Chapter 8: Insurance Law

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CHAPTER 8

Insurance Law

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A. COURT DECISIONS

§8.1. Application of causation principles to "exclusion" cases. In Standard Electric Supply Co. v. Norfolk & Dedham Mutual Fire Insurance Co. the Massachusetts Appeals Court enunciated a rule of causation for application to situations where an insured's loss is partially a result of a peril which is excluded from coverage by the insurance policy. The insured plaintiff in Standard Electric had personal property stored in a basement where it was damaged as a result of water seepage. The water was first discharged by the bursting of a pipe in a neighbor's cellar which was approximately eight feet away from and three feet higher than plaintiff's basement. The water reached plaintiff's property by seepage from the neighbor's cellar through the foundation and/or walls of plaintiff's building.

The plaintiff's property was insured "against all risks of physical loss" with certain specified exclusions. Among the defendant's policy exclusions was a typical water damage exclusion which provided in pertinent part: "This policy does not insure against loss caused by, resulting from, contributed to or aggravated by . . . water below the surface of the ground including that which . . . flows, seeps or leaks through . . . foundations, walls, basement or other floors . . . ." Water damage as such was not totally excluded, however, since the policy did provide specific coverage for "leakage or accidental discharge from automatic sprinkler systems."

The insurance company denied coverage, contending that the exclusion applied regardless of the original source of the water. The

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2 Id. at 123-24, 307 N.E.2d at 12.
3 Id. at 124, 307 N.E.2d at 12.
4 Id. at 124 n.1, 307 N.E.2d at 12 n.1.
5 Id. at 126 n.4, 307 N.E.2d at 13 n.4. While this inclusion of coverage for certain types of water damage has no apparent connection with the decision in this case, the court saw fit to note the fact in its opinion.
plaintiff argued that the exclusion was inapplicable because the ultimate cause of the damage to his property was the bursting of the neighbor's pipe. The Appeals Court, reversing the court below, agreed with the plaintiff.⁶

The general rule in analysis of "all risk" coverage is that recovery will "be allowed for all fortuitous loss . . . unless the policy contains a specific provision expressly excluding the loss from coverage."⁷ Applied literally, the water damage exclusion would seem to bar recovery here. The Appeals Court, however, noted "that a distinction should be drawn between an excluded event which is a cause and such an event which is the inevitable result of another event . . . ."⁸ One of the myths of insurance law has been that there are basic distinctions between the legal causation principles applied in tort law and those applied in insurance and other contract cases.⁹ As one commentator has concluded:

"The analogy between insurance and tort cases on issues of proximate cause is quite close. Where differences appear, they are more accurately explained . . . not as manifestations of a general tendency of insurance cases in contrast with tort cases but rather as consequences of enforcing one kind of contractual provision in contrast with another."¹⁰

*Standard Electric* presented the case of an excluded peril that is the result of an otherwise covered event. The court quite clearly applied tort causation principles to avoid giving effect to the exclusion. Customary principles of causation would reach back at least to the bursting of the pipe in a search for a legally liable actor. Thus, it would appear consistent to regard the water damage as a mere step in a longer chain of causation. This is precisely what the Appeals Court did when it recognized that the water damage was both a cause and "an event which is the inevitable result of another event . . . ."—the bursting of the pipe.¹¹

While *Standard Electric* does not break new ground,¹² it is a clarifying decision that offers considerable aid in ascertaining the legal effect that should be given to insurance policy exclusion clauses. Moreover, the causation principle applied by the court is sound both in law and

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⁶ Id. at 124, 307 N.E.2d at 12.
¹⁰ Id. at 318-19.
logic. As was long ago stated: "The cause of a cause is the cause of the effect."\textsuperscript{13} Application of this principle to the many disputes that arise out of the application of exclusion clauses in insurance policies will likely provide a practical and just means by which to resolve such disputes.

\textbf{§8.2. Subrogation: Other first party coverages.} In \textit{Morin v. Massachusetts Blue Cross, Inc.}\textsuperscript{1} the Supreme Judicial Court denied subrogation recovery by Massachusetts Blue Cross, Inc. and Massachusetts Blue Shield, Inc. against the proceeds of an automobile medical payments policy due a Blue Cross-Blue Shield subscriber. Plaintiff in \textit{Morin} was injured while riding as a guest passenger in a car insured under a standard "Massachusetts Combination Motor Vehicle Policy" containing the usual form of "Automobile Medical Payments" coverage to a limit of $2,000 per injured person. Plaintiff was also covered under a group insurance policy issued by the defendants, Blue Cross and Blue Shield. The latter policy contained the following subrogation provision:

"To the extent that benefits for services, supplies, or both are provided hereunder, Blue Cross and Blue Shield shall be subrogated and succeed to any right of recovery of the Member or Subscriber because of such services or supplies against any person or organization, except insurers on policies of health insurance covering the Member or Subscriber. The Member and the Subscriber shall pay over to Blue Cross and Blue Shield all amounts recovered by suit, settlement, or otherwise from any third person or his insurer to the extent of the benefits provided hereunder. . . ."\textsuperscript{2}

After paying approximately $3,500 in hospital and medical charges for plaintiff, Blue Cross and Blue Shield claimed $2,000 from the medical payment coverage provided by the automobile insurer on the strength of the above subrogation provision. The auto insurer drew its check payable jointly to plaintiff and Blue Cross-Blue Shield. Plaintiff then instituted suit for a determination of rights to the proceeds. A superior court finding in favor of Blue Cross-Blue Shield was reversed by the Supreme Judicial Court.\textsuperscript{3}

Dispositive of the Blue Cross-Blue Shield claim that the exception to its right of recovery against "insurers on policies of health insurance" did not apply to "medical payments" coverage was the Court's finding:

The words "medical payments" readily call up the idea of


\textsuperscript{2} Id. at 859, 311 N.E.2d at 915 (emphasis added), quoting group master medical policy.

\textsuperscript{3} Id. at 857-58, 869, 311 N.E.2d at 914-15, 921.
"health." An intelligent reader looking at the subrogation provision and asked whether he thought it applied to medical payments in the combination policy could be expected to wonder why the reason behind the exception for health insurance . . . would not embrace the medical payments coverage as well.4

In reaching that conclusion, the Court described the Combination Motor Vehicle policy as a "loose-knit combination" of policies, "one of which relates to medical payments."5 It then refused to find substance in the Blue Cross-Blue Shield argument that there was a meaningful distinction between "health" and "accident" insurance which would justify treating the medical payments policy as something other than "health insurance." In support of this finding the Court pointed to various statutory provisions, judicial decisions and leading texts where the terms "health insurance" and "accident insurance" are used in varied and inconsistent ways.6

The Court rejected the further contention of Blue Cross-Blue Shield that the obligation to pay over amounts recovered "from any third person or his insurer" provided a separate ground for recovery by the defendants, by noting that the plaintiff was not a third party, but rather was a recipient of a direct obligation from the medical payments insurer.7

The issue raised by the Morin case—whether any subrogation or "pay over" provision can extend to direct benefits due to an insured from other policies—is likely to become increasingly controversial in view of the growing acceptance of "no-fault" auto insurance plans, which are essentially enriched medical payments plans.8 In the instant case the Court recognized the issue and suggested that recovery by one insurer of proceeds due to an insured from a second insurer raised serious questions.9 While it seems unlikely that health insurers will succeed in attempts to use either a subrogation provision or a "pay over" clause to recover from no-fault insurers, it should be observed that such problems have been overcome in the health insurance field by the utilization of coordination of benefits provisions. The major difficulty that would be presented by a policy provision excusing payment in whole or in part by a health insurer where a no-fault auto benefit was available might be a delay in the delivery of benefits. In addition, it is not clear under present law that the public

4 Id. at 865, 311 N.E.2d at 919.
5 Id. at 863, 311 N.E.2d at 917.
6 Id. at 863-65 & n.9, 311 N.E.2d at 917-18 & n.9.
7 Id. at 866-67, 311 N.E.2d at 919-20.
9 1974 Mass. Adv. Sh. at 868, 311 N.E.2d at 920-21. The Court added: "[A] court . . . would have to hold that one party providing first party insurance benefits would be able to recover from another party who stands in the same shoes, without any reasonable distinction present to justify the apparent arbitrary result." Id. at 868 n.15, 311 N.E.2d at 920 n.15, quoting Capwell & Greenwald, Legal and Practical Problems Arising From Subrogation Clauses in Health and Accident Policies, 54 Marq. L. Rev. 255, 276 (1971).
could be assured that the resulting savings would be reflected in lower premium costs since the rates charged for health insurance are generally not as closely regulated as those for auto insurance.¹⁰

It is submitted that these difficulties could be substantially diminished by excusing the auto insurer from payment where health insurance is available. An effort to effectuate such a reform in Massachusetts was made by the Commissioner of Insurance in legislative recommendations in 1973 and 1974.¹¹ While those proposals have thus far not received legislative support, it seems likely that the enactment of a federal health insurance plan would raise the issue. The Morin case, in that context, can stand as an example of the need to draw appropriate provisions coordinating the obligations of the various insurers providing coverage to the policy holder.

§8.3. Rate regulation. A potentially significant gap in the effective regulation of workmen's compensation as well as fire and casualty rates was closed in the 1974 Survey year by the Supreme Judicial Court's affirmation of a disapproval by the Commissioner of Insurance of a workmen's compensation rate increase. Liberty Mutual Insurance Co. v. Commissioner of Insurance¹ was a challenge by all insurers writing workmen's compensation insurance in Massachusetts to a 1973 decision of the Commissioner disapproving a requested rate increase that had been filed by the insurers.² At issue was the authority of the Commissioner to disapprove a set of rates on the ground that "the allowance for expenses . . . will be excessive for participating stock carriers and mutual carriers."³ The Supreme Judicial Court affirmed the decision of the Commissioner on the narrow ground that he had discretion to so act under the circumstances and that "[o]n such matters [the Court is] not authorized to substitute [its] judgment for that of the Commissioner."⁴

The significance of the Court's decision and the regulatory action by the Commissioner that provoked the insurers' challenge is the flexibility introduced into the rate approval process for workmen's compensation rates and other forms of insurance rates subject to disapproval under the provisions of the fire rate regulatory law⁵ and the casualty rate law.⁶ Liberty Mutual raised for judicial interpretation the requirement that the rate maker and the regulator give "due consid-

¹ The Massachusetts statutes are typical. Auto insurance rates are extensively regulated. E.g., G.L. c. 175, § 113B. Health insurance rates are not as closely regulated and, indeed, there is no regulatory control over group rates at all. See G.L. c. 175, §§ 108, 110.

² The filing was made pursuant to G.L. c. 152, § 52.

³ 1974 Mass. Adv. Sh. at 1205-06, 313 N.E.2d at 898. "Participating stock carriers" are investor owned, stock insurance companies that pay dividends to policyholders.

⁴ Id. at 1214-15, 313 N.E.2d at 903.

⁵ G.L. c. 174A.

⁶ G.L. c. 175A.
eration . . . to dividends." Historically, the insurers had been allowed to use a set of "manual rates" that were based upon the demonstrated expense needs of insurance companies not paying policyholder dividends. Actuarial data disclosed in the Liberty Mutual case showed that these expense needs were far greater than those needed to meet the operating expenses of insurers paying dividends, primarily because the dividend paying insurers paid lower commissions to sales personnel. The Court noted the Commissioner's finding that as a result of the historic practice, due consideration to dividends merely provided the dividend paying companies with "an allowance . . . for fictitious expenses." While the Court found the historic method permissible, it upheld the Commissioner's departure from the practice as a proper exercise of discretion.

Thus, from the Court's decision in Liberty Mutual it would appear that some form of direct consideration of dividends is required that would presumably mandate some allowance beyond that for losses and expenses. The case, therefore, can be read as a partial victory for each side. It seems to guarantee to the insurers a consideration of dividends in rate making while at the same time affirming the authority of the Commissioner to regulate rates in accordance with demonstrated needs. It is in this latter sense that the decision closes a potentially significant gap in the regulator's authority.

Each of the major rating laws of Massachusetts contains a requirement that due consideration be given to dividends to policyholders. The Subcommittee of the National Association of Insurance Commissioners, which drafted and recommended the model rating law upon which the present provisions are based, recognized that a gap in regulation was left as a result of their approach to the dividend problem. The Subcommittee commented:

In the preparation of this Act [the model rate law] the subcommittee was aware of the fact that if an insurance law, as distinguished from a rating law, did not contain a provision empowering the commissioner to regulate dividends, there was, in effect, a gap in the chain of regulation governing rates . . . .

Neither the Massachusetts legislature nor those of most other states

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7 G.L. c. 152, § 52C(f)(1).
9 Id. at 1208, 313 N.E.2d at 899. Commission and brokerage expenses, as a percentage of net premiums earned in 1971, varied as follows: non-participating stock companies, 9.5%; participating stock companies, 5.2%; mutual companies, 1.8%. Id.
10 Id. at 1215, 313 N.E.2d at 903.
11 Id. at 1213-15, 313 N.E.2d at 902-03.
took steps to fill the gap. Consequently, total control over dividends has been vested in the management of insurers. Thus, as long as the administration of rating laws amounts to mere approval of rates high enough to meet the loss and expense needs of the higher cost insurers, those companies with lower expense needs are free to retain or distribute excess earnings without regulation. A requirement that each insurer demonstrate its own expense needs, supplemented by direct consideration of dividends, would offer the public far more assurance that the rates being charged are proper. The significance of *Liberty Mutual* is that it arms the regulator with the necessary authority to bring about that result.

**§8.4. Blue Cross coverage: Hospital contracts.** In *Commonwealth v. Mercy Hospital* the Supreme Judicial Court was called upon to interpret a recent statutory provision regulating the relationship between nonprofit hospital service corporations and hospitals in the Commonwealth following the expiration of the contract previously defining that relationship. The statute was enacted by the legislature when it appeared likely that Massachusetts Blue Cross, Inc., a nonprofit hospital service corporation, and at least some Massachusetts hospitals would fail to reach a new agreement defining payments to be made on behalf of Blue Cross subscribers. Prior to the legislative action, any hospital not under contract with Blue Cross would have been a non-participating hospital and, accordingly, Blue Cross would have been authorized to reimburse such hospitals for services rendered its subscribers only if the services were related to accident, emergency illness or quarantinable disease. Chapter 703 of the Acts of 1972 removed this limitation on Blue Cross' payments by providing that Blue Cross could either reimburse its subscriber directly or, upon a subscriber's written direction, make payment on his behalf to a non-participating hospital for services relating to accident, illness or maternity. The obvious intent of the legislation was to avoid a crisis upon the anticipated failure of Blue Cross and Massachusetts hospitals.

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15 The expense needs of an individual insurer may of course vary significantly from those of all other insurers of a particular type (stock, mutual, etc.). A proper rating system should recognize these variations as well as those by type of insurer.
16 This is the presumed goal of making rates subject to approval of a state authority.
to agree on a new contract.

The *Mercy Hospital* case was instituted by the Massachusetts Attorney General who petitioned, on the behalf of the Commonwealth’s citizenry, for a judicial construction of chapter 703. Specifically, the Court was asked to determine whether the statute imposed any obligations upon hospitals; the amount of reimbursement that Blue Cross was required to make to the hospitals if so directed by subscribers; and the limits, if any, the statute put upon the hospitals' right to collect additional amounts from Blue Cross subscribers after accepting payments from Blue Cross.6

Blue Cross intervened in the suit and contended that the statute required hospitals to accept payments made by Blue Cross as payments in full as if a contract existed. The hospitals countered by suggesting that the statute did not mandate acceptance of Blue Cross payments and, moreover, if the reimbursements were accepted, they were to be based on the increased charges current at the time that the services were rendered to a particular subscriber. The Court rejected both of these arguments.7 Had either been accepted, the statute’s presumed role in encouraging negotiations leading to a new contract would have been seriously undermined. The Blue Cross position would have provided its proponent with all the benefits of the expired contract. The hospital's argument, in turn, would have stripped Blue Cross of the benefit it receives from the agreed reimbursement formula in the customary contract.8 The Court concluded that the statute placed no obligations upon the hospitals but, if they chose to accept payment from Blue Cross, the rates of reimbursement were to be based on the terms of the expired contract.9

The final question was whether a hospital accepting Blue Cross payments had the right to recover additional amounts directly from the Blue Cross subscriber on whose behalf the payment had been made.10 The Court noted that chapter 703 required that the “reimbursements and payment . . . shall conform with such . . . guarantee of benefits as shall have been in effect pursuant to section five of this chapter [176A] immediately prior to the expiration of the then most commonwealth in the event of accident, illness or maternity or, upon the written direction of the subscriber, from making payment to said hospital for such services; provided, however, that the amount of such reimbursement and payment to any such hospital within the commonwealth shall conform with such method of payment and guarantee of benefits as shall have been in effect pursuant to section five of this chapter immediately prior to the expiration of the then most recent contract between said hospital and said corporation and shall be based upon the charges of the hospital in effect on such date.

7 Id. at 45-47, 306 N.E.2d at 437-38.
8 See id. at 47 n.2, 306 N.E.2d at 438 n.2.
9 Id. at 46-47, 306 N.E.2d at 438.
10 Id. at 47, 306 N.E.2d at 438.
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recent contract."\(^{11}\) As the "guarantee of benefits" in section 5 refers to the hospitals' obligation to provide services, the Court was faced with the dilemma of determining how a payment to a hospital can conform with a hospital's contractual duty to provide services.\(^{12}\) Accepting the judicial task of construing "the statute in such a way as to make it an effective piece of legislation,"\(^{13}\) the Court construed chapter 703 as requiring the hospital to provide the services specified in the Blue Cross contract without additional charge to the subscriber.\(^{14}\) To rule otherwise, the Court reasoned, would render the statutory "guarantee of benefits . . . a nullity since it would give the subscriber little more than he had without it."\(^{15}\)

Thus, the Court in *Mercy Hospital* succeeded in fulfilling the legislative intent of removing the statutory limitations\(^{16}\) which would have become effective upon the expiration of the contract between Blue Cross and the Massachusetts hospitals while, at the same time, preserving the concept of voluntary relations inherent in chapter 176A.\(^{17}\)

**§8.5. No-fault insurance.** In *Chipman v. Massachusetts Bay Transportation Authority*\(^1\) the Supreme Judicial Court narrowed the restriction on recovery of damages for pain and suffering prescribed in the Commonwealth's no-fault insurance law.\(^2\) Specifically, the Court held that where a plaintiff has no recourse to personal injury protection, the statute does not bar suit for damages for pain and suffering if the defendant is exempted from the no-fault scheme.\(^3\)

The case is also of interest from an insurance viewpoint because the Court raised in a footnote the possibility that a public carrier has a contractual duty to its passengers to provide safe carriage. Expressly left unresolved was the question of the constitutional impact of the no-fault law upon an action for breach of this contractual duty seeking damages for pain and suffering.\(^4\) It would appear the Court was inviting this issue for judicial scrutiny.

\(^{11}\) Id. at 47-48, 306 N.E.2d at 439, quoting Acts of 1972, c. 703. See note 5 supra.

\(^{12}\) 1974 Mass. Adv. Sh. at 48-49, 306 N.E.2d at 439. G.L. c. 176A, § 5 provides in part that "[e]very contract made by such corporation [Blue Cross] with a participating hospital . . . shall contain a provision whereby such hospital . . . guarantees to subscribers . . . the benefits of the subscriber's certificate in effect at the time such services are provided notwithstanding the ability of such corporation [Blue Cross] to pay therefor."

\(^{13}\) Id. at 49, 306 N.E.2d at 439.

\(^{14}\) Id. at 49-50, 306 N.E.2d at 439-40.

\(^{15}\) Id. at 49, 306 N.E.2d at 440.

\(^{16}\) See text at notes 4-5 supra.

\(^{17}\) 1974 Mass. Adv. Sh. at 50, 306 N.E.2d at 440. The Court's resolution of the ambiguity concerning G.L. c. 176A, § 5 should not conceal the judicial concern with broadly drafted legislation, which often is accorded a significance different from that envisioned by legislative draftsmen.
§8.6. Underwriting. Increased attention has been given by the Massachusetts legislature during the past several years to the difficulties that certain groups of persons have in obtaining insurance.¹ During the 1974 Survey year, four major pieces of legislation altering the underwriting freedom of insurers were passed.² The Acts reveal that the General Court has adopted two different approaches to the perceived problems. One approach is to mandate that every insurance policy contain certain prescribed benefits, whereas the other is to prohibit an insurer from refusing coverage on specified grounds.

In the area of mandated benefits, chapter 1174 of the Acts of 1973 requires fairly extensive benefits for the treatment of “mental and nervous conditions.”³ A second piece of legislation mandates automatic coverage for new-born children under health insurance contracts covering persons domiciled in the Commonwealth.⁴

In regard to prohibitions, newly enacted chapter 374 of the Acts of 1974 proscribes refusal of individual life insurance or membership in certain fraternal benefit societies “for the sole reason of blindness.”⁵ Chapter 668 of the Acts of 1974 prohibits refusal or limitation of accident, sickness, disability, life or endowment coverages “solely because of the sex of the insured.”⁶

Certainly the social goals advanced by this legislation are desirable. A careful examination of the Acts also discloses that the legislature has exercised considerable discretion in selecting the benefits that will be mandated, the policies in which they must be contained, and the persons to whom they will apply. It appears less certain, however, whether any real appreciation of the additional costs imposed upon the insuring public preceded legislative action. This concern was highlighted by a late 1974 request by Massachusetts Blue Cross for a rate increase to cover the mental illness costs. The Blue Cross request was accompanied by a public statement designed to make it clear that the legislature in mandating new benefits had also mandated increased costs.⁷ While the trend toward legislative interference with the freedom of insurers to exclude certain benefits seems clear, it is not apparent whether future legislative activity will be as discriminating in its targets as the activity to date.

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§8.7. **Rating laws.** Chapter 53 of the Acts of 1974 makes a fundamental change in the fire and casualty rating laws by requiring rate filings to be made at least fifteen days prior to the intended effective date and allowing the Commissioner of Insurance to extend the time an additional thirty days.¹