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Chapter 4: Insurance Law

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CHAPTER 4

Insurance Law

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§ 4.1. Chapter 93A — Bad Faith Refusal to Settle Liability Claims — Assignment of Insured's Rights. During the *Survey* year, the Supreme Judicial Court issued several significant decisions interpreting the scope of "unfair or deceptive acts or practices" under chapter 93A, the Consumer Protection Act, in the context of insurance. From the perspective of insurers doing business in the Commonwealth, *DiMarzo v. American Mutual Insurance Co.*[1] was probably the most significant such decision. The plaintiff in that action, Louis DiMarzo, sustained serious bodily injuries as a result of an automobile accident, and recovered the statutory maximum of $2,000 in personal injury protection ("P.I.P.") benefits from his own insurer, Providence Washington Insurance Company ("Providence Washington").[2] DiMarzo then brought suit against the alleged tortfeasor, William J. MacDonald, to recover damages for his bodily injuries.[3]

American Mutual Insurance Company ("American Mutual") had issued an automobile liability insurance policy to MacDonald that provided bodily injury coverage of $20,000 per person for injuries suffered by others.[4] Under this policy, American Mutual had a duty to defend MacDonald against any claims arising out of his operation of the insured automobile.[5] MacDonald, in turn, was under a duty to cooperate with American Mutual in any such defense.[6]

After investigating the accident, American Mutual determined that MacDonald was liable to DiMarzo, and that the damages for DiMarzo's bodily injuries exceeded its policy limits.[7] American Mutual initially took

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§ 4.1. [1] 389 Mass. 85, 449 N.E.2d 1189 (1983).

[2] *Id.* at 87-88, 449 N.E.2d at 1192-93.

[3] *Id.*

[4] *Id.* at 88, 449 N.E.2d at 1193.

[5] *Id.*

[6] *Id.*

[7] *Id.*

the position that a maximum of $18,000 was available under the policy for DiMarzo, because it had already reimbursed Providence Washington $2,000 for the P.I.P. benefits previously paid to DiMarzo.[8] Later, American Mutual paid another $200 to Providence Washington as reimbursement for "unallocated expenses," and reduced its settlement offer to $17,800.[9] DiMarzo rejected this offer.[10]

In February 1976, a master appointed by the superior court to hear DiMarzo's tort action against MacDonald filed a report recommending that judgment enter for DiMarzo in the amount of $75,000.[11] MacDonald did not appear for the scheduled master's hearing, and American Mutual was unable to reach him.[12] Throughout this period the parties discussed settlement, and at all relevant times DiMarzo remained willing to settle for $20,000, the face amount of the liability coverage.[13] American Mutual, however, insisted that only $17,800 remained available to be paid to DiMarzo in settlement, and refused to offer more.[14]

The tort case went to trial and the jury returned a verdict for DiMarzo in the amount of $104,000.[15] With interest and costs, judgment was entered for $149,068.78 and an execution was issued in that amount against MacDonald.[16] After the trial, American Mutual asserted that, due to MacDonald's non-cooperation and failure to appear at trial, it was only liable for $5,000, the minimum compulsory coverage then prescribed by chapter 90, section 34A.[17] Accordingly, American Mutual responded to service of DiMarzo's execution with an offer to pay only $2,800, calculated by deducting the $2,200 paid to Providence Washington from the minimum statutory coverage of $5,000.[18] This offer, too, was rejected by DiMarzo.[19]

In December 1978, DiMarzo hired a private investigator to find MacDonald.[20] The investigator was instructed to tell MacDonald that if he executed an assignment of all his rights and claims against American Mutual, DiMarzo would release him from all liability.[21] After a week, the

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[8] *Id.*
[9] *Id.* at 88 n.1, 449 N.E.2d at 1193 n.1.
[10] *Id.* at 88, 449 N.E.2d at 1193.
[11] *Id.* at 89, 449 N.E.2d at 1193.
[12] *Id.* at 88-89, 449 N.E.2d at 1193.
[13] *Id.* at 89, 449 N.E.2d at 1193.
[14] *Id.*
[15] *Id.*
[16] *Id.*
[17] *Id.*
[18] *Id.* at 90, 449 N.E.2d at 1193-94.
[19] *Id.* at 90, 449 N.E.2d at 1194.
[20] *Id.*
[21] *Id.*

investigator located MacDonald, and MacDonald executed the agreement.[22]

DiMarzo subsequently commenced a bad faith action against American Mutual, proceeding both individually in his own right, and as MacDonald's assignee.[23] Pursuant to chapter 93A, section 9, DiMarzo sent a demand letter to American Mutual.[24] Although the insurer continued to deny liability during trial of the bad faith action, it offered $50,000 to settle in full all of the claims of DiMarzo and MacDonald.[25] The offer was rejected.[26]

At trial, DiMarzo proceeded against American Mutual on six distinct causes of action. Specifically, DiMarzo's amended complaint sought: (1) to reach and apply the $20,000 proceeds of American Mutual's policy, pursuant to chapter 214, section 3(9) and chapter 175, section 113; (2) damages for breach of the contract of insurance, (as MacDonald's assignee); (3) multiple damages for failure to settle the tort claim in good faith (as assignee); (4) failure to settle a claim with due care (as assignee); (5) multiple damages for violations of chapter 176D, section 3(9), and chapter 93A, sections 2 and 9 (individually); and (6) multiple damages for willful and knowing violations of chapter 93A, sections 2 and 9 (as MacDonald's assignee).[27] In addition, DiMarzo asked for attorney's fees on all counts.[28]

DiMarzo prevailed on all counts.[29] He was awarded double damages in the amount of $386,716.06, plus interest of $44,289.75, attorney's fees of $71,962, and costs in the amount of $2,392.50.[30] In addition, the trial judge held that DiMarzo was entitled to reach and apply the full $20,000 policy proceeds, and awarded an additional $6,667 in attorney's fees to DiMarzo because of a special finding that American Mutual had lodged a frivolous counterclaim in violation of chapter 231, section 6F.[31] American Mutual requested direct appellate review by the Supreme Judicial Court.[32]

Confronted with the issue of whether the acts of American Mutual constituted unfair and deceptive practices under chapter 93A,[33] the Su-

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[22] *Id.*

[23] *Id.*

[24] *Id.*

[25] *Id.*

[26] *Id.*

[27] *Id.*

[28] *Id.* Counts 2, 3, and 4 were first tried in the superior court before a jury. Counts 1, 5, and 6 were tried before the judge alone. *Id.* at 91 n.4, 449 N.E.2d at 1194 n.4.

[29] *Id.* at 91-92, 449 N.E.2d at 1194-95.

[30] *Id.* at 92, 449 N.E.2d at 1195.

[31] *Id.*

[32] *Id.* at 92-93, 449 N.E.2d at 1195.

[33] Prior to October 1979, many requirements had to be satisfied to successfully bring an action under chapter 93A, section 9. Now, section 9 affords a remedy to anyone who has been "injured by another person's unfair or deceptive act or practice." The Court's analysis

preme Judicial Court upheld the superior court's findings in all material respects and its award of damages, with only two relatively minor amendments.[34] A threshold question concerned the assignability, under the law prior to the amendments of October 18, 1979, of MacDonald's chapter 93A, section 9 rights against his own insurer.[35] American Mutual had urged the invalidity of the assignment on the grounds that MacDonald did not understand the nature of the assignment instrument and that MacDonald did not suffer "a loss of money or property" as required by section 9, and therefore had no rights to assign.[36] The Court quickly disposed of these arguments. First, the Court noted the trial court's finding that MacDonald had manifested sufficient understanding and consent as to the assignment, and that even if he had not, the instrument would have been at most voidable.[37] Second, the Court stated that the adverse effect of a judgment on a litigant's financial status constitutes "a loss of money or property" irrespective of any actual execution.[38]

American Mutual argued that deduction of the P.I.P. payment from the amount of the liability coverage was permissible under the terms of the applicable statute, chapter 90, section 34M.[39] The Court found that even if American Mutual had acted under statutory authority, which the Court expressly did not find, the insurer would not be shielded automatically from liability under chapter 93A.[40] The Court reiterated its previous rejection of the proposition that an act or practice which is authorized by statute cannot constitute an unfair or deceptive practice under chapter 93A, section 2(a), emphasizing that inquiry must focus on the effect of the conduct on the public. According to the Court, the trier of fact must determine if the conduct was an unfair or deceptive act or practice.[41] The Supreme Judicial Court also rejected American Mutual's argument that the insurer was exempt from liability under chapter 93A, section 3(1)(a), because the acts at issue were allegedly permitted under laws administered by the Commissioner of Insurance.[42] Finding that this was a matter for determination at trial, the Court concluded that there was sufficient

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of the earlier requirements has no relevance to a discussion of the current form of chapter 93A. *See id.* at 93 n.7, 449 N.E.2d at 1195 n.7.

[34] *See id.* at 108, 449 N.E.2d at 1206.

[35] *Id.* at 93, 449 N.E.2d at 1195.

[36] *Id.* at 93 n.8, 449 N.E.2d at 1195-96 n.8.

[37] *Id.* at 93-94, 449 N.E.2d at 1196.

[38] *Id.* at 94, 449 N.E.2d at 1196.

[39] *Id.* at 95, 449 N.E.2d at 1197.

[40] *Id.* at 96, 449 N.E.2d at 1197.

[41] *Id.* (quoting Schubach v. Household Fin. Corp., 375 Mass. 133, 137, 376 N.E.2d 140, 142 (1978)).

[42] 389 Mass. at 96, 449 N.E.2d at 1197.

evidence from which the trial judge could have found no such exemption.[43]

Turning to the question of the superior court's findings on bad faith, the Court determined that "the evidence warranted the conclusion that American Mutual acted in bad faith and did not have a bona fide belief in the reasonableness of its position."[44] According to the Court, the evidence introduced at trial by DiMarzo showed that: (1) Providence Washington agreed to return the P.I.P. reimbursement to American Mutual in 1977, yet American Mutual continued to insist thereafter that its policy limits had been reduced; (2) American Mutual violated sound claims practice by not obtaining an early return of the P.I.P. reimbursement and by not resolving a matter of coverage in favor of its insured; (3) other insurance companies would offer the full liability limits of their policy, without any reduction on account of P.I.P payments, in similar circumstances; and (4) the Massachusetts Commissioner of Insurance understood that it was the practice of the insurance industry not to reduce liability policy limits by the amount of P.I.P. payments.[45] Considering this testimony in light of American Mutual's awareness of the distinct possibility that failure to settle with DiMarzo would lead to the entry of a substantial judgment in excess of policy limits against its insured, the Court found a sufficient basis to support the superior court's finding that American Mutual acted in bad faith in refusing to offer its full policy limit of $20,000.[46]

The Court also upheld the superior court's finding that the offer extended by American Mutual of $2,800 after receipt of the execution in the underlying tort action was made in bad faith.[47] According to the Court, the evidence showed that American Mutual made that offer knowing that it had previously waived its non-cooperation defense and had failed to exercise a valid reservation of a right to disclaim liability.[48] The Court noted that American Mutual knew as early as 1972, when MacDonald failed to attend his scheduled deposition in the underlying tort action, that its insured might not cooperate in his defense.[49] Nevertheless, American Mutual continued to defend MacDonald and made no effort to reserve its rights.[50] When MacDonald failed to appear for the master's hearing, American Mutual chose to proceed with that hearing without him, and, despite the opportunity to do so, again failed to disclaim liability or

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[43] *Id.* at 96-97, 449 N.E.2d at 1197.
[44] *Id.* at 97, 449 N.E.2d at 1198.
[45] *Id.* at 97-98, 449 N.E.2d at 1198.
[46] *Id.* at 99, 449 N.E.2d at 1198.
[47] *Id.*
[48] *Id.*
[49] *Id.* at 99, 449 N.E.2d at 1198-99.
[50] *Id.* at 99, 449 N.E.2d at 1199.

reserve its rights as to MacDonald's apparent non-cooperation.[51] Accordingly, the Court held that American Mutual waived any defense of non-cooperation by exercising "dominion over the case at an important point which made a significant and irrevocable change in MacDonald's position."[52] The Court specifically stated that an insurer must either expressly reserve its rights or disclaim liability on account of an insured's non-cooperation no later than the beginning of a jury trial at which a defense is afforded to the insured.[53]

American Mutual argued that MacDonald's disappearance obviated any requirement of a formal notification before proceeding to trial.[54] The Court rejected this on the grounds that American Mutual did not take sufficient affirmative steps to locate and secure the cooperation of MacDonald.[55] Thus, the Court upheld the trial judge's conclusion that "American Mutual's feeble and untimely attempt to reserve its right to disclaim liability was taken in bad faith."[56]

On the issue of damages, the Court ruled that although recovery under chapter 93A is not limited to actual damages, multiple damages awarded because of unfair settlement practices are limited to the amount of an insured's personal liability in excess of policy coverage.[57] The Court stated that "under chapter 93A, the plaintiff is entitled to recover for all losses which were the foreseeable consequences of the defendant's unfair or deceptive act or practice."[58] According to the Court, the judgment and execution entered against MacDonald were the foreseeable consequences of American Mutual's acts.[59] Thus, the Court opined that "[t]he damages suffered by MacDonald, as a result of American Mutual's wrongful refusal to settle the claim, are the amount for which MacDonald became liable in excess of his policy coverage."[60] In this regard, the Court concluded that the superior court erred in its award of damages in one respect.[61] The Court determined that policy coverage of $20,000 could not be included in calculating the damages awarded under the chapter 93A

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[51] *Id.*

[52] *Id.*

[53] *Id.* at 99-100, 449 N.E.2d at 1199.

[54] *Id.* at 100, 449 N.E.2d at 1199.

[55] *Id.*

[56] *Id.* American Mutual also attacked the superior court's finding on causation. The Court confirmed that causation is a question of fact, but held that, on the evidence, it could not say that the conclusions of the trial judge were "clearly erroneous." *Id.* at 101, 449 N.E.2d at 1199.

[57] *Id.* at 101, 449 N.E.2d at 1200.

[58] *Id.*

[59] *Id.* (citing International Fidelity Ins. Co. v. Wilson, 387 Mass. 841, 850, 443 N.E.2d 1308, 1314 (1983)).

[60] 389 Mass. at 101-02, 449 N.E.2d at 1200.

[61] *Id.*

counts because the policy proceeds were not part of the foreseeable damages that could be multiplied pursuant to chapter 93A.[62]

American Mutual further argued that pursuant to chapter 93A, section 9(3), its settlement offer of $50,000 was reasonable, thus ending any liability for violations of chapter 93A.[63] Again, the Supreme Judicial Court upheld the trial judge, on the ground that determination of the reasonableness of a tender of relief under chapter 93A is a question of fact.[64]

Finally, the Court discussed the reasonableness of the attorney's fees awarded by the superior court.[65] The Supreme Judicial Court refused to disturb that award, noting that the amount of attorney's fees under chapter 93A is within the broad discretion of the trial judge.[66] Nevertheless, the Court held that a separate, additional award of attorney's fees under chapter 231, section 6F, was not warranted, as it would be duplicative of attorney's fees awarded pursuant to chapter 93A.[67]

The *DiMarzo* case suggests that the Supreme Judicial Court will not hesitate to uphold a trial court's findings with regard to chapter 93A liability and damage awards in the insurance context. As a policy matter, the Court has served notice that insurers should carefully consider the potential for damage awards against their insureds in excess of policy limits, and also the possibility of subsequent awards of double or treble damages, attorney's fees, and costs directly against the company.

In this case, the superior court apparently decided that the insurance company was being unreasonably stubborn in not offering DiMarzo the entire $20,000 of policy coverage. As a result, although DiMarzo was initially willing to settle for $20,000, he ended up with close to $500,000.

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[62] *Id.*

[63] *Id.* at 102, 449 N.E.2d at 1200.

[64] *Id.*

[65] *Id.* at 106, 449 N.E.2d at 1202.

[66] *Id.* at 101-02, 449 N.E.2d at 1200.

[67] *Id.* at 107, 449 N.E.2d at 1203. As modified by the Supreme Judicial Court, final judgment was entered in DiMarzo's favor by the superior court, as follows: Count 1, $20,000 plus interest; Count 6, $129,068.78 plus interest, then doubled; Costs, $2,392.50; Attorney's Fees, $71,962. *Id.* Chief Justice Hennessey concurred with the opinion, but commented on the large damage award. *Id.* at 108, 449 N.E.2d at 1203 (Hennessey, C.J., concurring). He asserted that the findings of the superior court jury and judge were supported by the evidence, and the law was correctly applied. *Id.* Nevertheless, as a practical matter, Chief Justice Hennessey recognized that DiMarzo's good fortune would be, in the end, at the expense of insurance consumers who would be charged higher premiums for their liability coverage. *Id.* at 109, 449 N.E.2d at 1204 (Hennessey, C.J., concurring). Particularly as to the policy holders of "mutual" insurance companies, who possess direct ownership rights in such insurers by virtue of chapter 175, section 76, the *DiMarzo* result would appear in a sense to be "anti-consumer." Justice O'Connor also concurred with the Court's opinion, but in a lengthy and well-reasoned analysis disagreed with the Court's holding that American Mutual had waived its non-cooperation defense. *Id.* at 109-14, 449 N.E.2d at 1204-06 (O'Connor, J., concurring).

The *DiMarzo* decision will certainly give insurers reason to pause and consider negotiated settlements while defending third-party tort suits against their insureds, even where coverage questions arise between insurer and insured.

The impact of *DiMarzo* will have its advantages and disadvantages. One advantage is that more tort cases are likely to settle. Another is that insurance companies will be more concerned with dealing fairly and in good faith with their policy holders. On the other hand, certain tort plaintiffs may now be able to secure "windfall" settlement offers, greater than otherwise deserved, for no other reason than an overabundance of caution by insurance claims executives.

§ 4.2. Chapter 93A — Standing — Adversely Affected Requirement — Pattern of Unfair Claims Practices. In *Van Dyke v. St. Paul Fire & Marine Insurance Co.*,[1] the plaintiffs initiated a medical malpractice suit, and simultaneously proceeded separately against St. Paul Fire & Marine Insurance Co. ("St. Paul"), the liability carrier for the defendant physicians, because of the insurer's handling of the malpractice claim.[2] The essence of the complaint was that St. Paul, as the defendants' insurer, did not adequately investigate the plaintiffs' claims before rejecting a pretrial demand for settlement, and that St. Paul had an obligation to make a reasonable pretrial offer of settlement because liability was reasonably clear.[3]

During the course of the underlying medical malpractice litigation, and well prior to trial, the plaintiffs had sent a chapter 93A demand letter to St. Paul.[4] Enclosed with the letter was documentation supporting the plaintiffs' allegations of liability and damages.[5] St. Paul had responded to plaintiffs' settlement demand by stating that, based on the information in its possession, it believed a jury might find for the defendants.[6] For this reason, St. Paul declined to extend a pretrial settlement offer.[7]

St. Paul moved for summary judgment, relying on a policy provision precluding it from settling claims without the consent of its physician-insureds.[8] In addition, St. Paul argued that because liability in the underlying malpractice action was not "reasonably clear" when the demand letter was received, it had no obligation to extend a settlement offer.[9] In

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§ 4.2. [1] 388 Mass. 671, 448 N.E.2d 357 (1983).
[2] *Id.* at 672, 448 N.E.2d at 358.
[3] *Id.*
[4] *Id.*
[5] *Id.* at 673, 448 N.E.2d at 358.
[6] *Id.* at 673, 448 N.E.2d at 359.
[7] *Id.*
[8] *Id.*
[9] *Id.*

support of its position, St. Paul submitted affidavits establishing that the insurer had been advised by its trial counsel and a medical expert concerning the propriety of the medical care at issue.[10] The superior court granted St. Paul's motion, and the plaintiffs appealed.[11]

The Supreme Judicial Court affirmed the superior court judgment.[12] The Court found that St. Paul declined the plaintiffs' settlement demand in the belief that the liability of the defendant physicians was not "reasonably clear."[13] According to the Court, absent sufficient information to support its rejection of the demand letter under chapter 93A, St. Paul risked a future finding of liability.[14] The Court noted, however, that if, before rejecting that demand, St. Paul had conducted a proper investigation that revealed that liability was unclear, then St. Paul was warranted in rejecting the demand.[15]

The Court reasoned that although St. Paul had not established the absence of a material fact in dispute concerning the propriety of its claim settlement practices, the plaintiffs were not adversely affected by any unlawful methods, acts or practices of St. Paul.[16] St. Paul's refusal to settle meant only that the malpractice action proceeded to trial on its merits. Since the plaintiffs were not injured by the lack of settlement, even assuming that such refusal was a violation of chapter 176D, section 3(9)(d) and (f), the Court held that the plaintiffs had no claim under chapter 93A, section 9.[17] The Court did not reach the question of whether St. Paul's conduct was, in fact, violative of chapter 176D. Rather, the *Van Dyke* decision turned on the plaintiffs' inability to show that they were adversely affected by the violations alleged.[18]

Van Dyke appears to be the first appellate case interpreting the 1979 amendment to chapter 93A. This amendment broadened the class of persons who could maintain actions under chapter 93A. The 1979 amendment provided that "any person . . . who has been injured by another person's use of employment of any method, act or practice declared unlawful by section 2 . . . or any person violating the provisions

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[10] *Id.*

[11] *Id.*

[12] *Id.* at 672, 448 N.E.2d at 359.

[13] *Id.* at 673, 448 N.E.2d at 359.

[14] *Id.* at 678, 448 N.E.2d at 362.

[15] *Id.*

[16] *Id.* at 672, 448 N.E.2d at 359 (citing G.L. c. 93A, § 9).

[17] *Id.* G.L. c. 176D, § 3(9) lists the acts or omissions which constitute unfair claim settlement practices for insurance companies. Section 3(9)(d) covers "[r]efusing to pay claims without conducting a reasonable investigation based on all available information." Section 3(9)(f) covers "[f]ailing to effectuate prompt, fair and equitable settlements in which liability has become reasonably clear."

[18] 388 Mass. at 672, 448 N.E.2d at 359.

of subsection (9) of section 3 of chapter 176D may bring an action in the superior court . . . ."[19] Because of this amendment, the Court in *Van Dyke* found the class of persons entitled to assert a claim under chapter 93A for insurance claims settlement practices proscribed by chapter 176D, section 3(9), to be "substantially broadened" from what it was in 1977 when *Dodd v. Commercial Union Insurance Co.* was decided.[20] In *Dodd*, the Court held that only a policyholder could assert a chapter 93A violation against an insurance company for improper settlement of a claim.[21] The *Van Dyke* Court therefore allowed the plaintiffs to sue the insurance company directly.[22]

In addition, the *Van Dyke* Court held that one isolated act is not enough to impose liability on an insurance company under chapter 176D, sections 3(9)(d) and (f).[23] The Court noted that the language in these sections refers to multiple refusals or failures, not to a single act. According to the Court, a person whose rights were adversely affected by an insurance company's violation of section 3(9)(d) or (f) must therefore be affected by a pattern of unfair claim settlement practices and not by an isolated act. The Court then assumed that a single act in the handling of a claim violates chapter 93A, section 9, "if it is an act that as a part of a pattern of conduct would be a violation of chapter 176D, section 3(9)(d) or (f)."[24] This reasoning limits the liability imposed on insurance companies under chapter 176D, section 3(9)(f) and, therefore, their liability under chapter 93A, section 9.

The Appeals Court applied the *Van Dyke* decision during the *Survey* year in *Chub v. Electric Insurance Company*.[25] The plaintiff in *Chub* was injured in a two-car accident while driving his mother's car.[26] Because the liability insurer of the other motorist involved in the collision initially refused coverage, the plaintiff claimed coverage from Electric Insurance Company ("Electric Insurance") under the uninsured motorists portion of his parent's policy.[27] Later, the plaintiff obtained a settlement of $16,500 from the liability insurer for the other motorist.[28] Despite the lack of evidence that the plaintiff had sustained injuries in excess of $16,500, he commenced suit against Electric Insurance under chapter 93A, claiming that the defendant insurer had violated chapter 176D, section 3(9)(f)[29]

[19] G.L. c. 93A, § 9(1).
[20] 373 Mass. 72, 365 N.E.2d 802 (1977).
[21] *Id.* at 81-82, 365 N.E.2d at 807.
[22] 388 Mass. at 675, 448 N.E.2d at 360.
[23] *Id.* at 676, 448 N.E.2d at 360-61.
[24] *Id.* at 676, 448 N.E.2d at 361.
[25] 17 Mass. App. Ct. 61, 455 N.E.2d 646 (1983).
[26] *Id.* at 62, 455 N.E.2d at 647.
[27] *Id.*
[28] *Id.*
[29] *Id.*

in refusing to pay uninsured motorist benefits.[30] The record failed to show that the plaintiff was "adversely affected" by this alleged violation and the defendant insurer moved for summary judgment.[31] The superior court granted the defendant's motion, and the Appeals Court affirmed.[32]

Following the reasoning in *Van Dyke*, the *Chub* court reaffirmed that a plaintiff must be "adversely affected" by the alleged unfair practice violating chapter 176D to recover under chapter 93A, section 9. Because the plaintiff failed to prove damages in excess of the $16,500 he had received, the Appeals Court did not reach the question of whether Electric Insurance's alleged acts constituted, in fact, unfair claims settlement practices in violation of chapter 176D.

§ 4.3. Chapter 93A — Delay in Paying a Meritorious Claim. The issue in *Swanson v. Bankers Life Company*[1] concerned an insurer's delay in recognizing and paying a meritorious claim.[2] The plaintiff, Swanson, had a group insurance policy with the defendant, Bankers Life Company ("Bankers Life").[3] The policy provided coverage for Swanson's wife through the calendar year following Mr. Swanson's retirement for any medical condition existing on the date of his retirement which caused her to become totally disabled.[4] Mr. Swanson retired on August 31, 1977, and in the spring of 1978, Mrs. Swanson was hospitalized for the treatment of lung cancer.[5]

Mr. and Mrs. Swanson submitted claims under the Bankers Life policy for reimbursement of expenses incurred.[6] Bankers Life initially took the position that coverage was not available because Mrs. Swanson's treatment did not relate to a condition causing total disability that had existed on the date of Mr. Swanson's retirement.[7] The plaintiffs responded that medical records in the insurer's possession would authenticate the claim.[8] Bankers Life then requested that a "statement of claim form" be completed by Mrs. Swanson's attending physician.[9] Upon receipt and review of that form, Bankers Life continued to assert that Mrs. Swanson had a "new condition" for which benefits were not payable under the Bankers

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[30] *Id.*
[31] *Id.* at 61, 455 N.E.2d at 646.
[32] *Id.* at 63, 455 N.E.2d at 647.

§ 4.3. [1] 389 Mass. 345, 450 N.E.2d 577 (1983).
[2] *Id.* at 347, 450 N.E.2d at 579.
[3] *Id.*
[4] *Id.*
[5] *Id.*
[6] *Id.*
[7] *Id.*
[8] *Id.*
[9] *Id.*

Life policy, which covered only disabilities existing at the time Mr. Swanson's employment terminated.[10]

In due course, the plaintiffs' counsel sent Bankers Life what purported to be a written demand for relief under chapter 93A.[11] Although Bankers Life failed to reply in writing as required by section 9 of that statute, a representative of the insurer informed the plaintiffs' counsel by telephone that Bankers Life had no evidence that Mrs. Swanson's malignancy existed on August 31, 1977.[12] Finally, after further correspondance with plaintiffs and their doctors and hospitals, Bankers Life received a diagnostic radiology report indicating that Mrs. Swanson had a lung lesion as early as January, 1977, well prior to her husband's retirement.[13] Accordingly, on April 23, 1979, Bankers Life informed the Swansons' counsel that it intended to pay all benefits due under the contract.[14] On May 1, 1979, Bankers Life forwarded payment drafts to the Swansons' counsel, representing in total the sums then due under the policy.[15]

Notwithstanding this payment, the Swansons continued to pursue their claim under chapter 93A against Bankers Life.[16] The plaintiffs contended "that Bankers Life had an obligation to investigate the claim with greater diligence than it did."[17] This allegation was based on chapter 176D, section 3(9)(d), which defines an insurer's refusal "to pay claims without conducting a reasonable investigation based upon all available information" as an unfair claim settlement practice.[18]

The district court judge found for the plaintiffs in the amount which the parties agreed was payable under the policy, and then separately awarded damages under chapter 93A at double that amount, plus attorney's fees.[19] On appeal by Bankers Life to the appellate division of the district court department, the judgment below was vacated.[20] The appellate division found no chapter 93A violations, and ordered that the insurer pay only its policy proceeds.[21] The plaintiffs appealed to the Supreme Judicial Court.[22]

On appeal, the plaintiffs argued that the insurer's negligent failure to investigate their claim with reasonable diligence, and the resulting delay

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[10] *Id.*
[11] *Id.* at 348, 450 N.E.2d at 579.
[12] *Id.*
[13] *Id.*
[14] *Id.*
[15] *Id.*
[16] *See id.*
[17] *Id.* at 348-49, 450 N.E.2d at 579-80.
[18] *Id.* at 349, 450 N.E.2d at 580.
[19] *Id.* at 346, 450 N.E.2d at 578.
[20] *Id.*
[21] *Id.*
[22] *Id.* at 347-50, 450 N.E.2d at 579-80.

in Bankers Life's payment of sums due under the policy, was an unfair or deceptive trade practice in violation of chapter 176D, section 3(9)(d) and, thus, chapter 93A, section 9.[23] Although the Court acknowledged that, in theory, recovery could be had for a deceptive act resulting from a defendant's negligence, it nevertheless held that "not every negligent act is unfair or deceptive and thus unlawful" under chapter 93A, section 2.[24]

The Court rejected the plaintiffs' allegations,[25] stating that the defendant had not acted deceptively because Bankers Life's position on the claim was clearly stated to the plaintiffs.[26] In addition, the Court held that the defendant had not acted unfairly since the plaintiffs' counsel knew that to obtain coverage, Mrs. Swanson's illness had to exist on the date of Mr. Swanson's retirement.[27] Therefore, under chapter 93A, section 9, as it read prior to the 1979 amendment, the burden of proof to show a pre-existing condition was on the plaintiff.[28]

The *Swanson* case suggests that the Court will be reluctant to find chapter 93A violations when an insurer pays, albeit late, the full amount of a claim due under its policy. The Court in *Swanson* indicated that section 3(9) of chapter 176D, as applied through chapter 93A, is not aimed at penalizing the methods and practices employed in handling particular claims by innocent, though possibly negligent, insurers. This is true even where an insured can show "technical" violations of the claims handling standards of section 3(9), so long as no "actual damage" results from the insurer's conduct. In *Swanson*, Bankers Life's only "unfair" act was its failure to promptly accept liability for the Swansons' claim which, as a matter of public policy, should not subject an insurer to punitive damages after the omission has been rectified voluntarily and payment of policy proceeds has been made.

§ 4.4. Excess Liability Insurance — Exhaustion Of Underlying Limits. The plaintiff in *Thomson National Press Co. v. National Union Fire Insurance Co.*[1] manufactured large printing presses. Believing itself vulnerable to substantial personal injury claims by those who used the presses, Thomson National Press Co. ("Thomson") procured liability insurance in succeeding layers of coverage.[2]

Commercial Union Insurance Company ("Commercial Union") pro-

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[23] *Id.* at 349, 450 N.E.2d at 580.
[24] *Id.*
[25] *Id.*
[26] *Id.*
[27] *Id.* at 350, 450 N.E.2d at 580.
[28] *Id.*

§ 4.4. [1] 16 Mass. App. Ct. 242, 451 N.E.2d 432 (1983).
[2] *Id.* at 243, 451 N.E.2d at 433.

vided a primary policy with limits of $300,000 for each occurrence and $300,000 aggregate, for the period September 23, 1975 to September 23, 1978.[3] A first excess layer policy was provided by National Union Fire Insurance Company ("National") for the period September 23, 1976 through September 23, 1977,[4] with aggregate and per occurrence limits of $200,000.[5] During the year that Commercial Union's primary policy and National's first excess policy were both in effect, Thomson thus had liability coverage totaling $500,000 each occurrence and $500,000 aggregate.[6]

From July 7, 1976 through July 21, 1977, Thomson also had an excess umbrella insurance policy with Affiliated Factory Mutual Insurance Co. ("Affiliated").[7] This policy was not coordinated with the effective dates of the others, however, and the Affiliated umbrella policy expired during the policy periods specified in the primary and excess contracts of Commercial Union and National, described above.[8] Because of the lapse of Affiliated's coverage, Thomson obtained an umbrella insurance policy from Chicago Insurance Co. ("Chicago") for the period July 21, 1977 through July 21, 1978.[9] Chicago limited its liability for each occurrence, and in the aggregate, to $2,000,000 in excess of underlying insurance, which the Chicago policy required to be maintained with limits of $500,000 each occurrence, $1,000,000 aggregate.[10] The Chicago umbrella policy designated Commercial Union's policy as the primary underlying insurance.[11]

The underlying insurance requirement of $500,000 in the Chicago policy presented a problem because Commercial Union's primary policy was written with limits of only $300,000.[12] To meet this requirement, Thomson purchased additional coverage from National for the period July 21, 1977 through September 23, 1977.[13] The face of this policy, labelled "excess third party liability policy," named Commercial Union as the primary insurer with underlying limits of $300,000 each occurrence and in the aggregate.[14] National then limited its liability on this second excess policy to $200,000 each occurrence, with an aggregate liability of $700,000.[15]

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[3] *Id.*
[4] *Id.* at 244, 451 N.E.2d at 434.
[5] *Id.*
[6] *Id.*
[7] *Id.*
[8] *Id.*
[9] *Id.*
[10] *Id.*
[11] *Id.*
[12] *Id.* at 245, 451 N.E.2d at 434.
[13] *Id.*
[14] *Id.*
[15] *Id.*

With the issuance of that excess policy, Thomson's total coverage from Commercial Union and National was $500,000 each occurrence and $1,000,000 in the aggregate, thus apparently meeting Chicago's underlying insurance requirement.[16]

At the time National's second excess liability policy was issued on July 21, 1977, Commercial Union was defending Thomson, pursuant to the terms of its primary insurance policy, against a number of claims involving bodily injuries that occurred between September 23, 1976 and July 21, 1977.[17] Commercial Union ultimately paid out $300,000 on these claims, exhausting the aggregate limits of its primary policy.[18] Additionally, on its first excess policy, National paid $200,000 on bodily injury claims arising during the same period, September 23, 1976 to July 21, 1977.[19]

Subsequently, two more claims involving bodily injuries occurring after July 21, 1977 and before September 23, 1977, were asserted against Thomson and presented to National under its second excess liability policy.[20] Commercial Union had refused liability on these claims because the $300,000 aggregate liability limit of its primary policy had already been exhausted.[21]

At trial, the parties stipulated that when National issued its second excess coverage policy on July 21, 1977, neither Thomson nor National

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[16] *Id.*

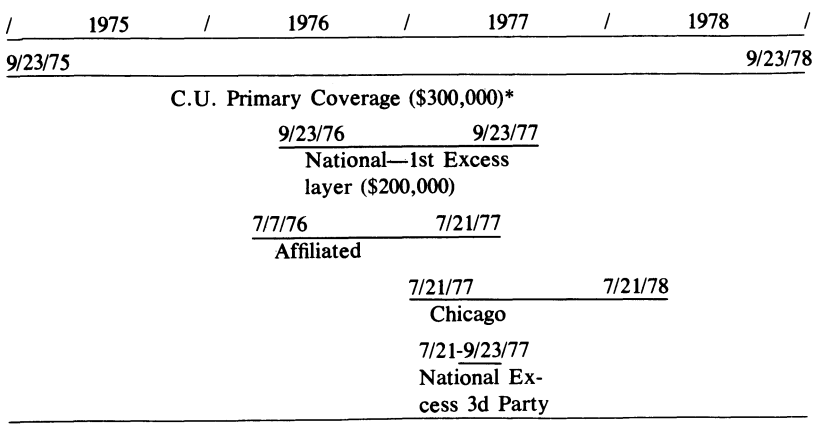
[17] *Id.*

[18] *Id.*

[19] *Id.*

[20] *Id.*

[21] *Id.* The chronology of the above claims with reference to the effective dates and coverages of Thomson's various liability policies is illustrated in the following time table, Table "A":



* Two claims were submitted between 9/23/76 and 7/21/77; C.U. Primary Coverage paid its limit of $300,000. Two more claims were submitted between 7/21/77 and 9/23/77.

knew that pre-exisiting but unreported claims would exhaust the primary insurance provided by Commercial Union.[22] The parties also agreed that if Commercial Union's underlying policy had an aggregate liability limit of $300,000, then no other insurance policy was in place to provide primary aggregate limits, not previously exhausted, for the policy period of National's second excess coverage.[23]

The superior court found that on July 21, 1977, Thomson had the primary coverage required by National's excess coverage policy.[24] In addition, the court concluded that on July 21, 1977, for a substantial premium, National had taken the risk that the claims against the primary carrier, Commercial Union, might eventually exhaust the primary coverage. Consequently, the superior court ruled that National was contractually obligated under its second excess policy to handle claims which involved injuries occurring during the policy period.[25]

Upon appeal, the central issue was whether the required underlying coverage had been "exhausted" with respect to claims brought under the second National excess policy.[26] The Appeals Court vacated the trial court's decision, holding that Thomson did not maintain the primary coverage in place as required by National's policy.[27] The court rejected Thomson's argument that the second National policy was ambiguous and therefore should be construed in the insured's favor.[28] Looking at the express language of the policy, the court stated that it "must construe the words in the policy in their usual and ordinary sense."[29] Because the court found no ambiguity in the policy's specifications of the underlying limits, it refused to construe the second excess policy strictly against National.[30] After deciding that neither the declarations nor the insuring agreements of National's policy were ambiguous, the court read those provisions as reflecting National's agreement only "to provide a limited amount of coverage for damages in excess of that protection afforded by Commercial [Union's] underlying insurance."[31]

The Appeals Court then addressed the question of whether Thomson could base its claim for excess coverage on the exhaustion of Commercial Union's liability due to payment of claims for injuries occurring before

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[22] 16 Mass. App. Ct. at 245, 451 N.E.2d at 434.

[23] *Id.* at 245-46, 451 N.E.2d at 434-35.

[24] *Id.* at 246, 451 N.E.2d at 435. The court found that the limits of Commercial Union's primary coverage was $300,000 per occurrence, aggregate $500,000-$1,000,000. *Id.*

[25] *Id.*

[26] *See id.* at 246-49, 451 N.E.2d at 435-36.

[27] *Id.* at 248-49, 451 N.E.2d at 435-36.

[28] *Id.* at 246, 451 N.E.2d at 435.

[29] *Id.* at 248, 451 N.E.2d at 436.

[30] *Id.*

[31] *Id.*

National issued the policy to cover losses for injuries sustained during National's policy period.[32] The court found for the insurance company, concluding that Thomson was attempting to convert National from an excess to an underlying insurer for the injuries occurring during its policy period, in conflict with the express terms of the policy.[33] According to the court, the endorsement clearly provided that National's excess coverage was available only when the stated aggregate limits were exhausted by claims based upon bodily injury or property damage occurring during the policy period, July 21, 1977 through September 23, 1977.[34]

To understand the significance of this decision, and how the case arose in the first place, the availability of the "drop down" policy provision typically found in excess liability policies similar to National's must be recognized.[35] Such policies typically provide that in the event of "exhaustion" of underlying coverage, the excess policy "drops down" and responds to the claim on a first dollar basis to the same extent as the exhausted policy would have done.[36] No such standard provision existed in Thomson's policy with National. The court, therefore, correctly placed the burden of the underlying insurance gaps on the insured and the broker who structured the coverage, rather than on the excess insurer. It is also noteworthy that the court in this case could find no ambiguity, since National's excess liability policy contained clear language. To rely on the precedential value of this case, therefore, an insurance company similarly must use clear policy language.

§ 4.5. Insurer's Duty To Defend — Coverage Exclusions. During the *Survey* year, the Appeals Court addressed the question of an insurer's duty to defend its insureds in two decisions. In the first case, *Terrio v. McDonough*,[1] an insured was sued by an ex-lover for sexual assault and battery.[2] The insured denied plaintiff's claim, alleging his own negligence rather than intentional conduct. In addition, the insured impleaded

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[32] *Id.*

[33] *Id.* at 248-49, 451 N.E.2d at 436.

[34] *Id.* According to the court, if Thomson believed that pre-policy-period injuries could exhaust the insurance underlying National's excess coverage, its misunderstanding was not due to any failure by National to use language which Thomson could " 'reasonably understand to be the scope of [its] coverage.' " *Id.* (quoting Slater v. United States Fid. & Guar. Co., 379 Mass. 801, 803, 400 N.E.2d 1256, 1258 (1980)).

[35] *See, e.g.*, G. COUCH, 16 COUCH CYCLOPEDIA OF INSURANCE LAW. 2D § 62:48 at 484-495 (Rev. ed. 1983); 1 THE UMBRELLA BOOK: ANALYSIS OF COMMERCIAL UMBRELLA AND EXCESS LIABILITY FORMS (1981). *See also* A. WINDT, INSURANCE CLAIMS AND DISPUTES § 6.12, at 257 (1982).

[36] *Id. See* Molina v. United States Fire Ins. Co., 574 F.2d 1176 (4th Cir. 1978). *But see* Reserve Ins. Co. v. Pisciotta, 30 Cal.3d 800, 640 P.2d 764, 180 Cal. Rptr. 628 (1982).

§ 4.5. [1] 16 Mass. App. Ct. 163, 450 N.E.2d 190 (1983).

[2] *Id.* at 164, 450 N.E.2d at 192.

Hartford Fire Insurance Co. (the "Hartford"), seeking coverage and an obligation to defend under its standard homeowners policy.[3]

Addressing the issue of the Hartford's liability, the Appeals Court reaffirmed the established rule that "an insurer has no obligation to defend when the allegations of a complaint describe with precision intentional conduct of a defendant which the insurance policy expressly excludes from coverage."[4] The court stated that the allegations in the complaint determine an insurance company's obligation to defend against a liability claim.[5] Consequently, according to the court, no duty to defend arises unless the insurer is, or should be aware of, facts indicating liability within the coverage of the policy.[6]

The second case, *Sterilite Corp. v. Continental Casualty Co.*,[7] involved a manufacturer of molded plastics that was insured under a comprehensive general liability ("C.G.L.") policy issued by Continental Casualty Co. ("Continental").[8] Sterilite manufactured plastic trays which were sold by a distributor, WRH, to Henry Heide, Inc. ("Heide").[9] Alleging that the trays were unfit for their intended use and not in conformity with the sample,[10] Heide sued WRH, Sterilite, and the material supplier, Dow, for damages in the amount of $600,000.[11]

The action against Sterilite was commenced on July 21, 1975, and Continental provisionally assumed its defense.[12] On August 21, 1975 Continental disclaimed responsibility with regard to damage to the trays, and on January 5, 1976 disclaimed all liability.[13] Sterilite then engaged its own counsel and sought a judicial declaration that Continental was obliged to undertake its defense.[14] The superior court held that Continental had breached its duty under the C.G.L. policy to defend its insured, and thus was obliged to indemnify Sterilite for the fees incurred for private defense counsel.[15] The Appeals Court, considering whether Continental had a duty to defend Sterilite in the third-party action commenced by Heide, affirmed.[16] According to the court, Continental had to either con-

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[3] *Id.*
[4] *Id.* at 168, 450 N.E.2d at 193.
[5] *Id.* at 166, 450 N.E.2d at 193.
[6] *Id.* at 167, 450 N.E.2d at 193.
[7] 17 Mass. App. Ct. 316, 458 N.E.2d 338 (1983).
[8] *Id.* at 316, 458 N.E.2d at 340.
[9] *Id.* at 317, 458 N.E.2d at 340.
[10] *Id.*
[11] *Id.*
[12] *Id.*
[13] *Id.*
[14] *Id.*
[15] *Id.* at 325, 458 N.E.2d at 344.
[16] *Id.* at 317-18, 458 N.E.2d at 340.

tinue the defense, or make an appropriate demonstration that the third-party claim did not in fact include matters for which there was coverage and thus absolve itself of a defense obligation.[17]

Discussing first the standard used to determine whether an insurer has a duty to defend, the court noted with approval that it is well-established Massachusetts law that:

> the question of the initial duty of a liability insurer to defend third-party actions against the insured is decided by matching the third-party complaint with the policy provisions: if the allegations of the complaint are "reasonably susceptible" of an interpretation that they state or adumbrate a claim covered by the policy terms, the insurer must undertake the defense.[18]

This broad standard includes all foreseeable losses lying within the range of the allegations in the complaint.[19] Using this analysis, the Appeals Court agreed with the superior court's finding that Heide's complaint was sufficient to invoke the duty of the insurer to defend under the policy provisions.[20] In matching policy provisions against the plaintiff's complaint for purposes of this analysis, the court held, the complaint's allegations must be read broadly rather than literally or narrowly.[21] According to the court, "for the duty of defense to arise, the underlying complaint need only show a *possibility* that the liability claim falls within the insurance coverage."[22]

The Appeals Court, therefore, found the reference in Heide's complaint to "loss of return on investment" adequate.[23] This claim, the court stated, would constitute damages falling within the C.G.L. policy's coverage against liability for property damage, defined by the policy in part as "loss of use of tangible property which has not been physically injured or destroyed provided such loss of use is caused by an occurrence during the policy period."[24]

The court then analyzed whether exclusions in the 1973 edition of the C.G.L. policy operated to absolve Continental of its duty to defend.[25] According to the court, Exclusion (n) clearly removed the "named insured's products" from coverage, but appeared inapplicable to the damages alleged by Heide for losses other than those associated with the trays.[26] Of greater significance, in the court's view, was Exclusion (m),

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[17] *Id.*
[18] *Id.* at 318, 458 N.E.2d at 340.
[19] *Id.*
[20] *Id.* at 319, 458 N.E.2d at 341.
[21] *Id.*
[22] *Id.*
[23] *Id.* at 320, 458 N.E.2d at 340.
[24] *Id.*
[25] *Id.* at 321, 458 N.E.2d at 342.
[26] *Id.*

often called the "business risk" exclusion, by which coverage under the C.G.L. does not apply:

> to loss of use of tangible property which has not been physically injured or destroyed resulting from . . . (2) the failure of the named insured's products . . . to meet the level of performance, quality, fitness or durability warranted or represented by the named insured; but . . . does . . . apply to loss of use of other tangible property resulting from the sudden and accidental physical injury to or destruction of the named insured's products . . . after such products . . . have been put to use by any person . . . other than the insured.[27]

In analyzing Exclusion (m), the court distinguished between the physical breakdown of the insured's product and the mere failure of the product to perform as warranted after sale to and usage by another.[28] According to the court, the later "failure" is a business risk and therefore excluded from coverage.[29] A breakdown situation, however, is not so excluded.[30] The court found that the complaint sufficiently alleged a breakdown situation.[31]

Although the duty to defend may temporarily attach, the court noted, an insurer has the right to show that an exclusion does in fact apply to eliminate coverage.[32] The court held that through declaratory action, an insurer frees itself of the duty to defend by demonstrating with conclusive effect that the third party cannot establish a claim within the insurance.[33]

In sum, *Sterilite* illustrates that in Massachusetts the duty to defend rules are very broad. The losses covered by the policy need not be directly stated in the complaint. A duty to defend will attach if the loss is foreseeable within the range of allegations in the complaint. Consequently, where there is the slightest doubt, an insurer in Massachusetts would be better advised to defend its insured from the outset while commencing a declaratory action to determine the scope of its duty to defend, rather than to deny coverage and defense, forcing its insured to incur fees and expenses for private defense counsel while the insurer's obligations remain uncertain.

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[27] *Id.*
[28] *Id.*
[29] *Id.* at 322, 458 N.E.2d at 343.
[30] *Id.*
[31] *Id.* at 323, 458 N.E.2d at 343.
[32] *Id.* at 323-24, 458 N.E.2d at 344.
[33] *Id.* at 323-24, 458 N.E.2d at 343-44.