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Chapter 5: Insurance Law

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CHAPTER 5

Insurance Law

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A. Judicial Decisions

§5.1. Motor vehicle liability insurance: The effect of no-fault concepts on the rate setting process. Controversies stemming from the enactment of personal injury no-fault motor vehicle liability insurance in Massachusetts continued to confront the Supreme Judicial Court during the 1972 Survey year. *Employers' Commercial Union Ins. Co. v. Commissioner of Ins.*,[1] which involved a constitutional attack on changes in the premium rate setting process, represents a break in a long string of victories for the insurance industry in auto rate cases.

In October of 1970 the Commissioner of Insurance established compulsory automobile insurance premium rates for 1971. However, because of the anticipated but undeterminable effect which no-fault concepts[2] would have on the claim experience of insurers, and because of the possibility of successful constitutional attack on all or part of the no-fault law, it was impossible to definitively establish "adequate, just, reasonable and nondiscriminatory"[3] rates at that time. Accordingly, the Commissioner and the insurers agreed that a premium endorsement should be attached to all 1971 policies which provided, *inter alia,* that "premiums . . . shall be deemed provisional and subject to recomputation."[4]

Recognizing the need of introducing additional flexibility into the rate setting process, the 1971 legislature enacted Chapter 977 of the

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§5.1. 1 1972 Mass. Adv. Sh. 1105, 283 N.E.2d 849.

2 Introduced by Acts of 1970, c. 670, as amended by Acts of 1970, c. 744. This Act became effective on January 1, 1971. Acts of 1970, c. 670 §10.

3 G.L., c. 175, §113B.

4 The premium endorsement read as follows: "It is agreed that: In the event of any change in the . . . premiums . . . applicable to the insurance afforded, because of a ruling of the Commissioner . . . or on adverse judicial finding as to the constitutionality of any provisions of Chapter 670 of the Acts of 1970 . . . , the premium stated in the declarations . . . shall be deemed provisional and subject to recomputation. If the final premium thus recomputed exceeds the premium stated . . . the named insured shall pay the excess to the company; if less, the company shall return to the named insured the excess of such final premium." 1972 Mass. Adv. Sh. 1105, 1109-1110, 283 N.E.2d 849, 853.

Acts of 1971, which added a new paragraph to G.L., c. 1975, §113B. This paragraph requires the Commissioner, when establishing rates for any ensuing year, to first determine whether rates for the current year are "adequate, just, reasonable and nondiscriminatory." If they are not, the Commissioner is directed to take this into consideration and to set rates for the ensuing year at levels that will result in compliance with the statutory standard for the *two years taken together*.[5]

Other provisions of Chapter 977, aimed more specifically at 1971 and 1972 premiums, directed the Commissioner to hold a hearing in November of 1971 to determine whether insurers would make an "unfair profit" from compulsory insurance premiums in 1971 and, if so, to direct them to establish a special reserve from which policyholders might share in any excess profits. If the Commissioner could not determine the amount of such "unfair profit" by December 1 (as was the case), he was directed to set provisional 1972 rates. At a subsequent hearing to be held in 1972, after information relating to the 1971 profits of insurers became available, the Commissioner was then to determine whether the provisional 1972 rates met the statutory standards, using the two-year averaging concept. If those standards were not met, the Commissioner was directed either to adjust and finalize the 1972 rates so that they were, or to direct the insurers to return any unfair profits to the 1971 policy-holders.[6]

As required by Chapter 977, the Commissioner set provisional 1972 rates in December of 1971 and ordered the insurance companies to establish a special reserve of 35% of the premiums received on compulsory insurance in 1971. The plaintiffs, representing various segments of the casualty insurance industry, then filed an action to challenge the constitutionality of Chapter 977. They argued that any order to refund excessive profits would be an unconstitutional taking of property and an unconstitutional impairment of contract, since the premiums had become the property of the insurance companies. Distinguishing an earlier and somewhat analogous case,[7] the Court rejected these arguments on the basis that the premium endorsement attached to all 1971 policies clearly rendered the premiums provisional and subject to change by ruling of the Commissioner. Therefore, the 1971 premiums were not the property of the insurance companies.[8]

The plaintiffs also argued that Chapter 977 was unconstitutional in that it allowed the Commissioner to issue an order that could be inequitable and discriminatory. Specifically, the plaintiffs argued that the Commissioner was given leave simply to reduce the provisional 1972 rates without ordering a refund of the excess profits from 1971 to

5 Acts of 1971, c. 977, §1A.

6 Id., §2.

7 Opinion of the Justices, 334 Mass. 711, 134 N.E.2d 923 (1956). In that opinion, the Court held unconstitutional proposed legislation that would have required the refunding of part of the 1956 compulsory premium charges.

8 1972 Mass. Adv. Sh. 1105, 1109, 283 N.E.2d 849, 853.

1971 policyholders. A person who held a policy in 1971 but not in 1972 would then be denied a rebate of his excessive 1971 premium payments while a new 1972 policyholder would receive a windfall rebate. The Court rejected this argument:

> The adjustment of 1972 rates for excessive profits for 1971 . . . is no different from using experience of previous years to determine the rates to be set for the future. Statute 1971, c. 977, merely requires the Commissioner . . . to add to his normal use of prior experience the procedure of looking at both years together for the purpose of setting fair current rates.[9]

The Court also cited the savings in time and expense to be realized by adjusting the 1972 rates instead of making rebates to individual 1971 policyholders.

While one may disagree with the Court's statement that the reduction of present rates contemplated by Chapter 977 is "no different" from using previous years' experience in the rate setting process, the basic concept of compensating for one year's inappropriate rates in the next year's rates seems generally reasonable. However, as the discrepancy in the earlier year's rates to be made up in the ensuing year's rates becomes larger, the "unfairness" of this technique becomes more pronounced. At some point this "unfairness" might rise to a constitutional issue.

It may be noted that *Employers' Commercial Union* created a potential dilemma for the insurance companies involved. The premium endorsement attached to 1971 policies specified that "the company shall return to the named insured" any premium rebate. This would seemingly give 1971 policyholders contractual rights to demand that premium excesses be returned to them. The Commissioner's exercise of his option to reduce provisional 1972 rates in lieu of returning excesses to 1971 policyholders might impair this constitutionally protected contract right. Fortunately, this problem never materialized since the insurance companies, pursuant to the Commissioner's "Findings and Order" dated October 11, 1972, promptly made rebates to all 1971 policyholders.

§5.2. Commissioner's power to regulate casualty insurance rates. Premium rates charged by Massachusetts insurers for certain types of casualty insurance are established by reference to the provisions of Chapter 175A of the General Laws.[1] Under this statutory scheme, rates may be determined by the insurers but must be filed with the Commissioner of Insurance. Rates so filed become effective unless disapproved by the Commissioner.[2] In *Travelers Indemnity Co. v. Commissioner of*

[9] Id. at 1111-1112, 283 N.E.2d at 854.

§5.2. [1] Chapter 175A is not applicable to the rates charged for certain specified types of insurance. G.L., c. 175A, §4, as amended by Acts of 1971, c. 896, §2. For example, the rates considered in §1, *supra,* are regulated under G.L., c. 175, §113B, and not under Chapter 175A.

[2] Disapproval of filed rates is governed by G.L., c. 175A, §7(a). For an over-

Ins.,[3] Travelers made a filing on its own behalf substantially increasing its noncompulsory "Private Passenger Automobile Physical Damage Rates." A hearing was held to produce additional information which would allow the Commissioner and his chief actuary to properly analyze and evaluate the filing. Two days after the hearing, the Commissioner filed a written opinion disapproving the filing, stating simply that it "does not meet the requirements of M.G.L. c. 175." Travelers appealed this decision to the Supreme Judicial Court,[4] arguing that the proposed rates were not "excessive, inadequate or unfairly discriminatory" within the meaning of G.L., c. 175A, §5(a)(4). Travelers assumed that the only permissible basis for disapproval could be the failure to meet these criteria. However, the Court indicated that other permissible grounds for disapproval also exist. Alluding to the "fundamental requirement" that sufficient supporting information be made available to allow the Commissioner to reasonably evaluate the rate filing,[5] the Court held that the Commissioner could disapprove a rate filing if the supporting information was not sufficient to allow him to measure the filed rates against the statutory criteria.[6]

However, the Commissioner's brief opinion disapproving Traveler's rate filing failed to specify "in what respect . . . such filing fails to meet the requirements of this chapter."[7] Since the statute so requires, the case was remanded to the Commissioner with instructions to modify his earlier opinion to comply with the statutory requirements.[8]

§5.3. Judicial review of the 1972 motor vehicle, increased limits insurance rates. Insurance companies which write compulsory motor vehicle bodily injury liability insurance are required to offer to their Massachusetts policyholders certain additional personal injury and death coverages characterized as increased limits insurance.[1] The rates for such coverages are set by the Commissioner of Insurance pursuant to G.L., c. 175 §113B. In December of 1971 the Commissioner set the 1972 rates for increased limits insurance at levels that continued in effect the 15% reduction which had been required for all motor vehicle insurance coverage by the 1970 no-fault law.[2] This decision was contrary to the recommendations of both the chief actuary and the Massachusetts Automobile Rating and Accident Prevention Bureau. It also

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view of the rate-setting process under Chapter 175A, see 1971 Ann. Surv. Mass. Law §11.20.

3 1972 Mass. Adv. Sh. 1415, 285 N.E.2d 442.

4 Such appeal may be brought under G.L., c. 175A, §19(c).

5 Mass. Medical Service v. Commissioner of Ins., 346 Mass. 346, 191 N.E.2d 777 (1963).

6 1972 Mass. Adv. Sh. 1415, 1417-1418, 285 N.E.2d 442, 444-445.

7 G.L., c. 175A, §7(a).

8 1972 Mass. Adv. Sh. 1415, 1419, 285 N.E.2d 442, 445.

§5.3. 1 G.L., 175, §113C.

2 Acts of 1970, c. 670, §6.

ignored the Supreme Judicial Court's prior declaration that a similar 15 percent reduction in property damage liability rates was unconstitutional because insurers "have a right to rates which are not confiscatory."[3] The bureau, joined by 22 insurance companies, appealed the Commissioner's decision in *Mass. Auto. Rating and Accident Prevention Bureau v. Commissioner of Ins.*,[4] arguing that the rates thus set were not "adequate, just, reasonable and nondiscriminatory."[5]

Since the 1972 rates attacked in this case merely continued a rate reduction made for 1971, plaintiffs in effect were challenging that previous reduction. The insurance companies had not challenged 1971 increased limits premium rates because they were pre-occupied with more important challenges to the controversial no-fault statute. The Commissioner argued that the failure to object to the 1971 rates amounted to an "acceptance" of such rates, and that this acceptance created an inference that the rates were not confiscatory.

With virtually no discussion, the Court rejected these arguments and held that the Commissioner had erred in setting the 1972 rates.[6] The opinion indicated that premium rates stemming from an unconstitutional statutory mandate[7] could not stand. In addition, the reduction in increased limits premiums was found to be "particularly inappropriate" because the savings anticipated under the no-fault system "can be expected to have no effect upon increased limits losses which continue to be assessed under traditional tort rules."[8]

Since the 1972 rates were invalid because based on 1971 rates that reflected an inappropriate reduction, the plaintiffs requested that the Commissioner's decision simply be modified to reflect an elimination of the 1971 reduction. The Court rejected this suggestion, preferring instead to allow the Commissioner to modify his own decision. The case was remanded to the Commissioner with an instruction "to make an appropriate adjustment to offset the fifteen percent reduction mandated by St.1970, c. 670, §6."[9]

§5.4. Taxation of insurance premiums: Status of dividends. In *State Tax Commission v. John Hancock Mut. Life Ins. Co.*, [1] the Supreme Judicial Court was asked to interpret a statutory provision that imposed an excise tax on the premiums paid for life insurance policies allocable to Massachusetts.[2] The statute defines the base on which the

3 Aetna Casualty and Surety Co. v. Commissioner of Ins., 1970 Mass. Adv. Sh. 1411, 1419, 263 N.E.2d 698, 703. See 1971 Ann. Surv. Mass. Law §11.1.
4 1972 Mass. Adv. Sh. 1113, 283 N.E.2d 862.
5 G.L., c. 175, §113B.
6 Id. at 1116, 283 N.E.2d at 864.
7 See note 2, *supra.*
8 1972 Mass. Adv. Sh. 1113, 1116-1117, 283 N.E.2d 862, 864.
9 Id. at 1117, 283 N.E.2d at 864.

§5.4. 1 1972 Mass. Adv. Sh. 255, 279 N.E.2d 656.
2 G.L., c. 63, §20 provides that a policy of a foreign insurer is allocable to Massachusetts if the insured is a Massachusetts resident. A policy of a domestic

excise tax is to be levied as "all amounts received as consideration for life insurance policies . . . [including] dividends applied to purchase additional insurance or to shorten the premium paying period. . . ."[3] However, confusion is introduced by subsequent language providing deductions for "dividends which . . . have been paid or credited to policyholders or applied to purchase additional insurance or to shorten the premium paying period."[4]

Dividends of mutual insurance companies, such as the taxpayer in this case, are essentially returns to policyholders of overpayments of premiums. The amount of such dividends is determined only after the cost of providing the particular insurance coverage involved has been precisely established. These dividends may be withdrawn by the policyholder in cash or left with the insurer. If left with the insurer, the dividends may be withdrawn in cash with interest at some later date or they may be used to purchase additional insurance or annuity contracts either when the dividend is declared or in later years. In the present case, a single issue was involved. In determining its tax liability for 1963, the taxpayer first deducted the full amount of all dividends paid in that year. In addition, it claimed a deduction for dividends declared in earlier years that had been left with the taxpayer and applied by policyholders to purchase paid-up insurance and annuity contracts during 1963. This, of course, represented the second time such amounts had been deducted. The State Tax Commission appealed a decision by the Appellate Tax Board upholding the taxpayer's second deduction.

A literal reading of the less than artfully drafted statute gives some support to the taxpayer's contention that deductions for a single dividend in more than one year are not precluded.[5] However, the Court, considered the provision as a whole, and reached an eminently reasonable conclusion. Focusing on the dynamics involved, the Court interpreted the language as merely permitting a deduction for the entire amount of dividends paid in the particular tax year, *regardless* of the disposition of such dividends by the policyholders involved. Further, it construed this blanket deduction as totally exhausting the taxpayer's deductions in respect to such dividends.[6] As a result, if dividends left with the taxpayer

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insurer is allocable to Massachusetts unless the insured is a resident of another state or country to which the insurer actually pays an excise tax.

[3] Id.

[4] Id.

[5] "The word 'premiums' as used in this section shall include all amounts received as consideration for life insurance policies . . . and shall include dividends applied to purchase additional insurance or to shorten the premium paying period . . . . In determining the amount of excise tax payable hereunder there shall be deducted, to the extent that they are properly allocable to premiums taxable hereunder, . . . (b) dividends which during said [preceding calendar] year have been paid or credited to policy holders or applied to purchase additional insurance or to shorten the premium paying period." Id.

[6] 1972 Mass. Adv. Sh. 255, 259, 279 N.E.2d 656, 659.

during any year for which a deduction has already been taken are applied by the policyholder to purchase paid-up insurance or annuities, the amount so applied is re-characterized as new premium income subject to tax.

The taxpayer also contended, unsuccessfully, that the statute was ambiguous and should therefore be construed in favor of the taxpayer.[7] While one may question the Court's conclusion that the statute was not ambiguous, it is more difficult to contest its further statement that, "[i]n any event, the rule cited by the taxpayer does not require or permit us to abandon the equally salutary basic rule of following a common sense approach in the interpretation and application of all statutes."[8]

§5.5. Unfair or deceptive act or practice: Exhaustion of administrative remedies. The defendant insurer in *Gordon v. Hardware Mutual Casualty Co.*[1] had in the late 1960's annually obtained permission from the Commissioner of Insurance to deviate from rates established by the appropriate rating organization for certain types of noncompulsory motor vehicle liability insurance.[2] The plaintiff had purchased such insurance from the defendant during these years, and had come to expect the approximately 15% reduction in premiums that had resulted from the rate deviations. However, the insurer sought no such reduction for 1970. The plaintiff became aware of this only when he received his 1970 policy, which included a notice of a premium that was higher than the previous year's. By the time he received the policy early in 1970, it was too late to seek other insurance from an insurer which had sought a rate reduction. Alleging that the failure to inform him that no reduction would be sought for 1970 was an "unfair or deceptive act or practice," the plaintiff brought a bill in equity in superior court under the Massachusetts Consumer Protection Act.[3] The plaintiff claimed as damages the difference between his 1970 premium and his 1969 premium. Upon the court's dismissal of the bill, the plaintiff appealed.

The Supreme Judicial Court affirmed the lower court's dismissal on the ground that the plaintiff had failed to exhaust his administrative remedies.[4] Noting the "comprehensive statutory scheme" for the regulation of insurance, and the broad supervisory powers given the Commissioner of Insurance,[5] the Court enumerated several specific statutory provisions which vested the Commissioner with authority to correct the alleged abuse including: (1) G.L., c. 175; §5 providing the Commissioner with power to revoke the license of a foreign insurance company such as the defendant; (2) G.L., c. 175 §§113B, and 113C, providing for

7 Id. at 260, 279 N.E.2d at 659, and cases cited therein.
8 Id. at 260, 279 N.E.2d at 659.

§5.5. 1 1972 Mass. Adv. Sh. 757, 281 N.E.2d 573. For another discussion of this case, see §10.6 infra.
2 Deviations from established rates are obtained under G.L., c. 175A. §9.
3 G.L., c. 93A, §9.
4 1972 Mass. Adv. Sh. 757, 762, 281 N.E.2d 573, 577.
5 The insurance industry is regulated under G.L., cc. 174A-178.

rate regulation with respect to certain coverages and for judicial review; (3) G.L., c. 175A, §11 providing policyholders "aggrieved" by application of the rate system with the right to compel a hearing with the insurer and, if no satisfaction is obtained from the insurer, to compel a hearing before the Commissioner; and, (4) G.L., c. 176D, §9 providing the Commissioner with authority to hold hearings and to request the Attorney General to seek an injunction against any "unfair or deceptive act or practice."[6] In light of this statutory framework, the Court felt that judicial recognition of the cause of action would invade the province especially assigned to the Commissioner by the legislature. It was therefore reluctant to circumvent this expression of legislative will.

The plaintiff argued that he should not be relegated to the administrative remedies cited by the Court, presumably since none of them allowed him to sue in his own right for the damage recovery which he sought under Chapter 93A. However, the test of administrative remedies in Massachusetts is not whether they are "in all respects as prompt and as broad" as the judicial alternatives, but whether they are *adequate*.[7] The Court did not find that " 'futility apparent in the application of the statute' which 'makes such resort to the administrative agency unnecessary.' "[8] While one may question whether administrative relief would ultimately prove adequate in the present case, it is difficult to challenge the proposition that administrative remedies should first be exhausted. As stated by the Court,

> Exercise of . . . [the Commissioner's] regulatory power may afford the plaintiff some measure of relief (if he is entitled to any relief) and, in any event, may affect the scope and character of any judicial relief which may be given.[9]

§5.6. Authority to write additional line of business: Administrative discretion. In *Rockland Mutual Insurance Co. v. Commissioner of Ins.*,[1] the plaintiff's business, which consisted principally of writing automobile property damage insurance, was seriously jeopardized by the enactment of the "no-fault property damage law."[2] Rockland's certificate of author-

[6] Chapter 176D, enacted by Acts of 1947, c. 659, has essentially been reenacted in an expanded form by Acts of 1972, c. 543. See §5.12, infra.

[7] Jordan Marsh Co. v. Labor Relations Comm., 312 Mass. 597, 601-602, 45 N.E.2d 925, 926 (1942).

[8] 1972 Mass. Adv. Sh. 757, 761, 281 N.E.2d 573, 576, citing Boston Edison Co. v. Selectmen of Concord, 355 Mass. 79, 84, 242 N.E.2d 868, 872 (1968). The Court was careful to note that it did not accept plaintiff's assumption that the Commissioner had no power to order the rebate: "Nor need we consider whether the commissioner could, under G.L., c. 175A, §11, require the defendant to make a rebate equivalent to the plaintiff's previous discount. We should not pass upon such questions without having the benefit of a prior determination by the commissioner." Id.

[9] Id. at 763, 281 N.E.2d at 577.

§5.6. [1] 1971 Mass. Adv. Sh. 1883, 277 N.E.2d 493.

[2] Acts of 1971, c. 978.

ity to write insurance did not expressly include the authority to write compulsory bodily injury motor vehicle liability insurance,[3] which Rockland felt was necessary in order to remain a viable insurance carrier.[4] The Commissioner of Insurance denied Rockland's formal application to amend its certificate to include such coverage. Rockland then sought a writ of mandamus to compel the Commissioner either to amend its certificate, or to issue a ruling that such amendment is not necessary. The plaintiff appealed the superior court's dismissal of the writ.

The principal controversy in the case was the meaning and interrelationship of two sections of Chapter 175 of the General Laws. Section 54C indicates that any insurer that meets certain financial and other requirements[5] "may insure" in respect to compulsory bodily injury motor vehicle liability insurance policies. On the other hand, Section 32 indicates that no domestic company "shall make or issue any contracts or policies of insurance . . . until it has obtained from the Commissioner a certificate . . . authorizing it to make or issue such policies or contracts." This latter section also authorizes the Commissioner to refuse to issue such certificate if such issuance would be "prejudicial to the public interest."[6]

The Commissioner refused Rockland's application under the "public interest" provision of Section 32. Rockland contended that Section 32 applied only to the *formation* of insurers and, consequently, that the Commissioner may not require an application to *amend* its certificate under this section.

Section 54C was initially adopted in 1945 as part of a program to allow multiple line underwriting by domestic companies already empowered to write certain lines. This section was interpreted by the Court as authorizing such companies to write the additional lines without formal amendment to the purposes and powers provisions of their charter documents.[7] In addition the Court found support for the proposition that Section 32 may have been intended to apply only at the time of in-

3 Rockland's certificate included authority to write insurance under G.L., c. 175, §§47 (First, Second (b) and Eighth clauses), 54E and 54F. Compulsory bodily injury motor vehicle liability insurance of the type here involved is written under G.L., c. 175, §54C.

4 Rockland apparently felt that its property damage coverage customers would switch to insurers that could also offer compulsory bodily injury coverage.

5 The Court assumed that Rockland met these requirements. Id. at 1885, 277 N.E.2d at 495.

6 G.L., c. 175, §32.

7 1971 Mass. Adv. Sh. 1883, 1885-1886, 277 N.E.2d 493, 495-496. It should be noted that these charter documents are not the same as the certificate of authority to write insurance required by Section 32.

The Court also cited the Commissioner's report recommending the 1947 multiple-line legislations, which stated, " 'We believe that the privilege of multiple line underwriting, so called, should be afforded companies now in existence *as they may see fit* to take advantage of the privilege.' " (Emphasis added by the Court). Id. at 1887, 277 N.E.2d at 496. The Court found no indication in these words, or in the report generally, that any amendment of the Section 32 certificate was to be required as a "prerequisite of taking advantage of §54C."

corporation and not in respect to subsequent changes in the type of insurance written, whether or not any such change involved Section 54C.[8] Despite these ambiguities which favored Rockland, the Court declined to grant the immediate relief requested. For years the Commissioner had in fact required amendments to a company's certificate whenever it desired to write a line of insurance not covered by the certificate, and the Court deferred to that established practice:

> [I]n a confused statutory situation, a consistent, long continued, administrative practice of the public officer charged with regulating a large industry is not lightly to be disregarded and is entitled to weight in statutory interpretation.[9]

The opinion also indicates a considerable reluctance to interpret the Commissioner's authority more narrowly than he contended was necessary to protect the public interest. Therefore the Court indicated that Rockland's proper course was to renew its application for amendment and to request a hearing before the Commissioner on its fitness to issue personal injury liability policies under Section 54C.[10]

A distinction should be kept in mind between the purposes and powers which may be included in an insurance company's charter and the particular lines of business which the Commissioner, by controlling the terms of an insurer's certificate of authority, may authorize a company to write. This distinction is inherent to the Massachusetts regulatory scheme, and control of that industry through the Section 32 certificate is an altogether reasonable regulatory technique.

§5.7. Insurer's duty to defend and indemnify. Three cases decided by the Supreme Judicial Court during the 1973 SURVEY year concerned the duty of insurers to defend legal actions brought against their policyholders. In each case, the insurer had refused to defend and judgment had been entered against the insured for damages covered by the policy. In subsequent actions to recover on the policies, each insurer disclaimed liability alleging behavior on the part of the insured that had tended to materially prejudice the defense effort.

In *Lombardi v. Lumbermens Mut. Cas. Co.*[1] the sole issue for the Court was an alleged breach by the insured of the cooperation clause

8 "For example, there is little or no basis for applying to a company already in operation (when it seeks an amendment of its certificate) the provision calling for the commissioner to determine 'that the company is without liabilities except' for organization expenses and (for some companies) its liabilities to stockholders for amounts paid in for shares." Id. at 1886, 277 N.E.2d at 496.

9 Id. at 1890, 277 N.E.2d at 498.

10 Id. at 1890-1891, 277 N.E.2d at 498-499. The Court also noted in passing that "[i]f the commissioner is to continue to assert power to require amendments of certificates issued under §32, there is obvious need for substantial legislative clarification of that section." Id. at 1888, 277 N.E.2d at 497.

§5.7. 1 1972 Mass. Adv. Sh. 461, 280 N.E.2d 149.

contained in a motor vehicle liability policy issued by Lumbermens.[2] In an action by Lombardi against the insured, counsel for Lumbermens had withdrawn, disclaiming liability on the ground that its insured had changed his story regarding an automobile accident. Following judgment against the insured in the earlier case, bills to reach and apply Lumbermens' "obligation" to its insured were commenced by Lombardi. The Superior court's decision in favor of Lombardi was appealed by Lumbermens. The alleged breach of the cooperation clause was based upon discrepancies between the insured's statements contained in the accident report and his testimony at trial more than three years later. The insured testified at trial that he had had four bottles of beer on the night of the accident, whereas he had stated in the accident report that he had had only one.[3] Although the " 'intentional furnishing of false information of a material nature either before or at trial is a breach of the cooperation clause,' "[4] the court held that this discrepancy was not *material* in that there was no showing at trial that the insured's driving ability had been affected by the amount of beer consumed. One can only speculate whether the materiality of such discrepancy would have been established at trial had counsel for Lumbermens not withdrawn.[5]

Airway Underwriters v. Perry[6] appears to be a straight forward case hardly worthy of appeal to the Supreme Judicial Court. Perry at one time owned an airplane that he insured with Airway Underwriters. He then sold the airplane to friends, who shortly thereafter were injured when the plane crashed. The injured parties sued Perry and received substantial judgments. After some initial involvement, counsel for Airway had withdrawn from the case prior to trial. Airways then brought a bill for a declaration that it had no obligation to satisfy the judgments obtained against its former insured in the earlier action. From a decision for Airways, Perry appealed.

The Court found multiple reasons to relieve Airway of liability. Perry had actively assisted the injured parties in their suit against him. This

[2] The opinion does not quote the wording of the particular cooperation clause. In Couch on Insurance 2d, §51:100 (1959) [hereinafter cited as Couch], it is said that "[l]iability insurance policies usually contain clauses which provide in substance, with some variations in language in the different policies, that the insured shall co-operate with the insurer and that, upon the insurer's request, the insured shall attend hearings and trials and shall assist in effecting settlements, securing and giving evidence, obtaining the attendance of witnesses, and in the conduct of suits."

[3] 1972 Mass. Adv. Sh. 461, 463, 280 N.E.2d 149, 151.

[4] Id. at 462, 280 N.E.2d at 151, citing Cassidy v. Liberty Mut. Ins. Co., 338 Mass. 139, 142, 154 N.E.2d 353, 355 (1958).

[5] Any attempt by counsel for Lumbermens to establish that the insured's driving ability had been affected by the beer would tend to prejudice the insured's case. A conflict of interest certainly would exist, and such an effort by counsel for Lumbermens might well amount to a breach of Lumbermens' duty to defend in good faith.

[6] 1972 Mass. Adv. Sh. 1239, 284 N.E.2d 604.

assistance was found to constitute fraud and collusion, and the Court indicated that " '[i]t has always been the law of this Commonwealth that a surety or indemnitor could avoid a judgment rendered against the principal or indemnitee, by showing it was procured by collusion or fraud.' "[7] Also, Perry was held to have violated the cooperation clause contained in the policy.[8] Perry had moved from Massachusetts before the earlier action had been commenced, leaving no forwarding address. Airway's investigator located him some months later in Texas, and located him once more after he had again moved without leaving an address; Airway withdrew from the earlier case upon Perry's third such disappearance.[9]

Finally, the policy which had been issued shortly before the sale, contained a recital that Perry was the sole owner of the aircraft. Airways did not learn of the transfer of title until after the accident. The Court considered these facts sufficient to relieve Airways of any obligation to defend Perry.[10] Curiously, however, the Court cited *Faris v. Travelers Indem. Co.*[11] in support of this proposition. *Faris* appears to be inapposite, since it dealt with *misrepresentation* of ownership at the time the policy issued, and not a *transfer* after the policy had been issued. *Faris* held that such misrepresentation completely voided the policy, since it constituted the failure of a condition precedent to the policy ever being effective.[12] In *Airways,* however, there was no dispute that Perry was in fact the sole owner on the date the policy issued. It is well established that "A prohibition against alienation is distinct from a representation or warranty by the insured as to the nature or extent of his title or interest at the time of his applying for insurance."[13] It may be that Perry's policy contained an alienation clause that precluded recovery upon transfer without due notice to Airways, or that Perry retained no "insurable interest" after the transfer, but the Court failed to mention either of these possibilities.

In the case of *Blais v. Quincy Mut. Fire Ins. Co.,*[14] the plaintiff sued one Hamilton for damages arising from a fire. Quincy had been invited to defend that action on the ground that any liability of Hamilton would be covered by a fire insurance policy issued by Quincy to Hamilton's father. However, Quincy declined to defend, on the ground that Hamilton was not an insured under its policy. The parties agreed that, although there would be a judgment against Hamilton, the plaintiff would

7 Id. at 1243, 284 N.E.2d at 607, citing Fistel v. Car and Gen. Ins. Corp., 304 Mass. 458, 460, 23 N.E.2d 895, 896 (1939).

8 Id. at 1243, 284 N.E. at 607.

9 For another recent discussion of a breach of the cooperation clause in a motor vehicle liability insurance policy, see 1971 Ann. Surv. Mass. Law §11.3.

10 1972 Mass. Adv. Sh. at 1242, N.E.2d at 606-607.

11 278 Mass. 204, 179 N.E.2d 605 (1932).

12 Id. at 209, 179 N.E.2d at 607.

13 Couch §37:1046.

14 1972 Mass. Adv. Sh. 195, 278 N.E.2d 746.

only attempt to recover on that judgment to the extent that Hamilton was covered under Quincy's policy. The plaintiff then brought a bill in equity to reach and apply Quincy's obligation to Hamilton. The trial court found that Hamilton was in fact covered by Quincy's policy, and Quincy did not perfect its appeal on this point. Quincy also argued that the judgment against the insured had been procured through bad faith and collusion.[15] The trial judge found otherwise and the Supreme Judicial Court declined to hold that he was plainly wrong: "In the absence of fraud or collusion the insurer would be bound by a judgment entered by default . . . . A judgment by consent stands no worse."[16]

§5.8. Fire insurance policy: Increase of hazard. In *Gorton v. Phoenix Ins. Co.*,[1] the plaintiff, a fish wholesaler, attempted to remodel a recently purchased building to accommodate fish freezers. To this end, a massive concrete block, used as a hydraulic counterweight by the former owner, had to be removed. Unfortunately, the single dynamite blast calculated to break up the block also totally demolished the building. The plaintiff brought suit in the United States District Court for the District of Massachusetts on a fire insurance policy issued by the defendant for so much of the loss as exceeded the minor damage which had been anticipated. Liability was disclaimed under a clause in the policy that provided that Phoenix " 'shall not be liable for loss occurring (a) while the hazard is increased by any means within the control or knowledge of the insured . . .' "[2]

Although the plaintiff had been told by the blaster, who was a licensed professional, that only minor damage would occur, the federal district court found that a reasonable man should have been apprehensive and expected more than minor damage.[3] Indeed, there was evidence that the plaintiff was in fact apprehensive. On two occasions he talked to his insurance advisor (who was not a Phoenix agent), seeking assurance that the fire insurance policy in question would cover any damage caused by the blast. Furthermore, the blaster required the plaintiff to execute a release as to any property damage which might result from the explosion. The court concluded that this amounted to an increase in hazard within the policy terms.[4] In response, the plaintiff argued that, despite the "in-

15 It is interesting to note that some courts would not even have allowed the defense of collusion to be raised in the present case. For example, in Ocean Acci. and G. Corp. v. Torres, 91 F.2d 464 (9th Cir.), cert. denied 302 U.S. 741 (1937), the insurer, invited to defend an action against the insured, declined on the basis that the policy did not cover the particular loss involved. In a subsequent suit against the insurer on the policy, the circuit court dismissed the defense of collusion summarily: "The . . . [insurer] cannot be heard to complain that the suit which it was invited to defend was collusive." Id. at 471.

16 1972 Mass. Adv. Sh. 195, 197, 278 N.E.2d 746, 747. (Citations omitted).

§5.8. 1 339 F. Supp. 241 (D. Mass. 1972).

2 Id. at 244.

3 Id.

4 The question of whether a hazard is increased is to be determined by the standard of the reasonable man. "A provision avoiding insurance because of an

crease in hazard" clause in the policy, the defendant was liable under a "repairs" clause. The Supreme Judicial Court had previously interpreted a similar "repairs" clause to permit "construction in a reasonable, proper and usual way even though such construction may increase the hazard."[5] Thus the issue for the Court was whether the blasting was a "usual, reasonable and proper" method of achieving the desired alteration. The plaintiff contended that it was, at least when conducted by a licensed blaster, as in the present case. The court rejected this argument, referring to considerable authority that characterized blasting as an ultra-hazardous activity and not a part of the ordinary building process.[6]

The Court did not foreclose the possibility that blasting, or even that the method of blasting employed in the present case, could ever be "reasonable, proper or usual" within the scope of a "repairs" clause. Nevertheless, it did apply the authorities cited, since the plaintiff offered no evidence to the contrary. Since the blasting was an increase in hazard, and since it was not covered by the "repairs" clause in the policy, the court held the defendant not liable for the loss.[7]

§5.9. Motor vehicle liability insurance: Scope of "loading and unloading" clause. In *LaPointe v. Shelby Mut. Ins. Co.*,[1] a motor vehicle owned by the plaintiff was insured by the defendant under a policy that covered liability arising out of the use of the motor vehicle, which expressly included "the loading and unloading thereof."[2] The insured vehicle, a truck, was used by an employee of the plaintiff to deliver a tank of propane gas to a dwelling. Unfortunately, the employee mistakenly installed the replacement tank at the wrong location. This mistake resulted in an explosion four hours later that caused both property damage and personal injuries. LaPointe, the employer, paid for the damage in settlement of a suit brought against him by the injured parties. He then sought a declaration that the defendant was liable under the insurance policy. From a decree granting such declaration, the defendant appealed.

The major issue on appeal was the scope of the "loading and un-

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alteration in the situation or circumstances which would increase the risk contemplates such alteration as would materially and substantially enhance the hazard, as viewed by a person of ordinary intelligence, care, and diligence." Couch §37:695. It should be noted that the policy language in the present case voided coverage, whether or not the insured had knowledge of the increase of hazard, so long as he had "control." Since Gorton had control over the blasting operation, it would appear that the court's reference to the defendant's knowledge of the risk, 339 F. Supp. at 244, was unnecessary to the decision.

5 Charles Dowd Box Co., Inc. v. Fireman's Fund Ins. Co., 351 Mass. 113, 119, 218 N.E.2d 64, 67 (1966).

6 339 F. Supp. 241, 245 (D. Mass. 1972), citing Restatement of Torts, §§519, 520 (1938), and Restatement of Torts 2d, §§427, 427A (1966).

7 Id. at 246.

§5.9. 1 1972 Mass. Adv. Sh. 731, 281 N.E.2d 253.

2 Id. at 734, 281 N.E.2d at 256.

loading" provision in the insurance policy. In an earlier case dealing with the interpretation of a similar provision, the Court had adopted the *complete operation rule*,[3] as opposed to the *coming to rest rule*.[4] The complete operation rule defines the operation of unloading as a "continuous transaction ending with the deposit of the goods in the hands of the purchaser."[5] In the present case, application of this test resulted virtually automatically in a holding that the loss was covered, since the tank of gas had never been delivered to the actual purchaser.[6]

Thus under the complete operation rule, the scope of the "loading and unloading" clause must be considered to be very broad, and to extend coverage substantially beyond the coverage afforded in the absence of the clause. One limitation, however, does exist: "There must be a causal connection between the use of the automobile, which includes loading and unloading, and the accident."[7] In the present case, the defendant argued that no such causal connection existed, since the loss arose, not from the unloading of the truck, but from the failure of the plaintiff to give his employee more explicit directions. The Court first noted that the question was not that of "proximate cause" in the usual tort sense. Then, drawing from two earlier federal cases[8] that purported to apply Massachusetts law, the Court held that it was sufficient that "installation of the tanks was 'necessary in order to carry out the delivery' and was 'an integral part of the unloading process.' "[9]

Finally, the defendant argued that it had not received timely notice of the accident, and was therefore excused from liability. The relevant policy clause required that notice be given "as soon as practical;" in Massachusetts, this has been interpreted to mean within a reasonable time.[10] Although the plaintiff had delayed approximately one month before sending written notice of the accident to the defendant, he had discussed the accident with one of defendant's agents a day or two after the accident. The Court experienced no difficulty in holding that notice

3 August A. Busch and Co. of Mass., Inc. v. Liberty Mut. Ins. Co., 339 Mass. 239, 158 N.E.2d 351 (1959). The "complete operation" rule is often viewed as the modern, or the majority, rule.

4 "Under the coming to rest doctrine, the term 'unloading' within the meaning of a motor vehicle liability policy comprises only the actual removing or lifting of the article from the motor vehicle up to the moment when the goods which were taken off the vehicle have actually come to rest and every connection of the motor vehicle with the process of unloading has ceased, and does not include any further handling of the goods incidental to their delivery to their destination." Couch §45:127.

5 August A. Busch and Co. of Mass., Inc. v. Liberty Mut. Ins. Co., 339 Mass 239, 243, 158 N.E.2d 351, 354 (1959).

6 1972 Mass. Adv. Sh. 731, 735, 281 N.E.2d 253, 256.

7 Id. at 736, 281 N.E.2d at 257.

8 Connecticut Indem. Co. v. Lee, 168 F.2d 420 (1st Cir. 1948); Lumbermens Mut. Cas. Co. v. Employer's Liab. Assur. Corp. Ltd., 252F.2d463(1stCir. 1958).

9 1972 Mass. Adv. Sh. 731, 736, 281 N.E.2d 253, 257.

10 Segal v. Aetna Cas. and Sur. Co., 337 Mass. 185, 148 N.E.2d 659 (1958).

had been timely, referring not only to the vagueness of the "loading and unloading" clause, which might easily confuse a layman, but also to the fact that the defendant's agent had not informed the plaintiff of possible insurance coverage.

§5.10. Motor vehicle liability insurance: Policy interpretation: Scope of coverage and the effect of an "excess insurance" clause. By definition, "liability" insurance involves the indemnification of the insured for liability to *others,* rather than the payment of losses for the insured's own physical injury or property damage. However, many automobile liability insurance policies contain an omnibus clause providing that the term "insured" includes any other person who uses the automobile with the named insured's consent. The question then arises whether the named insured may recover for his personal losses when he is injured while he is a passenger in his own car if the injury was caused by the negligence of an omnibus insured. In 1935, the Supreme Judicial Court held that an owner who had obtained a judgment against the driver of his automobile could not prevail in a subsequent action based on this judgment against his own insurer.[1] That policy was a compulsory liability insurance policy whose terms were prescribed by statute,[2] and the decision was therefore an interpretation of the *statute* on which the policy was based. Referring to the legislative intent "to provide a degree of certainty of compensation to those who, rightfully and carefully using the ways, are injured by the carelessness of operators of motor vehicles,"[3] the Court held that, even when riding as a passenger in his own car, the named insured could not recover under a policy that provided protection to "others."[4]

Transamerica Ins. Co. v. Norfolk & Dedham Mut. Fire Ins. Co., [5] decided this year, arose on similar facts. The owner-passenger obtained a judgment against the driver for personal injuries. The judgment was satisfied by the driver's automobile insurer, which, as a subrogee, brought the present action to establish the liability of the owner's insurer. However, this action was based upon noncompulsory liability insurance coverage whose terms were not prescribed by statute. For that reason, the issue of liability was *solely a matter of policy construction.* The policy provided coverage for the insured's liability for " 'damages because of bodily injury . . . *sustained by any person'.*"[6] The words "any person" were held to indicate the insurer's intention to provide broader coverage

§5.10. [1] MacBey v. Hartford Acci. and Indem. Co., 292 Mass. 105, 197 N.E. 516 (1935).

[2] G.L., c. 90, §34A. Under this section, insurance is provided to ". . . the insured and any person responsible for the operation of the insured's motor vehicle with his express or implied consent against loss by reason of the liability to pay damages *to others* for bodily injuries." (Emphasis added).

[3] 292 Mass. 105, 107, 197 N.E. 516, 517 (1935).

[4] Id. at 108, 197 N.E.2d at 518.

[5] 1972 Mass. Adv. Sh. 273, 279 N.E.2d 686.

[6] Id. at 274, fn. 4, 279 N.E.2d at 688, fn. 4. (Emphasis added by the Court).

than that afforded by the term "others" which is used in compulsory coverage. Referring to the established principle that language drafted by the insurer "is strictly construed and all ambiguities are resolved against the insurer,"[7] the Court held that "any person" included the owner in the coverage of the policy.[8]

In holding that the owner's policy covered his losses the Court created a further issue: how to distribute the losses between the two insurers involved. The driver's insurer had already paid for the owner's losses because the driver's policy on his own car covered this risk,[9] and, as indicated, the owner's losses were also covered by his own policy. The policies of both insurers contained identical "other insurance" clauses,[10] the effect of which, by themselves, would be to pro-rate the amount of the loss by comparing the maximum liability provisions of each policy to the total of the maximum liabilities of each policy.[11] However, the driver's policy also contained an "excess insurance" clause, which provided that " 'the insurance with respect to . . . other motor vehicles under Insuring Agreement IV shall be excess insurance over any other valid and collectible insurance.' "[12] Insuring Agreement IV was the provision in the driver's policy that covered the loss sustained by the owner. Accordingly, the driver's insurance coverage with his own insurance company was held to be "excess insurance"[13] and the coverage provided by the owner's insurance was the primary source of recovery.[14]

§5.11. Miscellaneous Cases. In *McDonough v. Hardware Dealers Mutual Fire Ins. Co.*,[1] at issue was recovery under a standard Massa-

7 Id. at 275, 279 N.E.2d at 688.

8 Id. at 276, 279 N.E.2d at 688.

9 ". . . 'such insurance as is afforded by this policy . . . applies with respect to any other motor vehicle . . . provided . . . [the insured's] actual operation . . . is with the permission, or reasonably believed to be with the permission, of the owner and is within the scope of such permission.' " Id. at 277, fn. 7, 279 N.E.2d at 689, fn. 7.

10 ". . . 'If the insured has other insurance against a loss covered by this policy the company shall not be liable under this policy for a greater proportion of such loss than the applicable limit of liability stated in the declarations bears to the total applicable limit of liability of all valid and collectible insurance against such loss.' " Id. at 276, fn. 5, 279 N.E.2d at 689, fn. 5.

11 For a general discussion of apportionment, see Couch §62:1 *et seq.*

12 1972 Mass. Adv. Sh. 273, 276, 279 N.E.2d 686, 689.

13 "Where, as in the instant case, the driver does not own the vehicle he was driving in the accident, the coverage on the car is primary while the coverage of the driver is excess as between two automobile insurers whose policies contain identical 'other insurance' clauses." 1972 Mass. Adv. Sh. 273, 276, 279 N.E.2d 686, 688-689. For a case involving apportionment between insurers when there are "other insurance" provisions but no applicable "excess insurance" provisions, see Kenner v. Century Indem. Co., 320 Mass. 6, 67 N.E.2d 769 (1946).

14 1972 Mass. Adv. Sh. 273, 276, 279 N.E.2d 686, 689. The actual amount of damages was well below the maximum liability under the owner's policy. Id. at 274, fn. 3, 279 N.E.2d at 687, fn. 3. Therefore, the owner's insurer was also the early source of recovery.

§5.11. 1 448 F.2d 870 (1st Cir. 1971).

chusetts fire insurance policy[2] for damages to the insured plaintiff's premises caused by water used in extinguishing a fire in a nearby building. The defendant insurer admitted liability for the immediate water damage to the plaintiff's building but contested liability for damages to the building's foundation occurring several months after the fire. The insurer argued that liability for this subsequent water damage was excluded by the policy.[3]

The trial court first suggested that the policy exclusion was "unambiguous in the company's favor,"[4] but then derogated from its unequivocal statement to characterize this construction as "quite as reasonable as the restricted construction urged by plaintiff."[5] On appeal, the Court of Appeals for the First Circuit reversed, indicating that the wrong approach had been used. The test approved by this court was: "[i]f there is a reasonable construction of the policy other than the literal one which is more favorable to the insured, under familiar principles he is entitled to it."[6] Considering the fact that water damage incidental to fire is normally within such policies and reading the particular exclusion in the light of other exclusions relating to water,[7] the court determined that the exclusion was ambiguous and that plaintiff was therefore entitled to recover. The insurer, when drafting the policy, could easily have avoided the ambiguity by the use of a few simple words.

In *Howard v. Equitable Life Ass. Soc.*,[8] the insured, a member of the United States Air Force, had been a crew member of a patrol aircraft that was forced to ditch in the ocean because of mechanical failure. Although the insured survived the crash uninjured, some eight to ten hours later he drowned. At issue was recovery by the beneficiary under an accidental death benefit clause that excluded recovery when death " 'resulted from . . . travel or flight in, or descent from, any aircraft of which the Insured was a . . . member of the crew . . . .' "[9] The scope of the "aviation clause" was a novel question in Massachusetts, and the decisions in other jurisdictions were not uniform.[10]

The plaintiff argued that, since the insured survived the crash and died from drowning, the causal chain between the insured's serving as a

2 The statutory requirements for such a policy are set forth in G.L., c. 175, §99.

3 The policy excluded recovery for " '[l]oss caused by, resulting from, contributed to or aggravated by . . . water below the surface of the ground. . . .' " 448 F.2d 870, 871.

4 Id.

5 Id.

6 Id.

7 Other exclusions of losses resulting from water damage which were found in the same section of the policy that included the present exclusion, related only to damage from water that was not related to a fire, such as floods and sewer backups. Id.

8 1971 Mass. Adv. Sh. 1589, 274 N.E.2d 819.

9 Id. at 1590, 274 N.E.2d at 820.

10 For a general discussion of policy exclusions relating to aircraft and aviation, see Couch §41:541 *et seq.*

crew member on an aircraft and his death had been broken. Specifically, the plaintiff raised the malfunction of the insured's exposure suit as an independent, and hence intervening, cause of death. The Court first noted that such malfunction had not been factually established. More importantly, the Court intimated that even if the malfunctioning exposure suit had intervened, such intervention would not change the Court's determination that the crash was the "legal cause" of death.[11] While perhaps not going so far as to approve a "but for" test, the Court did indicate a willingness to interpret the exclusion in a way highly favorable to the insurer. This willingness is best illustrated by the following quotation, cited with approval and taken from an opinion of the Court of Appeals for the Fourth Circuit in an analogous case:

> "In undertaking an aerial flight over the ocean in a land-based plane, man must reckon with the perils of the sea . . . . That men may remain alive for varying periods of time before succumbing does not change the picture. We think it a rather violent fiction to say that death, under such circumstances, comes from accidental drowning."[12]

Whitehall Co., Ltd. v. New Hampshire Ins. Co.[13] involved the interpretation of an insurance policy that covered goods "in transit" and "during transportation." A sealed trailer rented by the plaintiff insured, containing cases of whiskey, was stolen from a railroad yard two weeks after it had arrived at Boston by flat-car. The Court held that there was no liability on the part of the insurer, since, when stolen, the trailer was no longer in transit: " 'The natural meaning of the words "transit" and "transportation" . . . is that it shall be in the course of movement by some kind of carriage from one place to another.' "[14]

Boston Camping Distributor Co. v. Lumbermens Mut. Cas. Co.[15] involved a rather obvious interpretation of a clause in a general liability policy excluding liability for loss caused by " 'the discharge . . . of water . . . from automatic sprinkler systems.' "[16] The Court held for the insurer, rejecting the plaintiff's argument that a negligent act of one of its employees in actuating the sprinkler, rather than the sprinkler system discharge, was the direct cause of the loss.[17]

Colsch v. Travelers Ins.[18] involved a suit by Colsch against the defendant insurer alleging that in several respects the insurer's conduct of the defense in an earlier action against Colsch had been bungled. The

11 1971 Mass. Adv. Sh. 1589, 1591, 274 N.E.2d 819, 820.

12 Id. at 1592, 274 N.E.2d at 821, citing Order of United Commercial Travelers v. King, 161 F.2d 108, 109 (4th Cir. 1947), affirmed 333 U.S. 153 (1948).

13 1972 Mass. Adv. Sh. 647, 281 N.E.2d 234.

14 Id. at 647, 281 N.E.2d at 235, citing Koshland v. Columbia Ins. Co., 237 Mass. 467, 472, 130 N.E. 41, 43 (1921).

15 1972 Mass. Adv. Sh. 973, 282 N.E.2d 374.

16 Id. at 975, 282 N.E.2d at 375.

17 Id. at 975, 282 N.E.2d at 376.

18 1972 Mass. Adv. Sh. 778, 281 N.E.2d 593.

Court, in the process of sustaining the defendant's demurrer, set forth what must be established for liability in such a situation:

> "[O]ne who seeks to hold another responsible for neglect in the conduct of litigation must show that the action which has been neglected would probably have been successful, and therefore that its neglect has directly resulted in damages measured by the value or amount of the rights which were lost by the default."[19]

B. LEGISLATION

§5.12. Unfair acts or practices. In response to the McCarran-Ferguson Act,[1] passed by Congress in 1945, the Massachusetts legislature in 1947 enacted G.L., c. 176D, entitled "Unfair Methods of Competition and Unfair and Deceptive Acts and Practices in the Business of Insurance."[2] During the 1972 SURVEY year the legislature essentially re-enacted Chapter 176D, with various modifications and additions.[3] At the heart of the new statute are Sections 2, 3 and 6. Section 2 provides that no person may engage in any unfair or deceptive acts or practices in the insurance business. Section 3 sets forth an extensive list of practices expressly defined to be unfair or deceptive. Section 6 provides the Commissioner of Insurance with the means of establishing whether any other acts or practices not defined in Section 3 are unfair or deceptive.[4]

Many of the acts and practices defined in Section 3 as unfair are simply carry-overs from the earlier legislation.[5] However, several significant new categories have been added. For example, Chapter 176D now extensively defines unfair claim settlement practices: it is now an unfair or deceptive act or practice to compel ". . . insureds to institute litigation to recover amounts due under an insurance policy by offering substantially less than the amounts ultimately recovered in actions brought by such insureds,"[6] or to refuse ". . . to pay claims without conducting a reasonable investigation based upon all available information."[7] Further,

[19] Id. at 779, 281 N.E.2d at 594, citing McAleenan v. Mass. Bonding and Ins. Co., 232 N.Y. 199, 204-205, 133 N.E. 444, 446 (1921).

§5.12. [1] 15 U.S.C. §§1011-1015. In the anti-trust and unfair business practices areas, the McCarran-Ferguson Act limits federal control over the insurance industry only to the extent that state regulation exists. For a recent discussion of the scope of the McCarran-Ferguson Act, see 1971 Ann. Surv. Mass. Law §11.20.

[2] Acts of 1947, c. 659.

[3] Acts of 1972, c. 543.

[4] Under Section 6, the Commissioner may hold a hearing on a suspect act or practice whenever he ". . . shall have reason to believe that any such person has engaged or is engaging in this commonwealth in any unfair method of competition or any unfair or deceptive act or practice . . . and that a proceeding by him in respect thereto would be in the interest of the public."

[5] G.L., c. 176D, §§3(1)-(8) are substantially the same as subsections a and b of Section 4 of the old Chapter 176D (Acts of 1947, c. 659).

[6] G.L., c. 176D, §3(9)(g).

[7] Id., §3 (9)(d).

in response to the increasing interest of insurance regulators in the complaint handling procedures of insurers, the new Act defines as unfair the failure to keep complete records concerning the receipt, processing and disposition of all complaints.[8]

While the old Chapter 176D established a fairly expeditious means to combat those unfair or deceptive acts or practices expressly defined in the statute,[9] a substantially more cumbersome technique was prescribed to combat other unfair or deceptive acts or practices.[10] The new Chapter 176D, however, gives the Commissioner of Insurance the power to issue cease and desist orders against any act or practice which he finds to be unfair or deceptive, whether or not it is so defined in the statute.[11] Any such order is subject to judicial review;[12] and once the order becomes final, any violation subjects the violator to a maximum fine of $10,000.[13]

The provisions of the new Chapter 176D are substantially those of the Model Unfair Trade Practices Act approved by the National Association of Insurance Commissioners (NAIC) in December of 1971. The only differences of any significance relate to the fines and damages that may be imposed on recalcitrant insurers. For example, in an action to recover on an insurance policy, a court may award up to twenty-five percent of the claim as punitive damages under Chapter 176D if the plaintiff was damaged by an act or practice determined by the Commissioner to be unfair or deceptive.[14] The NAIC Model Act contains no such punitive damages provision. In addition, Chapter 176D requires the Commissioner to assess a fine of not more than $1,000 for "each and every" unfair or deceptive act or practice.[15] Under the NAIC Model Act the maximum *aggregate* fine would be $10,000, or, for "knowing" violations, $50,000.

The size of a fine under Chapter 176D could be astronomical, for example, in the case of an offending brochure that was widely distributed. The answer, of course, is that the Commissioner would never impose a maximum penalty in such a situation. In a sense, this last observation may be made of many sections in the new chapter. Some will characterize the legislation as a strong, consumer-oriented measure that gives

8 Id., §3 (10).

9 Under Sections 6 and 7 of the old Chapter 176D, (Acts of 1947, c. 659) the Commissioner could, after a hearing, issue a cease and desist order to any person found to be engaging in an act or practice defined by the statute as unfair or deceptive.

10 If, after a hearing, the Commissioner found that an act or practice not defined in the statute was in fact unfair or deceptive, Section 9 of the old Chapter 176D (Acts of 1947, c. 659) required him to seek, through the Attorney General, an injunction against such act or practice in the Supreme Judicial Court.

11 G.L., c. 176D, §7.

12 Id., §§8-9.

13 Id., §10.

14 Id., §7. In order for this provision to be applicable, the act or practice determined to be unfair or deceptive must have been defined as such in the statute.

15 Id.

the Commissioner the necessary power to deal with abuses. Others will characterize it as an attempt to enforce good business procedures by legislation and, hence, an example of legislative "over-kill." In any event, the Commissioner has been given a very inclusive statute, the beneficial impact of which depends essentially on the reasonable, impartial and consistent exercise of the Commissioner's discretion.

§5.13. Life insurance: Issuance to mentally retarded minors. Legislation passed during the 1972 SURVEY year prohibits Massachusetts life insurers from refusing to insure the life of any Massachusetts minor for the sole reason of mental retardation.[1] The prohibition applies only if the minor is at least 3 years old, if there is no other insurance in force or pending on the life of the minor, and only if the amount of the insurance applied for is "exactly" $1,500. The choice of the figure of $1,500 makes it clear that, in essence, this mandatory coverage is "burial insurance."

Because of the limited amount of the insurance involved, and because of its limited applicability, this particular piece of legislation is not significant in itself. The type of legislative action involved, however, is somewhat more controversial. While insurance companies, consistent with sound underwriting standards, have been issuing life insurance to many mentally retarded persons for years, such coverage has been denied in respect to the severely retarded who, as a group, have demonstrated a high mortality rate. In effect, Chapter 804 requires insurers to ignore sound underwriting standards. If this trend were continued, insurers might be required in the future to issue insurance in larger face amounts, on lives in other high-risk categories including persons afflicted with epilepsy, muscular dystrophy, cerebral palsy, and the like.[2] Under fundamental principles of insurance underwriting, premium charges for a given amount of insurance mount rapidly as the risk increases until, in respect to severe retardation or to young persons in other high-risk categories, such premiums are a significant percentage of the face amount of coverage. This kind of insurance is also very expensive for companies to write because the policy is small and the underwriting effort is unusually large. Since Chapter 804 does not limit the amount of premiums that may be charged, it should be expected to produce life insurance that is relatively expensive.

§5.13. [1] Acts of 1972, c. 804.

[2] Public policy considerations are also relevant to the type of legislative mandate involved here. Before anyone may insure the life of a third person for his own benefit, the law requires that he have an "insurable interest" in the life of the insured. Couch §24:118. "A person has an insurable interest in the life of another if he can reasonably expect to receive pecuniary gain from the continued life of the other person and conversely, if he would suffer financial loss from the latter's death." Id. §24:119. This insurable interest requirement is probably no bar to insurance under Chapter 804, given the relatively small amount of coverage involved. Generally the insurable interest must be "substantial in relation to the amount of the insurance." Id. §24:2. This requirement could create problems if, for example, the legislature decided to mandate relatively large insurance coverage for seriously impaired lives.

§5.14. Termination of employment: Notice of continued group coverage. Under the statutory scheme that governs certain types of group insurance, an insured leaving the group often remains covered for a period of time after his departure.[1] Chapter 353 of the Acts of 1972[2] requires any employer who terminates the employment to notify that employee, within ten business days, "of the date upon which his coverage under his group insurance policy shall terminate."

Chapter 353 is not totally free from ambiguity regarding the circumstances under which notice must be given. The statute applies only to an employer *"terminating employment* of an employee." It would thus appear to apply only when an employee is fired, and not when he voluntarily leaves his job. Under G.L., c. 175, §134, however, group life coverage continues for 31 days after the "termination of employment," which seems to include a termination brought on by the employee.

A curious feature of the notice provision is that, although it deals with insurance coverage, it is placed under the jurisdiction of the Commissioner of Labor and Industries, and not the Commissioner of Insurance.[3] However, this feature is not altogether unreasonable inasmuch as the Department of Labor and Industries regulates many aspects of the employer-employee relationship.[4]

§5.15. Preclusion of banking institutions from certain insurance activities. Chapter 718 of the Acts of 1972[1] is calculated to restrict banking institutions from competing with the insurance industry in respect to the sale of many types of insurance. It prohibits virtually all banking institutions[2] from becoming licensed insurance agents or brokers, except for the sale of accident, health and life insurance. This prohibition also applies to the officers and employees of such banking institutions, if ten percent or more of such person's aggregate net insurance commissions would arise from insurance written "on behalf of such bank or any of its borrowers."

§5.14. [1] For example, under G.L., c. 175, §110D, an elderly person insured as a member of a group against accident or sickness under G.L., c. 175, §110C, remains covered for 31 days after leaving the group. Also, under G.L., c. 175, §134, group life insurance coverage continues for 31 days after an insured member leaves the group. (This last provision should not be confused with the right given a former member, under the same Section 134, to obtain within 31 days of departure an equivalent individual life insurance policy without evidence of insurability).

[2] Adding §178 O to G.L., c. 149.

[3] Chapter 353 designates the new provision as G.L., c. 149, §178 O. G.L., c. 149 relates to labor and industries generally, and its provisions are administered by the Department of Labor and Industries.

[4] For example, the power to assure that dividends on group insurance policies inure exclusively to the benefit of the insured persons is also given to the Commissioner of Labor and Industries. G.L., c. 149, §178E.

§5.15. [1] Acts of 1972, c. 718, §1, adding §174E to G.L., c. 175.

[2] Chapter 718 applies to all federal and state banks, savings and loan associations, bank holding companies and their affiliates, credit unions, small loan companies and all organizations "controlled" by the foregoing.

The new Section 174E makes it clear that licensed agents and brokers may serve as directors of banking institutions and that loans may be made by such institutions to such agents and brokers. Also included in the statute are extensive provisions to assure that a banking institution which acquires the assets of a licensed agent or broker by foreclosure on a defaulted loan will dispose of such assets within one year.[3]

Apparently as a compromise between banking and insurance interests, a "grandfather clause" was included in Chapter 718.[4] Thus the prohibitions of the Act do not apply to institutions and individuals holding agent or broker licenses on the effective date of the Act, October of 1972.

Chapter 718 represents yet another skirmish in the continuing conflict between banking and insurance interests, brought on particularly by the former's efforts to provide a broader range of services. This conflict is also reflected in the continuing efforts by the Board of Governors of the Federal Reserve System to determine those types of insurance activities that may appropriately be carried on by affiliates of federal bank holding companies.[5]

§5.16. Acts affecting motor vehicle liability insurance. Many minor legislative changes were made during the 1972 SURVEY year relative to the statutory scheme of motor vehicle liability insurance coverage in Massachusetts. Most of these changes represented refinements of the no-fault approach effective in 1971 for personal injury coverage,[1] and in 1972 for property damage coverage.[2]

Under G.L., c. 90, §34M, the basic no-fault personal injury protection provision of the General Laws, benefits become due and payable from an insurer "upon receipt of reasonable proof of the fact and amount of expenses and loss incurred." Any insured who remains unpaid for more than thirty days after benefits become payable may commence an action against the insurer to compel payment. Chapters 313 and 319 of the Acts of 1972 were intended to expedite the payment process under Section 34M. Chapter 313[3] provides that, if the insurer is notified of the disability of the insured by a licensed physician, it must either begin medical payments within 10 days or notify the insured of its reasons for nonpayment. Chapter 319[4] gives the right to a speedy trial to an insured bringing an

3 Chapter 718 gives the Commissioner of Insurance the power to extend this one year requirement, if ". . . the interests of such bank or debtor will suffer materially by a forced sale of such property."

4 Acts of 1972, c. 718, §2.

5 The Federal Reserve Board has the power to determine what insurance activities are ". . . so closely related to banking or managing or controlling banks as to be a proper incident thereto." 12 U.S.C. §1843(c)(8). For some attempts to do so, see Regulation Y, 12 C.F.R. §222.1 *et seq.*

§5.16. 1 Acts of 1970, c. 670. For an analysis of the no-fault personal injury protection coverage, see 1970 Ann. Surv. Mass. Law §§22.1 et. seq.

2 Acts of 1971, c. 978. For an analysis of the no-fault property damage coverage, see 1971 Ann. Surv. Mass. Law §11.19.

3 Acts of 1972, c. 313, amending G.L., c. 90, §34M.

4 Acts of 1972, c. 319, amending G.L., c. 90, §34M.

action under §34M; it also specifies that if the insured recovers a judgment for *any amount* in such action, the insurer must also pay his "costs and reasonable attorney's fees."

Section 34M was further amended by Chapter 339 of the Acts of 1972. As originally enacted, Section 34M provided personal injury protection subject to a deductible $250, $500, $1,000, or $2,000, at the policyholder's option. Chapter 339 further extends the potential coverage available by adding a deductible of $100 to the policyholder's options.

An interesting aspect of the no-fault personal injury coverage enacted by Chapter 670 of the Acts of 1970 is the treatment of wages lost because of injury.[5] The recovery of lost wages is specifically provided for in G.L., c. 90, §34A,[6] unless such wages are recoverable under a wage continuation program. Consistent with this exclusion from coverage, Chapter 451 of the Acts of 1972[7] directs the Commissioner of Insurance to establish a separate risk category for those who establish that they are entitled to a continuation of wages under a program that provides at least 2 weeks of compensation for disability. If an insured pays premiums based on this lower risk category and subsequently discovers that his wage continuation program does not apply, he may recover lost wages under no-fault by paying the additional premiums that he would have paid if he were not subject to the lower risk category. Although the legislative intent expressed in Chapter 451 is laudable, an insured must produce "evidence that he qualifies to be placed in such classification" to qualify for the lower risk category. Many insureds may not feel that the modest premium reduction involved is worth the effort of producing such evidence.

No-fault concepts were introduced into the coverage of property damage to motor vehicles by Chapter 978 of the Acts of 1971.[8] The rates that may be charged for such coverage are set by the Commissioner under G.L., c. 175, §113B. Chapter 423 of the Acts of 1972 amends Section 113B to provide for "an appropriate reduction in the premium charges covering such vehicles which [the Commissioner] finds are less damageable than others due to safety features incorporated into such vehicles." As originally filed this legislation contained many questionable features, most of which were eliminated by amendment.[9] The original bill did, however, condition the reductions on compliance with federal motor vehicle safety standards,[10] and that criterion, unfortunately, was also eliminated. Unguided by any criteria, the Commissioner will predictably

5 See 1970 Ann. Surv. Mass. Law §§22.5-22.7.

6 Section 34A defines the "personal injury protection" that is the subject of Section 34M.

7 Amending G.L., c. 175, §113B.

8 Adding §34 O to G.L., c. 90.

9 H.R. No. 3172 (1972).

10 Federal motor vehicle safety standards are set by the Secretary of Transportation under the National Traffic and Motor Vehicle Safety Act of 1966 (15 U.S.C. §1381 *et. seq.*).

experience some difficulty in establishing classifications of "less damageable motor vehicles" that will be acceptable to both the insurance industry and consumers.

Finally, two other amendments relating to motor vehicle liability insurance should be briefly noted. Under Chapter 366 of the Acts of 1972,[11] premium charges for motor vehicle liability policies and bonds that are in effect for less than a full calendar year must be prorated according to the actual calendar days of coverage, unless the policy is cancelled by the insured. Finally, Chapter 299 of the Acts of 1972[12] prohibits insurers from requiring a medical examination of any applicant for motor vehicle liability insurance.

§5.17. Miscellaneous Acts. Individual accident and health insurance policies commonly include provisions that preclude recovery if an injury or sickness for which recovery is sought is the result of a condition that existed at the time the policy was issued. Chapter 714 of the Acts of 1972[1] potentially restricts the use of such provisions by requiring an insurer that denies liability under such a provision to accompany its letter of denial with "documented evidence of specific instances of actual treatment or observation of such pre-existing condition, illness or injury."

The minimum qualifications for applicants for insurance agent and broker licenses are enumerated in G.L., c. 175.[2] Chapter 162 of the Acts of 1972[3] now provides an exemption from those requirements for applicants who have received the designations of "Chartered Property and Casualty Underwriter" or "Chartered Life Underwriter" on the condition that they complete a certain number of hours of a "course of study, approved as to method and content by the Commissioner."

Chapter 421 of the Acts of 1972 affects various relatively minor amendments to the statutory scheme that regulates the sale of life insurance by Massachusetts savings banks.[4] The regulation and administration of Massachusetts savings bank life insurance is carried on principally by the Division of Savings Bank Life Insurance and the trustees of the General Insurance Guaranty Fund. The most significant aspects of Chapter 421 deal with the qualifications necessary for appointment as trustee of the Fund[5] and with the means whereby the cost of operating the Division is borne by the various banks writing life insurance.[6]

11 Amending G.L., c. 175, §113B.
12 Adding §113N to G.L., c. 175.

§5.17. 1 Adding §108(2)(a)(2A) to G.L., c. 175.
2 See G.L., c. 175, §§163, 163A (relating to agents); G.L., c. 175 §§166, 166A (relating to brokers).
3 Acts of 1972, c. 162, §§1 (amending G.L., c. 175, §163A), 2 (amending G.L., c. 175, §166A).
4 Such regulation is pursuant to G.L., cc. 26, 178.
5 Acts of 1972, c. 421, §1, amending G.L., c. 26, §9, specifies that the Commissioner of Savings Bank Life Insurance, who is also a trustee of the Fund, shall not be a salaried officer of any bank writing life insurance. Section 2 of Chapter 421, amending G.L., c. 26, §10, provides that after July 1, 1976, two

During the 1972 SURVEY year, the customary changes and additions to the chapters of the General Laws relating to pension and group insurance coverage of public employees were promulgated.[7] Suffice it to say that the changes made, relatively minor for the most part, continue the liberalizing trend in benefits observed in recent years.

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of the seven trustees of the Fund must be full-time salaried officers of banks writing life insurance. Section 2 also provides that no trustee may be affiliated with an ordinary life insurance company.

6 Acts of 1972, c. 421, §6, amending G.L., c. 178, §17.

7 G.L., c. 32, relating to retirement systems and pensions for public employees, was amended by Acts of 1972, cc. 284, 343, 793, and 809; G.L., c. 32A, which deals with group insurance coverage for "Persons in the Service of the Commonwealth," was amended by Acts of 1972, c. 686; G.L., c. 32B, concerning "Persons in the Service of Counties, Cities, Towns and Districts, and their Dependents," was amended by Acts of 1972, cc. 641 and 763.