

Scholarly Commons @ UNLV Boyd Law

Scholarly Works

Faculty Scholarship

2001

Recent Case Developments

Jeffrey W. Stempel

University of Nevada, Las Vegas -- William S. Boyd School of Law

Follow this and additional works at: <https://scholars.law.unlv.edu/facpub>



Part of the [Civil Procedure Commons](#), [Contracts Commons](#), [Insurance Law Commons](#), [Litigation Commons](#), [Other Law Commons](#), and the [Torts Commons](#)

Recommended Citation

Stempel, Jeffrey W., "Recent Case Developments" (2001). *Scholarly Works*. 251.
<https://scholars.law.unlv.edu/facpub/251>

This Article is brought to you by the Scholarly Commons @ UNLV Boyd Law, an institutional repository administered by the Wiener-Rogers Law Library at the William S. Boyd School of Law. For more information, please contact youngwoo.ban@unlv.edu.

RECENT CASE DEVELOPMENTS

*Jeffrey W. Stempel**

IN ORDER TO HAVE COMPLETE DISCRETION AS TO
BENEFIT DETERMINATIONS, ERISA PLAN
DOCUMENTS MUST CLEARLY STATE THAT BENEFIT
DETERMINATIONS ARE DISCRETIONARY

Herzberger v. Standard Ins. Co., 205 F.3d 327 (7th Cir.
2000).

Much of the Employee Retirement Income Security Act of 1974 (ERISA) deals with retirement benefits, but much of the daily administration of benefit plans involves health insurance coverage provided by employers, often administered through insurance coverage purchased by the employer. Employee beneficiaries and employers or the insurers administering the plan often disagree as to coverage, engendering litigation.

A continuing controversy on this front is the degree of freedom a benefit plan administrator (usually a health insurance company claims adjuster) has in denying such claims. For obvious reasons, employers and insurers prefer to have total discretion so that any benefit denials are final and not subject to successful court challenge. For equally obvious reasons, beneficiaries prefer to categorize a plan as providing coverage subject to certain contractual standards and norms of acceptable health insurance. Courts have had some difficulty in determining, from the plan documents, whether the plan's decision authority is discretionary or circumscribed.

* Professor of Law and Associate Dean for Academic Affairs, William S. Boyd School of Law, University of Nevada Las Vegas. Professor Stempel is the author of *LAW OF INSURANCE CONTRACT DISPUTES* (2d ed. 1999 & Supp. 2000) published by Aspen Law & Business. Portions of the case summaries were originally or simultaneously authored in substantially this format for the *Journal of Risk and Insurance* of the American Risk and Insurance Association, Box 9001, Mount Vernon, NY 10552-9001 (available at <http://www.aria.org/jri/>).

In *Herzberger*, the Seventh Circuit sought to bring some clarity to its own precedents, issuing an opinion that may be influential in other quarters. Writing for the court, Chief Judge Richard Posner framed the issue as:

whether language in plan documents to the effect that benefits shall be paid when the plan administrator upon proof (or satisfactory proof) determines that the applicant is entitled to them confers upon the administrator a power of discretionary judgment, so that a court can set it aside only if it was 'arbitrary and capricious,' that is, unreasonable, and not merely incorrect, which is the question for the court when review is plenary ("de novo"). The cases directly on point say 'no,' ruling that the language in the plan documents must confer discretion in clearer terms.

205 F.3d at 329 (citations omitted). Finding some of the case law unclear or arguably in tension, the court issued the *Herzberger* opinion to "clarify our position and reduce the tension." *Id.* at 330. In particular, the court found it "highly desirable to have a uniform national rule" because of the movement of workers and the multi-state operations of employers.

Where plan documents provide no indication of the scope of judicial review, the judicial review will be plenary and determine whether a plan administrator "got it right" under the terms of the coverage provided by the plan. However, because an ERISA plan is a contract between the employer and the employees, the employer is permitted to change the default standard of judicial review from one that is plenary to one that is more deferential, such as the "arbitrary and capricious" standard. But to make this change, the plan documents must be sufficiently clear. Where plan document language is ambiguous, the plan is construed as providing plenary review. As with insurance coverage generally, ambiguity is in effect construed against the drafter of the documents.

However, unless a contract involves something of highly personal taste, such as a commissioned portrait, the widest discretion that can be established is a yardstick of reasonableness. Even where the plan documents do clearly convey discretion to the administrator, the administrator's decisions must be reasonable rather than arbitrary and capricious. Although this standard provides some protection to the worker or beneficiary, it benefits the employer because health coverage issues are often sufficiently close or complicated that both sides can be said to have adopted "reasonable" or "non-arbitrary" positions. As the court put it:

The very existence of “rights” under such plans depends on the degree of discretion lodged in the administrator. The broader that discretion, the less solid an entitlement the employee has and the more important it may be to him, therefore, to supplement his ERISA plan with other forms of insurance. In these circumstances, the employer should have to make clear whether a plan confers solid rights or merely the “right” to appeal to the discretion of the plan’s administrator.

Id. at 331.

To clarify matters, the *Herzberger* panel, after circulating its draft opinion to the entire Seventh Circuit, issued and “commend[ed] to employers” what it deemed “safe harbor” language for employers to use if they wish to have their plan benefits decisions reviewed under the more deferential arbitrary and capricious standard used with discretionary plans. The court suggested the following language: “Benefits under this plan will be paid only if the plan administrator decides in his discretion that the applicant is entitled to them.” *Id.* According to the court: “An ERISA plan that contains such language will not be open to being characterized as entitling the applicant for benefits to plenary judicial review of a decision turning him down.” *Id.*

Although future beneficiaries will undoubtedly want to claim that the absence of such “safe harbor” language provides plenary review, the court stated that this was not necessarily a persuasive argument, finding that:

In some cases the nature of the benefits or the conditions upon it will make reasonably clear that the plan administrator is to exercise discretion. In others the plan will contain language that, while not so clear as our “safe harbor” proposal, indicates with the requisite if minimum clarity that a discretionary determination is envisaged.

Id. Thus, employers appear to have an advantage of either using the “safe harbor” language, which is presumably conclusive, or litigating the issue of the standard established by plan documents containing other language. However, beneficiaries have something of an advantage as well under *Herzberger* in that

the mere fact that a plan requires a determination of eligibility or entitlement by the administrator, or requires proof or satisfactory proof [or similar provisions] . . . does not give the employee adequate notice that the plan

administrator is to make a judgment largely insulated from judicial review by reason of being discretionary.

Id. at 332.

The court also defended the current regime of deference to plan administrators, so long as the plan documents adequately establish the discretion of the administrator.

An ERISA plan can stipulate for deferential review; it might be entirely rational for an employee to accede to and even prefer such a plan -- it might be cheaper. But the stipulation must be clear, and cannot merely be assumed from language that in the closely related setting of insurance contracts has never been thought to entitle the insurer to exercise a discretionary judgment in determining whether to pay an insured's claim. An employer should not be allowed to get credit with its employees for having an ERISA plan that confers solid rights on them and later, when an employee seeks to enforce the right, pull a discretionary judicial review rabbit out of his hat. The employees are entitled to know what they're getting into, and so if the employer is going to reserve a broad, unchanneled discretion to deny claims, the employees should be told about this, and told clearly.

Id.

In addition, the *Herzberger* court held that the employer was not estopped from denying benefits because it had supported Herzberger's application for social security disability benefits. The two positions were not inconsistent because Herzberger's claim was one for mental health disability under social security and the dispute between Herzberger and her employer was the degree to which mental health benefits were covered under the health provisions of the ERISA benefit plan in question.

**FEDERAL ANTI-INJUNCTION ACT DOES NOT PERMIT
POLICYHOLDER TO SUE IN STATE COURT AFTER
HAVING LOST IN FEDERAL COURT; INSURER MAY
HAVE SECOND LAWSUIT HALTED**

New York Life Ins. Co. v. Gillispie, 203 F.3d 384 (5th Cir. 2000).

Because the United States is a federal system where both state governments and the national government share power, there are certain constitutional and statutory restrictions on federal power co-existing with the right of the national government to have supreme or exclusive power in some areas. One example of this tension is the Anti-Injunction Act, 28 U.S.C. § 2283 (2000), which generally forbids federal courts from interfering with ongoing state court proceedings. However, an exception to the Act's general rule provides that federal courts may issue an injunction to halt or limit state proceedings in order to avoid relitigation of matters previously decided in federal court or to otherwise protect the federal courts from undue state interference.

A tenacious life insurance beneficiary recently tested the confines of the Anti-Injunction Act, but was unsuccessful before a unanimous panel of the Fifth Circuit Court of Appeals, which included the states of Texas and Louisiana. The court summarized the facts of the two lawsuits as follows:

Ronald Gillispie died in 1993. His wife, Sheree Gillispie, is the named beneficiary of a life insurance policy issued to Mr. Gillispie by New York Life Insurance Company. Shortly after Mr. Gillispie's death, Mrs. Gillispie submitted a claim to New York Life alleging entitlement to the proceeds of the policy. New York Life denied the claim, contending the Mr. Gillispie's death was the result of a suicide. Suicide is unambiguously excluded from coverage under the policy.

In 1995, Mrs. Gillispie filed a complaint against New York Life in the United States District Court for the Northern District of Mississippi, alleging breach of contract and bad faith denial of benefits. New York Life moved for summary judgement. Mrs. Gillispie's attorney did not respond to the motion. In early 1996, the court granted New York Life's motion for summary judgment, explicitly

finding that “all evidence points to the decedent’s death as a suicide.”

Mrs. Gillispie subsequently hired new counsel to represent her. Her new attorney succeeded in convincing the Chancery Court of Tippah County, Mississippi to order the issuance of an amended death certificate declaring the cause of Mr. Gillispie’s death to be accidental. In 1997, Mrs. Gillispie filed another complaint against New York Life, this time in the Circuit Court of Tippah County, Mississippi. The complaint stated the same basic causes of action as had the 1995 federal suit, alleging breach of contract and bad faith denial of benefits.

Gillispie, 203 F.3d at 386.

In response to the second suit in state court, the insurer removed the case to the United States District Court for the District of Mississippi, but the case was remanded to state court for lack of subject matter jurisdiction since the case involved both a Mississippi plaintiff and defendants other than New York Life who were Mississippi residents. New York Life then filed a separate claim in the Mississippi District Court seeking an order enjoining the state court suit, arguing that the second suit was precluded by the decision of no coverage in the first lawsuit, which was *res judicata*. Mrs. Gillispie argued that the Anti-Injunction Act barred the requested injunction and the trial court agreed.

The Fifth Circuit reversed the trial court, holding that the general rule of the Act was in this case clearly subject to the “relitigation exception” to the Act, which permits a federal court to halt state court proceedings that are repeats of prior federal court adjudication. The Act specifically states that a federal court may nonetheless issue an injunctive order “to protect and effectuate its judgments. 28 U.S.C. § 2283 (2000). According to the court, “[t]his exception ‘was designed to permit a federal court to prevent state litigation of an issue that previously was presented to and decided by a federal court.’” *Gillispie*, 203 F.3d at 387 (quoting *Chick Kam Choo v. Exxon Corp.*, 486 U.S. 140, 147 (1988)).

The Fifth Circuit applied a four-part test to determine whether the relitigation exception to the Act was applicable:

1. The parties to the later action must be identical to or in privity with the parties to the prior action;

2. The judgment issued in the first action must have been rendered by a court that had proper jurisdiction over the matter;

3. The prior action must have in fact resulted in a final judgment on the merits of the claim (nonfinal, preliminary rulings do not qualify); and

4. The 'same claim or cause of action must be involved in both suits.'

Id.

In *Gillispie*, the parties to both the federal and Mississippi actions were the same and the federal court in the first case had proper jurisdiction. The federal court's entry of summary judgment for New York Life was a final judgment on the merits of the claim. The Fifth Circuit saw the only colorable issue as being whether the 1995 federal suit and the 1997 state court suit involved the "same claim or cause of action." The Fifth Circuit found the cases to involve the same claim -- whether Mr. Gillispie died from suicide. Consequently, a federal court was empowered to and required to halt the duplicative second case in state court.

Mrs. Gillispie argued that the second action was different because it involved different facts, in particular the change in content of the official death certificate. The court found this distinction unimportant, however, because under the relitigation exception to the Anti-Injunction Act, the court focused on whether the first and second case involved the same *transaction*, not necessarily the exact same evidence. Applying this approach, there was no question that both lawsuits were about the same thing -- the circumstances of Mr. Gillispie's death and whether the life insurance policy provided coverage. *Id.*

MISSISSIPPI SUPREME COURT HOLDS UNINSURED
MOTORIST COVERAGE NOT TRIGGERED ABSENT
ACTUAL PHYSICAL CONTACT; NO COVERAGE FOR
"HIT AND RUN" INCIDENT RESULTING IN DEATH

Massachusetts Bay Ins. Co. v. Allstate Indem. Co. v. Joyner,
736 So.2d 877 (Miss. 2000).

The facts of this case read like something out of bad action movie. On September 19, 1996, on an interstate outside of Jackson, Mississippi, two cars

are traveling in the left lane. A black sport utility vehicle (SUV) is passing them on the right and finds its path blocked by a slow-moving truck. Rather than braking, the SUV swerves to the left. In the left lane, Evelyn Joyner swerves further left in response. In order to avoid a collision with the SUV, she enters the median of the highway, loses control, flips, and is killed. The other car in the left lane witnesses the tragedy as the black SUV continues speeding on into the night, never to be apprehended.

After Joyner's death, her surviving husband sought uninsured motorist benefits from Allstate (which provided \$30,000 in such coverage) and Massachusetts Bay (which had uninsured motorist limits of \$200,000). The theory of uninsured motorist coverage is that it provides the coverage that would have been available had the policyholder been able to bring a tort claim against an insured, tortfeasor driver. Normally, of course, drivers do not flee the scene of an accident, and a prospective plaintiff knows who is the alleged tortfeasor and finds out whether that driver has sufficient insurance. To the extent that the tortfeasor driver is uninsured or underinsured, the innocent driver may recover up to applicable policy limits from its uninsured or underinsured motorist coverage.

Hit-and-run drivers have always been a problem for uninsured motorist coverage disputes as well as society. A hit and run driver who escapes is constructively an uninsured motorist because neither he nor his insurance company can be brought before a court. In a typical hit-and-run case involving a collision, insurers normally pay uninsured motorist benefits unless they have significant grounds for suspecting that an accident was fraudulently staged. But what about a "miss-and-run" incident, where the escaping driver did not physically collide with the injured party but otherwise caused the injury? In hit and run cases of this sort, insurers have tended to resist paying claims, partially on general principles ("hit" should mean "hit," rather than "cause a swerve") and partially out of concern that fraud is more likely in the absence of physical impact.

Cases dealing with miss and run incidents are divided. In some states, such as Mississippi, insurers have been successful in codifying a physical impact requirement for uninsured motorist coverage. State law provides that an "uninsured motor vehicle" shall mean a:

motor vehicle of which the owner or operator is unknown; provided that in order for the insured to recover under the endorsement where the owner or operator of any motor vehicle which causes bodily injury to the insured is unknown, *actual physical contact must have occurred*

between the motor vehicle owned or operated by such unknown person and the person or property of the insured. MISS. CODE ANN. § 83-11-103 (1999) (emphasis added).

Mississippi recently took a strong position in favor of requiring physical impact for coverage, reversing, in a 7-2 opinion, a trial court ruling for the policyholder and entering judgment as a matter of law for the insurer. Despite the sympathetic factual situation and the loss to the Joyner family, the court felt constrained by what it regarded as the clear language of the statute. In so doing, it reaffirmed an approach of judicial restraint regarding the statute, stating that “[i]t is no answer that upon reflection the legislative enactment may be seen crude, inadequate or even foolish. Where the legislature has enacted upon a subject within its competence, we may not annul or evade what it has done.” *Massachusetts Bay Ins. Co.*, 763 So.2d at 879 (quoting *Anderson v. State Farm Auto Ins. Co.*, 555 So.2d 733, 734 (Miss. 1990)).

The court also examined the policies in question. The Allstate policy specifically required physical contact for uninsured motorist coverage. The Massachusetts Bay policy did not, but the court found it unambiguous because it stated that its hit-and-run coverage was restricted to “instances in which the unidentified car ‘hits’ an insured, the insured vehicle or a vehicle in which an insured is riding.” Thus, even though there was “no suggestion of the presence of fraud” in Joyner’s case, the court found no coverage under either the terms of the policies or the statute.

The dissenters, despite the policy language and the language of the statute, contended that the majority opinion did “not hold water.” Unlike the majority, the dissent saw the *Joyner* decision, not as following from statute and precedent, but moving away from Mississippi’s traditions of liberal interpretation of insurance policies in favor of the policyholder, and the vindication of public policy favoring compensation to victims of auto accidents.

In particular, the dissent argued for a “reasonable expectations” approach to coverage, even though it did not articulate the “reasonable expectations” doctrine by name. In the dissent’s view, a policyholder with uninsured motorist coverage reasonably expects coverage if injured in an accident by an uninsured driver. Evelyn Joyner was killed in an accident caused by a functionally uninsured car (the Black SUV could not be located), and it did not matter to her surviving husband that the cars had not collided. The Joyner family was just as injured and as in need of compensation regardless of whether the cars collided or one car rolled into a ravine.

The dissent also took what might be termed a functional view of the auto insurance contract rather than a formal view. The formal view, expressed by the majority, reasoned that if the statute and the policy require physical contact, then physical contact is a prerequisite to recovery. The dissent argued that the function of the physical contact requirement was to reduce the chances of fraud. In the *Joyner* case, there was an eyewitness, and it was conceded by the parties that there was no fraud or staging that led to the tragedy. Under these circumstances, reasoned the dissent, it was an elevation of form over substance to deny coverage for the Joyners. To balance the concerns of policyholder and insurer, the dissent suggested a general approach:

Anytime a car runs off the road and there is no evidence that another car was involved, there should be a presumption that a one car accident occurred. However, that presumption could be rebutted by the testimony of eyewitnesses. This would prevent fraud and at the same time prevent the injustice of prohibiting legitimate claims solely because there was no proof of physical contact.

Id. at 883.

**TAXI DRIVER'S SEXUAL ABUSE OF PASSENGER IS
INTENTIONAL ACT, NO ACCIDENT AS REQUIRED BY
AUTO INSURANCE POLICY; NO COVERAGE**

Kim v. Nat'l Indem. Co., 6 P.3d 264 (Alaska 2000).

Alaska's highest court recently added their state to the list of jurisdictions that have taken a hard doctrinal line against coverage of sexual abuse under common liability policies such as automobile, homeowners, or general liability insurance. Since the 1980s, child abuse and other sexual abuse claims appear to have been more frequently litigated, resulting in claims against liability insurers. Despite the unsavory aspects of these cases, tortfeasors, their victims (where the policy benefits have been assigned), or a third party (where a third party may proceed directly against an insurer) have argued that the abuse resulted from negligent supervision or structure, was the product of an unreasonable impulse, or was not intended to cause harm.

Where the policyholder is an entity that is only vicariously liable, claimants have had some success arguing that the insured's liability stemmed from negligence rather than volitional wrongdoing with intent to injure. Even in these cases, however, an employee or agent of the vicariously liable policyholder is often an "insured," triggering the bar to coverage for injuries "expected or intended from the standpoint of the insured."

Where a claimant policyholder is the active tortfeasor, insurance companies have had great success in defeating claims for coverage. The *Kim* case now puts Alaska squarely within that line of cases. Kim, a taxicab driver, "sexually abused a minor who was a passenger in Kim's cab. When the minor's mother sued the cab driver, Kim looked to his automobile insurer for coverage." 6 P.3d at 266. The insurer disputed coverage and prevailed before both the trial court and the Supreme Court of Alaska, which summarized the policy as follows:

At the time of the incident, Kim was insured under a commercial automobile insurance policy from National Indemnity Company. Kim had purchased this policy -- a \$300,000 single limit policy -- to provide basic insurance for his taxi. The policy provides coverage for "all sums an insured legally must pay as damages because of 'bodily injury' or 'property damage to which this insurance applies, caused by an 'accident' and resulting from the ownership, maintenance or use of a covered 'auto'. But the policy excludes coverage for "[b]odily injury' or 'property damage' *expected or intended* from the standpoint of the 'insured.'" It also excludes coverage for bodily injury or property damage arising out of the "abuse or molestation by anyone of any person while that person is in the care, custody or control of any insured."

Id. (emphasis added).

The *Kim* court found that the injury to the minor passenger was not an "accident" within the meaning of the auto policy because an "accident ordinarily does not include injuries that are intentionally inflicted by the insured." *Id.* at 267. The court also noted that Alaska, like many states, has a general public policy against permitting insurance coverage for intentional acts. The nature of the underlying tort made this a particularly clear case to the court, which stated:

We agree with the majority rule that "in liability insurance cases involving sexual abuse of children, the intent to cause

injury can be inferred as a matter of law.” The majority of courts agree with this rule because “the harm to the victimized child is no less serious when the abusive adult’s subjective intentions are purportedly ‘benign’.”

Because we infer an intent to injure as a matter of law from acts of child abuse and molestation, Kim’s subjective intent is irrelevant. Moreover, once the intent to injure is inferred, “it is unimportant that the scope of the injuries inflicted are greater than or different from the injuries which objectively might be expected.” Thus, in addition to not being an “accident,” Kim’s sexual abuse of L.W. was an intentional act for which the insurance policy specifically bars coverage.

Id. at 267-68 (citations omitted).

Because the sexual abuse was both intentional and not accidental, it fell outside of the coverage provided by the auto insurance policy even without considering the “abuse and molestation” exclusion in the policy. The claimant attempted to argue that the presence of the exclusion for abuse of someone “in the care, custody, or control” of the policyholder implied that the policy would otherwise cover sexual abuse claims where the victim was not in the care of the insured. The court rejected this argument. *Id.* at 269 (“We therefore conclude that the exclusion does not grant coverage to injuries resulting from the sexual abuse of a person who is *not* in the care, custody, or control of the insured.”) (emphasis added). If, under applicable state law, a taxi passenger would be considered under the care or custody of the cabdriver, this exclusion would also have clearly applied.

The claimant’s attempt to invoke the uninsured/underinsured motorist provisions of the auto policy also failed in view of the court’s holding that the injuries did not result from an “accident.”

TIME LIMIT FOR BRINGING ACTION UNDER
INSURANCE POLICY INCLUDES PERIOD FOR
OBTAINING SERVICE OF PROCESS

Wothers v. Farmers Ins. Co. of Washington, 5 P.3d 719
(Wash. App. Div. 1 2000).

Most insurance policies provide that a claim or legal action for recovery must be brought within a specified time period. In many states, this time period, like a statute of limitations, may be extended during a time when the policyholder is unaware of the loss or incapacitated. In other states, the time period begins to run when the loss occurs.

There has been little litigation over the issue of whether litigation rules might extend the time period for bringing suit. The Federal Rules of Civil Procedure, for example, provide that after a plaintiff files a complaint with a federal court, it has 120 days to serve the complaint on the defendant. Many states now have similar provisions. In Washington, the civil rules provide that a plaintiff has 90 days to effect service after filing an action. In *Wothers*, Washington's intermediate appellate court faced the issue of whether a policyholder meets the one-year deadline for bringing a claim under a homeowner's policy by filing a complaint with the court. The *Wothers* court held that the complaint must be served upon the insurer within the one-year period in order to be timely.

Deborah Wothers' home experienced damage from a snow storm on December 29, 1996. Wothers and Farmers Insurance Company disputed whether the storm had also caused damage to the foundation of the home (covered under the policy), or whether the cracks observed in the foundation were the result of pre-snowstorm settling (not covered under the policy). When the parties could not agree, Wothers filed suit on December 29, 1997 alleging breach of contract and violation of the state Consumer Protection Act. However, Farmers was not served with the suit until 99 days later -- April 7, 1998.

According to both the trial court and the appellate court, the bringing of the lawsuit was not complete until service of process against Farmers was made, which did not take place until after the expiration of the one-year period. In essence, the court found that the policy provisions imposing the one-year deadline trumped the civil rules on this point. Wothers did not get the benefit of the additional 90-days for service of process and her action would have been untimely under the policy even if she had effected service

on Farmers within the 90 days provided under the Washington Rules of civil litigation.

CO-BORROWERS CANNOT COLLECT CREDIT LIFE
INSURANCE UNLESS EXPRESSLY NAMED AS
BENEFICIARIES IN THE POLICY

Abbott v. CUNA Mut. Ins. Soc'y, 7 P.3d 852 (Wash. App.
Div. 2 2000).

The Washington judiciary issued a cautionary tale for co-borrowers. When a person, entity, or group goes into debt, it may elect to purchase credit life insurance. Under a typical credit life insurance arrangement, the policy is issued to a named insured, who pays premiums. The face value of the policy is the value of the debt which generally declines as the balance due on the debt declines (if it does not, the policy would not comply with normal groundrules regarding insurable interest and sound practices for avoiding adverse selection and minimizing moral hazard). If the named insured dies while the debt is still in force, the proceeds of the policy are used to pay off the debt.

In *Abbott*, an unusual factual situation led to the denial of payments sought. Eleanor Abbott was a licensed practical nurse who ran a licensed adult foster care facility in her home. One of her patients was Fred Epperly, a quadriplegic who needed a ventilator and round-the-clock care, which Abbott provided in exchange for \$15,000 per month paid by the State of Washington Department of Labor and Industries. Larry Ketchum was a neighbor and friend of Abbott. In late 1990, Abbott and Epperly opened a joint account at a credit union (the EECU), which contained \$149,000 of deposits by Abbott. In early, 1991, the EECU made five loans to Abbott and Epperly totaling \$149,000. Abbott was the primary obligor and Epperly the secondary obligor.

They then sought and obtained a joint credit life insurance policy from CUNA Mutual Insurance Society. The Policy provided that "[a]ny death benefits under this Policy will be paid to [EECU in order to] apply the benefits to reduce or pay off the loans for which payment is made. Any excess benefits will be paid . . . by separate check to the beneficiary named in the estate." 7 P.3d at 854. Epperly did not name any beneficiary other

than his estate. Abbott used the funds for remodeling of her home and to pay outstanding bills.

In mid-1991, Abbott, Epperly, and Ketchum engaged in a similar transaction with another credit union (KFCU), opening an account for \$50,000 and obtaining a loan for \$50,000 and a similar credit life policy. Abbott, Epperly and others also engaged in a series of similar transactions opening credit union accounts and taking loans that did not involve the credit life insurance at issue in this court case but, interestingly enough, noted by the court. *Id.* at 855. This resulted in the purchase of three Toyotas, a BMW, and other goods.

On August 31, 1991, Epperly died. Abbott and Ketchum asked the credit unions to claim against the credit life policies and to retire the amounts due on the loans. Both credit unions claimed as requested, but EECU also notified CUNA, with perhaps some understatement, that “[t]here are unusual circumstances surrounding this claim.” *Id.* CUNA denied the claims, and the credit unions satisfied the debts by using the Abbott-Epperly accounts for payment, leaving Abbott and Ketchum to claim against the insurance policies.

The appeals court did not address the coverage issue but ruled that Abbott and Ketchum could not collect because neither was named as a beneficiary in the policies. The primary beneficiary was the credit union, and it had been paid by the funds on deposit. The secondary named beneficiary, Epperly’s estate, was entitled to the money. The court noted that in credit life insurance, it is the life of the debtor that is insured and not the debt itself. *Id.* (citing COUCH ON INSURANCE § 1:43 (3d ed. 1995)). Recall that under the loan arrangements, Abbott was the primary obligor and Epperly the secondary obligor. After Epperly’s death, the life insurance policy was to pay proceeds as designated in the policy, which left Abbott and Ketchum out in the cold because of the credit union actions to protect themselves by using the savings accounts when CUNA refused to pay.

The *Abbott* opinion is perhaps even more interesting for the questions it did not address. For example, the court refused to address the question of whether CUNA was estopped from denying coverage or whether there was a proper insurable interest for Abbott and Ketchum to have policies on Epperly’s life. The court found these questions immaterial because neither was a beneficiary under the policies and there was no question that CUNA was not estopped from litigating the beneficiary question.

Perhaps, most intriguingly, the majority did not directly comment on what was an obviously suspicious set of circumstances. In less than nine months, Abbott (with some support from Ketchum) essentially became a

serial borrower and opener of credit union accounts, obtaining loans for the amounts on deposit and purchasing insurance on Epperly's life that was designed to pay off the loans. Epperly, a quadriplegic on a respirator, died at the end of these nine months. Had things turned out only a bit differently, Abbott would have enjoyed a substantial windfall by correctly estimating that Epperly would not live long. And, of course, as Epperly's care giver, Abbott was in perhaps the best position in the world to know Epperly's health. Certainly, she was far more knowledgeable about Epperly's health than either the insurer or the credit union. This is the type of information asymmetry that can create adverse selection and should have been more troubling to the court than the majority suggests.

In addition to knowing Epperly's health, Abbott was the person most responsible for his health. She took care of him. Even laypersons know that the level of care accorded a quadriplegic can have a dramatic impact on the lifespan of the patient. In an amicus curiae brief, the Washington State Medical Association argued that the court should, as a matter of law, hold that it violates public policy for a health care provider to obtain life insurance on a patient and that such transactions should be void ab initio.

In response to these concerns, many of which were raised in the concurring opinion of Chief Judge Armstrong, the majority reasoned that such issues must "be addressed to the legislature." On the question of the validity of the insurance itself, the majority found that the Revised Code of Washington § 48.18.030 (1) was clearly met regarding insurable interest; both Abbott, Epperly, and Ketchum had actual debt for which they could be held responsible by the credit unions even though they had equivalent funds on deposit. Although this might be a situation too conducive to fraud, "[a]mending the statute is a task for the legislature, not for any of the judges of this court; and exercising a higher level of care in the sale of credit life insurance is a task for CUNA and similar insurers." *Id.* at 858.

The concurrence took issue with this deference to the legislature and argued that the Abbott and Ketchum purchases of credit life insurance should be held void because it violated the twin evils underlying the insurable interest doctrine: wagering and moral hazard. In the view of the concurring judge, Abbott was wagering on Epperly's life (and would have won if she had only induced a shrewder beneficiary designation), and, as a result of the insurance had an incentive to do less for him in her capacity as caregiver. *Id.* at 859-61. The concurrence also saw the case as one where the credit union had no insurable interest because the savings account deposits equaled the debts. *Id.* at 859.

On the issue of the credit union's security, the concurrence appears to be incorrect. Although Abbott had the funds on deposit, there appears to have been no restraint on her access to these funds. Abbott could, at least in theory, have withdrawn a substantial part of the account while Epperly was on his death bed and spent the money before the credit union knew what had occurred. Under those circumstances, the credit union would then be extremely interested in the proceeds of the credit life insurance. Thus, it seems that the credit life policy was proper in the sense of providing some protection to the credit union.

On the issue of insurable interest and public policy in general, the concurrence raises interesting issues not adequately addressed by the majority. In the instant case, the many transactions appear to have resulted in a wash. Abbott has a remodeled house and cars, etc., but has lost all the savings she placed in the credit union. Because neither Abbott nor Ketchum was a named beneficiary in the Epperly estate, neither Abbott nor Ketchum can be said to have successfully pulled the proverbial "fast one" at the end of this particular day. But they may have come close. If the beneficiary designation had been differently handled, Abbott would have had home remodeling, cars, etc., free and clear and still have credit union accounts amounting to six figures. The bank would be repaid but the insurer would be out a good deal of money on a recently issued life policy for which only a few premiums were paid. In addition, the opinion provides no information about the Epperly estate, although it notes that he had a spouse and children. If Abbott or Ketchum received substantial bequests from the Epperly estate, the particular equities of this situation might again be at issue.

From a policyholder-oriented view, *Abbott* is also potentially troubling. For example, apply the court's decision to a less suspicious transaction. A mother and son open a bank account and take a loan, obtaining credit life insurance on the life of the son, who dies in a car accident. The bank quickly seizes the bank account to satisfy the debt while the insurer is slow in determining its coverage position. After the bank has acted, the insurer now has an ironclad defense: the credit life policy failed to name the mother as a beneficiary. The insurer received the premiums but is off the hook, a most unfair result if there have been several years of premium payments. In addition to losing her son, the mother has no more savings and has been deprived of the planned opportunity to pay off the loan over time while retaining her savings or being protected by the credit life policy.

Under the *Abbott* opinion, this sequence of events is a real possibility. If it occurs, does the mother have a bad faith claim against the bank or the

insurer? Only if they collude? In fact, under *Abbott*, it appears that this sequence of events could occur even if the mother has been clearly named as policy beneficiary. Eventually, she would be paid the outstanding balance of the note if the bank had already satisfied the debt by raiding her savings, but this could entail months of delay and financial disruption to the mother. By deciding on narrow grounds, the *Abbott* court leaves these questions unanswered. Apparently, it is caveat emptor for the depositor/debtor/insured as well as for the bank and the insurer -- but is that good public policy? The court could have, for example, refined the groundrules for interpreting insurance policies in situations where the underlying insurable interest was suspect or where the transaction has negative public policy implications. Perhaps, for example, in cases like *Abbott*, the normal ground rules for construction in favor of the policyholder or beneficiary should be neutralized or even reversed.

On the other hand, the majority has strong arguments for not delving further into this issue. In addition to deference to the legislature, the majority essentially suggests that banks and insurers are sufficiently sophisticated and that they should bear the consequences of loose underwriting of loans and policies. Although the *Abbott-Epperly-Ketchum* transactions look suspicious, the credit unions wrote loans of their own free will, and CUNA issued credit life policies of its own volition. A few cases like this might have the salutatory effect of inducing greater care in underwriting.

However, the "let the chips fall" approach has historically not been the view of the law in this area. If so, there would be no insurable interest doctrine as such and society would depend entirely on the self-interest and prudence of insurers to prevent the evils animating the doctrine. Instead, the law has provided to insurers a defense to coverage that is available (absent estoppel) even though the insurer's own sloppiness led to issuance of the policy. Certainly, society would not want to permit recovery to a psychotic killer (or his innocent beneficiaries) who obtained thousands of policies on the lives of comparative strangers. In this area, courts have been willing to act even where the legislature has not spoken with clarity. A case like *Abbott* presents the tough question of whether the court should have done more than simply decide the case before on the most narrow terms available. Although the court's mere recitation of the facts sounds like a made-for-television movie, the court never focused on the issue of why Epperly had anything legitimate to do with these transactions. He made no deposits, appeared to reap no benefits from the loans, and was not bringing income into the household that benefited from the loans.

The position of the Washington Medical Association, which argued for a per se rule against health care givers having insurance on patients, raises significant questions. Generally, the benefits of a life insurance policy may be freely assigned because life insurance today is both a financial planning tool and a means of protection against the contingency of untimely death. The assignee may even be someone in a position to effect the health of the insured. There is even a United States Supreme Court decision, written by Oliver Wendell Holmes, that permitted a prospective surgery patient to assign policy benefits to the physician who would perform the surgery. *Grigsby v. Russell*, 222 U.S. 149 (1911). However, the Court's view is not binding on states because insurance is largely under the control of state substantive law rather than federal law. Despite the venerable of *Grigsby* decision, states may want to consider the rule proposed by the Washington Medical Association or to distinguish between ordinary life insurance and credit life insurance as to the propriety of purchase, beneficiary designation, or assignment and the status of the parties.

Even for "ordinary" life insurance, there may be public policy issues worth considering. Despite *Grigsby*, one may recoil a little at the view that a surgeon is more likely to get paid if the patient does not survive the operation. But the doctor is subject to professional regulation, and the operating room is full of witnesses should things go wrong. By contrast, care of the disabled often occurs in individual homes or rooms and, thus, out of sight. At the same time, one can readily understand that a seriously ill patient may wish to provide for a valued caregiver by naming him or her as a life insurance beneficiary. But does this mean the state should permit the caregiver to go on a buying spree of insurance policies on the life of the patient?

Abbott makes interesting reading and clarifies some important aspects of credit life insurance, but can be viewed as a missed opportunity to articulate groundrules of insurability.

