Recent Court Decisions

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Retailer That Self-Insurers Not Subject to Bad Faith Claims for Arguable Errors in Adjusting Claim Involving Self-Insurance

Morrison v. Toys "R" Us, Inc., 441 Mass. 451, 806 N.E. 2d 388 (Supreme Judicial Court of Massachusetts—April 15, 2004)

An important limitation on bad faith actions, particularly when sounding in tort rather than in contract, is that they generally only apply to insurers. An ordinary breach of contract obligation or duty by a party that is not a fiduciary or near-fiduciary generally does not support a bad faith claim. Under the law of most states, bad faith actions or their analogs (e.g., a claim for enhanced damages) are available only when there is a special relationship between the parties. As discussed previously, the insurer-policyholder relationship is generally considered to be such a special relationship. The mere presence of risk management through risk distribution will not convert a situation to one supporting a bad faith claim, even when one of the actors involved is performing functions often performed by an insurer. For example, in a recent case, the Supreme Judicial Court of Massachusetts held that a tort claimant could not maintain an insurance bad faith claim against a toy retailer that was self-insured for its first million dollars of exposure. *See Morrison v. Toys "R" Us, Inc.*, 441 Mass. 451, 806 N.E. 2d 388 (2004).

The claimant was injured when a sign fell on her while shopping. Acting as its own self-insured claims adjuster, the toy store offered relatively low amounts in settlement, topping out at a $45,000 offer on the morning of trial. In a result likely to get the attention of tort reformers and company management, the jury returned a verdict of $1.2 million, later remitted to $250,000. Arguing that a self-insurer was nonetheless an insurer that had failed to settle a claim in good faith, the plaintiff then argued that the retailer was liable for damages under the state's unfair claims practices statute. The court rejected the claim, concluding that under these circumstances, the retailer was simply a defendant. *See* 806 N.E. 2d at 389–92. The purpose of such statutes and bad faith law generally to protect the policyholder facing third party claims where the insurer mangles the defense and settlement of such claims. Where a company is adjusting its self-insured retention, there is no problem of the company favoring itself at the expense of a policyholder. The company is not only the self-insurer but is also the policyholder.

A related issue arises when a claimant wishes to sue the administrator of an insurance plan. In certain contexts, courts will permit such claims but not in other situations. The key determinant is whether the third-party administrator is both acting like an insurer and subject to the danger that it will, like an insurer acting in bad faith, place its own economic interest ahead of the interests of the policyholder. If so, a bad faith action may lie against the third-party administrator. If instead the administrator is simply being paid a flat fee by the insurer or employer and the compensation is not based on claims experience, the administrator may be regarded as a mere agent of the insurer or employer and not as the functional equivalent of an insurer. *See Wolf v. Prudential Ins. Co of America*, 50 F. 3d 793 (10th Cir. 1995) (applying federal common law); *Wathor v. Mut. Assur. Adm'rs, Inc.*, 87 P. 3d 559, (Okla. 2004). *But see* 806 P. 3d at 564 (Opala, V.C.J. and Watt, C.J., dissenting) (arguing administrator could not be exonerated as a matter of law in the instant case and that failing to treat administrators as equivalent of insurers creates gaping and unjustified gap in bad faith tort liability).

STATE STATUTE APPLIED TO PRECLUDE CANCELLATION OF POLICY ABSENT SATISFACTION OF REQUIRED GROUNDS AND OBSERVANCE OF STATUTORY PROCEDURE

American Continental Ins. Co. v. Steen, 91 P. 3d 864, 2004 Wash. LEXIS 362 (Washington Supreme Court—May 14, 2004)

Substantive state insurance law generally limits the grounds on which an insurer may cancel a personal lines insurance policy. Commonly accepted grounds are nonpayment of premium, fraud or material misrepresentation, increase of risk, or loss of reinsurance. State law may provide additional statutory protections against even cancellation by mutual agreement as this may defeat the public policy goal of assuring that victims of tort-feasors be compensated. For example, Washington has a statute that provides

> No insurance contract insuring against loss or damage through legal liability for the bodily injury or death by accident of any individual, or for damage to the property of any person, shall be retroactively annulled by any agreement between the insurer and insured after the occurrence of any such injury, death, or damage for which the insured may be liable, and any such annulment attempted shall be void.

See Rev. Code of Wash. 48.18.320.

The Washington Supreme Court recently held that this "nonannulment" statute applies to both occurrence basis and claims-made liability policies and restricts cancellation accordingly. *See American Continental Ins. Co. v. Steen*, 91 P. 3d 864, 2004 Wash. LEXIS 362 (Wash. 2004). Cancellation and annulment are often treated as synonyms. The Washington Supreme Court, however, has found some distinction in the terms, finding that the term "cancellation" applies to prospective termination of a policy in the absence of a pending claim while "annulment" includes both prospective cancellation and rescission of a policy *ab initio*. *See Id.* at *11, n. 2.

Regardless of the nomenclatural distinction, statutes such as the one quoted above are designed to prevent claimants from being left in the lurch by cooperative cancellation between insurer and policyholder. "The statute voids agreements between insurer

and insured to cancel or rescind policies if, and only if, the agreement is made after the occurrence of a potentially covered injury, death, or damage." *See* at *14–*15.

A dissenting Justice disagreed to the extent a canceled claims-made policy did not involve a risk that had attached, stressing the traditional distinction between a prospective cancellation and a retroactive rescission. In the dissent's view, however, the language of the statute and its purpose did not forbid a claims-made insurer from rescinding a policy *ab initio* if there is proper ground or canceling the policy if a claim has not been made and "no notice has been received by the insurer." *See Id*. at *23, *35–*36 (Bridge, J., dissenting).

INSURANCE AGENT'S AGREEMENT TO "LOOK INTO" OBTAINING COMMERCIAL INSURANCE FOUND NOT TO FIND INSURER TO COVERAGE FOR FIRE LOSSES TO ARCHITECTURAL FIRM. UTAH DETAILS REQUIREMENTS FOR ENFORCEABLE ORAL AGREEMENTS OF INSURANCE OR FOR THE PROCURING OF INSURANCE

Harris v. Albrecht, 86 P. 3d 728 (Utah Supreme Court—February 6, 2004)

A recent Utah Supreme Court case illustrates that despite the many general pronouncements suggesting broad agent or broker liability, successful litigation against an agent that fails to "pick up and run with" a request for insurance is no easy matter. In this case, the erstwhile policyholder, who had a nearly 10-year relationship with the agent for personal lines of insurance, broached the subject of obtaining a business policy for his architectural firm. The conversation, at least as accepted for purposes of deciding the agent's summary judgment motion involved the business owner telling the agent "to place business and fire coverage on [his] equipment and the contents [of his office]." With the agent replying that "he would come out and look at [the] equipment." *See Harris v. Albrecht*, 86 P. 3d 728, 730 (Utah 2004). Sure enough, disaster struck and lead to litigation.

> On December 31, 1997 [several months after the conversation] a fire destroyed the building housing Harris' [the putative policyholder] architectural firm. The losses totaled $1,143,855.50. Harris attributed $940,000 to the loss of architectural plans and other valuable papers. While watching the building burn, Harris called Albrecht [the agent] and asked: "You placed that [business] coverage we talked about, didn't you?" Albrecht replied: "We talked about it Ken, but we never did anything about it."

See 86 P. 3d at 730.

Harris sued Albrecht alleging that Albrecht had a duty to procure the requested business insurance. Albrecht won via summary judgment at the trial court. The Utah Court of Appeals reversed. By a unanimous vote, the Utah Supreme Court found as a matter of law that agent Albrecht (who worked for State Farm) had not entered into a contract to procure insurance both because Albrecht's promise was limited to initiating the process by inspecting the property to be insured and because the brief conversation did not provide Albrecht with the minimum elements essential for forming an insurance agreement: time of risk, scope of risk, policy limit, and premium. The Utah Supreme Court appears to have regarded it as essential for the agent to know whether there had been prior losses in connection with the property as well

as the property's valuation; and any other business-specific information required to underwrite the risk of property damage and business interruption for the architectural firm. In short, there was no "meeting of the minds" sufficient to form either an oral contract of insurance or a contract to procure insurance of a certain configuration. *See* 86 P. 3d at 730–33 ("In the present case, Albrecht did not have sufficiently definite directions from Harris to consummate the final insurance contract.") (Also finding that Albrecht's prior relationship with Harris in connection with auto, home, boat, and recreational vehicle policies did not provide Albrecht sufficient information to fill gaps or supplement the request for business insurance.)

In addition, the agent had made no binding commitment to procure insurance in the absence of adequate information (a "bare acknowledgment" to procure insurance under Utah insurance agency parlance).

> Factors that indicate a duty [to procure insurance] include (1) whether Harris gave Albrecht an application, (2) whether Albrecht made a bare acknowledgment of a contract covering a specific kind of casualty even though all the terms had not been settled, (3) whether Albrecht made promises to procure insurance that lulled Harris into believing a policy had been procured, and (4) whether there were prior dealings where Albrecht took care of Harris' needs without consultation.

See 86 P. 3d at 733. The Court found that Harris could not show the applicability of any of these factors that would auger in favor of coverage and concluded:

> A contract to procure insurance may arise when the agent has definite directions from the insured to consummate a final contract; when the scope, subject matter, duration, and other elements can be found by implications; and when the insured gives the agent authority to ascertain some of the essential facts. A duty to procure insurance may arise when an agent accepts an application; makes a bare acknowledgment of a contract covering a specific kind of casualty; lulls the other party into believing a contract has been effected through promises; and has taken care of the insured needs without consultation in the past. *See* 86 P. 3d at 734–35.

In a particularly interesting passage of the opinion, the *Harris v. Albrecht* court emphasized the different contexts of personal lines insurance and different types of business insurance, suggesting that law at the margin may be more protective of putative policyholders in the personal lines context and more protective of agents as the business context becomes more complex:

> A significant distinction exists between business insurance policies and personal insurance policies. The ease of procuring an auto or homeowner's policy contrasts sharply with the customization required for a business policy. . . . A policy for an architectural business requires more customization than one for a simple retail business. Valuable papers, for which Harris now seeks to recover damages, were beyond Albrecht's authority to bind State Farm, and State Farm would likely have required Harris to take certain loss-reduction measures regarding the safekeeping of those papers before

binding them. It was impossible for Albrecht to provide Harris with a "standard business policy."

See 86 P. 3d at 733–34.

CALIFORNIA SUPREME COURT REFUSES TO GIVE LITERAL EFFECT TO JEWELERS' BLOCK POLICY LANGUAGE LIMITING COVERAGE

E.M.M.I., Inc. v. Zurich American Ins. Co., 84 P. 3d 38, 9 Cal. Reptr. 3d 701 (California Supreme Court—February 23, 2004)

Perhaps because of the high risk of moral hazard or outright fraud through "inside jobs" and because of the often suspicious-looking circumstances of jewelry losses (e.g., a courier stops to tie a shoe and the bag of gems is gone when he looks up), insurers have won a good deal of cases by persuading courts to take a fairly literal view of the requirement found in most jewelers' block policies that requires a gem courier to be "in or upon the vehicle" at the time of any theft from the vehicle. Many courts read the language literally to insist on the courier's physical contact with the vehicle if there is to be coverage for jewelry stolen from the courier while transporting the gems by car. However, the California Supreme Court held in *E.M.M.I., Inc. v. Zurich American Ins. Co.*, 84 P. 3d 385, 9 Cal. Rptr. 3d 701 (Cal. 2004), that the word "upon" is sufficiently ambiguous that it must be construed in light of the policyholder's reasonable understanding of the scope of coverage to include thefts that take place when the insured person is in close proximity to the vehicle and attending it. *See* 84 P. 3d at 397–98. *See also* 84 P. 3d at 388–96 (reviewing axioms of contract construction and prior case law). *See also* Annot, *Construction and Effects of "Jeweler's Block" Policies on Provisions Contained Therein*, 22 A.L.R. 5th 579 (1994); *Couch on Insurance* §1:57. Two Justices dissented. *See* 84 P. 3d at 398 (Kennard, J., joined by Brown, J., dissenting).

E.M.M.I. v. Zurich is a big win for jewelers' block policyholders in the supreme court of the largest state concerning an issue that arises with some frequency. Many jewelers block policies contain arbitration provisions, shrinking the number of reported cases, which will make gauging the impact of the decision more difficult. But the case will certainly be used by policyholders before other courts and arbitrators, many of whom are likely to agree with the majority's analysis. Although the position of the *E.M.M.I. v. Zurich* dissenters and insurers has linguistic support (to be "upon" a tangible object usually means in physical contact with the object), the *E.M.M.I. v. Zurich* majority approach makes more sense in terms of rational application of the purpose of the insurance policy.

The reason this language is in a jewelers' block policy is to attempt to ensure that valuable jewels are not left just sitting around without a human guard, even in a locked car or trunk. This at least serves the purpose of deterring a prospective thief unless the thief is willing to exert physical violence against the courier or guard. Of course, this will not stop every thief. Some will be happy to brandish a firearm, knife, or club or even to use it on the courier. A scan of urban newspapers reveals that some jewel thieves can be heinously craven in their willingness to kill in order to steal. The "upon" the vehicle requirement therefore is far from a perfect deterrent. However, the same level of deterrence should be achieved under the *E.M.M.I. v. Zurich* test. If the jewelry courier is next to a vehicle and attending it, thieves who are unwilling to

accost or assault the courier should be every bit as deterred regardless of whether the courier is touching the vehicle at a particular moment. In fact, a courier literally in the vehicle (e.g., sitting down, napping in the back seat) may be more vulnerable and present less deterrence than a courier pacing around the vehicle and ready to use a sidearm against a prospective thief.

Consequently, the *E.M.M.I. v. Zurich* result does not appear likely to be all that disastrous for insurers in operation. The problem, of course, is that the physical contact, "upon" the vehicle requirement is thought by insurers to make it harder for policyholders to recover when the courier is not only outside the vehicle but down the block getting a cup of coffee. But under the *E.M.M.I. v. Zurich* decision, an insurer should be able to defeat claims arising from losses when a vehicle was genuinely unattended by marshaling proof of what actually happened despite the courier's claims to have only been feeding the parking meter. Insurer counsel should remember that the "upon" the vehicle requirement is most properly styled as an exception to an exclusion for theft from vehicles (this was the California Supreme Court's view as well). Consequently, the burden of persuasion on the issue rests with the policyholder. If a courier's claims are doubtful, a court or arbitrator could find for the insurer simply by finding that the burden of proof on the issue has not been successfully shouldered.

CALIFORNIA SUPREME COURT REFUSES TO GIVE EFFECT TO AUTOMOBILE POLICY LANGUAGE RESTRICTING COVERAGE FOR PERMISSIVE USERS OF VEHICLE; COVERAGE-LIMITING LANGUAGE INSUFFICIENTLY "CONSPICUOUS, PLAIN, AND CLEAR" TO BE ENFORCED

Haynes v. Farmers Insurance Exchange, 32 Cal. 4th 1198, 89 P. 3d 381 (California Supreme Court—May 17, 2004)

Haynes involved an automobile policy that provided, in two separate portions of the policy, there was no coverage for claims made arising out of permissive use of the vehicle. Policyholder William Gallahair had purchased an "E-Z Reader Car Policy" from Farmers. He permitted Christopher Morrow to drive the car. Joshua Haynes was riding in the car when an accident occurred, prompting Haynes to sue Morrow and Gallahair for damages. Farmers denied coverage. A portion of the body of the policy entitled "Other Insurance" stated that for "an insured person, other than you or a family member," coverage was available "up to the limits of the Financial Responsibility Law only." An endorsement to the policy entitled "Permissive User Limitation" stated that liability insurance for claims arising through permissive use of the car by someone other than the insurer or a family member were limited to $15,000 per person/$30,000 per accident rather than the $250,000 per person/$500,000 per accident provided for the policy generally in the declarations page. *See* 89 P. 3d at 1202–1204.

The California Supreme Court held that the endorsement, although not textually unclear, was nonetheless unenforceable because the endorsement was not sufficiently "conspicuous, plain, and clear" to be enforced. *See* 89 P. 3d at 1205. In *Haynes*, the policy language limiting benefits available for accidents arising from permissive use was hardly trumpeted, but neither was it buried and camouflaged. The language at issue was contained in an endorsement and not a footnote to the body of the policy. The Court's holding is clearly based on the placement and hidden nature of the

coverage-limiting language rather than any lack of clarity in the language itself. Consequently, a case like *Haynes v. Farmers* is more accurately classified as an implicit reasonable expectations decision more than a case of construing ambiguous language against the insurer that drafted the policy. California precedent cited by the Supreme Court clearly establishes that California has long required that policy language not only be understandable but be sufficiently prominently placed to alert the policyholder if the "fine print" is to take away what apparently is given in the "large print" of the declarations pages. Although this could be viewed as an instance of a court resolving contextual ambiguity created by competing policy provisions, the approach is more of a reasonable expectations approach, arguably even a strong reasonable expectations approach. *Accord*, *Jauregui v. Mid-Century Ins. Co.*, 1 Cal. App. 4th 1544, 1547 (1991). The dissenting judge found the majority holding to run counter to the traditional duty to read a policy, reflecting the degree to which the *Haynes* decision rested more on policyholder expectations than on the policy language.

SOUTH CAROLINA FINDS NO "PROPERTY DAMAGE" ALLEGED IN HOMEOWNERS' CLAIMS OF INJURY TO HOME VALUE DUE TO DEFENDANTS BUILDING ON CONTAMINATED LAND

Auto-Owners Ins. Co. v. Carl Brazell Builders, Inc., 356 S.C. 156, 588 S.E. 112 (S.C. 2003)

The *Auto-Owners Ins. Co. v. Carl Brazell Builders, Inc.* arose when homeowners sued, claiming that developers and contractors associated with an upscale residential neighborhood knowingly built homes on land contaminated by hazardous waste and intentionally concealed this from the homeowners, resulting in damage to them. The homeowners purportedly lost property value because their homes were worth significantly less once the problems of the tainted underlying land came to light. Insurers for the builder defendants defended the litigation but also filed a federal court action for a declaratory judgment of no potential for coverage on the ground that the complaint against the builders did not sufficiently allege "physical" injury to "tangible" property.

The South Carolina federal district court certified to the state Supreme Court a number of questions, including one asking whether the CGL policies in question required a defense where the claims are "economic in nature and based solely on the diminution in value" of the homes. The South Carolina Supreme Court answered a unanimous "no" to this question (and therefore declined to answer the other three certified questions). The Court found that the allegations were of intangible financial loss due to decreased market value did not constitute physical injury to tangible property and hence were not "property damage" within the meaning of the CGL policy. *See* 588 S.E. 2d at 113–16, especially 588 S.E. 2d at 116, citing other cases similarly decided.

Policyholder counsel and attorneys for claimants should note that the claims involved alleged only economic loss. Presumably, if the complaint had contended that the hazardous waste or soil had caused some form of physical injury to the home (e.g., seeping chemicals into a floorboard, tainted soil tracked into rooms, meshing with carpeting, etc.), coverage may have been available because there would then by physically injurious contact with the tangible home itself. If that had been the case, the next issue to be raised by insurers was whether the alleged fraudulent misrepresentation was an accidental "occurrence" within the meaning of the CGL policy and whether the

pollution exclusion barred coverage. These issues were presented in the certified questions that the South Carolina Supreme Court declined to answer after it found coverage barred (and no duty to defend) because of the lack of an allegation of physical injury.

COURTS TAKE DIFFERENT APPROACHES TO ISSUE OF LIABILITY FOR VOLITIONAL POLICYHOLDER MISCONDUCT CAUSING INJURY

American Home Assurance Co. v. Pope, 360 F. 3d 848 (United States Court of Appeals for Eight Circuit—April 20, 2004) (applying Missouri law)

Beckwith v. State Farm Fire & Casualty Co., 83 P. 3d 275 (Nevada Supreme Court—January 30, 2004)

A variant of the fortuity/intentional act question arises when an insurer argues that a loss or claim is not the result of an "occurrence" under a policy. The term "occurrence" is usually defined to mean an "accident" (including continuous or repeated exposure to conditions, a part of the definition that negates any suggestion that an accident must be brief or isolated in time to be within coverage). Insurers may seek to defeat coverage for what they regard as questionable claims by arguing that the loss is not the result of an accident. By doing this, the insurer attempts to avoid precedent and ground rules of insurance coverage that are more advantageous to the policyholder. Under these ground rules of coverage, it is the policyholder's burden to show that a matter comes within coverage (e.g., that the loss stems from an "accident"). But if this point is conceded or the policyholder shoulders the burden, the burden of persuasion then shifts to the insurer if the insurer is seeking to successfully interpose an exclusion to coverage, whether the exclusion be for an "intentional act," "expected or intended injury," "self-inflicted injury," or a "criminal act."

Consequently, if the insurer can draw the coverage battle lines on the plain of the accident/occurrence definition rather than on one of these fortuity-based exclusions, the insurer is potentially relieved of its need to shoulder the burden of persuasion as well as the maxim that exclusions are strictly construed against the insurer and in favor of coverage. This can make a difference in case results.

For example, in *American Home Assurance Co. v. Pope*, 360 F. 3d 848 (8th Cir. 2004) (applying Missouri law) the insurer sought to invoke a criminal act exclusion in a case in which a psychologist had failed to report child abuse dangers posed by one of the doctor's patients and failing to report past abuse, a crime under relevant state law. The insurer argued that a crime is a crime is a crime and that, therefore, the criminal act exclusion barred coverage for the doctor sued by the other parent for failing to warn of future abuse dangers. The trial court accepted this defense but the Eight Circuit reversed, concluding that although the policy in question "may have excluded coverage of the criminal misconduct claim, [the insurer] did not show that any exclusion applied to [the] claim that [the policyholder] breached a common law duty to notify" the child's mother and caregivers of the dangers posed by the father. *See* 360 F. 3d at 848–49.

Contrast this with the insurer's success in *Beckwith v. State Farm Fire & Casualty Co.*, 83 P. 3d 275 (Nev. 2004) in which the insurer was successful in arguing that coverage was excluded because there was no "accident" and thus no "occurrence" where the policyholder struck a third party that had confronted him regarding bizarre antics

and where the policyholder had alleged the incident resulted from intoxication and delusions that the third party was an "evil master" that threatened the policyholder. According to the Nevada Supreme Court, the policyholder's delusions were "of no matter because he admittedly struck [the third party claimant] in the eye with the desire of getting away from him. This is a non-accidental intentional act even if Beckwith did not intend to harm [the claimant]." *See* 83 P. 3d at 277. Although the precedential value of this decision may be limited (two Justices dissented; one Justice concurred in the result but noted that involuntary intoxication would auger for a different result; the policyholder's conduct was both outrageous and his explanation bizarre and perhaps suspect; he had pleaded *nolo contendere* to criminal charges related to the assault and intent is usually an element of a crime). *See* 83 P. 3d at 278 (Rose, J. & Shearing, J., dissenting). *See* 83 P. 3d at 278 (Agosti, J., concurring). *See also Capitol Indemnity Corp. v. Blazer*, 51 F. Supp. 2d 1080 (D. Nev. 1999) (finding that determination of accident must be made from viewpoint of policyholder's state of mind; third party claim arising from barroom brawl is accidental occurrence under liability policy because policyholder did not make attack on customer; but no coverage because of exclusion for claims "arising out of" assault and battery). *Beckwith v. State Farm* illustrates the degree to which the insurer gains some advantage by shifting the linguistic focus to whether intentional conduct is an "accident" rather than fighting over whether an exclusion of intentionally caused injury might apply.

ENDORSEMENTS USED IN POLICY WITHOUT PROPER FILING AND APPROVAL REQUIRED BY STATE INSURANCE REGULATION VOID AND OF NO IMPACT ON PRIORITY BETWEEN NO FAULT AND LIABILITY COVERAGE

Clarendon National Mutual Insurance Co. v. Amica Mutual Insurance Co., 441 Mass 248, 805 N.E. 2d 8 (Supreme Judicial Court of Massachusetts—March 19, 2004).

During the 1996–1998 period, Clarendon issued business auto insurance policies to nine rental car companies doing business in Massachusetts. Customers of the companies were involved in some 19 car accidents during that time period. Claims ensued, some of which Clarendon refused to pay on the ground that its rental car policies were excess to the renter's own auto policies by virtue of endorsements Clarendon had added to the car rental company policies. In particular, the endorsements states that the car renter's own policy provides coverage, that the renter's policy "must pay its limits before we pay." Clarendon had not filed this "super-excess" endorsement with the Massachusetts insurance commissioner. Massachusetts law provides that proposed policy language must be filed with the insurance commissioner, who then has 30 days to act on the proposed policy language. If there is no action within that time, the endorsement is deemed constructively approved.

Clarendon conceded that it had not submitted the proposed policy language to the Commissioner as required by law but argued that Massachusetts law, specifically G.L. c. 175, §193, made the policy language effective by operation of law. Section 193 states that

> Any policy of insurance . . . issued in violation of any provision of this chapter shall be valid and binding upon the company issuing it, and the rights, duties, and obligations of the par6ties thereto shall be determined by this chapter.

See 805 N.E. 2d at 11. *See also Hewins v. London Assur. Corp*., 184 Mass. 177, 68 N.E. 62 (1903) (holding that where company uses policy language in violation of regulations, provision may still bind policyholder and insurer; remedy for insurer's violation of the law, assuming policy provision is not otherwise illegal, unconscionable, or in violation of public policy is regulatory fine rather than abrogation of provision at issue).

In reviewing the situation, the Massachusetts high court declined to give effect to the endorsement to the extent it conflicted with required language contained in the policies the car renter claimants had in connection with the insurance on their personal vehicles. The Court, reversing a prior ruling in the case, agreed with Clarendon that an endorsement used in violation of the regulations was not a complete nullity. It could, as per the *Hewins v. London* decision, be binding on the policyholder and the insurer. However, illegally used policy language could not be binding on third parties (other policyholders such as the car renters and their insurers) that were subject to regulatory strictures of their own. Said the Court:

> The commissioner's authority to approval all policies and endorsements before they may be issued is an integral component of her authority to set the language of compulsory motor vehicle liability policies, which we have recognized as necessary and incidental to her power to fix the rates for compulsory coverage under [relevant Massachusetts law]. Under the existing statutory scheme, only the commissioner may approve a policy, either expressly or by default.
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> The reading of [the statute] that Clarendon urges would effectively subvert the statutory scheme created for fixing compulsory motor vehicle liability insurance coverage rates. It would permit an insurer unilaterally to issue a policy that effectively overrides the standard policy language required of all other carriers, and in doing so alter the cornerstone on which the commissioner relies to set automobile insurance rates for the entire industry. Certainly, the Legislature did not intend 193 to produce such a result. Rather, 193 validates illegally issued policies for the limited purpose of protecting the issuer's insureds, as discussed. Because the endorsements were illegally issued, they have no effect on the policies approved by the commissioner and issued by the defendant insurers, and they are effectively void for purpose of this litigation.

See 805 N.E. 2d at 13.

FLORIDA SUPREME COURT TAKES BROAD APPROACH TO DETERMINING CAUSATION OF THIRD-PARTY INJURY CLAIMS; GUNSHOTS CAUSING INJURY TO PARTY PATRONS ARE MORE THAN ONE "OCCURRENCE"

Koikos v. Travelers Indemnity Co., 849 So. 2d 263 (Florida Supreme Court—March 6, 2003)

In *Koikos v. Travelers Indemnity Co.*, 849 So. 2d 263 (Fla. 2003), the policyholder was the owner of a restaurant in Tallahassee, Florida. He rented the premises to a Florida A&M University fraternity for a party. When two undesirables attempted to crash the

party, an altercation ensued. One of the party crashers fired "two separate—but nearly concurrent—rounds," hitting two different partygoers and causing serious injury to each. Each victim filed a separate lawsuit against Mr. Koikos as owner of the restaurant, alleging inadequate security. Koikos sought coverage for two separate occurrences. Travelers disagreed, arguing that there was only a single occurrence—inadequate restaurant security—causing the shootings. The Florida Supreme Court, interpreting a policy which defined an occurrence as including "continuous or repeated exposure to substantially the same general harmful conditions," overwhelmingly rejected the Travelers position on number of occurrences and embraced Mr. Koikos's view that each shooting of a different person was a separate occurrence to which full policy limits applied. Said the *Koikos* Court:

> We conclude that the inclusion of the "continuous or repeated *exposure*" language [found in a typical general liability policy] does not restrict the definition of "occurrence" but rather expands it by including ongoing and slowly developing injuries, such as those in the field of toxic torts. Therefore, we reject Travelers' reliance on the "continuous or repeated exposure" language as a basis for concluding that Koikos's negligent failure to provide security constitutes a single occurrence under the terms of the policy. The victims were not "exposed" to the negligent failure to provide security. If the victims were "exposed" to anything, it was the bullets fired from the intruder's gun.

Id. at 268 (Fla. 2003) (emphasis in original; citations omitted). In reaching its holding, the Florida Supreme Court in Koikos approved the liberal approach to determining causation and counting occurrences reflected in *American Indem. Co. v. McQuaig*, 435 So. 2d 414 435 So. 2d 414 (Fla. Ct. App. 1983), a frequently cited state appellate court case also favorable to policyholders seeking a finding of multiple occurrences. *Accord*, *New Hampshire Ins. Co. v. RLI Ins. Co.*, 807 So. 2d 171, 171 (Fla. App. 2002) (three shots fired over course of several minutes from three different locations within apartment complex constitutes three separate occurrences; "[t]he act which causes the damage constitutes the occurrence") (internal citations omitted).

Mississippi Case Restricting Insurance Litigation Discovery Under Gramm-Leach-Biley Act ("GLBA") Withdrawn and Depublished

Other cases read statute not to preclude disclosure pursuant to judicial process. In the last installment of Recent Court Decisions, the Mississippi Supreme Court decision *Equitable Life Assurance Society v. Irving*, So. 2d, 2003 Miss. LEXIS 408 (Miss. 2003) was discussed. In that case, the Court refused to permit plaintiff to discovery the names of others sold "vanishing premium" life insurance policies by the defendant insurer. Plaintiff sought the information on the grounds of attempting to establish a pattern or practice of deceptive marketing and sales of vanishing premium products, which are popular and attractive when interest rate projections are high but fall from favor in times of reduced interest, frequently leading to policyholders feeling deceived when they must continue to pay the premiums that supposedly would vanish. The Court held that the requested information was forbidden to be disclosed because the GLBA prohibits the release by financial institutions of private information absent an

exception to the bar on disclosure. Subsequently, the opinion was withdrawn and ordered depublished. *See Equitable Life Assur. Soc. v. Irving*, 2004 Miss. LEXIS 103 (Miss. Feb. 5, 2004). In addition, two West Virginia decisions have held that discovery is not precluded by the GLBA's privacy provisions. *See Marks v. Global Mortgage Group, Inc.*, 218 F.R.D. 492 (S.D.W.Va. 2003) (finding that claims against noninsurer financial institution may have discovery because of implicit judicial proceedings exception to nondisclosure provisions of federal law); *Martino v. Barnett*, 595 S.E. 2d 65 (W.Va. 2004) (holding that "nonpublic personal information may be subject to release pursuant to judicial process" in claim involving insurer and information about policyholder defendant).

Health Plan Required Under State Law to Provided Coverage for Prescription Contraceptives

In *Catholic Charities of Sacramento, Inc. v. Superior Court*, 32 Cal. 4th 525, 85 P. 3d 67, 10 Cal. Rptr. 3d 283 (2004), the California Supreme Court held that California's Women's Contraception Equity Act required an employer's health plan to cover prescription contraceptives on the same basis as other medication. *See* 85 P. 3d at 73-4. The employer in question asserted a first amendment exception to the law because of the opposition of the Roman Catholic Church to artificial contraception. The Court rejected the posited federal constitutional exception to the California law. *See* 85 P. 3d at 76-95.

Federal Appeals Court Concludes That Skydiver Is Not a "Passenger" for Purposes of Group Life Insurance Coverage

See Adams v. Continental Casualty Co., 364 F. 3d 952 (8th Cir. 2004) (applying federal common law of ERISA) (employee killed while skydiving not covered under employer's group accidental death benefits policy; Although policy provided "air travel" coverage while "riding as a passenger, and not as a pilot or crew member, in any aircraft being used for the transportation of passengers," there was also an exclusion for "riding in any vehicle or device for aerial navigation "; although a court could feasibly regard these textual provisions as sufficiently unclear to invoke the contra proferentem principle or resorted to maxim of construing exclusions narrowly and against insurer, court showed no interest in doing so, probably because of the inherent danger of skydiving and common sense distinctions between parachuting out of an airplane and riding an airplane).

Colorado Supreme Court Finds Damages Available for Emotional Distress May Be Available as Remedy for Insurer Bad Faith Even in the Absence of Proof of Physical Injury

See, e.g., Goodson v. American Standard Ins. Co., 89 P. 3d 409, 411 (Colo. 2004) ("in a tort claim against an insurer for breach of the duty of good faith and fair dealing, the plaintiff may recover damages for emotional distress without [the need for also] proving substantial property or economic loss").