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Extension 203

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Re: Recent Developments in Massachusetts Insurance Law, Second Quarter of 2011

The following will summarize the Massachusetts decisions which impact the insurance industry for the second quarter of 2011. If you would like to receive a copy of this newsletter via email, please send your email address to phowe@lecomtelaw.com.

AGENT

***The insurance agency was fined $100 for every sale by an unlicensed broker. The discovery rule applied to the four year statute of limitations.**

The broker had been licensed but had not renewed his license in 1997. He continued to sell insurance until 2001. This violated M.G.L. c. 175, Section 177. The Court ruled that the discovery rule and the four year statute of limitations applied under M.G.L. c. 260, Section 5A. The discovery rule tolls a mandated statute of limitations period until the cause of action is discovered or reasonably should have been discovered. *Friedman v. Jablonski,* 371 Mass. 482, 484-485 (1976) and *Hendrickson v. Sears,* 365 Mass. 83, 91 (1974).

The Court ruled that Section 5A permits the application of the discovery rule to an enforcement action brought by the Division of Insurance under c. 175, Section 177. M.G.L. c. 260, Section 5 imposes a two year statute but Section 5A imposes a four year statute of limitations.

Anawan Insurance Agency v. Division of Insurance, 459 Mass. 592 (April 29, 2011).

ANNUITY

***In order to be protected from creditors by the exemption under M.G.L. c. 175, Section 119A, the subject annuity must conform exactly to the language of the exemption in the statute.**

Section 119A protects a beneficiary's interest from his or her creditors only where the terms of the policy expressly prohibit the beneficiary from "commut[ing], anticipating[ing], encumber[ing], alienat[ing] or assign[ing] that interest in the Policy. *In re Sloss,* 279 B.R. 6, 13 (Bankr. D. Mass. 2002). If any one of these enumerated characteristics is not expressly contained in the annuity, it would not be exempt under Section 119A. The subject annuity contained one of the enumerated provisions, but not all. As such, the Court ruled that the annuity did not qualify for protection under Section 119A.

In re Lecair, Betty et al., 2011 WL 1899194 (U.S.B.C. May 19, 2011.)

AUTOMOBILE

***The insurance company violated both M.G.L., c. 93A, the Consumer Protection Act, and c. 176D, the Unfair Claims Practices Act, by delaying payment of PIP benefits for 11 months after the initial submission of the claim for medical bills.**

The insurance company paid the medical bills six months after the Plaintiff filed her action. The company argued that it had paid the bills prior to the entry of judgment and that the Plaintiff could not show any actual injury or loss as the result of the delay in paying the claim.

The Court rejected this argument ruling:

> "We conclude that, notwithstanding Metropolitan's ultimate payment of the outstanding bills, Chery has shown, for the purpose of surviving summary judgment, an ascertainable loss caused by Metropolitan's dilatory conduct.
>
> *******
>
> General Laws c. 176D, Section 3(9), and G.L. c. 93A 'were enacted to encourage the settlement of insurance claims…and discourage insurers from forcing claimants into unnecessary litigation to obtain relief.' *Clegg v. Butler, 424 Mass. 413, 419 (1997).*"

The Court went on to rule that a plaintiff seeking redress under c. 93A is not required to show a quantifiable amount of actual damages as an element of her claim. Rather a claimant "is required to show only that she suffered some loss caused by the defendant's allegedly unlawful conduct ." Here the claimant met that burden. [Page 2.]

Chery v. Metropolitan Property and Casualty Insurance Company, 79 Mass. App. Ct. 697 (June 16, 2011).

DUTY TO COOPERATE

*** The insurance company may not deny a claim for PIP [personal injury protection] benefits, where the insured has failed to appear for an I.M.E., without a showing of actual prejudice.**

The Insured missed his second scheduled independent medical exam and then the insurance company sent a written notice. Ten days later the insured's counsel telephoned the claims adjuster seeking to re-schedule the I.M.E. The Court ruled, "Because the record reveals that the insurer has not made 'an affirmative showing of actual prejudice resulting from' plaintiff's failure to attend the two previously scheduled IMEs, see *MetLife Auto & Home v. Cunningham* [59 Mass. App. Ct. 583, 590 (2003)] judgment should not have entered for the insurer." [Page 2.]

Cotton v. Hanover Insurance Company, 79 Mass. App. Ct. 1119, 946 N.E.2d 716 (May 18, 2011).

E.R.I.S.A.

***It was unreasonable, arbitrary and capricious for the insurance company and plan administrator to determine disability benefit eligibility comparing pre-disability W-2 income with post-disability W-2 income as well as all other income, including income from the ownership of the business, where this was not clearly set forth in the Plan.**

The Plan which governs the Group LTD Policy provides that employees are eligible for benefits when the employees “are not able to perform some or all of the material and substantive duties of [their] regular occupation” and

"have at least a 20% loss in [their] pre-disability earnings." The Plan defines "earnings" as, "Pre-disability earnings means your monthly rate of earnings from the employer in effect just prior to the date disability begins. Basic annual Earnings shall mean the Insured Person's earnings for the prior calendar year as reported by the Group Policyholder on form W-2, excluding commissions." (Page 6.) There is no further definition of the term "earnings" in the Plan.

Under the Plan, benefits will terminate when the Insured Person has "current earnings [that] exceed 80% of [his or her] pre-disability earnings." (Page 6.)

Following orthopedic surgery, the Insured, a co-owner of the employer physical therapy provider, returned to work. She worked fewer hours and received less salary than she had prior to the surgery. The insurer paid disability benefits for four years based on the decreased salary until it conducted an audit. Based on the audit, the insurer concluded that it had overpaid benefits as it had not properly taken into account the Insured's "business profits" which she had received from the employer and one other business when calculating pre-disability and post-disability monthly earnings. (Page 7.)

The Court ruled that the insurer's above interpretation of the term "earnings" to include "business profits" was unreasonable. The Plan defines, as noted above, the terms "pre-disability earnings" as well as "basic annual Earnings" with reference to the "unaccompanied" term "earnings". The plan defines "pre-disability earnings" as "your monthly rate of earnings from the employer in effect just prior to the date disability begins". It defines "Basic annual Earnings" as "the Insured Person's earnings for the prior calendar year as reported by the Group Policyholder on the form W-2, excluding commissions." (Pages 12-13.)

The Court ruled that the insurer's "interpretation also renders meaningless the only provision in the plan that appears to define 'earnings' in a substantive way. The plan defines 'Basic annual Earnings' with reference to W-2 earnings; elsewhere, the plan is silent as to what counts as earnings." (Page 14.)

D&H THERAPY ASSOCIATES, LLC; ROBIN DOLAN v. BOSTON MUTUAL LIFE INSURANCE COMPANY, 2011 U.S. App. LEXIS 8138 (1ST Cir., April 20, 2011).

FIRE

***Failure of the policyholder, a restaurant owner, to maintain its fire suppression system excluded coverage under the Policy.**

The Policy provided, "As a condition of this insurance, you are required to maintain the protective devices or services listed in the Schedule above…We will not pay for loss or damage caused by or resulting from fire if, prior to the fire, you:

1. Knew of any suspension or impairment in any protective safeguard…and failed to notify us of that fact; or

2. Failed to maintain any protective safeguard listed in the Schedule above, and over which you had control, in complete working order." (Page 2.)

An independent inspection informed the policyholder that, if he did not get the fire suppression system fixed, the restaurant would not be able to renew its liquor, food and health licenses that were scheduled to expire in six

months. The Policy required the policyholder to maintain the fire suppression system and to notify the insurer if the system was suspended or impaired. The policyholder did neither. The Court affirmed a summary judgment for the insurer including the judgment that the policyholder return the $15,000 advance from the insurer.

French King Realty, Inc. v. Interstate Fire and Casualty Company, 79 Mass. App. Ct. 653 (June 9, 2011).

IMMUNITY IN REPORTING TO INSURANCE FRAUD BUREAU

***There is qualified immunity for the insurer in its reporting a claim to the Insurance Fraud Bureau. If the claimant employee proves the insurer acted with malice or bad faith, there is no immunity from liability. In addition, the exclusivity of the workers compensation claims to the jurisdiction of the Department of Industrial Accidents does not apply to claims where the insurer acted in its own self-interest and abused the qualified privilege.**

The insured employee was injured on the job, was unable to work, filed his workers compensation claim and the insurer denied the claim for lack of supporting medical documentation. The employee became homeless while awaiting the adjudication of his claim before the Department of Industrial Accidents. As a condition of his residence at a homeless shelter at the YMCA the employee was required to participate in a training program involving performing janitorial functions. He received a stipend from the City of Boston and from the U.S. government. The training program did not consider the employee to be their employee. The state and federal revenue departments did not consider his stipend to be earnings or wages.

The insurer conducted surveillance and obtained videotape of the employee in his training program performing janitorial services. At a medical examination the employee signed a form that he was not presently working. He later declared he was making no wages. The insurer did not present its investigation to the D.I.A. judge, who ordered the insurer to pay workers compensation to the employee. The insurer then opened a fraud investigation file and reported the case to the Insurance Fraud Bureau, which conducted its own investigation and received additional information from the insurer.

The I.F.B. referred the matter to the Suffolk County District Attorney who charged the employee with workers compensation fraud and larceny. At that time the insurer's counsel contacted the employee's counsel to recover the benefits it had paid. During the same period the employee attempted suicide and began a series of hospitalizations.

The insurer sought in the D.I.A. proceedings to terminate the workers compensation it was paying, to recoup benefits paid and penalties. The insurer also contacted the employee's probation officer, who monitored the employee since he was on probation for an unrelated drug offense. The insurer sought to have the employee's probation surrendered as it would not have to pay benefits if the employee was incarcerated. The probation officer refused and the insurer wrote to the district attorney in an attempt to get him to surrender the probation. Despite his representation by counsel, the employee plead guilty at the criminal proceedings for workers compensation fraud and received a sentence of three years' probation and ordered to make restitution.

On the contrary, a subsequent D.I.A decision was in the employee's favor finding that he was totally disabled, his training activities did not constitute employment and were not evidence that he could have obtained work in the open labor market. Furthermore, the stipend did not constitute

earnings and the employee had no intention of defrauding the insurer. The insurer was ordered to pay back benefits with interest, attorney's fees and medical expenses.

The employee moved for a new trial in the criminal action which the Court granted in view of the D.I.A. decision. The Attorney General then filed a nolle prosequi of the criminal action. The employee then filed the pending action against the insurer.

The Court ruled that the I.F.B. reporting statute, St. 1996, c. 427, Section 13, mandates that insurers promptly report transactions to the I.F.B. where they merely "have[e] reason to believe" that fraud may have occurred. Additionally, the immunity granted by c. 427, Section 13 (i) is designed to further encourage reporting by shielding insurers from civil liability "[i]n the absence of malice or bad faith..." (Page 7.) The Court went on to rule that the insurer does not have a "duty of reasonable investigation" before reporting to the I.F.B. (Page 9.) The Court further ruled that it is the employee's burden to "demonstrate the existence of malice or bad faith" in order to defeat that immunity. (Page 10.)

However, the Court went on to rule, "The fraud reporting statute does not envision that, following a report to the IFB, the insurer will take an active role in pressing any ensuing criminal prosecution. See St. 1996, c. 427, [Section] 13 (e). Indeed, we have concluded, *supra at* (sic), that the statute is designed to keep insurers at a healthy remove from the prosecutorial process so that their financial interest in securing a fraud conviction does not result in overbearing or oppressive conduct. Where an insurer acts outside St. 1996, c. 427, [Section] 13, and inserts itself into the prosecutorial process, it is not acting pursuant to the statute and is not entitled to statutory immunity." (Page 11.) Consequently, there would be no summary judgment for the insurer.

The Court further ruled that the insurer's conduct in pursuing the criminal action was in the nature of a "collection effort". As such, they "fall outside the comprehensive framework of regulation that would justify extending workers' compensation exclusivity to [the employee's] final claim." (Page 14.) Again, the Court denied summary judgment to the insurer.

Maxwell v. AIG Domestic Claims, Inc., 460 Mass. 91, (Mass. June 30, 2011).

COMMENT

While the *Maxwell* decision is in the context of a workers compensation claim, we suggest that the Court would likely make a similar "qualified immunity" ruling on the reporting of other claims, such as individual disability income and property claims, to the Insurance Fraud Bureau.

LEGAL MALPRACTICE

*** The malpractice insurance company did not have to defend or provide coverage for what was essentially a fee dispute.**

The insured attorney left his former law firm and took with him some of their clients. The firm brought an action against him for the fees paid to him by one of those clients. The attorney tendered his defense to his legal malpractice insurer. The Court ruled that there was no coverage. *Reliance National Insurance Company v. Sears, Roebuck & Company,* 58 Mass. App. Ct. 645, 792 N.E.2d 145 (2003) and *Medical Records Associates, Inc. v. American Empire Surplus Lines Insurance Company,* 142 F.3d 612 (1st Cir. 1998). The underlying cause of action was not based on a covered "wrongful

act or omission in the provision of legal services; it was based on a wrongful act or omission in the operation of a business that happened to provide legal services." (Page 9.)

At its core, while the Complaint made allegations of misconduct by the attorney, it sought relief for the alleged violation of a fee sharing agreement. This is part of the billing function of a lawyer. It is not a covered professional service.

Clermont v. Continental Casualty Co. v. Freedman, DeRosa & Rondeau, 2011 WL 1235389 (USDC MA, March 29, 2011

LIFE INSURANCE - CLASS ACTION

***Delivery of a checkbook to draw on the account holding the group life insurance proceeds did not constitute the lump sum payment called for by the policies.**

The motion to dismiss a class action was denied. The Court ruled that, "the difference between the delivery of a check [for a lump sum] and a checkbook… is the difference between [the insurance company] retaining or [the insurance company] divesting possession of Plaintiff's funds. *Mogel v. UNUM Life Ins. Co. of Am.,* 547 F 3d 23, 26 (1st Cir. 2008). (Page 8.) Furthermore, the insurer earned more interest on the funds it held than on those it paid out to the beneficiaries. The Court ruled, "This theory of damage, at this stage, describes a sufficiently cognizable injury to avoid dismissal." (Page 9.)

Lucey et al. v. Prudential Insurance Company of America, 2011 WL 1740311 (USDC MA, May 5, 2011).

Please contact us if you would like copies of any of the above decisions.

Very truly yours,

/S/ Philip M. Howe

Philip M. Howe

PMH