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Extension 203

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

The following will summarize the Massachusetts decisions which impact the insurance industry for the fourth quarter of 2011. If you are not receiving this letter by email and you would like to, please send your email address to phowe@lecomtelaw.com.

ACIIDENTAL DEATH/EXPERT WITNESS

***The fall was not a major cause of death, although it did contribute. As such, the death was not accidental and the insurer's expert testimony in this regard was admissible although it was an elaboration on, and not contained in, his report.**

The Policy covered death if it was "caused by an accident 'directly and independently of all other causes.' " There was no coverage if death was "due to disease, bodily or mental infirmity, or medical treatment of these." There was evidence that the Insured suffered both a skull fracture from the fall and that she had suffered a stroke. [Page 4.]

The plaintiff beneficiary of the Policy presented evidence at trial that the Death Certificate, the testimony of the coroner and the plaintiff's expert neurologist found that the skull fracture was the cause of death.

The insurer's medical expert testified that the skull fracture contributed to the death but "was not a major cause of death". He elaborated that the "skull fracture as described doesn't seem like a mortal wound." [Page 5.] There was an issue as to whether this testimony went outside the scope of the expert's report. The expert conceded that his report did not expressly state that the skull fracture was not a mortal wound or that the stroke was a major as opposed to a contributing cause of death.

The Court ruled that the expert's opinion as expressed in his report was fundamentally that the Insured had suffered a stroke. While the expert's report suggested that the stroke and the skull fracture contributed to the death and never explicitly said that the stroke was the dominant cause of death, the report "clearly focused on the stroke." The Court ruled that it was a "reasonable elaboration of the opinion disclosed in the report, that 'the amount of bleeding described seems out of proportion to that which would be expected on the basis of trauma alone...' " [Page 8.]

The Court affirmed the verdict and judgment for the insurer.

Gay v. Stonebridge Life Insurance Company. 660 F.3d 58 (1st Cir. October 26, 2011).

AUTOMOBILE

***There was no liability coverage for the employee of the rental car company who struck a pedestrian while driving one of the rental cars without permission.**

The Policy provided coverage for liability incurred by the rental car company and anyone "using with [their] permission" an automobile which it owned. [Page 1.] An employee of the rental car company drove one of the car's home one evening in order to do an errand and hit a pedestrian when returning the car in the morning as he drove to work at the company. The employee had signed a document when hired that he was prohibited from using any of the vehicles unless he did so under the direction of a manager. The employee had tried unsuccessfully to get in touch with his manager before taking the car.

But, the employee had been placed in charge of the particular rental car office. He had the authority to make all decisions including decisions about should be permitted to take automobiles and for what purpose. However, in response to a special verdict question, the jury found that the employee was an unauthorized driver of the vehicle at the time of the accident. [Page 2.]

The Court ruled that G.L. c. 231, Section 85C did not apply which would create the presumption that the employee was driving at the time of the accident with the rental company's consent. But, the Policy at issue was an excess policy and not a compulsory policy as defined in G.L. c. 90, Section 34A. As such, Section 85C by its terms did not apply to the excess policy at issue.

United National Insurance Company v. Kohlmeyer, 81 Mass. App. Ct. 32, ____NE 2d. ___(MA App. Ct. December 14, 2011).

DUTY TO DEFEND

***There was no duty to defend the insured who was a participant in bar fight.**

The son of the policyholder under a homeowner's policy struck someone in a bar fight causing serious injuries. He was both prosecuted and the person whom he struck threatened to bring an action for personal injuries. While the prosecution was pending, the attorney for the policyholder's son tried to settle the potential civil action with the attorney for the person who was struck, who also wanted to avoid any participation in criminal proceedings.

The person struck made a settlement demand and as soon as the insurer received the demand it began its investigation responding via email "within minutes". The insurer's claim investigator within the week rejected the settlement demand and also visited the location of the fight. The claim investigator attempted to speak with the witnesses, attorneys, attended a Licensing Board hearing, obtained relevant report and transcripts. Less than three weeks after the initial demand, the insurer issued its reservation of rights letter indicating that it would handle the claim and told the policyholder that the insurer would continue to handle the claim despite some doubt that coverage existed.

The policyholder took the position that it would permit the claim investigator to interview his son and an additional witness only if the

insurer would agree that the interviews were privileged. The parties other than the insurer later agreed to a settlement but only if the insurer would agree to waive the voluntary payment provision in the policy or pay the settlement amount. The insurer refused to agree to any of the above.

The Court ruled that the insurer at no time rejected its responsibility to defend the policyholder's son nor did it fail to pursue the claim investigation. Such investigation was "not only permissible, but required…" [Page 8.] The insurer "acted quickly and diligently to uncover the facts relating to the incident and the value of the claim." [Page 10.] There was no breach of any duty to defend.

Vermont Mutual Insurance Company v. Maguire, 662 F. 3d 51 (1st. Cir. October 31, 2011.)

***The insurer had a duty to defend an action for sexual harassment brought by a former employee who filed in the Mass. Commission Against Discrimination, not in Court.**

The special business owner's Policy had an exclusion for claims for the violation of the rights of another and claims which would inflict "personal and advertising injury." [Page 2.]

The former employee endured a litany of sexual harassments from her supervisor and at some point the company owner knew of them.

The Court ruled that the fact that the former employee filed the action before the Mass. Commission Against Discrimination was irrelevant. The Policy covered a "suit" seeking damages because of "personal and advertising injury". The term "suit" applies to any civil proceedings seeking damages. [Page 4.]

The Court ruled further that the key is whether the allegations by the former employee "are reasonably susceptible of the interpretation that they state or roughly sketch a claim for damages because of injury *arising out of* one or more of the offenses specified as within personal or advertising injury coverage...[that is] oral or written publication, in any manner, of material that slanders or libels a person or publication, in any manner, of material that violates a person's right of privacy…The phrase 'arising out of' must be read expansively and has a broad meaning analogous to 'but for' causation." See *American Home v. First Specialty Insur. Corp.* 73 Mass. App. Ct. 1, 5 (2008) citing *Bagley v. Monticello Insurance Company,* 430 Mass. 454, 457 (1999). [Page 4.]

The action before the M.C.A.D. sought damages for injuries caused by behavior in the nature of slander and invasion of privacy that were part of a campaign of sexual harassment. Furthermore, the Court ruled, "An insurer's obligation to defend is not limited to valid claims; it extends even to claims potentially dismissible for lack of subject matter jurisdiction." [Pages 4-5.]

With respect to the exclusion for the invasion of the right of privacy, the employee notified the owner on three occasions of the harassment and the owner took no action. As a result, the Complaint

may be read as alleging that the owner actually "caused" the injuries at issue by failing to protect the employee from the harassment . [Page 7.] The Court further ruled that these allegations leave it possible for the employer "to be found liable based on something less than intentional and knowing infliction of injury on [the employee]…" As result, there is a duty to defend the owner and the exclusion did not apply. [Page 7.]

Norfolk & Dedham Mutual Fire Insurance Company v. Cleary Consultants, Inc., 81 Mass. App. Ct. 40 (December 16, 2011.)

ERISA LTD CLAIM/SURVEILLANCE

*** The Court remanded the LTD claim to the Plan Administrator for further consideration noting that the surveillance confirmed rather than disputed the disability claim after a detailed review of the evidence under the arbitrary and capricious standard.**

The insured employee was a nurse who became disabled from chronic abdominal pains due to pancreatitis, chronic pain syndrome or fibromyalgia, plus joint pains. She received "impressive amounts of narcotics to manage her pains which caused some negative side effects." [Page 3.] The Plan paid her LTD benefits for five years and then terminated them under an "any occupation" standard of disability.

The termination of LTD benefits was based in part on surveillance which showed the insured driving, walking, jogging, bending over, flying a kite and lifting her three year old child. [Page 3.] The independent medical examiners for the Plan agreed with the diagnoses but disagreed that they prevented the insured from working.

On appeal from the initial termination of benefits, the Plan had two additional independent medical examiners review the claim. They concluded that the insured's physical data did not explain the degree of pain or other symptoms and that she provided insufficient evidence of completely debilitating pain. [Page 4.]

The Court used the "arbitrary and capricious" standard to review the Plan's decision to terminate benefits. [Pages 5-6.]

The Court framed the issue that, while there seemed agreement on the insured's multiple diagnoses, the question was whether they disabled her from the occupations identified by the Plan including telephonic triage nurse, nurse case manager or utilization review nurse. [Page 6.] The insured's symptoms were serious and included pain, nausea, vomiting and diarrhea. She had seen many doctors, pain clinics, been recurrently hospitalized, treated with high doses of narcotics and undergone surgical procedures to relieve pancreatitis. [Page 7.]

The Court remanded the claim for further consideration by the Plan for two reasons. First, and most important, the Plan's physicians "emphasized the inconsistency between [the insured's] self-reported limitations and the surveillance video." The Court ruled that it was not apparent that any such inconsistency exists. [Page 8.] In over 90 hours of surveillance, the" most damning evidence the [Plan] can identify is the 15 minutes during which [the insured] carried a bucket or flower pot and 30 minutes during which [the insured] played with her three-year-old son in the park. On 10 of the 19 days on which surveillance is available, [the insured] engaged in no activity." [Page 8.]

Second, the Court wrote, "Thus most of the surveillance, far from contradicting [the insured's] disability, seems to confirm her lifestyle as generally housebound with occasional, limited activity." [Page 8.]

Maher v. Massachusetts General Hospital Long Term Disability Plan, ___F. 3d ___, 2011 WL 6061347 (1st Cir. December 7, 2011).

ERISA/ LIMITATION OF ACTIONS

*** The one year contractual limitation of actions was equitably tolled due to the Plan's misleading failure to give notice of this limitation.**

Without notice of the Plan's amendment adding a one year limitation of actions, the Insured disability claimant had fifteen years to file his action for disability benefits. The Court cited *Darwood v. Holder,* 561 F.3d 31, 36 (1st Cir. 2009) ruling that equitable tolling is "used to excuse a party's failure to take an action in a timely manner, where such failure was caused by circumstances that are out of his hands." The Court went on to rule that equitable tolling suspends the running of the limitations period if the plaintiff, in the exercise of reasonable diligence, could not have discovered information essential to his claim. [Page 8.]

The Court ruled that the Plan mislead the Insured. It was "required by federal regulation to provide [the Insured] with notice of his right to bring suit under ERISA and the time frame for doing so, when it denied his request for benefits." See 29 C.F.R., Section 2560.503-1(g) (1) (iv). The Plan did not include notice of either the right to sue or the one-year time limitation in its written rejection of the claim. [Page 8.] During the claim process the Insured

had requested a copy of the Plan document which the Plan produced without any limitation of the time within which to file suit. A week later the Plan

amended the document to establish the one year limitation but gave the Insured no notice of this amendment.

Ortega v. Orthobiologics, LLC, 2011 WL 5041744, ___ F.3d ___ (1st Cir. October 25, 2011).

ERISA/RISK OF RELAPSE

*** Risk of relapse into drug addiction was a disabling condition for an anesthesiologist.**

In the first iteration of this case, known as "*Colby I", Colby v. Assurant Employee Benefits, 603 F. Supp. 2d 223 (D. Mass. 2009),* the Court had ruled that it was arbitrary and capricious for the insurer to terminate long term disability benefits as the Policy did not exclude coverage for "the risk of drug abuse relapse." [Page 13.] The insurer also acknowledged that there would be coverage for an employee who was not disabled but for whom returning to her occupation would increase the risk of relapse of a physical ailment. [Page 13-14.] The Policy did not distinguish between mental and physical ailments.

The Court in *Colby 1* ruled that the insurer was precluded from denying the LTD benefits for the sole reason that the employee suffered from a "drug addiction rather than a physical ailment subject to relapse." [Page 14.] The Court remanded the case to the insurer for reconsideration of the claim under the interpretation of the policy consistent with the Court's decision.

The Court in *Colby II* wrote, "Forcing [a claimant] to relapse into drug addiction or lose [her] benefits would… thwart the very purpose for which disability plans exist: to help people overcome medical adversity, if possible, and otherwise to cope with it." [Page 20.] But, after the insurer's reconsideration of the claim it again denied the claim on essentially the same grounds that the risk of relapse into a drug related condition was not a disability. The Court in *Colby II* ruled that the insurer acted arbitrarily and capriciously in continuing to unreasonably interpret the Plan, and in disregarding the order of the Court from *Colby I.* The Court went on to rule that, moreover, the insurer failed to engage in the factual analysis as the Court in *Colby I* had directed, which was to examine whether the employee's risk of relapse was sufficiently high such that she could not perform at least one material duty of her occupation. [Page 23.]

Colby v. Assurant Employee Benefits, 2011 WL 4840682, ___F. Supp. 2d _____, (USDC MA, October 12, 2011).

ERISA/MEDICAL COVERAGE

*** There was no medical coverage for custodial care, which did not meet the criteria for medical necessity, although there was coverage for weaning the patient off the ventilator.**

It was not arbitrary and capricious for Blue Cross, the plan administrator, to deny medical coverage for certain post-heart attack care as custodial, which was not covered, and to pay other medical care which involved weaning the same patient from his ventilator. There was substantial evidence in the administrative record that the patient was comatose, there was no potential for improvement and that the care was not within the definition of medical necessity.

The factors in the Plan which determine medical necessity were whether the treatment was: 1. Required to diagnose or treat an illness; 2. Consistent with the diagnosis and treatment; 3. Essential to improve the net health outcome; 4. Cost effective; 5. Furnished in the least intensive care type of setting. [Pages 3-4.]

The weaning from the ventilator was medically necessary as it involved the presence of skilled nursing care.

Bonano v. Blue Cross and Blue Shield of Massachusetts, 2011 WL 4899902, ___F.Supp. 2d ___ (USDC MA October 14, 2011).

HOMEOWNERS

***There was no coverage under the primary Policy for the negligent death at the hands of the policyholder as there was an exclusion for damages which were reasonably foreseeable.**

The policyholder was attacked by two persons, fought back including use of a knife he was carrying, escaped, fled, reported the incident to the Police and one of his attackers later died from knife wounds. The policyholder was prosecuted and after a lengthy proceeding, took a plea in exchange for time served. As part of that proceeding, the policyholder admitted that he stabbed the attacker, created a high degree of likelihood that the substantial harm would result, and that the attacker died as a direct and proximate result of the stabbing.

In a wrongful death action brought by the family of the deceased, the Court found that the policyholder negligently caused the death, that the deceased was equally at fault and awarded $260,000.

The two Policies at issue covered an "occurrence" defined as bodily or property due to an "accident". The primary Policy excluded damages "caused intentionally by or at the direction of an insured; or resulted from any occurrence caused by an intentional act of any insured where the results are reasonably foreseeable." [Page 10.]

The umbrella Policy provided that coverage shall not extend to damages that are "either expected or intended from the standpoint of the insured." [Page 10.]

The Court ruled that the state court conclusion in the criminal action that the policyholder negligently caused the death was binding in this action. As a result, there is no coverage under the primary Policy as the "reasonably foreseeable" exclusion applied. [Page 12.] However, the death was not "expected or intended", which operated almost identical to an intentional act exclusion. As a result, there was coverage under the umbrella policy. [Page 14.]

Fire Insurance Exchange et al. v. Pring-Wilson, 2011 WL 6396518, ___ F. Supp. 2d___ (USDC MA, December 21, 2011.)

*** The motor vehicle exclusion in the homeowner's policy applied to exclude coverage for injuries from the motor vehicle accident at issue.**

The homeowners served alcohol to a minor who later was involved in an automobile accident. The Court ruled that the Policy excluded "personal injuries arising out of the use of a motor vehicle" by any person, distinguishing *Worcester Mut. Ins. Co. v. Marnell,* 398 Mass. 240, 242 (1986). [Page 2.]

Massachusetts Property Insurance Underwriting Association v. Berry, 80 Mass. App. Ct. 598, 954 NE2d 584 (October 6, 2011)

If you would like a copy of any of the above decisions, please contact us.

Very truly yours,

/S/ Philip M. Howe

Philip M. Howe

PMH