Recent Court Decisions

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Supreme Court Endorses Broad ERISA Preemption of Pure Eligibility Determinations by Plan Administrator; Federal Court the Exclusive Forum for Such Claims; Overlapping State Law Causes of Action Not Permitted

Aetna Health, Inc. v. Davila, 124 S. Ct. 2488, 159 L.Ed. 2d 312, 72 U.S.L.W. 4516, 2004 U.S. LEXIS 4571 (United States Supreme Court—March 23, 2004)

Juan Davila was a participant in an employer-provided benefit plan subject to ERISA (the Employee Retirement Income Security Act of 1974) and Ruby Calad was a beneficiary under another such plan. Under the terms of Davila's plan, administered by Aetna Health, Inc. (formerly Aetna U.S. Healthcare), requests for coverage and payment to health-care providers are reviewed by Aetna. Cigna Healthcare of Texas provided similar administration of Calad's plan.

Davila experienced arthritis pain. His treating physician prescribed Vioxx. Aetna refused to pay for reasons not stated in the Court's opinion but presumably because Vioxx was not a prescription medication included in the plan's coverage for arthritis. Davila did not contest or appeal this decision and did not buy Vioxx on his own. Instead, he purchased Naprosyn, "from which he allegedly suffered a severe reaction that required extensive treatment and hospitalization." *See* 124 S. Ct. at 2493.

Calad underwent surgery. Her treating physician recommended an extended hospital stay. However, a CIGNA discharge nurse "determined that Calad did not meet the plan's criteria for a continued hospital stay." As a result, CIGNA denied coverage for additional hospital days. Calad "experienced postsurgery complications forcing her to return to the hospital," injury she attributed to CIGNA's failure to extend her hospital stay. *See* 124 S.Ct. at 2493.

Both Davila and Calad sued Aetna and CIGNA, respectively under the Texas Health Care Liability Act ("THCLA," Texas Civil Practice and Remedies Code Ann. §§88.001–88.003), alleging that the defendants had been negligent and failed to exercise adequate care making coverage decisions under the plans and that these failings caused the injuries they experienced. The suits were filed in Texas state court. Aetna and CIGNA each removed the respective cases to federal court, on the ground that ERISA was the exclusive cause of action for such claims and that as such, the ERISA statute completely preempted the Texas state courts (or any state courts for that matter) from hearing the claims.

"Removal" is a legal device in which a case originally filed in state court is transferred to the local federal court pursuant to statute (28 U.S.C. §§1441–1448) because of the dominance of federal claims and the defendant's right to have the claims heard in a federal court, which is historically presumed to be less hostile to nonresident defendants and more competent in construing federal claims so that the defendant's rights are fully considered under federal law. Where a mixture of federal and state claims or causes of action (theories for requesting relief, such as breach of contract, commission of a tort, trespass upon property) is made in a complaint, the presence of the federal claim is generally enough to justify the removal of the case to federal court.

The Davila and Calad claims were a bit unusual in that neither expressly based claims for relief upon ERISA but rather drafted the complaints to allege only violation of THCLA and other state claims, without mentioning ERISA. The defendants were only too happy to point out in their removal papers that the claims inherently involved employee benefit plans subject to ERISA. From this, the defendants argued that removal from state to federal court was not only proper but was in fact required even if the Davila and Calad complaints did not specifically plead ERISA violations and claims. Further, and perhaps more important for purposes of benefits law, Aetna and CIGNA argued that they were not only entitled to a federal court forum for the dispute but that the same complete preemption that required removal prevented suit against a plan administrator under the Texas state law.

Generally, the existence of federal claims is determined by examining the face of the complaint. Consequently, a plaintiff may often avoid removal to federal court by simply not pleading any federal cause of action in the complaint. However, there is an exception to the "face of the complaint" test for determining the existence of federal jurisdiction and the propriety of removal.

> "When a federal statute wholly displaced the state-law cause of action through complete pre-emption," the state claim can be removed. *Beneficial Nat. Bank v. Anderson*, 539 U.S. 1, 8, 156 L.Ed. 2d 1, 123 S. Ct. 2058 (2003). This is so because "when the federal statute completely pre-empts the state-law cause of action, a claim which comes within the scope of that cause of action, even if pleaded in terms of state law, is in reality based on federal law." *Ibid.* ERISA is one of these statutes.

See 124 S. Ct. at 2494–95.

Aetna and CIGNA invoked this doctrine to seek removal. The defendants' argument, based on substantial lower court precedent, was that in a claim involving alleged wrongful denial of benefits under an ERISA-regulated plan, the case is inherently one subject exclusively to ERISA and not to any state statutes or state common law causes of action. This is the doctrine of "complete preemption" relied upon by Aetna and CIGNA in removing the cases to federal court.

When a properly completed petition for removal is made, the state court has no discretion and must send the matter to federal court. Once the case is in federal court,

the plaintiff (who obviously prefers the state court because he or she originally filed in state court) may ask the federal court to remand the matter to state court. Davila and Calad both requested remand and both were rebuffed by the federal district courts. At this juncture, with attempts at remand having failed, Davila and Calad could have amended their complaints to specifically allege violations of ERISA but declined to do so. Finding that in the absence of an ERISA claim, there was no right to sue the plan administrators over a coverage denial, the trial courts both then dismissed the Davila and Calad claims with prejudice. Plaintiffs then appealed to the U.S. Court of Appeals for the Fifth Circuit, which hears appeals from federal trial courts sitting in Texas, Louisiana, and Mississippi.

The Fifth Circuit reversed the remand orders and would have allowed the Davila and Calad suits to proceed in state court. The Fifth Circuit concluded that older precedent supporting a broad view of complete ERISA preemption was no longer correct and that the U.S. Supreme Court's decisions in *Pegram v. Herdrich*, 530 U.S. 211 (2000) and *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002) limited complete preemption to cases where the state law relied upon by a plaintiff was completely duplicative of ERISA's cause of action against plan administrators for wrongful denial of coverage. The Fifth Circuit saw the THCLA not as a law for collecting ERISA benefits (and hence not duplicative of the ERISA remedial measures of ERISA §502(a)) but instead saw the THCLA as a distinct law making plan administrators (e.g., HMOs and insurers) liable to plan members for injuries caused by erroneous denial of coverage.

The Supreme Court granted certiorari to review the Fifth Circuit decisions and reversed in a unanimous opinion. In essence, the Court completely rejected the Fifth Circuit's attempt to separate state laws from those that are congruent with ERISA's remedial provisions and those that grant remedies in addition to requiring coverage. The Court found this distinction too fine to protect the degree of exclusivity intended for ERISA by Congress. According to the Court

> The purpose of ERISA is to provide a uniform regulatory regime over employee benefit plants. To this end, ERISA includes expansive pre-emption provisions . . . which are intended to ensure that employee benefit plan regulation would be "exclusively a federal concern."
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> Therefore, any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted.

See 124 S. Ct. at 2495.

The Supreme Court further found that §502(a) of ERISA was in particular intended to be the exclusive remedy of a plan participant or beneficiary in the event of wrongful denial of benefits by the plan administrator. If a plan participant's claim against the administrator is "within the scope of §502(a), it is preempted by §502(a) and any

state law claims the participant might have had are precluded and/or folded into the §502(a) claim and become subject to 502(a) remedies alone."

In the Davila and Calad matters, the Court found that both complainants could have either challenged the denial of benefits or paid for the benefits (Vioxx or more days in the hospital) and then sought reimbursement from the plans. Consequently, their claims could have been presented as garden variety 502(a) claims for relief under ERISA rather than THCLA claims for damages for injury caused by wrongful denial of benefits. The Court was unwilling to allow Davila and Calad to avoid ERISA by refusing to participate in ERISA's remedial provisions and then instead suing under state law.

Davila and Calad took the position that they were not so much ducking ERISA as they were attempting to use state law to challenge the plan's incorrect determination of their medical needs as well as their contractual rights to coverage. Consequently, argued Davila and Calad, they were attacking "mixed" decisions of medical treatment and coverage eligibility. According to the plaintiffs, mixed decisions of this sort were not entitled to the same time of preemption protection accorded to "pure" eligibility decisions. The Court rejected this argument and attempt to deploy *Pegram v. Herdrich* (which established as a matter of national law the categorization of mixed medical and eligibility decisions). The Court reasoned that under the Texas law, there could be no liability if the plan's denial of eligibility for payment of a particular medical treatment was correct as a matter of the plan's provisions for eligibility. Consequently, reasoned the Court, the Texas law directly overlapped with or interfered with the plan's discharge of its ERISA-based determination of benefits, which was subject to specific federal regulation and a specified federal right of relief in the event of wrongful denial of coverage. *See* 124 S. Ct. at 2497-2498. The Court further reviewed the Fifth Circuit's reasons for reaching a contrary result and found "all of them erroneous." *See* 124 S. Ct. at 2498–2500.

In addition, Davila and Calad argued that the Texas law was one regulating insurance and thus was saved from ERISA preemption by the "saving clause" of the statute, which provides that ERISA does not preempt state insurance regulation. Unfortunately for them, however, this argument was not raised at the trial or the appellate level, a delay that as a practical matter hurt its chances of being accepted. Supreme courts and appellate courts may consider an argument not made at trial to have been "waived" by the party that failed to make it and also generally assume that an argument that was not raised at trial but was only recognized later in the litigation is something of a make-weight argument created by the party after it has seen mixed success with its other arguments.

Irrespective of the practicalities of litigation, the Supreme Court rejected the argument on doctrinal grounds. In particular, the Court found that the McCarran-Ferguson Act's protection of state insurance regulation did not require a finding that the THCLA was saved from ERISA preemption. In making this determination, the Court cited *Pilot Life v. Dedeaux*, 481 U.S. 41 (1987), an older case taking a very broad view of ERISA preemption that many had regarded as receding beneath the more recent tide of the Court's ERISA cases, which have permitted state law to require mandatory review of benefit denials (*Rush Prudential v. Moran*) and requirements that an HMO accept "any willing provider" (*Kentucky Ass'n of Health Plans, Inc. v. Miller*, 123 S. Ct. 1471

(2003). In *Aetna v. Davila*, the Court reaffirmed *Pilot Life* with some force, stating that

> [In *Pilot Life*, the] Court concluded that "the policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA"
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> [In addition, the Pilot Life Court found a] clear expression of congressional intent that ERISA's civil enforcement scheme be exclusive . . . that [the plaintiff's state law suit asserting improper processing of a claim for benefits under an ERISA-regulated plan is not saved by 514(b)(2)(A) [the provision of ERISA stating that state insurance regulation is not preempted by ERISA]
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> Pilot Life's reasoning applies here with full force. Allowing respondents to proceed with their state law suits would "pose an obstacle to the purposes and objectives of Congress." [citing Pilot Life]. . . Under ordinary principles of conflict pre-emption [the preemption that arises when state law directly conflicts with federal law], then, even a state law that can arguably be characterized as "regulating insurance" will be pre-empted if it provides a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA's remedial scheme.

See 124 S. Ct. at 2500.

Because the Court rejected the plaintiff's argument that the denial of Vioxx and more hospitalization was a mixed medical and coverage decision, it followed that a pure coverage determination by an ERISA plan administrator "is generally a fiduciary act" since plan administrators are fiduciaries under ERISA and may be responsible for penalties under ERISA for breach of fiduciary duty. *See id.* at 2500–2501. But if the plan administrator is not engaging in what can plausibly be classified as "medical maltreatment by a party who can be deemed to be a treating physician or such a physician's employer," the decision of the plan administrator is not generally considered a mixed decision but instead is a pure coverage determination subject to ERISA but not to state law as would be a mixed decision. *See id.* at 2502, quoting *Cicio v. Does*, 321 F.3d 83, 109 (2d Cir. 2003), *cert. pending sub nom. Vytra Healthcare v. Cicio*.

Unfortunately, however, the penalties for such breach provided under ERISA are often considerably less than those provided for comparable misconduct under state law. In here concurrence, Justice Ginsburg pointed this out and implicitly urged Congress to act.

> Because the Court has coupled an encompassing interpretation of ERISA's preemptive force with a cramped construction of the "equitable relief" allowable under 502(a)(3), a "regulatory vacuum" exists: "Virtually all

> state law remedies are pre-empted but very few federal substitutes are provided."

See id. at 2503 (citations omitted).

What neither the majority nor Justice Ginsburg points out is the degree to which this odd, sad situation exists because the Court has from its earliest ERISA decisions, particularly *Pilot Life*, failed to give much consideration to the purpose of ERISA envisioned by the enacting Congress. ERISA was designed to be a federal statute cleaning up a perceived problem of inadequately funded and administered retirement plans. The legislative history of ERISA reflects no significant consideration of group health benefits provided by employers. The expansive preemption provisions of ERISA were designed to prevent state pension or other financial regulations from interfering with the new national scheme for protecting pension benefits. The background of the ERISA's enactment does not suggest that Congress intended to replace a range of state law causes of action (e.g., bad faith claims against insurers, which *Pilot Life* held to be preempted by ERISA when the insurer was operating as an ERISA plan administrator) with a more restrictive federal remedy for workers who got less than they deserved under an employer-provided health-care plan. *See* Jeffrey W. Stempel and Nadia von Magdenko, *Doctors, HMOs, ERISA, and the Public Interest After Pegram v. Herdrich*, 36 *Tort & Ins.* L.J. 687 (2001) (reviewing background of ERISA and preemption cases through *Pegram*). A narrower reading of ERISA's preemption provision would also seem logical in light of the provision saving state insurance regulation from preemption. Prior to *Aetna v. Davila*, it appeared the Supreme Court had been moving away from the expansive preemptive sweep of *Pilot Life* and like-decided cases. After *Aetna v. Davila*, it is obvious that the Court continues to accord broad preemptive scope to ERISA and that any filling of the "regulatory vacuum" will have to come from Congress rather than the Court.

Justice Ginsburg's concurrence did note one area in which greater relief might be accorded plan participants without need for congressional legislation.

> The Government [of the United States as amicus curia] note a potential amelioration. Recognizing that "this Court has construed Section 502(a)(3) not to authorize an award of money damages against a non-fiduciary," the Government suggests that the Act, as currently written and interpreted, may allow at least some forms of "make-whole" relief against a breaching fiduciary in light of the general availability of such relief in equity at the time of the divided bench." [citing to the U.S. brief in the case; at one time, federal courts were divided into separate courts of law that could award monetary damages but not issue injunctions and courts of equity that could issue injunctions or other types of "equitable" relief but not award monetary damages.] As the Court points out, respondents [Davila and Calad] here declined the opportunity to amend their complaints to state claims for relief under 502(a); the District Court, therefore, properly dismissed their suits with prejudice. But the Government's suggestion may indicate an effective remedy others similarly circumstanced might fruitfully pursue.

See id. at 2503.

Of course, in light of the subsequent decision to pull Vioxx from the market, the Health Plan's refusal to authorize Vioxx treatment looks considerably less anticonsumer.

ON REMAND FROM U.S. SUPREME COURT, UTAH SUPREME COURT ORDERS PUNITIVE DAMAGES OF $9 MILLION AGAINST STATE FARM IN BAD FAITH CASE

Campbell v. State Farm Mutual Automobile Ins. Co., 2004 Utah LEXIS 62 (Utah Supreme Court—April 23, 2004); *cert. denied, 2004 U.S. LEXIS 6620 (Oct. 4, 2004)*

In April 2003, the U.S. Supreme Court made news when, during the course of setting aside a $145 million punitive damages award against State Farm, it also set forth new, more restrictive rules for awarding punitive damages. Acting pursuant to the Due Process Clause of the Fourteenth Amendment, the Court held that state courts were restricted in awarding punitive damages based on reprehensibility to actions of a defendant bearing sufficient connection to the state in question. The court further suggested that determining a reasonable relationship between an award of compensatory damages and a punitive damages award, courts should consider the size of the compensatory award. Although a small compensatory award accompanied by really reprehensible conduct might support a relatively high, double-digit multiple of punitive damages, large compensatory awards probably could not sustain such multiples. In particular, the Court suggested that only in rare cases could a large compensatory award be accompanied by a punitive damages award that was more than a single-digit multiple of the compensatory award. *See State Farm Mut. Auto. Ins. Co.*, 538 U.S. 408 (2003).

The *Campbell v. State Farm* case, which arose out of a 1981 auto accident, resulted in a more than $1 million compensatory award to the Campbells (and effectively to their assignees, others involved in the accident) based on the emotional distress inflicted on the Campbells when State Farm failed to settle claims against them within the policy limits of the Campbells' auto policy and then failed to post bond or pay the amount of the excess judgment until years later. The Utah Supreme Court had found State Farm's conduct sufficiently blameworthy that it approved a jury's award of $145 million in punitive damages. The U.S. Supreme Court reversed and remanded for further consideration, holding that the 145 : 1 ratio was simply too much and that the large award was tainted by the Utah courts' consideration of State Farm conduct that took place outside Utah and that appeared to have little or no impact within Utah.

On remand before the Utah Supreme Court, the antagonists recurred to the battle, with State Farm arguing that the proper reading of the U.S. Supreme Court's decision required a maximum ceiling on punitive damages at a 1 : 1 ratio in view of the large compensatory award to the Campbells (actually to Mrs. Campbell and to others who had been injured by Mr. Campbell's negligence in the 1981 accident; Mr. Campbell passed away in 2001). Counsel for the Campbells argued that the record in the case justified a 9 : 1 ratio, an argument that prevailed with the Utah Supreme Court. In an opinion displaying some barely concealed distaste for the U.S. High Court's second-guessing of its earlier decision, the Utah Supreme Court approved a $9 million punitive damages award. Along the way, the Utah Court found that this high an award was

justified by the degree of misconduct by the defendant even without consideration of activity outside Utah.

> The Supreme Court stopped well short . . . of punctuating its disagreement with the evidence we considered in our analysis by pinning State Farm's behavior to a particular location along the reprehensibility continuum. It instead simply issued the mandate that a "more modest punishment for this reprehensible conduct would have satisfied the State's legitimate objectives, and the Utah courts should have gone no further."

See 2004 Utah LEXIS 62 at *11 (citing U.S. Supreme Court opinion, 538 US. at 419–20).

The Utah Court then reviewed the three guideposts for assessing the reasonableness of punitive damages under the Due Process Clause as set forth in the Supreme Court's *Campbell* opinion and its progeny: reprehensibility of defendant conduct; ratio of compensatory damages to punitive damage; and comparable civil and criminal penalties. Based on an analysis of these factors, the Utah Supreme Court found, as it had found in its 2001 opinion rendering the $145 million award that, even considering only Utah-based misconduct, State Farm's conduct was sufficiently blameworthy to merit a large punitive damages award.

> [A]s we observed in Campbell I, State Farm attempted to diffuse the odious nature of its conduct by claiming that it did not "after all, involve murder, torture, or deliberate poisoning of the environment." [However,]
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> State Farm expressly assured the Campbells that their assets would not be placed at risk by the negligence and wrongful death lawsuit brought against them. The company then unnecessarily subjected the Campbells to the risks and rigors of a trial. State Farm disregarded facts from which it should have concluded that the Campbells faced a near-certain probability of having a judgment entered against them in excess of policy limits. When this probability came to pass, State Farm withdrew its expressions of assurance and told the Campbells to place a "for sale" sign on their house. These acts, all of which the [U.S.] Supreme Court conceded that State Farm had committed . . . and for which State Farm has not voiced so much as a whisper of apology or remorse, caused the Campbells profound noneconomic injury.

See id. at *19–*21.

In addition, the Court noted that the Campbells suffered significant damage from the insurer's conduct and that State Farm should have known this was likely in light of their vulnerability. Further, the Utah Court did not see State Farm's treatment of the Campbells as isolated misconduct but rather as part of a more widespread effort to attempt to save money in settling third-party claims against policyholders even though this put the policyholders at risk of jury verdicts and judgments in excess of amount of insurance available to the policyholder.

Reading the U.S. Supreme Court's decision as setting forth a near-insurmountable upper limit of a single-digit punitive: compensatory ratio in cases of large compensatory awards, the Utah Court found that a 9 : 1 ratio was apt. Rejecting State Farm's call for a 1 : 1 ratio, the Utah Court found that the instant matter was not

> a proper case to limit a punitive damages award to the amount of compensatory damages. The 1-to-1 ratio between compensatory and punitive damages is most applicable where a sizeable compensatory damages award for economic injury is coupled with conduct of unremarkable reprehensibility. This scenario. . . does not describe this case.
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> When considered in light of all of the [reprehensibility factors approved by the U.S. Supreme Court], we conclude that a 9-to-1 ratio between compensatory and punitive damages, yielding a $9,018,780.75 punitive damages award, serves Utah's legitimate goals of deterrence and retribution within the limits of due process.

See id. at *28–*29.

Although state law provides for civil and criminal penalties of "only" a few thousand dollars for fraud and misconduct, the Utah Court did not see these statutory penalties as requiring punitive damages awards of similarly low amount.

> The nature of a civil or criminal penalty provides some useful guidance to courts when fixing punitive damages because it reflects "legislative judgments concerning appropriate sanctions for the conduct at issue." However, the quest to reliably position any misconduct within the ranks of criminal or civil wrongdoing based on penalties affixed by a legislature can be quixotic. For example, while a $10000 fine for fraud may appear modest in relationship to a multi-million punitive damages award, it is identical to the maximum fine which may be imposed on a person in Utah for the commission of a first degree felony, the classification assigned our most serious crimes.

See id. at *44.

Of course, the Utah Supreme Court neglected to note that convicted felons not only may be fined but usually have to serve significant time in prison. By contrast, a monetary penalty is the only kind of penalty realistically facing a corporation, which as nonnatural entity, cannot be physically imprisoned (although an insurer could lose its license and individual executives implicated in corporate wrongdoing might be imprisoned). Also, it is not entirely clear which way the factor of corporate incorporeality augers concerning punishment. Because a company (corporation or mutual insurer) cannot be imprisoned, perhaps a much larger monetary penalty is required to achieve deterrence. Individuals can be deterred from criminal behavior by relatively small fines because they are also subject to the extreme deterrent power of the prospect of incarceration and deprivation of liberty.

In any event, the Utah Supreme Court has now assessed a very large punitive damages award, albeit not nearly as large as the award struck down by the U.S. Supreme Court.

State Farm filed a petition for a writ of certiorari, arguing that even the 9 : 1 award now in place is too large. The Campbells responded by noting the facts of record that have already twice prompted the Utah Court to conclude that the insurer behaved badly enough over a long enough period with wide enough impact, particularly acute harm to the Campbells, to justify a large punitive damages award. The U.S. Supreme Court denied certiorari, letting the case fade into history rather than further disrupting the evolving post-*Campbell* law of punitive damages.

INSURER HAS DUTY NOT TO MISREPRESENT SCOPE OF COVERAGE OR POLICY LIMITS TO THIRD-PARTY CLAIMANT

Railsback v. Mid-Century Insurance Co., 680 N.W.2d 652, 2004 S.D. LEXIS 71 (South Dakota Supreme Court—May 12, 2004)

Tina Railsback was a passenger in a car driven by Tom Hauglin. After the accident, Railsback made a claim against Hauglin, alleging negligence and seeking compensation for neck and back injuries. Hauglin was represented by his insurance company, Mid-Century, which had issued a policy to Hauglin with policy limits of $50,000 per person and $100,000 per accident. Acting without benefit of legal counsel and without commencing a formal lawsuit, Railsback negotiated a settlement of $25,000 with Mid-Century.

What otherwise would seem an uneventful case became considerably more significant when Railsback claimed she was misled by Mid-Century adjusters into believing that the Hauglin policy limits were $25,000 per person injured, half of the actual limits. Railsback alleged that had she known the true policy limits, she would not have settled for $25,000 but did so only because she thought this was the Mid-Century policy limit and the most that could reasonably be obtained. (Presumably, Haughlin had few assets of his own for satisfying any uninsured judgment.) Armed with a lawyer for round two of this drama, Railsback sued Mid-Century for defrauding her by misstating the policy limits. The trial court found in favor of the insurer and dismissed the claim, holding (1) that a liability insurer has no duty to speak truthfully to an injured third-party claimant and (2) that Railsback's claim was the equivalent of a direct action against the insurer by a person injured by the policyholder, something forbidden under South Dakota law as it is the case in most states.

The South Dakota Supreme Court unanimously reversed the trial court and remanded for further proceedings. This does not mean Railsback will inevitably win on remand. Railsback and Mid-Century put forth different versions of the facts surrounding the negotiations and settlement. Railsback claims the true facts show she was improperly misled by Mid-Century while the insurer argues that the actual facts at most show only that Railsback misinterpreted the information she received from the insurer. The state Supreme Court opinion is based to a large degree on the civil procedure principle that disputed facts must be viewed most favorably in light of the party seeking trial. Unless it can be show that there can as a matter of law be only one resolution of the facts, plaintiffs like Railsback are presumably entitled to have the jury or judge hear the evidence at trial. However, the Court's opinion not only establishes some clear "do

nots" for insurance companies but also suggests that insurers may in some cases be liable if they take unfair advantage of the claimant's misunderstanding of ambiguous circumstances.

The Supreme Court rejected the trial court's view that all was fair in love, war, and insurance adjusting.

> The relationship between an insurer and a third party claimant is not a fiduciary or confidential relationship. In fact, we have noted that the [liability] insurer stands in the shoes of the insured and therefore, the relationship between the claimant and the insurer is adversarial. The parties deal at arms length and there is no duty on the part of the insurer to disclose the policy limits during settlement negotiations. Therefore, to the extent the trial court held that there is generally no duty to disclose policy limits, it was correct. However, the question here is narrower. Specifically, whether an insurer may knowingly cause or further a claimant's misunderstanding of the policy limits to her detriment.
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> Mid-Century concedes that South Dakota law allows a claimant to affirm a settlement agreement and bring a fraud action against an insurance company without obtaining judgment against the insurance company.

See 680 N.W.2d at 654–655.

In addition, state law precedent established that an insurer may have a duty to disclose policy limits where this was in the best interests of the policyholder (e.g., if this would make resolution more likely and protect the policyholder from an excess judgment). But Mid-Century then argued that in the absence of an insurer's view that full disclosure would benefit the policyholder, the insurer was allowed to play its policy limits cards close to the vest. The Court rejected this view, noting that under prevailing tort law concepts, an action for deceit may lie against a party that does not outright lie but merely takes knowing and unfair advantage of another party's misunderstanding.

> Assuming all facts in favor of Railsback, there is a genuine issue of material fact whether the insurer deceived or defrauded her or made misrepresentations in the settlement negotiations . . . Drawing inferences from the facts in the record in favor of Railsback, it could be reasonably inferred that the adjusters were aware of and exploited her misinformation regarding the policy limits.
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> We do not accept the insurer's argument that an insurer never owes a claimant a duty to disclose policy limits just because it is an adversarial relationship.

See 680 N.W.2d at 655–56.

As to the issue of whether Railsback's suit was an impermissible "direct action" against the insurer, the court agreed with the general proposition that an absence of contractual privity between insurer and third-party claimant generally prohibits a third-party from suing the insurer for transgressions such as bad faith toward its policyholder, failure to negotiate, failure to accept a reasonable settlement demand, and so on. However, the Court saw Railsback's claim not as an impermissible direct action against an insurer for mistreatment of the policyholder. Rather, Railsback's claim was one arising not from the insurance contract but from tort-like duties not to mislead or deceive an adverse party in a legal matter. In particular, the Court found that it would not be logically consistent to require a defendant to deal in honest fashion with a plaintiff but then allow the defendant's insurer cart blanche for deception. According to the Supreme Court, the trial court decision

> would remove all rules of fair dealing in settlement negotiations between third-party claimants and insurance companies. The inequity of the determination can be clearly seen by the following example. If the tortfeasor was uninsured, and he and the claimant entered into settlement negotiations, the tortfeasor would be required not to defraud, deceive or make misrepresentations to the claimant. Under the trial court's interpretation of "direct action," the insurer, which stands in the shoes of the insured, has no such duty and cannot be held directly accountable. [This would create an untenable situation in which:]
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> First, insurance companies would have everything to gain and nothing to lose by systematically defrauding tort claimants into accepting low settlement offers.
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> Second, the opportunities for overreaching and committing fraud in releases of tort claims may be greater than in typical cases of commercial contract fraud, where the parties are more often on an equal footing.

See 680 N.W.2d at 657, quoting *DeSabatino v. United States Fidelity & Guar. Co.*, 635 F. Supp. 350, 355–56 (D. Del. 1986). In addition, the Supreme Court found that Railsback's action was not one arising "under the terms of the policy" and hence was not barred by South Dakota's ban on direct actions against the insurer for claims against the policyholder. *See* 680 N.W.2d at 657–58.

The *Railsback* opinion seems sensible in stating that minimal standards of honesty apply to opponents in legal matters. Although Railsback was negotiating informally with Mid-Century, the situation was obviously not far removed from litigation, which was the logical next step if an accord were not reached. Had the matter been in litigation, either policyholder Hauglin or his insurance company-appointed lawyer would have been required not to make misrepresentations to Railsback or to engage in similar deception. Although there is not a wealth of case law on the topic, it also seems logical to conclude that an insurer brokering a settlement of an auto accident

claim cannot lie or mislead without providing the plaintiff with grounds for setting aside the settlement.

In addition, a legal system permitting such self-serving deception by insurers might be disastrous for the policyholder. What if Hauglin was facing the prospect of an excess verdict? Under the circumstances, a truthful insurer might have been able to settle for the policy limits, protecting the policyholder. But an insurer that hornswaggles the plaintiff into a lower settlement by deception may find the settlement set aside, thereby needlessly exposing the policyholder to uninsured liability in excess of the actual policy limits or otherwise creating problems for the policyholder, particularly if the accident occurs in a small community of which tortfeasor and victim are both members. Presumbably the insurer does this only to save some of its money at the expense of protecting the policyholder—which sounds like bad faith. The mere absence of formal litigation should not bring a different analysis or justify tricking, deceitful behavior by an insurer that would not be permitted during formal litigation.

In addition, the civil rules of federal courts and nearly every state judicial system require that the defendant/policyholder disclose the policy limits or produce the actual policy to a litigation opponent, often without even a formal demand by the plaintiff. Although it may be tempting to say that Railsback got the legal representation for which she paid in "going it alone" against the insurer during informal negotiation rather than retaining counsel, it would make little sense to let an insurer take advantage of a third-party claimant in a manner that could almost never occur in formal litigation, where the rules and the presence of counsel and a supervising court nearly always result in full disclosure about insurance. If insurers routinely refuse to disclose limits or are deceptive when discussing limits during the adjustment process, this potentially creates a perverse incentive for claims to be turned into formal lawsuits simply so the claimant can be sure he or she is getting accurate information about policy limits.

Furthermore, this was an automobile accident insurance case. Each state has laws requiring auto insurance out of a belief that this is necessary regulation to ensure that victims of negligent driving are compensated. This public policy goals would be thwarted if insurers were able to pay less than policy limits for an injury based on concealing the actual amount of available auto insurance rather than on the basis of the severity (or lack thereof) of the claimant's injuries or disputes over the degree of the defendant/policyholder's negligence.

If anything, one can argue that the *Railsback* Court did not go far enough. Perhaps, despite the adversarial nature of the relationship between an auto accident claimant and the defendant driver's insurer, there should be an ironclad duty for the insurer not only to avoid fraud but to affirmatively provide the claimant with accurate and complete information about available coverage and policy limits. Such a rule would not only foster candor in dispute resolution but would also likely make the negotiation process more efficient and reduce litigation. Although full disclosure of limits might encourage some claimants to ask for more than they might otherwise seek, the insurance company would of course be under no obligation to pay a doubtful or inflated claim.

ADMINISTRATIVE PROCEEDING REGARDING ALLEGATIONS OF MEDICAID FRAUD DOES NOT CONSTITUTE POTENTIALLY COVERED "CLAIM" UNDER DIRECTORS AND OFFICERS LIABILITY POLICY

Treasure Valley Transit v. Philadelphia Indemnity Co., 88 P.3d 744 (Idaho Supreme Court—March 25, 2004)

Treasure Valley Transit (TVT), a nonprofit corporation that provides rural public transit for elderly, disabled, and low-income persons was notified in January 1999 that it was being investigated by the Medicaid Fraud Unit of the Idaho Department of Health and Welfare. The investigation focused on TVT's billing practices, where the possibility of fraud was a concern. "Specifically, TVT was suspected for billing [for] services not performed, billing Medicaid more for transportation services than TVT charged to the general public for the same services, and billing for more transportation than was actually provided." *See* 88 P.3d at 746. The Department indicated it might seek a refund of more than $400,000 of improper TVT charges for the 1996–99 time period. In addition, the Department suspended payment on pending TVT billings.

TVT contacted Philadelphia Indemnity, its Directors and Officers liability insurer and requested a defense of its interests in the Department investigation. The insurer refused to defend, taking the position that the Department investigation was not a "claim" within the meaning of the D&O policy. Philadelphia Indemnity's coverage counsel issued a coverage letter taking the same position. In July 2000, TVT and the Department settled the matter. The settlement provided for a Department agreement that TVT had not engaged in fraud and that no refund would be sought. However, the Department was permitted to withhold payment on some pending TVT billings. *See* 88 P.3d at 746.

TVT then approached Philadelphia Indemnity once again, seeking payment of $34,000 for counsel fees TVT expended in connection with the investigation and for payment of $65,000 that TVT viewed as the "damages" it had to "pay" the Department in the form of unpaid pending bills that were allowed to remain unpaid as part of the settlement. As might be expected, the insurer continued to dispute coverage. Its position was sustained by the trial court in a pretrial motion. Specifically, the trial court held that the Department investigation was not a "claim" under the D&O policy and the forgone pending billings were not a compensable "loss" under the policy. The Idaho Supreme Court agreed and affirmed the dismissal of TVT's claim.

The insurance policy defined a "claim" as "[a]ny proceeding before an administrative agency once it has concluded its investigative phase (if applicable)." *See* 88 P.3d at 747. The Court found this definition clear and unambiguous in the context of the dispute. The Department was investigating and did not "conclude" the investigation and then bring any proceeding "before" a Department tribunal or court. Rather, the Department simply resolved the matter with TVT without the necessity for a specific administrative proceeding. *See* 88 P.3d at 747. In addition, the record in the case reflected several references by TVT and the Department an investigation that was "pending" or "ongoing." *See* 88 P.3d at 747. Because there was no adjudication against TVT, there was no "loss" suffered by TVT within the meaning of the policy.

> Because the investigation into TVT's billing practices was still ongoing at the time TVT attempted to tender its defense to [the insurer], there was not a valid claim pursuant to the definition in the insurance policy which created an obligation in [the insurer] to defend, nor was there any loss for which [the insurer] was obligated to compensate TVT.

See 88 P.3d at 748–49.

The *Treasure Valley Transit v. Philadelphia Indemnity* decision is clearly correct, and squares with not only the terms of the specific policy language but also the concept of liability insurance, which generally defends "suits" or formal claims rather than demands or investigations and which generally pays for resulting settlements and judgments rather than for the costs of an investigation.

However, TVT has some ground for consternation since it now has no insurance to indemnify it for a fairly significant settlement that was financially significant and in some ways quite like a litigation settlement. On the other hand, D&O insurance is not generally available to provide a fund for the overall economic losses to a business. Rather, D&O coverage exists to protect insureds from the consequences of a successful claim that would otherwise result in out-of-pocket payments to a claimant. D&O insurance is not supposed to pay for a businesses costs of regulatory compliance and conduct designed to stay on the good side of government regulators. Nonetheless, if the Department's investigation had qualified as a "claim," the issue of whether the abandonment of pending billings was a "loss" would have been a much closer question.

The result in the case also suggests that a policyholder might be more successful in triggering insurance coverage by refusing to settle until a regulator has been forced to commence a formal administrative proceeding against the policyholder. But such a strategy would be a high risk gambit by the policyholder in that it would risk significantly more adversarial relations with regulators, higher defense costs, larger settlement payments or punishment, and negative publicity stemming from a higher profile dispute. Although businesses undoubtedly like to maximize insurance coverage, this is not their prime goal in most cases. Prudent conduct of the business is usually the goal, which suggests that TVT did the smart thing even though they could not get insurance coverage for it.

LIABILITY COVERAGE MAY BE TRIGGERED BY ACCIDENT INVOLVING FOOD DELIVERY WHERE PLAINTIFF ALLEGES FAILURE TO TRAIN AND SUPERVISE. AUTOMOBILE EXCLUSION NOT APPLICABLE AS A MATTER OF LAW

Crist v. Hunan Palace, Inc., 89 P.3d 573 (Kansas Supreme Court—May 14, 2004)

Hunan Palace is a Chinese food restaurant offering take-out and delivery cuisine. In July 1999, Hunan driver De Tong Chen was perhaps a bit too zealous in speeding delivery of Hunan's wares. While on an authorized delivery, Chen crossed the centerline of the road and collided with a vehicle driven by Sunny Crist. Crist sued Chen for negligent driving and also Hunan on a theory that it was responsible via respondeat superior for Chen's driving errors. (Respondeat superior is a legal doctrine that holds that the employer is liable for the torts of an employee if the worker was acting

within the scope of his or her employment at the time he or she acted negligently and caused injury.) Crist also sued Hunan alleging that Hunan as an organization had been negligent in training and supervising Chen.

At the time of the accident, Hunan had no business automobile insurance in force (the policy had lapsed). Hunan turned to its commercial general liability insurer, Utica National, for defense and coverage. Utica denied coverage because the CGL policy issued to Hunan, like most general liability policies, contained an automobile exclusion stating that the insurance did not apply to

> "Bodily injury" or "property damage" arising out of the ownership, maintenance, use or entrustment to others of any aircraft, "auto" or watercraft owned or operated by or rented or loaned to any insured. Use includes operation and loading or unloading.

See 89 P.3d at 576–77.

Crist, Chen, and Hunan reached a settlement, with Crist accepting an assignment of any available insurance of the defendants in return for an agreement not to execute upon the property of Chen, Hunan, or the restaurant's owner. As part of the settlement, the parties stipulated that Hunan had been negligent in its training and supervision of Chen and that this had contributed to the accident and injury. Crist then sought to garnish policy proceeds from Utica, which denied liability and challenged the underlying settlement. The trial court rejected Utica's defenses and held that Utica's CGL policy provided coverage. The Idaho Court of Appeals affirmed, as did the Idaho Supreme Court.

Drawing on similar precedent (*See Marquis v. State Farm Fire & Cas. Co.*, 265 Kan. 317, 961 P.2d 1213 (1998)), the Supreme Court held that despite the intertwinement of a "poor training and supervision of the driver-employee" claim and a "negligent driving by the employee" claim, the CGL policy covered accidentally inflicted injury stemming from the type of policyholder mismanagement alleged by Crist against Hunan. Under these circumstances, there was coverage under a CGL policy that could not be defeated by the contribution of negligent automobile operation by the employee.

Utica argued, however, that *Marquis v. State Farm* should be given a hard look and reversed even though it was a relatively recent decision because it was a 4-3 decision. The *Crist v. Hunan* Court rejected this argument and found that despite the closeness of the *Marquis* Court on the issue, the decision of the majority was nonetheless entitled to stare decisis effect and should not be overruled. Stare decisis is a legal doctrine holding that a court should adhere to prior precedent and refrain from overruling or disregarding a precedent only if the second court concludes that the precedent was either clearly wrongly decided or has been made incorrect due to intervening events. The *Crist* Court found neither condition met, particularly since the reasoning of the *Marquis* Court (that the auto exclusion did not defeat coverage under the CGL policy for mixed claims of bad driving and bad training and supervision) was and remains the majority rule in American courts. *See* 89 P.3d at 578–81 (citing cases and authorities).

Three Justices dissented, perhaps suggesting that the fissures on the Court remained as strong as at the time of the *Marquis* decision. The dissenters agreed with Utica that the *Marquis* decision limiting the reach of the automobile exclusion was inconsistent with other recent Kansas precedent and that the inconsistency should be resolved in favor of overruling *Marquis* and giving broader sweep to the automobile exclusion of the CGL. *See* 89 P.3d at 582.

The dissenters may not be completely convincing as to the issue of stare decisis but they clearly have a good point about the appropriate setting of a boundary between the CGL policy and a business auto policy. The auto policy, to state the obvious, is designed to protect businesses from claims arising out of the use of cars and trucks in their business. The CGL policy is designed to protect businesses from general liability risks. As a result, business auto policies do not provide coverage unless the third-party injury and claim arises out of the "use" of a motor vehicle and CGL policies exclude claims arising out of automobile use.

Although exclusions are to be construed narrowly against the insurer that drafted the policy, the auto exclusion in the Utica CGL policy issued to Hunan was broad in that it purported to exclude coverage for anything "arising out of" use of a motor vehicle. Giving full effect to the broad language of the exclusion would be perfectly consistent with the operation of these CGL and business auto insurance products and should not violate the reasonable expectations of the policyholder. Unfortunately, because Hunan had let its business auto coverage lapse, the Court was under some practical and sympathetic pressure to find coverage so that the innocent third-party victim could be compensated. But is that the correct analysis, notwithstanding that the *Crist v. Hunan* Court saw it as the majority approach in state courts?

"GOOD SAMARITAN" INJURED WHILE ATTEMPTING TO AID CAR ACCIDENT VICTIM SATISFIES USE-OF-MOTOR-VEHICLE TEST AND IS ENTITLED TO PURSUE A CLAIM FOR UNDERINSURED MOTORIST BENEFITS

Butzberger v. Foster, 89 P.3d 689 (Washington Supreme Court—May 6, 2004)

As the saying goes, no good deed goes unpunished. But in Washington, a good Samaritan's actions may be subject to underinsured motorist coverage. In November 1995, Frank Foster was driving his pickup truck on Interstate 5 when it overturned, trapping him inside. Jeffrey Butzberger stopped his car and came over to see if he could help. With tragic irony, Butzberger was killed by another passing, uninsured motorist. Butzberger's estate sued to recover underinsured motorist (UIM) benefits both from Foster's insurer (Allstate) and Butzberger's insurer (T.H.E. Insurance Co.).

The trial court entered an order ruling that Butzberger was entitled to the UIM benefits of his own vehicle but not the UIM benefits provided under the insurance policy covering the Foster pickup truck. The trial court found that Butzberger's injuries arose out of the use of his own car but did not involve the "use" of the Foster vehicle. The Washington Court of Appeals reversed in part, finding that Butzberger could seek UIM benefits under either policy. The Washington Supreme Court affirmed, holding that the injuries arose out of use of both vehicles.

After the Foster vehicle's rollover, Butzberger stopped his car about 75 feet away from the pickup truck and ran over to the truck, where he spoke with Foster for approximately 30–45 seconds. Although the record was not completely clear, it appears that Butzberger was at a minimum in close proximity to the truck (how else could he have conversed with Foster beside a noisy interstate?) and probably was in physical contact with the truck. However, Foster had submitted an affidavit (undoubtedly at the request of his insurer) stating that Butzberger was "a few feet away" from the truck and never was in physical contact with the vehicle. Butzberger was hit by the other motorist after he had stepped away from the Foster truck.

Foster's Allstate policy stated that it provided UIM coverage to "[a]ny person while in, on, getting into or out of an insured motor vehicle" and general liability coverage to "any other person using [the auto] with [the policyholder's] permission." The UIM provisions of the Butzberger T.H.E. policy state that it provides coverage for any person "occupying" the car and defines occupation as being "in, upon, getting in, on, out or off" of the automobile. The T.H.E. policy also states that there is general liability coverage for anyone "using" the vehicle with the policyholder's permission. Neither policy contains a definition of the term "using." *See* 89 P.3d at 692.

The Supreme Court found that Washington law (Rev. Code of Wash. 48.22.030) required that the terms of an auto policy's UIM coverage not be any narrower requiring "use" of the vehicle as a condition of coverage. Consequently, a narrower coverage provision requiring occupation or physical seating in a vehicle cannot reduce the coverage that would be available under a "use" of the vehicle analysis. *See* 89 P.3d at 692–93. Under Washington law, there is a four-factor test for determining whether an injury arises out of "use" of a car or truck:

> (1) there must be a causal relation or connection between the injury and the use of the insured vehicle; (2) the person asserting coverage must be in reasonably close geographic proximity to the insured vehicle, although the person need not be actually touching it; (3) the person must be vehicle oriented rather than highway or sidewalk oriented at the time; and (4) the person must also be engaged in a transaction essential to the sue of the vehicle at the time.

See 89 P.3d at 693, quoting *Rau v. Liberty Mut. Ins. Co.*, 21 Wash. App. 326, 334, 585 P.2d 157 (citations omitted) and citing additional cases.

The *Butzberger* Court eliminated the vehicle orientation factor, considered the other factors and found them sufficiently satisfied to require UIM coverage. Butzberger's estate will still have to prove fault on the part of the uninsured motorist but that seems a forgone conclusion since Butzberger was hit while off to the side of the road in a situation (prior truck flip) that should have alerted following cars to proceed with caution. In other cases, however, there could be real issues of contributory negligence. What if, for example, Butzberger had tried to cross several lanes of interstate traffic by darting out in front of the car that hit him? As to the factors associated with the Butzberger vehicle, the Court found:

- There was a clear causal relationship between Butzberger driving his car (because it placed him on the highway near the Foster accident) and his injury by the underinsured motorist as well as between Butzberger and the Foster truck (because it was the reason Butzberger stopped, left his vehicle, and was ultimately hit and killed).
- Butzberger was clearly in close proximity to both his car and to the Foster truck, even if he was touching neither at the precise moment that he was hit.
- Butzberger was doing something (traveling on an interstate) for which use of a motor vehicle was essential.

See 89 P.3d at 693–96. The Court also found that under Washington law, the use of an insured vehicle does not need to be the "proximate" or legally adequate cause of an injury but rather need only be an actual contributing cause (a "but for" cause [the injury would not have taken place but for the use of the car] or a "cause in fact" of the injury). *See* 89 P.3d at 694.

Rather than address whether Butzberger was "vehicle oriented" at the time of the incident, the Court decided to eliminate this factor from state law for assessing the question of "use" of a motor vehicle.

> [The vehicle orientation consideration] adds nothing to the analysis for purposes of UIM coverage. Additionally, a narrow focus on the injured person's physical orientation toward or away from the insured vehicle I contrary to the broad commonsense assessment of the reasonable expectations of the insured that the causal connection, geographic proximity, and essential transaction factors are designed to foster. Consequently we find it appropriate to abandon the vehicle oriented factor entirely. To the extent [earlier cases are to the contrary] they are overruled.

See 89 P.3d at 696. Had the Court kept vehicle orientation as part of the analysis, it probably could have concluded based on the facts of the incident that Butzberger was "vehicle oriented" at the time he was hit, even though he may have been going between the two vehicles at the precise moment of impact. Consideration of this factor, however, would have raised the question of whether he was oriented toward one vehicle at the expense of the other, thereby limiting UIM coverage to only one of the insured autos. With the vehicle orientation factor stripped away, Butzberger's estate was more clearly able to pursue UIM coverage under both the Allstate and T.H.E. policies.

Regarding the Allstate policy and the Foster vehicle, the Court considered whether a policyholder such as Foster could reasonably expect that there would be coverage for a person injured while attempting to rescue the policyholder from his vehicle at the time an underinsured motorist caused injury. Applying the three-factors of causal relation, geographic proximity, and essential use of the vehicle, the Court found that Foster and other similarly situated policyholders should reasonably expect coverage for UIM claims made by persons like Butzberger. According to the Court:

> Rescuing a stranded driver who is injured or in peril is essential to the continued use of the vehicle, as the vehicle cannot continue to its destination

> until the rescue has been accomplished. We hold a rescue effort to assist an occupant of another vehicle is a transaction essential to the use of that vehicle.

See 89 P.3d at 697.

Regarding the T.H.E. policy covering the Butzberger vehicle, the Court likewise found sufficient connection between use of the vehicle for travel and the efforts of Butzberger to assist another injured motorist.

> There is every indication Butzberger intended to proceed in his vehicle after his rescue effort was complete. The rescue effort was merely part of the process of Butzberger's ongoing travel. This demonstrates Butzberger was engaged in a transaction essential to the use of his own vehicle when he was killed.

See 89 P.3d at 698. The Court also awarded counsel fees to the estate, remanding to the trial court the issue of the reasonable amount of such fees. *See* 89 P.3d at 699. A single Justice dissented in part. *See* 89 P.3d at 699 (Bridge, J., dissenting).

GARAGE AUTO POLICY NOT REQUIRED TO INCLUDE UNDERINSURED MOTORIST COVERAGE

Hodge v. Raab, 85 P.3d 959 (Washington Supreme Court—April 29, 2004)

Although the Butzberger estate was able to pursue UIM claims in the case described above, the same Washington Supreme Court found that UIM coverage was not available under a garageowner's policy issued by Mutual of Enumclaw to Larry Raab's Auburn Valley Chevron. The garageowner's policy is an insurance product designed to provide liability coverage for gas stations and auto repair shops that regularly are working with vehicles that they do not own, occasionally driving the vehicles short distances to test repairs or look for mechanical problems. The Raab policy stated that Mutual would pay for damages the garage incurred due to bodily injury "resulting form garage operations." However, the policy excluded coverage for [a]ny auto used in connection with garage operations but not customer vehicles. An endorsement to the policy provided liability coverage for injury arising out of the use of customer vehicles in connection with garage business but specifically excluded claims made by employees. But the policy did not include uninsured motorist (UM) coverage. *See* 88 P.3d at 960.

Sure enough, an incident took place at the garage that challenged the gaps in the garageowner policy. Mark Hodge, a mechanic at the Haas Chevron, was working on customer Thomas Pullman's truck when "the customer engaged the ignition of the truck, causing the vehicle to lurch forward and pin Hodge against the wall of the garage." Pullman had no auto insurance. Hodge, therefore, sought coverage under the garage policy, only to find that it provided no UM coverage. Hodge then argued that state law required Mutual to offer or provide UM coverage in a garage policy, just as an insurer must offer or include UM coverage for personal auto policies. *See* 88 P.3d at 960.

The trial court rejected Hodge's argument, as did the Court of Appeals. The state Supreme Court, framed the issue as "whether a general liability garage policy that provides coverage for customers' vehicles is required by [state statute] RCW 48.22.030(2) to include uninsured motorist protection." *See* 88 P.3d at 961. The Court found no such requirement in the statute. "The statute does not mandate coverage in connection with every type of liability policy that will cover damages caused by vehicles." *See* 88 P.3d at 961.

> The policy at issue in this case provides general liability protection for garage operations, which is limited to property damage and nonexcluded bodily injury claims involving nonowned vehicles.
>
> * * *
>
> The policy in question is a general liability garage policy which provided coverage for garage operations. The policy was not issued to cover vehicles owned by the insured, but it does provide coverage for customers' vehicles.
>
> * * *
>
> When Mutual issued the policy to Raab it purported to cover accidents caused by customers' vehicles in limited circumstances but specifically excluded claims made by employees. Accordingly, Hodge was exempted from coverage under the terms of the policy and the [state workers compensation law] as Raab's employee. For this reason, Hodge could not prevail under the terms of the policy unless we determine that the general liability garage policy is subject to the statutory requirements. . . .
>
> The Statute contemplates uninsured motorist coverage in connection with new or renewal automobile policies for motor vehicles and insured registers or principally garages in Washington or waive such coverage in writing. . . .
>
> The statute specifically states that "[n]o new policy or renewal of an existing policy. . . shall be issued with respect to any motor vehicle registered or principally garaged in this state unless coverage is provided . . . for the protection of person insured . . ."

See 88 P.3d at 962.

The Court found that the Haas Chevron garage policy was not issued "with respect to" any vehicle subject to the statute. "Here, the accident involved a vehicle Raab neither owned, registered, nor garaged in this State. Therefore, the statutory mandate for uninsured motorist coverage does not apply to this policy." *See* 88 P.3d at 962–63.

The Court implicitly found that the scope of the garage policy was sensible and consistent with reasonable policyholder expectations. It provided coverage for liability that the shop might incur from operating nonowned vehicles in the course of its gas, service, and repair business. However, the garage policy did not cover claims by employees, which are generally subject not to a general liability regime for compensating

injury but to a workers compensation system of compensating workers injured on the job on a no-fault basis according to a schedule of benefits. Hodge could not evade the statutory workers comp scheme by suing Haas Chevron for negligence. Hodge could have obtained greater compensation by suing customer Pullman for negligence but declined to do so since Pullman lacked auto liability insurance.

Under the circumstances, there not only no statutory command that Haas have UM coverage in such cases, there was no public policy reason to require such coverage. The case does, however, perhaps illustrate the degree to which even the best-designed system of interlocking insurance coverage only works when people behave as they are supposed to behave. Customer Pullman failed to have the auto insurance and UM coverage that might have been expected of anyone old enough to own and drive a car. As a result, Hodge may have been undercompensated for his injuries. But this was not the fault of Haas or Mutual.

ECONOMIC LOSS DOCTRINE DOES NOT PRECLUDE NEGLIGENCE ACTION IN ADDITION TO STATUTORY CONSTRUCTION DEFECT CLAIM

Olson v. Richard, 89 P.3d 31 (Nev. 2004) (Nevada Supreme Court—May 12, 2004)

In August 1994, James and Candace Olson contracted to have a home built. The contractor abandoned the project after contracting with Aztech Plastering Co. to perform stucco work on the exterior of the house. Aztech did the stucco work but the Olsons found wanting. In particular, they objected to the rough finish. Aztech added polymer to the exterior of the stucco, but the finish remained rough. Worse yet, stucco fell off in places and the Olsons discovered water intrusion into the home after a rain. Although this is not as big a problem in Southern Nevada as in other parts of the country, it was nonetheless a big problem for the Olsons. They hired a construction expert, who attributed the problem to the poor application of the problematic plaster. In particular, the stucco was applied in a manner that blocked many of the "weep holes" of the windows (exterior egress openings in the windows that allow accumulated rainwater to escape so that the water will not seep into the house).

The Olsons made a claim against Aztech pursuant to the Nevada law known as Chapter 40, which governs construction defect claims. The Olsons alleged negligence, breach of contract, breach of warranty, and negligent misrepresentation. Aztech argued that a negligence claim was not permitted because the applied stucco was not a product and that tort claims for defective construction were precluded under the "economic loss" doctrine unless there was bodily injury or property damage to property other than the structure that was allegedly improperly constructed. The Nevada Supreme Court adopted the economic loss doctrine as a matter of common law in *Calloway v. City of Reno*, 116 Nev. 250, 993 P.2d 1259 (2000).

Calloway was not a Chapter 40 case. Although the statute was enacted before the *Calloway* decision, the construction problems at issue in *Calloway* predated enactment of the statute. Consequently, *Olson v. Richard* presented the Nevada Supreme Court with a case of first impression: do the *Calloway* precedent and the economic loss doctrine operate to preclude a claim of negligence against a builder or subcontractor in a Chapter 40 action, the statutory cause of action for defective construction that has supplanted Nevada common law claims of this type?

The Nevada Supreme Court, with one Justice in vigorous dissent, found that negligence claims against builders are permitted under Chapter 40. The trial court that had ruled in favor of Aztech on the issue and the jury ruled for Aztech. The Supreme Court in *Olson* remanded the case for a new trial with the negligence claim in the case.

Reviewing the language of Chapter 40, the Court found that it "in no way limits a homeowner's recovery to construction defects covered by a contract or warranty." The Court thus "presum[ed] that the Legislature envisioned that Chapter 40 would provide more than just contractual remedies." *See* 89 P.3d at 33. Because the statute (NRS 40.635(2)) also states that the statutory cause of action takes precedence "over any conflicting law otherwise applicable to the claim or cause of action," the Court concluded that *Calloway*, which was a common law decision, did not prevent the statute from permitting a negligence cause of action for construction defects. In addition, the Court noted that at the time Chapter 40 was enacted, the status of the economic loss doctrine under Nevada common law was unclear. Consequently, it could not be inferred that the Legislature intended the economic loss doctrine and the Calloway holding (which clearly came after the statute was passed) to apply to Chapter 40. *See* 89 P.3d at 33.

In dissent, one Justice argued that since Chapter 40 was intended to supplant common law claims for construction defects, the better reading of Chapter 40 was to apply the economic loss doctrine that was now part of the analogous common law. *See* 89 P.3d at 33, 34–35 (Becker, J., dissenting). In particular, the dissent noted that a predecessor version of Chapter 40 had included the word "negligence" but the word was removed in the final version of the bill. *See* 89 P.3d at 35.

The dissent acknowledged concern that a homeowner forced to proceed under a contract theory might encounter barriers to recovery such as lack of privity or warranty disclaimers. However, the dissent argued, this problem would be better met by eliminating or restricting these defenses in the context of homeowners claims rather than permitting negligence actions where there was only economic loss without personal injury or other property damage. *See* 89 P.3d at 36 (citing cases from other jurisdictions that have restricted contract defenses in construction claims).

> A homeowner whose property suffers from construction defects should be able to sue the developer or general contractors for repairs and consequential damages. When the developer or general contractor no longer exist, are insolvent, or possess insufficient funds to pay damages, then a direct suit against the subcontractors should also be available to the homeowners. However, neither issue is presented in this case. The Olsons sued under warranty claims. Privity and disclaimers did not bar recovery. The jury was instructed and heard evidence that the stucco was not applied in a workmanlike manner. They also heard evidence to the contrary. While I do not agree with the result, there is substantial evidence to support the jury's finding that the stucco was not defective. I would affirm the judgment entered below.

See 89 P.3d at 36.

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