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Extension 203

May 3, 2012

Re: Recent Developments in Massachusetts Insurance Law, First Quarter of 2012

The following will summarize the Massachusetts decisions which impact the insurance industry for the first quarter of 2012.

AUTOMOBILE

***The employer did not explicitly purchase underinsured motorist coverage for employees injured in the course of their employment.**

Under Massachusetts law, an employee may not recover under both workers compensation and under an employer's underinsured motorist coverage unless the employer explicitly purchased the underinsured coverage for the purpose of providing such coverage to employees injured in the course of their employment. *National Union Fire Insurance v. Figaratto,* 423 Mass. 346, 667 N.E. 2d 877 (1996).

The Court ruled that the plaintiff had failed to bear her burden to prove that the employer had purchased the underinsured motorist coverage to provide its employees with additional coverage. In fact, there was deposition testimony that the employer had been unaware that there even was such coverage. [Page 5.]

Baker v. St. Paul Travellers Insurance Company, 670 F.3d 119 (1st Circuit, 2012.)

DUTY TO DEFEND

***The insurer had no duty to defend an action for breach of contract as the commercial general liability policy covered liability due to tort, not breach of contract.**

The Complaint alleged only breach of contract for the defendant's failure to furnished leased airplanes as it was contractually obligated. The Complaint included no tort claims. The Court wrote that it was "not our role to sift through the tea leaves to predict additional claims that might be imbedded amongst those specifically alleged." [Page 6.]

Lopez & Medina Corp. v. Marsh U.S.A., Inc., 667 F.3d 58 (1st Circuit, 2012).

E.R.I.S.A.

*** Surveillance supported the denial of the claim for LTD benefits as it directly contradicted the limitations the Insured presented to the independent medical examiners.**

The Insured appeared in a wheelchair at the independent medical exam, but, under surveillance, stood and walked without assistance upon returning home. She also drove without assistance,

walked 75-100 feet quickly and pumped her own gas on the day before the exam. This contradicted her presentation to her own physician and to the physicians retained by the insurer for which, inter alia, she claimed that she could not stand without assistance. She also claimed that she had reflex sympathetic dystrophy, fibromyalgia and headaches. One of her attending physicians found that the Insured suffered from "severe limitation of functional capacity; incapable of minimum (sedentary) activity." [Page 2.]

The Insured's own functional capacity evaluation concluded that she could not work. The evaluator also found that the Insured "ambulated into the clinic with a very erratic pattern characterized by poor foot control and frequent dragging of toes." [Page 2.]

One of the physicians retained by the insurer examined the Insured noted that, while her sensory exam appears to be normal she needed "significant assistance and support even [in] moving from [the] chair to examination table and was unable to use her right hand." [Page 3.]

The Court ruled that the claim denial was not arbitrary and capricious under E.R.I.S.A. The insurer did not have to give special deference to the opinions of the attending physicians. The Court ruled that even "sporadic surveillance capturing limited activity" may be used to uphold the termination of benefits, particularly where the videos show the Insured engaging in activities that specifically contradict her claims as to how she spent her time and what activities she could tolerate. *Cusson v. Liberty Life Assur. Of Boston,* 592 F. 3d 215, 229 (1st Cir. 2010). [Page 4.] In addition to the surveillance, the insurer relied on a records review by a nurse, by three physicians and

by the physician whom it retained to examine the Insured. The insurer credited the opinions of the doctors who reviewed the file and surveillance footage that "directly conflicted with limitations recognized by her healthcare providers and claimed by the plaintiff." [Page 4.]

Gross v. Sun Life Assurance Company of Canada, 2012 WL 29061 (U.S.D.C. MA 2012).

LEGAL MALPRACTICE

*** The negligence of an attorney, who represented the property and casualty insurer in a subrogation action and who told the Insured he would pursue her personal injury claims as well, was not attributable to the insurer.**

The attorney for five years led the Insured to believe that he had been hired by the insurer to represent her interests as well as those of the insurer in seeking to recover damages from a heating oil delivery company. But, he did not file an action on her behalf and the statute of limitations expired. The Insured filed an action against the insurer claiming that the insurer was vicariously liable for the negligence and misrepresentations of the attorney.

The Court granted the insurer's Motion to Dismiss the Complaint ruling that the allegation was only that the attorney was the independent contractor not the employee of the insurer. The Court ruled that the insurer cannot be vicariously liable for the misrepresentations and negligence of the attorney because, as an attorney and an independent professional, he had a "non-delegable

duty of care" to the Insured as his client. As a result, any negligence by the attorney does not subject the insurer who retained him to vicarious liability, [Page 4.], relying on *Sullivan v. Utica Mutual Insurance Company*, 439 Mass. 387, 406-409, 788 N.E. 2d 522 (2003).

Sandman v. Quincy Mutual Fire Insurance Company, 81 Mass. App. 188, 961 N.E. 2d 135 (2012).

STATUTE OF LIMITATIONS

*** The statute of limitations is tolled and does not begin to run on an action against a fiduciary until the plaintiff actually discovers the cause of action, in this case for fraud.**

The fiduciary insurance agent's fraudulent concealment tolled the running of the statute of limitations for the Insured. The agent had assured the Insured that there was an insurance policy on his life for $500,000 when, in fact, the face amount of the policy was only $200,000. The insurer had sent out periodic statements that the face amount of the policy at issue was $200,000. But, the agent fraudulently stated that this was just a "base component and that a secondary benefit would make up the difference." [Page 3.] Ultimately, a new agent assigned to handle the policy contacted the Insured and insisted that the policy only provided $200,000 in coverage. This action followed.

The Court cited to *Demoulas v. Demoulas Super Mkts., Inc.,* 424 Mass. 501, 519 (1997) for its ruling that "…because a fiduciary owes a

duty of full disclosure to his or her principal, the fiduciary's failure to disclose 'constitutes fraudulent conduct and is equivalent to fraudulent concealment…' " Accordingly, where there is a fiduciary duty, the applicable statute of limitations is tolled until "the plaintiff has actual knowledge of either the harm or the fiduciary's implicit or explicit repudiation of his or her obligations." [Page 8.] The fraud by the fiduciary did not toll the statute of limitations as to the other non-fiduciary defendants.

Passatempo v. McMenimen et al., 461 Mass. 279, 960 N.E. 2d 275 (2012).

UNFAIR ACTS IN INSURANCE

*** Violation of the Unfair Acts in Insurance statute results in doubling the amount of the underlying judgment, not just doubling the lost interest from delaying payment of that judgment, resulting in a $22.6 million award.**

The underlying action for catastrophic personal injuries from an automobile accident resulted in a verdict of $11.3 million. [p. 3.] On the issue of violation of the Unfair Acts in the Business of Insurance, c. 176 D, and of the Consumer Protection Act, c. 93A, there was a separate action and a bench trial resulting in a finding that the third party administrator for the excess insurer had violated c. 176 D by failing to effectuate a prompt, fair and equitable settlement before trial of the underlying personal injury action. [p. 4.] The Court went on to rule with respect to causation, "the plaintiff is required to prove that the defendant's unfair or deceptive act caused an adverse consequence or loss." Citing to *R.W. Granger & Sons v. J & S*

Insulation, 435 Mass. 66, 80-81 (2001) and *Iannacchino v. Ford Motor Company,* 451 Mass. 623, 630-631 (2008). [P. 5.]

With respect to the measure of damages, the Court noted that the legislature had amended c. 93A in 1989 adding that the "amount of actual damages to be multiplied by the court shall be the amount of the judgment on all claims arising out of the same and underlying transaction or occurrence…" [P. 5.] The Trial and Appeals Courts had used "loss of use", that is lost interest, as the basis of an award of multiple damages under c. 93A. The Supreme Judicial Court replaced that basis with the amount of the underlying judgment ruling that the above language of the 1989 amendment required them to do so resulting in the doubling of the $11.3 million award in the underlying action. The Court rejected the insurer's argument that the underlying judgment was against the Insured, not against the insurer. The Court noted that there is no such requirement in the 1989 amendment that the underlying judgment be against the insurer. [P. 6]

The Court further ruled that the unfair settlement practice is intimately bound up with the underlying negligence judgment. In this case, the plaintiff in the underlying action suffered catastrophic injuries resulting in paraplegia. The failure to effectuate a prompt settlement is particularly harmful to the claimant because high unpaid medical expenses make prompt receipt of insurance funds extremely important. "Insurers also have a greater incentive to delay settlement as long as possible, hoping to force the claimant to accept a lower offer." [P. 7.]

The subject automobile accident had occurred on January 9, 2002. The claims investigator informed the insurers including the defendant administrator on April 8, 2002 that the insured driver was clearly liable. On September 28, 2004 the plaintiffs in the underlying action recovered a

judgment for $11.3 million. The insurers finally settled on June 2, 2005 but the plaintiffs retained their c. 93 A claims. [P. 4.]

Rhodes vs. AIG Domestic Claims et al., 461 MA 486 (February 10, 2012.)

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