Chapter 17: Insurance

J. Albert Burgoyne
CHAPTER 17

Insurance

J. ALBERT BURGOYNE and GEORGE E. DONOVAN

A. GENERAL INSURANCE — COURT DECISIONS

§17.1. Insurance agents: Agency contract. In White v. Universal Underwriters Insurance Co., an agent sought an accounting under an insurance agency contract terminated by mutual agreement of the parties. A number of questions were raised concerning "contingent commissions," "expiration ownership," and "accounting dates." In remanding the case to the Superior Court for further proceedings, the Supreme Judicial Court held that when an accounting is made under a contingent commission agreement at a date after the accounting date fixed by the agreement, any loss experience data or modifications in reserve estimates which become available subsequent to the accounting date must be used in making the accounting. Moreover, the Court directed that upon remand the defendant insurer should have the opportunity to update the experience figures, so that the accounting would reflect the most recently available data. It dismissed the possibility that this rule would unreasonably invite nonperformance by a party who might anticipate that upon an accounting based upon estimated reserves he would owe a substantial balance, suggesting that in such a case the obligation should be treated as liquidated as of the date the account should have been stated, with interest payable from that date. The Court further held that physical damage policies written for terms that did not coincide with the calendar year and which had been reinsured by the defendant as of the termination date of the agency contract were, as between the parties, closed business to be treated for purposes of fixing the accounting date as policies which "shall have been terminated by expiration or cancellation." In awarding the plaintiff damages for the wrongful appropriation of his expirations, the Court found nothing inconsistent in the agency agreement that gave to the insurer, for the purposes of policy service and premium collection, possession of the expiration records of all policies.

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with premiums unpaid thirty days after termination of the agreement, but preserved the exclusive rights of the plaintiff to such records for any policy on which the premiums had been fully paid within ninety days of the termination date.

§17.2. Motor vehicle insurance: Definition of insured. *The Travelers Insurance Co. v. Safeguard Insurance Co.*¹ was a bill for a declaratory judgment to determine liability under two policies, a general liability policy issued by Travelers and a motor vehicle liability policy issued by Safeguard. An employee of the food store insured under the Travelers policy had deposited two bags of groceries in the automobile of one of the store's customers and had then pulled the automobile door to close it, catching and severely injuring the fingers of the customer. Safeguard had issued its policy insuring the customer's automobile. The trial judge ruled that Safeguard had no obligation to pay for the injuries sustained, and that Travelers was bound to assume the defense of the store in an action by the injured customer to recover for his injuries. From this ruling Travelers appealed, arguing that any liability to its customer imposed on the store would be on the theory of respondeat superior, that in this event the store would have an action against the employee for reimbursement, and that in this action Safeguard would be obliged to defend the employee under the policy issued by it to the customer.

Under the motor vehicle liability policy, Safeguard was bound to "pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages because of bodily injury . . . sustained by any person, caused by accident and arising out of the ownership, maintenance or use of the motor vehicle." The policy defined "insured" to include "any person while using the motor vehicle and any person or organization legally responsible for the use thereof, provided the actual use of the motor vehicle is . . . with the permission of" the named insured or his spouse. The Court found that the store owner's employee was not an insured under these provisions, holding that if what the employee did in this case was a "use" of the automobile, it was too casual and too remote from the operation of the motor vehicle to qualify him as an "insured." In many cases it has been held that loading or unloading a motor vehicle is a use or operation thereof.² In these cases, however, the motor vehicle was typically a commercial vehicle, usually being used at the time of the injury in the regular course of soliciting trade or delivering merchandise. In the present case there was no evidence that the motor vehicle was involved in any such use, so as to bring the insured's employee within the coverage of the Safeguard policy.

§17.3. Motor vehicle insurance: Nonowned automobiles. In *MacLellan v. Liberty Mutual Insurance Co.*¹ the plaintiff executor


¹ §17.3. 1346 Mass. 415, 193 N.E.2d 577 (1963).
sought to reach and apply the proceeds of an insurance policy written by the defendant insurer in satisfaction of a judgment obtained by him against one Walter G. Bruce for the death of Barbara A. MacLellan in an automobile accident. At the time of the accident Bruce, an employee of the Trustees for County Aid to Agriculture, was driving his own automobile in the trustees’ business. The policy in suit was issued by Liberty Mutual to the trustees, and afforded coverage only for the use by persons other than the named insured in the named insured's business of automobiles neither owned nor hired by the named insured. By its terms the policy covered the liability only of the named insured and of any executive officer of the named insured. Bruce was not an executive officer and therefore could not be brought within the insuring agreements. The Supreme Judicial Court rejected the argument that Bruce was brought within the terms of the policy as an insured person by the declarations entry designating the number of “Class 1” persons as ten, of whom Bruce was admittedly one, observing that this entry merely described the hazard insured and could not be construed as enlarging the policy definition of insured.

§17.4. Motor vehicle insurance: Uninsured motorists coverage. The plaintiff in Fazio v. The Employers' Liability Assurance Corp. sought to recover, under the “protection against uninsured motorists” coverage of a Massachusetts Motor Vehicle Liability Policy issued by the defendant insurer, for bodily injury, which she alleged she sustained when her automobile was sideswiped by a hit-and-run automobile. The insurer denied liability, and the plaintiff filed a demand for arbitration with the American Arbitration Association. In its answer to this demand the insurer stated that “[A]ll coverage questions which are in controversy, including but not limited to the question of whether a hit-and-run motor vehicle was involved in the alleged accident, are not the subject matter of arbitration and the insurer expressly reserves and does not waive its right to set up as a defense any and all coverage defenses which it has to this claim.” Following arbitration proceedings properly conducted, the arbitrator made an award in which the plaintiff's claim was “denied in its entirety.” The defendant insurer appealed an order of the Superior Court granting the plaintiff’s motion to vacate the arbitrator's award.

The plaintiff’s motion to vacate was based upon supposed defects apparent upon the face of the award, namely, (1) that the arbitrator exceeded his authority, and (2) that the reasons for denying her claim cannot be determined from the award. The matters which were to be decided by arbitration, in accordance with the policy insuring agreement, were limited to the fault of the hit-and-run motorist and the damages to which the claimant was entitled. While the rather inep
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language of the award, denying the plaintiff's claim "in its entirety" seems to encompass a finding with regard to the liability of the insurer and, further, seems to resolve questions of coverage which the parties had agreed were not subject to arbitration, the Supreme Judicial Court interpreted it as meaning no more than that the plaintiff was awarded nothing. The Court, confirming the arbitrator's award, pointed out that while evidence could have been introduced to show that the arbitrator's findings exceeded the scope of the agreement, none had been offered, and that in these circumstances it is the legal presumption that arbitrators pursue the submission, deciding only the matters contained in it, and also that they decide all matters submitted to them.4 As to the second ground for plaintiff's motion to vacate, the Court found that the plaintiff was not entitled to any statement of reasons. The only requirement of the arbitration condition is that the award be in writing and carry the signature of the arbitrator. The findings of fact and the conclusions of law upon which the award is based need not be given.5

§17.5. Fire insurance: Subrogation. Eastern Restaurant Equipment Co. v. Tecci1 was an action brought for the benefit of the plaintiff's fire insurer, who sought to be subrogated to the plaintiff's claim against the defendant under a conditional sale contract and a promissory note for the purchase and installation of certain restaurant equipment supplied by the plaintiff. Under the terms of the contract, the risk of loss of the equipment and the obligation to insure were imposed upon the conditional vendee, but the conditional vendor was authorized to insure the equipment for the benefit of the vendor and his assigns at the expense of the vendee and to charge the cost of the insurance to the vendee. The contract further provided that the destruction of the equipment would not relieve the vendee from liability for the full purchase price. The vendee neglected to obtain insurance, despite his contractual obligation. However, the equipment was automatically insured under a blanket policy maintained by the vendor, which covered goods that any purchaser failed to insure in an amount equal to the unpaid balance of his account at the time of loss. Following assignment of the vendee's note to a finance company and

4 Sperry v. Ricker, 4 Allen 17, 19-20 (Mass. 1862).


http://lawdigitalcommons.bc.edu/asml/vol1964/iss1/20
partial payment by the vendee, the equipment was completely destroyed by fire and the vendor's insurer paid the assignee the full amount of the unpaid balance less the unearned interest. At no time did the vendor seek to charge the vendee with the cost of insurance.

It is now generally held that insurance of a vendor's interest under a conditional sale contract is closely similar to insurance of a mortgagee's interest in mortgaged property. In the early Massachusetts case of King v. State Mutual Fire Insurance Co., the Supreme Judicial Court, emphasizing the personal character of the policy of insurance, refused to allow the insurer of the mortgagee to succeed by subrogation to his rights against the mortgagor, thus allowing the mortgagee to enforce both of his contract rights, one against the insurer and one against the mortgagor. The effect of that decision has been overcome, however, when the mortgagee has agreed that the insurer shall be subrogated as required by the provision of the standard fire policy. In the present case the conditional vendor's policy was not in the record, and there was no showing that it contained a subrogation provision.

The case is one that closely resembles an exception to the King v. State Mutual rule set down by Chief Justice Shaw, applicable to the case in which the mortgagee may under the mortgage agreement cause the property to be insured at the expense of the mortgagor. In those circumstances the insurance is treated as collateral security furnished by the debtor, and in the event of loss the insurance proceeds extinguish the debt pro tanto. In the view of the Court, this rule should also apply to conditional vendors and should apply if the premium for the vendor's policy is chargeable to the vendee, thus forestalling the possibility of allowing the vendor to decide not to charge the premium to the vendee after a loss has occurred, thereby preventing the vendee from receiving the benefit of the insurance. In giving the vendee the benefit of the vendor's insurance, the Court specifically noted that the result is consistent with the recent holding of the federal district court in In re Future Manufacturing Cooperative, Inc., but eschewed the broad general grounds of that decision, which involved a policy containing a subrogation clause. Presumably, the result in the Tecci case would have been different if there had been a showing that the policy required subrogation of the insurer to the vendor's rights against the vendee.

§17.6. Railroad blanket bond: Fidelity of employees. In Boston & Maine R.R. v. Actea Casualty and Surety Co. the railroad sought to recover under an employees blanket bond which obligated the defendant insurer to indemnify it "against any loss . . . for which the

2 27 Cush. 1 (Mass. 1851).

Insured is legally liable ... through Culpable Negligence as defined ... on the part of any one or more of the Employees. ...” Culpable negligence is defined in the bond to mean “only gross carelessness in the performance or omission of duties, or the deliberate assumption of risk by an Employee in violation of printed or written instructions, rules or regulations of the Insured. ...” Loss was sustained by the railroad following a freight agent's release of shipments to a consignee on order-notify bills of lading at a time when the aggregate value of shipments not paid for exceeded the limit specified in a delivery bond that had been posted by the consignee. The shipments were released by the freight agent at the direction of the railroad's regional sales manager, who informed him that the president of the railroad had directed release of the shipments to the consignee.

At the trial before the District Court for Massachusetts, the judge, sitting without a jury, dismissed the complaint on the ground that the employee's authority to exercise credit supervision over the consignee had been abrogated by the railroad's regional sales manager when he instructed the employee to release the shipments, with the result that the employee could not thereafter be negligent in supervising the credit status of the consignee's account so as to bring his actions within the coverage of the blanket bond. On appeal the circuit court relied upon the language of the bond and affirmed the judgment for the insurer on the ground that the employee, in following the instructions of the regional sales manager, who had asserted that he was under instructions from the company president, could not be said to be guilty of "gross carelessness" or "deliberate assumption of risk in violation of printed or written instructions."

The court observed that "gross carelessness" is undefined in Massachusetts case law, but that gross negligence is a well-established legal concept. Although the terms are not synonymous, gross carelessness goes as far as gross negligence in regards to the degree of departure from the standard of reasonable care. It implies an indifference to consequences, a disregard of the cautions that would prevent a reasonable man from taking a specific course of action. The release of the shipments in this case was a breach of contract between the railroad and the shippers; it left the railroad without the protection of the delivery bond, but it was not the consequence of the freight agent's gross carelessness. He did only what he was ordered to do by superiors presumably authorized to give such orders.

§17.7. Medical service corporation: Subscribers' rates. In Rose v. Board of Review in the Division of Insurance,1 the plaintiff, a participating physician under contract with the defendant Massachusetts Medical Service, Inc. (Blue Shield), sought a review as an aggrieved party2 in the Superior Court of a decision by the defendant


2 G.L., c. 176B, §12, provides in part as follows: "Any dispute or controversy arising between a medical service corporation and any participating physician . . . may . . . be submitted by any person aggrieved to a board serving in the division.
Board of Review in a dispute over the physician’s right to a fee for services in excess of that fixed by the Blue Shield fee schedule. The Superior Court affirmed the order of the Board that the plaintiff return to his patient the amount of his fee in excess of that permitted by the fee schedule for a “service benefit member,” which this patient was by definition, under a group Blue Shield agreement with Harvard University, the patient’s employer. The plaintiff appealed this decision to the Supreme Judicial Court.

The provisions of its agreement with Blue Shield obligated Harvard to pay to Blue Shield on a monthly basis 108 percent of the amounts paid by Blue Shield to participating physicians for services rendered to Harvard’s covered employees. This agreement, which became effective July 1, 1960, together with a copy of the subscriber’s certificate, was filed with the Division of Insurance on July 20, 1960, in accordance with the statutory requirement. No schedule of the charges made by Harvard to the employee-subscribers was filed, nor does it appear from the opinion of the Court what these charges were. The plaintiff physician contended that the failure to file a schedule of these charges was a failure to comply with the statute, invalidating the agreement between Blue Shield and Harvard, and that, as a consequence, the plaintiff was not a participating physician in respect to Harvard employees. The Court rejected this argument, holding that the dominant purpose of the statute was to regulate the operations of a nonprofit medical service corporation, not to regulate the operations of an employer who makes an agreement with it to furnish group medical service benefits. The Court at least inferred that there was not literal compliance with the statutory filing requirement, but observed that literal compliance would not satisfy the statutory purpose, since the rates charged to the subscribers do not include the contribution made on the employee’s behalf by the employer.

In the view of the Court, the requirement that the rates charged by Blue Shield for the services of its participating physicians be filed with the Commissioner of Insurance, in the case of group agreements, is met...
by filing the over-all rates charged to the employer of the subscribers, and such a filing is adequate compliance with the statute. The Court also agreed with the Board's finding that the filing made in this case came within the classifications of risks permitted by the statute and agreed that the charge made by Blue Shield to group subscribers may be a fixed charge, but may also be a charge which is not exactly determinable in amount until some time after the expiration of coverage.

§17.8. Nonprofit service plans: Subscribers over age sixty-five. On May 21, 1964, the House of Representatives adopted an order requesting the opinion of the Supreme Judicial Court on whether a bill that would require nonprofit hospital service plans (Blue Cross) and nonprofit medical service plans (Blue Shield) to afford persons over age sixty-five premium rates no higher than those charged group subscribers would violate the equal protection clause of the Federal Constitution or Article X of the Declaration of Rights of the Constitution of Massachusetts if the same obligation was not imposed upon all other hospital and medical service plans offered in the Commonwealth. The Court, noting a lack of clarity of intent in the proposed statutory language, a paucity of factual information upon which to examine the basis for the distinction made, and the narrowness of the constitutional inquiry propounded, stated that it was unable to point to anything in the bill that would render it repugnant to the constitutional provisions specified. It did suggest, however, that some question might have been raised concerning the reasonableness of singling out as beneficiaries persons over sixty-five and of imposing the burden of higher compensating premium rates upon other subscribers. In the circumstances, the Court advised that it would reconsider the question, unaffected by this opinion, if litigation should arise following enactment of the proposed legislation.

§17.9. Policy insuring agreements: Defense, settlement, supplementary payments. The question of an insurer's liability to pay an insured's counsel fees when a declaration in tort is broad enough to state a cause of action within the coverage of a policy but has been so framed as to omit statement of a fact that would bring the loss within a policy exclusion was raised in Magoun v. Liberty Mutual Insurance

4 Although it does not appear to modify the statutory filing requirement, the Court was constrained to point out that the filing in question was within the type of situation contemplated by the fifth paragraph of G.L., c. 176B, §4: "Nothing in this section shall be construed to prohibit as unreasonable or unfairly discriminatory the establishment of classifications or modifications of classifications of risks based upon size, expense, management, individual experience, purpose, location or dispersion of hazard or any other reasonable considerations, or to prohibit retrospective refunds. Acquisition costs in connection with the solicitation of subscribers and costs of administration shall at all times be limited to such amounts as the commissioner shall approve."

The declaration alleged that the defendant "was engaged in the handling of a load of steel at the freight depot ... [and] so negligently and carelessly handled said load of steel that by reason thereof, the steel fell on" the decedent. The facts developed by Liberty's investigation prior to suit disclosed that at the time of the accident causing the death the defendant was engaged "in loading the steel joists onto trucks" on the premises of a railroad company.

The policy in suit was a schedule general liability policy (manufacturers' and contractors' form) which bound Liberty Mutual to pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages because of bodily injury or death caused by accident and arising out of the insured's premises and all operations necessary or incidental thereto. This insuring agreement was subject to the standard loading and unloading exclusion, which recites that the policy "does not apply ... to the ... use, including loading or unloading, of ... automobiles while away from such premises or the ways immediately adjoining. . . ." The policy also contained the standard insuring agreement obligating the insurer to defend the insured in an action for damages within the coverage of the policy.2

The insurer, both before and after suit was filed, communicated to the insured its willingness to undertake the defense of the action under a reservation of its rights to disclaim liability under the policy. The insured was unwilling to have the insurer represent him under the terms of the reservation and retained his own counsel. Thereafter, the insurer co-operated with the counsel retained by the insured in the defense of the tort action, which ultimately resulted in a judgment for the insured. The insured thereupon demanded reimbursement of counsel fees, which the insurer denied, contending that it should not be required to pay the insured's legal expenses in view of its offer to assume the defense of the tort action under a reservation of rights, the insured's refusal of that offer, and its surrender to the insured of control of the defense of that tort action.

In Massachusetts, Salonen v. Paanenen3 firmly established the doctrine that no estoppel arises against an insurer by reason of its defense of an action against its insured after it has acquired information justifying a disclaimer when such defense is conducted under a reservation of rights. The insurer is faced with a dilemma when it discovers a basis for disclaiming liability. If it continues to defend, it risks the loss of its right to disclaim. If it refuses to defend, it risks liability for breach of the covenant to defend. In Salonen the Court was care-

1 §17.9

Anonymous 1964 Annual Survey of Massachusetts Law

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2 This provision reads in part: "As respects the insurance afforded by the other terms of this policy the company shall: (a) defend any suit against the insured alleging such injury ... and seeking damages on account thereof, even if such suit is groundless, false or fraudulent; but . . . the company may make such investigation, negotiation and settlement of any claim or suit as it deems expedient. . . ."

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ful, however, to point out that it was not holding that the insurer may reserve its rights to disclaim and at the same time insist upon retaining control of the defense. And this was not the precise question reached in *Magoun*, since the plaintiff had no recovery and the insurer did not at any time insist upon retaining control of the defense.

The case does raise the question, however, of the insurer's liability to pay the insured's legal expenses when, as here, there is a possible divergence of interests and the insurer has acquiesced in the insured's insistence upon retaining his own counsel and has co-operated in the successful defense of the action. In the view of the Court, the failure of the insurer to reach agreement with the insured regarding the cost of the defense, which the insurer was obligated to furnish, created an uncertainty that should be resolved against the insurer. While the case would seem to suggest that the insurer in these circumstances could avoid liability for such costs by making appropriate reservations, it is difficult to see how it could overcome the insured's refusal to consent to such reservations.

B. GENERAL INSURANCE — LEGISLATION

§17.10. Motor vehicle insurance: Merit rating. During the 1964 Survey year the legislature once again responded to the recurring demand that merit rating of liability insurance be made available to Massachusetts motor vehicle owners. A bill filed on behalf of the Commissioner of Insurance would have amended the statute directing the Commissioner to establish risk classifications and premium rates for compulsory motor vehicle liability policies to include a provision that "the commissioner may establish further classifications of risks for accident-free drivers." Acts of 1964, Chapter 391, revised the Commissioner's bill by amending the statute to require that the "commissioner shall, annually, . . . fix and establish fair and reasonable classifications of risks, including classifications of risks based on accident involvement. . . ." In addition to changing the permissive character of the Commissioner's bill, the enactment eliminated the "accident-free" emphasis of that bill and substituted the troublesome concept of "accident involvement." These significant changes made in one of the shortest bills introduced in the session reflect the difficulties that have been encountered over the years in successive efforts to develop a merit-rating plan that is at once politically attractive and actuarially sound. The very carefully constructed merit-rating provisions of the ill-fated Highway Safety Act of 1953 were retained for less than six weeks after they became effective on January 1, 1956, as the General Court hastily responded to the complaints of those motor vehicle owners who were subjected to premium surcharging. It is actuarially

§17.10. 1 G.L., c. 175, §113B.
impossible to give a very large number of accident-free drivers a meaningful reduction in insurance premiums without simultaneously imposing on the accident-involved drivers substantially increased insurance premiums. Moreover, there does not seem to be an effective way to persuade the driver who does not receive the reduced premiums reserved for the accident-free driver that he is not being surcharged for his accident involvement. It is, of course, the imposition of surcharges that makes merit rating unpopular with those who do have accidents. This difficulty is further compounded by the apparent unwillingness of those who are not insurance professionals to accept the perfectly sound underwriting concept of accident involvement as a basis for modifying insurance premiums, and their insistence that liability for an accident must be finally established in order to impose on a driver a merit-rating surcharge or to deny him a merit-rating credit. Unhappily, it is almost a certainty that such an arrangement can only be expected to increase the volume of motor vehicle tort litigation and to inhibit the development of any significant premium reduction for “accident-free” drivers.

Following the enactment of this statutory change, a number of serious questions concerning its implementation by the Commissioner of Insurance arose almost at once. Perhaps the most troublesome of these were whether losses other than compulsory insurance losses, or accidents occurring prior to the effective date of the enactment were to be taken into account in fixing the merit-rating classifications. These questions were in effect avoided by accomplishing the implementation of the statute in a series of steps. By order of the Commissioner, the experience period hereafter for each calendar year of coverage will be the twelve-month period beginning on September 1 of the second preceding calendar year, with the first such period to begin on September 1, 1964, thus excluding losses occurring prior to the statutory change. “Accident-free” and “accident-involved” classifications will be established for calendar year 1965 but with no differences in premiums for such classifications because of accident experience. Not until calendar year 1966 will different premiums be established for these additional classifications. For the present, only compulsory insurance losses will be taken into account, but the Commissioner has disclosed an intention to file additional legislation that would authorize the inclusion of property damage, extraterritorial, and guest coverage as an integral part of the plan.

The Commissioner has sought to resolve the problem of “accident involvement” by defining these words to mean involvement in “any accident which occurs during the experience period which results in bodily injury or death to a person or persons, as a consequence of which an amount has been paid as a loss or an amount is held as a

4 Compulsory insurance losses are those paid or payable under a motor vehicle liability policy as defined in G.L., c. 90, §34A; excluded are guest and extraterritorial bodily injury liability losses, all property damage liability losses, and all physical damage losses.
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reserve for a claim made under Coverage A only of a Massachusetts Statutory Motor Vehicle Policy (compulsory) covering a motor vehicle to which the plan applies.” It would appear, however, that the Commissioner is not unaware of the potential difficulties inherent in using loss reserves as a basis for merit rating, since he has also disclosed an intention to establish a Board of Review within the Insurance Department “to consider” the complaint of any motorist who may feel that an insurance company may have “unjustifiably” settled a claim against him. It is unclear what action, if any, could be taken by such a Board. Whether this effort at merit rating will prove to be more durable than past efforts, only time will tell.

§17.11. Motor vehicle insurance: Compulsory coverage. Each year numerous bills are filed to extend the scope of compulsory insurance; the proposals this Survey year included bills to make mandatory property damage liability insurance, extraterritorial coverage, and bodily injury liability limits above the historical $5000/$10,000 minimums. One relatively small extension was accomplished by Acts of 1964, Chapter 517, which broadened the compulsory coverage of accidents arising out of the ownership, operation, maintenance, control, or use of a motor vehicle “upon the ways of the commonwealth” to “upon the ways of the commonwealth or in any place therein to which the public has a right of access.” While this new language seems destined to raise some new problems in determining the question of “right of access” it does bring the compulsory coverage into shopping plazas, automobile service stations, drive-in theatres, and the like. It is a little difficult to understand the legislature’s unwillingness to adopt the bill as originally filed, in which form it would simply have made the entire extraterritorial coverage mandatory, unless lingering constitutional misgivings remain. In any case, it may be expected that continued efforts will be made to broaden the compulsory coverage, and these efforts seem likely to succeed, either through modest step-by-step changes over a period of several years or through major legislation enacted in one year.

§17.12. Motor vehicle insurance: Assigned risks. During the 1964 Survey year a major effort was made to ease the problems confronting applicants for motor vehicle insurance who are obliged to use the facilities of the Massachusetts Motor Vehicle Assigned Risk Plan, and to eliminate a number of questionable practices of some insurance brokers, practices which the Commissioner of Insurance has sought to curb by issuing a series of administrative orders. House Bill No. 923 would have supplied the basic statutory change required to enable the insurance industry to make available to all motor vehicle registrants “immediate certification” on their registration applications that the mandatory insurance has been afforded with respect to the motor vehicle being registered. This immediate certification, under a plan

§17.11. 1 Amending G.L., c. 90, §34A (defining “motor vehicle liability policy” and “motor vehicle liability bond”), and §34D (prescribing conditions for a cash deposit in lieu of a motor vehicle liability policy or bond).
devised by the industry, could be obtained from any insurance company or from the insurance company agent of the registrant's choice and it would be executed in the name of the assigned risk plan if the risk was not acceptable on a voluntary basis. Under such a plan the whole process of obtaining insurance under the assigned risk plan would be simplified and streamlined, both for the applicant and for the companies, all of which are obliged to assume a proportionate share of assigned risks. Despite the almost unanimous support of virtually all segments of the insurance industry, this legislation was referred to a special commission for further investigation and study.1

§17.13. Group health insurance. Acts of 1964, Chapter 236, amended the definition of general or blanket accident and health policies1 to permit the issuance of such policies to a bank or group of banks to cover groups of persons who are debtors of such bank or group of banks up to the amount of the indebtedness. This legislation also authorizes the purchase of such group insurance by a bank or group of banks2 and the payment to any such bank or group of banks of a service charge reasonably related to the cost of administering the insurance.3

§17.14. Policy conditions: Appraisal. In 1961 a new section1 was added to the insurance law, requiring all motor vehicle physical damage insurance policies to contain in substance the statutory arbitration provision for resolving a failure of an insured and an insurance company to agree on the amount of a loss under such a policy. This statutory requirement was aimed at a small number of companies that were not using policies prepared in accordance with the Standard Provisions for Automobile Policies and which made no arbitration arrangements available to its policyholders. Acts of 1964, Chapter 171,2 adds a further statutory requirement to discipline such nonconforming companies. By this enactment motor vehicle physical damage policies must contain a provision imposing upon the insured the duty to give notice to the company in the event of loss and to the police if the loss is by theft, and imposing upon the company the obligation to pay the amount of the loss within sixty days after the filing of proof of loss. Policies prepared in accordance with the standard provisions conform to this requirement because they contain in substance this newly required provision.

§17.15. Insurance companies: Participating policies. A bill1 filed during the 1963 session of the legislature at the request of the Com-
missioner of Insurance proposed legislation to equalize the regulation of participating stock and mutual companies by subjecting stock companies qualified to issue policies on a participating plan to the statutory provisions regulating the payment of dividends by mutual companies. The proposed legislation was specifically confined to workmen's compensation insurance, however, and would have expanded only the provisions of the Workmen's Compensation Act relating to the dividends of mutual companies to encompass the payment of dividends by participating stock companies. Under existing law, dividends of participating stock companies are not subject to any of the regulatory provisions applicable to mutual companies, including not only those relating to workmen's compensation insurance, but also those specifically applicable to compulsory motor vehicle liability insurance and those applicable to all forms of casualty and property insurance generally.

The basic requirements of the statutory regulation of mutual company dividends call for a classification system based upon kinds of insurance and an equal rate of dividends, payable if any are declared, on all policies insuring risks in the same classification. The special provision concerning workmen's compensation insurance authorizes the further classification of this type of risk into groups distinguished by the nature of the employer's business and the degree of the liability of injury, and also the declaration of dividends in accordance with the experience in each of these classifications. The special provisions relating to compulsory motor vehicle liability insurance require the separate classification of such insurance and the declaration of dividends only from earnings on this classification of business. The requirement of an equal rate of dividend on all policies within a dividend classification has been applied to all special classifications authorized or required by the workmen's compensation and compulsory motor vehicle liability insurance laws.

In the absence of any specific statutory restriction, it would appear that stock companies authorized to issue policies on a participating plan can elect to write some policies on a participating basis and others on a nonparticipating basis, and can pick and choose on a risk-by-risk basis which of its policyholders will be given the advantage of a participating dividend. It would also seem that such a company would have no obligation to declare an equal rate of dividend to all policyholders to whom it had issued participating policies. In these circumstances, unless it can somehow be shown that the statutory prohibition against unfair or deceptive trade practices requires other-

2 G.L., c. 152, §§53.
3 Id., c. 152, §53.
4 Id., c. 175, §113B.
5 Id. §47, defines the kinds of insurance that companies may be authorized to write in Massachusetts.
6 Id., c. 176D, prohibits unfair methods of competition and unfair and deceptive acts and practices in the business of insurance.
wise, these companies can, for competitive or other reasons, engage in pricing practices that may be unfairly discriminatory, or that, in any event, may not be used by the mutual companies. That competitive pressures of this kind are developing seems clear from the adoption in recent months by some stock companies of participating sliding scale dividend plans based upon loss experience and modifications of commission levels.

The Commissioner's original bill was returned to the Division of Insurance for further study, with directions to report back before June 3, 1964, with legislative recommendations. The Commissioner's report recommended enactment of a bill very similar to that originally filed, with the addition of a specific provision relating to assigned risks. The measure was passed by the Senate but was rejected by the House in the closing hours of the legislative session. Thus "equality of regulation" was postponed for at least one additional year.

§17.16. Insurance premium finance agencies. Acts of 1964, Chapter 727, adds to the General Laws a new chapter subjecting premium finance agencies to detailed regulation under the supervision of the Commissioner of Banks. The new law requires any person seeking to engage in the business of financing insurance premiums to pay an initial one hundred dollar inspection fee and an annual three hundred dollar license fee for each office maintained. If application for licensing three or more offices is made at one time, the inspection fee is limited to three hundred dollars. Exempted from the provisions of this law are insurance agents and brokers who have no more than fifteen thousand dollars in outstanding premium balances at any one time, insurance premiums financed at no more than six dollars per one hundred dollars per annum, insurance charges included in installment sales of property, goods, or services, and policies of life, endowment, and retirement income insurance or annuity contracts.

§17.17. Insurance companies. Acts of 1964, Chapter 31, authorizes insurance companies to defer up to $12\frac{1}{2}$ percent, or such larger percentage as may be approved by the Commissioner of Insurance, of the annual salary of an officer or employee beyond the three-year statutory limit formerly imposed upon salary agreements.

Acts of 1964, Chapter 154, amends the statutory provision requiring every insurance company to conduct business only in its corporate name and to display only that name on its policies and contracts to permit two or more insurers under a common management and doing business as an insurance company group, with the approval of the Commissioner of Insurance, to display on its policies the name of the

7 Resolves of 1964, c. 76.

§17.16. 1 Adding G.L., c. 255C.
§17.17. 1 G.L., c. 175, §35.
2 Id. §18.
company group or the names of the individual members of the group, provided that the individual policies as issued clearly indicate the specific company assuming the risk. When identical policy forms are used by the individual companies, the company group can promote efficiency and economy of operation by the use of policies prepared in the manner authorized by this statute.

C. Life Insurance

§17.18. Insurer's defense of misrepresentation in application: Alcoholism. A life insurance policy, being a contract, is voidable within its contestable period for misrepresentations leading to its issuance. Under Massachusetts law the question of whether a misrepresentation will be grounds for avoidance depends upon whether it was made with actual intent to deceive or whether the matter misrepresented increased the risk of loss. Whether these situations exist is most often for the jury to decide. But in some instances, once the fact of misrepresentation has been established, it is held that as a matter of law the matter misrepresented increased the risk of loss. That this is the case when the matter misrepresented is a history of alcoholism was reaffirmed in The Merchants National Bank of Newburyport v. New York Life Insurance Co. The insured in that case had represented in his application for a policy in 1959 that he had never used alcoholic beverages to excess nor been treated for alcoholism. In fact, however, he had reported excessive drinking to a doctor in 1957, and after the policy had been issued he stated to a hospital that he had consumed one to two fifths of alcohol each day from early 1956 until November, 1958, and that thereafter "he was sober seventy-five percent of the time." Other representations, as to hospitalization, illness, and consultation of physicians, and their falsity, were likewise established by answers to a demand by the defendant company under General Laws, Chapter 231, Section 69, for admission of facts. A directed verdict for the defendant was held by the Supreme Judicial Court to be correct, since the misrepresentation concerning the use of alcohol materially increased the risk as a matter of law.

Because the insurance contract apparently had been made in California, where the insured had been domiciled, the Court also considered the law of that state and held that the same result would be reached in view of all the various admitted misrepresentations.

§17.19. Variable annuities. In 1960 the General Court amended General Laws, Chapter 175, by inserting Section 132F. It thereby

§17.18. 1 G.L., c. 175, §186.

permitted freer investment in common stocks and equities of funds received by life insurance companies under policies and contracts issued in connection with pension or profit sharing plans. It allowed such "pension contracts" to reflect to a degree, beyond fixed and guaranteed amounts of return, the earnings (or losses) from these less rigidly conservative investments. However, such contracts are still required to contain a basic standard annuity, guaranteed as to both amount and duration, and are not true variable annuity contracts. The statute was designed to achieve a balance between the security-oriented standard annuity concept and the capital-appreciation-seeking variable annuity. By Chapter 848 of the Acts of 1963, the legislature went even further by authorizing the making of contracts for the payment of true variable annuities. Such contracts may be made by variable annuity insurance companies organized for that purpose and may, subject to the usual approval of the form thereof by the Commissioner of Insurance, be written on an individual or group basis. They will provide for the purchase of a fixed number of annuity units and for the payment of annuity benefits varying in amount, entirely reflecting the investment results of a portfolio of investments in which the money received by the company in connection with such contracts has been deposited. Assets set aside for variable annuity contracts may (unlike most of the basic assets of life insurance companies) be invested wholly or partly in common stocks or other equities, subject to limitations on the amounts to be invested in, or loaned upon, the common stocks or shares of any one institution. The unit value of the variable annuity contract is to be determined semiannually and made known to the annuitant and the Commissioner. In order that this may be done, any common stock purchased for variable annuity contracts must be one listed or admitted to trading in a securities exchange located in the United States or Canada, or publicly held and traded in the "over the counter market" as defined by the Commissioner and for which market quotations have been available. Sale or negotiation of variable annuity contracts, and the contracts themselves, are subject not only to insurance laws but also to the Sale of Securities Act.2 Life insurance companies may not only invest in the stock of variable annuity companies, but in such investments they are not subject to the usual limitation that no life company may hold more than 10 percent of the stock of any one corporation.

§17.20. Insurance companies: Deferred compensation of officers, trustees, or employees. Insurance companies have formerly been forbidden by General Laws, Chapter 175, Section 35, to make any deferred compensation agreements with any of their officers, trustees, or employees extending beyond three years from the date of the agreement. This law has been amended by Acts of 1964, Chapter 81, to allow up to 12½ percent of the annual compensation to be deferred beyond the three-year period, and an even larger percentage may be deferred if the Commissioner of Insurance approves.

2 G.L., c. 110A.
§17.21. Insurance companies: Use of insurance group name. Acts of 1964, Chapter 154, amends General Laws, Chapter 175, Section 18, so as to allow, subject to approval by the Commissioner of Insurance, two or more insurers under a common management, representing themselves as an insurance company group or similar insurance trade designation, to head their policies or contracts with either the group name or trade designation or with the names of the individual members of the group. However, the company assuming the insurance must be specifically identified.

§17.22. Nonlapsation for failure to pay premiums during strike of collection agents. Acts of 1963, Chapter 796, provides that no life insurance policy, noncancellable disability insurance contract, hospital expense or hospital and surgical expense contract "now or hereafter in force in the commonwealth, premiums for which are normally collected by insurance agents employed by the insurer" shall terminate or lapse by reason of default in payment of any premium, installment, or interest on any policy loan payable to the insurer during the period its agents are on strike. The statute gives the premium payer a grace period of thirty-one days immediately following the "authorized" termination of the strike in which to pay the premium, installment, or loan interest, during which time the policy or contract is to continue in full force and effect. Provision is made, in the event a claim arises during a strike or grace period, for deduction of the overdue premium or installment and interest thereon, and of the amount of any policy loan and interest, from the amount payable under the policy.¹

§17.23. Tax lien: Interests in endowment policies. In United States v. Brody,¹ discussed in the 1963 Annual Survey,² the Federal District Court for Massachusetts decreed the foreclosure of a tax lien on the taxpayer's interest in two endowment policies, despite the facts that the policies had not been formally surrendered and were not physically within the court's jurisdiction and that the taxpayer neither had been personally served nor had appeared in the foreclosure suit. Upon appeal by the insurer, this action has been upheld by the Court of Appeals for the First Circuit in Equitable Life Assurance Society of U.S. v. United States.³ The carefully considered opinion by Judge Aldrich expresses disagreement, however, with some of the reasoning of the district court.

The defaulting taxpayer was the endowment beneficiary under each policy, and the government had been designated as the revocable beneficiary of the death benefits payable if the taxpayer died before the policies matured. At maturity the endowment sum was to become

¹The statute has been attacked before the Supreme Judicial Court as unconstitutional in its application to companies. A decision is expected during the 1965 Survey year.

³231 F.2d 29 (1st Cir. 1964).
payable upon surrender of the policies. The policies also provided that before maturity the taxpayer could surrender them for cash or borrow against them up to their respective loan values. One of the policies had matured before the government filed notice of lien.\(^4\) The other had been fully paid up in advance but had not yet matured at the time action was commenced\(^5\) to enforce the lien. The action was brought in the District of Massachusetts, although it was not claimed that the taxpayer (who had absconded) was then domiciled here. Equitable, a New York corporation, was doing business in Massachusetts. Service on the taxpayer was made only by publication.\(^6\)

The insurer pressed on appeal the contention that the taxpayer, an indispensable party,\(^7\) had been ineffectively served by publication, and that in his absence it was not liable upon the policies unless they were physically surrendered. The district court had rejected the contention that physical surrender of the policies was a condition precedent to the insurer's liability, saying that first\(^8\) and third\(^9\) circuit cases so holding had been "discredited" sub silentio by the United States Supreme Court in United States v. Bess.\(^10\) The court of appeals agreed that such surrender is not necessary here, but defended the Massachusetts Mutual and Penn Mutual decisions.

The Massachusetts Mutual case was not brought to reach property of the insured, but rather to enforce a penalty against the insurer for its failure to honor the government's demand that property of the insured in its possession be paid over to the government. Consequently neither the insured nor his beneficiary appeared before the court in that case. Since the policy in that case was unmatured, it might have had a real value to the insured or his beneficiary far greater than its cash surrender value, which is actually its minimum

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4 Under Int. Rev. Code of 1954, §6321, which provides for such a lien "upon all property and rights to property, whether real or personal, belonging to" the delinquent taxpayer.
5 Under Int. Rev. Code of 1954, §7403: "(a) In any case where there has been a refusal or neglect to pay any tax . . . a civil action [may be filed] . . . to enforce the lien of the United States under this title with respect to such tax . . . or to subject any property, of whatever nature, of the delinquent, or in which he has any right, title or interest, to the payment of such tax or liability."
   "(b) All persons . . . claiming any interest in the property involved in such action shall be made parties thereto."
6 Pursuant to 28 U.S.C. §1655 (1958), which provides: "In an action in a district court to enforce any lien upon . . . real or personal property within the district, where any defendant cannot be served within the State . . . the court may order the absent defendant to appear or plead. . . ."
   "Such order shall be served on the absent defendant personally if practicable. . . . Where personal service is not practicable, the order shall be published. . . ."
   "Any defendant not so personally notified may, at any time within one year after final judgment, enter his appearance, and thereupon the court shall set aside the judgment and permit such defendant to plead. . . ."
7 See Section 7403(b), quoted in note 5 supra.
8 United States v. Massachusetts Mutual Life Ins. Co., 127 F.2d 880 (1st Cir. 1942).
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worth. This would have been the case if the death of the insured (at which time the full face value would have been payable) had been imminent while the cash surrender value was low. Therefore, the right to convert the insurer's primary obligation, payment of the face amount to the beneficiary upon the insured's death, into an obligation to pay a lesser cash value to the insured upon surrender of the policy, was a right of substance. In some circumstances a court might order the insured to exercise this right, but, as has been stated, he was not before the court in Massachusetts Mutual to be subject to such an order, nor was his beneficiary present so as to be bound by any decision cutting off such rights as she had. The insurer, after paying the government a penalty measured by the value of the policy, might later have been obliged to pay the actual proceeds of the policy to the insured or his beneficiary.

The court in Equitable stated that the fully matured policy was absolutely owing, except for whatever effect should be given to the surrender requirement, and held that the special circumstances of the Massachusetts Mutual case did not apply here. Physical surrender of the policy, said the court, was a mere housekeeping matter that would enable the insurer to tidy up its affairs but the lack of which could not by itself prevent the government from reaching the proceeds of the policy. The court analogized the situation to the requirement of presentation of a bankbook in order to obtain funds on deposit. It distinguished it from Massachusetts Mutual, where physical surrender of the unmatured policy would symbolize an election by the insured to terminate the insurer's obligation to pay the beneficiary the death benefit when due, and to accept in lieu of this the substantially different performance of payment of the cash surrender value to the insured.

Having thus decided with respect to the matured policy that its physical surrender was not an essential prerequisite to invoking the obligation to pay the endowment proceeds, the court proceeded to the question of whether the government could reach those proceeds. It held that the obligation was sufficient to support a tax lien under Section 6321 and an action to enforce it under Section 7403 of the Internal Revenue Code of 1954 and decided that any chose of sufficient vitality to support a lien cognizable under Section 7403 must equally qualify as property under Section 1655 of Title 28, even though the principal use of the latter section has been in connection with liens upon tangible property. The "property," i.e., the insurer's obligation, was apparently considered "within the district," since personal jurisdiction over the insurer had been obtained here (as it probably could have been obtained in any district of the United States) and in compliance with Section 1655, notice had been given sufficient to meet the requirements of due process of law.

The court went on to discuss the unmatured policy in suit and held that with respect to that policy also the government had a lien

that was enforceable in this action. *Massachusetts Mutual*, it said, held only that the insurer there was not “in possession” of property or rights to property of the insured so as to be subject to a penalty for failure to pay it over to the government. That is, no exercise of the right to terminate the insurer's primary obligation by requesting cash surrender value had been made by, or binding, the insured so as to reduce the insurer's obligation to a simple debt, like a bank deposit “in possession.” But *Massachusetts Mutual* did not hold that the government did not have a lien against the policy contract; rather it assumed that it did have such a lien. Likewise, said the court, there was a lien against the unmatured policy in this case. Moreover, it stated, the government this time had proceeded properly to enforce its lien, joining the insured, who was thus afforded the opportunity to protect his interests in the policy while the insurer was protected against double liability.12

Finally the court adverted to the problems which might arise when the publication provisions of Section 1655 of Title 28 of the United States Code are applied to insurance policies. That section18 allows a defendant who is not personally notified of an action with respect to property in which he claims an interest to have the judgment set aside within one year and to plead. In the case of foreclosure of a lien on a simple debt, the problem posed by this provision is not acute. Money has changed hands and is presumably retrievable. But if the judgment of the court was that a policy be surrendered for its cash value, possibilities of more serious inequities arise. If the judgment is vacated is the policy to be revived? In justice to the insured, perhaps it should be. On the other hand, such revival of surrendered policies would leave insurers, through no fault on their part, open to elections to revive policies made because, since the time of the original judgment, the insured had suffered a loss exceeding the surrender value of the policy. That is, insurers may be subjected to increased claims because of an opportunity given to policy owners to make elections based upon hindsight. The court in *Equitable* suggested that the problem can be avoided if original judgments do not decree outright surrender of policies but rather the taking of loans thereon to the full extent of the policy value, save enough to pay interest (and thus keep the policies in force) for a year after judgment.

12 The court apparently considered that obtaining quasi in rem jurisdiction over the unmatured policy obligations, with notice to the insured, was sufficient joining of the insured to enable the policy chose to be dealt with as though there were in personam jurisdiction over the insured making him amenable to judicial orders that he apply for cash or loan values. The unmatured policy obligations are fluid and indefinite, in that by the policy's terms the insured can elect among alternative performances and no particular sum can be said to be due until he either does so or dies without having done so, or the policy matures. Nevertheless, the court considered that they were sufficiently “property” to support a lien and to give quasi in rem jurisdiction so as to bind the insured by the court's order electing among the various potential obligations of the insurer.

18 Section 1655, note 6 *supra.*