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Chapter 11: Insurance Law

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CHAPTER 11

Insurance Law

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A. COURT DECISIONS

§11.1. Motor vehicle insurance rate cases: Attacks on constitutional and procedural grounds. The 1971 SURVEY year once again found the commissioner of insurance called upon to defend insurance premium rates and classifications established either directly by the Massachusetts legislature or pursuant to statutory authority by the commissioner himself. The principal cases were *Aetna Casualty and Surety Co. v. Commissioner of Insurance,*[1] *Travelers Indemnity Co. v. Commissioner of Insurance,*[2] and *Insurance Rating Board v. Commissioner of Insurance.*[3] These three cases will be discussed together, even though two of them concerned 1970 rates, because of similarities in the subject matter and in the reasoning employed by the Supreme Judicial Court. These cases illustrate the distinction, not always clearly appreciated, between judicial disapproval of rates because they are so low as to be confiscatory and unconstitutional, and disapproval on the ground that the rates have not been established in accordance with appropriate procedural or statutory standards.

In *Aetna,* the plaintiff (70 insurance companies and a rating organization) challenged a provision of the Acts of 1971 that required property damage liability rates for 1971 to be set at least 15 percent lower than comparable 1970 rates.[4] The plaintiff charged that the rates were confiscatory and unconstitutional despite the statutory declaration that the 15 percent reduction produced rates which were "adequate, just, reasonable and nondiscriminatory."[5] The Supreme Judicial Court correctly refused to accord any weight to this language, indicating that the legislature cannot constitutionally exempt its activities from judicial review.

Because the commissioner of insurance had admitted all facts contained in the pleadings, the *Aetna* Court was confronted with a record

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Mr. Wadsworth wrote §§11.1 to 11.16, and Commissioner Ryan wrote §§11.17 to 11.19.

§11.1. [1] 1970 Mass. Adv. Sh. 1411, 263 N.E.2d 698.
[2] 1970 Mass. Adv. Sh. 1537, 265 N.E.2d 90.
[3] 1971 Mass. Adv. Sh. 401, 268 N.E.2d 144.
[4] Acts of 1970, c. 670, §6, amending G.L., c. 175, §113B.
[5] Ibid.

that indicated a substantial aggregate property damage underwriting loss in 1969 for all companies writing such insurance in Massachusetts. Projecting from 1969 industry experience and using 1969 rates reduced by 15 percent (1970 rates were not yet established), an aggregate underwriting loss of over $34 million was projected for 1971 with regard to the Massachusetts property damage business of all the companies. Moreover, based on these assumptions, each individual company writing such insurance in Massachusetts in 1971 would experience an underwriting loss on such insurance. The Court rejected the commissioner's contention that insufficient detail had been shown as to the effect of the rates on each individual insurer. In addition, although not expressly adopting the principle, the Court did cite authority for the proposition that the "aggregate experience of a group of insurers may be deserving of greater weight than that of an individual company."[6]

The commissioner also argued that the bill was demurrable because it sought a review of constitutional adequacy as to automobile liability insurance only, and not as to the "overall automobile insurance situation." The Court had no difficulty rejecting this contention, finding a clear legislative intent "that each type of automobile liability insurance coverage be considered and treated separately from all others for rate purposes."[7]

The most fundamental contention made by the commissioner in the *Aetna* case was that the Commonwealth, as part of its plenary power to regulate insurance, had the power to prescribe rates irrespective of the effect of such rates on insurers, and that the only option available to insurers who could not write insurance on a profitable basis was simply to cease writing such insurance. The Court indicated that the Commonwealth's regulatory power over insurance does not extend so far: "The writing of insurance is a lawful business and the Commonwealth may not impose unconstitutional conditions upon the exercise of the right to engage therein."[8] The opinion further declared that although rates need not be such as to guarantee a profit to all insurers, the commissioner may not constitutionally set rates which apparently would result in a loss to all. Insurers "have a right to rates which are not confiscatory, or which satisfy any higher applicable statutory standards."[9] The Court thereupon ruled that the automobile property damage liability insurance rates set by the legislature for 1971 were confiscatory and unconstitutional.

The Supreme Judicial Court chose, as precedent, cases relating for the most part to limitations on the ability of the legislature, acting pursuant to the so-called police power, to restrict otherwise lawful activities.[10] Somewhat surprisingly, no direct reference was made to

[6] 1970 Mass. Adv. Sh. 1417, 263 N.E.2d 702.
[7] Id. at 1418, 263 N.E.2d at 703.
[8] Id. at 1418, 263 N.E.2d at 703.
[9] Id. at 1419, 263 N.E.2d at 703.
[10] E.g., see Opinion of the Justices, 322 Mass. 755, 79 N.E.2d 883 (1948) (cemetery

rate cases arising in other contexts, especially in respect to public utility rates,[11] nor did the Court cite the language in the opinion that first established the constitutionality of compulsory motor vehicle insurance in Massachusetts:

> A fundamental principle of rate making by public authority is that in general the rate so established must be sufficient to yield a fair return on the reasonable value of the property used or invested for doing the business after paying costs and carrying charges. Rates not sufficient to yield such return are unjust, unreasonable and confiscatory.[12]

In the *Travelers* case, the Supreme Judicial Court, in a brief opinion relying principally on *Aetna*, held unconstitutional a provision of the Acts of 1968 that had directed the commissioner of insurance to establish for 1970 the same compulsory liability classifications as were in effect in 1967 and rates no higher than the 1967 rates.[13] When the plaintiffs (46 insurance companies and a rating organization) filed a request with the commissioner for a hearing on compulsory liability rates, he declined on the ground that no hearing was necessary in the face of the legislature's mandate.

Using 1967 rates and projecting underwriting experience from that of 1968 (the most recent year for which statistics were available), the master to whom the case was referred estimated that the plaintiffs would sustain an aggregate loss in 1970 of more than $13 million on compulsory insurance. Moreover, only one of the insurers would have had an operating profit. The Court held that based upon these findings the 1967 rates were confiscatory and unlawful for use in 1970, and were not "adequate, just, reasonable and nondiscriminatory" as required by G.L., c. 175, §113B. The commissioner was thereupon ordered to establish the 1970 rates and risk classifications in accordance with those statutory standards.[14]

Adherence to the statutory standards of G.L., c. 175, §113B was itself the issue in the *Rating Board* case. The Commissioner claimed to have discharged his statutory duty to establish "adequate, just, reasonable and nondiscriminatory premium charges" when, after a public hearing, he disapproved the property damage and medical payments insurance rates proposed for 1970 by two insurance rating organizations. His disapproval, expressed in a brief written opinion, left the 1969 rates in effect. The rating organizations did not contend that the

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associations may not be precluded from selling grave monuments); Wyeth v. Cambridge Bd. of Health, 200 Mass. 474, 86 N.E. 925 (1909) (undertakers may not be required to be embalmers).

[11] See especially New England Tel. and Tel. Co. v. Department of Pub. Utils., 331 Mass. 604, 121 N.E.2d 896 (1954).

[12] Opinion of the Justices, 251 Mass. 569, 610, 147 N.E. 681, 700 (1925).

[13] Acts of 1968, c. 643, §2A, amending G.L., c. 175, §113B.

[14] Once established, these rates and classifications were to be retroactive to January 1, 1970.

rates thus continued were confiscatory and unconstitutional, but rather that the commissioner had failed to comply with prescribed procedures in setting the rates. The Supreme Judicial Court agreed with the plaintiffs and indicated that the commissioner had not discharged his statutory duty by simply disapproving the proposed rates. The Court accepted the principle that "[r]ates are not adequate, fair and reasonable if a large aggregate loss for the preceding year and a probable greater loss for the year in issue are ignored and the preceding year's rates simply renewed."[15] Without further evidence, however, the Court was unwilling to find that renewal of the 1969 rates in fact violated the aforementioned principle, for the record did not include admissions by the commissioner, as there were in *Aetna*, that extensive underwriting losses had been incurred in the preceding year. What the Court did hold in the *Rating Board* case was that the commissioner's findings were insufficient to enable the justices "to determine (a) whether his order and conclusions are warranted by appropriate subsidiary findings, and (b) whether such subsidiary findings are supported by substantial evidence."[16] The case was remanded to the commissioner so that he could develop a record that would list his subsidiary findings and conclusions and indicate "the manner in which the various elements which he considers and incorporates in his determination are combined so as to arrive at the rates. . . ."[17] The Court's decision seems to have been compelled by precedent[18] and, moreover, is necessary if the courts are to maintain an effective review of the rate-setting process.

Another aspect of the decision should be noted. Information regarding the investment income of the insurers had been requested and received by the commissioner for use in establishing compulsory liability rates. He had also generally adopted the insurers' formula for determining the appropriate amount of the earnings to be apportioned to the relevant lines of insurance. However, the Court indicated that the commissioner had erred to the extent that he had included in the apportionment formula income from premiums and reserves related to lines of insurance other than compulsory liability. This inclusion was deemed contrary to the holding in *Aetna* that each type of coverage must be treated separately from all others for rate-setting purposes.

§11.2. Motor vehicle liability insurance: Scope of definition of the insured. In *Drescher v. Travelers Insurance Co.*,[1] the principal insured had purchased an automobile to be used by his son, who was a student at the University of Massachusetts. The plaintiff, a close

[15] 1971 Mass. Adv. Sh. 401, 404, 268 N.E.2d 144, 147.

[16] Id. at 407, 268 N.E.2d at 149.

[17] Ibid.

[18] See Massachusetts Bonding and Ins. Co. v. Commissioner of Ins., 329 Mass. 265, 273, 107 N.E.2d 807, 812 (1952), citing Insurance Co. of North America v. Commissioner of Ins., 327 Mass. 745, 753, 101 N.E.2d 335, 340 (1951).

§11.2. [1] 1971 Mass. Adv. Sh. 799, 269 N.E.2d 651.

friend of the principal insured's son, was driving the car at the time of an accident which resulted in the deaths of the principal insured's son and a second passenger. An action on behalf of the estate of the second passenger had resulted in a settlement payment by the driver of over $25,000. The issue before the Supreme Judicial Court in *Drescher* was whether the plaintiff driver was an "insured" within the meaning of the principal insured's motor vehicle liability insurance policy, for if this was established, the insurer would be liable for the $25,000 settlement payment. The relevant policy provision, commonly called an omnibus clause, defined the *insured* as the "named insured" (the father) and anyone using the car with the permission of the named insured, "provided his actual operation or (if he is not operating) his other actual use thereof is within the scope of such permission."[2]

The more modern cases typically hold that use of an automobile by a person other than the permittee (the son in this case) is impliedly authorized by the principal insured if he has given "broad and unfettered dominion" over the automobile to the permittee.[3] On the other hand, where the principal insured has instructed the permittee not to allow others to drive the automobile, a second permittee (the driver in this case) is not likely to be considered an insured under an omnibus clause.[4] Courts have often, however, found an implied authorization in spite of seemingly clear instructions by the principal insured.[5] Omnibus clauses in automobile policies are construed liberally and courts therefore assume, unless a contrary intent is manifested, that a general dominion was granted to the permittee.[6]

In *Drescher,* the Supreme Judicial Court found that the father had given his son general dominion over the car, having placed no restrictions on its use. "Since the [father] . . . appears to have delegated such broad responsibility to his son, it is reasonable to assume that the driving of the car by the plaintiff while the son was riding in it and for his purposes was impliedly sanctioned by the father."[7] Accordingly, the Court held that the plaintiff was an "insured" within the meaning of the policy.[8] The implied permission of the father was

[2] Id. at 800, 269 N.E.2d at 653.

[3] National Farmers U.P. and Co. v. State Farm Mut. Auto. Ins. Co., 277 F. Supp. 542 (D. Mont. 1967). The Supreme Judicial Court adopted the liberal rule and cited decisions from six other jurisdictions in support of its position. For a discussion of the issue of implied permission, see 7 Appleman, Insurance Law and Practice §4361 (1962, Supp. 1972).

[4] Baesler v. Globe Indem. Co., 33 N.J. 148, 162 A.2d 854 (1960).

[5] National Farmers U.P. and Co. v. State Farm Mut. Auto. Ins. Co., 227 F. Supp. 542 (D. Mont. 1967).

[6] Travelers Corp. v. Kaminski, 304 F. Supp. 481 (D. Md. 1969); Farm Bureau Ins. Co. v. Allied Mut. Ins. Co., 180 Neb. 555, 143 N.W.2d 923 (1966). See 7 Appleman, Insurance Law and Practice §4361 (1962, Supp. 1972).

[7] 1971 Mass. Adv. Sh. 799, 802, 269 N.E.2d 651, 653-654.

[8] Cases relied on by the trial judge in reaching a contrary result were easily distinguished by the Court inasmuch as they all involved the use of automobiles outside the specific and limited purposes for which they were loaned.

based on the fact that the plaintiff had been driving the car "while the son [the permittee] was riding in it and for his [the son's] purposes." However, in three of the cases cited by the Court in support of its holding, the permittee was not in the car when the accident occurred, and the use of the car was "for his purposes" only to the extent that the permittee had loaned the vehicle as a friendly gesture.[9] *Drescher,* therefore, would appear to provide support for the proposition that it should make no difference in a particular case whether the permittee was in the vehicle at the time of the accident, or whether he was receiving some particular benefit from the use of the vehicle by someone else.

§11.3. **Motor vehicle liability insurance: Breach of cooperation and assistance clause.** *Foshee v. Insurance Co. of North America*[1] involved a determination of whether the insured had breached the cooperation and assistance clause in his motor vehicle liability policy and thus excused the insurer from liability. The plaintiff, who had been a guest injured while riding in the insured's car, had originally brought an action for injuries against the insured in the Boston Municipal Court. Although the insurer had directed several communications to the insured at his last known address, the insured failed to appear at trial. The insurer's counsel thereupon withdrew his appearance, and a default was entered. The insurer participated no further in the action and notified the insured at his last known address that the insurer had disclaimed all liability under the policy. Although the default was thereafter removed by the insured, a final default in the action was later entered in the superior court. The plaintiff, having secured a default judgment against the insured, then brought a bill in equity to reach and apply the noncompulsory coverage of the insured's motor vehicle liability policy. The trial judge dismissed this bill.

The Supreme Judicial Court experienced little difficulty upholding the dismissal. First, the Court cited the general rule that in an action such as that in *Foshee,* any defense available to the insurer against the insured is also available to the insurer against the plaintiff.[2] The Court also treated as "well settled" the proposition that an insurer's liability terminates if the insured commits a material breach of the

[9] In one case, the permittee was living away from home with another family. He loaned the car to a member of that family for use in grocery shopping. Kresbsbach v. Miller, 22 Wis. 2d 171, 125 N.W.2d 408 (1963). In a second case cited by the Court, the permittee was away at college. After he had returned from a picnic, accompanied by a friend and the friend's date, it was discovered that the girl had forgotten an item at the picnic area. The car was loaned to the permittee's friend so that he could return to the picnic area with his date. Peterson v. Armstrong, 176 So. 2d 453 (La. 1965). In a third case cited in Drescher, the permittee had use of a company car. He allowed his son to use the car to drive to a restaurant, but the accident occurred while the son was driving several college students back to their campus. Utica Mut. Ins. Co. v. Rollason, 246 F.2d 105 (4th Cir. 1957). See also Standard Accident Ins. Co. v. Allstate Ins. Co., 72 N.J. Super. 402, 178 A.2d 358 (1962).

§11.3. [1] 1971 Mass. Adv. Sh. 813, 269 N.E.2d 677.
[2] Imperiali v. Pica, 338 Mass. 494, 156 N.E.2d 44 (1959).

cooperation clause. Finally, it accepted the finding of the trial judge that the insurer had exercised due diligence and good faith in attempting to locate its insured.[3] Nonetheless, before a disclaimer of liability may be enforceable, it must be demonstrated that the breach of the cooperation clause was material. On the question of materiality, the Court cited some Massachusetts decisions which indicated that great difficulty on the part of the insurer's counsel in locating and communicating with the insured amounts to a material breach of the cooperation clause, justifying a disclaimer of liability when the insured thereafter fails to appear at trial.[4]

It should also be remembered that a Massachusetts insured does not meet the required norm for cooperation simply by keeping his insurer notified as to his current address. The insured in *Imperiali v. Pica*[5] had cooperated in every respect except in his failure to assist counsel for the insurer in preparing necessary answers to meet the other party's demand to admit facts. In upholding the enforceability of the insurer's disclaimer, the Supreme Judicial Court stated that "[a]n insured cannot excuse his failure to furnish 10 percent of the cooperation requested of him by showing that he had cooperated as to 90 per cent."[6]

§11.4. Motor vehicle liability insurance: Limitation of liability. *Johnson v. Travelers Indemnity Co.*[1] concerned an attempt by an insurer to limit its liability arising out of a loss covered by more than one policy of insurance. The insureds owned three automobiles, each covered by a separate liability insurance policy that included protection against uninsured motorists. Liability on that protection was limited in each of the policies to $5000 per person. The insureds' young son was covered by each of the policies at the time he was struck and killed by an automobile driven by an uninsured motorist. The superior court issued a decree which provided that if liability were determined and damages assessed, recovery might be had on each policy up to one-third of the damages, with an upper limit of $5000 per policy; that is, there might be a potential maximum recovery of $15,000 if actual damages so warranted.

On appeal to the Supreme Judicial Court, the insurer asserted that its total liability should be governed by a provision, appearing in each policy, which specified that when a loss is covered by more than one policy,

> the damages shall be deemed not to exceed the higher of the

[3] For a decision holding that the insurer had failed in its duty to communicate with the insured, see Cormier v. Crosta, 1971 Mass. Adv. Sh. 416, 268 N.E.2d 131 (rescript opinon). See also Tomlinson v. Goldberg, 121 Pa. Super. 125, 182 A. 765 (1936); Tuder v. Commonwealth Cas. Co., 10 N.J. Misc. 1206, 163 A. 27 (1932).

[4] Peters v. Saulinier, 351 Mass. 609, 222 N.E.2d 871 (1967); Polito v. Galluzzo, 337 Mass. 360, 149 N.E.2d 375 (1958). For a similar holding in another jurisdiction, see Patton v. Washington Ins. Exch., 288 Ill. App. 594, 6 N.E.2d 472 (1937).

[5] 338 Mass. 494, 156 N.E.2d 44 (1959).

[6] Id. at 500, 156 N.E.2d at 48.

§11.4. [1] 1971 Mass. Adv. Sh. 869, 269 N.E.2d 700.

> applicable limits of liability of this insurance and such other insurance, and the company shall not be liable for a greater proportion of any loss to which this coverage applies than the limit of liability hereunder bears to the sum of the applicable limits of this insurance and such other insurance.[2]

This provision, urged the insurer, should limit its total liability to $5000, one-third being payable under each policy. The Court agreed that the clause, if valid, would indeed limit liability on each policy to one-third of $5000. However, the Court interpreted the statutory language applicable at the time[3] to require that *each* policy provide uninsured motorists coverage of no less than $5000. Accordingly, it was held that the "other insurance" clause in the policy was ineffective to the extent of its conflict with the statutory language, and the decree of the superior court was affirmed.

It should be noted that the section of the General Laws interpreted by the Supreme Judicial Court in *Johnson* was repealed the year after the insureds' son was killed.[4] However, the present statutory scheme would dictate the same result as that reached by the Court in *Johnson*.[5]

§11.5. Disability insurance: Definition of total disability. *Town of Norwell v. Hartford Accident and Indemnity Co.*[1] involved the meaning to be given to the term *total disability* appearing in a group disability insurance policy issued by defendant to the town of Norwell, covering certain of its employees. Particularly in issue were the weekly payments which would be made under the policy for up to two years to persons who were totally disabled as the result of accidental bodily injury. The employee involved, a police officer, returned to work at his own request approximately eleven weeks after his initial accident. He left again, however, after about ten days, having found himself unable to carry out his normal duties. As of December 1970 he still had not returned to work as a police officer.

Total disability was defined in the policy as the "complete inability of an Insured Person to perform each and every duty of his regular occupation until Weekly Indemnity has been payable for one

[2] Id. at 870, 269 N.E.2d at 701.

[3] At the time of the death of the insured's son, G.L., c. 90, §34L provided that no motor vehicle liability policy could be issued without uninsured motorists coverage, in an amount "no less than" that set for compulsory liability insurance under G.L., c. 90, §34A (which required coverage of "at least five thousand dollars on account of injury to or death of any one person, and subject to such limits as respects injury to or death of one person, of at least ten thousand dollars on account of any one accident resulting in injury to or death of more than one person. . . .").

[4] G.L., c. 90, §34L, repealed by Acts of 1968, c. 643, §6.

[5] Acts of 1968, c. 643, §5 added Section 113L to G.L., c. 175. Section 113L provides that no policy shall be issued with respect to a motor vehicle, trailer or semitrailer registered in the Commonwealth unless the policy provides for uninsured motorists coverage "in amounts or limits prescribed for bodily injury or death for a liability policy under this chapter. . . ." Liability for bodily injury or death is governed by G.L., c. 175, §112, which incorporates the limits set by G.L., c. 90, §34A. See n.3 *supra*.

§11.5. [1] 1971 Mass. Adv. Sh. 35, 265 N.E.2d 915.

hundred and four weeks during any time of continuous disability."[2] The town of Norwell argued that the claimant was totally disabled if he was unable to perform even one of his regular duties as a police officer. Completely opposite was the insurer's argument that if the claimant could perform even one of his regular duties, he was not totally disabled under the policy. The insurer maintained that its obligation terminated when the claimant returned to work because, even for the fairly brief time involved, the claimant had performed some of the duties of a police officer. After examining the very ambiguous policy language, the master to whom the case had been referred agreed with the town of Norwell. The Plymouth Superior Court entered a final decree affirming the master's finding that the officer was in fact unable to perform "each and every duty of his regular occupation."

On appeal by the insurer, the Supreme Judicial Court determined that total disability in fact existed, but the decision does not seem to have been based on the time-honored principle that ambiguity in policy language is to be construed against the insurer. Instead, perhaps feeling that neither party's interpretation was consistent with the purposes of disability insurance, the Court said:

> Complete physical or mental incapacity of the insured . . . is not essential to his total disability. . . . It is sufficient that his disability is such that it prevents him from performing remunerative work of a substantial and not merely trifling character.[3]

The Court viewed the claimant's unsuccessful attempt to return to work at his "regular profession" as tending to confirm rather than negate the existence of total disability.[4]

§11.6. Disability insurance: Statements in the policy application. Each of the insured's statements in a policy application is generally characterized as either a representation or a warranty. G.L., c. 175, §186 enables the insurer to avoid the policy upon a showing of any misrepresentation made by the insured that increases the risk of loss or is made with actual intent to deceive.[1] However, if statements in

[2] Id. at 37, 265 N.E.2d at 916.

[3] Id. at 37, 265 N.E.2d at 917, citing Zakon v. Metropolitan Life Ins. Co., 328 Mass. 486, 489-490, 104 N.E.2d 603, 605 (1952).

[4] The Town of Norwell decision is consonant with the prevailing rule of law as expressed in North American Accident Ins. Co. v. Miller: "It has been held that, where the policy limits the right to indemnity to a continuous period of [total] disability, the continuity is not broken by the fact that the insured returned to his work at long intervals and worked for only short periods while still suffering from the injury." 193 S.W. 750, 756 (Tex. Civ. App. 1917). For more recent cases expressing the same viewpoint, see Joyce v. United Ins. Co., 202 Cal. App. 2d 654, 21 Cal. Rptr. 361 (1962); Sullivan v. North American Accident Ins. Co., 150 A.2d 467 (D.C. Mun. App. 1959); Erreca v. Western States Life Ins. Co., 19 Cal. 2d 388, 121 P.2d 689 (1942); Wood v. Federal Life Ins. Co., 224 Iowa 179, 277 N.W. 241 (1938). See also 1A Appleman, Insurance Law and Practice §651 (1965, Supp. 1972).

§11.6. [1] G.L., c. 175, §186 provides: "No oral or written misrepresentation or war-

the insured's application are expressly made conditions precedent to the effectiveness of the policy, and if there is a material misstatement, coverage under the policy may be denied without reference to Section 186.[2]

In *Shaw v. Commercial Insurance Co.*,[3] two accident, health, and disability policies had been issued to the plaintiff, a surgeon, "in consideration of the statements [of the insured] in the application" for the policy. Another provision in each policy indicated that, after two years, only fraudulent misstatements in the application might be used to avoid the policy. The trial judge found that the policy provisions served to make the accuracy of all material statements in the applications conditions precedent to the effectiveness of the policies. He found, moreover, that the plaintiff had made false statements regarding his own mental health, although the statements were "not made fraudulently and with knowledge of their falsity."[4] The Supreme Judicial Court reversed, holding simply that nothing in the policy made the truth of statements in the application a condition precedent. The case was remanded for a factual determination as to whether the policy could be avoided under the criteria set forth in Section 186. The Supreme Judicial Court's decision is consistent with the test set out in *Charles, Henry and Crowley Co. v. Home Insurance Co.*, which held that a statement in an application may be a condition precedent rather than a representation or warranty only if

> (1) the statement made by the insured relates essentially to the insurer's intelligent decision to issue the policy; and (2) the statement is made a condition precedent to recovery under the policy, either by using the precise words "condition precedent" or their equivalent.[5]

There are other interesting aspects to the case. In the application for one of the policies, Dr. Shaw answered that he had not received "medical attention or advice" for the preceding five years, when in fact shortly before completing the application he had consulted a medical doctor for psychotherapy with regard to marital difficulties. The Court indicated that any ambiguity in the question as to whether

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ranty made in the negotiation of a policy of insurance by the insured or in his behalf shall be deemed material or shall defeat or avoid the policy or prevent its attaching unless such misrepresentation or warranty is made with actual intent to deceive, or unless the matter misrepresented or made a warranty increased the risk of loss." For a decision holding that the insurer was entitled to avoid the policy because of the insured's misrepresentations, see Pahigian v. Manufacturers' Life Ins. Co., 349 Mass. 78, 206 N.E.2d 660 (1965).

[2] "[G.L., c. 175, §186] does not apply to provisions in a policy which, by agreement of the parties, are made conditions precedent to the duty of performance on the part of the insurance company." Lopardi v. John Hancock Mut. Life Ins. Co., 289 Mass. 492, 495, 194 N.E. 706, 707 (1935).

[3] 1971 Mass. Adv. Sh. 961, 270 N.E.2d 817.

[4] Id. at 964, 270 N.E.2d at 820.

[5] 349 Mass. 723, 726, 212 N.E.2d 240, 242 (1965).

psychotherapy constituted "medical attention or advice" was to be construed against the insurer. The clear lesson for insurers is to broaden the scope of their questioning.

Both policies contained a provision that made recovery for disability dependent on the insured's being "regularly attended" by a qualified physician during the period of disability. The plaintiff attempted to show that a symptom of his illness was his inability to recognize that he was mentally ill, i.e., to recognize that he was disabled and should be regularly attended. This condition, he claimed, should excuse him from the policy requirement and his past failure to comply with it. The Court apparently found no evidence that the insured was not fully capable of appreciating the policy requirement. As to Dr. Shaw's ability to assess his own situation, the Court noted the evidence of his awareness that others thought him to be ill.

§11.7. Life insurance: Misrepresentations in policy application. *James H. Boyle and Sons v. Prudential Insurance Co.*[1] involved the principle that a life insurance policy may not be avoided by the insurer because of misrepresentations in the policy application if the insurer's examining physician incorrectly records information truthfully given by the applicant.[2] This principle becomes very important when, as in the present case, the policy surely would never have been issued if the examining physician had properly recorded the information given by the applicant.

The plaintiff corporation was the beneficiary under a life insurance policy issued by the defendant on the life of the corporation's president, John F. Boyle. Evidence was presented by another company officer that he and Boyle had gone together to undergo a physical examination in connection with their respective applications for life insurance from Prudential. The doctor who examined them acted in behalf of the insurer and recorded information where required on the policy applications. After Boyle's death during the contestable period, Prudential tendered to the beneficiary the premiums paid on the deceased's policy, plus interest, but refused to pay the face value of the policy on the ground that material misrepresentations had been made by Boyle in his policy application. At trial, Prudential offered evidence that at the time of his application, Boyle knew that he had several maladies, including a blood disorder, none of which was acknowledged on his signed application for life insurance. The company officer who had accompanied Boyle testified that they had been examined together by the doctor. He also testified that when Boyle explained "his whole blood situation" to the doctor, the latter replied, "I wish you hadn't said it. I didn't hear it. . . . There is nothing

§11.7. [1] 1971 Mass. Adv. Sh. 505, 268 N.E.2d 651.

[2] G.L., c. 175, §186 allows the insurer to avoid the policy if the misrepresentation was made "with actual intent to deceive" or if the misrepresentation "increased the risk of loss." For a general discussion, see Kappes, Misrepresentation as It Relates to Policies of Ordinary Life Insurance, in ABA Section of Insurance, Negligence and Compensation Law, Proceedings 65-90 (1965).

wrong with your blood that's serious." The credibility of the company officer was pivotal because the examining physician had died before trial.

As to the insured, the most favorable inference that the jury could draw was that he had disclosed the truth to the physician, who had nonetheless filled out the application otherwise. The trial judge, however, refused to charge the jury as requested by the plaintiff's counsel, and the charge contained no reference to the possibility that the defendant's examining physician had incorrectly recorded Boyle's truthful statements as to his health. The jury found for the defendant. Although the Supreme Judicial Court agreed that the evidence of any misrecording was "not impressive," the Court ruled that the trial judge should have charged the jury as to the inference that could be drawn if the testimony of the company officer were believed. The trial judge's failure to do so was considered reversible error.

The rationale for the Supreme Judicial Court's decision is developed in considerably greater detail in *Sullivan v. John Hancock Mutual Life Insurance Co.,* where the Court said:

> Under the majority doctrine . . . it was a question of fact for the jury whether truthful answers were given by the insured and improperly recorded by an agent of the defendant. . . . It would be unfair to permit an insurance company to avoid a contract of insurance because of the failure of a company's own insurance agent or examining physician correctly to record the answers given by an applicant.[3]

§11.8. Life insurance: Waiver of premiums. In *King v. Prudential Insurance Co.,*[1] the insured became totally disabled during the grace period of a life insurance policy and died approximately one month after the grace period had expired. The issue in the case was whether the waiver of premium benefit had become effective and had preserved the policy from lapse. It was the insurer's contention that the waiver of premium provision required that notice of total disability be given during the lifetime of the insured, which had not been done. The Supreme Judicial Court rejected this contention, noting an ambiguity in the policy's notice provision that it felt could reasonably lead the average person to conclude that no notice of any kind was required until there had been six months' continuous disability.

The Court, however, went further and adopted the general rule that, in the absence of unequivocal language to the contrary, the waiver of premium provision is activated at "the commencement of the disability itself, and not the time when proof of that disability [is] submitted. . . ."[2] In enunciating this rule, the Court expressly indicated its disapproval of language contained in a 1937 Massachusetts decision

[3] 342 Mass. 649, 654, 174 N.E.2d 771, 774 (1961).

§11.8. [1] 1971 Mass. Adv. Sh. 335, 267 N.E.2d 643.
[2] Id. at 340, 267 N.E.2d at 647.

which indicated that there could be no waiver of premiums that became due prior to the date when actual proof of disability was received by the insurer.[3] In *King,* the Court adopted a rule that has been accepted by a majority of the courts that have considered the issue of total disability occurring during the grace period. A leading case, with reasoning the Supreme Judicial Court found persuasive, is *Minnesota Mutual Life Insurance Co. v. Marshall,* in which the Eighth Circuit Court of Appeals stated:

> The right of the insured to have his premiums discontinued during disability is one that he had paid for. To make its operation depend upon the time of proof of disability, and not the time of disability itself, which was the real thing that he was protecting himself against, renders the provision of the policy under construction inoperative and the right of no value.[4]

Old Colony Trust Co. v. Brockton Savings Bank,[5] another case decided during the 1971 SURVEY year, involved a fact situation similar to that in *King.* The insured became totally disabled during the 30-day grace period on several term savings bank life insurance policies and died approximately a week after the grace period had expired. The banks argued that premiums were not waived until "permanent disability" had been established, which required a six-month period of disability, and that, accordingly, the policies had lapsed. The Court passed over this issue and allowed recovery on the policies under the terms of riders, peculiar in the context of term insurance, which indicated that if total disability commenced during the grace period, the unpaid premium would become a debt on the policy to be paid out of policy proceeds.

§11.9. Business interruption loss insurance: Mitigation of loss. *Gordon Chemical Co. v. Aetna Casualty and Surety Co.*[1] concerned a substantial claim under a business interruption loss insurance policy issued by the defendant. Gordon Chemical Co. (Gordon) purchased monomer plastic that it converted to polystyrene and sold to Hammond Plastics, Inc. (Hammond). Hammond, in turn, processed the polystyrene into plastic molding pellets that it sold to various purchasers. Gordon was severely damaged by fire and explosion in 1963 and was unable to manufacture its product for approximately fifteen months. The business interruption loss policy covered, for the period which was reasonably required for resumption of business, the actual loss of net profits and certain necessarily continuing charges and expenses. Gordon's loss within the policy was over $211,000.

During the period of interruption, Hammond purchased polystyrene

[3] Sherman v. Metropolitan Life Ins. Co., 297 Mass. 330, 335, 8 N.E.2d 892, 894 (1937).

[4] 29 F.2d 977, 978 (8th Cir. 1928). See also the numerous cases cited in King, 1971 Mass. Adv. Sh. 335, 340, 267 N.E.2d 643, 647; and 15 Appleman, Insurance Law and Practice §8309 (1944, Supp. 1972).

[5] 1971 Mass. Adv. Sh. 1238, 271 N.E.2d 619.

§11.9. [1] 1971 Mass. Adv. Sh. 101, 266 N.E.2d 653.

from other sources and operated more profitably than before. Somewhat surprisingly as a matter of economic fact, it was conceded that if Gordon had purchased polystyrene and sold it to Hammond, it would have suffered no loss within defendant's policy. The defendant contended that Gordon was obligated to purchase polystyrene and sell it to Hammond, but the defendant apparently did not raise the question of a general duty to mitigate damages. Its principal argument was based on three "resumption of operations" conditions contained in the policy. The policy provisions required the insured, if possible, to mitigate its damages (1) by a complete or partial resumption of operation of the damaged property, (2) by making use of other available property (defined narrowly), or (3) by making use of available stock (raw, in process, or finished). The Supreme Judicial Court held that none of these three conditions required Gordon to purchase polystyrene manufactured by competitors and sell it to Hammond.

Another argument of the defendant was that Gordon and Hammond, which had common management and a substantial overlap of stock ownership, should be treated as a single corporation for purposes of the insurance policy. The Court found no justification for disregarding the separate corporate entities, indicating that this could be the result only "where the corporation is a sham, or is used to perpetrate deception to defeat a public policy. . . ."[2]

§11.10. Medical service corporation: Participation of podiatrists. *Godfrey v. Massachusetts Medical Service*[1] challenged the constitutionality of certain aspects of the nonprofit medical service plan called Blue Shield.[2] One provision of the General Laws indicates that Blue Shield *may* enter into contracts with "physicians, dentists, podiatrists and optometrists,"[3] but another provision specifies that physicians *shall* have the right to participate.[4] The plaintiffs claimed that the equal protection and due process clauses of the Fourteenth Amendment were violated (1) by the statutory scheme that allows physicians but not podiatrists to participate in Blue Shield as of right, and (2) by the action of Blue Shield in excluding podiatrists from participation. The decision in this case is discussed in §16.6 *infra,* in the chapter on constitutional law.

B. Legislation

§11.11. Advance payments by insurers: Notice of statute of limita-

[2] Id. at 106, 266 N.E.2d at 657, citing New England Theatres, Inc. v. Olympia Theatres, Inc., 287 Mass. 485, 493, 192 N.E. 93, 97 (1934).

§11.10. [1] 1971 Mass. Adv. Sh. 969, 270 N.E.2d 804.

[2] The Blue Shield program is governed by various sections of G.L., c. 176B.

[3] Id. §4. When the present action first arose, Section 4 provided that a medical service corporation might enter into contracts with "physicians, dentists, chiropodists (podiatrists) and optometrists"; but the Acts of 1970, c. 443, §§33, 34 eliminated all references to "chiropodist" and substituted "podiatrist."

[4] G.L., c. 176B, §7.

tions. Legislation enacted by the General Court in 1967[1] provided that with respect to claims or suits for damages arising out of bodily injury, property damage, or death, the potentially liable party (or his insurer) may advance money to pay bills on behalf of the claimant without such payment affecting the question of ultimate liability for such damages. Not only is the fact of such payment inadmissible evidence on the issue of liability, it is also inadmissible on the issue of mitigation of damages. However, such payments may be credited against any judgment obtained relating to the claim.

Chapter 141 of the Acts of 1971 adds the requirement that an insurer (but not a person otherwise potentially liable) who makes such payments shall, at the time of making such payment, give written notice to the claimant of the statute of limitations applicable to his claim and the time within which he must commence an action to enforce such claim. Strict compliance with the notice provision is sought by the somewhat curious legislative technique of specifying that in the case of advance payments made without timely notice, the date on which the cause of action on the basic claim accrues is delayed until the notice is in fact given. This penalty for noncompliance apparently applies equally to the insurer and the person principally liable. On the other hand, if the insurer gives timely and otherwise proper notice when making the advance payment, the cause of action would presumably accrue as usual, that is, at the time of the occurrence which gave rise to the damages, rather than at the time the notice was given.

The intent of this legislation is to warn claimants that although they may have received some payments, they must still press their claims by appropriate legal means. Although the legislative goal is worthy, the legislative scheme for accomplishing this end must be characterized as peculiar and likely to produce future litigation. For instance, what of the situation where the judgment entered against the person principally liable is for an amount in excess of his policy limits, but the action would have been barred by the appropriate statute of limitations if it were not for the failure of the insurer to give the required notice?

§11.12. Group insurance: Public employees. The General Laws provide substantially similar group insurance coverage for active and retired employees of the Commonwealth (Chapter 32A) and of its municipal units (Chapter 32B). The legislative history of these chapters discloses the liberal trend in employee fringe benefit legislation that has become characteristic in recent years. This history also indicates that amendments to these chapters have been made in a remarkably unsystematic manner. The 1971 SURVEY year illustrates this well, for no less than seven separate chapters of the Acts of 1971 have effected amendments to Chapters 32A and 32B, although most of the amendments are of a relatively minor nature.

Chapter 166 of the Acts of 1971 adds a provision to Chapter 32A which, subject to rules promulgated by the Massachusetts Group In-

§11.11. [1] G.L., c. 231, §140B.

surance Commissioner, permits covered employees to treat the various types of group coverage provided by Chapter 32A as separable and to apply for selected types and amounts of coverages.[1]

Prior to the passage of Chapter 825 of the Acts of 1971,[2] there was a substantial reduction upon retirement with respect to the type and amount of certain basic group coverages (life insurance, accidental death and dismemberment insurance, etc.) available to employees of the Commonwealth. The effect of the 1971 amendment is to allow an employee to maintain after retirement, on a 50 percent contributory basis, many of the benefits enjoyed during active employment.

Chapter 791 of the Acts of 1971[3] provides for payment by the Commonwealth of 50 percent of the group health insurance premium required to be paid to continue such health insurance coverage for the spouse (and certain dependents) of a deceased or retired employee. Prior to this amendment, the surviving spouse was required to pay the entire cost of the insurance.

Chapter 432 of the Acts of 1971[4] amends Chapters 32A and 32B in virtually identical ways. The general legislative scheme of both chapters provides (with minor differences between the chapters) that a portion of the dividends, refunds, or rate credits relating to the group insurance, in excess of certain administrative costs, be used for the benefit of the persons covered by the various group policies. Prior to the 1971 amendments, the persons who might be so benefited were only the "insured employees." This category has now been expanded to include "retired employees."

Chapter 167 of the Acts of 1971 extends the time during which an active or retired employee may be covered by the optional group life and group accidental death and dismemberment insurance provided under Chapter 32B.[5] Coverage now applies until the time the insured reaches age 70.

The Acts of 1971 also amended Chapter 32B so as to authorize appropriate governmental units to provide for group disability income insurance covering nonoccupational injury or disease.[6] One-half of the cost of the benefit will be paid by the insured, and the remainder will be contributed by the governmental unit involved.

§11.13. Regulation of insurers: Authorized investments. For generations, life insurance companies were models of ultraconservative investment practice. However, recent years have witnessed a dramatic expansion of the types of activities engaged in and the types of investments held. Chapter 218 of the Acts of 1971 relates to the latter category and amends G.L., c. 175 by adding Section 66E, which expressly

§11.12. [1] Acts of 1971, c. 166, amending G.L., c. 32A, §6. G.L., c. 32B, §5 was amended in an identical fashion by Acts of 1970, c. 269.

[2] Amending G.L., c. 32A, §10.

[3] Amending G.L., c. 32A, §11.

[4] Amending G.L., c. 32A, §§9, 9A and G.L., c. 32B, §8A.

[5] Acts of 1971, c. 167, amending G.L., c. 32B, §11A. G.L., c. 32A, §10A was amended in the same manner by Acts of 1969, c. 229.

[6] Acts of 1971, c. 203, §2, amending G.L., c. 32B by adding §11F.

authorizes the acquisition and holding of limited partnership interests of all kinds by domestic life insurance companies. The new section does, however, contain quantitative limits, specifying that no acquisition of a limited partnership interest may be made if the cost would exceed 2 percent of the company's total assets or if such cost, plus the book value of all other limited partnership interests held by the company, would exceed 10 percent of the company's total assets.

In point of fact, several of the large domestic life insurance companies have held limited partnership interests for some time, feeling that such investments were authorized by G.L., c. 175, §§66, 66A, or 66B. To other companies, however, the question of whether such authority existed was substantial enough to cause them to refrain from making such investments. In short, the issue was confused. The 1971 amendment, which authorizes the holding of limited partnership interests acquired at an earlier date as well as the acquisition of new interests, has put the matter to rest.

§11.14. Regulation of insurers: Crime of criminal usury. During the 1971 SURVEY year, legislation was enacted defining *criminal usury* as the receipt by the lender, from or on account of the borrower, of interest and expenses exceeding "twenty per centum per annum upon the sum loaned."[1] The definition was expressly made inapplicable to "any corporation subject to control, regulation or examination by any state or federal agency." A further provision exempted any lender who notified the attorney general of his intent to make loans that otherwise would be criminally usurious. Although insurance companies rarely loaned money at a rate exceeding 20 percent, and although the statute appeared to exempt insurance companies inasmuch as they are regulated by their domiciliary state's insurance department,[2] there were instances when insurance companies deemed it prudent to notify the attorney general pursuant to the statute, particularly when the intended loans would involve convertible debt or warrants to purchase common stock.

Chapter 368 of the Acts of 1971 has amended the criminal usury law so as to exempt any "lender" (formerly any "corporation") subject to control, regulation, or examination by any state or federal "regulatory" agency (the word "regulatory" has also been added). The first change expands the scope of the exemption to apply to such lenders as business trusts, limited partnerships, and individuals. The second change, by defining "agency" in a meaningful way, should satisfy even the most cautious that insurance companies may rely on the statutory exemption, for state insurance departments are clearly state regulatory agencies.

§11.15. Optional uninsured motor vehicle coverage: Establishment of rates. General Laws, c. 175, §113C requires insurers, as a condition of issuing compulsory motor vehicle liability policies or acting

§11.14. [1] Acts of 1970, c. 826, amending G.L., c. 271 by adding §49.

[2] The apparent exemption for insurance companies would arise under G.L., c. 271, §49(e).

as surety on motor vehicle liability bonds in Massachusetts, to offer certain specified minimum amounts of various types of automobile insurance coverage to persons purchasing such policies or bonds. Chapter 520 of the Acts of 1971 makes Section 113C applicable to uninsured motor vehicle insurance coverage. It requires that, as of January 1, 1972, there be so offered at least $15,000 of uninsured motor vehicle insurance coverage on account of injury to or death of one person, and $40,000 on account of any one accident resulting in multiple injuries or death. This optional insurance is to be additional coverage beyond the mandatory uninsured motor vehicle coverage required by G.L., c. 175, §113L. However, the additional amount of insurance chosen must not exceed the amount of optional bodily injury coverage also purchased under Section 113C.

Acts of 1971, c. 896, §1 effects a further amendment to Section 113C by specifying that the rates for all the types of optional coverage included in Section 113C be established by the commissioner, after public hearings, in accordance with the terms of G.L., c. 175, §113B.

§11.16. Miscellaneous acts. The General Laws limit the charges which may be made of an insured by insurance premium finance agencies.[1] Chapter 148 of the Acts of 1971[2] indicates that charges for group credit life insurance covering the debt incurred by the insured shall not be deemed to be a charge in violation of the applicable statutory provision so long as the charge is less, generally, than "fifty cents per one hundred dollars per year of the sum of the agreed monthly installments contracted to be paid. . . ."

The numerous kinds of theft insurance policies often specify that recovery is dependent upon "visible signs of forcible entry" accompanying the theft. Such provisions are included so as to protect insurers against "inside jobs" and from the type of frauds that would otherwise inevitably occur. While such provisions are reasonable limitations of liability on the part of the insurer, they often act to preclude recovery with respect to meritorious claims when the required visible signs of forcible entry cannot be established. Chapter 532 of the Acts of 1971[3] represents an attempt to aid claimants with respect to the theft of personal articles from locked automobiles or trailers by specifying that "the fact that such motor vehicle or trailer was stolen shall be *prima facie* evidence that there was a forcible entry." (Emphasis added.)

General Laws, c. 175, §113H established the assigned risk pool, by which "applicants for insurance who are in good faith entitled to and are unable to procure through ordinary methods motor vehicle liability insurance" may obtain such insurance. Chapter 656 of the Acts of 1971 adds two sentences to Section 113H that call for the imposition of fines on any insurance agent or broker or any insurance company or officer thereof who places an insured in such an assigned risk pool because of age, sex, race, creed, color, occupation, or principal place of garaging.

§11.16. [1] G.L., c. 255C, §14, by reference to G.L., c. 175, §162B.
[2] Adding §14A to G.L., c. 255C.
[3] Adding §79I to G.L., c. 233.

General Laws, c. 175, §111E, prior to the adoption of Chapter 849 of the Acts of 1971, authorized, with the prior written approval of the commissioner of insurance, the issuance of professional liability coverage for bodily injury and property damage covering the members of a charitable corporation formed under Massachusetts law and having at least 25,000 members, of whom not less than 75 percent were covered. The 1971 amendment reduces the membership requirement from 25,000 to 500.

C. No-Fault Automobile Insurance

§11.17. Introduction. During the 1971 Survey year, the Massachusetts no-fault auto insurance plan,[1] the first in the nation, became effective. In view of the drastic departure from traditional tort liability concepts accomplished by the plan, the paucity of both judicial and legislative action on the subject has been somewhat surprising.[2] The most significant occurrence, and the only judicial pronouncement dealing with no-fault, was the decision of the Supreme Judicial Court in *Pinnick v. Cleary*[3] sustaining the validity of the plan in the face of sweeping constitutional challenges. Although there was a host of legislative proposals to modify or repeal no-fault, all but one were rejected,[4] and the legislature demonstrated its continued faith in the no-fault concept by enacting a no-fault property damage plan to take effect on January 1, 1972.[5] Moreover, the apparent success of the Personal Injury Protection plan in reducing insurance company costs prompted the legislature to enact two statutes, one designed to return to Massachusetts compulsory automobile insurance policyholders

§11.17. [1] G.L., c. 90, §§34M, 34N; G.L., c. 175, §§22E-22H, all of which were inserted by Acts of 1970, c. 670.

[2] Although judicial and legislative action in Massachusetts has been subdued, the no-fault debate has been vigorously pursued by commentators and by legislatures in other states. See, e.g., Symposium on Nonfault Automobile Insurance, 71 Colum. L. Rev. 189 (1971); Danzig, The Fault with "No Fault," 7 Trial Lawyers Q. 4 (1970); Lawton, Psychological Aspects of the Fault System as Compared with the No-Fault System of Automobile Insurance, 20 Kan. L. Rev. 57 (1971); Simonett and Sargent, Minnesota Plan: A Responsible Alternative to No-Fault Insurance, 55 Minn. L. Rev. 991 (1971); Fournier, No Fault System: Social Protection Insurance: A New Approach to an Old Problem, 38 Ins. Counsel J. 139 (1971); Tanney, Is No Fault Insurance Best for Florida?, 45 Fla. B.J. 186 (1971); Dacey, "No Fault"—End of a Civilized Tort System, 6 New Eng. L. Rev. 79 (1970).

No-fault automobile insurance plans have been recently enacted in several states. Del. Code Ann., tit. 21, §2118 (Supp. 1971); Fla. Laws 1971, c. 252, §§1-14; Ill. Ann. Stat., c. 73, §§1065.150 et seq. (Smith-Hurd Supp. 1972); Ore. Laws and Res. 1971, c. 523, §§1-12; P.R. Laws Ann., tit. 9, §§2051-2065 (Supp. 1970). South Dakota has enacted an optional no-fault insurance coverage supplementing the insured's regular motor vehicle liability insurance.

[3] 1971 Mass. Adv. Sh. 1129, 271 N.E.2d 592, discussed in §11.18 *infra*.

[4] Acts of 1971, c. 794 amended the no-fault personal injury statute to provide that in any case where an insured receives compensation under a wage continuation program and also receives benefits for the same purpose from another source (presumably damages for lost wages received in an action in tort), the insured will be entitled to reimburse the wage continuation program without loss of his standing under the program.

[5] Acts of 1971, cc. 978, 1079, discussed in §11.19 *infra*.

any "excess" or "unfair" profits earned by insurers, the other imposing a tax on increased insurer income attributable to the no-fault plan.[6]

§11.18. Personal Injury Protection plan: Constitutional challenge. The essential feature of the Massachusetts no-fault automobile insurance plan was challenged in the case of *Pinnick v. Cleary*.[1] The case was presented directly to the Supreme Judicial Court, upon a report by Justice Reardon, as a bill for declaratory relief. In the bill, the plaintiff attacked the constitutionality of Chapter 670 of the Acts of 1971, which had imposed the no-fault plan. The facts of the case were not in contention. Two days after the plan became effective, the plaintiff, Pinnick, was injured in an automobile accident caused "exclusively by the negligence of the defendant." The common law tort damages of the plaintiff would have consisted of $115 expended for reasonable and necessary medical costs, $650 in lost wages, and $800 for alleged pain and suffering—a total claim of $1565. Both the plaintiff and the defendant were insured, each with coverage as provided by Chapter 670. The defendant, in response to a demand brought against him in the amount of the plaintiff's claim, pleaded Chapter 670 in defense. The defendant claimed that the plaintiff must seek from his own insurer benefits up to $2000 before proceeding against a tort-feasor, and that since the plaintiff's medical expenses did not exceed $500, he was not entitled to claim pain and suffering as an element of his damages. The Court, in an opinion by Justice Reardon, held that the no-fault automobile insurance plan as applied to the plaintiff was not invalid with respect to either the state or federal constitution, and that the defendant was not liable to the plaintiff for damages for pain and suffering or for damages for which the plaintiff was compensated under the no-fault plan.

In reaching its holding, the Court first summarized the basic provisions of the no-fault plan, "not as a holding or ruling on any part of the statute, but only to permit a better understanding" of the Court's opinion.[2] The essential feature of the plan is the provision for Personal Injury Protection benefit payments, which are made by the insurer to the insured or others who are entitled to collect in his right for specified expenses up to $2000 as they accrue, without regard to fault on the part of the insured. Among the specified expenses are those for medical costs, costs for household services ordinarily rendered by the injured party, and 75 percent of lost wages. To the extent the insured receives benefits up to $2000, he foregoes any rights he may have

[6] Acts of 1971, c. 977, §2 directs the commissioner of insurance to hold hearings to determine the existence and extent of unfair profit from compulsory liability insurance and to direct the return of such profits in an appropriate manner to the policyholders. Acts of 1971, c. 555, §27A imposes a new excise tax on increased income earned by insurers as a result of the enactment of no-fault.

§11.18. [1] 1971 Mass. Adv. Sh. 1129, 271 N.E.2d 592.

[2] Id. at 1136, 271 N.E.2d at 599. The summary of the provisions of Chapter 670 in the text is taken from the Court's opinion and includes only selected portions of the no-fault statute.

to a tort recovery against a tort-feasor. Expenses in excess of $2000 as well as the difference between the plaintiff's actual loss of wages and the 75 percent recovery under no-fault may be recovered in a common law action in tort, but pain and suffering are not compensable unless the reasonable and necessary medical expenses of the plaintiff are greater than $500 or unless the plaintiff suffers death, dismemberment, permanent and serious disfigurement, fracture, or loss of sight or hearing.

The Court first found it necessary to contend with the plaintiff's arguments that the common law action in tort had the status of a "vested property right," and further that the tort action was protected by the Bill of Rights as being a necessary safeguard for the protection of the "right of personal security and bodily integrity," a right allegedly recognized in *Griswold v. Connecticut.*[3] In answering the first argument, the Court relied upon the proposition that "[n]o person has a vested interest in any rule of law entitling him to insist that it shall remain unchanged for his benefit,"[4] and the justices could find no provision of the Massachusetts Constitution that would require a different result.[5] The plaintiff's *Griswold* argument was disposed of by the Court as being "inapposite." Unable to find a factor that would distinguish the legislature's alteration of the tort action from any other legislative alteration of preexisting common law rights, the Court concluded that "the principles by which Chapter 670 should be judged are those generally applied when economic and social regulations enacted under the police power are attacked as a violation of due process and equal protection of the laws."[6]

In discussing the due process issues, the Court looked to whether the no-fault law bore a reasonable relation to a permitted legislative purpose and whether the law provided a reasonable and adequate substi-

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In its summary of the statute, the Court described the wage benefit payable under no-fault to an unemployed person as follows: "[H]e is entitled to the same percentage of wages he can prove he would have received from work he would have had had he not been injured." Id. at 1133-1134, 271 N.E.2d at 597. Although dictum, the above-quoted passage indicates that the Court read Chapter 670 as explicitly modifying the traditional tort rule with respect to "loss by reason of dimunition of earning power," as expounded, for example, in Doherty v. Ruiz, 302 Mass. 145, 18 N.E.2d 542 (1939). The Court seems to have adopted the view that the proper measure of damages would be amounts "actually lost by reason of the accident." The conclusion that is implicit in the above-quoted dictum was reached by this author in 1970 Ann. Surv. Mass. Law §22.7.

[3] 381 U.S. 479, 486 (1965) (Goldberg, J., concurring).

[4] As authority for the quoted proposition, the Court cited New York Central R.R. v. White, 243 U.S. 188 (1917) (holding constitutional under the Fourteenth Amendment due process clause the New York workmen's compensation statute, which altered the common law rights and liabilities of employer and employee in personal injury cases), and Munn v. Illinois, 94 U.S. 113 (1876) (rejecting a Fourteenth Amendment due process challenge to an Illinois statute establishing the maximum rate that public warehousemen were permitted to charge for the storing and handling of grain).

[5] The Court declined to follow Commonwealth v. Boston Transcript Co., 249 Mass. 477, 144 N.E. 400 (1924), to the extent that dictum in the opinion indicated that the legislature might be precluded from abolishing a given common law right of action.

[6] 1971 Mass. Adv. Sh. 1129, 1140, 271 N.E.2d 592, 601.

tution for the preexisting common law right that had been altered.[7] The Court had no difficulty enumerating the "obvious" ills against which the no-fault law was directed. First and foremost was the impact on the judicial system of motor vehicle related litigation, measured both in terms of court time and in terms of the administrative burden placed on the court clerks. Other evils mentioned were the high cost of automobile insurance in Massachusetts, the low cost-to-benefit ratio prevailing in the automobile tort insurance system generally, and the unequal allocation of benefit payments among persons eligible to receive them. On the question of whether the law provided a reasonable and adequate substitute remedy in place of the preexisting common law right, the Court drew an analogy between the principles underlying workmen's compensation legislation and the principle underlying no-fault legislation. Although admitting that the parallel was inexact, the Court nonetheless felt that the changes in rights effected by Chapter 670 could be described in the same terms as the changes effected by workmen's compensation.[8] Under Chapter 670, motorists receive lower insurance rates and rapid payment of compensation up to $2000. In return for these benefits, the nonnegligent driver limits his right to damages for pain and suffering. The negligent driver, or the driver whose negligence cannot be determined, receives an additional benefit in that he will receive the same payments up to $2000 as were received by the nonnegligent driver, will be sheltered from claims against him by nonnegligent drivers up to $2000, and will be free from liability for pain and suffering claims to the extent the plaintiff is not permitted to sue therefor. The exchange of rights in cases involving pedestrians was also considered by the Court:

> Pedestrians, too, may be negligent or non-negligent; they, too, are therefore afforded the certainty of prompt recovery of a limited amount and limited exemption from liability instead of the necessity of tort proceedings or no compensation at all and liability to an unlimited amount.[9]

In its discussion of the equal protection issues, the Court was concerned with whether the classifications drawn by the legislature were reasonably related to a permissible public purpose or whether they were arbitrary, irrational, or invidiously discriminatory. The Court considered whether the purpose of eliminating minor claims for pain and suffering was a proper legislative objective. Again referring to the

[7] The Court declined to discuss the circumstances under which a legislature might abrogate a common law right of recovery without fashioning a statutory remedy as a substitute, although the power of the legislature to do so had been discussed in Opinion of the Justices, 309 Mass. 571, 34 N.E.2d 527 (1941). The Court also declined to offer an opinion on whether its reasonable substitution test was constitutionally required. 1971 Mass. Adv. Sh. 1129, 1148 n.16, 271 N.E.2d 592, 605 n.16.

[8] In particular, the Court drew upon New York Central R.R. v. White, 243 U.S. 188 (1917), which held constitutional the institution of workmen's compensation in New York.

[9] 1971 Mass. Adv. Sh. 1129, 1150, 271 N.E.2d 592, 607.

"crisis faced by the courts of the Commonwealth and the part played by the abundance of personal injury claims in contributing to it," the Court concluded that the legislature "could reasonably have thought that the number of such cases was largely attributable to speculative and exaggerated claims for pain and suffering in instances of relatively minor injury." To eliminate minor claims effectively, objective and easily applicable rules were necessary. The Court concluded that the rules actually selected by the legislature were rationally related to eliminating the claims, and that the $500 medical expense limit and the exceptions recognized thereto were "rationally related to seriousness of injury in general, and thereby to seriousness of pain and suffering." The selection of the $500 limit was reasonable enough so as not to be subject to attack.

In a separate concurring opinion, the Chief Justice stated that he was disagreeing with much of the reasoning employed by the majority and was concurring on the ground that the presumption of constitutional validity had not been overcome by the plaintiff. The Chief Justice took issue with what he considered to be the lauding of no-fault and questioned whether the majority was in a position to weigh the desirability or wisdom of the plan. The Chief Justice, though he concurred in the result, declared that he

> would remand this case to the Superior Court for the purpose of conducting an appropriate judicial inquiry into those controverted facts, beyond the sphere of judicial notice, upon which the existence of a rational basis for the no-fault insurance plan and the classification system contained within it might depend.[10]

As the first case involving a judicial examination of no-fault automobile insurance, *Pinnick* will undoubtedly receive much scrutiny by practitioners, legislators, and the judiciary. Although the discussion in the majority opinion is broad in scope, the holding of the case is explicitly restricted to the facts before the Court; the concurring opinion of the Chief Justice points out a number of countervailing considerations that the majority did not choose to address in its opinion. Although the basic concept of no-fault insurance has passed the constitutional test in Massachusetts, it is submitted that there may be particular applications of the concept that will be subject to further constitutional scrutiny by the Supreme Judicial Court.

§11.19. No-fault property damage plan. The apparent success of the no-fault personal injury plan encouraged the Massachusetts legislature to extend some of the principles of compensation without fault to cases involving property damage caused by automobiles. The new property damage plan was enacted as Chapter 978 of the Acts of 1971[1] and was promptly amended by Chapter 1097.[2] It should be noted at

[10] Id at 1167-1168, 271 N.E.2d at 617.

§11.19. [1] Acts of 1971, c. 978, §1, amending G.L., c. 90, by inserting §34.
[2] Acts of 1971, c. 1097, §§2, 3, amending G.L., c. 90, §34.

the outset that it is inaccurate to refer to the new property damage plan as being a no-fault plan, that is, one that entitles claimants under the plan to payment in compensation of damage to their automobiles whether or not the claimant was at fault. What the new plan does is to replace the traditional third-party tort compensation system with a direct, first-party system for the payment of most vehicle damages resulting from accidents between Massachusetts operators.

Basic provisions. Chapter 978 provides that every person who has in force a policy or bond with respect to motor vehicle liability must also maintain "property protection insurance" as defined by the act. The coverage of property protection insurance is described in terms similar to those describing the traditional Massachusetts compulsory property damage liability insurance:

> [T]he insurer will pay on behalf of the insured all sums the insured shall become legally obligated to pay as damages because of injury to or destruction of property . . . caused by accident and arising out of the ownership, maintenance or use . . . of the insured motor vehicle, subject to a limit of not less than [$5000] because of injury to . . . property of others in any one accident.[3]

In addition to the above coverage, every policyholder must elect one of three options offered by property protection insurance policies:

(1) *All-risk coverage* provides that the insurer will compensate the policyholder for any direct and accidental loss of or damage to the vehicle covered by the policy in force, which loss or damage is "caused by collision of the insured vehicle with another object or with a vehicle to which it is attached, or by upset of the insured vehicle."[4] Benefits under all-risk coverage are to be paid "without regard to negligence, comparative negligence, gross negligence or fault of any kind."[5]

(2) *Restricted coverage* provides that only in certain specified cases will the insurer compensate the policyholder for accidental loss of or damage to the vehicle covered by property protection insurance. The instances in which compensation will be paid are as follows: (a) where the policyholder would have been entitled, except for the exemption from liability granted by the statute, to recover his damages by an action in tort against another identified person who is also covered by property protection insurance; (b) where the policyholder is entitled to a tort recovery for damages against another identified person not exempt from liability under the statute; in this case, the policyholder is under a duty to take all steps required to preserve the right of subrogation of the insurer; (c) where the insured vehicle is lawfully parked and the damage is caused by being struck by a vehicle owned by another identified person;[6] (d) where the insured vehicle is involved in

[3] Acts of 1971, c. 978, §1.
[4] Id. c. 1097, §2.
[5] Id. c. 978, §1.
[6] The requirement that the insured vehicle be "lawfully parked" may lead to some nice questions of statutory construction. If "lawfully" is strictly construed, one's

a rear end collision with another vehicle owned by an identified person who was traveling in the same direction; (e) where the operator of the vehicle causing the accident is, "as a result of his operation at the time the loss or damage was incurred," convicted of being under the influence of a drug (alcohol or narcotics) or is convicted of a moving traffic violation; in the event, however, that the operator of the insured vehicle is himself convicted of the enumerated offenses as a result of his operation of his vehicle at the time of the accident, the coverage under (e) disappears.

Restricted coverage is intended to have the same general effect as that of the tort compensation system: the person who is damaged through the greater negligence of another recovers his damages. Payments under restricted coverage provisions (c), (d), or (e) are to be made regardless of whether the insured, under usual tort principles, would have been entitled to recover damages from another person; any such payment to which the insured becomes entitled may not be lessened by a showing of facts that would have been a basis for the application of principles of comparative negligence. Restricted coverage payments under provisions (a) and (b) are not to exceed the amounts payable under a tort action for damages to the vehicle, and the deductible (if any) is to be taken into account in full as a deduction against the amount that would have otherwise been recoverable in tort. The payments from the insurer under all-risk and restricted coverages are subject to a $100 or $50 "deductible"; the amount of the payments is limited to the actual cash value of the vehicle less such deductible. The statute was written with the expectation that all parties subject to it would elect some amount of deductible.

(3) *No coverage for own car* provides that the policyholder is not entitled to property protection insurance payments for damage to his own vehicle. Under this coverage, the policyholder gives up the right to recover for damages to his own vehicle from others insured under property protection insurance, and in return the policyholder is "exempt from liability to such persons" as provided by the statute.

In return for the motorist's acceptance of a limited property damage recovery under the three available options, Chapter 978 provides:

> Every owner, authorized operator or other person legally responsible for the operation of any vehicle to which [the statute] applies . . . shall be exempt from all liability [that any] property protection insurance policyholder and his insurer might otherwise have been entitled to claim . . . for accidental loss of or damage to any vehicle to which this [statute] applies.[7]

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insurance coverage would expire at the same moment as one's time at the parking meter or at the instant one left one's car in a no-parking zone. If "parked" is strictly construed, coverage would not exist if one were merely sitting in a motionless car with the motor running. It is submitted that for the purposes of the act, "lawfully parked" ought to be read as comprehending any time the insured vehicle is motionless at the side of the road or off the road.

[7] Acts of 1971, c. 978, §1.

The effect of the above exemption provision is to eliminate any recourse to the common law action in tort for any damage to vehicles in accidents involving only persons subject to the property protection insurance plan.

Additional provisions. There are some additional provisions of the statute that are worthy of note:

(a) For the first time, insurers must offer, at the option of the policyholder, coverage for the loss of the use of an insured vehicle as a result of an accident.

(b) Payments under all-risk coverage or provisions (c), (d), and (e) of restricted coverage are due and payable 15 days after the insurer has received reasonable proof that the claimant is a policyholder, that an accident occurred, and that damage to or loss of the vehicle was suffered in the claimed amount. Failure of the insurer to pay within such period entitles the insured to commence an action in contract for payments claimed to be due, and if the court finds such failure to have been unreasonable, it shall award the claimant double the amount of claimed damages plus costs and reasonable attorney's fees.

(c) Where one of the vehicles, involved in the accident is not a private passenger vehicle as defined by the commissioner of insurance, the right of subrogation exists with respect to an insurer who makes payments under all-risk or restricted coverage.

D. Student Comment

§11.20. Sufficiency of Massachusetts casualty insurance rate regulatory provisions under the McCarran Act: Fleming v. Travelers Indemnity Co.[1] The insurance industry, as an element of interstate commerce, is naturally subject to federal regulation. Congress, however, by enacting the McCarran-Ferguson Act[2] (hereinafter called the McCarran Act), expressed its willingness to limit federal control over the industry to the extent that the states would assume the task of regulation. Since the passage of the McCarran Act in 1945, its call for state regulation has been met with varying legislative responses. In *Fleming*, the regulatory scheme adopted by Massachusetts was attacked on the ground that it failed to meet the standards contemplated by Congress. The plaintiff argued, and this comment will attempt to show, that Congress did not call upon the states merely to enact regulatory legislation, but rather that Congress intended to confer control over the business of insurance only where the states acted to regulate affirmatively.

The Massachusetts Casualty and Surety Rate Regulatory Law[3] pro-

§11.20. [1] 324 F. Supp. 1404 (D. Mass. 1971).

[2] 15 U.S.C. §§1011-1015.

[3] G.L., c. 175A. As regards automobile insurance, the chapter concerns only noncompulsory coverage. Rates for compulsory coverage are set under Chapter 175, Sections 113A-113L. These rates cannot be effective until approved by the commissioner in accordance with Section 113A. Chapter 175A also applies, inter alia, to various types of homeowner's insurance, including property, theft, and liability, but not including fire insurance.

vides for the setting of insurance rates in the following manner. First, the law permits the insurance companies to enter into rating organizations.[4] The organizations allow subscribing companies to pool the expenses involved in compiling a rate structure. Moreover, the rating organizations can frequently determine rates far more efficiently than can an individual company. The rate uniformity resulting from the use of rating organizations may also serve to protect policyholders by discouraging excessive price competition and thus promoting solvency and stability within the industry. To this end, cooperation among rating organizations or among rating organizations and individual companies is also authorized.[5]

After the rate structure has been compiled, the rates are filed with either the commissioner of insurance or his designated representative.[6] The filing must state the type of coverage contemplated and the date when the new rates are to become effective. Although the effective date may not precede the filing date, the rates may go into effect without prior approval. This is the "file and use" provision, which permits the insurance companies to begin using the rates as soon as they have been filed. Subsequent to the filing, the commissioner may, at his discretion, review the filings and request additional supporting data. The applicable statute, however, provides him with only general standards to apply in conducting his review.[7] If at any time he should determine that the rates filed are not consistent with those statutory standards, the commissioner is empowered to call a hearing (upon not less than ten days' notice) and afterward to issue an order disapproving the rates, indicating the date when they will cease to apply, and specifying the reasons for the disapproval.[8]

In *Fleming*, the plaintiff's claim arose out of a situation in which certain insurance companies, including the defendant, had filed for a rate increase through a rating organization. The increase was to be effective the same day as the filing. The commissioner of insurance

[4] G.L., c. 175A, §8.

[5] Id. §8(d).

[6] Id. §6(a) provides in part: "Every insurer shall file with the commissioner or his designated representative every manual of classifications, rules and rates, every rating plan and every modification of any of the foregoing which it proposes to use. Every such filing shall state the effective date thereof, which shall not be prior to the filing date, and such filing shall indicate the character and extent of the coverage contemplated. The commissioner may require such insurer to furnish the information upon which it supports such filing. . . ."

[7] Id. §5 provides in part: "(a) All rates shall be made in accordance with the following provisions:—

"1. Due consideration shall be given to past and prospective loss experience, within and outside this commonwealth, to catastrophe hazards, if any, to a reasonable margin for underwriting profit and contingencies, to investment income on unearned premium reserves and loss reserves, to dividends, savings or unabsorbed premium deposits allowed or returned by insurers to their policy holders, members or subscribers, to past and prospective expenses both countrywide and those specially applicable to this commonwealth, and to all other relevant factors within and outside this commonwealth. . . .

"4. Rates shall not be excessive, inadequate or unfairly discriminatory."

[8] Id. §7(a).

disapproved the increase but did not call a hearing. On appeal by the insurance companies, the Supreme Judicial Court found the disapproval to be procedurally defective and held that the rate increase had been continuously in effect since the date designated in the filing.[9] Subsequent to the Court's decision, the plaintiff in *Fleming* brought his complaint, alleging that the insurance companies had acted illegally in combination and that the Massachusetts "file and use" procedure had allowed the companies, in effect, to operate outside of any state regulation. Such lack of regulation, claimed the plaintiff, should render the insurance companies subject to federal antitrust laws in accordance with the following provision of the McCarran Act:

> No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such Act specifically relates to the business of insurance: *Provided,* That after June 30, 1948, the Act of July 2, 1890, as amended, known as the Sherman Act, and the Act of October 15, 1914, as amended, known as the Clayton Act, and the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended, *shall be applicable to the business of insurance to the extent that such business is not regulated by State law.*[10] [Emphasis added.]

The defendant insurance companies argued that the Massachusetts "file and use" provision had been enacted in order to regulate the insurance industry, and that plaintiff's claim was essentially directed toward the wisdom of the legislation. In granting the defendants' motion to dismiss, the federal District Court for Massachusetts held that under the McCarran Act, if a state has legislated without sham or

[9] Insurance Rating Bd. v. Commissioner of Ins., 1970 Mass. Adv. Sh. 1285, 260 N.E.2d 922. Rates calling for a 26.9 percent increase for private cars and a 26.4 percent increase for commercial cars were filed December 24, 1969, to be effective the same day. Later that day, the commissioner wrote to the rating board, indicating that the "rule used by the board in determining the effective date of the filing was entirely unclear, nebulous, and inconsistent," and that the data submitted to justify the increases was "insufficient, . . . incomplete and does not justify any rate revision nor does it support the revision filed by . . . [the board]." Id. at 1286, 260 N.E.2d at 923. Accordingly, the commissioner informed the board that the rates were disapproved and that it could request a hearing under G.L., c. 175A, §19(a). Five days later the commissioner again wrote the board. The next day, December 30, 1969, the board submitted a second filing calling for the same rates that had been disapproved by the commissioner on December 24. These rates were to take effect on December 31, 1969. Once again the commissioner disapproved the filing and notified the board of its right to a hearing under Section 19(a). The rating board then brought this bill in equity asking that the rates be declared effective as of December 31, 1969. The Supreme Judicial Court found that Sections 6(a) and 7(a) "when read together, do not allow the commissioner to disapprove rates and thereby make them ineffective without a hearing." 1970 Mass. Adv. Sh. 1285, 1288, 260 N.E.2d 922, 924. The commissioner's power to request additional or supporting information "does not preclude the filing from taking effect, nor can it be used as the basis of any decision or ruling by the commissioner that the filing shall not take effect." Ibid.

[10] 15 U.S.C. §1012(b).

pretense, an allegation that the legislation is so ineffective as to necessitate application of a federal statute is not a claim upon which relief can be granted.[11] The court construed the McCarran Act as requiring only that states prescribe "general standards of conduct" for the insurance industry and "procedures for effectuating those standards."[12] Since the McCarran Act itself contains no specific suggestions as to what kind of regulatory program the states are expected to adopt, the court found no reason for holding that a "file and use" provision was not contemplated.[13] In fact, under the interpretation adopted in this decision, any type of good faith legislation on the subject of insurance rates would be sufficient to meet the requirements of the McCarran Act. It is submitted, however, that Congress did not intend to be so lenient. More specifically, it is submitted that the Massachusetts "file and use" provision is not consistent with the Congressional mandate in the act.

The McCarran Act was passed in response to *United States v. South-Eastern Underwriters Association*[14] (hereinafter called *SEUA*), a decision designating the business of insurance as commerce and thus subject to federal regulations when conducted across state lines. For 75 years prior to the decision, the industry had been operating outside federal regulation because of an earlier determination that insurance was not commerce.[15] In *SEUA,* the Supreme Court noted that the bulk of the insurance industry was conducted by "comparatively few companies located, for the most part, in the financial centers of the East."[16] As a result, the flow of premium payments and policy disbursements invariably crossed state lines, even though the actual insurance contracts were generally written intrastate. Accordingly, the Court held:

> No commercial enterprise of any kind which conducts its activities across state lines has been held to be wholly beyond the regulatory power of Congress under the Commerce Clause. We cannot make an exception of the business of insurance.[17]

While the *SEUA* decision did not expressly prohibit state regulation of insurance, many states and insurance companies feared that it might have such an effect.[18] The McCarran Act was enacted to allay those fears and to give effect to the belief that state regulation of insurance was in the public interest.[19] However, in restoring this power to the states, Congress had no intention of allowing them to preempt the field. As will be discussed below, supporters of the McCarran Act did

[11] 324 F. Supp. 1404, 1406.
[12] Ibid.
[13] Ibid.
[14] 322 U.S. 533 (1944).
[15] Paul v. Virginia, 75 U.S. (8 Wall.) 168 (1869).
[16] 322 U.S. 533, 541.
[17] Id. at 553.
[18] H.R. Rep. No. 143, 79th Cong., 1st Sess. (1945).
[19] 15 U.S.C. §1011.

not construe it to be inconsistent in any way with residual federal control over the insurance industry.

There were various legislative alternatives with which Congress might have responded to the *SEUA* decision. An inquiry into the intent of Congress when it legislated the McCarran Act might thus begin with a consideration of those options which Congress refused to take. One such option was the Bailey-Van Nuys Bill,[20] described in the Congressional Record as "a bill to affirm the intent of the Congress that the regulation of the business of insurance remain within the control of the several States and that the acts of July 2, 1890, and October 15, 1914, as amended, be not applicable to that business. . . ."[21] Earlier versions of the McCarran Act represented other legislative alternatives to the final form which the bill assumed. Like the Bailey-Van Nuys measure, these earlier versions provided for little federal control over insurance. Specifically, they did not even contain the clause which was directly at issue in *Fleming*, namely, the proviso that federal regulations will be inapplicable only to the extent that the states have regulated.[22] In fact, the Federal Trade Commission Act was to be inapplicable under any circumstances.[23] The rejection of the aforementioned alternatives, coupled with the wording of Section 1012(b)[24] of the McCarran Act, indicates that Congress was unwilling to deny completely the applicability of the Sherman and Clayton Acts to the insurance business.

The McCarran Act was passed nine months after the *SEUA* decision and contained a provision designed to give the states sufficient opportunity to enact regulatory programs in conformance with that decision.[25] The provision suspended the applicability of the Sherman and Clayton Acts for three years, subject to exceptions for acts of boycott, coercion, or intimidation.[26] Implicit in the concept of the moratorium was the intention that the suspended controls would be available even after the states had enacted or improved their own regulatory systems. The House Judiciary Committee report explained that the purpose of the McCarran Act, in part, was

> to ensure a more adequate regulation of this business in the States

[20] S. 1362, 78th Cong., 1st Sess. (1943).

[21] 89 Cong. Rec. 7689 (1943).

[22] 91 Cong. Rec. 478 (1945). The entire subsection (b) of Section 2 of the early versions of the McCarran Act read as follows: "No act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, or which imposes a fee or tax upon such business, unless such act specifically so provides." 91 Cong. Rec. 478 (1945). The section was eventually amended to add the proviso relied upon by the plaintiff in the Fleming case.

[23] Ibid. Section 3 of this version of the McCarran Act stated simply that "Nothing contained in the Act of September 26, 1914, known as the Federal Trade Commission Act, as amended . . . shall apply to the business of insurance or to acts in the conduct of that business."

[24] 15 U.S.C. §1012(b).

[25] H.R. Rep. No. 143, 78th Cong., 1st Sess. (1943).

[26] 15 U.S.C. §1013.

by suspending the application of the Sherman and Clayton Acts for approximately two sessions of the State legislatures, so that the States and the Congress may consider legislation during that period. It should be noted that this bill, by the moratorium proposed therein, does not repeal the Sherman and Clayton Acts.[27]

Those who opposed the legislation were concerned that the states were being awarded too much power, although even the opponents of the measure do not appear to have doubted that the states should play a major role in regulating insurance. Ironically, these opponents, led by Senator Pepper (D. Fla.), seem to have been motivated by a fear that Section 1012(b) would be interpreted exactly as it has been and that the control exercised by the federal government would be dangerously reduced.[28] Supporters of the bill argued at length that it did not diminish the role of the federal government:

Mr. Murdock. [W]e convey no authority, we simply recognize their right to regulate. Insofar as they fail to cover the same ground covered by the Sherman Act and the Clayton Act, those acts become effective again.[29]

Perhaps the best indication of the attitude taken on the question of the respective powers of the state and federal governments is contained in the following exerpt from the Senate floor debate. The participants were Senator White (R. Me.), the Senate minority leader; Senator McCarran (D. Nev.), cosponsor of the McCarran Act and chairman of the judiciary committee (which had already considered the measure); and Senator Murdock (D. Utah), also a member of that committee.

Mr. White. [I]s it not perfectly clear that the force and effect of these Federal statutes may be applicable and shall be applicable to whatever extent the State law fails to occupy the ground and engage in regulation? As I take it, there are two jurisdictions.

Mr. McCarran. There always are.

Mr. White. There is the State, authorized to act to whatever extent seems proper.

Mr. McCarran. That is correct.

Mr. White. Then the Federal Government can come in, and it does come in and may legislate beyond the limit of the State legislation.

Mr. McCarran. To the extent that the State does not regulate.

Mr. Murdock. Mr. President, does the Senator from Maine take the position that, under the conference report, it becomes necessary for the Congress to act again affirmatively, subsequent to any State action taken?

Mr. White. Not at all; that is not my view of the matter at all. My view is that the State may regulate. If, however, the State goes

[27] H.R. Rep. No. 143, 79th Cong., 1st Sess. (1945). See also 91 Cong. Rec. 480 (1945).
[28] 91 Cong. Rec. 1444 (1945).
[29] Ibid.

only to the point indicated, then these Federal statutes apply throughout the whole field beyond the scope of the State's activity.

Mr. McCarran. That is a correct statement.

Mr. Murdock. Without any subsequent action on the part of Congress?

Mr. White. Without any subsequent action on the part of Congress.[30]

This exchange seems to reveal the feeling of the participants that state and federal regulations were to be complementary.

An examination of the legislative history of the McCarran Act strongly indicates that a claim that a state's system of insurance rate regulation is ineffective should be actionable. A state should not be said to have regulated simply by virtue of the fact that it has legislated, even if the legislation was enacted in good faith. That the states were to some extent on trial follows inescapably from the history of the act. The record is replete with examples of the guarded manner in which Congress recognized the rights of the states to regulate insurance.

Mr. Barkley.[31] . . . I have reached the conclusion that by granting the moratorium . . . we are denying ourselves as a Congress no authority ultimately to deal with the subject.[32]

Mr. O'Mahoney.[33] [L]et me say that one of the House conferees . . . used this sentence, which I thought was extremely apt: "This is a bill to authorize the States to regulate the insurance business; and if the States do not regulate it, the Federal Government can."[34]

Mr. Murdock.[T]he conference report . . . in my opinion, not only grants a moratorium but allows the States to come affirmatively into the picture. If they do something objectionable, something we do not want done, then Congress reserves the right to strike it down, and . . . we could make both the Clayton Act and the Sherman Act applicable in their full vigor against anything the States might do.[35]

While these comments make it clear that state regulations had to measure up to certain standards, the exact manner in which a state could fulfill its responsibility under the McCarran Act is not so obvious. It seems beyond dispute, however, that any state legislation that permitted abuses in the nature of those perpetrated by SEUA would be unacceptable.[36]

Senator Pepper, however, was not convinced. He referred to Section 1012(b) as granting not a three-year moratorium but a "perpetual

[30] Ibid.

[31] Alben Barkley (D. Ky.), the Senate majority leader.

[32] 91 Cong. Rec. 1488 (1945).

[33] Joseph C. O'Mahoney (D. Wyo.), third-ranking Democrat on the Senate Judiciary Committee.

[34] 91 Cong. Rec. 1486-1487 (1945).

[35] Id. at 1484.

moratorium," arguing that the section would be read to allow the states to preempt the field.[37] Specifically, he was concerned that the states might permit abuses like those uncovered in the *SEUA* case. Senator Ferguson, a supporter of the bill, replied that neither the bill nor the *SEUA* decision had been designed to reverse the history of the insurance business, a history that revealed that unrestricted price competition among insurance companies was not in the public interest. He added that the McCarran Act merely sought to prevent the excesses of rating organizations without abolishing the organizations completely. Accordingly, Senator Ferguson suggested that a state was free to authorize such organizations provided it also enacted means by which they could be regulated.[38] The states were, in effect, given the power to decide whether or not the antitrust laws mentioned in the act would apply, but that power was merely the option to decide whether or not they would regulate the insurance industry.[39]

In lengthy correspondence with Senator Radcliffe, another supporter of the bill, President Roosevelt indicated the type of legislation that he expected to emerge during the moratorium.

> [T]here is no conflict between the application of the antitrust laws and effective State regulation of insurance companies, and there is no valid reason for giving any special exemption from the antitrust laws to the business of insurance. . . . The antitrust laws do not conflict with *affirmative* regulation of insurance by the States such as agreed insurance rates if they are *affirmatively* approved by State officials.[40] [Emphasis added.]

After signing the McCarran Act, the president declared:

> After the moratorium period, the antitrust laws . . . will be applicable . . . except to the extent that the States have assumed the responsibility, and are effectively performing that responsibility . . . It is clear from the legislative history and language of this Act, that the Congress intended no grant of immunity from monopoly. . . . Congress did not intend to permit private rate fixing . . . but was willing to permit the actual regulation of rates by affirmative action of the states.[41]

[36] SEUA had been composed of nearly two hundred insurance companies, which allegedly controlled 90 percent of the fire and "allied lines" of insurance in six southern states. The association was alleged to have conspired to fix premium rates and agents' commissions; to have boycotted, coerced and intimidated nonmember companies into joining the association; and to have similarly caused persons needing insurance to buy only from SEUA members and on SEUA terms. 322 U.S. 533, 534-535. During the period from 1931 to 1941, the insurance companies operating in these six states collected $488 million in premiums, while paying out only $215 million on policies. Id. at 542.

[37] 91 Cong. Rec. 1479 (1945).

[38] Id. at 1481.

[39] Id. at 1443.

[40] Id. at 482.

[41] The Public Papers and Addresses of Franklin D. Roosevelt: 1944-1945, at 587 (Rosenman ed. 1950), as cited in Rose, State Regulation of Property and Casualty Insurance Rates, 28 Ohio St. L.J. 669, 706 (1967).

Apparently, the president felt that the states had to do more than simply legislate. They had to regulate and do so "affirmatively" and "effectively." Those two terms appear frequently during the Senate discussion of the bill, indicating that many supporters of the measure shared expectations similar to those of the president. What is more important, the Senate floor debate just prior to the passage of the act called into question the good faith legislation criterion utilized in the *Fleming* decision.

> *Mr. Ferguson.* After the moratorium has expired, if a State has not legislated on the subjects covered by the three acts to which reference has been made, those acts shall be applicable to the business of insurance. But insofar as the State . . . has specifically legislated on the subject, the three acts shall not apply. . . .
>
> *Mr. O'Mahoney.* I believe the Senator from Michigan went a little further than was his intention [in saying] that if the States have legislated, certain things will take place. The bill says if the States have regulated.
>
> *Mr. Ferguson.* I had reference to legislation dealing with regulation. . . .
>
> *Mr. Barkley.* I should like to ask, in this connection, whether, where the States attempt to occupy the field but do it inadequately —by going through the form of legislation so as to deprive the Clayton Act, the Sherman Act, and the other acts of their jurisdiction, it is the Senator's interpretation of the conference report that in a case of that kind, where the legislature fails adequately even to deal with the field it attempts to cover, these acts still would apply?
>
> *Mr. McCarran.* That is my interpretation.[42]

Senator Barkley does not appear to have been concerned with the question of whether or not the inadequate state legislation was a sham, but rather with the inadequacy itself, regardless of the legislature's good intentions. Senator Barkley's concern raises the same question posed by the plaintiff in *Fleming*.

The position taken by the federal district court in *Fleming* is not unique; other courts have also held, in effect, that any legislation which is not sham and which covers the area of insurance regulation fulfills the requirements of the McCarran Act and renders the federal antitrust laws inapplicable.[43] This position is typified by a 1969 decision of a federal district court in Mississippi.

> This statute [the McCarran Act] reflected the public policy of re-

[42] 91 Cong. Rec. 1443-1444 (1945).

[43] See Allstate Ins. Co. v. Lanier, 361 F.2d 870 (4th Cir.), *cert. denied*, 385 U.S. 930 (1966); North Little Rock Transp. Co. v. Casualty Reciprocal Exch., 181 F.2d 174 (8th Cir. 1950); California League of Indep. Ins. Producers v. Aetna Cas. and Sur. Co., 175 F. Supp. 857 (N.D. Cal. 1959); and National Cas. Co. v. Federal Trade Commn., 245 F.2d 883 (6th Cir. 1957), *aff'd per curiam*, 357 U.S. 560 (1958).

> fraining from interference with regulation of insurance companies by the several states . . . and of giving broad national support to state regulation of the insurance business by throwing the weight of Congressional power behind state systems. . . It is only when a state has not acted that federal legislation becomes effective. . . . A state "regulates" the business of insurance . . . when it "generally proscribes . . . or permits or authorizes certain conduct on the part of the insurance companies". . . . Whether the statutory plan of a state's regulation of insurance "embodies the wisest and most effective of regulation" is not for the courts to decide.[44]

The result in *Fleming* was predictable in view of the prior judicial practice of looking only for *some* regulation by the state. However, as will be discussed, most of the cases prior to *Fleming* did not represent a challenge to a regulatory pattern similar to that in Massachusetts.

Of the decisions relied on by the *Fleming* court, *Allstate Insurance Co. v. Lanier*[45] represents the only direct challenge to a state regulatory system as violative of the federal antitrust laws. However, in that case it was the insurance companies themselves who objected to a North Carolina statutory provision that required them to join a rating organization and abide by the rates it promulgated. The statute also required all rates to be approved by the commissioner of insurance,[46] who was an elected official. On such facts, a holding that the North Carolina legislation was regulatory within the meaning of the McCarran Act can hardly be said to justify a holding that *any* state legislation enacted in good faith is sufficient to comply with the requirements of the act. The regulations held sufficient in *Allstate* were considerably more stringent than those upheld in *Fleming*.

The *Fleming* decision contains no reference to *North Little Rock Transportation Co. v. Casualty Reciprocal Exchange*,[47] but the latter case provides another example of a state regulatory scheme that was upheld by a federal court. In *North Little Rock*, the plaintiff

[44] Holly Springs Funeral Home, Inc. v. United Funeral Service, Inc., 303 F. Supp. 128, 135 (N.D. Miss. 1969). This position has not gone uncriticized: "These decisions, indicating that state legislation constitutes regulation within the meaning of the section 2(b) proviso of the McCarran Act, seem erroneous. Such a rationale offers an easy formula for the solution of jurisdictional conflicts: If a state statute covers the practice involved, the state's jurisdiction is deemed exclusive. From a public policy viewpoint, effective administration of such legislation should be a prerequisite to state regulation. Since state regulatory machinery lags behind its statutory framework in nearly every state, a regulatory vacuum is created, not effectively reached by the states and into which the federal government cannot enter. Since the property and casualty insurance industry constitutes a substantial segment of the national economy and is imbued with the public interest, it should not be allowed to operate outside both state and federal control." Rose, State Regulation of Property and Casualty Insurance Rates, 28 Ohio St. L.J. 669, 711 (1967).

[45] 361 F.2d 870 (4th Cir.), *cert. denied*, 385 U.S. 930 (1966).

[46] N.C. Gen Stat. §58-248 (enacted 1939).

[47] 181 F.2d 174 (8th Cir. 1950).

alleged, in effect, that an Arkansas statute authorizing the licensing of rating organizations did not constitute regulation under the McCarran Act. The United States Court of Appeals for the Eighth Circuit correctly held that the McCarran Act permits such organizations so long as they are "licensed and supervised" by the state.[48] It should be noted, however, that Arkansas law provided that the rates filed by a rating organization could not become effective, in the absence of actual approval by the insurance commissioner, for at least fifteen days after filing.[49] Accordingly, in upholding the rating organization and the state laws sanctioning it, the court did not have to face the issue of whether a state could effectively supervise under a "file and use" provision. *North Little Rock,* like *Allstate,* thus does not provide much support for the *Fleming* proposition that good faith legislation amounts to adequate regulation of the insurance industry.[50]

The *Fleming* rationale has been reinforced by a decision just rendered in Ohio in an action that challenged that state's "file and use" provision.[51] The challenge went somewhat beyond that presented in *Fleming,* in that the Ohio regulations were alleged not only to be ineffective but also to be mere pretenses insofar as the insurance superintendent's office did not and could not enforce even the limited prerogatives provided in the state's "file and use" provision.[52] "The essence of the complaint is that there is an absence of state regulation

[48] Id. at 177.

[49] Ark. Acts of 1947, Act 116, §4.

[50] Other decisions cited in Fleming that have held federal antitrust laws inapplicable to the insurance industry are even more distinguishable. In California League of Indep. Ins. Producers v. Aetna Cas. and Sur. Co., 175 F. Supp. 857, (N.D. Cal. 1959), the plaintiffs sought to invoke federal antitrust laws against several insurance companies that had allegedly entered into an agreement to lower the commissions paid to agents. Although permitting them to cooperate in such matters, California law specifically prohibits the companies from entering into agreements. Cal. Ins. Code §1853.6 (enacted 1947). Clearly, an express prohibition must fall within the meaning of *regulate* as used in Section 1012(b) of the McCarran Act. Insofar as the plaintiffs were afforded a remedy under the state regulations, federal antitrust laws were quite properly held inapplicable. In National Cas. Co. v. Federal Trade Commn., 245 F.2d 883 (6th Cir. 1957), *aff'd per curiam,* 357 U.S. 560 (1958), the commission claimed that allegedly unfair advertising practices of insurance companies were of an interstate nature and hence not susceptible to effective regulation by the states. In a per curiam decision, the Supreme Court emphasized that the advertising was in fact conducted on a local basis and could thus be controlled under state law. Accordingly, federal antitrust law was held not to apply where the states had regulated.

It was in the above two cases that the courts first spoke of regulation as a general prohibition of certain standards of conduct. 175 F. Supp. 857, 860; 357 U.S. 560, 564. It is significant, however, that both decisions emphasized the prohibitory nature of the state statutes in question, implying that regulation may require the prohibition of certain activities by insurance companies and rating organizations, although the prohibited activities need not be specifically described. Under such a standard, a state has not regulated if the companies can do whatever they please despite the existence of a state statute.

[51] Ohio AFL-CIO v. Insurance Rating Bd., 451 F.2d 1178 (6th Cir. 1971).

[52] Specifically, the plaintiffs alleged that the staff of the superintendent of insurance was inadequate to review information relating to rate changes; that such rate increases had never been challenged by the Ohio Department of Insurance; and that " 'the De-

[as required by the McCarran Act] and that the state has abdicated its function of regulating the automobile insurance industry in favor of regulation by the automobile insurance industry itself."[53] The Sixth Circuit Court of Appeals affirmed the district court's dismissal of the complaint, for essentially the same reasons advanced by the district court in *Fleming*, and held that regulation under Section 1012(b) of the McCarran Act is satisfied " 'when a State statute generally proscribes . . . or permits . . . certain conduct.' "[54] Mention was made by the circuit court that it had not found a satisfactory definition of *regulation* in the legislative history of the act.[55] The plaintiffs' allegations regarding the state's failure to enforce the regulations were summarily dismissed on the ground that "there is nothing in the language of the McCarran Act or in its legislative history to support the thesis that the Act does not apply when the state's scheme of regulation has not been effectively enforced."[56] What the court seems to have overlooked is its own assessment of the plaintiff's complaint, namely, that Ohio's regulatory scheme resulted in no regulation whatsoever.

Besides finding that nothing in the McCarran Act precluded "file and use" regulations, the court in *Fleming* offered a second rationale for its decision, based upon a line of decisions beginning with *Parker v. Brown*.[57] In that case the United States Supreme Court held that a state may authorize or create a combination that would ordinarily violate the federal antitrust laws, so long as the authorization is made in an attempt to further a legitimate state interest. *Parker* involved a complex legislative program for regulating the marketing of produce in California so as to "conserve the agricultural wealth of the State," to maintain prices, and to "prevent economic waste in the marketing of agricultural products of the state."[58] The program provided for the creation of a board of produce growers that would establish various marketing policies and make decisions as to which crops might be sold and at what price the crops would be offered. Detailed in the program were the manner in which the board was to be constituted and the procedure by which it was to reach the relevant decisions. Moreover, a state commission was charged with enforcement of the policy pronouncements issued by the growers. The Supreme Court rejected a claim that the program stood in violation of the Sherman Act:

> The Sherman Act makes no mention of the state as such, and gives no hint that it was intended to restrain state action or

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partment does not even employ or have on its staff an actuary so as to be able to examine the rate filing.' " Id. at 1180.

[53] Id. at 1180.

[54] Id. at 1181, citing California League of Indep. Ins. Producers v. Aetna Cas. and Sur. Co., 175 F. Supp. 857, 860 (N.D. Cal. 1959).

[55] 451 F.2d 1178, 1181-1182 (6th Cir. 1971).

[56] Id. at 1184. But see the legislative history discussed earlier in this comment.

[57] 317 U.S. 341 (1943).

[58] Id. at 346.

> official action directed by a state. . . .
>
> There is no suggestion of a purpose to restrain state action in the Act's legislative history. The sponsor of the bill which was ultimately enacted as the Sherman Act declared that it prevented only "business combinations". . . . That its purpose was to suppress combinations to restrain competition and attempts to monopolize by individuals and corporations, abundantly appears from its legislative history.[59]

Parker thus established the inapplicability of the antitrust laws to state action.

Decisions following *Parker* have been marked by a consistent extending of judicial sympathy for state-authorized combinations. A particularly interesting decision, cited in *Fleming*, is *Miley v. John Hancock Mutual Life Insurance Co.*,[60] where several Massachusetts insurance companies allegedly conspired with the State Employees' Group Commission (also named as a defendant) to win a contract for group insurance of state employees. The lowest bid on the contract had been submitted by a Minnesota firm, whereas the rates bid by the Massachusetts companies corresponded to those they had filed on a different contract bid with the New York insurance commissioner. Because the Massachusetts companies could not lower their bids without seriously jeopardizing their chances of doing business in New York, the companies arranged with the State Employees' Group Commission to have a bid matching that of the Minnesota firm submitted by a small Massachusetts company that did no New York business. This small firm was awarded the contract and promptly resold 95 percent of it to the larger Massachusetts companies. The ensuing antitrust action brought by a prospective broker of the Minnesota firm was dismissed as an improper inquiry into state action in a legitimate state sphere, namely, the regulation of insurance.

In matters of insurance, the regulatory initiative has been left to the states under the McCarran Act; *Parker* simply prevents the federal antitrust laws from restricting the chosen method of state regulation. Consequently, it should be noted that the issue in *Miley* is somewhat different from that in *Fleming*. In *Miley*, as in *Parker*, the court was concerned with the question of whether the challenged state action was proper in view of the federal antitrust laws.[61] In *Fleming*, however, plaintiff's contention was that there had been no state action because the "file and use" provision permitted insur-

[59] Id. at 351.

[60] 148 F. Supp. 299 (D. Mass.), *aff'd per curiam*, 242 F.2d 758 (1st Cir.), *cert. denied, 355 U.S. 828 (1957)*.

[61] See E. W. Wiggins Airways, Inc. v. Massachusetts Port Authority, 362 F.2d 52 (1st Cir.), *cert. denied*, 385 U.S. 947 (1966); and Washington Gas Light Co. v. Virginia Elec. Power Co., 438 F.2d 248 (4th Cir. 1971). In the latter case the court declared, "The teaching of Parker v. Brown is that the antitrust laws are directed against individual and not state action. When a state has a public policy against free competition in an industry important to it, the state may regulate that industry in order to control, or in a proper case,

ance companies to operate without any state regulation.

Parker, however, is susceptible of a narrower reading than many courts have given it. The decision contained the caveat that "a state does not give immunity to those who violate the Sherman Act by authorizing them to violate it, or by declaring that their action is lawful. . . ."[62] This caveat seems to imply that before activities may be sheltered under the *Parker* doctrine, they must be established as state activities. Private combinations, even though authorized by the state, are not protected from the federal antitrust laws.[63] Whether or not conspiratorial activities are public or private is thus a threshold question since the *Parker* doctrine cannot be applied unless those activities are characterized as public. Presumably, a combination is public if it is actively controlled by the state; only then does it become "state action." In short, application of the *Parker* doctrine requires raising the same issue as was raised in interpreting Section 1012(b) of the McCarran Act: Has the state truly regulated the various business combinations in the insurance industry?

The difficulties in defining *regulate* are apparent from the number of decisions in which an attempt at definition has been made.[64] Given this abundance of decisions, it is somewhat surprising that no Massachusetts court has addressed itself directly to the problem. Consider, however, the following examples from other jurisdictions:

> "Regulate" means to govern or direct according to rule, to bring under the control of constituted authority.[65]

> Every element of this definition involves restraint, the exercise of a power over a thing by which its activities are ruled or adjusted, or directed to certain ends.[66]

These definitions seem to cast the regulator in a much more active

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to eliminate competition therein. It may even permit persons subject to such control to participate in the regulation, provided their activities are adequately supervised by independent state officials." Id. at 251, citing Asheville Tobacco Bd. of Trade, Inc. v. Federal Trade Commn., 263 F.2d 502, 509 (4th Cir. 1959).

[62] 317 U.S. 341, 351 (1943). See also Washington Gas Light Co. v. Virginia Elec. Power Co., 438 F.2d 248 (4th Cir. 1971).

[63] In Schwegmann Bros. v. Calvert Distillers Corp., 341 U.S. 384 (1951), the Supreme Court considered a Louisiana statute which authorized wholesale and retail liquor distributors to enter into contracts providing that the "buyer will not resell 'except at the price stipulated by the vendor.' " Id. at 386. Furthermore, the law provided that once any retailer entered into such a contract, all other retailers with knowledge of the contract were prohibited from underselling him; they became bound by his agreement. Id. at 387. The Court found that the state was simply permitting members of the liquor industry to fix prices at their discretion. Citing the Parker case, the Court held that "when a state compels retailers to follow a parallel price policy, it demands private conduct which the Sherman Act forbids." Id. at 389.

[64] 76 C.J.S. 610-616 (1952).

[65] Farmington River Co. v. Town Plan and Zoning Commn., 25 Conn. Supp. 125, 137, 197 A.2d 653, 660 (Super. Ct. 1963). See also Salt Lake City v. Revene, 101 Utah 504, 508, 124 P.2d 537, 539 (1942).

[66] State v. Bass, 177 Tenn. 609, 615, 152 S.W.2d, 236, 238 (1941), citing Nashville v. Linck, 80 Tenn. 499, 512 (1883).

role than does Chapter 175A of the Massachusetts General Laws. To govern, direct, or restrain implies the right to function as a protagonist, not merely the option to respond to various situations. It may be permissible to equate state regulation with state action, but action should be distinguished from reaction. The mere option to disapprove does not seem to correspond with the right to regulate, any more than the right to veto corresponds with the right to legislate.

Chapter 175A of the Massachusetts General Laws places the commissioner of insurance in a position of merely reacting on matters of rate review. Because the statute makes rate review optional, there is no assurance that the commissioner will exercise even the limited power he has been given. The following excerpts are from an opinion that the Massachusetts attorney general issued shortly after Chapter 175A was enacted:

> The words used by the Legislature in this connection—"If at any time the commissioner finds that a filing does not meet the requirements of this chapter, he shall, after a hearing . . . issue an order . . ." do not indicate a legislative intent to require of the commissioner the duty to review every filing immediately upon its receipt or to review it upon his own motion at any particular time, or indeed to review it at all unless he has reason to believe that it does not meet the statutory requirements. . . .
>
> 6. Your sixth question reads:
>
> "May the Commissioner permit a filing to be effective without review unless and until a complaint is made with him in the manner outlined in section 7(b) by any person aggrieved?" . . .
>
> I am confirmed in my opinion with relation to your last five questions by the fact that the Legislature, prior to the passage of the statutes in question, rejected proposed amendments to them which required examinations of filings by the Commissioner within a specific period or as soon as reasonably possible after filing. In the form in which said section 7 was finally enacted by the General Court, it would appear to have been the legislative intent to leave the matter of review of filings to the sound discretion and judgment of the Commissioner. . . .[67]

Even when the commissioner chooses to review a particular rate filing, it seems clear that his disapproval will not be retroactive to the date of filing. Although the Supreme Judicial Court has not ruled on the retroactivity question,[68] the wording of Chapter 175A leaves little room for doubt:

> If at any time the commissioner finds that a filing does not

[67] Op. Atty. Gen. 38, 39-40 (Dec. 15, 1947).

[68] The Supreme Judicial Court determined that resolution of the retroactivity question was not necessary to its decision in Insurance Rating Bd. v. Commissioner of Ins., 1970 Mass. Adv. Sh. 1285, 260 N.E.2d 922.

> meet the requirements of this chapter, he shall, *after a hearing held upon not less than ten days' written notice,* . . . issue an order specifying in what respects he finds that such filing fails to meet the requirements of this chapter, and stating when, *within a reasonable period thereafter,* such filing shall be deemed no longer effective.[69] [Emphasis added.]

The notice requirement means that a minimum period of ten days will pass before the commissioner has effective jurisdiction over the rates. It is questionable whether there is any regulation—by even the most relaxed standards—during this grace period of at least ten days. It could also be argued that the lack of authority in the commissioner to disapprove retroactively is not consonant with the Supreme Court's pronouncement that "a state does not give immunity to those who violate the Sherman Act by authorizing them to violate it. . . ."[70] Massachusetts has, in effect, granted the insurance companies immunity to act in combination and to fix rates without any state interference for at least ten days—and possibly much longer.

Before enacting Chapter 175A, the Massachusetts legislature considered one other major alternative, the so-called All-Industry Bill,[71] drafted by a national committee representing various segments of the insurance industry. This bill provided for more stringent regulation of insurance companies. Some of the major features of the model bill have been described as follows:

> After the rate is filed with the insurance commissioner, the all-industry bills provide (a) that no premium schedule shall be effective until fifteen days after its filing; (b) that the commissioner may extend this period of suspense for another fifteen days; (c) that the commissioner may, before the period of suspense expires, disapprove any rate schedule if it is excessive, inadequate, or unfairly discriminatory, in which case it shall be ineffective; (d) that the commissioner may, after a schedule has become effective and either in a response to a complaint or on his own motion, hold a hearing concerning the propriety of such schedule, and may, after such hearing, disapprove the schedule, either in whole or in part, so far as future transactions are concerned. If the commissioner fails to disapprove a filing within the waiting period or the extension, then the filing is deemed to meet the requirements of the act. This provision is the so-called deemer clause: rates are deemed approved unless affirmatively disapproved by the commissioner.[72]

[69] G.L., c. 175A, §7A.

[70] Parker v. Brown, 317 U.S. 341, 351 (1943).

[71] Mass. House Bill 1090 (1947).

[72] Rose, State Regulation of Property and Casualty Insurance Rates, 28 Ohio St. L.J. 699, 701 (1967). The cited provisions are virtually identical to those proposed in Mass. House Bill 1090 §§4, 5 (1947).

The committee on insurance rejected the All-Industry Bill:

> That bill imposes upon the Commissioner the wholly impracticable duty of reviewing and approving thousands upon thousands of rates within a brief period of time. The detailed and particularized policing of rates involved in a law of this character would saddle the Commissioner with an impossible administrative task, substantially increase the expense to this Commonwealth of operating the Insurance Department, and would substitute the Commissioner's judgment for that of experienced insurance underwriters.[73]

The committee majority also claimed that the All-Industry Bill was not truly representative of the insurance industry,[74] and the objections raised by dissident factions in the industry are contained throughout the majority report. Moreover, the majority argued that the tighter regulations in the All-Industry Bill would make rate deviation so difficult as to stifle competition and encourage monopoly. The majority concluded that state regulation of insurance was indeed in the public interest, but that the "federal requirements as set forth in [the McCarran Act] can adequately be met with a minimum of regulation by adoption of [proposed Chapter 175A]."[75]

It is suggested that the majority's reasoning in rejecting the stricter All-Industry Bill and opting for the present law does not correspond to the spirit with which Congress expected the states to enact regulatory legislation. Where Congress had asked for regulation, the majority sought only to "occupy the field;"[76] where Congress and the president had emphasized the need for "effective and affirmative" enactments, the majority spoke in terms of a "minimum of regulation." Indeed, the committee's minority report[77] represents a far better approximation of the congressional purpose. That report analyzed the obligations placed upon the states by the McCarran Act in a much more positive manner: "To meet federal requirements rates must be adequately and *affirmatively* regulated. Anything less than the regulation required by the Commissioner's All-Industry bills will not meet that test."[78] Moreover, the minority was most vigorous in its denunciation of the measure that was to become Chapter 175A. What is particularly interesting is that the objections raised closely parallel those asserted by the plaintiff in *Fleming*. The minority considered the bill recommended by the majority a "palpable sham" because:

> (a) All filings become effective immediately, and therefore the

[73] Report of the Committee on Insurance Sitting as a Special Recess Committee to Study State Regulation of the Insurance Industry, Mass. Senate Bill 610 at 18-19 (1947).

[74] Id. at 15. This argument was vigorously disputed in the minority report, which included excerpts from the address of an insurance representative to the General Court. He claimed that the insurance companies could not possibly be so naive as to adopt restrictions they did not think necessary. Id. at 30.

[75] Id. at 24.

[76] Id. at 14.

[77] Id. at 25.

[78] Id. at 27.

Commissioner cannot—

(1) Prevent the use of illegal rates.

(2) Require refunds if excessive rates have been charged the public.

(3) Require the company to collect additional premiums if inadequate rates have been charged.

(4) Correct or prevent unfair discrimination even between policyholders of the same company.

(5) Prevent "flash" filings.

(6) Protect adequately the public against excessive rates.

(b) Rates made by concert of action, namely bureau rates (prohibited under the Sherman Act unless regulated by the states under the provisions of [the McCarran Act]) could be used indefinitely.

(c) There is absolutely no provision whatever in the majority's bills requiring the Insurance Commissioner to review rates before they are charged to the public.[79]

The minority's criticisms point out that under Chapter 175A insurance companies may theoretically operate indefinitely without any state regulation. For example, a completely arbitrary and unsupported rate may be filed and used for at least ten days.[80] Just prior to the effective date of the commissioner's disapproval, similar rates may be filed, and again, for another ten days or more, the commissioner cannot prevent their use. This procedure obviously could be repeated. On the other hand, it has been suggested that the expense of compiling a rate system operates to deter the insurance companies from filing rates that the companies know the commissioner will not accept. Thus it is argued that in practice a "file and use" provision offers as much protection as a requirement for prior approval of rates by the commissioner.[81] It should be noted, however, that a rate filing need not be accompanied by any supporting data,[82] thereby inviting a simple percentage increase that could be compiled with relatively little expense. In practice, the most effective deterrent to "flash filings" may well be the fear that flagrant abuses will cause the legislature to enact more effective regulations.

If it is found that the Massachusetts "file and use" provision does not regulate within the meaning of the McCarran Act, the courts should have little difficulty in indicating the standards for sufficient regulation. Presumably, such regulation would provide the commissioner with jurisdiction over rates at all times and thus eliminate the jurisdictional lapse between the time of filing and the time the order of disapproval becomes effective. Regulations such as those contained in the All-Industry Bill, which a majority of states have enacted,[83] would be

[79] Id. at 27-28.

[80] In Minnesota, a disapproval cannot become effective before 30 days. Minn. Stat. Ann. §70A.11(1) (1969).

[81] Note, The Regulation of Insurance Rates, 47 Colum. L. Rev. 1314, 1329 (1947).

[82] Insurance Rating Bd. v. Commissioner of Ins., 1970 Mass. Adv. Sh. 1285, 260 N.E.2d 922.

[83] Waiting-period provisions are currently in force in 25 states. [The years here given

sufficient insofar as failure of the commissioner to act within the waiting period creates a presumption of approval. In other words, under the all-industry regulations it is theoretically impossible for rates to go into effect against the wishes of the commissioner.[84]

If a "file and use" provision were held insufficient under the McCarran Act, any retroactive application of the federal antitrust laws would clearly subject the insurance industry to prohibitive damages. Although most examples of prospective application of a decision are in the field of criminal law,[85] the United States Supreme Court has indicated that prospective operation may be justified in civil cases as well. In *Linkletter v. Walker,* which contains a thorough analysis of the issue, the Court declared that "the accepted rule today is that in appropriate cases the Court may in the interest of justice make the rule prospective."[86] If the Massachusetts "file and use" provision were declared

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are those of enactment.] Alaska Stat. §21.39.040(d) (1966); Ariz. Rev. Stat. Ann. §20-345B (1954); Ark. Stat. Ann. §66-3110(2) (1959); Colo. Rev. Stat. Ann. §72-11-5(2) (1947); Fla. Stat. Ann. §627.101 (1959); Hawaii Rev. Stat. §431-694(e) (1955); Iowa Code Ann. §515A.4 (1965); Kan. Stat. Ann. §40-928(d) (1947); Ky. Rev. Stat. Ann. §304.13-050(2) (1970); La. Rev. Stat. §22:1407D (1964); Md. Ann. Code art. 48A, §242(d)(7) (1951); Mich. Stat. Ann. §24.12408(2) (1948); Neb. Rev. Stat. §44-1408 (1947); Nev. Rev. Stat. §694.100 (1947); N.M. Stat. Ann. §58-10-5(d) (1971); N.Y. Ins. Law §184 (McKinney 1948); N.D. Cent. Code §26-28-04 (1947); Okla. Stat. Ann. tit. 36 §902G (1953); Pa. Stat. Ann. tit. 40, §1184 (d) (1947); R.I. Gen. Laws Ann. §27-9-10 (1948); S.C. Code Ann. §37-694 (1947); S.D. Code §31.3804(4) (1947); Utah Code Ann. §31-18-3(2) (1947); Wash. Rev. Code Ann. §48.19.440 (1947); W. Va. Code Ann. §33-20-4(e) (1957). New Hampshire's statute has a "file and use" provision, but the statute also gives the commissioner discretionary power to suspend rates for up to 30 days pending his review of them. N.H. Rev. Stat. Ann. §414:5(a) (1947).

[84] Obviously, regulations requiring prior approval of rates would be sufficient. Such provisions are now in force in two states. [The years here given are those of enactment.] N.C. Gen. Stat. §58-248 (1939); Va. Code Ann. §38.1-253 (1952). Missouri requires prior approval of all rates made in concert or through rating organizations. Mo. Ann. Stat. §379.465 (1947).

Three states have "free competition" regulations. Cal. Ins. Code §1853.6 (1947); Ga. Code Ann. §56-510 (1967); Mont. Rev. Codes Ann. §40-3643 (1969). These regulations do not require any filings at all, but they prohibit insurance companies from adhering to rating agreements. See n.50 *supra.* Arguably, this type of regulation prevents antitrust abuses, but in so doing it may sacrifice many benefits which might be derived from the use of rating organizations.

Besides Massachusetts, 15 states have "file and use" or similar provisions. Ala. Code tit. 28, §394 (1945); Del. Code Ann. tit. 18, §2506 (1970); Ind. Ann. Stat. §39-5242(d) (1967); Me. Rev. Stat. Ann. tit. 24-A, §2306 (1969); Minn. Stat. Ann. §70A.06(1) (1969); Miss. Code Ann. §5834-03(c) (1946); N.J. Stat. Ann. §17:29A-6, 7 (1944); Ohio Rev. Code Ann. §3937.03(c) (Baldwin 1964); Ore. Rev. Stat. §737.205(1) (1969); Tenn. Code Ann. §56-603(c) (1945); Texas Ins. Code art. 5.15(d) (1945); Vt. Stat. Ann. tit. 8, §4655 (1947); Wyo. Stat. Ann. §26.1-272 (1947). In Connecticut and Wisconsin, rates may actually be effective for a "reasonable time" prior to filing. Conn. Gen. Stat. Ann. §38-201(n) (1969); Wis. Stat. Ann. §625.13 (1969).

At this writing, Illinois, which has used the all-industry system and then "free competition," has no casualty insurance regulations. The "free competition" statute, Ill. Ann. Stat. c. 73, §1065.18-1 (1969), expired August 1, 1971, and new regulations have yet to be enacted.

[85] See Stovall v. Denno, 388 U.S. 293 (1967); Johnson v. New Jersey, 384 U.S. 719 (1966); Tehan v. Shott, 382 U.S. 406 (1966); James v. United States, 366 U.S. 213 (1961).

[86] 381 U.S. 618, 628 (1965).

insufficient under the McCarran Act, the courts would have no difficulty in finding it appropriate to apply the ruling prospectively. Retrospective application would result in severe economic consequences under the Sherman Act and would be unfair because of the extent to which the former standards had been relied upon.

Conclusion. It has been the purpose of this comment to demonstrate that the legislative history of the McCarran Act does not support a ruling that mere legislation, enacted in good faith and without sham or pretense, is sufficient regulation under the act. The legislative history and the types of "state action" customarily left immune from federal antitrust laws suggest that states must regulate *effectively* in order to comply with the McCarran Act. Accordingly, a claim that state insurance regulations are so ineffective as not to be regulatory should constitute a legitimate cause of action.

An examination of the Massachusetts regulatory scheme, particularly the "file and use" provision, reveals that the state has failed to take complete, that is, effective, jurisdiction over the insurance industry because of the commissioner's inability to control rates in the period between the date of filing and the effective date of any subsequent disapproval. The Massachusetts system was enacted out of policy considerations which did not properly conform to those that motivated the supporters of the McCarran Act. It is submitted, therefore, that legislative or judicial action should be taken to give effect to the congres- purpose underlying the McCarran Act.

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