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NEW DEVELOPMENTS IN KANSAS INSURANCE LAW

*Robert H. Jerry, II**

The interest of academicians in insurance law has greatly increased during the 1980s. During this period a new one-volume treatise was published,¹ and an older treatise was substantially revised.² Three new insurance law casebooks appeared on the market (one of which has already gone to a second edition),³ an older casebook was updated,⁴ and this author is aware of plans for the publication of three more. The theory of insurance regulation was explored in an important work,⁵ and the law reviews are giving increased attention to insurance law issues. This heightened interest is long overdue; indeed, practitioners who have long understood the relevance of insurance law might profess perplexion that academia took so long to give the field its due. Clearly, the liability insurance crisis of the 1980s, the related issues of tort reform, the dispute over the use of gender in insurance rating, and the implications of AIDS for insurance underwriting have all focused public attention in varying degrees on insurance law and regulation. But these highly visible issues are only a small portion of recent insurance law developments, as anyone involved in the field knows. Insurance is involved in some way in almost every transaction or event that occurs; inevitably, then, new questions and problems continually arise.

Since 1959 the *Kansas Law Review* has encouraged commentary on recent developments in Kansas insurance law.⁶ This article

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1. R. JERRY, *UNDERSTANDING INSURANCE LAW* (1987).
2. R. KEETON & A. WIDISS, *INSURANCE LAW* (abr. student ed. 1988).
3. E. FISCHER & P. SWISHER, *PRINCIPLES OF INSURANCE LAW* (1986); K. YORK & J. WHELAN, *INSURANCE LAW* (2d ed. 1988); R. HENDERSON, *INSURANCE LAW* (1989).
4. W. YOUNG & E. HOLMES, *CASES AND MATERIALS ON THE LAW OF INSURANCE* (2d ed. 1985).
5. K. ABRAHAM, *DISTRIBUTING RISK: INSURANCE, LEGAL THEORY, AND PUBLIC POLICY* (1986).
6. See, e.g., Oldfather, *Insurance*, 8 KAN. L. REV. 308 (1959).

continues this tradition, examining developments that have occurred during the last five years.⁷

I. PROPERTY INSURANCE

A. *The Mortgagor-Mortgagee Relationship*

Normally the owner of real estate subject to a mortgage is required by the mortgagee to purchase property insurance for the mortgagee's benefit. This causes most owners to purchase an owner-mortgagee insurance policy, which contains a clause designating the mortgagee as the loss payee and a "standard mortgage clause." The standard mortgage clause provides that proceeds be paid to the mortgagee "as interests appear" or words to that effect, that the mortgagee's coverage will not be invalidated by any act or neglect of the mortgagor, and that if the insurer pays proceeds to the mortgagee in circumstances in which the mortgagor's coverage is invalid, the insurer will be subrogated to the mortgagee's rights against the mortgagor.⁸ The Kansas Supreme Court reaffirmed this understanding of the standard mortgage clause in *Neises v. Solomon State Bank*,⁹ a 1985 decision.

In *State Farm Fire & Casualty Co. v. Liggett*,¹⁰ the mortgagee, through the inadvertence of the insurance agent who sold the policy to the mortgagor, was not designated as the loss payee on the insurance policy obtained by the mortgagor. Under the terms of the mortgage, the mortgagor was required to purchase insurance for the protection of the mortgagee. Following an earlier Kansas decision,¹¹ the court held that the mortgagee, even though not

7. The coverage of this survey begins where the 1984 survey ended: in the middle of volume 233 of the Kansas Reports and volume 8 of the Kansas Court of Appeals Reports. See Jerry, *Recent Developments in Kansas Insurance Law: A Survey, Some Analysis, and Some Suggestions*, 32 KAN. L. REV. 287 (1984). This Survey will not discuss the tort reform issues that have a very close nexus with medical malpractice insurance rates and coverages. See *Farley v. Engelken*, 241 Kan. 663, 740 P.2d 1058 (1987) (holding unconstitutional the legislation abrogating the collateral source rule in medical malpractice cases); *Kansas Malpractice Victims Coalition v. Bell*, 243 Kan. 333, 757 P.2d 251 (1988) (holding unconstitutional 1986 H. 2661). This survey will also omit *Barnes v. Kansas Dep't of Revenue*, 238 Kan. 820, 714 P.2d 975, *appeal dismissed*, 479 U.S. 911 (1986), in which the court in a four-to-three decision rejected a constitutional challenge to the provisions of the Kansas Automobile Injury Reparations Act pertaining to suspension of a license for failure to maintain insurance.

8. See generally R. JERRY, *supra* note 1, § 53A.

9. 236 Kan. 767, 696 P.2d 372 (1985).

10. 236 Kan. 120, 689 P.2d 1187 (1984).

11. *Robinson v. Breuninger*, 152 Kan. 644, 107 P.2d 688 (1940).

designated as the loss payee, was entitled to the protection required in the mortgage and provided by the policy and possessed an equitable lien upon the proceeds of the insurance to the extent of its interest.¹²

A common fact pattern giving rise to disputes among mortgagor, mortgagee, and insurer involves the alleged or actual arson of the mortgagor. In *Neises* the court considered what burden the insurer must carry to establish that the insured has voided his policy by his own arson. A few courts in other jurisdictions impose a burden on the insurer to establish that a fire loss resulted from the insured's arson; these courts typically require the insurer to prove the arson by "clear and convincing evidence."¹³ The *Neises* court rejected this approach, instead holding that "the insurer's evidence need only be by a preponderance of the evidence or more probably true than not."¹⁴ The court said the insurer's arson defense was fundamentally a claim that the insured committed an unlawful act that constituted a simple breach of contract. As such, the insurer's evidence of the insured's arson "need not be clear and convincing, exclude any reasonable doubt, preclude any other possibility, or be the only reasonable explanation for what occurred."¹⁵

*B. Recovery for Insurer's Breach of Duty to Pay Proceeds:
Attorney's Fees*

Kansas has two statutes relevant to the award of attorney's fees. Section 40-908 of Kansas Statutes Annotated, which dates to 1893, states that the court shall allow a plaintiff a reasonable sum as an attorney's fee for services in any action in which judgment is rendered against any insurance company on any policy given to insure property in Kansas against loss by fire, tornado, lightning, or hail.¹⁶ Section 40-256 of Kansas Statutes Annotated, adopted in 1931, provides that whenever an insurer "without just cause or excuse" fails to pay the full amount of loss and the insured recovers a judgment against the insurer on that account, the plaintiff shall be awarded a reasonable sum as an attorney's fee.¹⁷

12. *Liggett*, 236 Kan. at 126, 689 P.2d at 1192.

13. *See Neises*, 236 Kan. at 775, 696 P.2d at 378 (citing three jurisdictions).

14. *Id.* at 776, 696 P.2d at 378.

15. *Id.*

16. KAN. STAT. ANN. § 40-908 (1986).

17. *Id.* § 40-256 (1986). *See Friedman v. Alliance Ins. Co.*, 240 Kan. 229, 239, 729 P.2d 1160, 1167 (1986) (when insurer refused to pay claim in situation in which there was dearth of other cases and a "good faith question of coverage," awarding attorney fees to successful plaintiff was unwarranted); *Kansas Farm Bureau Ins. Co. v. Miller*, 236 Kan. 811, 820, 696 P.2d 961, 968 (1985) (attorney fees not justified under KAN. STAT. ANN. § 40-256, when insured showed no bad faith on part of the plaintiffs and as there existed a "valid controversy" in the case).

If the legislature intended to replace section 40-908 with section 40-256, it failed to do so; section 40-908 was not repealed. Section 40-908 is narrower than section 40-256 in the sense that it only applies to the specifically enumerated kinds of insurance, but it is broader than section 40-256 in the sense that it calls for attorney's fees whenever the insured prevails in the litigation, regardless of whether the insurer's refusal to pay proceeds was made with "just cause or excuse."¹⁸

In *State Farm Fire & Casualty Co. v. Liggett*,¹⁹ the Kansas Supreme Court held, affirming an earlier holding,²⁰ that sections 40-908 and 40-256 are not inconsistent, and that section 40-908 is not repealed by section 40-256. Accordingly, any insured fitting within the scope of section 40-908 is entitled to attorney's fees, even when the insurer acts in good faith, with just cause, and with a reasonable excuse in refusing to pay proceeds.

In *Liggett*, the mortgagee-bank was not designated as a loss payee and thus was not an insured under the policy. The court in *Liggett* essentially reasoned that the benefits of section 40-908 run to insureds, not to parties who have equitable liens upon the proceeds payable to insureds. As such, the mortgagee-bank was held not entitled to an attorney's fee under section 40-908.²¹ Whether the mortgagee-bank would have been entitled to attorney's fees had it been named the loss payee is not clear from the court's opinion. The court said the "Bank's claim against the insurance carrier was derivative, at least until the claim of the policyholder was defeated";²² this could also be said about a loss payee's claim.²³ The court noted that the insureds did not leave it to the bank to pursue the insurer, but instead actively asserted their own rights;²⁴ this could have occurred if the bank were a loss payee. The court said the bank was not a named insured;²⁵ a bank as loss payee is not the "named insured" either, although the loss payee can be considered an "insured" that is identified in the policy. Normally

18. See *Thomas v. American Family Mut. Ins. Co.*, 233 Kan. 775, 780, 666 P.2d 676, 680 (1983) (attorney fees allowed under KAN. STAT. ANN. § 40-908 when judgment exceeded insurer settlement offer).

19. 236 Kan. 120, 127-28, 689 P.2d 1187, 1193-94 (1984).

20. *Ferrellgas Corp. v. Phoenix Ins. Co.*, 187 Kan. 530, 358 P.2d 786 (1961).

21. *Liggett*, 236 Kan. at 127, 689 P.2d at 1193.

22. *Id.* at 128-29, 689 P.2d at 1194.

23. The coverage for the mortgagee protects the mortgagee's security interest, which is a lien on the property, and as such can be called "derivative" in nature.

24. *Liggett*, 236 Kan. at 129, 689 P.2d at 1194.

25. *Id.* at 129, 689 P.2d at 1194.

the owner-mortgagee policy is considered two policies in one.²⁶ Thus, the mortgagee is an insured, and, it would seem, is entitled to attorney's fees under section 40-908. *Liggett*, however, does not decide this question.

Another uncertainty in section 40-256 is whether the statute allows the recovery of attorney's fees when a liability insurer has breached the duty to defend. It is settled that when an insurer unjustifiably refuses to provide a defense to an insured, the insured who must obtain defense counsel is entitled to recover defense costs as damages for the insurer's breach of contract.²⁷ The unresolved question is whether the insured can recover attorney's fees incurred in bringing an action against the insurer for breach of the duty to defend. Arguably, these attorney's fees are foreseeable, consequential damages naturally arising out of the insurer's breach: if the insurer breaches the duty to defend, the insured will have to hire an attorney not only to defend the underlying suit but also to bring a suit to recoup those damages.²⁸ Yet American courts generally require each party in litigation to bear its own attorney's fees. This principle suggests that the insured suing the insurer for breach of its duties should pay for the insured's own attorney.²⁹

The language of section 40-256 seems directed to failures of insurers to pay claims for proceeds due under policies, not to losses arising when an insured incurs additional expenses due to the liability insurer's failure to provide a defense.³⁰ This is how the court read the statute in *Harper v. Prudential Insurance Co. of America*,³¹ when it stated that attorney's fees shall be allowed "if it appears from the evidence that the insurance company has refused *without just cause or excuse to pay the claim.*"³² To the

26. As stated in *Neises v. Solomon State Bank*, 236 Kan. 767, 696 P.2d 372 (1985), the standard mortgage clause "creates a new and independent contract which entitles the mortgagee to recover under the policy of insurance, notwithstanding the effect of any act or neglect on the part of the owner or mortgagor of the property." *Id.* at 777, 696 P.2d at 379 (citing *Fancher v. Carson-Campbell, Inc.*, 216 Kan. 141, 144, 530 P.2d 1225, 1228 (1975)). *Neises* also stated that the standard mortgage clause "operates as a distinct and separate contract between the insurer and the mortgagee." *Neises*, 236 Kan. at 778, 696 P.2d at 380.

27. See *Spruill Motors, Inc. v. Universal Underwriters Ins. Co.*, 212 Kan. 681, 512 P.2d 403 (1973).

28. See, e.g., *Lanoue v. Fireman's Fund Am. Ins. Cos.*, 278 N.W.2d 49 (Minn. 1979).

29. See, e.g., *Fuller v. Lloyd*, 714 S.W.2d 698 (Mo. Ct. App. 1986); *Heshion Motors v. Western Int'l Hotels*, 600 S.W.2d 526 (Mo. Ct. App. 1980); *Reis v. Aetna Casualty & Sur. Co.*, 69 Ill. App. 3d 777, 387 N.E.2d 700 (1978).

30. See *Jerry*, *supra* note 7, at 308-09.

31. 233 Kan. 358, 662 P.2d 1264 (1983).

32. *Id.* at 372, 662 P.2d at 1274 (emphasis in original).

same effect is *Sloan v. Employers Casualty Insurance Co.*,³³ in which the court stated that "[t]he statute speaks of a company which has 'refused' to pay. This surely contemplates a demand [presumably for payment] which has been denied."³⁴

A broader reading of section 40-256 is suggested by a more recent Kansas case. In *Missouri Medical Insurance Co. v. Wong*,³⁵ the court approved a trial court's apparent finding that both section 40-256 and the insurer's breach of its obligation to defend entitled the insured, who was "compelled to employ independent counsel and [had] incurred attorney fees and expenses in establishing coverage and plaintiff's duty to defend," to a judgment against the insurer for all such attorney's fees, expenses, and costs.³⁶ Although the scope of the holding in *Wong* is arguable,³⁷ the decision provides some support for allowing the insured to recover as damages the attorney's fees incurred in bringing the action against the insurer for breach of the duty to defend. Such a result, however, gives section 40-256 a broader construction than its plain language seems to allow.

Wong made clear that the benefits of section 40-256 belong only to insureds and cannot be claimed by third parties such as tort victims, who have no contractual relationship with the insurer.³⁸

33. 214 Kan. 443, 521 P.2d 249 (1974).

34. *Id.* at 444, 521 P.2d at 251. See also *Insurance Co. of N. Am. v. Medical Protective Co.*, 570 F. Supp. 964, 974 (D. Kan. 1983), *aff'd*, 768 F.2d 315 (10th Cir. 1985).

35. 234 Kan. 811, 676 P.2d 113 (1984).

36. *Id.* at 822-23, 676 P.2d at 122-23.

37. Paragraph 24 of the trial court's finding stated that § 40-256's provisions "are applicable to declaratory judgment actions such as this," thereby indicating that § 40-256 was part of the authority for the award of attorney's fees. *Wong*, 234 Kan. at 822, 676 P.2d at 122. In paragraph 29, however, the trial court stated that "plaintiff had a contractual duty to provide a defense to its insured, defendant Wong, under the terms of its policy, and that includes this declaratory judgment action, aside from any right defendant Wong has to an allowance of fees pursuant to K.S.A. 40-256," thereby suggesting that the contract, and not necessarily § 40-256, was the basis for the award of fees. See *id.* at 822, 676 P.2d at 123. If this is what *Wong* means, the case would be squarely consistent with *Upland Mut. Ins. Co. v. Noel*, 214 Kan. 145, 519 P.2d 737 (1974). In *Noel*, the court held that "[w]here an insurance company denies coverage and the duty to defend under a homeowner's liability insurance policy and brings a declaratory judgment action against the insured to determine that issue, the insured is entitled to recover attorney fees and expenses incurred in defense of the declaratory judgment action if it is determined that there is coverage and a duty to defend." *Id.* at 145, 519 P.2d at 738. *Noel* did not rely on § 40-256, but instead reasoned that the insurer "is obligated under its policy to reimburse the insured Noels for all reasonable expenses incurred at the company's request," and the filing of a declaratory judgment action that the insured was required to defend was deemed such a "request." *Noel*, 214 Kan. at 152, 519 P.2d at 743.

38. *Wong*, 234 Kan. at 825, 676 P.2d at 124.

This result gives the statute an identical construction in the third-party insurance setting and the first-party insurance setting: in no event can noninsureds claim attorney's fees.³⁹

C. *Calculating Actual Cash Value*

A limitation on the proceeds payable under a property insurance policy is that the insured may not recover more than the property's "actual cash value." Sometimes the policy expresses the actual cash value limitation along with a reference to depreciation. At other times the actual cash value limitation stands alone. Except for the occasional reference to depreciation, most policies do not define actual cash value, instead leaving it to courts to determine what the phrase means when the insurer and insured cannot agree on an appropriate adjustment of the loss.⁴⁰

In *Thomas v. American Family Mutual Insurance Co.*,⁴¹ the Kansas Supreme Court determined the meaning of "actual cash value" in a "dwelling owners policy" covering the insured's residence at the time a windstorm caused a tree to fall upon and damage the insured's roof. The insured rejected the insurer's offer to settle the loss, and the insured filed suit seeking damages of 3165 dollars.⁴² The jury returned a verdict of 2545 dollars, which was reduced by the trial court to 2445 dollars to take into account the policy's 100-dollar deductible. The insurer appealed.

The insurer promised in the policy to pay for a covered loss "to the extent of the actual cash value of the property at the time of loss, but not exceeding the amount which it would cost to repair or replace the property with material of like kind and quality within a reasonable time after such loss."⁴³ Thus, the policy lacked a specific reference to depreciation. The court noted that under Kansas's valued policy statute, if the house had been completely destroyed, the policy's coverage (20,000 dollars) would have been deemed the value of the property without any offset for depreciation.⁴⁴ Because the insured's recovery for a total loss would not have been reduced by the property's depreciation, the court

39. See *supra* text accompanying notes 21-26.

40. R. JERRY, *supra* note 1, § 93[d].

41. 233 Kan. 775, 666 P.2d 676 (1983).

42. Cents are omitted in this summary.

43. *Thomas*, 233 Kan. at 776, 666 P.2d at 677.

44. KAN. STAT. ANN. § 40-905(a) (1986) provides that if an improvement on real property is insured against loss by fire, tornado, windstorm, or lightning, and the property is "wholly destroyed," the "amount of insurance written in such policy shall be taken conclusively to be the true value of the property insured, and the true amount of loss and measure of damages."

reasoned that a recovery for a partial loss should not be offset by depreciation.⁴⁵ Also, the court considered it important that the policy lacked a reference to depreciation. The court declined "to read such a provision into the policy," which did "not appear to us to be ambiguous."⁴⁶ Finally, the court noted the insured's reasonable expectations: "we are of the opinion a reasonable person in the same predicament as appellee would not expect depreciation to be considered to reduce and impair his ability to repair his partially damaged dwelling."⁴⁷

If the court in *Thomas* had allowed depreciation to be taken into account in calculating actual cash value, the proceeds paid to the insured would not have been sufficient to replace the roof, and the insured would have been required to contribute additional money to the replacement. From one perspective, such a result does not make the insured whole. Yet the insured lost a "used roof" worth much less than a new roof; taking depreciation into account means that the insured is compensated in full for the used roof and is thus made whole. Indeed, if the used roof is replaced with a new roof without any cost to the insured, the insured receives a windfall in the form of a free roof for however long the damaged roof was on the house prior to its destruction. Insurance is not supposed to provide the insured with a benefit exceeding net loss.⁴⁸ The insured who receives a free roof for a period of years, however, arguably receives such an excess benefit.

The insurer's argument would have had more appeal if the insured could have replaced the damaged roof with a "used roof" of like kind and quality at no greater cost than the amount of proceeds recovered. If, for example, the insured had lost a five-year-old car, it would be possible to remedy the loss by giving the insured an equivalent used car. But in circumstances in which the insured cannot go onto the market and use the proceeds to replace what was lost, measuring the insured's loss by the replacement cost (that is, actual cash value without regard to depreciation) is a closer approximation of the insured's actual loss. In *Thomas*, that method of computation happened to coincide with the literal language of the policy, even if the insurer had not intended to compute the loss in that manner.

45. *Thomas*, 233 Kan. at 776, 666 P.2d at 678.

46. *Id.* at 777, 666 P.2d at 678. In so ruling, the court repudiated the analysis in Unified School Dist. No. 285 v. St. Paul Fire & Marine Ins. Co., 6 Kan. App. 2d 244, 627 P.2d 1147 (1981), in which the court defined actual cash value as "cost of repair or replacement, less applicable depreciation." *Id.* at 252, 627 P.2d at 1154.

47. *Thomas*, 233 Kan. at 778, 666 P.2d at 679.

48. See R. JERRY, *supra* note 1, § 41.

As a result of *Thomas*, insurers have changed the policy forms to make clear that the actual cash value computation requires taking depreciation into account. This means that an insured who wishes to be reimbursed for the full replacement cost of property should be certain to purchase that kind of coverage.

It is worth noting that the court in *Thomas* limited its holding to the "facts in this case."⁴⁹ In *Insurance Company of North America/Aetna Insurance Co. v. City of Coffeyville*,⁵⁰ the federal district court, per Judge O'Connor, refused to apply *Thomas* because of different facts. On August 5, 1983, the city's electrical power plant exploded. The policy covering the loss stated that the city was covered "to the extent of the actual cash value of the property at the time of loss, but not exceeding the amount which it would cost to repair or replace the property with material of like kind and quality within a reasonable time after such loss."⁵¹ The city argued that depreciation should not offset the amount of recovery, which would mean that the city would recover approximately 2.6 million dollars for the loss of the power plant instead of approximately 1.7 million dollars. In interpreting the phrase "actual cash value" as meaning replacement cost minus depreciation, the court noted several differences between the facts of *City of Coffeyville* and *Thomas*. In *City of Coffeyville* the policy offered the insured the option of either actual cash value coverage or replacement cost coverage. Having declined replacement cost coverage, the city would not reasonably expect to receive it.⁵² Also, the policy had a special endorsement providing the insured with replacement coverage without deduction for depreciation for losses less than one thousand dollars, thereby suggesting that depreciation would be taken into account for larger losses.⁵³ Finally, another loss was settled by the parties under the same policy by deducting depreciation from the replacement cost.⁵⁴

II. PERSONAL INSURANCE

A. Health Insurance and Assigned-Risk Plans⁵⁵

In 1969 the legislature authorized the Insurance Commissioner to establish an assigned risk plan for individuals who are unable

49. *Thomas*, 233 Kan. at 778, 666 P.2d at 679.

50. 630 F. Supp. 166 (D. Kan. 1986).

51. *Id.* at 169 (quoting *Thomas v. American Family Mut. Ins. Co.*, 233 Kan. 775, 776, 666 P.2d 676, 677 (1983)).

52. *City of Coffeyville*, 630 F. Supp. at 169.

53. *Id.*

54. *Id.* at 169-70.

55. The author gratefully acknowledges the research assistance of David Roberts in preparing this section.

"through ordinary methods" to procure accident or sickness insurance. Under such a plan, Kansas accident and health insurers could be required to provide insurance to an "equitable apportionment" of insureds who were unable to procure coverage.⁵⁶ To date, no mechanism has developed in Kansas under this statute to address the needs of those persons unable to obtain health insurance.

In 1986 the Insurance Department proposed legislation that would have established a pooled risk program in Kansas.⁵⁷ This legislation was not enacted, but the legislature did pass a statute requiring the Insurance Commissioner to collect data from accident and health insurers regarding the number of health insurance risks declined or coverage limitations imposed. In addition, the legislature instructed the Commissioner to report to the Governor and legislature, "no later than the commencement of the 1988 regular session of the Kansas legislature, data obtained . . . along with a proposed plan . . ."⁵⁸ According to the statute, the legislature would review the proposed plan and would decide whether the plan was needed.

In January 1988 the Insurance Department issued its report, which concluded that "a need for a risk pool arrangement, however small it may be, has been identified."⁵⁹ The Department recommended establishing "a pooled risk program to be administered either through a risk assignment mechanism or through a single plan administered by a selected insurer or administrator."⁶⁰ The Department's recommendation was proposed in the 1988 legislature as Senate Bill 674; this bill was based on model legislation prepared by the National Association of Insurance Commissioners ("NAIC").⁶¹ This bill died in committee, but the Senate did pass a resolution calling for an interim legislative study on the issue.⁶² In December 1988 the Special Committee on Commercial and Financial Institutions released its report, which recommended "that no legislation be enacted that would direct or authorize the creation

56. KAN. STAT. ANN. § 40-2112(a) (1986).

57. KANSAS INS. DEP'T, ACCIDENT AND HEALTH RISK POOL REPORT Jan. 1988, at 1.

58. Act approved Apr. 11, 1986, ch. 178, 1986 Kan. Sess. Laws 840, 841 (codified at KAN. STAT. ANN. § 40-2111(c) (1986)).

59. KANSAS INS. DEP'T, *supra* note 57, at 6.

60. *Id.* at 3. According to the Department's report, about 15 states have enacted legislation creating risk pools; 9 of those pools are currently active, and the other 6 are expected to become active sometime during 1988. *Id.* at 5.

61. See Model Health Insurance Pooling Mechanism Act, I MODEL LAWS, REGULATIONS & GUIDELINES (Nat'l Ass'n of Ins. Comm'rs) 145-1 (Apr. 1984).

62. See S. Res. 1882, 1988 Kan. Senate Journal 1782.

of a health and accident pooling mechanism in Kansas at this time.”⁶³ The Committee was influenced by the high potential cost of the program (approximately 4.8 million dollars in the tenth year of operation) relative to the number of persons projected to be assisted (approximately 3000 persons).⁶⁴ The Committee also noted an ongoing study of the needs of the medically indigent, however, and left open the possibility that risk pooling might be appropriately discussed at a later time in the context of this broader issue.⁶⁵

B. Limits on the Time Between Accident and Death

Most accidental death benefit endorsements to life insurance policies (the so-called “double indemnity” provisions) require the accidental death to result within a specified number of days, usually 90 or 120, after the injury causing the death. These clauses essentially provide a contractual limitations period after the expiration of which the insurer is certain that the beneficiaries will not claim that the death was accidental. Part of any insurer’s concern is that when a person with severe injuries survives for a long period after an accident, the probabilities increase that the ultimate death will result from a nonaccidental cause, which should not entitle the beneficiary to double indemnity benefits. In such circumstances, the limitations clause minimizes the uncertainty regarding what caused the insured’s death.

In recent years, however, medical advances have made it possible to prolong life for extended periods of time, thereby increasing the likelihood that someone injured in an accident will survive the limitations period before succumbing to an injury. This could create a perverse incentive for the insured or a beneficiary to refuse or withhold life-lengthening treatment to enhance the chances that the presumably inevitable death will occur within the ninety-day period. This situation has led to the argument in several cases that the limitation periods violate public policy and are therefore void. Some courts have accepted this argument, whereas others have enforced the limitations clauses as written.⁶⁶

63. *RE: Proposal No. 11—Funding an Accident and Health Assigned Risk Pool*, in REPORT ON KANSAS LEGISLATIVE INTERIM STUDIES TO THE 1989 LEGISLATURE at 117, 127 (1988).

64. The fiscal impact of the Insurance Department’s proposal was evaluated in a private study commissioned by the Department. *See id.* at 125.

65. *Id.* at 126-27.

66. *See generally* R. JERRY, *supra* note 1, § 64[c].

The Kansas Supreme Court considered the validity of these clauses in *Hawes v. Kansas Farm Bureau*.⁶⁷ In December 1980 the insured sustained a deep cut on his hand that healed slowly. Concurrently, he spilled on his hand an antibiotic used to treat his cattle for shipping fever. In mid-March 1981 he became ill and was diagnosed as having aplastic anemia, which can be caused when a substance in the antibiotic is introduced into the human body. He died of the anemia on September 4, 1981. On appeal, it was undisputed that the insured acquired the anemia through accidental means—the spilling of the antibiotic on his cut hand no later than February 1981.

The deceased was the insured on two life insurance policies, each of which had double indemnity endorsements providing benefits if the insured died as a result of accidental bodily injury “within ninety days from the date of such injury.”⁶⁸ The plaintiff, the insured’s beneficiary, argued that the ninety-day requirements were invalid and unenforceable. First, the plaintiff argued that the clauses were unconscionable, but the court held that the doctrine of unconscionability was inapplicable to the limitations clause.⁶⁹ The plaintiff’s second principal argument was that the limitations violated the public policy of Kansas. The plaintiff’s basic point was that a person injured in an accident might base his decision on whether to seek life-sustaining procedures on whether his policies have limitations clauses. The court rejected this argument, observing that it could be used to invalidate a host of reasonable exclusions and limitations in life and health insurance policies.⁷⁰ The court then quoted at length from an Illinois decision, *Kirk v. Financial Security Life Insurance Co.*,⁷¹ in which the court, after surveying both sides of the issue in detail, held that the limitations clause did not offend that state’s public policy. The court took special note of *Kirk*’s point that such limitations have been used for many years in life insurance policies, and any decision declaring the clauses invalid should be made, if at all, by the legislature or the Insurance Commissioner.⁷²

67. 238 Kan. 404, 710 P.2d 1312 (1985).

68. *Id.* at 405, 710 P.2d at 1314 (emphasis omitted).

69. *Id.* at 406, 710 P.2d at 1315. The court quoted at length from *Willie v. Southwestern Bell Tel. Co.*, 219 Kan. 755, 549 P.2d 903 (1976), and stated in a conclusory paragraph that its research revealed no case in which a limitations clause was struck down as unconscionable and that the doctrine was inapplicable.

70. The court referred to exclusions and limitations of covered services contained in medical and health care insurance policies and Medicare. *Hawes*, 238 Kan. at 408, 710 P.2d at 1316.

71. 75 Ill. 2d 367, 389 N.E.2d 144 (1978).

72. *Hawes*, 238 Kan. at 413, 710 P.2d at 1320.

The court in *Kirk* was correct when it observed that no matter which limitations period is chosen, some people will succumb to their injuries one day before the end of the limitations period, and others will succumb one day after the period. Some degree of arbitrariness is unavoidable. Thus, the issue is not so much the length of the clauses, but whether insurers should be allowed to insert the clauses in accidental death benefit policies at all. Some of the arguments attacking the clauses are strong, but eliminating the clauses would undoubtedly cause the issue "what caused the insured's death" to arise in a greater number of cases. This would lead to additional uncertainty and increased costs; the Kansas Supreme Court was unwilling to approve a doctrine that would entail these consequences.

C. *The AIDS Crisis and Insurance Underwriting*

Federal projections state that by the end of 1991, the total number of AIDS cases in the United States will reach 270,000, with 179,000 deaths, unless better treatments are found. In 1991 alone, approximately 54,000 Americans are expected to die as a result of AIDS. Perhaps as many as one and a half million Americans are infected with the AIDS virus, and estimates of the percentage of infected individuals who will progress to AIDS are as high as one hundred percent.⁷³ The potential impact of this crisis on the life and health insurance industry is profound.⁷⁴

Because having the AIDS virus is a risk factor that correlates very strongly with reduced longevity and increased usage of health care services, life and health insurers have a strong incentive not only to test for the virus, but also to use other underwriting guidelines that identify individuals who are in groups in which the virus is more prevalent. On the other hand, many oppose testing for the virus (as well as insurer access to the results of prior tests) on the ground that confidentiality of the test results is difficult to maintain, and applicants whose results are disseminated, even inadvertently, to third parties can suffer greatly on this account.

In September 1987 the Kansas Insurance Commissioner issued a temporary regulation establishing standards for use in underwriting life, accident, and health insurance risks when AIDS is a consid-

73. N.Y. Times, Mar. 16, 1987, at A1, col. 1; *The AIDS Crisis: What it Means for the Insurance Industry*, INS. LITIGATION REP. 282, 282 (1987).

74. See generally Schatz, *The AIDS Insurance Crisis: Underwriting or Overreaching?* 100 HARV. L. REV. 1782 (1987); Clifford & Iuculano, *Aids and Insurance: The Rationale for Aids-Related Testing*, 100 HARV. L. REV. 1806 (1987); Pascal, *Statutory Restrictions on Life Insurance Underwriting of Aids Risk*, 54 DEF. COUNS. J. 319 (1987).

eration.⁷⁵ The temporary regulation, Kansas Administrative Regulation 40-1-36, does not prohibit testing for the AIDS virus. When an applicant is requested to take a test, however, the insurer must obtain "written informed consent" from the applicant, must provide the applicant with "printed material prior to testing containing factual information describing AIDS" and informing the person what steps should be taken if the test results are positive, and must administer a second, more accurate test to substantiate an initial positive test result.⁷⁶ Insurers are allowed to ask diagnostic questions on applications, but insurers are instructed to frame such questions so as not to elicit information on "lifestyle, sexual orientation or other inferential information."⁷⁷ In addition, insurers are instructed that adverse underwriting decisions are to be based on sound actuarial principles.

III. LIABILITY INSURANCE

A. *Multiple Versus Single Occurrences*

In liability insurance, it is sometimes difficult to determine whether there has been one occurrence or multiple occurrences. The majority of courts follow "cause analysis"; the number of occurrences depends on the number of causes. If there is one cause, such as one loss of control of a vehicle or one release of a product into the marketplace, there is one occurrence. A minority of courts follow "effect analysis"; the number of occurrences is viewed from the victim's viewpoint, and each injury is viewed as a separate occurrence. Thus, if an out-of-control vehicle strikes two vehicles in succession, two occurrences have happened; when a product is released into the marketplace and causes injury, the number of occurrences will depend on the number of people injured.⁷⁸

In *North River Insurance Co. v. Huff*,⁷⁹ the federal district court considered whether several different loan swap transactions con-

75. The Kansas regulation was influenced by, but goes considerably beyond, a model regulation proposed by the NAIC in late 1986 titled *Medical/Lifestyle Questions and Underwriting Guidelines, I MODEL LAWS, REGULATIONS & GUIDELINES* (Nat'l Ass'n of Ins. Comm'rs) 162-1 (July 1986). The essence of the NAIC's proposed regulation was a prohibition on use of sexual orientation in the underwriting process or in determining insurability.

76. KAN. ADMIN. REGS. 40-1-36 (temporary regulation effective Sept. 17, 1987).

77. *Id.*

78. See R. JERRY, *supra* note 1, § 65[c].

79. 628 F. Supp. 1129 (D. Kan. 1985).

stituted separate occurrences under a policy that covered the liability of a savings association's directors, officers, and employees. Each transaction involved the same method of financing the loan, and each was part of one loan-swap program. The court did not agree with the insurer, however, that there had been only one occurrence. Instead, the court reasoned that each loan swap involved a separate transaction: the transactions occurred at different times, involved different borrowers, were for different purposes, had different collateral, and did not involve interrelated loans. Also, the court noted that the damage was caused not by the program but by the insured's alleged negligence in making or approving unprofitable loans. As a result, the court concluded that each loan constituted a separate occurrence under the policy.⁸⁰

B. Hazardous Wastes and Liability Insurance Coverage

Hazardous and toxic substances are causing increasingly difficult pollution problems in increasingly diverse settings. The derailed train or overturned truck carrying chemicals has been a risk for years. In the 1980s new problems are emerging. Our nation is discovering that storage tanks buried many years ago are now deteriorating and leaking their contents into the adjacent groundwater. For decades businesses put their chemical wastes into barrels and dumped them, or hired a carrier who then dumped them, at landfills or other sites where no mechanisms existed to confine the chemicals once the barrels began to deteriorate. Our nation now must clean these sites; the price tag for this effort will be enormous. Predictably, those who operate, own, or use toxic waste sites are now being asked to pay for the damages caused by these sites and for the cleanup costs. In many of these situations the operators, owners, and users ask their liability insurers to pick up the tab.

The commercial liability insurance policy in use from the mid-1960s until the mid-1980s covered an "occurrence," which was defined as "an accident, including continuous or repeated exposure to conditions, which results during the policy period, in bodily injury or property damage neither expected nor intended from the standpoint of the insured."⁸¹ Beginning in 1973, some occurrences were excluded from coverage under a "pollution exclusion": if the occurrence was of a kind identified in the pollution exclusion, no coverage would exist. Even if the event fell within the exclusion,

80. *Id.* at 1133-34. In another issue in the case, the insurer was found to have waived a fraud defense by failing to mention it in its reservation of rights letter. *Id.* at 1134.

81. R. JERRY, *supra* note 1, § 65[d], at 337.

however, coverage would exist if the event fell within an exception to the exclusion. If the discharge or other release of pollutants was "sudden and accidental," the exclusion would be inapplicable by virtue of the exception, and the occurrence would be covered. In short, coverage existed under the standard commercial liability form used widely from 1973 until recently if an "occurrence" occurred and the pollution exclusion was not applicable. If the pollution exclusion was applicable, no coverage existed unless the event fell within the exception to exclusion. Needless to say, this policy, which is difficult to describe and even harder to understand, has resulted in an enormous amount of litigation.⁸² Results reached by the courts in the many cases are diverse and frequently irreconcilable.

In a recent Kansas case, *American Motorists Insurance Co. v. General Host Corp.* ("AMICO"),⁸³ a federal district court considered the scope of coverage for pollution damage under the standard commercial liability form. Neighboring landowners sued the operator of a salt company, claiming that careless operation of the salt plant resulted in tons of salt brine polluting the environment, thereby causing the aquifer under their land to become unfit for irrigation purposes. In one of these actions, plaintiffs obtained a judgment for 3.06 million dollars in actual damages and 10 million dollars in punitive damages. The parent company of the operator purchased a liability policy for annual policy periods running from November 1, 1981, to November 1, 1984. A fourth one-year policy was terminated on June 15, 1985. The insurer argued that coverage for the claimed damages was not available under the policies, and the federal district court, per Judge Theis, agreed.

Judge Theis examined the language of the pollution exclusion, which many courts have found ambiguous. Judge Theis, however, agreed with courts that have found the exclusion to be clear: "The meaning of the words 'sudden' and 'accidental' are not so obscure as to make the clause containing them a nullity. . . . The language is clear and plain, something only a lawyer's ingenuity could make ambiguous."⁸⁴ The salt pollution in question did occur over a long period of time (fifty to seventy-five years), and Judge Theis was unable to fit that event within the scope of the exception for

82. For further discussion see *id.* § 65[e]; R. Jerry, *Hazardous Wastes and Liability Insurance*, in UNIV. OF KANSAS DEP'T OF CONTINUING EDUC., ENVIRONMENTAL LAW: THE LAW OF HAZARDOUS WASTE MANAGEMENT (1988).

83. 667 F. Supp. 1423 (D. Kan. 1987).

84. *Id.* at 1428, 1429.

“sudden” events.⁸⁵ Furthermore, Judge Theis found no “occurrence” in the facts of the case:

Without discussing whether defendants intended to pollute the environment, it cannot be gainsaid that such a result should have been anticipated and expected. . . . Without “damage neither expected nor intended from the standpoint of the insured” no “occurrence” can be found to exist; and without an occurrence no coverage is extant.⁸⁶

AMICO involved particularly extreme facts. In many cases, the disputed event occurs during a much shorter period of time. In *AMICO*, as the court noted, the pollution at issue was the cumulative effect of an industrial process that had been ongoing for about seventy-five years, and had been known by the insured to be a potential hazard for about fifty years. Because of those circumstances, Judge Theis is probably correct that most courts reaching pro-insured results in other fact situations would have agreed with his pro-insurer result in *AMICO*.⁸⁷

Interestingly, Judge Theis’s opinion did not bring the litigation to an end. In recent months attorneys for insureds in hazardous waste litigation have focused on statements made by the insurance industry at the time the pollution exclusion was being reviewed by state insurance regulators for inclusion in the commercial general liability policy. In these statements industry representatives asserted that the proposed pollution exclusion did not substantially alter the coverage provided by the standard liability policy. Insureds now argue that, by the insurance industry’s own admission, the pollution exclusion did not significantly narrow coverage, contrary to what many courts have concluded in pro-insurer decisions today.⁸⁸

Relying on “new evidence,” specifically, the recently discovered representations concerning the pollution exclusion made on behalf of the insurance industry to state regulators at the time the pollution exclusion was introduced, the insureds moved to vacate the judgment in *AMICO* under Federal Rule of Civil Procedure 59(e). Judge Theis did not discuss the “new evidence” in detail, and he nevertheless concluded that the evidence supported, rather than contradicted, his prior conclusions.⁸⁹ It is difficult to under-

85. *Id.* at 1428-29.

86. *Id.* at 1430.

87. *See id.* at 1431.

88. *See Claussen v. Aetna Casualty & Sur. Co.*, 676 F. Supp. 1571 (S.D. Ga. 1987); Price, *Evidence Supporting Policyholders in Insurance Coverage Disputes*, 3 NAT. RESOURCES & ENV'T. 17 (Spring 1988).

89. *American Motorists Ins. Co. v. General Host Corp.*, 120 F.R.D. 129, 133-34 (D. Kan. 1988).

stand, however, how the industry's representations in the early 1970s that the pollution exclusion merely clarified existing coverage are consistent with a conclusion that the exclusion restricted coverage. Regardless, the "new evidence" only pertained to the pollution exclusion, and Judge Theis had an independent ground for his decision that had nothing to do with the exclusion: there was no occurrence, and therefore no coverage.⁹⁰

C. *The Duties of the Tortfeasor's Insurer to the Victim's Secured Party*

In first-party insurance when multiple parties have an interest in the insured property (e.g., mortgagor-mortgagee, vendor-vendee, or bailor-bailee), the questions of how much and who the insurer pays arise frequently and often present great difficulty.⁹¹ In *Scholfield Brothers, Inc. v. State Farm Mutual Automobile Insurance Co.*,⁹² the Kansas Supreme Court considered a similar issue in the *third-party* setting. Parrish, the insured, while negligently operating her own vehicle, demolished an automobile owned and operated by Clafer. The Clafer vehicle, which was uninsured, was subject to a lien held by General Motors Acceptance Corporation ("GMAC").

Clafer was, of course, required by her contract with GMAC to keep first-party insurance in force on the vehicle, but she had allowed her insurance to lapse. Pursuant to its contract with Clafer, GMAC was entitled to acquire insurance to protect its own interest, but it had not done so. Had first-party insurance been in force on the vehicle, the insurer would have paid for the loss to the respective interests of Clafer and GMAC and then could have asserted subrogation rights against the tortfeasor, Parrish. This ultimately would have caused the loss to fall on Parrish's insurer. Indeed, even if GMAC were not named as a secured party on the title, GMAC would have had an equitable lien on the proceeds of the insurance up to the amount of the mortgage debt.⁹³

Unfortunately, however, no first-party insurance was in force. Parrish's liability insurer, State Farm, paid Clafer 3681 dollars for the "total loss" of her vehicle and received assignment of the vehicle and title from Clafer. The title showed GMAC as a secured

90. *Id.* at 133.

91. R. JERRY, *supra* note 1, §§ 53-53G.

92. 242 Kan. 848, 752 P.2d 661 (1988).

93. See *State Farm Fire & Casualty Co. v. Liggett*, 236 Kan. 120, 126, 689 P.2d 1187, 1192 (1984) (involving real estate); *Robinson v. Breuninger*, 152 Kan. 644, 648, 107 P.2d 688, 691 (1940) (involving real estate).

party. GMAC refused to assign its interest in the vehicle to State Farm because it had not been paid the debt owed by Clafer. State Farm then returned title to GMAC, which essentially amounted to an abandonment by State Farm of any interest in the vehicle.

After the settlement, Clafer stopped making payments to GMAC. GMAC then exercised its recourse rights and assigned the contract back to the car dealer, Scholfield Brothers, which made Scholfield the owner of the security interest. Clafer later filed for bankruptcy, listing a debt to Scholfield of 3642 dollars. Of course, had Clafer continued to make payments to GMAC (or Scholfield), no party would have been unjustly enriched or unfairly deprived. Unfortunately, however, Clafer obtained the insurance proceeds and then became insolvent, with Scholfield being one of her creditors. If Clafer had possessed first-party insurance, and if the first-party insurer had agreed with State Farm's calculation of the loss, the first-party insurer would have paid 3642 dollars in proceeds to GMAC and 39 dollars to Clafer, thereby making both parties whole. State Farm, however, as Parrish's liability insurer, had paid Clafer for the loss, which resulted in a windfall to the soon-to-be-insolvent Clafer and a loss to Scholfield, as the successor to GMAC.

Having suffered a loss, Scholfield sought to hold State Farm responsible under the theory that State Farm knew of GMAC's security interest, and that when State Farm settled with Clafer, State Farm destroyed GMAC's secured interest, thereby committing the tort of conversion. The essence of Scholfield's argument was that the liability insurer had a duty to make sure that proceeds payable because of its own insured's negligence are paid in a way that reimburses all who hold partial interests in property damaged by the insured. The court rejected this argument, instead reasoning that the debtor, having a right to possession, has a right to receive the full amount of damages, but must hold the proceeds in trust for the secured party in an amount equal to the debt owed the secured party. This means that the tortfeasor has no duty to join the secured party in a lawsuit brought by the tortfeasor, even if the tortfeasor has notice of the security interest.⁹⁴

After *Scholfield Brothers*, secured creditors cannot assume that a liability insurer for the party causing damage to the secured party will pay proceeds to debtor and creditor, as their interests may appear. This is true even if the liability insurer has actual notice of the security interest. Of course, with the first-party insurer, the creditor can insist that a policy be taken out for the

94. *Scholfield Bros.*, 242 Kan. at 851-53, 752 P.2d at 663-65.

benefit of both creditor and debtor, and the insurance industry today willingly cooperates with the creditor's wishes by inserting the standard mortgage clause in first-party insurance policies. In contrast, in the liability insurance setting, the creditor is not in privity with the insurer. After *Scholfield Brothers*, it would behoove a creditor to require in its contract with the debtor that the debtor assign all rights to insurance proceeds recovered as reimbursement for damage to the property that serves as security for the debt to the creditor, and that the creditor collect first out of these proceeds for the amount of the debt.

D. The Duty to Defend and Conflicts of Interest

One of the duties that the insurer owes the insured under a policy of liability insurance is to provide a defense to any claim against the insured falling within the coverage, even if the claim is groundless, false, or fraudulent.⁹⁵ As summarized in *Patrons Mutual Insurance Association v. Harmon*,⁹⁶ the insurer owes no duty to defend the insured when the claims made against the insured fall entirely outside the coverage. The pleadings themselves, however, are not dispositive. The insurer must consider any facts brought to its attention or facts that it could reasonably discover in determining whether there is a duty to defend. If these additional facts give rise to potential liability under the policy, a duty to defend exists.⁹⁷

The insurer will ordinarily provide an attorney to the insured to represent the insured's interests whenever a claim within coverage is made against the insured. The attorney selected by the insurer is obligated, obviously, to represent zealously the insured's interests. Nevertheless, the attorney is retained and compensated by the insurer, creating the potential for the insurer inadequately representing the insured's interests should the insured's and insurer's interests conflict.⁹⁸

One situation in which a conflict between insurer and insured can develop is when a plaintiff's claim does not clearly indicate whether the insured who caused an injury to the plaintiff acted intentionally or negligently. Both the insurer and the insured benefit from arguing that no tort occurred at all. Assuming some tort occurred, however, the insured will want to argue that the tort was negligently inflicted and therefore covered, whereas the insurer

95. R. JERRY, *supra* note 1, § 111, at 561.

96. 240 Kan. 707, 732 P.2d 741 (1987).

97. *Id.* at 709-10, 732 P.2d at 744.

98. R. JERRY, *supra* note 1, § 114.

may want to argue that the tort was intentionally inflicted and therefore was not covered. In such a situation, the insurer's and insured's interests clearly conflict.⁹⁹

*Patrons Mutual Insurance Association v. Harmon*¹⁰⁰ presented this sort of conflict. The insured's son sued the insured for damages arising out of the insured's allegedly negligent killing of the insured's wife (and son's mother). The insurer contended that the killing was intentional, thereby disqualifying the insured from coverage. The court referred to the earlier case of *Bell v. Tilton*,¹⁰¹ in which it held that an insurer's mere retention of an attorney to represent an insured under a reservation of rights does not collaterally estop the insurer from challenging fact findings relevant to coverage in the underlying action. *Bell* presented a similar conflict of interest; the insurer had hired independent counsel to defend the insured in the civil action and had notified the insured that it was reserving all rights under the policy. The court in *Harmon* approved this procedure: "This procedure protects both the insured's and the insurer's interests and rights and eliminates the necessity of multiple suits to determine the same issues. We believe this is the proper procedure to protect the rights of both parties under their contract."¹⁰²

In *Harmon*, the insured, Ron Harmon, held a gun that fired. The bullet struck his wife Karen in the head, killing her. A jury found Harmon guilty of voluntary manslaughter. While the criminal trial was pending, the insured's son commenced a wrongful death action against his father, claiming that he negligently shot and killed the plaintiff's mother. Patrons, the insurer, refused to defend on the ground that no coverage existed under the homeowner's policy. Patrons filed a declaratory judgment action to determine if liability coverage existed under the policy. Before a hearing on Patron's motion for summary judgment was held, the trial judge in the underlying action found that, as a matter of law, Harmon had negligently shot and killed his wife. In the declaratory judgment action Harmon argued that the finding in the underlying action was binding on Patrons in the declaratory judgment action under the mutuality rule of collateral estoppel,¹⁰³ and the court agreed:

99. See *id.* § 115, at 617-18.

100. 240 Kan. 707, 732 P.2d 741 (1987).

101. 234 Kan. 461, 674 P.2d 468 (1983).

102. *Harmon*, 240 Kan. at 712, 732 P.2d at 745.

103. The court articulated a three-part test for mutuality in *McDermott v. Kansas Pub. Serv. Co.*, 238 Kan. 462, 712 P.2d 1199 (1986). The third element of the test is that the party against whom the claim is asserted be a party or in privity with a party to the prior adjudication.

Because Patrons was in privity with a party, Ron Harmon, in the wrongful death action, it was bound by that judgment. An exception to the rule would allow Patrons, the insurer, to refuse to defend its insured in the original action and, if the insured lost, would allow the insurer to relitigate the same issue against its insured in a subsequent action. We are not inclined to create a special exception to the mutuality requirement of collateral estoppel for insurance companies.¹⁰⁴

This reasoning is problematic. Although Harmon was Patrons' insured and it is correct to say that Patrons was "in privity" with Harmon, Patrons could not have represented Harmon in the wrongful death action because its interests were adverse to Harmon's.¹⁰⁵ When interests are adverse, regardless of whether privity is present, the nonparticipating party should not be bound to a fact finding in the action going to a final judgment. As the court itself acknowledged, numerous courts have recognized in this situation that the insurer should not be estopped from relitigating the issue of intent.¹⁰⁶ Without refuting this criticism specifically, however, the court simply stated that the independent counsel approach followed in *Bell* was preferable. Although this may be true,¹⁰⁷ it is not responsive to Patrons' contention that it should not be bound to fact findings in the underlying action because its interests were adverse to those of the insured.

Nevertheless, the court on an earlier occasion had warned that ordinarily a declaratory judgment action should not be used to resolve coverage when a question of fact is the main issue or when the purpose of the action is to try the fact as a determinative issue.¹⁰⁸ This warning is also predicated on a questionable view of collateral estoppel, but as long as the court adheres to this view, insurers should follow the approach recommended in *Harmon*: when the insured's and insurer's interests conflict, appoint independent counsel for the insured, and provide a full defense under a reservation of rights. This should save the coverage issue for possible later litigation and enable the insurer to avoid being estopped to litigate a fact issue determinative of coverage.

E. The Intentional Act Exclusion

That liability insurers have a legitimate interest in excluding coverage for injury or damage intentionally caused by the insured

104. *Harmon*, 240 Kan. at 711, 732 P.2d at 744-45.

105. The court recognized this later in the opinion. *See id.* at 712, 732 P.2d at 745.

106. *See id.* (citing cases).

107. R. JERRY, *supra* note 1, § 114[c][5].

108. *United States Fidelity & Guar. Co. v. Continental Ins. Co.*, 216 Kan. 5, 8-9, 531 P.2d 9, 12-13 (1975).

is not seriously questioned. The premiums charged for liability insurance assume that fortuitous loss is covered; if the insured controls the risk, the ability of the insurer to calculate fair rates is frustrated. Even more obvious is the public policy against indemnifying people for loss caused by their willful wrongdoing.¹⁰⁹ Thus, the typical liability insurance policy excludes injury or damage that is either expected or intended from the standpoint of the insured.¹¹⁰ This phrase has been interpreted at least three different ways in decisions of courts around the nation.¹¹¹

The Kansas Supreme Court faced this issue in *Bell v. Tilton*,¹¹² in which the insured, an eleven-year-old boy, shot a friend in the eye with a BB gun while playing a "game" they had devised. It was undisputed that the insured did not intend to inflict the severe injury on his friend's eye that resulted, but there was evidence that he intended to strike one of the boys at which he was shooting and to cause a sting. The trial court concluded that the insured should have expected an injury to result from firing a BB gun toward his friend's face.¹¹³ The Supreme Court agreed, stating:

[I]t was not necessary for the [insurer] to show [the insured] specifically intended to strike Christopher Bell in the eye with a BB pellet in order to deny liability. Rather, if from the acts, circumstances, and inferences of the case, it appeared [the insured] had the desire to cause the consequences of his acts or he believed the consequences were substantially certain to result, his conduct was intentional and the policy exclusion was operative.¹¹⁴

Applying this test, the court concluded that substantial, competent evidence supported the finding that the insured had acted intentionally in shooting his friend.

It is, of course, arguable whether the insured's conduct in *Bell* met the court's own test. As the court recognized, the insured did not intend to cause the severe injury that resulted. Moreover, it is questionable whether any eleven-year-old boy playing with a BB gun in the unsafe manner involved in *Bell* believes that severe consequences are substantially certain to result, although it can be

109. R. JERRY, *supra* note 1, § 63B.

110. *Id.* at 305.

111. *Id.* § 63B[b], at 306. Under one approach, if the intentional act results in injuries or damage that are a natural and probable result of the act, the loss has been caused intentionally. The majority approach requires that the insured intend both the act and to cause some kind of injury or damage. A third approach requires that the insured have had the specific intent not only to injure but also to cause the particular type of injury suffered.

112. 234 Kan. 461, 674 P.2d 468 (1983).

113. *Id.* at 469, 674 P.2d at 475.

114. *Id.* at 472, 674 P.2d at 477.

said that boys should know (and probably have been told, although they probably do not believe) that severe consequences can result from such action. Nevertheless, the court clearly repudiated a rule that would require the insurer to show that the insured possessed specific intent not only to act, but also to cause the particular kind of injury suffered. The court's own extensive analysis before stating a rule suggests that the court meant to enforce the exclusion whenever the insurer shows that the insured intended both to act and to cause some kind of injury, even though the precise kind of injury resulting is different in character and severity than the kind of injury intended. Intent to injure can, of course, be inferred from the nature of the act and the foreseeability of harm flowing naturally from that act. Consciously firing a BB gun at someone's face easily meets this alternative test, and this is the test that the court probably meant to articulate in *Bell*.¹¹⁵

F. Risk Retention Groups¹¹⁶

In the late 1970s, problems with the availability of product liability insurance caused Congress to consider establishing a federally regulated insurance program for product liability or completed operations risks. In 1981 Congress finally enacted the Product Liability Risk Retention Act,¹¹⁷ which permitted businesses to self-insure through insurance cooperatives called "risk retention groups" and to purchase insurance on a group basis at more favorable rates. Congress contemplated that one licensing state would regulate the risk retention or purchasing group and that restrictions would be placed on the authority of nonlicensing states to regulate the group.

In October 1986 Congress amended the Act to allow the creation of risk retention groups for many other kinds of liability insurance.¹¹⁸ It was hoped that this legislation would increase the availability of liability insurance, and that the availability of this alternative would cause insurers to make their products more affordable. Under the Act as amended in 1986, a risk retention group is a corporation or other limited liability association formed for the primary purpose of assuming and spreading all, or a

115. See R. JERRY, *supra* note 1, § 63B[b], at 308-09.

116. The author gratefully acknowledges the research assistance of David Roberts in preparing this section.

117. 15 U.S.C. §§ 3901-3904 (1982), amended by 15 U.S.C. §§ 3901-3906 (Supp. 1988).

118. Risk Retention Amendments of 1986, Pub. L. No. 99-563, 100 Stat. 3170 (codified at 15 U.S.C. §§ 3901-3906 (Supp. 1988)).

portion of, the liability exposure of its members.¹¹⁹ The group must be licensed or chartered and authorized to do business as a liability insurer under the laws of one state;¹²⁰ this distinguishes the group from the typical liability insurer, which must be licensed in every state where it does business. The Act contains separate and distinct provisions for purchasing groups. The definition of a purchasing group is much less restrictive; a trade association could ordinarily fit within the statutory definition of a purchasing group.¹²¹

In 1983 the NAIC approved its Model Risk Retention Act.¹²² This model act, which was amended in 1987 in light of the 1986 federal legislation, was designed to regulate the formation and operation of risk retention groups and purchasing groups to the fullest extent permitted by federal law. As of October 1988 thirty-three states had adopted the revised model act, one state had adopted the older version, and legislation was pending in one more state.¹²³

During the 1986 session the Kansas legislature enacted a statute authorizing the formation of product liability risk retention groups and specifying certain standards for their regulation.¹²⁴ In the 1987 session the legislature enacted, with only a few departures, the NAIC's revised model act, which closely adheres to the authority granted by the 1986 federal legislation.¹²⁵ As of August 1988, 202 purchasing groups had filed an intention to form in Kansas under the Federal Risk Retention Act of 1986; 39 of those groups had been issued certificates of compliance.¹²⁶ As of the same date forty-three risk retention groups had filed with the Kansas Insurance Department, and thirteen of those, all involving health care providers or medical personnel, had been authorized to operate within the state.¹²⁷

119. 15 U.S.C. § 3901(a)(4) (Supp. 1988).

120. An exception exists for groups chartered as an offshore risk retention group under the 1981 statute. *Id.* § 3901(a)(4)(C)(ii).

121. *Id.* § 3901(a)(5)(A).

122. Model Risk Retention Act, II MODEL LAWS, REGULATIONS, & GUIDELINES (Nat'l Ass'n of Ins. Comm'rs) 705-1 (Jan. 1987).

123. *Id.* at 705-17 to 705-20 (Oct. 1988).

124. Act approved Apr. 14, 1986, ch. 166, 1986 Kan. Sess. Laws 815 (amended 1987).

125. Act approved Apr. 17, 1987, ch. 172, 1987 Kan. Sess. Laws 837.

126. KANSAS INS. DEP'T, NEWSLETTER, Aug. 1988, at 4.

127. *Id.* For further information on risk retention groups generally, see Myers, *Regulatory Authority Under the Risk Retention Act*, 6 J. INS. REG. 72 (1987); Ling, *Development of Association Insurance Captives: Application of the Federal Risk Retention Act to Developed and Developing Countries*, 5 J. INS. REG. 384 (1987); Business Insurance, Oct. 31, 1988, at 1; Bader, *Risk Retention Groups: A Risk-Management Alternative*, J. OF ACCT. Sept. 1988, at 152; Business Insurance, Nov. 21, 1988, at 1.

IV. OTHER MATTERS

A. *Duty to Procure Insurance*

In a variety of circumstances agents and brokers have been held liable under both contract and tort theories for failing to procure insurance for the benefit of an individual or some other entity.¹²⁸ A similar kind of claim arises when an individual alleges that someone unaffiliated with the insurance industry who is in a fiduciary or contractual relationship with that party breached an obligation to procure insurance for that party's benefit.

Clearly, if A enters into a contract with B to purchase an insurance contract for the benefit of B, A's failure to perform its contractual obligation will result in A being held liable to B for breach of contract.¹²⁹ In *Wicina v. Strecker*¹³⁰ the issue was whether a private high school owed a duty to a student-athlete to purchase disability insurance that would protect the student-athlete from financial loss caused by an injury suffered while participating in a school-sponsored athletic activity.

Wicina, a sophomore football player at Bishop Miege High School, suffered severe, permanent injuries during a game. The student medical insurance policy obtained by the defendants (the Catholic high school, the Catholic Archbishop, the school superintendent, the coprincipals of the school, and the insurance agent responsible for advising the school) did not provide lifetime disability coverage for student athletes. The plaintiff alleged that an insurance policy providing lifetime care expenses for catastrophically injured student-athletes was available to the high school through the State High School Activities Association, but the defendants decided not to purchase it.¹³¹ The plaintiff also alleged that the defendants had a duty and obligation to provide for the protection of the student-athletes and that the defendants negligently performed this duty by failing to properly insure the students and by failing to properly advise the students and their parents about the limitations of the coverage.¹³² The district court dismissed

128. R. JERRY, *supra* note 1, § 35[2]-[3].

129. In *Swanston v. McConnell Air Force Base Fed. Credit Union*, 8 Kan. App. 2d 538, 661 P.2d 826 (1983), the Kansas Court of Appeals held that the trial court erred in not allowing the jury to consider whether representations by a credit union in promotional material created a contract between the borrower and the credit union whereby the union promised to procure insurance on the debtor's life sufficient to pay the debt in the event of the debtor's death.

130. 242 Kan. 278, 747 P.2d 167 (1987).

131. *Id.* at 279, 747 P.2d at 169.

132. *Id.* at 280, 747 P.2d at 170.

the plaintiff's complaint on the ground that the defendants had no duty to purchase or to advise the plaintiff about disability insurance. The Kansas Supreme Court affirmed.¹³³

The supreme court first examined section 72-8416 of Kansas Statutes Annotated, which provides with regard to public school districts that "the board of education of any school district *may* purchase insurance contracts" against loss resulting from sickness and injury suffered by students on school premises or during school-sponsored activities.¹³⁴ The court held that the plain language of the statute did not require school districts to purchase insurance for their students' benefit.¹³⁵

The plaintiff next argued that section 72-8501 of Kansas Statutes Annotated, which provides that "the practice of teaching and its related services, including school administration and supervisory services, shall be designated as professional services,"¹³⁶ created a professional-care duty that the defendants breached by failing to procure adequate insurance. The court rejected this argument as well, stating that all of the cases recognizing a professional-care duty involved educational malpractice or the act of teaching; thus, these cases did not provide authority for recognizing a duty to insure.¹³⁷

The plaintiff also argued that the contract between the private school and the student imposed a duty on the defendants to procure insurance. The court noted, however, that the contract between school and student had no express requirement about insurance, and it was unwilling to make a new contract for the parties.¹³⁸ The court distinguished cases in which insurance agents and brokers have been held liable for failure to procure insurance, noting that in the procurement of insurance, educators and school administrators are not subject to the same standard of care as brokers and agents.¹³⁹

Finally, the plaintiff advanced an argument based on the duty of a volunteer: once the school district undertook to procure insurance, it had a duty to perform this duty in a nonnegligent manner. The defendants breached this duty, it was argued, by failing to procure additional disability insurance. The court rejected this argument, noting that the school performed fully what it

133. *Id.* at 279, 747 P.2d at 168.

134. KAN. STAT. ANN. § 72-8416 (1985) (emphasis added).

135. *Wicina*, 242 Kan. at 282, 747 P.2d at 171.

136. KAN. STAT. ANN. § 72-8501 (1985).

137. *Wicina*, 242 Kan. at 283, 747 P.2d at 172.

138. *Id.*

139. *Id.* at 284, 747 P.2d at 172.

undertook to do, that is, to procure medical insurance. The school did not undertake to procure disability insurance, and therefore the plaintiff could not have relied on such an undertaking.¹⁴⁰ Further, the court observed that the failure to obtain insurance did not increase the plaintiff's risk of being injured and that the plaintiff did not rely on the defendants' promise to procure insurance when he decided to play football.¹⁴¹

The court also expressed sensitivity to placing no greater burdens on private schools than the legislature placed on public schools. The court believed that recognizing a duty in this instance would cause private schools to provide no insurance at all, because no liability would attach when the school opted to do nothing, as opposed to the situation in which the school undertook to do something, but then performed the task negligently.¹⁴² For all of the foregoing reasons, the court held there was no common-law, statutory, or contractual duty to properly insure or to advise the plaintiff about the medical insurance purchased by the defendants for the plaintiff.

Although *Wicina* was a unanimous decision, the case involves more difficult issues than the court's unanimity suggests. That football is a violent sport with occasionally serious and sometimes catastrophic injuries is well known. Arguably, a school should no more send student football players onto the practice or game field without helmets than it should send them onto the field without insurance for disabling injuries. Clearly, a school district would be negligent for allowing student football players to engage in a contact scrimmage without helmets; the injury is foreseeable, and the lack of helmets will play an important causal role in the students suffering injury.¹⁴³ By the same token, it is arguably negligent for a school district to allow student football players to engage in a violent sport without adequately securing protection against severe, foreseeable financial loss. By this analysis, the lack of insurance plays a causal role between the injury-causing event and the financial loss. Such a duty, if it exists, is a common-law duty arising out of the fiduciary or contractual relationship existing

140. *Id.* at 286, 747 P.2d at 173.

141. *Id.* at 285-86, 747 P.2d at 173.

142. *Id.* at 286, 747 P.2d at 173.

143. The point about helmets shows the limitations and weaknesses in the volunteer principle in RESTATEMENT (SECOND) OF TORTS § 323 (1963). If the school undertakes to provide equipment for the players, and it provides no helmet, the school could be held liable. To borrow from the court's analysis, using the volunteer principle as the predicate for liability would induce schools to provide no equipment at all when sending players onto the football field. This suggests that the volunteer principle is itself inapt, or the court viewed it too narrowly.

between school and student. The legislature's immunization of public schools from this kind of common-law liability does not necessarily mean that private schools should enjoy the same immunity.

The primary difficulty with the foregoing argument is determining when such a duty to procure insurance ends. Serious injuries are less frequent in basketball, soccer, or swimming, but they sometimes occur. If the school has a duty to procure insurance for its students who play football, what about other sports? In addition, if a duty to procure insurance exists, how much insurance is necessary? Is it negligent to purchase anything less than lifetime disability benefits in unlimited amounts? Insurance agents and brokers are expected to act reasonably, not to assume the worst-case scenario whenever they make recommendations to consumers. Do student-athletes (meaning their parents or guardians) have a duty to protect their own interests, thereby lessening any duty owed by the school? After all, in *Wicina*, the student's family could have purchased first-party insurance for the lifetime losses, but apparently did not do so. Why should the school district bear the risk of the failure of the student's family to protect against these contingencies? Of course, the plaintiff alleged that the school district failed to advise the student's family about the insurance coverages and their limitations. Perhaps the plaintiff wanted to argue that he trusted the school to provide adequate coverage, just as he trusted the coaches to give him suitable equipment. But are not the occurrence of these catastrophic losses as well known by parents of football players as by school officials?

Wicina does not stand alone in holding that schools have no duty to procure insurance for the benefit of their students.¹⁴⁴ Nevertheless, there is something troubling about the result in *Wicina*. If the consternation does not stem from the observation that going on the football field without disability insurance is as ill-advised as going on the field without a helmet, it must stem from the realization, illustrated once again by the facts of *Wicina*, that our nation, as a whole, does a terrible job of providing for the needs of victims of disabling injuries.

B. Private Right of Action under Unfair Trade Practices Statute

All states have adopted the substance, and in many instances the letter, of the NAIC's model act titled "An Act Relating to

144. The court relied extensively on *Friederich v. Board of Educ.*, 59 Ill. App. 3d 79, 375 N.E.2d 141 (1978), which involved similar facts and in which the court reached the same result.

Unfair Methods of Competition and Unfair and Deceptive Acts and Practices in the Business of Insurance.”¹⁴⁵ Kansas has adopted most of the model act as the Kansas Uniform Trade Practices Act (“KUTPA”), codified at sections 40-2401 to 40-2414 of Kansas Statutes Annotated. In several states, courts have considered whether the statute affords a right of action to private parties, or whether the legislature merely intended the statute as a mechanism for administrative enforcement for the benefit of the public at large. Most courts have held that only the insurance department or commissioner has authority to bring an action based upon the act, but there are a few decisions to the contrary.¹⁴⁶

In *Spencer v. Aetna Life & Casualty Insurance Co.*¹⁴⁷ the Kansas Supreme Court held that no tort of bad faith exists in first-party insurance.¹⁴⁸ In so holding, however, the court discussed the KUPTA, noting that the existence of the detailed administrative remedies in the statute cut against recognizing a judicial remedy for first-party insureds aggrieved by their insurers’ conduct. In *Earth Scientists (Petro Services) Ltd. v. United States Fidelity & Guaranty Co.*,¹⁴⁹ a federal district court decision, Judge O’Connor concluded that the Kansas Supreme Court would not imply a private cause of action under the KUPTA. Given the specific language of the statute, which repeatedly refers to the “commissioner’s” power and authority, the existence of separate attorney fee’s statutes for successful insured-plaintiffs in some situations, the legislature’s specific provision for private causes of actions in some other statutes, and the decisional authority in most other jurisdictions, Judge O’Connor’s prediction of how the Kansas Supreme Court would decide the issue is probably correct. If no private cause of action exists, the individual insured aggrieved by an unfair trade practice has two remedies: a suit on the insurance contract or a report to the Insurance Commissioner who might then commence a proceeding under the KUPTA.¹⁵⁰

C. Misrepresentation

As generally understood, the defense of misrepresentation is described as follows:

145. II MODEL LAWS, REGULATIONS & GUIDELINES (Nat’l Ass’n of Ins. Comm’rs) 900-1 (Oct. 1988); see *id.* at 900-11 for respective statutes of adopting states.

146. R. JERRY, *supra* note 1, § 25[b].

147. 227 Kan. 914, 611 P.2d 149 (1980).

148. See Jerry, *supra* note 7, at 298-300.

149. 619 F. Supp. 1465 (D. Kan. 1985).

150. *Id.* at 1470.

A representation is a statement, either oral or written, made by the insured to the insurer which forms at least part of the basis on which the insurer decides to enter into the contract. If a representation (1) is untrue or misleading, (2) is material to the risk, and (3) is relied upon by the insurer in agreeing to issue the policy at a specified premium, the insurer can void the policy or refuse a claim for payment of proceeds on account of the misrepresentation (unless the policy has become incontestable).¹⁵¹

The foregoing statement, which accurately describes the approach followed by most courts, does not include any requirement that the misrepresentation be made intentionally, deliberately, or willfully. A minority of courts have stated that an insurer has no defense unless the insured intentionally committed the misrepresentation, although it is important to note that many of these cases involved misrepresentations of opinion (not fact), which cannot exist in the absence of intent to deceive.¹⁵²

Recently, the Kansas Supreme Court articulated for the first time a general test in an insurance law case for the misrepresentation defense. This occurred in *American States Insurance Co. v. Ehrlich*,¹⁵³ in which the insurer sought to rescind a contract of automobile liability insurance on the grounds that the coinsureds fraudulently misrepresented their marital status. The court stated that a fraudulent misrepresentation requires the following:

A statement by the insured as a fact of something which is untrue, and which the insured states with the knowledge that it is untrue and with an intent to deceive, or which he states positively as true without knowing it to be true, and which has a tendency to mislead, where such fact in either case is material to the risk.¹⁵⁴

The issue in *Ehrlich* was whether the materiality element of the test had been met. The court approved the test of materiality used in virtually all jurisdictions: a representation is material if it induces a reasonable insurer to enter into a contract that it would otherwise have refused or to accept a lower premium than it would otherwise have required.¹⁵⁵ As applied to the facts of *Ehrlich*, this meant the insurer failed to carry its burden that the insured's misrepresentation about his marital status was material to the risk covered by his automobile insurance policy.¹⁵⁶

151. R. JERRY, *supra* note 1, § 102[a].

152. *See generally id.* §§ 102[a]-[f].

153. 237 Kan. 449, 701 P.2d 676 (1985).

154. *Id.* at 452, 701 P.2d at 679.

155. *Id.* at 453, 701 P.2d at 679. *See generally* R. JERRY, *supra* note 1, § 102[d].

156. *Ehrlich*, 237 Kan. at 454, 701 P.2d at 680.

The court also observed that the trial court's refusal to cancel the policy was correct because the insured failed to introduce any evidence that it relied on the misrepresentation regarding marital status.¹⁵⁷ The essence of reliance is inducement: the insurer must be induced by the misrepresentation to issue the policy to the insured. In many cases, it is possible to infer from a misrepresentation's materiality that the insurer relied upon it.¹⁵⁸ *Ehrlich*, however, cautions insurers that raise the misrepresentation defense to introduce specific evidence of reliance, and not to assume that the evidence of materiality is sufficient to satisfy this other element of the defense.

Although it did not affect the outcome of the case, the difficulty with *Ehrlich* is the court's apparent endorsement of intent as an element of the misrepresentation defense. Under the court's formulation of the defense, in Kansas a negligent or accidental misrepresentation is not a basis for a defense by the insurer, even if the misrepresentation is material to the risk. In contract law, when parties contract on the basis of mistaken information in circumstances in which that information is basic to the contract and has "a material effect on the agreed exchange of performances," the adversely affected party is entitled to rescission unless that party bears the risk of the mistake.¹⁵⁹ When an applicant for insurance unintentionally conveys material, false information to the insurer, and the insurer contracts on that basis without its own fault or negligence, the insurer arguably should have no less right to rescind under the insurance law's misrepresentation doctrine than under contract law's mistake doctrine. As long as courts recognize that many questions asked by insurers request the applicant to state belief instead of fact,¹⁶⁰ deleting the intent requirement from the test for establishing a misrepresentation would have no adverse effect on applicants.

157. *Id.* at 455, 701 P.2d at 680.

158. R. JERRY, *supra* note 1, § 102[e].

159. RESTATEMENT (SECOND) OF CONTRACTS § 152(1) (1981).

160. When the insurer asks, "Do you have a heart condition?" the insurer should be understood to ask, "Do you believe that you have a heart condition?" When the applicant answers "no" to the question when the applicant unknowingly has a heart condition, the applicant has not misrepresented a fact because, regarding his belief whether he had a heart condition, he answered the question truthfully and accurately. The question, "Have you been hospitalized during the last year?" seeks a representation of fact, not belief. An inaccurate answer, if material and relied upon, should give the insurer a defense. The insurer should not have to prove that the inaccurate answer was made with intent to deceive.

D. Other Insurance Clauses

To reduce the liability of the insurer when the insured possesses multiple coverages on the same risk, almost all property, liability, and health policies have "other insurance" clauses. These clauses attempt to prioritize or coordinate the coverage of two or more policies that apply to the same risk.¹⁶¹ Sometimes the other insurance clauses in the multiple policies conflict. In *Western Casualty & Surety Co. v. Universal Underwriters Insurance Co.*,¹⁶² a 1983 decision, the Kansas Supreme Court held that when other insurance clauses are in irreconcilable conflict, the clauses are deemed to be mutually repugnant and are to be disregarded. In such instances, the loss is prorated equally up to the limits of the policy with the lower limits.

Western Casualty involved a conflict between virtually identical excess coverage clauses.¹⁶³ In the situation in which one insurer has a pro rata clause and the other has an excess clause, it is possible to "reconcile" the clauses by saying that the policy with the excess clause provides coverage only after the pro rata policy is exhausted. Most courts have so held.¹⁶⁴

In *Farmers Insurance Co. v. Prudential Property & Casualty Insurance Co.*,¹⁶⁵ the Kansas Court of Appeals allowed an uninsured motorist insurer to rely upon an excess clause to escape responsibility for contributing to a death-claim settlement. The excess clause, as applied, made the insurer's responsibility secondary to that of the two other uninsured motorist carriers, who were held to have primary responsibility for the loss. Picking, a passenger in a vehicle operated by Miller, was killed when the Miller vehicle collided head-on with another vehicle operated by Insley. Insley was uninsured; Miller's vehicle was insured by plaintiffs Farmers Insurance and Shelter Insurance. Farmers and Shelter contributed equally to a settlement of Picking's heirs' wrongful death action, and each sought contribution from Prudential, which had issued insurance policies to Picking's mother covering three vehicles. In other words, Picking was entitled to uninsured motorist benefits under five policies issued by Farmers, Shelter, and Pru-

161. R. JERRY, *supra* note 1, § 97.

162. 232 Kan. 606, 657 P.2d 576 (1983). This case is discussed in Jerry, *supra* note 7, at 312-14.

163. *Western Casualty* was applied in *Hennes Erecting Co. v. National Union Fire Ins. Co.*, 813 F.2d 1074, 1077 (10th Cir. 1987), which involved two conflicting excess other insurance clauses.

164. R. JERRY, *supra* note 1, § 97[d][1].

165. 10 Kan. App. 2d 93, 692 P.2d 393 (1984).

dential. Prudential, however, refused to contribute, arguing that its policies were excess over the Farmer's and Shelter's policies by virtue of an excess other insurance clause in the Prudential policies.

The plaintiffs argued that Prudential's clause diluted the coverage required by the uninsured motorist statute, but the court of appeals disagreed, noting that the loss suffered by Picking's heirs was reimbursed in full by the Farmers and Shelter policies.¹⁶⁶ Accordingly, there was no frustration of the compensatory objective of the uninsured motorist statute. The court of appeals further observed, as had the court in *Western Casualty*, that "there is no reason that, once assured full coverage will be afforded the insured, the insurers cannot be permitted to attempt to make their coverage secondary to the coverage of others."¹⁶⁷ The court of appeals acknowledged that "if several insurers have an equal claim to secondary status, the provisions relied upon may be disregarded as mutually repugnant and the insurers forced to share pro rata," as contemplated by *Western Casualty*.¹⁶⁸ The court noted, however, that "if the circumstances permit only one insurer to rely on another insurance clause to assert a secondary liability position, enforcement of the resulting priority in a contribution action does not violate public policy."¹⁶⁹ The logic of the court's opinion suggests that if a pro rata clause collides with an excess clause, the excess clause will be enforced, and the excess insurer will not be forced to share pro rata with the other insurers.

This is exactly what the Court of Appeals later held in *Western Casualty & Surety Co. v. Trinity Universal Insurance Co.*¹⁷⁰ Both Western and Trinity issued policies of property insurance on a tavern and its contents. Western's policy contained an excess clause, whereas Trinity's policy contained a pro rata clause. Trinity argued that the two clauses were mutually repugnant and that each insurer should pay a pro rata share of the claim. Western argued that it had no responsibility as the excess carrier until Trinity's obligations were exhausted. After discussing the approaches various courts around the nation have applied in this situation, the court approved the approach followed by most courts that have faced the question:

166. Although the Farmers and Shelter policies had a similar excess clause, it was undisputed that the clauses were inapplicable because the named insureds under those policies owned the car in which Picking was killed. *Id.* at 95, 692 P.2d at 395.

167. *Id.* at 97, 692 P.2d at 397.

168. *Id.*

169. *Id.* at 97-98, 692 P.2d at 397.

170. 13 Kan. App. 2d 133, 764 P.2d 1256 (1988).

[T]he policy containing the pro rata clause is other collectible primary insurance which triggers the excess clause in the second policy. The policy containing the excess clause is not considered to be other valid and collectible primary insurance for the purpose of triggering the pro rata clause. The policy containing the excess clause becomes secondary coverage only.¹⁷¹

Whatever the limits of the *Western Casualty* rule, the rule can be very difficult to apply in health insurance, which involves a large number of claims for typically small amounts and in circumstances in which the coinsurance and deductible requirements of the various policies are likely to differ. The Kansas Supreme Court encountered this problem in *Blue Cross & Blue Shield, Inc. v. Riverside Hospital*.¹⁷² Leslie Stadalman was insured under her employer's group health plan (the "Riverside plan"). She was also covered as a dependent on her husband's employer's group health plan (the "BC-BS plan"). The Riverside plan refused to pay Leslie's medical expenses on the ground that it provided coverage secondary to that of the BC-BS plan. Initially, the BC-BS plan refused to pay her claim for the same reason. Eventually, however, the BC-BS plan paid her claim, reserving the right to seek contribution and indemnity from Riverside. The BC-BS plan had a complicated other insurance clause that explained when the BC-BS plan would be primary and when it would be secondary; the Riverside plan said that it was always secondary to other plans. The district court held the other insurance clauses to be mutually repugnant and directed that each plan pay half of the Stadalman claim, in accordance with the Kansas Supreme Court's 1983 decision.¹⁷³ The Kansas Supreme Court agreed with BC-BS, however, that such a proration procedure when applied to employee health care group plans has significant difficulties because of the differences in deductibles, covered services, and coinsurance provisions.¹⁷⁴ Accordingly, the court approved a different approach for employee health care group plans: when other insurance clauses can be reconciled, the court should do so; if the other insurance clauses are in conflict, however, the insured's own coverage is primary unless another group supplies primary coverage, and the coverage for the insured as a dependent serves as secondary coverage.¹⁷⁵ In this instance the court said that the Riverside plan was primary, and the BC-BS plan was secondary. This meant that

171. *Id.* at 141, 764 P.2d at 1263.

172. 237 Kan. 829, 703 P.2d 1384 (1985).

173. *See supra* note 162 and accompanying text.

174. *Blue Cross & Blue Shield*, 237 Kan. at 835-36, 703 P.2d at 1390.

175. *Id.* at 836-37, 703 P.2d at 1390-91.

the entire claim was to be charged against Riverside, in a precise amount to be determined upon remand.¹⁷⁶

To what extent the court in *Riverside Hospital* modified the *Western Casualty* rule is not clear. At a minimum, *Western Casualty* is superseded for employee health care group plans. Presumably *Riverside Hospital* would be followed for a group health insurance plan offered outside the employment setting, and it seems likely the rule would be followed for individual health insurance plans. Clearly, *Western Casualty* remains good law for automobile insurance plans, the situation in which that case arose. It would seem that *Western Casualty* remains good law for other property and liability insurance plans, but the court's willingness to revise the rules in the health care situation could open the door to re-examination of the rules in other settings. This will occur, however, only if there is an insurer willing to expend the time, energy, and resources to seek a reversal of a rule that makes considerable sense outside the health insurance setting.

V. AUTOMOBILES

A. *Uninsured Motorist Coverage: Hit-and-Run Accidents*

One of the reasons uninsured motorist coverage was offered by insurers and later made mandatory in some states was the prevalence of hit-and-run accidents. Compulsory liability insurance statutes provided no protection for the victim of an accident if the tortfeasor could not be identified.¹⁷⁷ Although the problem is obvious, the solution is not so clear. On the one hand, the public policy of maximizing coverage for victims of accidents favors the broadest coverage possible. This suggests that whenever a third party causes an accident and leaves the scene, the victim should be able to reach the uninsured motorist coverage. On the other hand, if no restrictions are put on coverage, any insured could claim in any one-vehicle accident that the incident was caused by an unknown third party's negligent conduct and thereby recover proceeds under the uninsured motorist coverage.

Some states have sought to reconcile these competing interests by either requiring a physical contact as a prerequisite to recovering uninsured motorist benefits or permitting the insurer to exclude such coverage in the absence of a contact. In other states, the physical contact requirement is specifically prohibited by statute.

176. *Id.*

177. See R. JERRY, *supra* note 1, § 131, at 643-44.

In states without statutory guidance, some courts have upheld physical contact requirements in insurance policies, but a slightly greater number of courts have held such requirements contrary to public policy and therefore invalid.¹⁷⁸ Kansas has resolved the issue in this manner: section 40-284(e)(3) of Kansas Statutes Annotated allows insurers to exclude coverage for hit-and-run accidents when there is no physical contact and no competent evidence to prove the facts of the accident from a disinterested witness not making a claim under the policy.¹⁷⁹ In other words, an insured in Kansas can recover uninsured motorist benefits in the absence of a physical contact, but only if a disinterested witness is able to provide evidence corroborating the insured's claim that an unknown third party's negligence caused the loss.

In *Clements v. United States Fidelity & Guaranty Co.*,¹⁸⁰ the Kansas Supreme Court considered whether section 40-284(e)(3) was unconstitutional as a violation of the equal protection and due process clauses of the United States and Kansas Constitutions.¹⁸¹ The plaintiff suffered injury when the car she was driving hit a utility pole. She claimed she was forced off the road when an unidentified vehicle cut in front of her. No physical contact with that vehicle occurred, and no one else witnessed the accident. The insurer refused to pay the claim, which fell squarely within the exclusion to the policy.

The court observed that section 40-284 specifies the *minimum* amount of uninsured motorist coverage that must be purchased and does not limit the maximum coverage allowed. Therefore, the authorization of an exclusion to the coverage does not violate a fundamental right protected by either the federal or state constitutions.¹⁸² The court also observed that the insured was not fore-

178. *Id.* § 133[d]. This was the result in *Simpson v. Farmers Ins. Co.*, 225 Kan. 508, 592 P.2d 445 (1979), in which the court held that physical contact clauses were attempts to dilute the broad coverage mandated by statute and thus offended public policy. *Id.* at 515, 592 P.2d at 450. In response to *Simpson*, the legislature in 1981 amended KAN. STAT. ANN. § 40-284 to authorize the physical contact requirement. In 1984 the disinterested witness language was added to the statute. See *infra* note 179 and accompanying text.

179. KAN. STAT. ANN. § 40-284(e)(3) (1986 & Supp. 1988).

180. 243 Kan. 124, 753 P.2d 1274 (1988).

181. The plaintiff also argued that KAN. STAT. ANN. § 40-284(e)(3) violated the "right to a remedy" provision in § 18 of the Kansas Bill of Rights. *Clements*, 243 Kan. at 128, 753 P.2d at 1277. The court found no infringement of § 18, which the court stated creates no rights of action but only requires that Kansas courts be open and afford remedies for such wrongs that are recognized by law. If the plaintiff's injury is not a wrong for which a remedy is recognized by law, the plaintiff has no constitutional right under § 18 that is vulnerable to infringement. *Id.* at 128-29, 753 P.2d at 1277-78.

182. *Clements*, 243 Kan. at 124, 753 P.2d at 1275.

closed from purchasing uninsured motorist protection for losses caused in the absence of physical contact; therefore, none of her rights was violated by the statute.¹⁸³ To buttress this conclusion, the court noted that the physical contact requirement is a reasonable basis for classification and bears a rational basis to the objective sought, namely, reducing fraudulent claims. As such, the authorization of the exclusion does not present a due process or equal protection problem.¹⁸⁴

B. *Underinsured Coverage*

As of 1981 Kansas law required automobile liability insurers to offer, separate from the mandatory liability insurance, uninsured motorist coverage, but there was no requirement for underinsured coverage. Effective January 1, 1982, the Kansas uninsured motorist statute was amended in two major respects.¹⁸⁵ First, uninsured motorist insurance became mandatory. Insureds could purchase either an amount of uninsured motorist insurance equal to their liability limits, or an amount equal to the mandatory minimum liability coverage. Second, the new statute required that uninsured motorist insurance also contain "underinsured" motorist coverage. Under the new underinsured coverage, the insured could collect from the insured's own insurer any damages for injury or death exceeding the liability coverage of the tortfeasor, but in no event could the insured's recovery exceed the insured's own uninsured motorist coverage.

In *Haas v. Freeman*,¹⁸⁶ the issue was whether the plaintiff-insured could name his own insurer, which was potentially liable as the underinsured carrier, as a defendant in his action against the tortfeasor. In the uninsured motorist situation, a plaintiff-insured may sue the uninsured carrier directly without joining the tortfeasor, may sue the uninsured carrier and the tortfeasors in one action, or may sue the tortfeasors alone without joining the insurer.¹⁸⁷ The plaintiff in *Haas* sought to apply the uninsured motorist rule to the underinsured setting. The court, however, noted some differences between the uninsured and the underinsured setting: (1) the underinsured case always involves an active opposing party plus that party's insurer, unlike the uninsured situation;

183. *Id.* at 129, 753 P.2d at 1278.

184. *Id.*

185. Act approved Apr. 24, 1981, ch. 191, 1981 Kan. Sess. Laws 836 (codified as amended at KAN. STAT. ANN. § 40-284 (1986 & Supp. 1988)).

186. 236 Kan. 677, 693 P.2d 1199 (1985).

187. See *Winner v. Ratzlaff*, 211 Kan. 59, 65, 505 P.2d 606, 611 (1973).

(2) whether an underinsured situation exists is an unresolved issue until the amount of damages is finally adjudicated, whereas lack of insurance altogether is known at the very beginning; and (3) having two insurers as defendants, which is impossible in the uninsured setting, could confuse the jury.¹⁸⁸ Accordingly, the court set forth the following procedures for an underinsured coverage situation. First, the injured insured shall notify the insured's own carrier that he wishes to invoke the underinsurance coverage in the manner specified in his policy. Second, the insurer may intervene at its election; if it elects to intervene, it shall be named as a party; if it elects not to intervene, section 60-454 of Kansas Statutes Annotated¹⁸⁹ shall apply. Third, in either case, the underinsured carrier shall be bound by any judgment obtained in the action.¹⁹⁰

In 1985 the Special Committee on Financial Institutions and Insurance considered proposed reforms to the uninsured and underinsured motorist statute. The Special Committee focused on the "offset provision" of section 40-284(b) of Kansas Statutes Annotated¹⁹¹ and ultimately decided to recommend no change in that provision. In the course of the Committee's deliberations, however, a problem surfaced concerning how the victim's insurer could protect its right of subrogation while simultaneously meeting its other obligations. The Committee recommended a solution, which was enacted in 1986 with only slight modifications and was codified at section 40-284(f) of Kansas Statutes Annotated. This section recognizes that an underinsured carrier "shall have subrogation rights under the provisions of K.S.A. 40-287 and amendments thereto."¹⁹² If a victim reaches a "tentative agreement to settle for liability limits" with the underinsured tortfeasor, the insured must give written notice via certified mail to the underinsured carrier. Then, within sixty days of the receipt of this notice, the underinsured carrier "may substitute its payment to the insured

188. *Haas*, 236 Kan. at 682, 693 P.2d at 1203.

189. "Evidence that a person was, at the time a harm was suffered by another, insured wholly or partially against loss arising from liability for that harm is inadmissible as tending to prove negligence or other wrongdoing." KAN. STAT. ANN. § 60-454 (1983).

190. *Haas*, 236 Kan. at 683, 693 P.2d at 1204.

191. The "offset provision" is the "to the extent" clause of KAN. STAT. ANN. § 40-284(b) (1986). This provision limits the victim's recovery through underinsurance to the amount by which the victim's uninsured motorist coverage exceeds the tortfeasor's liability coverage. Another way to view the offset is as a prohibition on stacking the tortfeasor's liability coverage onto the victim's underinsured coverage. If, for example, the victim's uninsured motorist coverage is at the minimum, and the tortfeasor's liability insurance is at the minimum, the victim collects no underinsured benefit.

192. KAN. STAT. ANN. § 40-284(f) (1986).

for the tentative settlement amount. The underinsured motorist coverage insurer is then subrogated to the insured's right of recovery to the extent of such payment and any settlement under the underinsured motorist coverage."¹⁹³ If the underinsured carrier fails to pay the insured the amount of the tentative settlement within sixty days, the underinsured carrier loses its right to subrogation. The effect of this statute is to eliminate the difficult entanglements created when the victim attempts to procure the limits of the tortfeasor's insurance; the settlement arguably would discharge the tortfeasor's liability, thereby quashing the underinsured carrier's subrogation right. Concern over these consequences had the effect, as the Special Committee explained, of leading "to situations in which neither party [would] take the initial step toward settlement of the claim."¹⁹⁴

One effect of section 40-284(f) in situations in which the insured's injury exceeds the limits of the insured's uninsured motorist coverage is to give the insurer a subrogation right before the insured is made whole. This is not the common-law rule in Kansas.¹⁹⁵ In other words, under the statute, if an insured with an injury exceeding the limits of the uninsured motorist coverage proposes to settle with the tortfeasor's insurer for the policy limits of the tortfeasor's insurance, the victim's insurer is entitled to assert a subrogation right against the proceeds paid by the tortfeasor's insurer, even though the victim is not made whole. For example,

193. *Id.*

194. *Re: Proposal No. 13—Uninsured and Underinsured Motorists*, in REPORT ON KANSAS LEGISLATIVE INTERIM STUDIES TO THE 1986 LEGISLATURE at 129, 133 (1985). Another difficulty is illustrated by the pre-section 40-284(f) decision in *Horace Mann Ins. Co. v. Ammerman*, 630 F. Supp. 114 (D. Kan. 1986). Ammerman, who was killed in an auto accident in which the other car's driver (Chadwick) was negligent, had underinsured coverage with Horace Mann of \$250,000. Chadwick had liability coverage of \$50,000. Ammerman's widow gave Chadwick a release in exchange for the \$50,000 limits. The release stated that Ammerman's widow retained the right to seek underinsured benefits from Ammerman's insurer with the intention that Horace Mann would retain a subrogation right. Horace Mann later argued that the release quashed its subrogation rights, thereby making the underinsured coverage void. Ammerman's widow sought the \$200,000 difference from Horace Mann. The court ultimately decided the case in favor of the insured's widow. KAN. STAT. ANN. § 40-284(f) makes clear that the insurer does not lose its subrogation right when the insured reaches a "tentative agreement" with the tortfeasor's insurer and that the insurer does not acquire a subrogation right until the underinsured carrier pays the insured in substitution for the tentative settlement amount. For further discussion, see Scott, *General Analysis of Kansas Uninsured/Underinsured Motorist Statute*, in S. FABERT, R. FISHER, P. HASTY, & G. SCOTT, CURRENT ISSUES IN KANSAS AUTO INSURANCE 104-07 (1988).

195. See *Federal Sav. & Loan Ins. Corp. v. Huff*, 237 Kan. 873, 704 P.2d 372 (1985); *Halpin v. Frankenberger*, 231 Kan. 344, 350-51, 644 P.2d 452, 455 (1982).

assume an insured suffers a 100,000-dollar loss, the insured has 60,000 dollars in uninsured motorist benefits, and the tortfeasor has a 50,000-dollar liability policy. The insured proposes to settle with the tortfeasor in exchange for the tortfeasor's insurer's payment of 50,000 dollars. The insured's carrier then has the option to substitute its payment to the insured (60,000 dollars) for the tentative settlement amount, but the insured's carrier is then subrogated to the insured's claim against the tortfeasor. Upon exercising this subrogation right, the insured's carrier will recover 50,000 dollars from the tortfeasor's insurer. Thus, when all rights have been asserted, the liability carrier will have paid 50,000 dollars, and the insured's carrier will have paid 10,000 dollars.

Entitling the insurer to a subrogation right before the insured is made whole would no doubt seem unfair to the victim whose loss has not been fully compensated. Insureds might wish to believe that underinsured coverage means that when they are not made whole by the victim's liability insurance they can look to their own insurer for the difference, but this is not what the statute provides. Indeed, this result does not differ from what can happen under the stacking prohibitions now found in the insurance statutes.¹⁹⁶ An insured may have access to multiple coverages, but the insured can only collect once, even though the insured's loss is not fully compensated. One answer to the argument that antistacking provisions are unfair is that the insured should purchase more coverage under one policy. In the underinsured setting, the answer is that the insured, to avoid a loss exceeding policy limits, should purchase more uninsured motorist insurance.

C. *The No-Fault Statute*

1. PIP Benefits and Limitations on the Right to Sue in Tort

In 1987 the personal injury protection benefits and tort threshold of the Kansas Automobile Insurance Reparations Act ("KAIRA") were amended, effective January 1, 1988. Each of the six categories of minimum PIP benefits required in every automobile policy were increased. The minimum disability benefits and survivors benefits were increased from a maximum of not less than 650 dollars per month to 900 dollars per month. Funeral benefits were increased from 1000 dollars to 2000 dollars per individual. Medical benefits

196. Stacking of uninsured motorist coverages is prohibited, KAN. STAT. ANN. § 40-284(d) (1986), stacking of PIP coverages is prohibited, *id.* § 40-3109(b), and insurers are authorized to insert provisions prohibiting stacking of liability coverages. *Id.* § 40-3107(i)(5).

were increased from a limit of not less than 2000 dollars to 4500 dollars. Rehabilitation benefits were increased from a limit of not less than 2000 dollars to 4500 dollars. Substitution benefits were increased from a maximum of twelve dollars per day to twenty-five dollars per day.¹⁹⁷

Whenever mandatory first-party benefits are increased, premiums must increase unless some cost savings are achieved elsewhere in the compensation system. In most no-fault statutory schemes, these savings are achieved by eliminating the victim's right to sue in tort for some kinds of damages below stated thresholds. Since 1974 a Kansas accident victim cannot sue in tort for "pain, suffering, mental anguish, inconvenience and other non-pecuniary loss because of injury" unless the injury either requires medical treatment costing at least 500 dollars or meets a verbal threshold.¹⁹⁸ Effective January 1, 1988, the monetary threshold was raised to 2,000 dollars.¹⁹⁹ It is only partially accurate to assert that the legislature in 1987 made Kansas a stronger no-fault state because the legislature merely corrected for the erosion in the threshold (as well as the erosion in the value of the mandatory PIP benefits) caused by inflation during the years after 1974.

Prior to 1988 the Kansas no-fault scheme was "in balance" in the sense that the savings achieved by restricting the right to sue in tort were sufficient to pay for the mandatory first-party benefits.²⁰⁰ According to a Department of Transportation report, automobile insurance premiums in Kansas were nine percent lower in 1983 than they would have been if the no-fault law had not been enacted.²⁰¹ The report also revealed that this inflation-restraining effect occurred at the same time more benefits were provided to accident victims than were provided in the average traditional tort-liability jurisdiction.²⁰² In short, prior to 1988 the

197. Act effective Jan. 1, 1988, ch. 173, 1987 Kan. Sess. Laws 848, 849 (codified at KAN. STAT. ANN. § 40-3103 (1986 & Supp. 1988)).

198. KAN. STAT. ANN. § 40-3117. As an alternative to the monetary threshold in § 40-3117, if the victim's injury "consists in whole or in part of permanent disfigurement, a fracture to a weightbearing bone, a compound, comminuted, displaced or compressed fracture, loss of a body member, permanent injury within reasonable medical probability, permanent loss of a bodily function or death," the victim retains the right to sue in tort for noneconomic loss. *Id.*

199. Act approved May 14, 1987, ch. 173, 1987 Kan. Sess. Laws 848, 859.

200. U.S. DEP'T OF TRANSP., COMPENSATING AUTO ACCIDENT VICTIMS: A FOLLOW-UP REPORT ON NO-FAULT AUTO INSURANCE EXPERIENCES 4, 31 (May 1985).

201. *Id.* at 31.

202. The average traditional liability state returned 43.2 cents of every premium dollar to claimants in the form of benefits, whereas Kansas returned 47.0 cents of every dollar. *Id.* at 4, 31.

evidence indicates that the Kansas no-fault system was working well and was achieving its goals, and there is no reason to think this is still not the case. Whenever first-party benefits are enhanced, however, a chance exists that the no-fault scheme might become out-of-balance, as it has in several states where legislatures have mandated broader benefits but failed to adjust the right-to-sue threshold sufficiently upward to generate the savings that hold premium increases in check.²⁰³ A fair prediction is that the Kansas statutory scheme will remain in balance, but only some experience with the new benefit levels and threshold can validate this prediction.

In *Stang v. Caragianis*,²⁰⁴ the supreme court reconsidered the meaning of the verbal threshold in section 40-3117 of Kansas Statutes Annotated. Plaintiff Stang, a passenger in an automobile, sought to recover damages from the defendant for injuries suffered when the vehicle in which she was riding collided with the defendant's vehicle. The trial court granted a directed verdict for the defendant limiting the plaintiff's recovery to ninety percent of her pecuniary losses on the ground that the threshold in section 40-3117 had not been met, thereby foreclosing the plaintiff from seeking nonpecuniary damages.

The plaintiff asked the court to reconsider its 1978 decision in *Smith v. Marshall*,²⁰⁵ in which the court held that the verbal threshold "permanent disfigurement" in the statute requires a disfigurement "of substance," meaning an injury of some severity and seriousness. In *Smith*, the court affirmed the trial court's finding that an innocuous discoloration of the victim's leg extending approximately one and one-fourth inches in length and about one-half inch in width at its widest point was not a "permanent disfigurement" as a matter of law. The court rejected the plaintiff's request, noting that most courts since *Smith* that have considered the issue have required the disfigurement to be "significant as well as permanent."²⁰⁶ The court also refused to overturn the jury's determination that a scar on the plaintiff's cheek approximately five centimeters in length and one centimeter in width did not constitute a permanent disfigurement.²⁰⁷ The plaintiff contended that the trial court erred in letting the jury decide whether the threshold was reached. The court rejected this contention, explain-

203. *Id.* at 15-17.

204. 243 Kan. 249, 757 P.2d 279 (1988).

205. 225 Kan. 70, 587 P.2d 320 (1978).

206. *Stang*, 243 Kan. at 256, 757 P.2d at 285.

207. *Id.* at 256-57, 757 P.2d at 285-86.

ing that its approval of the trial court's ruling in *Smith* that no permanent disfigurement had occurred as a matter of law did not mean that all such determinations in the future would have to be made by the trial judge, instead of a jury.²⁰⁸

2. Subrogation and PIP Benefits

Under section 40-3113a of Kansas Statutes Annotated, whenever an insured who has received PIP benefits suffers injuries that cross the threshold in section 40-3117, the PIP insurer enjoys a right of subrogation against the tortfeasor to the extent of "duplicative personal injury protection benefits provided to date of such recovery and [the insurer] shall have a lien therefore against such recovery. . . ."²⁰⁹ In *State Farm Mutual Automobile Insurance Co. v. Kroeker*,²¹⁰ the court examined the meaning of this provision. The defendant's husband was fatally injured in an automobile collision in which the other driver was entirely at fault. State Farm not only insured the defendant's husband but also had issued a 50,000-dollar liability policy to the negligent driver. State Farm paid PIP benefits to the defendant, and offered to settle the negligent driver's liability for 50,000 dollars less a setoff for PIP benefits already paid. State Farm justified this offer by contending that in its status as the deceased husband's insurer, it enjoyed a subrogation right against the 50,000-dollar payment to the extent of PIP benefits paid. The defendant argued that her loss far exceeded the 50,000 dollars tendered by State Farm and that the liability insurance proceeds were not duplicative of PIP benefits paid to her.

In 1977, in *Easom v. Farmers Insurance Co.*,²¹¹ the court announced three rules to be applied when a PIP insurer claims a

208. *Id.* at 258, 757 P.2d at 286. The court also rejected the plaintiff's argument that the threshold requirements are affirmative defenses under KAN. STAT. ANN. § 60-208(c), which were allegedly waived by the defendant when the defendant failed to raise them before trial. Instead, the threshold is an element of the plaintiff's case on which the plaintiff bears the burden of proof. *Stang*, 243 Kan. at 250-52, 757 P.2d at 281-82. In addition, the court rejected the plaintiff's argument that services performed for her by her husband after the accident could be counted toward meeting the \$500 medical expense threshold. *Id.* at 258-59, 757 P.2d at 286-87. The court concluded that the trial court erred in submitting to the jury any claim based on the plaintiff's loss of earning capacity as a model, where the only evidence was that the plaintiff aspired to be a model and there was no evidence that the aspiration was realistic or that the claimed disfigurement impaired that aspiration. *Id.* at 260, 757 P.2d at 287-88.

209. KAN. STAT. ANN. § 40-3113a(b) (Supp. 1988).

210. 234 Kan. 636, 676 P.2d 66 (1984).

211. 221 Kan. 415, 560 P.2d 117 (1977).

right to reimbursement out of the insured's recovery against a tortfeasor: (1) the PIP insurer's right to reimbursement for PIP benefits paid is limited to damages recovered by the insured that are "duplicative" of the PIP benefits; (2) such damages duplicate the PIP benefits when failing to reimburse the PIP insurer would result in double recovery by the insured; (3) PIP benefits are *presumed* to be included in any recovery obtained by an injured insured, whether by judgment or settlement, in the absence of proof to the contrary, and the burden to supply such proof is on the insured.²¹² Two years later the court elaborated upon *Easom*, holding in *Russell v. Mackey*²¹³ that when the insured settles all of the insured's claim, including elements of damage represented by PIP benefits, the recovery obtained is duplicative, and the insurer is entitled to reimbursement. The lesson of *Russell* is that an injured insured should not settle all of the insured's claim, but should attempt to get only a partial settlement. If this is not feasible, the insured should attempt to work out a settlement with the PIP insurer for a reduction in the amount to be paid for a settlement of the insurer's subrogation rights.

Under the facts of *Kroeker*, the court concluded that the insured had not obtained a settlement of all of her claim, but instead had only reached a partial settlement with the tortfeasor's estate. The defendant-insured obtained a judgment against the estate for slightly over 600,000 dollars, which, after payment of the 50,000 dollars in liability proceeds, would leave unreimbursed damages of slightly over 550,000 dollars. The court ordered a remand of the case to the district court, where defendant would be allowed to present evidence that the 50,000 dollars in proceeds did not afford her a double recovery. The court stated: "Clearly the payment of the entire \$50,000 to the insured Kroeker will not result in a *double recovery*, if it can be shown that her actual damages exceeded \$50,000 plus the \$5,550 PIP benefits previously paid."²¹⁴

Kroeker was reaffirmed in *Kansas Farm Bureau Insurance Co. v. Miller*,²¹⁵ a 1985 decision. Foley, a passenger, suffered permanent injuries when the vehicle driven by Miller was involved in a one-car accident. Miller had 15,000 dollars in liability coverage plus the PIP benefits required by law. Foley was covered for PIP benefits under seven policies carried by his father on various

212. These three rules were summarized in *Kroeker*, 234 Kan. at 643-44, 676 P.2d at 73.

213. 225 Kan. 588, 592 P.2d 902 (1979).

214. *Kroeker*, 234 Kan. at 647, 676 P.2d at 75 (emphasis in original).

215. 236 Kan. 811, 696 P.2d 961 (1985).

vehicles. Miller's liability insurer, Hartford, happened to be the same insurer on one of the seven Foley vehicles. Hartford paid Foley over 9000 dollars in PIP benefits, and then sought pro rata reimbursement from the carriers on the other six policies. Hartford, in an effort to settle its liability as Miller's insurer, proposed to settle Foley's case by paying the full 15,000 dollars to Foley on the condition that the other carriers waive their subrogation rights to the amounts to be paid by them as PIP benefits. One of the carriers, Farm Bureau, which had policies on four of the Foley vehicles, refused to waive its subrogation claim. It was stipulated by the parties that Foley's damages for bodily injuries had a value of not less than 75,000 dollars, which was well beyond the liability coverage available. Applying *Kroeker*, the court ruled that the PIP insurers were not entitled to subrogation because their payments were not duplicative of the 15,000 dollars to be paid by Hartford in its capacity as the liability insurer.²¹⁶

When read together, *Kroeker* and *Miller* make it clear that the PIP insurer is not entitled to subrogation if the value of the insured's claim exceeds the liability proceeds plus the PIP payments made. If the insured settles with the tortfeasor for the entire claim, however, the PIP insurer is entitled to subrogation.

It is interesting to note that only the first sentence in section 40-3113a(b) applies to the situation in which PIP benefits have already been paid, and this is the sentence that limits the insurer's subrogation rights by use of the term "duplicative"—the insurer is subrogated only to the extent of duplicative PIP benefits. The second sentence of section 40-3113a(b) applies to the situation in which the insured obtains a judgment before the completion of the payment of PIP benefits, and this sentence does not use the word "duplicative." The second sentence states that when such a judgment or settlement occurs, and when that judgment exceeds the amount of PIP benefits already paid, the settlement or recovery shall be credited against future payments of such PIP benefits. The Insurance Commissioner interprets the statute as giving the insurer a subrogation right *only* when the recovery duplicates PIP benefits, regardless of when the judgment is obtained.²¹⁷ The Commissioner's interpretation reads the second sentence as a mere extension of the principle of the first sentence in the situation in

216. *Id.* at 818, 696 P.2d at 967.

217. KAN. ADMIN. REGS. 40-3-39 (Supp. 1987) provides: "The phrase 'the amount of such judgment, settlement, or recovery,' as contained in and applied to, the second sentence of K.S.A. 40-3113a(b), means amounts which are duplicative of payable personal injury protection benefits."

which the judgment precedes the conclusion of the payment of benefits. The statute can be read as creating an either-or situation, however, and when the judgment precedes the paying of benefits, there is a dollar-for-dollar credit of the judgment against the insurer's obligation to make future PIP payments. This latter reading draws support from the court's observation in *Kroeker* that the word "duplicative" was inserted in section 40-3113a(b), but was left out of section 40-287, the subrogation section of uninsured motorist benefits.²¹⁸ The argument is that the legislature had a special purpose in inserting the word "duplicative" in section 40-3113a(b), the legislature knew what it was doing, and the legislature must have also known what it was doing when it did not insert the word "duplicative" in the second sentence of section 40-3113a(b). By this analysis, the second sentence of section 40-3113a(b) gives the insurer a dollar-for-dollar reimbursement, just like section 40-287. Clarification of this issue must await a future case.

D. *The Household Exclusion*

The "household exclusion" is sometimes found in the liability coverages of automobile insurance policies. The provision typically states that no coverage exists for any obligation an insured may have to a member of the insured's family who is residing in the same household as the insured. The purpose of the clause is to eliminate coverage when one family member's negligence injures another family member. The insurer's main concern is, of course, familial collusion: the negligent family member may assist the injured family member in securing a judgment and recovering proceeds.²¹⁹

The fear of collusion reflected in the household exclusion is also the underpinning of the intrafamily immunities. In many states, including Kansas, the doctrines of interspousal and parent-child immunities have been eroded.²²⁰ To the extent it is the state's policy to limit these immunities and to allow tort claims to be asserted in the intrafamily setting to compensate victims of accidents, the household exclusion frustrates the state's purpose by

218. *Kroeker*, 234 Kan. at 647, 676 P.2d at 75.

219. See generally R. JERRY, *supra* note 1, § 135C.

220. See *Nocktonick v. Nocktonick*, 227 Kan. 758, 611 P.2d 135 (1980) (abolishing parent-child immunity at least with respect to automobile accidents); *Flagg v. Loy*, 241 Kan. 216, 734 P.2d 1183 (1987) (overruling *Guffy v. Guffy*, 230 Kan. 89, 631 P.2d 646 (1981), and abolishing interspousal immunity).

allowing liability insurers to deny coverage when the tort claim is asserted.²²¹

In 1980 the Kansas Supreme Court abrogated the parent-child immunity in automobile accidents.²²² At that time, however, Kansas recognized the doctrine of interspousal immunity, and this was confirmed in a 1981 decision.²²³ Thus, as a practical matter, in 1980 the household exclusion only prevented children from seeking a recovery from their parents for negligently operating a vehicle. In 1981, in *DeWitt v. Young*,²²⁴ the supreme court held a household exclusion invalid on the ground that it frustrated the policy and objectives of the KAIRA. The legislature responded shortly thereafter by amending the KAIRA to authorize household exclusion clauses.²²⁵

In 1984, however, the statute authorizing household exclusions was repealed, effective July 1, 1984.²²⁶ This presumably returned Kansas to the situation that prevailed under the *DeWitt* decision: household exclusions are invalid. This is suggested in Justice Herd's opinion in *Hilyard v. Estate of Clearwater*.²²⁷ *Hilyard* was actually a consolidation of two cases, in which the issue in each was the validity of the household exclusion. In both cases, minor children were suing their parents for damages suffered as a result of the parents' negligent operation of a motor vehicle in which the children were passengers. Both accidents occurred in 1983, before the repeal of the household exclusion authorization statute. The supreme court refused to apply the repeal retroactively, which meant that the household exclusions were valid in each case.²²⁸ In dictum, however, Justice Herd stated that if the repeal of the household exclusion authorization were retroactive, "[t]his would render the household exclusion clause in State Farm's policies invalid."²²⁹

The importance of *DeWitt* and the 1984 repeal of the household exclusion authorization became greater in 1987, when the supreme court overruled prior case law and abolished the doctrine of

221. R. JERRY, *supra* note 1, § 135C, at 676.

222. *Nocktonick*, 227 Kan. at 758, 611 P.2d at 135.

223. *See Guffy*, 230 Kan. at 89, 631 P.2d at 646.

224. 229 Kan. 474, 625 P.2d 478 (1981).

225. Act approved Apr. 24, 1981, ch. 191, § 2(i)(1), 1981 Kan. Sess. Laws 836, 839 (repealed 1984).

226. Act approved Apr. 13, 1984, ch. 167, § 2, 1984 Kan. Sess. Laws 798, 801; Act approved May 9, 1984, ch. 175, § 1, 1984 Kan. Sess. Laws 855, 857.

227. 240 Kan. 362, 729 P.2d 1195 (1986).

228. *Id.* at 366, 729 P.2d at 1198.

229. *Id.* at 365, 729 P.2d at 1197.

interspousal immunity.²³⁰ Thus, in Kansas, it is now possible for a family member to bring a tort action against another family member for negligence arising out of an auto accident. Presumably, any effort by an insurer to exclude liability coverage is invalid under the authority of *DeWitt* and the repeal of the statute that reversed *DeWitt*.

E. Notification Requirements for Cancellation of Policy

In the 1960s general public concern about the availability and affordability of automobile insurance ultimately caused attention to be focused on the cancellation procedures used by some insurers. Eventually, legislatures in many states enacted statutes limiting insurers' rights to cancel automobile policies. These statutes typically detailed the procedures that insurers must follow to cancel a policy, and a common requirement is that the insurer notify the insured to effect a cancellation.²³¹

In most cases in which the propriety of a cancellation is at issue, the insured challenges the procedures followed by the insurer in canceling the policy. The most common targets of these procedural attacks are the nature and sufficiency of the notice. Courts have reached diverse results in these cases; some courts require proof of actual receipt of the notice by the insured, whereas other courts simply require that the insurer establish that the cancellation notice was deposited in the mail pursuant to the company's ordinary business practices.²³²

In 1960 the Kansas Supreme Court held in *Koehn v. Central National Insurance Co.*²³³ that a standard cancellation clause in an automobile insurance policy, which stated that the "mailing of notice . . . shall be sufficient proof of notice,"²³⁴ required actual receipt of the cancellation notice by the policyholder. In *Richmeier v. Williams*,²³⁵ a 1984 Kansas Court of Appeals decision, the court held, relying on *Koehn*, that an insurer's mailing of a notice of cancellation of an automobile policy for nonpayment of premium was not effective unless actually received by the insured. The policy in *Richmeier* stated that it might be canceled during the policy period "by mailing to the named insured . . . at least 10 days

230. *Flagg v. Loy*, 241 Kan. 216, 734 P.2d 1183 (1987).

231. R. JERRY, *supra* note 1, § 62A[3].

232. *Id.* at 284.

233. 187 Kan. 192, 354 P.2d 352 (1960).

234. *Id.* at 193, 354 P.2d at 353 (emphasis omitted).

235. 9 Kan. App. 2d 222, 675 P.2d 372 (1984).

notice . . . if cancellation is for nonpayment of premium."²³⁶ The court noted that section 40-3118(b) of Kansas Statutes Annotated, which had been enacted after *Koehn*, lacked any express requirement of notice when the cancellation is for nonpayment of premium:

[E]xcept for termination of insurance resulting from nonpayment of premium . . . , no motor vehicle liability insurance policy, or any renewal thereof, shall be terminated by cancellation or failure to renew by the insurer until at least 30 days after mailing a notice of termination, by certified or registered mail or United States post office certificate of mailing, to the named insured at the latest address filed with the insurer by or on behalf of the insured.²³⁷

In the court's view, this statute did not alter the insurer's contractual undertakings, which it interpreted, again relying on *Koehn*, to require actual notice when the nonrenewal is for failure to pay the premium.

The supreme court revisited the cancellation area in *Feldt v. Union Insurance Co.*²³⁸ The insurer sought to cancel the insured's automobile policy because of misrepresentations by the insured about his driving record. The insurer mailed the notice to the insured's last known address, but the insured alleged that he never received the notice because he was temporarily staying at a different address while his parents were vacationing out of the country. The district court granted summary judgment for the insurer, but the court of appeals reversed, relying on *Koehn* and *Richmeier*. The supreme court, in reinstating the district court's judgment, held that section 40-3118(b) "clearly does not require the insurer to provide proof of actual receipt by the insured."²³⁹ It is only necessary for the insurer to mail notice of termination by certified or registered mail, or United States Post Office certificate of mailing, to the insured at the last address provided by the insured.²⁴⁰ The court reasoned that section 40-3118(b) constituted a clear rejection of the rule articulated in *Koehn*.²⁴¹

236. *Id.* at 223-24, 675 P.2d at 374.

237. KAN. STAT. ANN. § 40-3118(b) (1986).

238. 240 Kan. 108, 726 P.2d 1341 (1986).

239. *Id.* at 111, 726 P.2d at 1343.

240. Certified or registered mail has a "tracking" mechanism because the sender of the letter will receive a confirmation if the letter is actually received. The "certificate of mailing" is simply a receipt, acquired at the time the letter is mailed, that confirms the fact of mailing. It provides no confirmation that the letter was received. Using a certificate of mailing is more attractive to insurers because the certificate costs only about 50 cents, considerably less than the cost of sending a certified or registered letter.

241. *Feldt*, 240 Kan. at 111, 726 P.2d at 1343-44.

Although the court in *Feldt* said *Richmeier* was inapplicable, the court's reasoning in *Feldt* is difficult to reconcile with *Richmeier*. It is true, as the court stated, that section 40-3118(b) did not apply in *Richmeier* because *Richmeier* involved cancellation for nonpayment of a premium, for which section 40-3118(b) states no requirements. Yet, despite the absence of any statutory requirement that any particular kind of notice of cancellation be given, the court in *Richmeier* interpreted the policy to require the giving of actual notice. Presumably, the policy in *Feldt*, the notice provisions of which were substantially similar to those in *Richmeier*,²⁴² could also have been construed to require more notice than the statute required, but the court in *Feldt* did not do this. Be that as it may, it would have been incongruous to have interpreted section 40-3118(b) as requiring the insurer to prove actual receipt of a notice of cancellation for nonpayment of premium, when the apparent purpose of the exception in the statute concerning cancellation for nonpayment of premium is to make it easier for insurers to cancel policies for that reason.

Currently, then, section 40-3118(b) does not require actual receipt of notice of cancellation of an automobile insurance policy. In addition, under the statute, no notice of any kind is required for cancellation of an automobile insurance policy for nonpayment of premium. Presumably, however, the automobile insurance contract between insurer and insured could place a greater burden on the insurer. Although *Koehn* also involved automobile insurance, that case's requirement that notice actually be received might represent the Kansas rule for cancellation cases not involving automobile insurance.

F. Direct Actions Against Motor Carriers

Apart from a few exceptional situations, the victim of a tort has no claim against the tortfeasor's insurer until the underlying liability of the tortfeasor to the victim is established. The source of this general rule is the "no-action clause" typically found in a liability insurance policy, which ordinarily provides that no action lies against the insurer until the insured's obligation has been

242. The policy in *Richmeier* said that the policy might be canceled during the policy period "by mailing to the named insured . . . at least 10 days notice . . . if cancellation is for nonpayment of premium Proof of mailing of any notice shall be sufficient proof of notice." *Richmeier v. Williams*, 9 Kan. App. 2d 222, 223-24, 675 P.2d 372, 374 (1984). In *Feldt*, the policy provided that cancellation could not occur unless "we [meaning the insurer] . . . mail notice to the named insured by certified or registered mail or United States post office certificate of mailing" *Feldt*, 240 Kan. at 110, 726 P.2d at 1342.

determined by a final judgment or in a settlement agreement approved by the insurer. Thus, if a third party were to sue the insurer as the beneficiary of a contract between insurer and insured, the third party would lose because the contract upon which the third party is asserting rights specifies that the insurer owes nothing to the insured—and concomitantly to the third party—until the underlying liability of the insured to the third party is established by judgment or settlement agreement. One of the exceptional situations is when a statute specifically authorizes the victim's direct action against the insurer, thereby superseding any no-action clause in the contract between insurer and insured.²⁴³

Section 66-1,128 of Kansas Statutes Annotated has been construed as providing a party injured by a negligent insured motor carrier with a direct action against the insurer. By no means is this result clearly mandated by the language of the statute, but this construction is set forth in a long line of cases dating back to the supreme court's 1937 decision in *Twichell v. Hetzel*.²⁴⁴ In *Nirschl v. Webb*,²⁴⁵ a 1986 decision, the supreme court retreated from this line of authority when it held that the trial court did not err in excluding the defendant-insurer as a named defendant at the jury trial in which the sole issues were the comparative fault of the drivers of the two vehicles involved in the accident and the damages suffered. The court noted that there was no issue regarding the insurer's negligence (indeed, it is difficult to imagine a situation in which the insurer's negligence would be at issue), and it found no logical reason for injecting the subject of insurance into the trial.²⁴⁶ The insurer did remain a party to the lawsuit for the purpose of paying any resulting judgment if its insured were found liable, but the insurer's involvement was not revealed to the jury. The court said there may be circumstances in which the trial court would be justified in advising the jury of the presence of an

243. See generally R. JERRY, *supra* note 1, § 84[b].

244. 145 Kan. 139, 64 P.2d 557 (1937). Other cases in this line of authority include *Jones v. Thunderbird Transp. Co.*, 178 F. Supp. 9 (D. Kan. 1959); *Boyles v. Farmers Mut. Hail Ins. Co.*, 78 F. Supp. 706 (D. Kan. 1948); *White v. Goodville Mut. Casualty Co.*, 226 Kan. 191, 596 P.2d 1229 (1979); *Sterling v. Hartenstein*, 185 Kan. 50, 341 P.2d 90 (1959); *Billups v. American Sur. Co.*, 170 Kan. 666, 228 P.2d 731 (1951); *Fitzgerald v. Thompson*, 167 Kan. 87, 204 P.2d 756 (1949); *Waugh v. Kansas City Pub. Serv. Co.*, 157 Kan. 690, 143 P.2d 788 (1943). The origin of this line of authority is in the notion that a liability policy pays proceeds directly to the victim, whereas a "loss policy" pays proceeds for which the insured may become liable to pay. This distinction is plainly one of form, not substance, but its early recognition resulted in the creation of a limited form of direct action in Kansas.

245. 239 Kan. 90, 716 P.2d 173 (1986).

246. *Id.* at 94, 716 P.2d at 177.

insurer as a party to the case, and it suggested that when a separate attorney for the insurer actively participates in the case, such advice may be necessary. Under the particular circumstances of *Nirschl*, however, it was not error for the trial court to order that the insurer's presence in the litigation as a named party not be mentioned to the jury.²⁴⁷

VI. APPENDIX

A. Other Cases

1. Interpretation

a. Property Insurance

Interpretation of "Improvements and Betterments" and Value Reporting Clauses in Fire Insurance Policy: Ron Henry Ford, Lincoln, Mercury, Inc. v. National Union Fire Ins. Co., 8 Kan. App. 2d 766, 667 P.2d 907 (1983) ("improvements and betterments" clause in a fire insurance policy, which covers lessee's use interest in fixtures, alterations, etc. added to the leased property, only covers improvements added during the lease term; under value reporting clause in particular policy, report of values filed after loss but within grace period of policy is not effective).

Interpretation of Scope of Coverage of Property Policy: Mears v. Hartford Fire Ins. Co., 8 Kan. App. 2d 760, 667 P.2d 902 (1983) (property insurance policy for cattle, by its unambiguous terms, covered calves born in herd after policy was issued).

Interpretation of Provision Relating to Permissible Fliers of Aircraft; Exclusions and Causation: Western Food Products Co. v. United States Fire Ins. Co., 10 Kan. App. 2d 375, 699 P.2d 579 (1985) (provision relating to permissible fliers of aircraft found unambiguous; held that insurer need not establish a causal link between excluded activity and accident resulting in loss when exclusion clearly states that no coverage exists under certain circumstances).

Interpretation; "Mysterious Disappearance"; All-Risk Insurance: Empire Underground Storage, Inc. v. Protective Nat'l Ins. Co., 685 F. Supp. 1187 (D. Kan. 1988) (under all-risk policy, insured has burden to show that loss occurred during policy period; when

247. *Id.* at 95, 716 P.2d at 177.

all-risk policy insuring propane in underground caverns covered "mysterious disappearance" and no inventory was required at inception of policy, insurer implied insured amount of propane recorded in insured's books and accepted risk that loss could be disclosed on taking of inventory; thus, when inventory during policy period showed mysterious loss of approximately 50,000 barrels of propane, loss occurred within the policy period even though the last prior physical inventory occurred about three years before inception of policy).

Interpretation of "Resident of Household" Under Homeowner's Policy: Friedman v. Alliance Ins. Co., 240 Kan. 229, 729 P.2d 1160 (1986) (personal property belonging to son of insured, who was moving the property in a U-Haul between apartment at University of Texas, where son had just graduated, and location of new job in Alabama, was stolen during move; held that sufficient competent evidence existed to support trial court's finding that son was resident of his father's household at the time of loss).

Interpretation of "Resident Spouse": Lorence v. Farmers Alliance Mut. Ins. Co., 9 Kan. App. 2d 112, 673 P.2d 460 (1983), review denied, 234 Kan. 1076 (1984) (when policy covered named insured and resident spouse, but named insured and spouse were divorced prior to fire loss, former spouse is not entitled to coverage for personal belongings left in house belonging to named insured but in which former spouse resided).

Interpretation; Scope of Exclusion in Banker's Blanket Bond: Kansas State Bank & Trust Co. v. Emery Air Freight Corp., 656 F. Supp. 200 (D. Kan. 1987) (bank used overnight mail service to ship U.S. treasury receipts with face value exceeding \$2.5 million; receipts were lost; underwriter on banker's blanket bond issued to bank claimed the exclusion for loss of property while with carrier for hire, but excepting from exclusion nonnegotiable instruments while in possession or custody of carrier for hire; underwriter argued that treasury receipts were negotiable; held that policy is not ambiguous, and loss is covered).

Interpretation; Inland Marine Policy; "Loss of Market" Construed: Boyd Motors, Inc. v. Employers Ins. of Wausau, 670 F. Supp. 310 (D. Kan. 1987) (insurer issued inland marine policy to Volkswagen Credit, Inc. for benefit of car dealers; plaintiff-dealer's inventory damaged by hail, for which it received proceeds for cost of repair; plaintiff sought additional sum under inland marine policy under theory that repaired inventory was worth less than new inventory; held that policy exclusion for "loss of market" was unambiguous and applicable, and plaintiff was not entitled to additional sum).

b. Personal Insurance

Interpretation of "Insured" in Life Insurance Policy: Lightner v. Centennial Life Ins. Co., 242 Kan. 29, 744 P.2d 840 (1987) (wife was owner and sole beneficiary of six life insurance policies on her husband; husband and wife were killed simultaneously in accident; district court ordered proceeds, under terms of policies, to estate of husband, where larger estate tax was incurred; on appeal, court notes that "insured" in the policies sometimes referred to the insured and sometimes to the owner, and thus the term was ambiguous; held that because wife purchased the policies on life of her husband to prevent proceeds from going to husband's estate and that her estate is entitled to the proceeds of insurance on husband's life).

Interpretation; Life Insurance Beneficiary Designation: Pierce v. Pierce, 12 Kan. App. 2d 810, 758 P.2d 252 (1988), *aff'd by a split court*, 244 Kan. 246, 767 P.2d 292 (1989) (when divorce decree required husband to maintain life insurance with his two minor children as beneficiaries, husband's attempt to change the beneficiary when he remarried was of no force and effect; the words "minor children" in separation agreement are words of identification, and use of those words does not mean that children are entitled to benefits only during their minority).

c. Liability Insurance

Exclusion in General Liability Policy for Contractor Concerning Property Damage for Work Performed by Contractor: Owings v. Gifford, 237 Kan. 89, 697 P.2d 865 (1985) (exclusion in a general liability policy for "property damage to work performed by or on behalf of the named insured [the contractor] arising out of the work or any portion thereof, or out of materials, parts, or equipment furnished in connection therewith" held to exclude damage to the house being constructed by the builder and not to cover damages arising from the builder's faulty construction; such damages might be covered by a performance bond or a guarantee of contractual performance for repair or replacement of faulty workmanship, but the liability policy does not serve as this bond or guarantee).

Household Exclusion; Homeowner's Liability Policy: Patrons Mut. Ins. Ass'n v. Harmon, 240 Kan. 707, 732 P.2d 741 (1987) (held that household exclusion in homeowner's liability policy was not ambiguous, and son's wrongful death claim alleging death of mother, both of whom were insureds, was excluded under language providing no coverage for any insured for bodily injury or death to another insured).

“Completed Operations” Coverage; Contractor’s Liability Policy: Nash v. Hartford Accident & Indem. Co., 11 Kan. App. 2d 326, 720 P.2d 1129 (1986) (when policy is read as a whole and not in fragmented manner, policy is unambiguous and does not provide “completed operations” coverage for insured’s carpentry business).

Interpretation; Effect of Declaration Page: Thompson v. Harold Thompson Trucking, 12 Kan. App. 2d 449, 748 P.2d 430 (1987) (general rules of construction of insurance policy stated; declarations page is not actual part of the contract, unless specifically included by reference; held that insurer in workers’ compensation policy wishing to limit scope of coverage to classification of operations listed in the declarations can do so only by express exclusion).

Aviation Insurance; Air Traffic Operator Liability Endorsement: Forum Ins. Co. v. Seitz Aviation, Inc., 241 Kan. 334, 737 P.2d 29 (1987) (in specific facts presented, an air taxi operator liability endorsement to an aviation policy held to apply only to liability arising from the negligent operation, maintenance, or use of the aircraft in the interstate carriage of persons or property as a common carrier for compensation or hire).

d. Automobiles

Interpretation of “Insured” in Automobile Dealer’s Insurance Policy: Western Motor Co. v. Koehn, 242 Kan. 402, 748 P.2d 851 (1988) (Koehn damaged dealer’s automobile while test driving it; dealer’s insurer (Universal) who paid for loss, sought subrogation against Koehn, who had liability insurance with State Farm; Universal denied coverage to Koehn; Koehn claimed he was covered under Universal liability policy and therefore Universal could not assert subrogation against Koehn, its own insured; district court held that customer was not insured under Universal policy; court of appeals reversed, 12 Kan. App. 2d 215, 738 P.2d 466 (1987), and supreme court affirmed this reversal; therefore, Universal had a subrogation right against Koehn).

Interpretation; Phrase “Domestic Employment”; Loading and Unloading Provision: Canal Ins. Co. v. Earnshaw, 629 F. Supp. 114 (D. Kan. 1985) (phrase “domestic employment” in policy exception from employment exclusion for injuries arising out of and in the course of “domestic employment” referred to household-related nature of the work performed rather than location of where work was performed; thus, coverage of employer was excluded; individual involved in loading or unloading insured vehicle from which alleged injury arose did not qualify as insured under

policy exclusion providing that person was covered only if he were lessee or borrower of the vehicle or employee of the named insured or of such lessee or borrower).

Interpretation of "Occupying" in Exclusion Clause of Auto Policy: *Beasley v. State Farm Mut. Auto. Ins. Co.*, 9 Kan. App. 2d 561, 682 P.2d 689 (1984) (employee of insured was injured when employee's arm was caught in trash compactor lid of insured's truck; held that under facts of case, employee was "in and on" and therefore "occupying" the insured vehicle within the meaning of the loading-unloading exclusion clause when the injury occurred and therefore was entitled to PIP benefits).

Interpretation of Replacement Vehicle Coverage in Auto Insurance Policy: *Continental Ins. Co. v. Entrikin*, 9 Kan. App. 2d 384, 680 P.2d 913 (1984) (whether a newly acquired vehicle is a replacement for an insured vehicle is not determined by insured's failure to convey title to replaced vehicle within the statutory period, in absence of specific language to contrary in insurance policy; whether vehicle is a "replacement" depends on a variety of listed factors).

Interpretation of "a Person" in Uninsured Motorist Coverage; Meaning of "Automobile" in Statute: *Klamm v. Carter*, 11 Kan. App. 2d 574, 730 P.2d 1099 (1986) (an exclusion in uninsured motorist coverage that denied coverage for "a person" injured while occupying a motor vehicle owned by named insured but not insured under policy was construed to apply to a named insured injured while riding his uninsured motorcycle; under terms of the policy, thirty-day grace period of coverage for newly acquired vehicles does not include a newly purchased motorcycle; automobile as used in KAN. STAT. ANN. § 40-284 includes motorcycles).

Interpretation of "Regular Use" Exclusion of Automobile Policy: *Central Sec. Mut. Ins. Co. v. DePinto*, 235 Kan. 331, 681 P.2d 15 (1984) (policy covers cars used by insured with permission of owner, but not cars "furnished for the regular use" of insured; "regular use" exclusion held not ambiguous; "regular use" exclusion defined as continuous use, uninterrupted normal use for all purposes, and without limitation; customary use as opposed to occasional use; whether "regular use" exists is deemed a question of fact; held that van driven by nursing student twice a week to transport other students was not furnished for the regular use of the student and thus not excluded from the coverage).

2. Property Insurance

Consequential Damages; Interest on Proceeds Wrongly Withheld by Insurer: *Hochman v. American Family Ins. Co.*, 9 Kan. App.

2d 151, 673 P.2d 1200 (1984) (in action against insurer to recover cost of repairs of insured combine, court held that interest incurred by insured on sums borrowed for repairs is recoverable as consequential damages when the borrowing was necessitated by the insurer's failure to timely pay the claim).

Attorney Fees in Garnishment Action Against Insurer: Farmco, Inc. v. Explosive Specialists, Inc., 9 Kan. App. 2d 507, 684 P.2d 436 (1984) (attorney fees are recoverable under KAN. STAT. ANN. § 40-256 in a garnishment action by a judgment creditor against the judgment debtor's insurance carrier, and this right to attorney fees is not superseded by the garnishment statutes; KAN. STAT. ANN. §§ 40-256 and 40-2004 allow for recovery by any "plaintiff," which includes owner of property on which work is done by contractor who was required to procure insurance for benefit of owner).

Visible Marks Requirement; Federal Crime Policy: Baugher v. Secretary of Housing & Urban Dev., 623 F. Supp. 1228 (D. Kan. 1985) (federal crime insurance policy required that felonious abstraction of property be evidenced by visible marks on exterior of premises at place of entry; prior to loss, storage unit was secured by two combination locks and one key lock; when loss discovered, combination locks were missing but key lock was in place; held that missing locks constituted "visible marks" within the meaning of the policy).

Business Interruption Insurance; Amount of Recovery: Midland Broadcasters, Inc. v. Insurance Co. of N. Am., 636 F. Supp. 165 (D. Kan. 1986) (when radio station's broadcast tower was damaged by windstorm, causing station to be off the air for two days and at reduced power for two months thereafter, station could not recover under policy for loss of advertising sales after station was restored to full power, based upon evidence that station's ratings suffered as a direct result of the business interruption even after station was restored to full power).

3. Personal Insurance

McCarran-Ferguson Act; ERISA Preemption; Health Insurance: Blue Cross & Blue Shield v. Bell, 798 F.2d 1331 (10th Cir. 1986) (Kansas mandated provider law, which required insurer to pay for services of specific providers, constituted "business of insurance" within meaning of McCarran-Ferguson Act and was thus exempt from ERISA preemption).

Life Insurance; Late Premium Payments; Waiver and Forfeiture: Roberts v. Metropolitan Life Ins. Co., 808 F.2d 1387 (10th Cir. 1987) (insured paid premiums late every quarter beginning in 1977,

relying upon a credit for the available loan value of the policy plus a remittance after the grace period; insurer did not require reinstatement application until 1979, when reinstatement was denied; district court held that insurer's conduct justifiably led insured to believe that late premium payments would be accepted without fulfillment of the reinstatement requirement, even after grace period; reversed and remanded, because late payment in question was almost 100 days late, whereas prior payments were no more than 15 days late; additional findings necessary on whether insurer's course of conduct extended period for paying premiums by nearly 100 days).

Disability Insurance; Occupational Versus General Disability Coverage; Effect of Conduct Clause: *Moots v. Bankers Life Co.*, 10 Kan. App. 2d 640, 707 P.2d 1083 (1985) (general definitions of occupational disability and general disability coverages discussed; construed "conduct clause," which purported to exclude coverage if the insured engages in any occupation, work, or employment for compensation during the disability, as duplicating the insuring clause and not requiring a departure from customary rules of construction of disability coverages).

4. Liability Insurance

Duty to Defend; Constitutionality of Health Care Provider Insurance Act: *Harrison v. Long*, 241 Kan. 174, 734 P.2d 1155, appeal dismissed, 108 S. Ct. 50 (1987) (physician's insurer and Health Care Stabilization Fund settled malpractice claim against physician over the objection of physician; physician claimed Health Care Provider Insurance Act was unconstitutional because it took away physician's right to defend himself; held that provisions of Act denying physician the right to continue litigation does not deprive physician of property right or due process right under either the federal or state constitution).

Duty to Defend; Attorney Fees: *Missouri Medical Ins. Co. v. Wong*, 234 Kan. 811, 676 P.2d 113 (1984) (when the Health Care Stabilization Fund provides a defense to an insured in circumstances in which the primary insurer has failed to perform its duty, the Fund is entitled to recover the amount paid to settle the claim to the extent of the primary insurer's policy limits and also attorney fees and expenses incurred in defending against the claim).

Excess versus Primary Insurer; Duty to Settle: *Insurance Co. of N. Am. v. Medical Protective Co.*, 768 F.2d 315 (10th Cir. 1985) (primary insurer acted negligently and in bad faith in pursuing settlement negotiations in medical malpractice action; excess insurer is entitled to be subrogated to insured's right to assert a claim for bad faith against primary carrier).

5. Automobile Insurance

ICC-Licensed Interstate Motor Carriers; Liability Insurance Coverage: American Gen. Fire & Casualty Co. v. Truck Ins. Exch., 660 F. Supp. 557 (D. Kan. 1987) (federal statutes and regulations pertaining to interstate carrier's use of nonowned equipment did not render carrier or its insurer exclusively liable for personal injuries or property damage sustained in accident involving equipment; insurer of truck lessor not entitled to contribution from insurer of lessee-carrier when lessee was insured as permissive user under lessor's policy).

No-Fault; Subrogation Right of Insurer When Tortfeasor Was Not Operator of Automobile: Yunghans v. Carson, 9 Kan. App. 2d 45, 670 P.2d 928 (1983) (insured was injured when his truck struck a steer; insured sued steer's owner on theories of negligence and absolute liability; held that pursuant to literal application of statute's language, insurer that has paid PIP benefits to its insured does not have a right of subrogation under KAN. STAT. ANN. § 40-3113a when the insured obtains a duplicative recovery from a tortfeasor other than an owner, operator, or occupant of a motor vehicle or a person legally responsible for the tortious acts of such person).

Disability PIP Benefits: Dewey v. Allstate Ins. Co., 739 F.2d 1494 (10th Cir. 1984) (district court did not err in awarding insured maximum monthly disability benefit under KAIRA because, even though insured was only partially disabled during last three of nine months of disability, evidence supported finding that the value of insured's lost services was at least the maximum).

Subrogation Under Section 40-3113a of Kansas Statutes Annotated; Reduction of PIP Carrier's Recovery for Insured's Attorney Fees: American Family Mut. Ins. Co. v. Griffin, 9 Kan. App. 2d 482, 681 P.2d 683 (1984) (history of § 40-3113a and legal principles thereunder summarized; PIP carrier's obligation to pay attorney fees for recovery of duplicative PIP benefits does not depend on actual pecuniary benefit to it from activities of insured's attorney; this is extension from principle that PIP carrier must pay its share of the fees even if it is also the tortfeasor's liability carrier, and the payment of fees is merely an entry on its own books; noted that when the PIP and the liability insurer are the same insurer, the liability for the insured's attorney fees can be avoided if the insurer makes advance payments to the injured insured under KAN. STAT. ANN. § 40-275, according to the holding of Howard v. Edwards, 9 Kan. App. 2d 763, 689 P.2d 911 (1984), summarized below).

"Struck By" Requirement For Receiving PIP Benefits: Pestock v. State Farm Auto. Ins. Co., 9 Kan. App. 2d 188, 674 P.2d 1062

(1984) (KAN. STAT. ANN. § 40-3107(f) requires that one not an occupant of a motor vehicle be "struck by" a motor vehicle to receive PIP benefits; plaintiff's minor daughter was struck and fatally injured by motorist in front of plaintiff's house; plaintiff, who neither saw nor heard the accident, arrived at the scene a few minutes later, and subsequently required psychiatric care, is not entitled to PIP benefits under driver's insurance policy).

Subrogation; Section 40-3113a of Kansas Statutes Annotated: O'Donnell v. Fletcher, 9 Kan. App. 2d 491, 681 P.2d 1074 (1984) (ordinarily, when insured is not fully reimbursed for loss, insured is proper party to bring suit against third-party wrongdoer for entire loss, holding in trust any recovery duplicative of payments made by insurer; section 40-3113a alters this general rule and provides that if injured person fails to bring action against tortfeasor within 18 months after date of accident, that failure operates as assignment of injured person's tort claim to the insurer, who can then sue to recover damages duplicative of PIP benefits paid; under statute, insurer may enforce claim in its own name even though injured party was only partly recompensed).

Scope of "Drive Other Car" Exclusion in Automobile Insurance Policy: Ramsey v. Kansas Farm Bureau Ins. Co., 237 Kan. 86, 697 P.2d 863 (1985) (exclusionary provision of "drive other car" clause in automobile insurance policy held to exclude coverage if the other car is owned by a member of the insured's household or is provided for regular use to the named insured).

No-Fault and Liability Insurance; Advance Payments When Liability Insurer is Also PIP Carrier; Calculating Attorney Fees: Howard v. Edwards, 9 Kan. App. 2d 763, 689 P.2d 911 (1984) (when liability carrier is also injured party's PIP carrier, liability carrier can still make advance damage payments under § 40-275; when advance payments are made and these payments are deducted from a subsequent settlement or judgment, the insurer has not recovered PIP benefits and the plaintiff's attorney is not entitled to a fee for such an alleged recovery).

Uninsured Motorist Coverage Issued to Corporation; Who Enjoys Coverage: Sears v. Wilson, 10 Kan. App. 2d 494, 704 P.2d 389 (1985) (when uninsured motorist policy is issued to a corporation, standard form language referring to insured's family members and relatives is a nullity; absent clause expressly granting coverage to family members of an employee of a corporate named insured, family member is only covered by corporation's uninsured motorist policy when occupying a vehicle covered by the policy).

Definition of "Monthly Earnings" in Section 40-3103(1) of Kansas Statutes Annotated; Constitutionality of KAIRA: Burriss v. Northern Assurance Co., 236 Kan. 326, 691 P.2d 10 (1984),

cert. denied, 474 U.S. 821 (1985) (social security and retirement benefits do not constitute "monthly earnings" as defined in § 40-3103(1); the KAIRA's allowance of certain benefits to injured employed persons and their survivors, but not to unemployed persons and their survivors, does not render the KAIRA unconstitutional under the due process or equal protection clauses of the United States Constitution).

Definition of "Uninsured Automobile" in Insurance Policy: *Kansas Farm Bureau Ins. Co. v. Miller*, 236 Kan. 811, 696 P.2d 961 (1985) (court rejected insured's argument that "uninsured automobile" should be defined as any automobile on which the tortfeasor has purchased less liability insurance than the insured carries; court noted that legislature closed this gap in 1981 when "underinsured motorist" provisions in KAN. STAT. ANN. § 40-284(b) were adopted; court was unwilling to write into the policy underinsured coverage for 1978 accident).

Definition of Insured Under Uninsured Motorist Coverage: *Girrens v. Farm Bureau Mut. Ins. Co.*, 238 Kan. 670, 715 P.2d 389 (1986) (the definition of insureds under uninsured motorist coverage cannot be more restrictive than the class covered by the liability coverage for personal injury and property damage under KAN. STAT. ANN. § 40-3107; the term "dependent person" in policy "relates to a monetary or otherwise generally accepted familial dependence for care and sustenance").

Effect of Mentioning Insurance Coverage Before Jury When Insurer is Party to Lawsuit Under Direct Action Statute: *Klinzmann v. Beale*, 9 Kan. App. 2d 20, 670 P.2d 67 (1983) (when insurer is party to lawsuit under KAN. STAT. ANN. § 66-1,128, a direct action statute, merely mentioning insurance before the jury lacks the inherent prejudice that would occur in a case in which the insurer is not, and cannot legally be, a party; held that comments before the jury by the plaintiffs' counsel, which might have been reversible error in a nondirect action setting, were not grounds for reversal when the insurer was a party).

No-Fault; Monetary Threshold for Tort Action: *Smith v. Vanguard Products Corp.*, 9 Kan. App. 2d 585, 682 P.2d 1313 (1984) (the \$500 medical expense threshold in KAN. STAT. ANN. § 40-3117, which was recently increased to \$2000, refers to the value of "medical treatment"; replacement of eyeglasses damaged in a collision is not "medical treatment" for the purpose of meeting the monetary threshold when the insured suffers no injury to the eyes requiring any different correction than was required before the collision).

6. Miscellaneous

Statutory Requirements; Effect on Policy's Coverage: *Missouri Medical Ins. Co. v. Wong*, 234 Kan. 811, 676 P.2d 113 (1984)

(the policies of an out-of-state insurer that does business in Kansas must be construed to contain the coverage required by Kansas statutory law; held that occurrence policy sold in Kansas by Missouri insurer is actually a "claims-made" policy as required by KAN. STAT. ANN. § 40-3402(a); the insurer's limit of liability is not shielded by the minimum statutory requirement of \$100,000 per occurrence and \$300,000 aggregate, however, and the insurer is held liable to provide coverage of \$1,000,000, as set forth in the limits of the coverage).

Group Insurance; Conflict of Laws: *Simms v. Metropolitan Life Ins. Co.*, 9 Kan. App. 2d 640, 685 P.2d 321 (1984) (KAN. STAT. ANN. § 40-2,105 does not apply to policy issued prior to statute's enactment or to insurance contract made outside Kansas; group insurance policy is "made" when master policy is delivered, not when certificates of coverage to individual employees are issued).

Retrospective Premium Policy; Burden to Show Reasonableness of Settlements: *Transit Casualty Co. v. Topeka Transp. Co.*, 8 Kan. App. 2d 597, 663 P.2d 308 (1983) (when insurer seeks retrospective premiums based on amounts it has paid in settling claims against its insured, burden is on insurer to establish that the settlements were made in good faith and were reasonable in amount).

Interpleader; When Does Insurer "Make Payment": *Bryan v. Davis*, 11 Kan. App. 2d 691, 732 P.2d 805 (1987) (insurer in interpleader action is discharged from liability under policy upon paying to the clerk of the district court the full amount of the policy; payment is "made" when insurer makes such payment to the court).

Misrepresentation: *Missouri Medical Ins. Co. v. Wong*, 234 Kan. 811, 676 P.2d 113 (1984) (argument that insurer could cancel policy because of insured's misrepresentation as to place of residence was invalid when insurer's agents knew at time of issuance of policy exactly where the insured was practicing medicine).

Bad Faith; Extracontractual Liability of Insurer to Insured: *United of Omaha Life Ins. Co. v. Reed*, 649 F. Supp. 837 (D. Kan. 1986) (Reed's claims for health expenses were denied by health insurer on ground that Reed's status as employee had terminated; Reed argued he was told by insurer's agent that he could convert the group coverage to individual coverage; held that Reed has no cause of action for bad faith, which is not recognized as tort in Kansas; held that Reed does have cause of actions for misrepresentation, reformation, and breach of contract, but Reed has no claim for extracontractual damages because he alleged no independent tort causing "additional injury").

Timeliness of Notice of Loss: *Home Life Ins. Co. v. Clay*, 11 Kan. App. 2d 280, 719 P.2d 756 (1986) (held that district court

erred in granting summary judgment for an insurer on a bond when the insured bank delayed giving notice for 18 months after the discovery of a loss; surety will not be relieved of liability on its bond unless it can show it was prejudiced by the delay in giving notice of loss).

Employer Estopped to Deny Existence of Health Insurance Coverage: Cory v. Binkley Co., 235 Kan. 906, 684 P.2d 1019 (1984) (when employee's job status changed to that of independent contractor, and employee did not understand when status changed so that no insurance would be provided by employer, sufficient evidence existed to support the verdict that the employer, which had undertaken to procure health insurance for its employees, should be equitably estopped to deny the existence of coverage).

B. Statutory Changes

1. Property Insurance

Title Insurance Rate Regulation: Act approved May 17, 1988, ch. 156, 1988 Kan. Sess. Laws 957, 966 (to be codified at KAN. STAT. ANN. § 40-1111(d)) (effective July 1, 1989, subjects title insurance rates to the requirements of casualty rate regulation).

2. Personal Insurance

Group Insurance; Replacement Policies: Act approved Apr. 14, 1988, ch. 160, 1988 Kan. Sess. Laws 973, 973-74 (to be codified at KAN. STAT. ANN. § 40-2209(A)) (prohibits group accident and sickness insurers from applying individual underwriting on replacement group policies issued to one employer; but allows replacing insurers to impose a waiting period not to exceed one year "upon coverage for conditions of health which existed prior to the date of enrollment of such employee, dependent or family member, hospitalization in progress on the date of enrollment need not be covered, and the plan may impose participation requirements, define full-time employees and otherwise design the coverage for the group as a whole to be negotiated between the employer and insurer").

Life Insurance; Interest on Proceeds: Act approved Apr. 17, 1987, ch. 164, 1987 Kan. Sess. Laws 800 (amends KAN. STAT. ANN. § 40-447 to provide that an insurer that fails to pay proceeds of life insurance within ten days after the date of receipt of due proof of death shall pay interest on sums unpaid after the ten-day period at an annual rate of not less than the current rate of interest on death proceeds left on deposit with the insurer plus one percent computed from the date of the receipt).

Health Insurance; Coverage for Drug and Alcohol Abuse and Mental Illness: Act approved Apr. 24, 1986, ch. 174, 1986 Kan. Sess. Laws 831 (codified at KAN. STAT. ANN. § 40-2,105 (1986)) (requires group and individual health insurance policies to include minimum coverage for drug and alcohol abuse and mental illness).

Life and Health Insurance Guaranty Association: Act approved Apr. 25, 1986, ch. 180, 1986 Kan. Sess. Laws 850 (major revision of Kansas life and health insurance guaranty association act; limits the protection of the act to residents only; places limits on coverage available; reinstates coverage for annuities).

3. Casualty Insurance

Casualty Insurance; Rate Regulation: Act approved May 17, 1988, ch. 155, 1988 Kan. Sess. Laws 940 (effective January 1, 1989, modifies fire, marine, inland marine, and casualty rate regulation procedures, including requiring the consideration of investment income in making insurance rates, placing the burden of proof on the company or rating organization to show that the proposed rates meet the statutory standards, requiring rate filers to provide all supporting information requested by the Insurance Commissioner at the filer's expense, and giving the Insurance Commissioner the authority to order prospective adjustments in premiums regarding a disapproved rate; also requires an insurer withdrawing from the state either totally or partially to give the Commissioner 60 days notice of intent).

Cancellation by Insurer of Property and Casualty Insurance; Insurer's Permissible Grounds: Act approved Apr. 18, 1986, ch. 168, 1986 Kan. Sess. Laws 820 (codified at KAN. STAT. ANN. § 40-2,120 (1986)) (no policy of property or casualty insurance, other than accident and sickness insurance, used primarily for business or professional needs that has been in effect for 90 days or more may be canceled except for one of six enumerated reasons; insurer must give at least 60 days advance notice of intent not to renew; requires insurer to give insured reasons for cancellation or non-renewal of existing policy).

4. Auto Insurance

Uninsured/Underinsured Motorist Coverage; Offering Requirements Under Excess Policies: Act approved Apr. 19, 1988, ch. 152, 1988 Kan. Sess. Laws 907 (codified at KAN. STAT. ANN. § 40-284 (Supp. 1988)) (provides that uninsured or underinsured motorist coverage need not be offered or provided under umbrella excess policies or other policies that are not primary).

5. Miscellaneous

Discrimination in Rates; Blindness: Act approved Apr. 16, 1987, ch. 171, 1987 Kan. Sess. Laws 831 (codified at KAN. STAT. ANN. § 40-2404 (Supp. 1988)) (prohibits unfair discrimination in the underwriting or rating of insurance policies based on the insured's blindness).