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THE STATE SUPREME
COURT INSURANCE
COVERAGE CASE
Compendium

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A Word from the Publisher...

Welcome to the State Supreme Court Insurance Coverage Case Compendium!

This just-published Compendium contains a dozen carefully selected, highly important state Supreme Court decisions, involving a wide variety of insurance coverage law issues, expertly summarized and analyzed by the professionals at **FC&S Legal: The Insurance Coverage Law Information Center**.

This Compendium of cases is culled from the **2014 Insurance Coverage Law Case Digest**, which includes hundreds of decisions from courts across the country covering numerous insurance coverage law issues that are of significance to insurance companies, policyholders, and the lawyers who represent them.

The **State Supreme Court Insurance Coverage Case Compendium** includes the following case law developments:

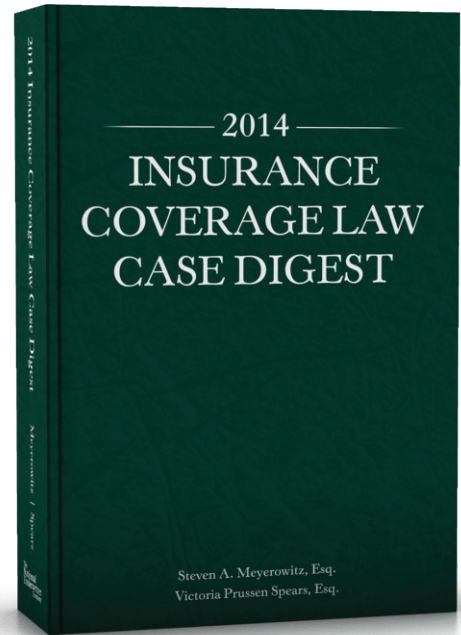
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About The Insurance Coverage Law Case Digest

The dozen cases featured in the **State Supreme Court Insurance Coverage Case Compendium** have been carefully selected from the hundreds of cases summarized and analyzed in the **Insurance Coverage Law Case Digest**, written by Steven A. Meyerowitz and Victoria Prussen Spears, the Director and Associate Director, respectively, of **FC&S Legal: The Insurance Coverage Law Information Center**.

Insurance Coverage Law Case Digest is a one-of-a-kind comprehensive case law reference for busy insurance coverage professionals. Practical and handy, this must-have tool offers:

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- Hundreds of the year's most important cases, from state and federal courts—summarized and analyzed
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THE STATE SUPREME COURT INSURANCE COVERAGE CASE *Compendium*

SOUTH CAROLINA SUPREME COURT “RELUCTANTLY” ENFORCES FAMILY MEMBER EXCLUSION IN FLORIDA POLICY

April 9, 2014 Steven A. Meyerowitz, Esq., Director, FC&S Legal

The South Carolina Supreme Court has ruled, “[r]eluctantly,” that a family member exclusion in a Florida automobile insurance policy was enforceable in South Carolina courts and that it did not offend South Carolina public policy.

The Case

Dorris W. Green, Jr., owned two cars: a Blazer driven primarily by him, and a Honda driven by his wife. Both cars were insured under a policy issued to Mr. Green in Florida. The Honda was registered in that state, but the Blazer was registered in South Carolina. Mr. Green maintained a Florida driver’s license, but the family lived in South Carolina.

Mr. Green’s wife was driving the Honda with her minor child in the car when it was involved in an accident for which she apparently was at fault. Mr. Green argued that as a matter of public policy the courts of South Carolina should refuse to recognize the validity of the family member exclusion in the Florida policy.

The dispute reached the South Carolina Supreme Court.

The Policy

The policy provided:

There is no coverage for [Bodily Injury] for which a **covered person** becomes legally responsible to pay to a member of that **covered person’s** family residing in that **covered person’s** household.

The Supreme Court’s Decision

The court found that the exclusion was enforceable.

In its decision, it first explained that the mother was a covered person under the policy; that the injured child resided in the mother’s household; and that the family member exclusion was valid under Florida statutory law.

The court then rejected Mr. Green’s argument that because South Carolina had abolished parental immunity, enforcement of the family member exclusion violated public policy. The court explained that it was true that South Carolina had abolished parental tort immunity and that, as a result, Mr. Green’s child could sue his mother. Nonetheless, the court continued, the issue was not a question of common law immunity from suit but rather of the enforceability of a contract provision, adding that the abolition of parental immunity in South

Carolina did “not create a public policy bar to enforcement of the valid family member exclusion in [the] Florida automobile insurance policy.”

The court also found that although the action arose out of the mother’s negligence in South Carolina, that did not mean that South Carolina law applied; rather, it decided, the substantive law of Florida governed the validity of the insurance contract’s terms.

Finally, the court rejected Mr. Green’s reliance on South Carolina cases refusing to apply out-of-state intrafamily immunities as a matter of public policy, explaining that Mr. Green was conflating South Carolina’s public policy refusing to enforce other jurisdictions’ common law tort immunities in South Carolina courts with “construction of an out-of-state automobile insurance contract exclusion.”

Accordingly, the court said that it “[r]eluctantly” had to conclude that the family member exclusion contained in the Florida automobile policy, being valid under both Florida statutory authority and Florida public policy, was not void as against South Carolina public policy when applied in South Carolina litigation.

The case is *Green v. United States Automobile Ass’n Auto and Property Ins. Co.*, No. 27373 (S.C. April 2, 2014). Attorneys involved include: Bernard McIntyre, of Beaufort, for Appellant; Charles R. Norris, of Nelson Mullins Riley & Scarborough, LLP, of Charleston, and C. Mitchell Brown, of Nelson Mullins Riley & Scarborough, LLP, of Columbia, for Respondent.

THE STATE SUPREME COURT INSURANCE COVERAGE CASE *Compendium*

ABSOLUTE POLLUTION AND INDOOR AIR QUALITY EXCLUSIONS FOUND AMBIGUOUS BY NEVADA SUPREME COURT

June 2, 2014 Steven A. Meyerowitz, Esq., Director, FC&S Legal

The Supreme Court of Nevada, in response to questions certified by the U.S. Court of Appeals for the Ninth Circuit, has ruled that the absolute pollution exclusion and the indoor air quality exclusion in a motel's insurance policy were ambiguous and has decided that they did not exclude coverage of claims arising from carbon monoxide exposure.

The Case

As the court explained, four people died from carbon monoxide poisoning while sleeping in a room directly above a pool heater in the Casino West Motel. Casino West sought coverage for the deaths from its insurer, Century Surety Company, but Century denied the claims based on two provisions of Casino West's general liability policy: the absolute pollution exclusion and the indoor air quality exclusion.

After Century denied coverage, it brought a declaratory relief claim in federal district court. In response, Casino West filed a counterclaim. Century then moved for summary judgment on both its claim and Casino West's counterclaim.

The federal district court denied Century's motion. The court determined that the policy exclusions were ambiguous and interpreted the ambiguity in Casino West's favor. With permission from the federal district court to appeal the interlocutory decision, Century sought review by the Ninth Circuit, which certified questions to the Nevada Supreme Court after determining that existing Nevada law did not clearly resolve the issue.

Now, the Nevada Supreme Court has issued its decision.

The Exclusions

The absolute pollution exclusion excluded coverage for:

- (1) "[b]odily injury" or "property damage" arising out of the actual, alleged or threatened discharge, dispersal, seepage, migration, release or escape of "pollutants":
 - (a) At or from any premises, site or location which is or was at any time owned or occupied by, or rented or loaned to, any insured. However, this subparagraph does not apply to:
 - (i) [Building-heater exception:] "[b]odily injury" if sustained within a building caused by smoke, fumes, vapor or soot from equipment used to heat that building.

The policy defined a pollutant as:

any solid, liquid, gaseous or thermal irritant or contaminant, including smoke, vapor, soot, fumes, acids, alkalis, chemicals, and waste.

The indoor air quality exclusion excluded coverage for:

"[b]odily injury," "property damage," or "personal and advertising injury" arising out of, caused by, or alleging to be contributed to in any way by any toxic, hazardous, noxious, irritating, pathogenic or allergen qualities or characteristics of indoor air regardless of cause."

The Court's Decision

In its decision, the court pointed out that the scope of the absolute pollution exclusion was "a matter of first impression in Nevada." The court then found that the exclusion permitted "multiple reasonable interpretations of coverage."

On the one hand, the court said that it was reasonable to categorize carbon monoxide as a pollutant because it was a gaseous element that contaminated the air, making it dangerous and sometimes deadly to breathe and, therefore, that it was reasonable to conclude that the policy would not cover any damage that carbon monoxide caused.

The court also said, however, that limiting the exclusion's applicability to claims for traditional environmental pollution also was reasonable:

Taken at face value, the policy's definition of a pollutant is broad enough that it could be read to include items such as soap, shampoo, rubbing alcohol, and bleach insofar as these items are capable of reasonably being classified as contaminants or irritants. So, if no limitations are applicable, the pollution exclusion would seem to preclude coverage for any accident stemming from such items, including a person slipping on a puddle of bleach or developing a skin rash from using a bar of soap. Such results would undoubtedly be absurd and contrary to any reasonable policyholder's expectations.

The court then declared that a "reasonable policyholder" could construe the absolute pollution exclusion to "only apply to traditional environmental pollution."

The court also found that the building-heater exception did "not necessarily preclude" it from limiting the exclusion to traditional environmental pollution because "one reasonable explanation for the inclusion of the building-heater exception is that it was meant to clarify that the absolute pollution exclusion does not apply to a particular situation, rather than to expand the absolute pollution exclusion's scope beyond the parameters of how that exclusion has previously been interpreted."

The court ruled that, in light of the exclusion's "ambiguity," it had to interpret the provision to effectuate Casino West's reasonable expectations, and it held that "the absolute pollution exclusion does not bar coverage for the injuries caused by carbon monoxide in this case."

The court reached the same conclusion with respect to the indoor air quality exclusion, finding it "subject to multiple reasonable interpretations."

In the court's view, one could read the exclusion's language to exclude coverage "for any injury caused by any condition of the air, regardless of whether the condition is permanent or temporary." On the other hand, the court said, limiting the exclusion's applicability only to inherent and continuous air quality issues also was reasonable. The court stated:

As with the pollution exclusion, the indoor air quality provision is drafted so broadly that, if no limitations are applied to it, its applicability could stretch well beyond a reasonable policyholder's expectations

and lead to absurd results. For instance, read to exclude coverage for any condition of the air, the policy would not cover any injury resulting from a guest's inhalation of smoke from a fire inside the motel, but would cover any burn injuries caused by that same fire. Such potentially absurd results illustrate the need for some limitations on the exclusion's applicability.

The court declared that the indoor air quality exclusion's "ambiguity" required that it be interpreted to effectuate Casino West's reasonable expectation that the exclusion only applied to "inherent and continuous conditions." Simply put, the court concluded that:

a policyholder could reasonably expect that the indoor air quality exclusion applies only to continuously present substances that render the air harmful, and that the policy allows recovery for an unexpected condition that temporarily affects the air quality inside of a building.

Accordingly, the court concluded that the indoor air quality exclusion did "not bar coverage for the injuries at issue in this case."

The case is *Century Surety Co. v. Casino West, Inc.*, No. 60622 (Nev. May 29, 2014) (*en banc*). Attorneys involved include: McDonald Carano Wilson LLP and James W. Bradshaw and Debbie A. Leonard, Reno; Woolls & Peer and H. Douglas Galt, Los Angeles, CA, for Appellant; Burton Bartlett & Glogovac and Scott A. Glogovac, Reno, for Respondent; Armstrong Teasdale LLP and Kevin R. Stolworthy and Conor P. Flynn, Las Vegas, for Amicus Curiae Complex Insurance Claims Litigation Association.

FC&S Legal Comment

A federal district court in Oklahoma recently reached a different result, ruling that an indoor air exclusion barred coverage of claims against a hotel alleging bodily injuries resulting from carbon monoxide that escaped from a leaking indoor swimming pool heater.

THE STATE SUPREME COURT INSURANCE COVERAGE CASE *Compendium*

WHETHER POLICY LANGUAGE IS AMBIGUOUS SHOULD BE DETERMINED ONLY AFTER LANGUAGE IS EXAMINED IN LIGHT OF POLICY'S OVERALL CONTEXT, OHIO SUPREME COURT SAYS

September 10, 2014 Steven A. Meyerowitz, Esq., Director, FC&S Legal

The Ohio Supreme Court has ruled that, in determining whether a policy provision is ambiguous, courts must consider the context in which the specific language of the provision is used.

The Case

After Julia S. Augenstine's vehicle collided with a flatbed trailer owned by Stinson J. Crews and Stinson Crews Trucking (together, "Crews"), Ms. Augenstine, who was 86 years old, died.

The executors of Ms. Augenstine's estate filed a survivorship action and an action alleging wrongful death against Crews. Crews then filed a third-party complaint against Century Surety Company, seeking a declaration that Crews was entitled to coverage in the wrongful-death action as an insured under a commercial general liability ("CGL") insurance policy that had been issued by Century.

Century counterclaimed, seeking its own declaration that the CGL policy excluded coverage in the wrongful-death action.

The trial court held a bench trial on the issue of liability. It found that Crews' negligence was the sole proximate cause of the accident and entered a judgment of \$251,552.04 in compensatory damages against Crews. An appellate court affirmed the trial court's judgment assigning Crews sole liability for the accident.

Crews and Century agreed to submit Crews' declaratory judgment action to the trial court for a decision on the briefs. After examining the CGL policy that Century had issued to Crews, the trial court's analysis focused on a provision in the policy providing that "mobile equipment" was not included within the definition of "auto" and, therefore, was not excluded from coverage. The trial court wrote that to determine whether the trailer qualified as "mobile equipment," it had to decide whether the paving machinery that Crews transported on the trailer was "cargo" as used in the policy. The trial court found the term "cargo," which was not defined in the policy, to be ambiguous and, accordingly, construed this language against Century, the insurer. The court concluded that the CGL policy provided coverage in the underlying wrongful-death action.

An intermediate appellate court affirmed, and Century appealed to the Ohio Supreme Court.

The Policy

The policy provided that Century:

will pay those sums that the insured becomes legally obligated to pay as damages because of “bodily injury” or “property damage” to which this insurance applies.

The policy also provided:

SECTION I—COVERAGES

COVERAGE A BODILY INJURY AND PROPERTY DAMAGE LIABILITY

* * *

2. Exclusions

This insurance does not apply to:

* * *

g. Aircraft, Auto Or Watercraft

“Bodily injury” or “property damage” arising out of the ownership, maintenance, use or entrustment to others of any aircraft, “auto” or watercraft owned or operated by or rented or loaned to any insured. Use includes operation and “loading or unloading.”

The policy defined:

auto

as:

SECTION V—DEFINITIONS

* * *

2. “AUTO” MEANS:

- a. A land motor vehicle, *trailer* or semitrailer designed for travel on public roads, including any attached machinery or equipment; or
- b. Any other land vehicle that is subject to a compulsory or financial responsibility law or other motor vehicle insurance law in the state where it is licensed or principally garaged.

However, “auto” does not include “mobile equipment.”

(Italics added.)

The policy defined:

Mobile equipment

as:

12. “Mobile equipment” means any of the following types of land vehicles, including any attached machinery or equipment:

- a. Bulldozers, farm machinery, forklifts and other vehicles designed for use principally off public roads;
- b. Vehicles maintained for use solely on or next to premises you own or rent;
- c. Vehicles that travel on crawler treads;

- d.** Vehicles, whether self-propelled or not, maintained primarily to provide mobility to permanently mounted:
- (1)** Power cranes, shovels, loaders, diggers or drills; or
 - (2)** Road construction or resurfacing equipment such as graders, scrapers or rollers;
- e.** Vehicles not described in **a.**, **b.**, **c.** or **d.** above that are not self-propelled and are maintained primarily to provide mobility to permanently attached equipment of the following types:
- (1)** Air compressors, pumps and generators, including spraying, welding, building cleaning, geophysical exploration, lighting and well servicing equipment; or
 - (2)** Cherry pickers and similar devices used to raise or lower workers;
- f.** Vehicles not described in **a.**, **b.**, **c.** or **d.** above maintained primarily for purposes other than the transportation of persons or cargo.

(Italics added.)

The Ohio Supreme Court's Decision

The Ohio Supreme Court reversed.

In its decision, it explained that the outcome of the case hinged on whether the CGL policy insured the trailer used by Crews. The court then considered Century's argument that the lower courts improperly had determined that the relevant policy provisions were ambiguous. It agreed with Century that the language of the provisions in its policy had to be examined in the context of the overall policy and with respect to the policy's purpose.

The court reasoned that because courts "must examine the insurance policy as a whole to determine the parties' intentions, it follows that courts must also examine the policy as a whole when determining whether a word or phrase of the policy is ambiguous."

The court then noted that, in this case, the trial court and the intermediate appellate court both had found the word "cargo" to be ambiguous. The court stated that, in doing so, the lower courts had "isolated the word 'cargo,' rather than examining the intended scope of the policy as a whole." In the court's view, a consideration of the overall context of the policy showed that the policy was "unambiguous in excluding the trailer from coverage."

The court pointed out that the policy excluded coverage for any bodily injury or property damage arising from the use of an "auto" by the insured and that Section V(2)(a) of the policy stated that a "trailer" designed for travel on public roads was an "auto" for purposes of the policy. This provision, the court stated, established a "fundamental premise" of the policy: trailers were "excluded from coverage."

The court acknowledged that the policy provided an exception to the "auto" exclusion and that anything qualifying as "mobile equipment" as defined by the policy was excepted from the definition of "auto." The court, however, rejected Crews' argument that the trailer qualified as "mobile equipment," ruling, instead, that it was "clear" that the trailer did not qualify as "mobile equipment." The court found that when read in context with the rest of Section V(12), it was "clear" that the catchall provision of subsection f was meant to classify as "mobile equipment" those land vehicles not specifically named in Section V(12) that were of the same subclass of vehicles as those that were named in the section. A trailer, the court found, was "not of the same subclass as the land vehicles identified in Section V(12)."

Because it concluded that the trailer did not belong to the subclass of land vehicles set forth in Section V(12) of the CGL policy, the court stated that the precise definition of the word "cargo" as used in that section was "irrelevant," and the policy's failure to define the term "cargo" did not create an ambiguity. Instead, the court

concluded, the “plain language” of the CGL policy excluded trailers from coverage as autos pursuant to Section V(2)(a) of the policy.

The case is *Sauer v. Crews*, No. 2013–0283 (Ohio Sep. 2, 2014). Attorneys involved include: Plymale & Dingus, L.L.C., and M. Shawn Dingus, for appellees; Davis & Young and Richard M. Garner, for appellant; Koehler Neal, L.L.C., and Timothy J. Fitzgerald, urging reversal for amicus curiae Ohio Association of Civil Trial Attorneys.

THE STATE SUPREME COURT INSURANCE COVERAGE CASE *Compendium*

STATUTE PERMITTING OFFSET AGAINST "OLD AGE AND SURVIVOR INSURANCE BENEFITS" REFERRED ONLY TO FEDERAL SOCIAL SECURITY BENEFITS, MINNESOTA SUPREME COURT DECIDES

August 21, 2014 Steven A. Meyerowitz, Esq., Director, FC&S Legal

The Minnesota Supreme Court has ruled that a school district could not offset its disability-benefit payments to a former teacher against his government-service pension benefits, finding that the Minnesota law permitting an offset against "old age and survivor insurance benefits" referred only to federal Social Security benefits.

The Case

Gary Ekdahl alleged that he was injured while working for Minnesota Independent School District # 213. He sought and was awarded permanent total disability benefits. The district, relying on Minn.Stat. § 176.101, subd. 4 (2012), requested an offset of its disability-benefit payments by the amount of government-service pension benefits Mr. Ekdahl was receiving, arguing that the Minnesota statute authorized an offset for "any old age and survivor insurance benefits."

The compensation judge denied the requested offset, concluding that Mr. Ekdahl's government-service pension benefits were not "old age and survivor insurance benefits," as that phrase was used in the statute.

The Workers' Compensation Court of Appeals ("WCCA") reversed, concluding that government-service pension benefits were included in the phrase "old age and survivor insurance benefits," and thus could be offset from the district's disability-benefit payment.

The dispute reached the Minnesota Supreme Court.

Minnesota Law

Minnesota Statutes § 176.101, subd. 4, provides:

This compensation shall be paid during the permanent total disability of the injured employee but after a total of \$25,000 of weekly compensation has been paid, the amount of the weekly compensation benefits being paid by the employer shall be reduced by the amount of any disability benefits being paid by any government disability benefit program if the disability benefits are occasioned by the same injury or injuries which give rise to payments under this subdivision. *This reduction shall also apply to any old age and survivor insurance benefits.*

(Emphasis added.)

The Minnesota Supreme Court's Decision

The court reversed the WCCA and reinstated the decision of the compensation judge, ruling that the phrase "old age and survivor insurance benefits," as used in Minn.Stat. § 176.101, subd. 4, did not include pension benefits received by a former government employee but only included federal Social Security benefits under the Social Security Act.

Mr. Ekdahl did not receive any Social Security benefits, the court observed, concluding that the statutory offset provision did not encompass his retirement annuity.

The case is *Ekdahl v. Independent School District #213*, No. A14-0089 (Minn. Aug. 13, 2014). Attorneys involved include: DeAnna M. McCashin, Schoep & McCashin, Chtd., Alexandria, MN, for relator; Timothy P. Jung, Lind, Jensen, Sullivan & Peterson, P.A., Minneapolis, MN, for respondent; Charlene K. Feenstra, Joshua M. Steinbrecher, Heacox, Hartman, Koshmrl, Cosgriff & Johnson, P.A., Saint Paul, MN, for amicus curiae Workers' Compensation Reinsurance Association; Thomas J. Grundhoefer, Edward S. Cadman, MSBA Legislative Counsel, Saint Paul, MN, for amicus curiae Minnesota School Boards Association.

FC&S Legal Comment

The programs covered by the Social Security Act include Social Security disability insurance, Supplemental Social Security income, Social Security retirement benefits, and Social Security dependent benefits. The Minnesota Supreme Court in *Ekdahl* did not decide which of these programs was subject to offset under section 176.101, subdivision 4.

THE STATE SUPREME COURT INSURANCE COVERAGE CASE *Compendium*

NEBRASKA SUPREME: "DISCHARGE," "DISPERSAL," "SPILL," "RELEASE," AND "ESCAPE" ENCOMPASS "ALL POSSIBLE MOVEMENTS" BY WHICH HARMFUL EXPOSURE TO LEAD-BASED PAINT MAY OCCUR

September 16, 2014 Steven A. Meyerowitz, Esq., Director, FC&S Legal

The Nebraska Supreme Court has ruled that the manner of exposure to lead-based paint was not a material fact that should prevent summary judgment in an insurance coverage dispute because the manner of exposure did not affect whether there had been a "discharge, dispersal, spill, release or escape" for purposes of the policy's pollution exclusion.

The Case

State Farm Fire & Casualty Company brought an action for declaratory judgment, claiming its rental dwelling policy issued to Jerry Dantzler excluded coverage for personal injuries allegedly sustained by Mr. Dantzler's tenant as a result of exposure to lead-based paint. In cross-motions for summary judgment, State Farm and Dantzler requested a determination as to whether a policy exclusion precluded coverage for the tenant's personal injury claim. The trial court sustained State Farm's motion for summary judgment and concluded as a matter of law that the pollution exclusion barred coverage under State Farm's policy.

An intermediate appellate court in Nebraska reversed the entry of summary judgment, concluding that in the absence of proof as to how the tenant allegedly had been exposed to lead-based paint, it could not determine as a matter of law whether the pollution exclusion barred coverage. It reasoned that whether the alleged exposure to lead-based paint had occurred through a "discharge, dispersal, spill, release or escape," as specified in the exclusion, was a factual determination that depended upon the manner of exposure.

The dispute reached the Nebraska Supreme Court.

The State Farm Policy

The policy provided:

COVERAGE L—BUSINESS LIABILITY

If a claim is made or a suit is brought against any **insured** for damages because of **bodily injury, personal injury, or property damage** to which this coverage applies, caused by an **occurrence**, and which arises from the ownership, maintenance, or use of the **insured premises**, we will:

1. pay up to our limit of liability for the damages for which the **insured** is legally liable; and
2. provide a defense at our expense by counsel of our choice....

....

SECTION II EXCLUSIONS

1. Coverage L—Business Liability [does] not apply to:....

i. **bodily injury** or **property damage** arising out of the actual, alleged or threatened discharge, dispersal, spill, release or escape of pollutants:

(1) at or from premises owned, rented or occupied by the **named insured**;

....

As used in this exclusion:

....

"[P]ollutants" means any solid, liquid, gaseous or thermal irritant or contaminant, including smoke, vapor, soot, fumes, acids, alkalis, chemicals and waste.

(Emphasis in original.)

The Court's Decision

The court reversed, declaring that the terms "discharge," "dispersal," "spill," "release," and "escape" encompassed "all possible movements" by which harmful exposure to lead-based paint occurred. Accordingly, the court concluded, the manner of exposure to lead-based paint was not a material fact that prevented summary judgment because the manner of exposure did not affect whether there had been a "discharge, dispersal, spill, release or escape" for purposes of the pollution exclusion.

This conclusion, the court said, avoided the "practical difficulties" of compelling a trial court hearing the declaratory judgment action to make a finding as to the causation of the alleged injuries in the underlying personal injury case to determine whether a "discharge, dispersal, spill, release or escape" had occurred. From a practical perspective, the court concluded, this would be "problematic."

The case is *State Farm Fire & Cas. Co. v. Dantzler*, No. S-12-1042 (Neb. Sep. 12, 2014). Attorneys involved include: Michael A. Nelsen, of Marks, Clare & Richards, L.L.C., for appellant; Patrick S. Cooper and David J. Stubstad, of Fraser Stryker, P.C., L.L.O., for appellee State Farm Fire & Casualty Company.

THE STATE SUPREME COURT INSURANCE COVERAGE CASE *Compendium*

WASHINGTON SUPREME FINDS BLANKET EXCLUSIONS OF NEURODEVELOPMENTAL THERAPIES IN HEALTH INSURANCE POLICIES "VOID" AND "UNENFORCEABLE"

October 16, 2014 Steven A. Meyerowitz, Esq., Director, FC&S Legal

The Washington Supreme Court, interpreting two Washington laws – the neurodevelopmental therapies mandate, RCW 48.44.450, and the mental health parity act, RCW 48.44.341 – has ruled that blanket exclusions of neurodevelopmental therapies ("NDT") in health insurance contracts were "void and unenforceable."

The Case

In 1989, the Washington legislature mandated coverage for NDT (speech, occupational, and physical therapy) in employer-sponsored group plans for children under age seven (the "NDT mandate"). RCW 48.44.450. In 2005, the legislature enacted the mental health parity act, mandating coverage for "mental health services." RCW 48.44.341.

As explained by the Washington Supreme Court, the two named plaintiffs in this case were O.S.T. and L.H. When O.S.T. was just six months old, he began having difficulties feeding and was diagnosed with a feeding disorder. Problems with O.S.T.'s health worsened as he got older. By his third birthday, therapists believed that O.S.T. was autistic. Between 2006 and 2008, he received speech, physical, and occupational therapy from Boyer Children's Clinic. After leaving the Boyer Children's Clinic, he continued to receive NDT from Children's Communication Corner; the Hearing, Speech and Deafness Center; and Seattle Children's Hospital. In 2009, the autism diagnosis was confirmed following an evaluation with Seattle Children's Hospital.

L.H. was diagnosed with expressive language disorder, myotubular myopathy, profound hypotonia, and severe hydrocephalus, and was treated with speech, occupational, and physical therapy from Boyer Children's Clinic.

Both plaintiffs either were or had been insured under health policies issued by Regence BlueShield that contained blanket exclusions for NDT. Regence BlueShield did not cover O.S.T.'s therapies, so O.S.T.'s parents paid for the services. It was unclear whether Regence BlueShield had denied any of L.H.'s claims.

The plaintiffs filed a class action complaint, alleging breach of contract and seeking injunctive relief.

The trial court granted partial summary judgment to the plaintiffs, holding that "any provisions contained in Regence BlueShield policies issued and delivered to Plaintiffs O.S.T. and L.H. on or after January 1, 2008 that exclude coverage of neurodevelopmental therapies regardless of medical necessity are declared invalid, void and unenforceable."

The dispute reached the Washington Supreme Court.

The Washington Laws

RCW 48.44.450 provides:

- (1) Each *employer-sponsored* group contract for comprehensive health care service[s] ... shall include coverage for neurodevelopmental therapies for covered individuals age six and under.
- (2) Benefits provided under this section shall cover the services of those authorized to deliver occupational therapy, speech therapy, and physical therapy....
- (3) Benefits provided under this section shall be for medically necessary services as determined by the health care service contractor. Benefits shall be payable for services for the maintenance of a covered individual in cases where significant deterioration in the patient's condition would result without the service. Benefits shall be payable to restore and improve function.

(Emphasis added.)

RCW 48.44.341 provides:

- (2) All health service contracts providing health benefit plans that provide coverage for medical and surgical services shall provide:
 - (b) For all health benefit plans delivered ... on or after January 1, 2008, coverage for:
 - (i) Mental health services....

The law defines:

mental health services

as:

medically necessary outpatient and inpatient services provided to treat mental disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of disorders.

RCW 48.44.341(1).

The Washington Supreme Court's Decision

The court affirmed the trial court.

The court held that the NDT mandate and the mental health parity act were "unambiguous," did "not conflict," and that NDT may constitute "mental health services" if the therapies were medically necessary to treat a mental disorder identified in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (4th rev. ed. 2000) ("*DSM-IV-TR*"). Therefore, the court declared, the blanket exclusions of NDT in the plaintiffs' health contracts were "void and unenforceable."

The court explained that the scope of each statute was different. One statute addressed NDT generally and did not require that they be used to treat a mental disorder recognized in the *DSM-IV-TR*, while the other broadly mandated coverage for all medically necessary treatment for mental disorders recognized in the *DSM-IV-TR*, except as expressly excluded (provided the contract covered medical and surgical services).

Accordingly, the court declared that the NDT mandate created a "minimum level of required coverage for neurodevelopmental therapies." It added that when NDT were medically necessary to treat mental disorders

in the *DSM-IV-TR*, the “mental health parity act requires additional coverage.” Insurers must meet the requirements of both acts, the court found. It concluded:

Regence BlueShield’s blanket exclusion of neurodevelopmental therapies in its individual policies violates the mental health parity act. If neurodevelopmental therapies are medically necessary to treat mental disorders (and the contract provides coverage for medical and surgical services), Regence BlueShield must provide coverage for the therapies. The exclusion is void and invalid as a matter of Washington law.

The case is *O.S.T. v. Regence Blueshield*, No. 88940–6 (Wash. Oct. 9, 2014). Attorneys involved include: Timothy James Parker, Jason Wayne Anderson, Gregory Mann Miller, Carney Badley Spellman PS, Seattle, WA, for Appellant; Eleanor Hamburger, Richard E. Spoonemore, Sirianni Youtz Spoonemore Hamburger, Seattle, WA, for Respondent(s).

THE STATE SUPREME COURT INSURANCE COVERAGE CASE *Compendium*

TEXAS SUPREME COURT: VACANCY CLAUSE IN HOMEOWNER'S POLICY IS ENFORCEABLE

September 2, 2014 Steven A. Meyerowitz, Esq., Director, FC&S Legal

The Texas Supreme Court, affirming an intermediate appellate court's decision, has ruled that a vacancy clause in a homeowner's insurance policy was enforceable by the insurer.

The Case

A house in Irving, Texas, that had been vacant for several months was damaged when fire spread to it from a neighboring property. The house was insured under a homeowner's insurance policy issued by Farmers Insurance Exchange containing a clause suspending dwelling coverage if the house was vacant for over 60 days. The homeowner had not purchased an available endorsement providing coverage for extended vacancies, and the insurer denied the homeowner's claim, even though the vacancy was not related to the loss.

Litigation ensued and the trial court granted judgment for the homeowner. The court of appeals held that the vacancy provision had to be applied according to its terms and reversed.

The case reached the Texas Supreme Court.

The Policy

Section I.A. of Farmers' policy provided:

SECTION I PROPERTY COVERAGE

COVERAGE A (DWELLING)

We cover:

1. The dwelling on the **residence premises** shown on the declarations page including structures attached to the dwelling.

The policy also provided:

9. "Residence Premises" means the **residence premises** shown on the declarations page. This includes the one or two family dwelling, including other structures, and grounds where an **insured** resides or intends to reside within 60 days after the effective date of this policy.

The policy also provided, in “Section I—Conditions,” the following:

13. Vacancy. If the insured moves from the dwelling and a substantial part of the personal property is removed from that dwelling, the dwelling will be considered vacant. Coverage that applies under Coverage A (Dwelling) will be suspended effective 60 days after the dwelling becomes vacant. This coverage will remain suspended during such vacancy.

Texas Insurance Law

Texas insurance law provides:

Fire Insurance: Breach by Insured; Personal Property Coverage.

Unless the breach or violation contributed to cause the destruction of the property, a breach or violation by the insured of a warranty, condition, or provision of a fire insurance policy or contract of insurance on personal property, or of an application for the policy or contract:

- (1) does not render the policy or contract void; and
- (2) is not a defense to a suit for loss.

Tex. Ins. Code § 862.054.

The Texas Supreme Court’s Decision

The court affirmed.

In its decision, the court found that, when the insured vacated the dwelling and no longer resided there, full coverage remained in place for 60 days beyond the vacancy date, after which there was no coverage for the dwelling. According to the court, the vacancy clause addressed the scope of coverage and was not an exclusion because the clause did not limit Farmers’ liability as to, or carve out, a particular type of loss but “effectively expand[ed] coverage” to encompass a 60 day period beyond the time the homeowner no longer resided in the dwelling. After that time, the court said, there was no coverage for the dwelling.

The court then ruled that the term “breach” as used in Section 862.054 did not include a homeowner’s actions in vacating the home and “triggering” the vacancy clause.

Finally, the court found that Farmers could rely on the vacancy clause to deny the claim even though the property’s being vacant had not prejudiced Farmers. The court said that the case was “not about breach” but was about the coverage purchased by the homeowner that Farmers had agreed to provide. The homeowner, the court concluded, sought “to have us re-write the insurance policy under the guise of ‘construing’ it so Farmers provides coverage it did not agree to provide, and [the homeowner] receives coverage she did not contract for.”

The case is *Greene v. Farmers Ins. Exchange*, No. 12–0867 (Tex. Aug. 29, 2014). Attorneys involved include: D. Bradley Kizzia, William Michael Ucherek II, for Bob Greene, as Next Friend of Lewayne Greene; Rebecca E. Bell, Stephen G. Good, Steven A. Springer, for Farmers Insurance Exchange.

THE STATE SUPREME COURT INSURANCE COVERAGE CASE *Compendium*

CONNECTICUT SUPREME: INSURER'S PRE-INSOLVENCY BREACH OF DUTY TO DEFEND DID NOT ESTOP STATE'S INSURANCE GUARANTY ASSOCIATION FROM CONTESTING CLAIM UNDER INSOLVENT INSURER'S POLICY

October 21, 2014 Steven A. Meyerowitz, Esq., Director, FC&S Legal

The Connecticut Supreme Court has ruled that an insurance company's pre-insolvency breach of its duty to defend a claim during an underlying litigation did not estop the Connecticut Insurance Guaranty Association (the "Association") from contesting its obligation under the Connecticut Insurance Guaranty Association Act (the "Act") to pay a claim made under the insolvent insurer's policy.

The Case

In May 2000, Susan and Rodney Drown filed a medical malpractice action against Associated Women's Health Specialists, P.C., and two of its physicians with respect to care rendered to Ms. Drown preceding, during, and following delivery of her son. The Drowns alleged, among other things, that the two physicians had negligently failed to diagnose a placental abruption, which had resulted in brain damage to their son. The Drowns alleged that Health Specialists was vicariously liable for the physicians' negligence, but did not plead claims of direct negligence against Health Specialists. At some point during the proceedings, the Drowns withdrew the counts against one of the physicians without any settlement of those claims.

Health Specialists was insured through a professional liability insurance policy issued by Medical Inter-Insurance Exchange. For a period of approximately six years following notice of the claim, Exchange agreed to provide, and did provide, a legal defense to Health Specialists, without asserting any reservation of rights under the insurance policy.

In June 2006, Health Specialists' counsel, Thomas Anderson, informed Exchange's senior claim representative that, in light of information gleaned through depositions, he had reached the conclusion that liability favored the Drowns and that settlement options should be pursued. In July 2006, Mr. Anderson informed the senior claim representative that a mediation session had been scheduled for September 28, 2006, and that Exchange's presence was required at that session by order of the court because it had the authority to settle the action.

Exchange failed to send a representative to the September mediation session, and the mediation was continued until December 7, 2006.

In October 2006, Exchange's general counsel wrote a letter to Health Specialists for the first time to "remind [it] of some important limitations on coverage..." The letter went on to state that, "pursuant to exclusion (i), there is no coverage for [Health Specialists] for its vicarious liability for the acts of individual physicians." Thereafter,

Exchange failed to send a representative to the December mediation session, despite having been specifically alerted again by counsel that the court required the presence of such a representative. As a result, the trial court rendered a default judgment on the issue of liability against Health Specialists because Exchange had failed to appear at the mandated mediation sessions on behalf of its insured.

In March 2007, Health Specialists and Ms. Drown, individually and on behalf of the Drowns' son, executed a settlement agreement whereby Health Specialists agreed that it was liable for the full amount of the policy, \$2 million, and that it would assign to the Drowns its rights to recover against Exchange. In return, the Drowns agreed that they would not proceed directly against Health Specialists' assets.

The trial court dismissed the action against Health Specialists.

In April 2008, Exchange, domiciled in the state of New Jersey, was declared insolvent by a New Jersey state court judge. As a result, the Association assumed liability for Exchange's obligations to the extent that claims under its policies were covered under the Act.

Thereafter, the Association brought a declaratory judgment action, seeking a declaration that it had no obligations under the policy that Exchange had issued to Health Specialists for the Drowns' claims. The parties moved for summary judgment. The trial court granted the defendants' motion, concluding that Exchange's breach of its obligation to provide a defense had resulted in a default being entered against Health Specialists, and that the Association, therefore, was liable to the same extent as Exchange would have been for such a breach.

An intermediate appellate court reversed, concluding that Exchange's breach of its duty to defend Health Specialists did not estop the Association from enforcing the policy exclusion because, under the Act, the Association was liable only for "[c]overed claim[s]" as defined by Connecticut General Statutes § 38a-838 (5).

The dispute reached the Connecticut Supreme Court.

Connecticut Law

Connecticut General Statutes § 38a-838 (5) provides:

"Covered claim" means an unpaid claim, including, but not limited to, one for unearned premiums, which arises out of and is within the coverage and subject to the applicable limits of an insurance policy to which sections 38a-836 to 38a-853, inclusive, apply issued by an insurer, if such insurer becomes an insolvent insurer after October 1, 1971, and (A) the claimant or insured is a resident of this state at the time of the insured event; or (B) the claim is a first party claim for damage to property with a permanent location in this state....

Connecticut General Statutes § 38a-841(a) provides:

Said association shall: (1) Be obligated to the extent of the covered claims existing prior to the determination of insolvency and arising within thirty days after the determination of insolvency, or before the policy expiration date if less than thirty days after the determination, or before the insured replaces the policy or causes its cancellation, if he does so within thirty days of such determination, provided such obligation shall be limited as follows: (A) With respect to covered claims for unearned premiums, to one-half of the unearned premium on any policy, subject to a maximum of two thousand dollars per policy; (B) with respect to covered claims other than for unearned premiums, such obligation shall include only that amount of each such claim which is in excess of one hundred dollars and is less than three hundred thousand dollars for claims arising under policies of insurers determined to be insolvent prior to October 1, 2007, and four hundred thousand dollars for claims arising under policies of insurers determined to be insolvent on or after October 1, 2007, except that said association shall pay the full amount of any such claim arising out of a workers' compensation policy, provided in no event shall said association be obligated (i) to any claimant in an amount in excess of the

obligation of the insolvent insurer under the policy form or coverage from which the claim arises, or (ii) for any claim filed with the association after the expiration of two years from the date of the declaration of insolvency unless such claim arose out of a workers' compensation policy and was timely filed in accordance with section 31-294c; (2) be deemed the insurer to the extent of its obligations on the covered claims and to such extent shall have all rights, duties, and obligations of the insolvent insurer as if the insurer had not become insolvent ... (4) investigate claims brought against said association and adjust, compromise, settle, and pay covered claims to the extent of said association's obligations, and deny all other claims. The association shall pay claims in any order it deems reasonable including, but not limited to, payment in the order of receipt or by classification. It may review settlements, releases and judgments to which the insolvent insurer or its insureds were parties to determine the extent to which such settlements, releases and judgments may be properly contested....

General Statutes § 38a-851(a) provides:

Whenever any covered claims arise from a judgment under any decision, verdict or finding based on the default of an insolvent insurer or based on such insolvent insurer's failure to defend an insured, said association, either on its own behalf or on behalf of such insured, may apply to have such judgment, order, decision, verdict or finding set aside by the same court or administrator that made such judgment, order, decision, verdict or finding and said association may defend against any such claim on the merits of the case.

The Connecticut Supreme Court's Decision

The court agreed with the appellate court that the Exchange's pre-insolvency breach of its duty to defend did not estop the Association from contesting its obligation to pay claims under the policy.

In its decision, the court reasoned that that rule was consistent with the Association's "limited purpose" of paying only "covered" claims on behalf of insolvent insurers to insureds who otherwise would be left with a limited recovery, if any, following the insolvency of their insurer. The court pointed out that the Association did not replace the insolvent insurer and did not assume all of the insolvent insurer's responsibilities and obligations. Rather, it said, the Act limited the extent of the Association's obligations so that the Association remained a "limited purpose entity rather than a full service insurer."

The court added that the protection the Association provided was limited based on its status as a nonprofit entity and the method by which it was funded. Because insurers may pass on the costs of the assessments made against them by the Association, the court observed, it was "in reality" policyholders who paid for the protections afforded by the Association. Limitations on the association's obligations, therefore, provided "another form of protection against increased premiums for policyholders in addition to the primary protection afforded all claimants against losses resulting from insurer insolvency."

Thus, the court concluded, the Association was not estopped from challenging the existence of a covered claim, even when the insolvent insurer otherwise would have been bound to pay that claim because of a breach of its coverage obligation.

The case is *Connecticut Ins. Guaranty Ass'n v. Drown*, No. 18975 (Conn. Oct. 21, 2014). Attorneys involved include: Sean K. McElligott, for the appellants (defendants); Kurt M. Mullen, with whom were Thomas P. O'Connor and, on the brief, Mark D. Robins, pro hac vice, and Charles W. Pieterse, for the appellee (plaintiff).

FC&S Legal Comment

Although the Act is based on a model statute drafted by the National Association of Insurance Commissioners that has been adopted in substantial part by the legislatures of many of states, courts have reached different conclusions on this issue.

Some have held that the conduct of an insolvent insurer did not bind an insurance guaranty association to pay an otherwise “uncovered claim.” See, e.g., *Illinois Ins. Guaranty Fund v. Santucci*, 384 Ill.App.3d 927 (2008) (“[The defendant] ignores [the fact] that the [guaranty fund] is not an insurance company and that [the insurer’s] decision to defend without a reservation of rights does not bind the [guaranty fund]. Rather, by statute, the [guaranty fund] assumed the policy obligations of [the insurer] only to the extent that those obligations were statutorily defined ‘covered claims.’”); *Valentin–Rivera v. New Jersey Property–Liability Ins. Guaranty Assn.*, No. A–1925–09T1 (N.J. Ct.App. March 25, 2011) (insolvent insurer’s defense without reserving rights did not estop guaranty association from challenging existence of “covered claim” because, inter alia, “conservation of [guaranty fund’s] resources is necessary to achieve the [state guaranty act’s] stated goals” [internal quotation marks omitted]); *Lopez v. Texas Property & Casualty Ins. Guaranty Ass’n.*, 990 S.W.2d 504 (Tex. Ct.App. 1999) (“Because [the] appellants’ claim is for a loss outside policy coverage, [the] appellants’ claim for recovery of the judgment against [the insured] is not a covered claim under the terms and conditions of the policy. Therefore, the [g]uaranty [a]ssociation is [statutorily] prohibited from paying [the] appellants’ claim,” despite the fact that the insolvent insurer had defended the insured during the underlying action without reserving its rights.)

Also worth noting is a decision from Maryland’s highest court, *Property & Casualty Ins. Guaranty Corp. v. Beebe–Lee*, 431 Md. 474 (2013) (that claim is not covered by insolvent insurer’s policy provides “sound reason” for guaranty association to contest settlement). The case concerned when a guaranty association could “properly contest” a personal injury settlement entered into by an insurer prior to insolvency, as opposed to remaining obligated to continue to defend and pay. In discussing the lack of coverage under the policy as a ground for contesting a settlement, the Maryland court distinguished *Lopez* and *Santucci* as involving either a stipulation or a judicial finding that the claims at issue were not “covered claims” under the policy and guaranty association statute, although it described that as a “sound reason” to contest the settlement. The court held that the state’s guaranty act permitted the guaranty association “to review and properly contest settlements to the extent that the insolvent insurer could have had it not become insolvent. In addition, [the guaranty association] may contest settlements on limited grounds that would not have been available to the insurer. Once a claimant demonstrates that there has been a valid settlement, [the guaranty association] bears the burden of showing why the claim is excluded from coverage. These reasons include, but are not necessarily limited to, fraud, collusion, duress, mutual mistake, or the failure of the insurer to use reasonable care in investigating or settling the claim.” Although this holding would seem to suggest that lack of coverage was a reason for a guaranty association to contest a settlement, the Maryland court acknowledged, but did not address, the guaranty association’s claim that the go-kart accident at issue was not covered under the applicable policies, concluding only that the facts demonstrated that the insolvent insurer had used “reasonable care” in evaluating the merits of the underlying case prior to settling it. (“Just because [the guaranty association] might have been able to negotiate a better settlement or successfully defend the case at trial does not mean it can re-open the settlement agreement now.”)

Other courts have reached a different result. See, e.g., *Hall v. MPH Transportation, Inc.*, 58 Pa. D. & C.4th 482 (Com.Pl. 2002) (Pennsylvania trial court held that, under the applicable statute, a guaranty association had “an unconditional right to set aside a default judgment which occurred during the insurer’s rehabilitation or insolvency and while the insurer and defendant were incapable of defending the claim on the merits. The same should not be true, however, for default judgments or verdicts that were entered at a time when the defendant and then solvent insurer had the ability to defend the claim and protect their interests.” The statute at issue in *Hall* (40 Pa. Stat. Ann. § 991.1819(b)) addressed default judgments that had been entered against an insolvent insurer and provided:

As to any covered claims arising from a judgment under any decision, verdict or finding based on the default of the insolvent insurer or its failure to defend an insured, the association, either on its own behalf or on behalf of such insured, may apply to have such judgment, order, decision, verdict or finding set aside by the same court that made such judgment, order, decision, verdict or finding and shall be permitted to defend against such claim on the merits.

Other courts also have decided that an insolvent insurer's conduct may operate to estop a guaranty association from challenging its coverage obligation under the policy, even under statutes requiring the existence of a "covered claim" to bind the association. See, e.g., *California Ins. Guaranty Assn. v. Workers' Compensation Appeals Board*, 10 Cal.App. 4th 988 (1992) (workers' compensation coverage obligation for insolvent insurer, created by estoppel because of agent's conduct representing that coverage existed creating oral binder of insurance, operated to bind guaranty association because obligations of insolvent insurer included those created by law as well as policy). Cf. *Aloha Pacific, Inc. v. California Ins. Guaranty Assn.*, 79 Cal.App. 4th 297 (2000) (noting that 1992 decision "does not hold that every estoppel affixed to an insolvent insurer will also be imposed upon [California's guaranty association]" (emphasis omitted) and limited effect of 1992 decision to workers' compensation policies, rather than other forms of insurance).

The Delaware Court of Chancery subsequently followed the 1992 California decision by estopping that state's guaranty association from refusing to defend an insured who had relied on the conduct of his insolvent insurer in defending him for more than four years without a reservation of rights or disclaiming coverage. See *Delaware Ins. Guaranty Assn. v. Sezna*, No. Civ. A. 13070 (Del. Ch. Aug. 25, 1994) (holding "claim by estoppel is not expressly excluded from coverage" by statute defining "covered claim," and, "moreover, is encompassed within the meaning of and purpose behind the [state's guaranty act]"), *aff'd*, 659 A.2d 227 (Del. 1995).

THE STATE SUPREME COURT INSURANCE COVERAGE CASE *Compendium*

CONTRIBUTORY NEGLIGENCE BARS NEGLIGENT PROCUREMENT SUIT AGAINST INSURANCE AGENT, ALABAMA SUPREME COURT RULES

May 15, 2014 Steven A. Meyerowitz, Esq., Director, FC&S Legal

The Alabama Supreme Court has ruled that, as a matter of law, a negligent procurement claim against an insurance agent was barred by the doctrine of contributory negligence.

The Case

On September 2, 2010, Brandon Morris, an agent for Alfa Life Insurance Corporation, met with Dante Colza to assist him in completing an application for a life insurance policy in the amount of \$150,000.

At the close of the meeting, Mr. Colza's wife, Kimberly Colza, wrote a check payable to Alfa for \$103.70, the monthly "Preferred Tobacco" premium rate.

Mr. Colza was examined by the medical examiner on October 15, 2010. The next day, he was killed in an accident. Two days later, Alfa received the medical examiner's report, which indicated that Mr. Colza's family had a history of heart disease, that his cholesterol was above 255, and that he had had moving traffic violations in the preceding five years.

In light of Mr. Colza's high cholesterol level and his family history of heart disease, the Alfa underwriters determined that he was not eligible for the Preferred Tobacco rate for which he had applied; rather, the proper classification for Mr. Colza would have been the Standard Tobacco rate, which had a higher premium. Additionally, the underwriters said, in light of Mr. Colza's moving vehicle violations, he was a greater risk to insure and a "rate-up" of \$2.50 per \$1,000 worth of coverage was required. The new rate for the Standard Tobacco premium and the rate-up apparently would have resulted in a monthly premium of \$182.55 per month.

Alfa subsequently notified Ms. Colza that no life insurance coverage was available for Mr. Colza's death "because no policy was issued and the conditions of coverage under the conditional receipt were not met."

Ms. Colza brought suit and a jury determined that Mr. Morris had negligently failed to procure insurance for Mr. Colza. The trial court entered a judgment in the amount of \$100,000 against him, and he appealed, arguing that the Colzas' contributory negligence entitled him to a judgment as a matter of law on Ms. Colza's negligent procurement claim.

The Application

The application provided:

I understand and agree with the Company that:

1. Any policy issued as a result of this Application shall constitute a single and entire contract of insurance.... Only the President, a Vice President, the Secretary or Actuary of the Company may waive or vary a contract provision or any of the Company's rights or requirements and such waiver must be in writing. Only the Company's Underwriters have any authority to accept or approve the insurance applied [for] or to pass upon insurability.
2. To the best of my knowledge and belief all of the statements and answers on the Application are true, complete, and correctly stated, and I understand the statements and answers are submitted to the Company as the basis for any policy issued, and if incorrect can be cause for cancellation or loss of coverage.
3. Unless the policy becomes effective at an earlier date due to full and complete fulfillment of the conditions in the Conditional Receipt, any insurance issued by the Company will not become effective until this Application has been approved and accepted by the Underwriting Department of the Company, and the policy issued has been delivered to the owner of the policy personally and payment to the Company of the full first premium during the lifetime and continued insurability of the Proposed Insured has been made.
4. I authorize the Company to amend this Application by a notation in the space set aside for "Home Office Endorsements" to correct apparent errors or omissions and to conform the Application to any policy that may be issued by the Company. Acceptance of the policy issued based on this Application will be acceptance of its terms and ratification by me of any changes specified in the section marked "Home Office Endorsements." Any change in plan or amount of insurance or added benefits must be agreed to in writing.

The application agreement referenced another document entitled "Conditional Receipt," which stated:

1. CONDITIONS TO COVERAGE: NO INSURANCE WILL BECOME EFFECTIVE BEFORE THE DELIVERY AND ACCEPTANCE OF A POLICY OF INSURANCE UNLESS AND UNTIL EACH AND EVERY ONE OF THE FOLLOWING CONDITIONS IF [sic] FULFILLED EXACTLY:
 - (a) The amount of the premium deposit made with the application must be at least equal to the amount of the full first premium for the mode of payment selected in the application and for the plan and the amount of insurance applied for.
 - (b) All medical examinations, tests, x-rays and electrocardiograms required by the Underwriting Department of the Company must be completed and received at its Home Office in Montgomery, Alabama, within sixty (60) days from the date of completion of Part 1 of the application....
 - (c) The Company's Underwriting Department at its Home Office must be satisfied that on the Effective Date, as defined below, the Proposed Insured(s) ... was insurable at a risk acceptable to the Company under its rules, limits and standards for the amount applied for at the Company's standard published rates corresponding to the age of such person, without any modification either as to plan, amount, riders, supplemental agreements, and/or rate of premium.
 - (d) On the Effective Date, as defined below, the state of health and all factors affecting the insurability of the Proposed Insured ... must be as stated in the application.
2. EFFECTIVE DATE: When every one of the conditions contained in paragraph 1 have been fulfilled exactly and completely, then insurance, as provided by the terms and conditions of the policy applied for and in use by the Company on the Effective Date, but for an amount not exceeding that specified in paragraph 3, will become effective as of the Effective Date. "Effective Date," means the latest of (a) the date of completion of the application PART 1; (b) the date of completion of all

medical examinations, tests, x-rays, and electrocardiograms required by the Company; or (c) the Date of Issue, if any requested in the application.

3. LIMITS OF COVERAGE: The total amount of life insurance, including accidental death benefits, which may become effective prior to delivery and acceptance of a policy of insurance shall not exceed \$100,000.
4. RETURN OF THE DEPOSIT: If any one or more of the conditions in paragraph 1 have not been fulfilled exactly and completely there shall be no liability on the part of the Company except to return the premium deposit in exchange for this receipt. If the application is not accepted and approved by the Company within sixty (60) days from the date of this receipt, then no policy will be issued.
5. OFFER OF MODIFIED POLICY: If all of the conditions in paragraph 1 have not been fulfilled completely and exactly but the Company does accept and approve the application upon a modification as to plan, amount, premium rate and/or disallowance of any supplementary benefit applied for, the policy offered shall take effect as of the date which the Company offers to issue said policy, provided that the owner accepts delivery of the policy by paying the full first premium or balance thereof, and if required by the Company signs an Amendment of Application therefor, during the lifetime and continued insurability of the Proposed Insured ... according to the Company's standards, within sixty (60) days from the issue date of the policy.
6. NO AGENT, GENERAL OR SPECIAL, OR ANY OTHER PERSON IS AUTHORIZED BY THE COMPANY TO WAIVE OR MODIFY IN ANY WAY ANY OF THE CONDITIONS OR PROVISIONS CONTAINED IN THIS CONDITIONAL RECEIPT.

(Capitalization in original.)

The Alabama Supreme Court's Decision

The Alabama Supreme Court reversed.

In its decision, the court declared that it was "almost never reasonable for an individual to ignore the contents of documents given him or her in association with a transaction." (In *Potter v. First Real Estate Co.*, 844 So.2d 540 (Ala.2002), the court said that this general rule may be avoided when there have been misrepresentations regarding the contents of a document and there were special circumstances, a special relationship between the parties, or the plaintiff suffered from a disability rendering him or her unable to discern the contents of the document; none of those situations applied in this case, the court said.)

According to the court, the documents in this case "clearly apprised the Colzas that [Mr. Colza] was not guaranteed immediate coverage upon submitting his application for life insurance to [Mr.] Morris. By not reading the documents, they took a risk and put themselves in danger's way."

The court added that it did "not think it unreasonable to conclude as a matter of law that, in this day and age, any adult of sound mind capable of executing a contract necessarily has a conscious appreciation of the risk associated with ignoring documents containing essential terms and conditions related to the transaction that is the subject of the contract."

Thus, the court held, because the Colzas had put themselves "in danger's way" and had a "conscious appreciation of the danger" of suffering a monetary loss in the event Mr. Colza died before the conditions for immediate coverage were met, any negligent procurement claim was barred by the doctrine of contributory negligence.

Accordingly, the court concluded, Mr. Morris was entitled to judgment as a matter of law in his favor on Ms. Colza's negligent procurement claim based on the Colzas' contributory negligence.

The case is *Alfa Life Ins. Corp. v. Colza*, No. 1111415 (Ala. May 9, 2014).

FC&S Legal Comment

Courts are divided as to whether a plaintiff's contributory negligence can, as a matter of law, bar a recovery on a negligent procurement claim when the plaintiff failed to read documents that would have notified him or her regarding the extent of the insurance coverage that the defendant agent actually procured for him or her.

For example, in *General Insurance of Roanoke, Inc. v. Page*, 464 S.E.2d 343 (Va. 1995), an insured asserted a negligent procurement claim against his insurer and the agent who sold him a policy covering his business property and equipment after incurring a loss in a fire and discovering the insurance policy sold him by the agent did not cover approximately \$16,000 of that loss. In holding that the defendants were entitled to a judgment as a matter of law as a result of the insured's negligence in failing to read his insurance policy, the Supreme Court of Virginia stated:

The agent contends on appeal, as it did at trial, that [the insured's] failure to read the insurance policy constituted negligence, as a matter of law, and that such negligence proximately caused his losses and precluded recovery against it. While we previously have not decided the precise issue presented in the present case, we have held that one who signs an application for life insurance without reading the application or having someone read it to him is chargeable with notice of the application's contents and is bound thereby.... We also have held that the failure of a grantor to read a deed will not relieve him of obligations contained therein.... While the decisions cited are contract cases, we think the same rule should apply in negligence actions.

In the present case, [the agent] handed [the insured] the insurance policy that stated plainly on its face that the building was insured for \$20,000 and the personal property of others on the premises was insured for \$15,000. [The insured], however, never so much as looked at the insurance policy, but simply placed it in a desk drawer.

[The insured] testified that he has reading difficulties. [The insured] had a duty, nonetheless, to have his wife, who occasionally helped with business matters, or someone else read the policy to him if he could not read it. We conclude, therefore, that [the insured's] failure to read the policy or to have someone read it to him constitutes negligence as a matter of law that bars a recovery against the agent."

(Footnote omitted.)

See also *Dahlke v. John F. Zimmer Ins. Agency, Inc.*, 567 N.W.2d 548 (Neb. 1997) (affirming a judgment as a matter of law entered in favor of the defendant insurance agency and agent on the plaintiff's negligent procurement claim because "[the plaintiff's] failure to read the policy provisions insulates the insurance agent from liability"); *Keown v. Holman*, 234 S.E.2d 868 (S.C. 1977) (reversing a judgment entered on a jury verdict in favor of the plaintiff on his negligence claim against an insurance agent who failed to automatically renew a policy upon its expiration because the "plaintiff was contributorily negligent in not reading his policy [and] defendant's motion for a directed verdict should have been granted on this ground").

Some jurisdictions, however, instead have taken the position that an insured's failure to read an insurance policy might amount to contributory negligence barring a negligent procurement claim but that such failure does not constitute contributory negligence as a matter of law. The Supreme Court of Montana explained this view in *Fillinger v. Northwestern Agency, Inc.*, of Great Falls, 938 P.2d 1347 (Mont. 1997):

Under similar circumstances involving the relationship between the insured and their agent, several jurisdictions have held that while the insured's failure to read the policy may amount to contributory negligence, it does not operate as a bar to relief as a matter of law.... We are persuaded by the reasoning of this line of authority that an insured does not have an absolute duty to read their policy, but their failure to do so may amount to contributory negligence.

THE STATE SUPREME COURT INSURANCE COVERAGE CASE *Compendium*

INDEPENDENT EQUITABLE CAUSE OF ACTION FOR MEDICAL MONITORING IS REJECTED BY NEW YORK'S TOP COURT

January 8, 2014 Steven A. Meyerowitz, Esq., Director, FC&S Legal

New York's highest court, the New York Court of Appeals, has refused to recognize an independent equitable cause of action for medical monitoring.

The Case

The plaintiffs in this case, all over the age of 50, smoke or smoked Marlboro cigarettes with histories of 20 pack-years or more. (A "pack-year" is the equivalent of smoking one pack of Marlboro cigarettes a day for a year.) None of the plaintiffs has been diagnosed with lung cancer, and none currently are under investigation by a physician for suspected lung cancer.

The plaintiffs brought a putative class action against Philip Morris USA, Inc., in federal court, asserting claims sounding in negligence, strict liability, and breach of the implied warranty of merchantability. The plaintiffs requested equitable relief, namely, the creation of a court-supervised program, at Philip Morris' expense, that would provide them with Low Dose CT Scanning of the chest ("LDCT"), which the plaintiffs claimed was a type of medical monitoring that assisted in the early detection of lung cancer.

At the completion of discovery, the district court granted Philip Morris summary judgment with regard to the plaintiffs' negligence and strict liability claims, but ordered further briefing concerning the breach of implied warranty claim and on the issue of whether the New York Court of Appeals would recognize an independent cause of action for medical monitoring.

In the interim, the plaintiffs served a fourth amended complaint asserting, in addition to their prior causes of action, a separate, equitable cause of action for medical monitoring, seeking the establishment of the medical monitoring program. The district court dismissed the breach of implied warranty and medical monitoring claims, holding that although the New York Court of Appeals likely would recognize the latter claim, the plaintiffs had failed to plead that Philip Morris' allegedly tortious conduct was the reason that they had to secure a monitoring program that included LDCT scans.

The U.S. Court of Appeals for the Second Circuit affirmed the dismissal of the plaintiffs' negligence, strict liability, and breach of implied warranty claims, but, acknowledging that the New York Court of Appeals had not considered whether an independent cause of action for medical monitoring existed in New York, certified the following questions of law to the New York Court of Appeals:

- (1) Under New York Law, may a current or former longtime heavy smoker who has not been diagnosed with a smoking-related disease, and who is not under investigation by a physician for such a suspected disease, pursue an independent equitable cause of action for medical monitoring for such a disease?

- (2) If New York recognizes such an independent cause of action for medical monitoring,
- A. What are the elements of that cause of action?
 - B. What is the applicable statute of limitations, and when does that cause of action accrue?

The Decision by the New York Court of Appeals

The court answered the first certified question in the negative, and declined to answer the second certified question as academic.

In its decision, the court acknowledged that there were “significant policy reasons” that favored recognizing an independent medical monitoring cause of action. The court observed that there certainly was “an important health interest in fostering access to medical testing” for those whose exposure had resulted in an increased risk of disease, adding that medical testing “could lead to early detection and treatment, not only mitigating future illness but also reducing the cost to the tortfeasor.”

The court continued by noting, however, that “the potential systemic effects of creating a new, full-blown tort law cause of action” could “not be ignored.” For example, it said, dispensing with the requirement that a plaintiff demonstrate physical injury before being entitled to recover in tort could permit “tens of millions” of potential plaintiffs to recover monitoring costs, effectively flooding the courts while concomitantly depleting the purported tortfeasor’s resources for those who actually had sustained damage.

Moreover, the court said, it was “speculative, at best,” whether asymptomatic plaintiffs ever would contract a disease; allowing them to recover medical monitoring costs without first establishing physical injury “would lead to the inequitable diversion of money away from those who have actually sustained an injury as a result of the exposure.”

Finally, the court declared that, from a practical standpoint, there was “no framework concerning how such a medical monitoring program would be implemented and administered.” Courts generally lacked the technical expertise necessary to effectively administer a program heavily dependent on scientific disciplines such as medicine, chemistry, and environmental science, the court pointed out.

The court concluded that the legislature was “plainly in the better position to study the impact and consequences of creating such a cause of action, including the costs of implementation and the burden on the courts in adjudicating such claims.”

The case is *Caronia v. Philip Morris USA, Inc.* (N.Y. Dec. 17, 2013). Attorneys involved include: Victoria E. Phillips, for appellants; Kenneth J. Parsigian, for respondent; Product Liability Advisory Council, Inc.; American Chemistry Council et al.; Business Council of New York State, Inc., et al.; and American Legacy Foundation et al., amici curiae.

FC&S Legal Comment

State high courts are divided on whether an independent cause of action for medical monitoring should lie absent any allegation of present physical injury or damage to property. Some have refused to recognize such equitable claims for the imposition of court-supervised medical monitoring program absent such injury or harm (see *Henry v. The Dow Chem. Co.*, 701 N.W.2d 684 (Mich. 2005)(reaffirming “the principle that a plaintiff must demonstrate a present physical injury to person or property in addition to economic losses that result from that injury in order to recover under a negligence theory”); see also *Lowe v. Philip Morris USA, Inc.*, 183 P.3d 181 (Or. 2008)(“negligent conduct that results only in a significantly increased risk of future injury that requires medical monitoring does not give rise to a claim for negligence”)).

Others, however, have dispensed with the physical injury requirement and have recognized an independent medical monitoring cause of action (see *Donovan Philip Morris USA, Inc.*, 914 N.E.2d 891 (Mass. 2009)(concluding

that the cause of action is in tort, not equity); *Bower v. Westinghouse Elec. Corp.*, 522 S.E.2d 424 (W.Va. 1999) (holding that a plaintiff who does not allege a present physical injury may recover future medical monitoring costs); *Redland Soccer Club, Inc. v. Department of the Army and Dept. of Defense of the U.S.*, 696 A.2d 137 (Pa. 1997)(stating that the injury in a medical monitoring claim was an economic one); *Burns v. Jaquays Mining Corp.*, 752 P.2d 28 (Ariz. Ct. App. 1988)).

THE STATE SUPREME COURT INSURANCE COVERAGE CASE *Compendium*

MED MAL POLICY DID NOT COVER EXONERATED DEATH ROW INMATE'S CLAIM AGAINST PHYSICIAN WHO HAD TESTIFIED AT HIS TRIAL, MISSISSIPPI SUPREME COURT DECIDES

September 2, 2014 Steven A. Meyerowitz, Esq., Director, FC&S Legal

The Mississippi Supreme Court, affirming a lower court's decision, has ruled that the "clear and unambiguous language" of a medical malpractice insurance policy did not provide coverage for a claim brought against the insured physician by an exonerated death row inmate against whom the physician had testified in his criminal trial.

The Case

Kennedy Brewer was convicted of murder in large part due to Dr. Steven Hayne's expert testimony at his trial regarding Dr. Hayne's autopsy of the murder victim. Mr. Brewer served 15 years in prison – including seven years on death row – before he was exonerated on the basis of DNA evidence that excluded him as the murderer.

Mr. Brewer sued Dr. Hayne for malicious prosecution, fraud, and negligent misrepresentation. Dr. Hayne sought coverage for the suit under a medical malpractice insurance policy he had purchased from The Doctors Company and The Doctors Company Insurance Services (together, "The Doctors"). The Doctors declined to provide coverage, arguing that Mr. Brewer had not been a "patient" of Dr. Hayne's and that The Doctors, therefore, was under no obligation to cover Dr. Hayne with respect to Mr. Brewer's suit.

Dr. Hayne sued The Doctors, which moved for summary judgment. The trial court found that a lawsuit by an exonerated non-patient regarding testimony that Dr. Hayne had given as an expert witness did not fall within the policy's coverage. The dispute reached the Mississippi Supreme Court.

The Policy

The policy provided:

A. WHAT THE EXCHANGE WILL PAY

The Exchange will pay, on your behalf, all sums which you become legally obligated to pay for a claim but excluding any legal liability for punitive or exemplary damages or statutory or other fines.

The policy defined a "claim" as:

Written notice, demand, cross claim, lawsuit, an arbitration proceeding or screening panel, which is first reported to the Exchange during the policy period, which asserts a demand for money or that you should reduce your bill, which alleges injury, disability, sickness, disease, or death to a patient arising from your rendering or failing to render professional services subsequent to the retroactive date....

(Emphasis added.)

The Mississippi Supreme Court's Decision

The court affirmed.

In its decision, the court found that The Doctors had contracted with Dr. Hayne that it would pay for and defend him against a claim alleging that Dr. Hayne had injured a patient in rendering or failing to render professional services to a patient. The court pointed out that Mr. Brewer did not contend that Dr. Hayne had injured the human body upon which he had performed the autopsy or that the corpse on which the autopsy had been performed was Dr. Hayne's patient, or that he was Dr. Hayne's patient.

Because Mr. Brewer was not Dr. Hayne's patient, the "plain language of the policy" meant that the insurer was not obligated to defend Dr. Hayne in Mr. Brewer's lawsuit, the court held.

The case is *Hayne v. Doctors Co.*, No. 2013-CA-00252-SCT (Miss. Aug. 28, 2014). Attorneys involved include: Christopher Tyler Kent, John Michael Duncan, attorneys for appellant; Karen Korff Sawyer, William E. Whitfield, III, attorneys for appellees.

THE STATE SUPREME COURT INSURANCE COVERAGE CASE *Compendium*

WORKERS' COMP INSURER MAY FORCE EMPLOYEE TO SETTLE TORT ACTION, WISCONSIN SUPREME COURT RULES

July 24, 2014 Steven A. Meyerowitz, Esq., Director, FC&S Legal

The Wisconsin Supreme Court has ruled that a workers' compensation insurance company may compel an employee to accept a settlement offer in a tort action. The court rejected the employee's arguments that such a result violated his statutory rights under Wisconsin's workers' compensation law and his rights to a jury trial and due process.

The Case

Russell Adams sued Northland Equipment Company, Inc., and its insurance carrier, Cincinnati Insurance Company, for personal injuries he allegedly sustained while plowing snow for his employer, the Village of Fontana, Wisconsin. Northland offered \$200,000 to settle Mr. Adams' claim. The village's workers' compensation insurance carrier, League of Wisconsin Municipalities Mutual Insurance Company ("LWMMIC"), accepted Northland's offer and moved the trial court to compel Mr. Adams to accept it as well.

The trial court granted LWMMIC's motion.

An intermediate appellate court affirmed.

The dispute reached the Wisconsin Supreme Court, where Mr. Adams argued that the trial court had erred because a workers' compensation insurer could not compel an employee to accept settlement of a third party tort claim. He contended that Wis. Stat. § 102.29(1) could not be interpreted to permit the trial court to compel settlement because such an interpretation would violate his right to a jury trial under Article I, Section 5, of the Wisconsin Constitution. He also contended that the trial court's order violated procedural due process and was the product of an erroneous exercise of discretion because, among other things, the trial court had not conducted an evidentiary hearing.

Wisconsin Law

Wisconsin Stat. § 102.29(1) provides:

- (a) The making of a claim for compensation against an employer or compensation insurer for the injury or death of an employee shall not affect the right of the employee ... to make claim or maintain an action in tort against any other party for such injury or death, hereinafter referred to as a 3rd party; nor shall the making of a claim by any such person against a 3rd party for damages ... affect the right of the injured employee or the employee's dependents to recover compensation. An employer or compensation insurer that has paid or is obligated to pay a lawful claim under this chapter shall

have the same right to make claim or maintain an action in tort against any other party for such injury or death....

- (b) ... Each shall have an equal voice in the prosecution of the claim, and any disputes arising shall be passed upon by the court before whom the case is pending, and if no action is pending, then by a court of record or by the department.

Article I, Section 5 of the Wisconsin Constitution provides:

The right of trial by jury shall remain inviolate, and shall extend to all cases at law without regard to the amount in controversy; but a jury trial may be waived by the parties in all cases in the manner prescribed by law. Provided, however, that the legislature may, from time to time, by statute provide that a valid verdict, in civil cases, may be based on the votes of a specified number of the jury, not less than five-sixths thereof.

The Wisconsin Supreme Court's Decision

The court affirmed, concluding that a trial court may compel an employee to accept settlement of a workers' compensation claim.

In its decision, the court explained its conclusion by observing that, in such a claim, both the employee and the workers' compensation insurer shared the right to sue third parties; the employee and the workers' compensation insurer had an equal voice in the prosecution of the claim; recovery from the claim was apportioned in the manner described in Section 102.29(1)(b); and the trial court was empowered to resolve any disputes arising between the employee and the workers' compensation insurer during the prosecution of their claim, including those disputes involving settlement.

The court also found that its interpretation of Section 102.29(1) did not violate Mr. Adams' right to a jury trial because the claim Section 102.29(1) created was not the counterpart of a cause of action at law recognized at the time of the adoption of the Wisconsin Constitution.

The court also decided that the trial court's authority to compel an employee to accept settlement did not violate procedural due process because judicial resolution of disputes was part of the statutory claim.

Finally, the court concluded that the trial court appropriately had exercised its discretion by defining the dispute, taking stock of the relative positions of the parties, and considering matters that impacted the fairness of the settlement.

The case is *Adams v. Northland Equipment Co., Inc.*, No. 2012AP580 (Wisc. July 22, 2014). Attorneys involved include: For the plaintiff-appellant-petitioner, there were briefs by Thomas E. Greenwald, Rockford, and oral argument by Thomas E. Greenwald; For the defendants-respondents, Northland Equipment Company and Cincinnati Insurance Company, there was a brief by James M. Ryan, Dustin T. Woehl, and Kasdorf, Lewis & Swietlik, S.C., Milwaukee, and oral argument by James M. Ryan.

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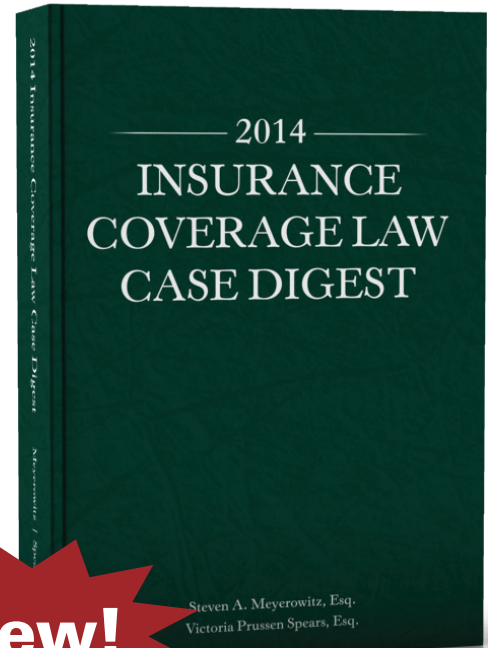
2014 Insurance Coverage Law Case Digest

By Steven A. Meyerowitz, Esq. and Victoria Prussen Spears, Esq.

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