasoning that should be applicable to insurance coverage disputes. *Gerrits* found that an architect's building too close to a lot line could not be an accident if it was the effect of a "natural and probable consequence of an act or course of action." *Id.* at 1074.

But between the time of *Gerrits* and *CTC*, Florida law had for some time stated that "foreseeability," a well-established tort doctrine, was a suitable yardstick for construing accident-based liability policies. Almost by definition, a policyholder who is sued for negligence is accused of failing to notice what was reasonably foreseeable. Put another way: if negligence in the construction of a building vitiates insurance coverage under a contractor's policy, it is difficult to see any real value in the policy. To fulfill its purpose, a liability policy should cover policyholders for unintended damages even where the acts giving rise to allegations of negligence were voluntary.

In particular, the *CTC* court noted the policy's exclusion for claims of injury expected and intended from the standpoint of the insured (a typical term in liability insurance) and read this *in pari materia* with the term "accident" to conclude that the policy's design was to cover unintended injury but not to cover intentional injury (as opposed to unintended injury from intentional action, which is covered). The court also noted that this was the view of leading scholars, specifically citing ROBERT E. KEETON & ALAN I. WIDISS, *INSURANCE LAW*, §5.4(c) at 511 (1998). *See State Farm* at 1076.

The *CTC* court further viewed the term "accident" as at least ambiguous since it was undefined in the policy itself and was susceptible to the reading offered by *CTC*. Under the standard insurance maxim of *contra proferentem* (ambiguities are construed against the drafter), *CTC* would be accorded a favorable construction conveying coverage. *See id.*

The *CTC* court, however, affirmed a line of precedent holding that some actions by a policyholder might be "so inherently dangerous or harmful that injury was sure to follow" and that these activities as a matter of law could not be deemed accidents even where the policyholder claimed that the resulting injury was unintended. *See id.* (citing *Landis v. Allstate Ins. Co.*, 546 So. 2d 1051 (Fla. 1989) (sexual abuse by insured not an "accident" or "occurrence."))

With the *CTC* decision, Florida law regarding the meaning of "occurrence" and "accident" squares far better with the bulk of modern cases which have, like *CTC*, focused on whether the injury was intended by the policyholder rather than whether the injury resulted from intended activity.

The *CTC* view and modern Florida law fit far better with the purpose of liability insurance, which is to provide coverage for tort liability rather than to provide coverage only for involuntary activity. If the latter view and the *Gerrits* decision were to prevail, policyholders might arguably be covered only for reflex actions and spasms.

For example, under *Gerrits*, an insurer could argue that lawsuits resulting from speeding or driving under adverse conditions were not covered "accidents" under an automobile policy. Of course, in the forty-five years between *Gerrits* and *CTC*, Florida cases had not taken such an extreme view and had subtly confined *Gerrits* to its most narrow realm, usually by implicitly assuming that bad driving or the like was not intended. Because the *CTC* case involved essentially the same type of contractor error at issue in *Gerrits* and both involved clearly volitional action (home building), the Florida Supreme Court could not easily distinguish or confine *Gerrits* without reversing it, leading to the court's candid and unanimous burial of the now-discredited *Gerrits* precedent and its erroneous reasoning regarding "accidents" and liability claims.

SUPREME COURT HOLDS RIGHT TO CLAIM  
WORKERS' COMPENSATION BENEFITS NOT A  
"PROPERTY RIGHT" UNDER CONSTITUTION;  
UTILIZATION REVIEW OF INJURED EMPLOYEE'S  
MEDICAL BILLS NOT "STATE ACTION"

*American Manufacturers Mutual Insurance Co. v.  
Sullivan*, 526 U.S. 40, 119 S. Ct. 977 (1999)

Pennsylvania has a typical workers' compensation system in which employers are held liable without fault for work-related injury to employees (subject to certain exceptions such as employee misconduct or fraud in the claim). In return, the employee's rights of compensation against the employer for such injuries are determined "exclusively" by the remedies of the workers' compensation statute. The employee may not sue the employer for additional damages beyond those set forth in the prevailing schedule of benefits under the prevailing workers' compensation statute.

To ensure that workers' compensation claims are paid, Pennsylvania requires that the employer obtain private insurance, obtain insurance from the State Workers' Insurance Fund, or obtain state permission to self-insure. If liability for a work-related injury is not at issue, the statute requires that employers or insurers pay the "reasonable" and "necessary" medical expenses

of the employee within thirty days after receiving the bill. Once the insurer has paid the medical provider, the matter is final. The insurer may not seek reimbursement even if it comes to find that the charges were unnecessary or excessive.

However, the reasonableness or necessity of a medical bill may be challenged under a system of "utilization review," in which the insurer (or self-insuring employer) files a notice with the Workers' Compensation Bureau of the Department of Labor and Industry. The Bureau then notifies the parties of the requested review, which is conducted by a private "utilization review organization" ("URO"), comprised of licensed health care providers for the type of treatment at issue. The URO then determines "whether the treatment under review is reasonable or necessary for the medical condition of the employee" according to "generally accepted treatment protocols," with any doubts to be resolved in favor of the employee. 34 PA. CODE §§127.470(a); 127.467, 127.471(b) (1998). The statute also requires that the review be completed within thirty days. If the insurer prevails, the employee may seek to have the decision overturned by a workers' compensation judge or further judicial review by the general jurisdiction courts of the state. If the employee prevails, the insurer must pay immediately with ten percent interest on the money and must also pay the costs of the review itself.

A class of employees subjected to utilization review challenged the statute as an unconstitutional deprivation without adequate due process of law of their property right to receive prompt payment of medical benefits. The United States Court of Appeals for the Third Circuit agreed and specifically found that the utilization review procedure was faulty in that it did not notify the employees themselves of the insurer's or employer's challenge and did not give the employees a right to participate in the procedure and defend the reasonableness and necessity of their medical bills. *See Sullivan v. Barnett*, 139 F.3d 158 (3d Cir. 1998). As a result, Pennsylvania changed its review procedures.

Insurers did not challenge the "new, improved" procedures designed to give injured employees notice and opportunity to be heard. However, workers' compensation insurers did successfully petition for Supreme Court review of the constitutional premises underlying the employees' victory. Specifically, insurers and employers argued that the review procedure was not "state action," that is, conduct by the state government or its agents that subjects the state to scrutiny and regulation under the Due Process Clause of the United States Constitution. Due process requirements, when applicable, require that a person not be deprived of a property interest without notice and opportunity to be heard in a timely manner and reasonable fashion before a



sufficiently neutral and qualified factfinder. Insurers and employers also argued that the employee's claim for payment of medical benefits was not "property" within the meaning of the Due Process Clause.

The Supreme Court agreed with the insurers and employers on both constitutional questions. Specifically, the Court held that utilization review conducted by private entities was not "state action" even though it was authorized by the state, with insurers required to notify the state when the procedure was invoked. The Court also held that the injured employee's claim for medical benefits is not a "property right" until it has been officially determined as such by the review process or the courts that the employee is in fact entitled to the benefits claimed.

Reviewing precedent, the Supreme Court noted at the outset of the opinion that the Constitution does not reach "merely private conduct, no matter how discriminatory or wrongful." *Sullivan*, 119 S. Ct. at 985 (quoting *Blum v. Yaretsky*, 457 U.S. 991, 1002 (1982) and *Shelley v. Kramer*, 334 U.S. 1, 13 (1948)). To have state action, there must be (1) a violation of a rule of conduct imposed by the state that is (2) committed by a state actor. In *Sullivan*, the Court found that a private insurer's decision to withhold payment for disputed medical treatment is not "fairly attributable" to the State. "[T]he mere fact that a business is subject to state regulation does not by itself convert its action into that of the State for purposes of the [Due Process requirements] of the Fourteenth Amendment." *Id.* at 986 (quoting *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345, 350 (1974)). "Faithful application of the state-action requirement in these cases ensures that the prerogative of regulating private business remains with the States and the representative branches, not the courts." *Id.* Further, "[a]ction taken by private entities with the mere approval or acquiescence of the State is not state action." *Id.* (citations omitted). Because the State of Pennsylvania was not controlling the utilization review decisions, the Court held that there was no state action in any reduction or denial of medical claims. The Court found that these decisions are made by private parties and that the standards of generally accepted medical protocols were also deemed to be privately generated (by the medical community) rather than established by the State.

The Court also rejected the employees' argument that state workers' compensation laws essentially delegate to the private sector powers traditionally reserved to the states and therefore should be viewed as "state action." In light of the history of state workers' compensation laws, the Court found it clear that no-fault compensation for work injuries was not a historical function of the state or the private sector. Rather, it was imposed on employers by the state as part of early twentieth century labor law reforms that overruled the common law.

Although the Court could have rested its reversal of the Third Circuit upon the state action ground alone, it also went on to decide the matter of whether claims for statutorily required medical benefits are “property” under the Constitution. The Court, in the twentieth century, has extended constitutional protection to nontraditional forms of property such as licenses, government contracts, government jobs, and public assistance benefits. However, the *Sullivan* Court did not place workers’ compensation claims in the same category of constitutional protection received by these nontraditional forms of “new property.” Public assistance entitlements (recognized as “property” in *Goldberg v. Kelly*, 397 U.S. 254 (1970)) are perhaps the outer boundary of protected property and could be analogized to workers’ compensation benefits. However, the Court distinguished the instant situation from the statutory entitlement in *Goldberg v. Kelly*, where the individual’s initial right to receive a determined level of benefits was clear and he had been receiving those benefits prior to being cut off by the State.

[F]or an employee’s property interest in the payment of medical benefits to attach under state law, the employee must clear two hurdles. First, he must prove that an employer is liable for a work-related injury, and second, he must establish that the particular medical treatment at issue is reasonable and necessary. Only then does the employee’s interest parallel that of the beneficiary of welfare assistance in *Goldberg* and the recipient of disability benefits [held to be constitutionally protected property in *Matthews v. Eldridge*, 424 U.S. 319 (1976)].

[The employees] obviously have not cleared both of these hurdles. While they indeed have established their initial eligibility for medical treatment, they have yet to make good on their claim that the particular medical treatment they received was reasonable and necessary. Consequently, they do not have a property interest – under the logic of their own argument – in having their providers paid for treatment that has yet to be found reasonable and necessary. To state the argument is to refute it, for what [the employees] ask in this case is that insurers be required to pay for patently unreasonable, unnecessary, and even fraudulent medical care without any right, under state law, to seek reimbursement from providers. Unsurprisingly, the Due Process Clause does not require such a result.

119 S. Ct. at 990. The key determinant of when a statutory entitlement becomes a property right appears to be the degree to which the full value and legal claim to the entitlement has been sufficiently determined. Until workers' compensation claims have been determined to be reasonable and necessary there is no property right protected by the Constitution. Where such a determination has been made, however, the statutory entitlement presumably becomes a property right and Due Process protection presumably attaches.

Justice Ginsburg concurred separately in *Sullivan* and joined only the "property" definition portion of the Chief Justice Rehnquist's majority opinion. Justice Ginsburg found that claims for medical benefits are not property under the Constitution to be dispositive and that the portion of the opinion attempting to "clean up and rein in our 'state action' precedent" was unnecessary and should not have been decided. *Id.* at 991.

Once a claim for statutory entitlement has become sufficiently established to constitute constitutionally protected "property," Justice Ginsburg found "that due process requires fair procedures for the adjudication of respondents' claims for workers' compensation benefits, including medical care." *Id.* This view is not inconsistent with the majority opinion. Concurring specially, Justices Breyer and Souter made a similar point. While they also agreed with the majority that the mere claim for benefits was not property, "there may be individual circumstances in which the receipt of earlier payments leads an injured person reasonably to expect their continuation, in which case that person may well possess a constitutionally protected 'property' interest." *Id.*

Justice Stevens was the lone dissenter. He considered the utilization review process to be state action in view of the States' pervasive involvement in workers' compensation matters even if the State did not directly control individual determinations of the reasonableness and necessity of claimed medical benefits. He added that procedures prior to the litigation were defective in failing to notify employees and provide an opportunity to participate in the review process but endorsed the changes made in the wake of the case.

The *Sullivan* decision is important for a number of reasons. First, it holds that workers' compensation insurers and utilization review panels may not, under ordinary circumstances, be subjected to the same constitutional requirements to which governments must adhere. Whether the decision is in fact a "reining in" of state action precedent as suggested by Justice Ginsburg's dissent is a matter for deliberation among constitutional scholars. Without doubt, however, *Sullivan* resisted any expansion of state action doctrine and emphasized that Constitutional constraints generally will not reach purely

private conduct. There will undoubtedly be future litigation, as there has been throughout the century, as to the definition of "purely private." In addition, the "state action" aspect of *Sullivan* will probably be important in other contexts. For example, claims of discrimination alleging a violation of the Equal Protection Clause of the Fourteenth Amendment of the Constitution are not actionable unless the discrimination results from state action.

Second, *Sullivan* holds that workers' compensation insurance benefits are not the sort of property rights to which constitutional protection attaches, at least not until there has been a determination of the employee's entitlement to the benefits. Presumably, the reasoning of *Sullivan* would obtain and apply to other insurance policies and programs operated as a result of a state statutory system or mandate. The key factor for future applications of *Sullivan* would appear to be the degree, if any, to which state officials themselves are involved in the active operation and decisionmaking of a utilization review process or benefits dispute.

NO AMBIGUITY IN BOILER POLICY ABOUT  
MEANING OF "EXPLOSION" AND TYPES OF  
OBJECTS EXCEPTED FROM EXCLUSION; ALL-  
RISK INSURER MUST PROVIDE COVERAGE  
ARISING OUT OF WOOD PULP MANUFACTURING  
DISASTER

*Stone Container Corp. v. Hartford Steam Boiler  
Inspection & Insurance Co.*, 165 F.3d 1157 (7th Cir.  
1999), *reh'g denied*, Nos. 97-1860, 97-1989, 1999 U.S.  
App. LEXIS 3607 (7th Cir. Mar. 4, 1999).

Policyholder Stone Container Corporation ("Stone"), a manufacturer of wood products, operated a "pulp digester" at its plant. This machine makes pulp by having wood chips placed in a tank with chemicals and then heating the contents under pressure from steam piped into the tank, all of which cause the wood chips to decompose into woodpulp fiber. A thin area of the steel shell of the tank ruptured and blew a twenty-eight-ton (yes, twenty-eight-ton, not a misprint) fragment of the pulp digester tank into the air. According to the Court, the fragment "landed more than 200 feet away with disastrous results. Besides much property damage, several workers were killed. The plant was forced to shut down for months. Stone Container incurred total losses in excess of \$80 million." *Id.* at 1159.

In the wake of this disaster arose a contest between two insurers over their respective coverage responsibilities. Stone had a boiler and machinery insurance policy from Hartford Steam Boiler Inspection as well as an all-risks policy from Lloyd's. The boiler insurer argued that it was not responsible because of an exclusion in its policy for losses caused by "explosion," while the policyholder and the all-risk carrier argued that (a) the incident was not an "explosion," and alternatively (b) if an explosion, the pulp digester was an object falling under the terms of a list of exceptions to the exclusion for explosion-related losses in the boiler policy. In a procedural oddity of the case, Lloyd's advanced funds to Stone and Stone commenced a declaratory judgment action against only Hartford Steam Boiler Inspection, seeking a determination that the boiler policy provided primary coverage. As the court commented, "[i]t is unclear to us what incentive Stone has to press such a suit vigorously, the dispute really being between the insurance companies; but it has done so." *Id.*

The trial court held that the boiler insurer must provide coverage, reasoning that the term "explosion" was sufficiently ambiguous that it must be construed against the insurer that drafted the policy and that the status of

objects excepted from the exclusion was ambiguous. The United States Court of Appeals for the Seventh Circuit reversed in an opinion by Chief Judge and University of Chicago law professor Richard Posner.

The policyholder argued that “for exclusion purposes” the term “explosion” should be read narrowly to mean any “sudden and violent release of energy (which of course we have here) caused by combustion or other chemical reaction (which we don’t have here).” *Id.* According to the court, “Stone believes that the same word should be read narrowly when it appears in an exclusion from coverage, and broadly when it appears in an exception to an exclusion, even if the context is the same.” *Id.* However, “Stone offer[ed] no support for this suggestion . . . beyond the principle that ambiguities in insurance contracts should be resolved in favor of the insured.” *Id.* at 1160. Furthermore, “the proposed definition of ‘explosion’ is not only narrow, but weirdly narrow. It seems to exclude the explosion of an atomic bomb, since a nuclear reaction is not a form of combustion or chemical reaction, at least in the usual senses of these words.” *Id.* The proposed definition imposing coverage on the boiler insurer would also have excluded volcanic explosions, a tire blowout, bursting matter caused by a bullet, and “to take an example very close to home, the explosion of a boiler as a result of the failure of a valve to open.” *Id.*

Stone (on behalf of Lloyd’s) had argued for this definition because the pulp digester’s demise stemmed from metal failure under steam pressure rather than through incendiary combustion. Hence, Stone and Lloyd’s were hoping to have the term “explosion” confined to combustion-based blowups that did not include steam-pressure-based blowups. The Seventh Circuit strongly rejected this suggestion as both too narrow as a matter of text and common sense understanding.

[A] blast that blows 28 tons of steel and concrete more than 200 feet away is the ordinary person’s idea of an explosion, whatever the precise cause of the explosion. . . . even the engineering firm that Stone hired to investigate the accident called it an explosion – a “Boiling Liquid Expanding Vapor Explosion (BLEVE) of a large, steam-pressurized vessel.”

*Id.*

A more difficult question for the court was whether the pulp digester explosion nonetheless fell back within coverage under an exception to the explosion exclusion. As is often the case for insurance policies, the policy set forth a generalized exclusion (for explosions) but also created a more limited

number of “exceptions” to the exclusion that provided coverage for certain types of explosions fitting within the exception. In particular, the exception provided that notwithstanding the explosion exclusion, there was coverage for loss caused by or resulting from the explosion of an “object.” Boiler insurance generally applies to insured “objects” of the policyholder at a particular location. The exception in the Hartford policy applied to objects

of a kind described below . . . : Explosion of any: (1) Steam boiler; (2) Electric steam generator; (3) Steam piping; (4) Steam turbine; (5) Steam engine; (6) Gas turbine; or (7) Moving or rotating machinery [if the explosion is] caused by centrifugal force or mechanical breakdown.

*Id.* at 1159 (quoting boiler policy).

The court concluded that the pulp digester was neither one of the enumerated objects nor was it “of a kind” with those objects. The digester was closest to the steam boiler but was not considered its equivalent. A boiler creates steam while the pulp digester used steam piped in from outside.

In engineering lingo, the steam boiler is a “fired pressure vessel,” the pulp digester an “unfired pressure vessel.”

\* \* \*

Even if the essential commonality of the objects embraced by the exception to the exclusion . . . is the use of steam, [the pulp digester is not “of a kind” with these objects.] Stone’s error is its refusal to read “of a kind” contextually. The term introduces a list of kinds of object . . . “Steam boiler” denotes a class of objects, not a single object. A class is a kind; the phrase “of a kind” introduces the various kinds or classes of object subject to the explosion exclusion. Steam boilers are one kind; steam pipes another; and so on. Pulp digesters are a kind of object, but not one of the kinds in the list. The distinction between fired and unfired pressure vessels helps to show this. These are two different kinds of pressure vessel. One includes steam boilers but not pulp digesters; the other includes pulp digesters but not steam boilers. One is covered by the boiler and machinery insurance policy; the other is not.

\* \* \*

[W]e do not think that “of a kind,” read in context as all contractual language must be read, is ambiguous . . . This is a *boiler* and machinery policy, which gives a manufacturer or other user of a narrow range of industrial equipment in which Hartford specializes additional protection for accidents involving the enumerated items, which besides moving or rotating machinery consist of steam boilers and closely related, specifically enumerated types of equipment. Stone [and Lloyd’s] wants to convert it to an “all risks” policy.

*Id.* at 1161.

The court focused not only on the textual context of the disputed language but upon the nature and purpose of boiler and machinery insurance. Because boiler insurance is specified risk insurance, terms like “of a kind” are not to be interpreted with undue breadth. Furthermore, noted the court, language is not to be automatically construed against an insurer simply because the language is open-ended to some degree. “[T]he rule that ambiguities in insurance contracts are to be resolved in favor of the insured comes into play only after the insurance company has had an opportunity to present evidence designed to dispel the ambiguity.” *Id.* at 1161. The court also noted this as the correct approach to extrinsic evidence and the ambiguity principle in both noninsurance and insurance contracts. The majority opinion further assessed the distinction between “patent” and “latent” ambiguity and the minority rule (not applicable in Illinois) that permits use of extrinsic evidence only in cases of latent ambiguity.

Because the pulp digester, although in retrospect a machine presenting great danger from explosion, was not the type of object covered under the boiler and machinery policy, the boiler insurer (Hartford) was not required to provide coverage. The coverage burden for this “nonboiler” risk fell on the all-risk insurer (Lloyd’s).



LIABILITY INSURER NOT VICARIOUSLY LIABLE  
FOR MALPRACTICE COMMITTED BY INSURER  
RETAINED TO DEFEND POLICYHOLDER AGAINST  
THIRD PARTY CLAIM

*State Farm Mutual Auto. Ins. Co. v. Traver*, 980 S.W.2d  
625 (Tex. 1998).

Under the usual terms of an automobile liability policy, the insurer has a duty to defend and also the right to control the defense and possible settlement of any claims against the policyholder brought by third parties. This usually includes the insurer's right to select and supervise defense counsel – at least to some extent along with the insurer's responsibility to pay defense counsel. But under the rules of legal ethics, the lawyer's client is the policyholder. It is to the policyholder to whom the lawyer owes duties of loyalty, zealous representation, and the avoidance of conflict of interest or other factors that might undermine the lawyer's professional judgment about how best to defend the case. This tension in the "tripartite" relationship among insurer, counsel, and policyholder has long been problematic and the source of considerable academic commentary and bad faith litigation.

Where an insurer fails to settle a claim within the policy limits and the third party obtains a judgment against the policyholder in excess of the limits, the liability insurer is frequently sued for bad faith refusal to settle. Recently, a policyholder in this situation not only sued the insurer for bad faith but also sought to hold the insurer liable for the alleged legal malpractice of the defense lawyer selected by the insurer. The Texas Supreme Court rejected this attempt in *State Farm v. Traver*, 980 S.W.2d 625 (Tex. 1998). Specifically, the court held that an insurer "is not vicariously liable for the malpractice of an independent attorney it selects to defend an insured." *Id.* at 626.

Mary Davidson, a State Farm policyholder, collided with Calvin Klause, also a State Farm policyholder, in an automobile accident. Mary Jordan, a passenger in the Klause car, was severely injured and brought suit. She obtained a \$375,000 award plus \$100,000 in prejudgment interest, an amount well in excess of the \$25,000 per person liability limits in both the Davidson and Klause automobile insurance policies issued by State Farm. Davidson died shortly after trial, but her estate (administered by Traver) pressed her claim alleging that State Farm had committed bad faith in spurning a settlement demand within policy limits made by Jordan. Davidson also alleged that State Farm was liable for the conduct of the defense attorney who failed to adequately defend Davidson while vigorously defending Klause.

Davidson also alleged that her second-class defense had been a deliberate attempt by State Farm to protect itself from liability that might befall it for failing to agree to a settlement that paid the full Klausé policy limits to the third party claimant and victim of the accident (Jordan).

Jordan initially made a joint settlement demand to both defendants for their combined policy liability limits (\$50,000) plus Klausé's underinsured motorist coverage (\$20,000). State Farm refused, offering instead Davidson's policy liability limit (\$25,000), Klausé's underinsured motorist coverage (\$20,000), but only \$5,000 of Klausé's liability coverage. Jordan refused this counteroffer. Although State Farm later increased its offer to include Klausé's full liability coverage (thus meeting Jordan's original demand), Jordan also refused this offer.

*Id.* at 626-27 n.2.

In Texas, as in other states, the insurer is ordinarily liable for the amount of any excess judgment against the policyholder where the plaintiff made a demand for settlement at or below the policy limits and where there was no reasonable basis for rejecting the settlement offer. Davidson alleged that the seriousness of the Jordan injuries and the degree of fault likely to be attributed to Klausé or Davidson had made it imperative that State Farm accept the settlement under *Stowers Furniture Co. v. American Indemnity Co.*, 15 S.W.2d 544 (Tex. Comm'n App. 1929), the venerable Texas precedent permitting a policyholder's cause of action against the insurer for negligently refusing a settlement offer within policy limits. By counteroffering in the face of Jordan's policy limits settlement demand rather than settling, State Farm was liable under *Stowers* according to Davidson. Although *Stowers* and its progeny in Texas are often discussed as "negligent" failure to settle cases, the *Stowers* doctrine in Texas functions like the law of other states permitting a claim of "bad faith" by the policyholder where there is a failure to settle within policy limits.

In addition, Davidson argued that State Farm should also be vicariously liable for the attorney's lackluster defense of Davidson, which allegedly included "failing to attend several key depositions and by failing to offer a meaningful defense at trial." *Traver*, 980 S.W.2d at 626. Davidson also alleged that State Farm was actively liable for bad faith in that it had "orchestrated this malpractice to avoid potential *Stowers* liability to Klausé arising from the settlement negotiations." *Id.* The court in *Traver* permitted the bad faith claim to be further prosecuted on remand but specifically

rejected any vicarious liability for insurers due to attorney malpractice. To be liable for attorney mishandling of the case, the liability insurer must have in some way contributed to the malpractice. In Texas, after *Traver*, mere vicarious liability is not enough.

The court in *Traver* based its decision on the status of the allegedly malpracticing attorney as an independent contractor. He apparently was neither in-house counsel to State Farm nor an employee of a "captive" law firm that does business exclusively as a representative of a particular insurer. Treating the matter as one of agency, the court stated that a principal (in this case, State Farm) can be liable for an agent's conduct only when it has a right to control the agent (in this case, the lawyer). Although State Farm did have control over whether the attorney accepted settlement offers, and presumably could have replaced him with new counsel under the terms of a typical auto liability policy, State Farm did not have a right to micromanage the attorney's litigation conduct, according to the court. Lacking such complete control, State Farm could not be held liable for the attorney's malpractice.

Although the Texas Supreme Court did not decide more than it had to decide in the *Traver* case, the decision does suggest that insurers may be liable for attorney miscues where the insurer does closely control counsel's handling of the matter. This aspect of *Traver* could take on additional importance in light of recent insurer efforts to establish strict case management guidelines for retained counsel. These guidelines often establish presumptive restrictions of counsel regarding discovery, legal research, and other pretrial activities and trial preparation. Retained counsel are usually required to obtain insurer approval in order to deviate from the guidelines. In such cases, substandard attorney defense of a liability claim could be laid at the feet of the micromanaging insurer and create liability under a theory of active control rather than vicarious liability.

IDAHO SUPREME COURT RULES THAT  
POLICYHOLDERS' SETTLEMENT WITH  
AUTOMOBILE INSURER EXTINGUISHES  
SUBROGATION ACTION BY LIABILITY INSURERS  
AGAINST AUTO INSURER

*Stonewall Surplus Lines Insurance Co. v. Farmers Insurance Co. of Idaho*, 971 P.2d 1142 (Idaho 1998),  
*reh'g denied* Feb. 24, 1999.

Jerry Oldham was using his mother Penny MacDonald's car while delivering pizza for a Domino's franchise owned by Confluence Pizza, Inc. While making a delivery, Oldham struck a pedestrian and a lawsuit followed. The pedestrian plaintiff sued both Oldham and Confluence, alleging negligent driving and negligent hiring while also attacking Domino's former policy of guaranteed thirty-minute delivery, which has since been abandoned by Domino's, in large part because of adverse publicity and litigation.

Oldham sought defense and coverage under his mother's automobile policy (issued by named defendant Farmers) and Confluence sought defense and coverage under an excess business liability policy (Progressive Casualty Insurance Company) and a commercial general liability umbrella policy (Stonewall Surplus Lines Insurance Company). Farmers denied coverage to Oldham and MacDonald, invoking an endorsement excluding coverage where the vehicle is used for work where the "primary duties are the delivery of products and services." *Stonewall Surplus*, 971 P.2d at 1144. But MacDonald denied ever receiving this endorsement (which the Court implicitly treated as clearly excluding coverage under the facts of the case).

Progressive and Stonewall stepped into the breach left by Farmers and defended the suit, eventually settling and obtaining discharge for both Oldham and MacDonald as well as for Confluence and Domino's. Then the two commercial liability insurers, along with Oldham and MacDonald, sought reimbursement from Farmers, arguing that Farmers should have provided coverage. Farmers then settled with Oldham and MacDonald. The stipulation of settlement "provided that the claims of Stonewall and Progressive, the remaining plaintiffs, would not be affected or abridged by the settlement." *Stonewall Surplus*, 971 P.2d at 1144.

Notwithstanding the language of the settlement, the Idaho Supreme Court, affirming the trial court, held that the resolution of the Oldham/MacDonald claim against Farmers extinguished any right Progressive or Stonewall might have to seek indemnity from Farmers.

The court reasoned that the Progressive and Stonewall claims were prosecuted under a theory of equitable subrogation and that the resolution of the policyholder claims against Farmers eliminated the alleged payment of a debt owed by the auto insurer. As a result, the court dismissed the liability insurers' claims against Farmers. Said the court:

Farmers argues that had Progressive and Stonewall sought indemnification directly from Penny MacDonald, MacDonald could have sought relief from Farmers for any judgment against her, assuming such relief was in accord with the terms of the policy MacDonald had with Farmers. Because Progressive and Stonewall, however, chose to sue Farmers directly, Idaho law bars the action.

Farmers' argument is well taken. A third party may not directly sue an insurance company in an attempt to obtain the coverage allegedly due the insurer's policyholder.

\* \* \*

It is well established that absent a contractual or statutory provision authorizing the action, an insurance carrier cannot be sued directly and cannot be joined as a party defendant. . . We are aware of no direct action statute in Idaho.

*Id.* at 1145-46 (citing *Pocatello Indus. Park Co. v. Steel West, Inc.*, 621 P.2d 399, 407 (Idaho 1980)).

Continued the court:

Here, Domino's and Confluence, and their insurers Stonewall and Progressive, have not sued the tortfeasor Oldham and the owner of the vehicle, MacDonald. Rather, they have pursued a direct action against Farmers, the insurer of MacDonald. This type of direct action is not supported by the case law and moreover, there is no direct action statute in Idaho.

*Id.* at 1146 (footnote omitted).

In addition to deeming the Progressive and Stonewall claims an impermissible direct action, the court rejected the liability insurers' contention

that Progressive and Stonewall were “insureds” under the McDonald policy because it defined an “Insured person” as “[a]ny other person or organization with respect only to legal liability for acts or omissions of: a. Any person covered under this part while using your Insured car.” *Id.* at 1147. The court held that this clause was clear but did not have the meaning asserted by Progressive and Stonewall. The clause was designed to extend insured status to those facing liability by operation of law (“legal liability”) rather than liability because of a contractual undertaking. The court ruled that Progressive and Stonewall were liable only because they were insurers of Confluence (rather than tortfeasors themselves). Consequently, the liability insurers were not tort defendants entitled to coverage under the auto policy. *Id.* at 1146-47.

The court also ruled that Progressive and Stonewall would not be permitted to amend their complaint to allege a bad faith action against Farmers, ruling that this type of action did not lie against another insurer under Idaho law, at least not without something establishing a closer relation and duty from Farmers to the commercial liability insurers. In essence, the court viewed the relation of Farmers and the liability insurers as mere happenstance because Oldham took a job delivering pizzas. There was never any relation voluntarily established between the insurers that could give rise to a duty of good faith and fair dealing. *See id.* at 1148.

Justice Schroeder registered a lone dissent, focusing on the specific language of the settlement agreement between Farmers and Oldham/MacDonald, which specifically stated that it was not to extinguish the action of Progressive and Stonewall against Farmers. Under these circumstances:

Having paid the claim by Jacks against MacDonald, Farmers’ insured, Progressive and Stonewall should be permitted to litigate the claim MacDonald would have had against Farmers for coverage.

*Id.* at 1150.

The *Stonewall Surplus* majority opinion accords with the general rule disfavoring direct actions against insurers and viewing contract and subrogation rights as springing from the privity relationship between policyholder and insurer. The net result of the case is to place substantial coverage responsibility on insurers close to the risk and logically related to the matter. Progressive and Stonewall insured a pizza delivery operation, which not surprisingly can lead to litigation arising out of auto accidents taking place during the course of pizza delivery.

But the decision can be criticized as perhaps excessively formalist and overly favorable to Farmers. The rule against direct actions is a rule designed to prevent third-party tort plaintiffs from suing the insurer before a jury less sympathetic to the insurance company than it would be toward the individual policyholder and tort defendant. The mere fact that the third-party plaintiff cannot bypass the policyholder and sue the insurer does not necessarily suggest that the insurer is immune from any lawsuit where the policyholder is not a plaintiff. The court does not explain why someone with a claim for relief against an insurer should not be entitled to pursue it so long as it is not an attempt to bypass or avoid a more appropriate suit directly against the policyholder. Of course, in this case, Progressive and Stonewall were adverse to the policyholder but were aligned with the policyholder in seeking to force Farmers to pay.

Notwithstanding the general rule that claims against a contracting party must usually spring from the rights of the other contracting party, Farmers was well aware that it was arguably implicated in the litigation and that the commercial liability insurers had ridden to the rescue in a serious claim that arguably was covered under the auto policy. In addition, an auto insurer without a business pursuits exclusion (and MacDonald claimed no exclusion was in effect because of lack of notice) is arguably at least as close to the risk as is the liability insurer of the business setting the car in motion on business (although my own view is that the liability insurer is the closer insurer to the risk, a view that CGL counsel would surely dispute, as perhaps would others).

Furthermore, the settlement between Farmers and Oldham/MacDonald purported not to prejudice the Progressive/Stonewall claim but the Court's holding gave the settlement exactly that effect. Laypersons such as Oldham and MacDonald may not have known that their arrangement with Farmers would wipe out the claim of the two insurers that had protected them from the injured pedestrian's lawsuit. Farmers' counsel presumably knew this and at a minimum appeared to have taken advantage of Oldham and MacDonald (if not having deceived them outright as to the impact of the settlement) as well as having taken advantage (albeit now judicially affirmed advantage) of Progressive and Stonewall. The court opinion does not describe the extent of the tort plaintiff's injuries or the amounts of the settlement.

In a run-of-the-mill case without serious injury, there is nothing particularly inequitable about requiring the commercial liability carrier to pay everything just because an auto insurer was shrewd enough to settle with a policyholder and thereby avoid defending the claim or paying a subrogation claim. But what if the claim was large (e.g., \$1,000,000) and the costs of defense significant, with the commercial insurers paying a significant sum to settle the matter (e.g., \$500,000), and with the auto insurer settling for

relatively little (e.g., a few thousand dollars) with the auto policyholder, who really has little incentive to insist that the auto insurer make a fair payment to the liability insurer. Under those circumstances, should the auto insurer be able to escape all other potential responsibility simply by giving its policyholder small change and obtaining a release, something it could do only because of the presence of other, paying insurers? The Idaho Supreme Court never addresses these issues, perhaps because the equities of the case did not suggest them. For example, the actual facts of the case may have been very favorable to Farmers in suggesting that the business use exclusion was indeed part of the MacDonald auto policy. Nonetheless, the absolute formalism of the court in *Stonewall Surplus*, and the breadth of the bar on actions by insurers against one another in a case of this type, can be seen as troubling.

The case also suggests that liability insurers in this situation would be better off (certainly in Idaho and probably in most jurisdictions) obtaining an assignment of rights from the automobile policyholder. If McDonald and Oldham had assigned their rights against their auto insurer to the liability insurers, there would presumably be no bar to the suit. And, after assignment, the auto policyholders would no longer have a right to compromise the coverage claim against the auto insurer. However, to properly receive such an assignment, the liability insurers would presumably need to provide adequate consideration or something of value in return. Simply agreeing to defend the lawsuit, which the liability insurers probably were required to do in any event under their policies with the Confluence Pizza, would probably not be enough. But it would probably not be improper for the liability insurer to pay the auto policyholders something in return for the assignment so that the liability insurers could be certain to preserve their rights, if any, for contribution from the auto insurers.



CALIFORNIA RULE REQUIRING PREJUDICE TO  
INSURER BEFORE LATE NOTICE VOIDS  
COVERAGE NOT PRE-EMPTED BY ERISA  
ACCORDING TO SUPREME COURT, CONTINUING  
COURTS' EVOLUTION TOWARD NARROWER  
PREEMPTIVE SCOPE OF ERISA

*UNUM Life Ins. Co. of America v. Ward*, 526 U.S. 358  
(1999).

Holding that California's "notice-prejudice" rule is a law "which regulates insurance," the United States Supreme Court rejected an insurer's argument that the Employee Retirement Income Security Act ("ERISA") preempts California law regarding the consequences of an insured's late notice to its health insurer.

John Ward was insured under an employer-provided group disability policy issued by UNUM Life Insurance Company of America, working for his employer from 1983 until he became permanently disabled due to severe leg pain. He was diagnosed as having a diabetic neuropathy condition in December 1992. In early 1993, he qualified for state disability benefits and then informed his employer. In July 1993, he was ruled eligible for social security disability. He continued to communicate with his employer, but UNUM did not receive proof of Ward's disability claim until April 1994, five months later than the time limit under the policy (November 1993 was the deadline in view of Ward's situation). He submitted his claim to UNUM after the time limit established by the policy. UNUM denied Ward's claim as untimely and he sued pursuant to ERISA's right of action to recover benefits.

California's general rule is that when an insured's claim is untimely, the insurer may use this as an effective defense only if the insurer can prove that it was actually prejudiced by the delay. Prejudice means more than mere inconvenience or the possibility of prejudice. The insurer must usually demonstrate that it is unable to adequately evaluate the claim or defend a third-party claim due to the delay in notice. For example, if a key item of evidence has vanished between the deadline for notification and the actual receipt of notice, the insurer often can demonstrate sufficient prejudice to defeat the claim (assuming that alternative, comparable evidence does not remain available). This form of "notice-prejudice" rule is the approach followed by most American jurisdictions (one notable exception is New York, which does not require the insurer to prove prejudice).

UNUM argued that as an insurer providing an employee benefit plan subject to ERISA, it was not governed by the California notice-prejudice rule

because of ERISA's broad preemption provisions. Generally, ERISA preempts the operation of state law upon an employer-employee benefit plan. The statute provides that that ERISA "shall supercede" state law to the extent that state law "relate[s] to any employee benefit plan." See 29 U.S.C. §1144(a) (1975). However, another provision of the statute exempts from the preemption provision "any law of any State . . . [which] regulate[s] insurance . . ." companies. *Id.* at §1144(b)(2)(A). UNUM argued that the notice-prejudice rule in California was not a state law regulating insurance, but only a state common law approach to late notice for insurance contract claims. The Court rejected the insurer's argument, concluding that the California notice rule was part of the warp-and-woof of state insurance regulation.

In its first ERISA preemption case in 1987, the Court took an extremely broad approach to ERISA preemption, holding that ERISA preempted state bad faith law claims against insurers. See *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987). Since then, the Court has moved in somewhat halting steps toward a more restrained view on preemption. Today, the Court professes to decide preemption on a case-by-case basis measuring the reach of the statute's preemption provision "in context." In *Ward*, the Court inquired whether as a matter of "common sense," the provision in question regulates insurance. The Court also looked to its precedents applying the "reverse-preemption" (where state law displaces otherwise applicable federal law) of the McCarran-Ferguson Act, 15 U.S.C. §1011 *et seq.* (1945).

The Court found the notice-prejudice provision to be a law that as a practical matter was confined to insurance rather than contract law generally. This distinguished the California notice provisions from the bad faith claim and consequent punitive damages remedy that the Court found preempted in *Pilot Life*, a case in which the Court held that Mississippi's bad faith law applied to all contracts even though it was most commonly triggered in insurance claims. Because the notice law was an integral part of insurer and insured relations and applied only to insurance claims, the Court also found that it met the McCarran-Ferguson Act's criteria for being part of the regulation of insurance by the state.

NEW YORK JOINS RANKS OF COURTS HOLDING  
ERISA NOT A BAR TO MEDICAL MALPRACTICE  
SUITS AGAINST PHYSICIAN IN HMO THAT IS  
PART OF EMPLOYER-PROVIDED HEALTH  
BENEFITS.

*Nealy v. U.S. Healthcare HMO*, 711 N.E.2d 621 (N.Y. 1999).

In a case of the sort that has been raised in Congress as grounds for passage of legislation to protect HMO patients' rights, New York's highest court has ruled that doctors working for an HMO are not immune from malpractice suits based on state law even where the doctor's services are rendered for an HMO operating pursuant to an employer-provided plan subject to the Employee Retirement Income Security Act (ERISA). The federal ERISA statute contains a broad preemption clause (see the discussion of the *UNUM v. Ward* case above) that makes state law inapplicable to ERISA-sponsored employee benefit plans except to the extent that the state law is one regulating insurance. Although a medical malpractice action is not insurance regulation, the New York Court of Appeals still found no bar to the litigation. The plaintiff's suit, which arose out of alleged nontreatment or inferior treatment, was against the physician and not against the insurer or plan administrator. Consequently, even if ERISA's preemption clause operated to prevent state law-based suits directly against the ERISA plan, the preemption clause did not apply to bar suits against agents of the plan, particularly when the doctor/agent was being sued for medical malpractice rather than for implementation of the plan.

The plaintiff alleged that her husband sought treatment for coronary artery disease from Dr. Ralph Yung and that as a result of Dr. Yung's failure to provide adequate treatment, including prompt examination by a specialist, her husband died of a massive myocardial infarction nearly six weeks after first approaching Dr. Yung. The decedent patient had a history of heart disease and had previously been treated with angioplasty by a specialist when the decedent had been covered by a Blue Cross plan prior to his switch to an employer-provided HMO. The allegations of negligence against Dr. Yung at least touched upon delays induced by Dr. Yung's following of HMO-mandated procedures governing referral to specialists and use of physicians that were not part of the Aetna/U.S. Healthcare HMO which had designated Dr. Yung as the decedent's primary physician. Notwithstanding this brooding omnipresence of the issue of the HMO's possible negative effect on Dr. Yung's delivery of medical services, the court characterized the action as one

sounding in medical malpractice, rather than a suit against the HMO for breach of contract, fraud, or bad faith.

Here, plaintiff alleges that Dr. Yung, as a direct provider of medical services, violated the duties and standard of care owed to his patient by improperly assessing the nature and extent of his condition and by failing to take reasonable steps to provide for his timely treatment by a specialist . . . Plaintiff does not allege that Dr. Yung is responsible for delay caused by US Healthcare's decision-making process with respect to coverage or benefits. Her claim against Dr. Yung is that he failed to take timely action to treat her husband.

*Nealy*, 711 N.E.2d at 625.

In rendering its decision, which predated by a month the *UNUM v. Ward* case in the U.S. Supreme Court, the New York court took a similar approach to interpreting ERISA and arguably focused even more on the purpose of the statute rather than the literal text of the law, which preempts state law that "relates to" an employee benefit plan. Rather, the New York court read Supreme Court precedent (accurately in light of the Court's subsequent approach and holding in *Ward*) as moving away from textual literalism (the words "relate to" can be stretched to a near-infinite point) to "a more pragmatic approach" since the Court's decision in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 514 U.S. 645 (1995) (hereinafter *Travelers*). *Travelers* found no ERISA preemption of New York's law that exempted Blue Cross and Blue Shield from a surcharge on hospital bills paid by other employee benefit plans to fund state-sponsored insurance coverage goals. As the *Nealy* court interpreted that holding, the "Supreme Court . . . held that the indirect economic influence of the surcharges did not interfere with the congressional goal of uniform standards of plan administration." *Nealy*, 711 N.E. 2d at 625.

Rather, the *Nealy* court interpreted ERISA's preemption provision as aiming to facilitate the development of a uniform national law governing employee benefit plans and a standard system to guide the processing of claims and disbursement of benefits rather than to supplant all state law touching upon benefit plans or insurance.

[C]onsidering the objectives of the ERISA statute, it is clear that Congress did not intend to preempt claims, such as those now before us. Plaintiff's claims do not bind an

employee plan to any particular choice of benefits, do not dictate the administration of such a plan and do not interfere with a uniform administrative scheme. . . . To the contrary, plaintiff's claims are consistent with ERISA's "principal object": the protection of plan participants and beneficiaries.

*Id.* at 625-26.

The issue in *Nealy* is similar to, but distinct from, the issue in *Ward*. In *Ward*, the insurer, operating pursuant to an employee benefit plan, argued for preemption because of its status, but the Supreme Court rejected the argument because state law invoked by the claimant was state law directed at the governing of insurer-insured relations. Such "laws regulating insurance" are a specific exception to ERISA preemption. By contrast, the court in *Nealy* found that the claim itself was not a claim against the ERISA plan but only a claim against a doctor operating in the penumbra of the plan. As a result, the non-insurance nature of the claim did not make it subject to preemption.

The *Nealy* approach will not necessarily control in similar cases in other jurisdictions and probably will eventually be the subject of more federal court resolution, perhaps even U.S. Supreme Court review. For example, the United States Court of Appeals for the First Circuit (hearing appeals from federal trial courts in Massachusetts, Rhode Island, Vermont, New Hampshire and Maine), regarded a similar claim against a doctor for inadequate treatment as being a suit against the insurer and subject to ERISA because the conduct was indisputably part of the process used to assess a participant's claim for a benefit payment under the plan. According to the First Circuit, ". . . [A]ny state-law-based attack on this conduct would amount to an 'alternative enforcement mechanism' to ERISA's civil enforcement provisions . . . and [is] therefore completely preempted." *Danca v. Private Health Care Systems, Inc.*, 185 F.3d 1, 6 (1st Cir. 1999). Although the *Danca* and *Nealy* cases could be distinguished on their facts, there is a clear divergence of approach between the two cases, one that may eventually require resolution by the U.S. Supreme Court.

The *Nealy* court also alluded to the interesting but unsettled issue of "whether the US Healthcare HMO was even a 'plan' within the meaning of the ERISA preemption provision." *Nealy*, 711 N.E.2d at 625, n.3. The HMO might more properly be characterized as simply a service provider to an ERISA plan rather than the plan itself. In an amicus brief supporting Plaintiff *Nealy*, the U.S. Secretary of Labor, who is charged with interpreting and enforcing the provisions of ERISA, took this position. However, many courts adjudicating claims against an employer-provided HMO coverage have

implicitly assumed or concluded that the HMO could raise the ERISA preemption defense. The *Ward* case did not address this question but arguably also made this assumption or reached this implicit conclusion since the court in *Ward* could have invoked UNUM's lack of status as an ERISA "plan" as a basis for rejecting UNUM's defense to Ward's late notice claim, but it did not do so. However, it is not clear that the "definition of plan" argument against preemption was developed before the court in *Ward*, or consciously considered by the court, even if the court chose not to discuss the question in its opinion.

Although different facets of ERISA preemption law, *Nealy* and *Ward* read together demonstrate the recent judicial focus on the purpose of ERISA rather than the breadth of the preemptive language. Increasingly, insurer defenses based on ERISA preemption must be consistent with the public policy goals of ERISA in order to apply to prevent claims against insurers or others providing benefits or treatment pursuant to an employer-provided health plan.

IN A DIVIDED OPINION, CALIFORNIA LIMITS  
POLICYHOLDER DAMAGES FOR BAD FAITH  
FAILURE TO SETTLE TO COVERED  
COMPENSATORY DAMAGES ONLY; INSURER  
NOT RESPONSIBLE FOR PUNITIVE PORTION OF  
EXCESS JUDGMENT

*PPG Industries, Inc. v. Transamerica Ins. Co.*, 975 P.2d  
652 (Ca. 1999).

PPG Industries is the successor in interest to Solaglas California, a distributor and installer of replacement windshields for cars and trucks. In 1982, the driver of a GMC truck with a Solaglas-installed windshield was in a serious accident. The windshield popped out and ejected the driver, rendering him a quadriplegic. The driver sued Solaglas for compensatory and punitive damages.

Solaglas called on its liability carrier, Transamerica, which had issued \$1.5 million of coverage for such claims. However, the policy excluded coverage of punitive damages. In addition, California law prohibits insuring of punitive damages liability. Transamerica assumed the defense of the claim. The case proceeded to trial and resulted in judgment for Solaglas – but the judgment was reversed on appeal and the case remanded for retrial.

While retrial was pending, the plaintiff offered to settle for Solaglas's policy limits of \$1.5 million. Solaglas urged Transamerica to accept the offer but Transamerica refused. In retrospect, Transamerica could have done a better job of predicting the trial's outcome: the plaintiff won a judgment of \$5.1 million in compensatory damages and \$1 million in punitive damages. The punitive award was based on the jury's finding, affirmed on appeal in the underlying case, that Solaglas knowingly used a windshield installation procedure that created the risk of a "popping out" windshield, as occurred in the accident that rendered plaintiff a quadriplegic.

Plaintiff's judgment was satisfied by Transamerica's payment of its policy limits (\$1.5 million) plus costs and interest (\$1.277 million), with Solaglas paying the \$1 million punitive damage award and its excess insurer paying the additional \$3.6 million in compensatory damages. PPG, as successor to Solaglas, then sued Transamerica for bad faith conduct in refusing to settle the claim for the \$1.5 million policy limits. It appears that the excess insurer did not pursue Transamerica for the \$3.6 million it was required to pay because Transamerica (the primary liability insurer) had failed to accept what in retrospect was clearly a reasonable settlement demand. PPG sought recovery of the \$1 million punitive damage component of the judgment.

The bad faith case forced the California courts to choose between two competing legal doctrines: (1) the principle that punitive damages liability is generally not insurable and not the responsibility of a tortfeasor's liability insurer; and (2) the principle that an insurer whose bad faith conduct causes harm to the policyholder is responsible for the damages that proximately flow from the bad faith conduct. PPG argued that the latter principle should control and that it should be able to be repaid for its punitive liability by Transamerica because it had been Transamerica's bad faith refusal to settle that caused Solaglas (and hence PPG) to incur the \$1 million liability. The California Supreme Court deferred to the principle against indemnity of punitive damages liability and held that PPG could not recover.

In the ordinary bad faith claim by a policyholder because of an insurer's failure to settle, the measure of damages is the amount of the judgment in excess of the policy limits and other incidental and consequential damages that can be traced to the insurer's failure to settle. It should be noted that California defines "bad faith" in this context as simply the insurer's failure to accept the reasonable settlement offer within policy limits (assuming the insurer is controlling the defense of the underlying claim). A finding of insurer bad faith for refusal to settle does not in and of itself imply that the insurer acted maliciously or intended to harm the policyholder.

Notwithstanding this general measure of damages geared to the amount of the verdict, the court refused to apply the standard formula to the portion of a judgment comprised of punitive damages. The court reasoned that California's policy against insuring punitive damages had equal or greater force. Hence, it was in the court's view inappropriate to permit PPG to recover funds from an insurer for a liability that was uninsured under both the express terms of the policy and under California statute.

In ruling against the policyholder, the court acknowledged that PPG's liability for the punitive award was "caused" by the insurer's failure to settle. However, according to the court, public policy factors argued against recovery. Specifically, the court relied on policy concerns of (a) "not allowing liability for intentional wrongdoing to be offset or reduced by the negligence of another"; (b) the purpose of punitive damages, which is "to punish the [policyholder] defendant and to deter future misconduct by making an example of the defendant"; and (c) the state's declared "public policy prohibit[ing] indemnification for punitive damages." *PPG Industries*, 975 P.2d at 656-57. According to the court: "[t]o require Transamerica to make good the loss PPG incurred as punitive damages in the third party lawsuit would impose on Transamerica an obligation to indemnify, a violation of the public policy against indemnification for punitive damages." In the instant case, the court characterized the punitive damages award as flowing not so much from Transamerica's failure to settle but from Solaglas's "own morally reprehensible behavior in installing the windshield on the truck." *Id.* at 656-58.

The ruling in favor of the insurer came from a sharply divided court. Four justices were in the majority and joined the main opinion of Justice Kennard, but three justices dissented in an opinion authored by Justice Mosk. The dissent argued that the holding unduly favors insurers over insureds in that it elevates the public policy against punitive damages indemnification over an at least equally strong public policy: making insurers pay in full for bad faith refusal to settle. The dissent saw this as a public policy running throughout contract law: the measure of damages for breach of contract should be sufficient to make the injured party whole. If not for Transamerica's failure to settle, Solaglas/PPG would have incurred no liability. In particular, the dissent found that adherence to the insurer's duty to defend (from which comes the duty to settle), and the covenant of good faith and fair dealing were policy considerations at least as important as the public policy in favor of tortfeasors bearing the cost of punitive damages liability without insurance.

The case also demonstrates that the California high court's division on insurance coverage cases does not divide neatly into pro-insurer or pro-



policyholder judges. *PPG Industries* dissenting Justice Mosk was the author of the *Buss v. Superior Court* opinion, 939 P.2d 766 (1997) which held that a liability insurer has a right to seek reimbursement from the policyholder for the costs of defending uncovered claims that were not potentially within coverage where the insurer has defended a lawsuit against the policyholder that alleges both covered and uncovered claims. *PPG Industries* majority opinion author Justice Kennard had dissented in *Buss*, arguing that the insurer was contractually obligated to defend the entire "suit."

ATTORNEY GENERAL'S PROSECUTION OF LAW  
FIRM FOR AUTO INSURANCE FRAUD NOT  
IMPROPER OR UNCONSTITUTIONAL BECAUSE OF  
FUNDING BY AND CONTACT WITH STATE  
INSURANCE FRAUD BUREAU

*Commonwealth v. Ellis*, 708 N.E.2d 644 (Mass. 1999).

Massachusetts, like many states, operates an insurance fraud division of its Attorney General's office and an insurance fraud bureau. These entities focus on investigating and prosecuting insurance fraud. The anti-fraud bureau is funded by statutorily established procedure in which insurers doing business in Massachusetts fund the division. As a result, insurance fraud defendants recently challenged their convictions as tainted by improper conflict of interest. The Massachusetts Supreme Judicial Court rejected the challenge, ruling that the funding system for the anti-fraud division did not violate the constitution. Although the court did not expressly address the issue of any violation of the rules of lawyer professional responsibility, or other laws, the court implicitly found no other legal infirmity with the system, although it did raise public policy concerns as to the wisdom of the system's operation.

The Insurance Fraud Bureau ("IFB") of the Attorney General's office is charged with investigating any claims of fraudulent insurance transactions and referring any infraction to the appropriate prosecutor. Instances of alleged fraud are brought to the attention of the IFB by insurers who have been victimized by the fraud. A state statute in fact requires insurers to report any instances of suspected fraud. Where the IFB is satisfied that fraud has taken place, it is required to refer the matter to the Attorney General ("AG"), the appropriate state district attorney, or the United States Attorney for Massachusetts. In addition to any other applicable criminal penalties, those committing fraud, if successfully prosecuted, "shall be ordered to make

restitution to the insurer for any financial loss sustained" because of the fraud. The AG has historically appointed a half-dozen or more assistant AGs who work full time with the IFB.

The IFB is governed by a board of 15 members, five from the Automobile Insurance rating bureau, five from the Workers' Compensation rating bureau, and five public officials. An executive director presides over the IFB. The IFB is funded by the two rating bureaus, who are assessed an amount determined by the Commissioner of Insurance based on actual costs of operating the IFB and conducting the investigations. During fiscal 1999, these amounts were over \$1 million.

The court observed:

There is no authority bearing on whether a prosecutor, acting pursuant to authorizing legislation, may properly prosecute a class of crimes involving an industry that indirectly provides funds to support those prosecutions. There is considerable authority concerning the impropriety of a prosecutor, or a prosecutor's client, having a substantial interest in the outcome of the criminal proceedings. Much of that authority is not based on constitutional considerations. In the cases before us, however, the defendants must rest their main argument on constitutional grounds because the structure of the process that they challenge is prescribed by statute. . . . [T]he circumstances of these cases are unique.

*Ellis*, 708 N.E.2d at 647-48.

Despite the unique nature of the challenge to the Massachusetts anti-fraud bureau, the court considered the potentially analogous impact of cases such as *Young v. United States ex rel Vuitton et Fils, S.A.*, 481 U.S. 787 (1987), in which the United States Supreme Court found a violation of due process when a civil litigant was appointed by the trial court to prosecute criminal contempt charges against its opponent. In *Young*, there was simply too much incentive for the prosecutor to litigate the case in a manner that would provide it advantages in the related civil case. By contrast, in *Ellis* and other insurance fraud prosecutions, the affected insurer is funding the prosecutor in only an indirect and attenuated manner. Essentially, the court in *Ellis* concluded that no one insurer, even a large insurer, is central enough to the funding of the IFB to have undue influence over the prosecutor in a way that could result in a deprivation of the defendant's constitutional rights.

Although the Massachusetts Constitution prohibits the improper use of state power for private interests, this provision was not violated by the IFB structure and funding scheme. The court found that there was a legitimate public interest in prosecuting and deterring insurance fraud, and that the benefits of the IFB operation accrued to the citizenry generally rather than only to affected insurers. Because the funding scheme was industry-wide, the IFB could be said to be engaged in generalized anti-fraud activity rather than targeted activity designed to provide reimbursement to any particular insurer. Consequently, the IFB operation did not in the court's view pose the sort of threat to prosecutorial independence and impartiality that would justify setting aside a conviction.

The court's decision was based on constitutional law due process reasoning in a narrow sense. The court framed the question for decision as "whether there is such a degree of potential IFB influence inherent in the statutory pattern that constitutionally based consideration require that a court take some action to alleviate the problem. We conclude that there is no such influence inherent in the statutory plan." *Id.* at 651. The rationale of the *Ellis* decision also suggests that the court did not find the IFB system to create any unethical prosecutorial conduct under the governing norms of legal ethics. However, it is important to note that a different antifraud system could run afoul of either constitutional norms or applicable rules of lawyer professional conduct if it made for too much insurer control of the prosecutorial function. For the court, the

important point is that, in the process, the prosecutor must retain total control over the course of the investigation and all discretionary decisions. A victim's direct funding of substantial expenses of a prosecutor's office would raise a question of control because, in such a case, the prosecutor may lose or appear to lose his impartiality because he may be beholden to the victim for assisting him.

*Id.* However, nonmonetary cooperation and assistance from the victim is permitted, and financial assistance that is not "substantial" poses no constitutional problem under *Ellis*, although even a modest amount of direct, self-interested financial assistance accepted by a prosecutor would pose problems under the legal ethics rules of most states.

The *Ellis* court was impressed not only by the general nature of the funding and lack of any intended direct benefit to any particular insurer, but also by the fact that any insurer withdrawal of funding could be, and likely would be, made up by the Legislature. Similarly, the court was not greatly

concerned about an overly cozy relationship between the insurance industry and the assistant AGs that prosecute IFB matters. In the court's view, these attorneys so clearly worked for and answered to the Attorney General that there was no significant risk that their independent prosecutorial assessment of cases would be overly compromised by the IFB process. "The only obligation [of the AG's] division is to review each IFB report. The statute leaves matters of further investigation and any decision to prosecute exclusively in the [AG's] control." *Id.* at 644, 652.

The court also noted that as a matter of actual operation, insurance companies accounted for only half the fraud cases brought to the IFB and that only about twenty percent of the cases investigated resulted in referrals to the AG. Similarly, meetings jointly attended by IFB and AG personnel were regarded only as permissible cooperation rather than undue interaction between the prosecutor and insurers. The court found it "more problematic" that the IFB provided some direct assistance to the AG's anti-fraud division and had reimbursed an assistant AG for a computer hard drive for use in tracking cases and holding data. However, this more direct monetary assistance was considered too minimal to raise constitutional concerns. Implicitly, the court also found no violation of the rules of professional conduct from this minor amount of direct financial assistance when offered through an umbrella organization rather than a particular insurer interested in the prosecution of a particular case.

However, notwithstanding its rejection of the criminal defendant's challenge to the IFB/AG anti-fraud operation, the court expressed some concern over the concept of industry-funded, industry-led anti-crime operations.

Our conclusion that the defendants have not demonstrated that their constitutional rights have been or will be violated by the statutory pattern that they challenge should not be construed as our endorsement of the system as desirable. Because of the closeness of the IFB and the Attorney General's insurance fraud division, there is the possibility of private interests improperly influencing the exercise of prosecutorial discretion in a particular case. The seemingly favored treatment of insurance fraud matters, financed initially by insurers and ultimately by consumers, over other criminal matters may be difficult to justify on policy grounds. Absent, however, a showing of a violation of constitutional rights or a demonstration that this court

must step in to assure a fair trial, these considerations are not for us.

*Id.* at 654 (footnote omitted).

Justice Fried, a former Harvard Law Professor and Solicitor General during the Reagan Administration, concurred specially to take issue with the court's discussion regarding the prudence of the IFB arrangement. Justice Fried regarded it as gratuitous political commentary on the arrangement rather than legitimate judicial decision-making.

Once we have concluded that 'the defendants have not demonstrated that their constitutional rights have been or will be violated' by this scheme, it really does not matter whether we 'endorse the system [] as desirable.' . . . We are not in the business of issuing or withholding such endorsements. Nor need anyone 'justify' to us wholly lawful legislative schemes 'on policy grounds.'

*Id.* at 654-55 (Fried, J., dissenting). Nonetheless, Justice Fried set forth his own views regarding the wisdom of the Massachusetts anti-insurance fraud system:

I can see quite good policy grounds for an arrangement that assures that criminality such as is charged here, which poses no threat of violence and has no obvious victims but still robs the public, will get sufficient prosecutorial attention to deter predators. But my views on that score are of no moment and I would not inject them into the decision of these cases.

*Id.*

MUGGING OF DRIVER WHILE CHANGING TIRE  
"ARISES FROM USE" OF AUTOMOBILE AND IS  
SUBJECT TO COVERAGE UNDER FLORIDA LAW

*Blish v. Atlanta Casualty Co.*, 736 So. 2d 1151 (Fla. 1999).

For decades, auto insurers and policyholder claimants have debated whether a policyholder's injury arose out of the use or operation of the insured

motor vehicle. State law jurisprudence differs and cases within the same state can be highly fact specific and difficult to reconcile. Almost all courts assess the issue according to the degree to which the injury arises out of auto-related activity. But courts continue to diverge, even within the same state, regarding the operationalization of this inquiry. Some courts take a more restrictive view and require that the auto be in use for transportation rather than some other purpose such as storage, sleeping, sitting, or socializing. Florida has not historically imposed this sort of restriction but has traditionally required that there not be any significant break in any asserted causal link between auto use and injury. When injuries arise from crime on the highway, courts have sometimes required that the criminal be attempting to steal or misuse the vehicle in order for coverage to be obtained for the policyholder. In *Blish*, the Florida Supreme Court disapproved this approach and held that “the motivation of the assailant is not dispositive” to such questions of auto insurance coverage. The policyholder was entitled to coverage for injuries suffered when mugged while changing a tire.

Karl Blish was on his way home in his car when he suffered a tire blowout. While on the side of the road changing the tire, Blish was set upon by several attackers who robbed him of approximately \$100. Blish recovered enough to change the tire and went home, at first apparently willing to chalk the incident up as simply a painful, bad experience. When abdominal pain persisted, he sought medical treatment and was discovered to have a ruptured spleen, which was removed. Blish filed a claim for first-party personal injury protection (“PIP”) benefits under his auto policy. The insurer denied coverage, contending that Blish was injured by the perpetrators’ criminal conduct rather than through an accident resulting from automobile operation. The county court agreed with Blish, but the district court of appeals reversed.

The Florida Supreme Court found Blish’s injuries covered under the auto policy. In reversing the intermediate appellate court, the supreme court disapproved of the lower court’s focus on whether the attackers had made any attempt to possess or use Blish’s car. Florida law requires that a claim for PIP benefits “arise out of” ownership, maintenance, or use of a motor vehicle. There is no requirement that tortfeasors be attempting to use or misuse the vehicle. Consistent with earlier precedent, the court in *Blish*, however, noted that the term “arise out of” is broad but can not be so liberally construed as to make a claim covered, no matter how distant the presence of the automobile. There must be “some nexus” between the automobile and the injury. The court stated that the nexus requirement is not satisfied if the motor vehicle is merely the situs of the injury “through pure happenstance.”

Rather than focus solely on the location of injury in relation to the covered auto, the court in *Blish* instructed that “courts should ask: Is the injury

a reasonably foreseeable consequence of the use (or the ownership or the maintenance) of the vehicle?" According to the court:

In the present case, Blish's injuries were an unfortunate but eminently foreseeable consequence of the use and maintenance of the pickup truck: Blish was using the truck for routine transportation purposes after dark when the truck sustained a mechanical failure, i.e., a blowout; he responded in a normal and foreseeable fashion, i.e., he attempted to change the tire on site with the tools and spare tire he carried in the vehicle for that purpose; he was in the act of repairing the vehicle, i.e., he was turning the lug nuts on the faulty tire, when he was injured.

Under these circumstances, the actual source of the injury-causing blow is not dispositive – whether it came from a negligent driver in a passing vehicle or a violent group of passing thugs is not decisive. It was the use and maintenance of the truck that left Blish stranded and exposed to random acts of negligence and violence, and he was in the very act of performing emergency maintenance when he was injured.

*Id.* at 115.